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Empowering the managed Care Provider: Not as Easy as It Sounds

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Managed care remains one of the most highly publicized issues in employee benefits, with its accompanying controversy causing concern to the consumer and the employer. *The authors of this article discuss the very basic things consumers of health benefits should know about their plans in order to be prepared, as well as what they should reasonably expect from employers that sponsor the plans.*

Managed health care is a big issue. It is as big as the share of gross domestic product accounted for by health (nearly 13%); the share of employees and their dependents who are enrolled in managed care plans (nearly everybody with coverage if nearly all plans with managed care features a are included); or the proportion of federal and sate budgets devoted to health care programs (19% and 15%, respectively).

But managed care is also a small issue. It can be as small as the extra distance a patient may have to travel to reach a provider participating in his plan; the cry of a child that makes a parent wonder whether to visit the emergency room; or the question a seriously ill patient wants to ask her doctor.

Managed care can even be as small as a single word: pre-certification and referral are two that come to mind.

We wrote *The Complete Idiot's Guide to Managed Health Care*™ (Korczyk and Witte 1998) to deal with these "small" issues. Consumers are struggling with a new system (providers and networks rather than doctors and hospitals); new rules (choosing a gatekeeper physician, obtaining precertification and referrals); and new penalties for not following the rules (referrals, once a mere doctor-to- doctor courtesy, can now determine whether the patient can be seen at all). Making the transition from a passive patient to an active consumer is no small task, and we don't see anyone else helping them do it.

We took no stance for or against managed care. We treated it like the weather-complain all you want, it just is.

While our book is written in the breezy, accessible style characteristics of the series of which it is a part, it is based on extensive interviews and solid research about what consumers and providers need to know-and often don't. Below we explain a baker's dozen of the most important things we found, the issues that can make the difference between smooth functioning and near-complete disaster in the typical consumer's encounter with the health care system. Some items on this list may surprise some readers, but we have solid evidence behind every concern. By finding ways to help consumers understand these and other concepts, employers, plans, health care providers and regulators can help make both

managed care and the health care system as a whole work better for everyone.

Manager Care By Any Other Name

Consumers should know what type of plan they are enrolled in and how the type of plan they choose will affect their care. Many don't know, however, and it may not always be their fault.

One problem in identifying plan types can be names. In our experience, every plan is "select," "optimum" or "choice" these days - the name may have little or nothing to do with whether the plan is a fee-for-service plan, a managed care plan or a hybrid arrangement.

But even if the consumer identifies the plan correctly, the type of plan may not indicate how it works. The tools of managed care have spread far beyond standard managed health care plans - nearly all participants are in plans that use at least some of these tools. Our sources told us that some large fee for - service - plans are more tightly managed than some small health maintenance organizations such as (HMOs).

We recommend that, before enrolling, our readers carefully examine all plan materials, including any plan report cards that may be supplied. Such statements describe the type of care that plans provides (how likely members are to receive health screenings, for example) and how happy other people in that plan have been. If, after exercising due diligence in plan choice, the plan member is not satisfied, we recommend taking advantage of open season if available. If the employer does not offer open season, we suggest making a careful and reasoned presentation to the employer. After all, the employer is providing this plan in part to compete for better employees, so it should be concerned about employees' appreciation of the services provided (but see more on employers below).

Who's Who: Is The Plan, The Insurer Or The Employer Responsible?

If you have car insurance with, say, Allstate, you can call the company from anywhere in the United States and the person who answers will be able to figure out what payments you are entitled to in the event of an accident. But many consumers don't understand that you can't call the insurance company whose name is on an employer-sponsored plan to find out what to do if you need treatment. The company may offer hundreds of plans, all different in each state for each employer.

This conclusion is exacerbated when the person trying to obtain care for the member is not the one insured. In one case a non-custodial parent was trying to get care for her son during his summer visit. Since she only knew the name of the insurance company offering the plan under which the son was covered, and nothing about the plan or its provisions, she was understandably frustrated in trying to obtain care for him (more on family issues below). The growing number of adult children trying to obtain care for elderly parents - often in distant cities - should be alerted to similar problems.

