USING CARE

How Can I Get the Most from My Plan?

You will get the best care if you:

Stay Informed

- Read your health insurance policy and member handbook. Make sure you understand them, especially the information on benefits, coverage, and limits. Sales materials or plan summaries cannot give you the full picture.
- See if your plan has a magazine or newsletter. It can be a good source of information on how the plan works and on important policies that affect your care.
- Talk to your health benefits officer at work to learn more about your policy.
- Ask how the plan will notify you of changes in the network of providers or covered services while you are part of the plan.

Take Charge

- Ask your doctor about regular screenings to check your health. Discuss your risk of getting certain conditions. What lifestyle choices and changes might you need to make to lower your risks or prevent illness?
- Ask questions and insist on clear answers.
- Ask about the risks and benefits of tests and treatments. Tell your doctor what you like and dislike about your choices for care.
- Make sure you understand and can follow the doctor's instructions. You may want to bring another person along or take notes to help you remember things.

Keep Track

- Write down your concerns. Start a health log of symptoms to help you better explain any health problems when you meet with your doctor.
- Set up health files for family members at home. This will help you to monitor care. Include health histories of shots, illnesses, treatments, and hospital visits. Ask for copies of lab results. Keep a list of your medicines, noting side effects and other problems (such as other drugs and foods that should not be taken at the same time).

Return to Table of Contents

How Do I Obtain Care?

Learning what you can expect from your health plan and how it works are key steps to getting the care you need. Ask these questions:

- When are the offices open? What if I need care after hours?
- How do I make appointments? How quickly can I expect to be seen for illness or for routine care?
- If I need lab tests, are they done in the doctor's office or will I be sent to a laboratory?
- Will most of my appointments be with the primary care doctor? Will nurse practitioners or physician's assistants sometimes give care as well?
- Is there an advice hotline? Some plans have toll-free phone services that help members decide how to handle a problem that may not require a doctor's visit.

Find out how your plan provides care outside the service area and what you must do to get care. This is especially important if you travel often, are away from home for long periods, or have family members away at school.

Return to Table of Contents

What if I Have to Go to the Hospital?

The time to find out what rules your plan has on hospital care is before you need it.

Planned Hospitalizations

Unless it is a medical emergency, your health plan or primary care doctor will probably have to give advance approval (preadmission certification) for you to go to the hospital. Otherwise, the cost of your hospital care may not be covered. Ask these questions:

- What hospitals are part of the plan network?
- Is there a limit on how long I can stay in the hospital?
- Who decides when I am to be discharged?
- Will needed followup care, such as nursing home or home health care, be covered by the plan?
- If I have a serious medical problem, will the plan provide someone to oversee care and make sure my needs are met?

Ask how your plan handles getting a second doctor's opinion on whether surgery or another treatment is needed. Are second opinions encouraged or required? Who pays?

Emergency or Urgent Care

If you have a true medical emergency, you should go to the nearest hospital as fast as possible. It is important for you to know what kind of medical problems are defined as emergencies and how to arrange for ambulance service, if needed. Most plans must be told within a certain time after emergency admission to a hospital. If the hospital is not part of the plan network, you may be transferred to a network hospital when your condition is stable. Ask these questions:

- How does the plan define "emergency care?" What conditions or injuries are considered emergencies?
- How does the plan handle "urgent care" after normal business hours? Urgent care is for problems that are not true emergencies but still need quick medical attention. Check with your plan to find out what it considers to be urgent care. Examples may include sore throats with fever, ear infections, and serious sprains. Call your primary care doctor or the plan's hotline for advice about what to do. The plan may also have urgent care centers for members.
- How do I get urgent care or hospital care if I am out of the area? How must I tell the plan and how soon after I get the care?

Return to Table of Contents

What if I Am Not Satisified with My Care?

Getting the best care and services means understanding how your health plan works, what your rights are, and how to complain if you need to.You have the right to get copies of test results as well as medical information about yourself. If you are in a managed care plan, you can ask to change your primary care doctor if you are unhappy with the relationship. You may also be able to switch plans during open enrollment.

Most plans have an appeals process that both you and your doctor may use if you disagree with the plan's decisions. If your plan refuses to provide or pay for services, you can complain or file a grievance about any decision you feel is unfair—or you can appeal it.

You can contact the member services division of your plan for more information or to complain. Use your plan's complaint process fully before taking other action.

Be sure to keep written records of:

- All correspondence with the plan.
- Claims forms and copies of bills.
- Phone conversations—the date and time, the people you speak with, and the nature of each call.

If the plan does not satisfy you, you may decide to bring the matter to the attention of your employee benefits manager, your State insurance commissioner, your State department of health, or the legal system. If you are a Medicare or Medicaid beneficiary, you have additional ways through those programs to file a grievance about the care received from a plan or provider. For information, contact your State's medical Peer Review Organization or State Medicaid Program.

Return to Table of Contents

Other Care Issues

Primary Care Doctors

Your primary care doctor will serve as your regular doctor, managing your care and working with you to make most of the medical decisions about your care as a patient. In many plans, care by specialists is only paid for if your are referred by your primary care doctor.

An HMO or a POS plan will provide you with a list of doctors from which you will choose your primary care doctor (usually a family physician, internists, obstetrician-gynecologist, or pedicatrician). This could mean you might have to choose a new primary care doctor if your current one does not belong to the plan.

PPOs allow members to use primary care doctors outside the PPO network (at a higher cost). Indemnity plans allow any doctor to be used.

Return to Table of Contents

Pre-Existing Conditions

A pre-existing condition is a medical condition diagnosed or treated before joining a new plan. In the past, health care given for a pre-existing condition often has not been covered for someone who joins a new plan until after a waiting period. However, a new law—called the Health Insurance Portability and Accountability Act—changes the rules.