Employees especially should be able to sort out identities and responsibilities when things are changing in their workplace. If their firm merges with or is acquired by another, declares bankruptcy, or even just changes plans, coverages and benefits could change. Either the employer, the plan or both could be responsible for informing the consumer about these changes. If in doubt, employees should ask, and ask for written confirmation of reassuring responses.

Choosing A Doctor

One of the more difficult issues in managed care can be the provider network -who's in, who's out and how to obtain care from a non -network provider. Today, nearly all hospitals and physicians participate in at least some managed care programs, and many plans have broad provider coverage within the communities they serve.
But no plan enrolls all the providers in its area. In addition, plans can drop doctors, and doctors can drop plans. We counsel our readers to be alert for changes in plan affiliation among their providers, asking even before every appointment to avoid unpleasant surprises.

Preferred provider organizations (PPOs) and plans with point-of-service (POS) options make it easy for a member to consult a non-network provider. The option to do so can be attractive to consumers with established physician relationships. But what if serious illness strikes and the bills that are reimbursed at a lower rate - or not at all - start to mount? Consumers who make the choice to bypass their network providers also need to ask what their plan will pay if a non-network physician orders a hospital stay or surgery. Some plans may not pay at all. Of course, the consumer can change to a network provider upon receiving a serious diagnosis. But such a change would mean forging a new provider relationship just when the stakes are the highest - not necessarily the approach guaranteed to bring the consumer the best medical results.

The freedom of provider choice many plans offer could thus turn out to be very expensive. We urge our readers to give their network providers a close look.

Times Have Changed: The Impact Of Managed Care On The Medical Office

Long, long years of conditioning have bred a hardy type of patient -the type who is still willing to wait hours for a doctor who is running late. Amazingly, doctors don't treasure these patients, though they should.

We don't believe patients should settle for a badly managed office (translation: Don't wait). By putting pressure on physicians' incomes, managed care plans have put a premium on good office management. A well-managed office schedules patients efficiently and sees them promptly. Emergencies will arise, as will schedule back up, but the office staff should explain delays promptly and offer to reschedule if the delay is substantial or the patient is unable to wait.

Patients who face repeated unexplained delays when arriving promptly for a scheduled appointment are in a dangerous office. Bad office management is seldom limited to the waiting room. A badly managed office will also have submitting insurance claims properly, causing patients to spend hours straitening out their bills or overpay for their health care just to get the bills settled. And patients who are not scared off by wasting time and money should remember this -to the doctors, office that all important mammogram report or prostate screening test is just another piece of paper. A staff that can't handle the paperwork that determines how it gets paid certainly won't be able to handle the paperwork that determines the patient's medical future.

Some experts advise mentioning front office problems to the doctor, especially if the problems are recent or the patient has been seeing the doctor for a long time. But we believe the doctor probably already knows, at least in serious cases (his paycheck is affected, too) and either doesn't care or doesn't know what to do.

Words Never To Use

No, this advice is not about language to use in polite company, but about words that can jeopardize a patient's rights and foreclose health care options. Two words no health care plan member should ever use are lawyer and experimental.

There may come a time when a deadlock with a health care plan seems unbreakable. Maybe the babysitter took a child to the emergency room for a non emergency condition or didn't get the right authorizations once she got there. Maybe an employee got sick out of town and wasn't sure he could wait to have surgery until he got home and could see a net work provider (true story). Whatever the cause, there is a bill the size of a mortgage payment on the table and no one seems to be taking responsibility for it.

Time to call the plan's member service office or the employer's human resources office and threaten legal action, right?

Wrong.

Sometimes, the only way to resolve a health care plan dispute is to hire an experienced attorney. But that is the members private business. Threatening the plan's member services office with a lawsuit or making threats to one's employer's human resources staffers can endanger even a legitimate complaint. Threats can close off the flow of information to which the aggrieved plan member may be legally entitled. And HR staff people are employees, too. Threatening the plan or the firm with legal action - whether justifiable or not -can force colleagues to choose between the complainant and their loyalty to their employer. Employees should not be surprised if years of collegiality on the company softball team take a back seat to colleagues' concerns about their job.

Another word plan members should expunge from their vocabularies -but often don't -is

experimental. Here is where the file of plan documents we advise our readers to keep comes in especially handy. Many plans flatly exclude experimental procedures from coverage (some have exceptions for promising treatments or very seriously ill patients). A patient who wants coverage, need to convince the plan that the treatment is encompassed within the plan's legal language.

Informed consent forms are especially important here. A patient who signs an informed consent form agreeing to an experimental treatment may find it difficult, if not impossible, to recover treatment costs from his or her health plan.

Privacy Issues

Poll after poll tells us that Americans are concerned about their privacy, whether from telemarketers, business or government. Yet in the health care area, consumers can perpetrate some of the most egregious abuses of their own privacy if they are not careful. In fact, sometimes they are even advised to do so!

Many people assume that the employer sponsoring their health care plan will be their first defense when plan problems strike. So, implicitly, the complexity of the plan or the attendant bureaucracy doesn't matter -better minds will work it out for the afflicted consumer.

The employer can be helpful, but only to a limited extent. Our sources told us the employer should be involved primarily if the plan is violating its contractual terms. Suppose the employee is being charged $10 per doctor visit while the plan provides for a $5 charge. The employer should resolve the discrepancy; or the member is having trouble getting confirmation of coverage (this can happen if the company has just changed plans), the employer should step in.

But the employer usually won't step into routine billing disputes. And the consumer who wants coverage of a leading -edge treatment should definitely not expect support from the employer. As one corporate executive we interviewed for our book told us, the company's self insured plan (if the company offers more than one plan) probably doesn't cover the treatment either. The company therefore won't support the consumer in obtaining treatment that it has

to decide before a crisis strikes.

While millions of people in the United States lack health care coverage, sometimes the problem can be an embarrassment of riches. In one case, a pregnant wife changed jobs, acquiring coverage in her own name during the pregnancy. Not understanding that her coverage then became primary for her care, she continued to use her husband's coverage for the remainder of the pregnancy and the delivery. When the family reached the hospital checkout desk, they were surprised to find that neither plan was proposing to take financial responsibility for the blessed event. Families with multiple sources of coverage need to understand when primary coverage pays and when secondary coverage does.

We advise our readers to couple every life change with a reassessment of their health care coverage (before deciding on a honeymoon spot, the color for the nursery, the right college, the divorce lawyer, or a retirement haven). We know they won't do it but we advise it.

You Never Loose Your Right To Call 911

Emergency care was an Achilles' heel of the pre-managed care of the health care system. To many people used ER's expensive resources for non-emergency care, resulting in both higher health care cost and lower health care quality. After all, the ER staff doesn't know the patient or his medical history and shouldn't treat chronic or non-emergency conditions.

But sometimes consumers may go to the opposite extreme. When a consumer enrolls in a health care plan, he or she agrees to follow the plan's rules. These plans can include using only network hospitals. But consumers don't always understand the rules are different for emergencies.

George Anders recounts a tragedy that resulted from such a misunderstanding. Parents of a critically ill newborn traveled a lengthy distance to a network hospital -passing several other hospitals along the way -while their child's condition got ever more serious (Anders1996). They did not understand that they could have called 911 or stopped at any of the hospitals they passed. Most plans require only that the patient be transferred to a network hospital once stabilized. The child survived but was permanently handicapped.

An emergency is not the moment when people want to read their plan documents to understand their rights in detail. We urge our readers to do that before a crisis strikes. But in a true emergency, we urge them to respond to the crisis first.

You Never Loose Your Right To Use Your Common Sense

This rule is the corollary to the rule immediately above, but has a broader application. One attorney with an extensive practice challenging insurance company benefit denials told us that he is astounded at the number of affluent clients who are unwilling to pay for a second opinion in the event of a serious illness or injury if their plan does not do so. Second -and

even third -opinions differ from the first opinion an astounding percent of the time, and patients faced with a serious diagnosis can benefit from the information such opinions can provide.