Under the law, most of which goes into effect on July 1, 1997, a pre-existing condition will be covered without a waiting period when you join a new group plan if you have been insured the previous 12 months. This means that if you remain insured for 12 months or more, you will be able to go from one job to another, and your pre-existing condition will be covered—without additional waiting periods—even if you have a chronic illness.

If you have a pre-existing condition and have not been insured the previous 12 months before joining a new plan, the longest you will have to wait before you are covered for that condition is 12 months.

To find out how this new law affects you, check with either your employer benefits office or your health plan.

Return to Table of Contents

Tips on Choosing a Doctor

Your doctor will be your partner in care, so it is important to choose carefully from the doctors available to you. In some managed care plans, you will generally be limited to choosing from only certain doctors; in other plans, some doctors may be "preferred," which means they are part of a network and you will pay less if you use them. Ask your plan for a list or directory of providers. The plan may also offer other help in choosing.

You can ask doctors you know, medical societies, friends, family, and coworkers to recommend doctors. You may also contact hospitals and referral services about doctors in your area.

Once you have the names of doctors who interest you, make sure they are accepting new patients. Here's how to check doctors out:

- Ask plans and medical offices for information on their doctors' training and
  experience.
- Look up basic information about doctors in the Directory of Medical Specialists,

available at your local library. This reference has up-to-date professional and biographic information on about 400,000 practicing physicians.
- Use "AMA Physician Select," which is the American Medical Association's free service on the Internet for information about physicians (http://www.ama-assn.org).

You may also want to find out:

- Is the doctor board certified? Although all doctors must be licensed to practice medicine, some also are board certified. This means the doctor has completed several years of training in a specialty and passed an exam. Call the American Board of Medical Specialties at 800-776-2378 for more information.
- Have complaints been registered or disciplinary actions taken against the doctor? To find out, call your State Medical Licensing Board. Ask Directory Assistance for the phone number.
- Have complaints been registered with your State department of insurance? (Not all departments of insurance accept complaints.) Ask Directory Assistance for the phone number.

Once you have narrowed your search to a few doctors, you may want to set up "get acquainted" appointments with them. Ask what charge there might be for these visits, if any. Such appointments give you a chance to interview the doctors—for example, to find out if they have much experience with any health conditions you may have.

Return to Table of Contents

Sources of Additional Information

Many organizations have information that can help you understand your health care choices. Some helpful materials and contacts are listed.

General Information

"Checkup on Health Insurance Choices"
"Questions To Ask Your Doctor Before You Have Surgery"
Agency for Health Care Policy and Research
Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907
800-358-9295

"The Consumers Guide to Health Insurance"
Health Insurance Association of America

555 13th St. N.W., 600 East
Washington, DC 20004-1109
202-824-1600

"Guide to Health Insurance for People with Medicare"
"Your Medicare Handbook"
"Managed Care Plans"
Health Care Financing Administration
7500 Security Blvd.
Baltimore, MD 21244-1850
800-638-6833

"Putting Patients First"
National Health Council
1730 M St., NW, Suite 500
Washington, DC 20036-4505
202-785-3910

"Managed Care: An AARP Guide"
American Association of Retired Persons
611 E St., N.W.
Washington, DC 20049
202-434-2277

"Choosing Quality: Finding the Health Plan That's Right for You"
National Committee for Quality Assurance
2000 L St., N.W., Suite 500
Washington, DC 20036
800-839-6487

"Consumers' Guide to Health Plans"
Consumers' Checkbook
Center for the Study of Services
733 15th St., N.W., Suite 820
Washington, DC 20005
202-347-7283

Accreditation and Quality

Accreditation Association for Ambulatory Health Care; 9933 Lawler Ave.; Skokie, IL 60077-3708; 847-676-9610

Accredits outpatient health care settings such as ambulatory surgery centers, radiation oncology centers, and student health centers. Call for a list of accredited organizations.

Community Health Accreditation Program; 350 Hudson St.; New York, NY 10014; 800-669-1656, extension 242

Accredits community, home health, and hospice programs; public health departments; and nursing centers. Call for a list of accredited organizations.

Consumer Coalition for Quality Health Care; 1275 K Street, N.W.; Suite 602; Washington, DC 20005; 202-789-3606

A national, nonprofit organization of consumer groups advocating for consumer protections and quality assurance programs and policies. Call with general questions about quality issues or for consumer materials on managed care and activities at the State level.

Joint Commission on Accreditation of Healthcare Organizations; One Renaissance Blvd.; Oakbrook Terrace, IL 60181; 630-792-5000

Evaluates and accredits nearly 20,000 health care organizations and programs including almost 12,000 hospitals and home care organizations, and more than 7,000 other health care organizations that provide long term care, behavioral health care, laboratory and ambulatory care services. The Joint Commission also accredits health plans, integrated delivery networks, and other managed care entities. Visit Quality Check on the Joint Commission's Web site (http://www.jcaho.org) for more information on individual accredited organizations or for general information about assessing the quality of health care organizations.

National Committee for Quality Assurance; 2000 L St. N.W., Suite 500; Washington, DC 20036; 800-839-6487; Web Site: http://www.ncqa.org

Accredits HMOs and other managed care organizations. Call for the NCQA Accreditation Status List, Accreditation Summary Report, publications list, or for general information about quality.

Utilization Review Accreditation Commission; 1130 Connecticut Ave. N.W., Suite 450; Washington, DC 20036; 202-296-0120

Accredits PPOs and other managed care networks. Call for a list of accredited organizations.

Return to Table of Contents

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