Patients who need a specialist referral but can't get it from the plan are also not without alternatives. It is not uncommon to hear of patients who believe they have a problem. It is not uncommon to hear of patients who believe that they have a problem that their plan's providers can't find and won't refer to an outside provider to diagnose. These patient often don't know -but should -that even if a non-network provider diagnose a medical problem, the plan is typically required, by it's terms to treat them for it. At most, the member is out the cost of the initial visit to obtain the diagnosis. We urge our readers to calculate what they save by enrolling in a managed care plan (and we show them how). Set this money aside and then draw on it for exactly these times.

Watch out for the Irrevocable Error

Plan Members can seek forgiveness from their spouse, family, friends or Supreme Being -but not from their health care plan. We devote a great deal of time in our book advising readers how to trouble shoot health plan problems, but there are some that can defy troubleshooting. These are the irrevo- cable errors. Here are a few of the ones we identified:
Members who don't request pre-certification for a procedure if a plan requires it -even if the patient expects the re-certification to be turned down. Missing this step can make it impossible for the patient to recover treatment costs later.

Employees who fail to enroll in a new employer's plan as soon as they are eligible
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the ability of plans to restrict coverage for conditions that were treated prior to the patient's enrollment in the plan. But an employee who fails to enroll in the plan as soon as she is eligible can be required to wait up to 18 months before preexisting conditions are covered.

Members who do not enroll a new dependent within a plan's prescribed time window
This time window is usually 30 days after the consumer marries, adopts or gives birth to the depen-dent. After this period, the dependent will have to wait for coverage of any preexisting conditions.

Members who miss deadlines for enrolling in or maintaining COBRA continuation health care coverage

Coverage under COBRA (consolidated Omnibus Budget Reconciliation Act of 1985) can plug coverage gaps that occur under a variety of circumstances. But consumers wishing to continue their health care coverage after they are no longer eligible to participate in a group plan have a number of deadlines to observe. And we found that many company plans, even large ones, make serious errors in administering COBRA coverage. Therefore, we urge

readers to know not just what they need to do but also what the company or the plan needs to do under the law. The U.S. Department of Labor offers free leaflets is also a useful source of information.

“I’m Mad As Hell…”

William Holden could stick his head out the window in a movie Network and yell, “I’m mad as hell and “I’m not going t o take it anymore!” But this won’t work when the consumer and the provider or plan disagree.

Most people have no idea what to do next. We outline a range of options in our book. One is to ask the doctor in the network (even tightly controlled plans such as staff model HMOs will allow this). We also explain appeals, grievances and arbitration -and suggest that the consumer be represented by an attorney any time the other side will be. Yet another option - best to use in a serious, life-threatning emergency when nothing else is working -is hiring an attorney and going straight to court.
We found this material hard to write in our book -it threatened to become a legal treatise -and we had to dig to get the information. It’s not neatly set out in the plan documents. So that is why you hear about a family appealing a denial of treatment to its plan member services department (true story, and not the right place).

There are Rules, And Then There Are Rules

Every generalization has its exception. Suppose a cancer patient has six weeks after surgery to make a decision about subsequent treatment -but the plan has turned down the initial request and wants 90 days to rule on an appeal (legislation pending in Congress as we write this would provide expedited appeals for serious cases). Suppose a treatment request has been turned down, and the patient has been told by the plan administrator or other responsible party that it will never be approved.
Members don’t have to follow plan rules at the expense of their health or lives. In an emergency (the cancer case would qualify) or if the patient believes appealing the treatment decision is futile, the patient may not have to exhaust all administrative remedies before going to court. But this should only be done with the advice of an experienced attorney, preferably one with a record for winning not only cases but also attorney fees.

When Too Much Is Enough

Most of the public discussion about managed care plans, especially in the media, revolves around delays or denials of care. After all, denials are inherent in the basic philosophy of managed care that is duplicative, harmful or unnecessary.

But few people will be prepared for the possibility that patients can be over treated in managed are plans just as in the days before utilization review became a household word. One reason can be financial. With some high-profit surgeries -hysterectomies are one

example -doctors told us of their belief that some managed acre plans select participating physicians because they are willing to recommend surgery.

But another reason is simply this -all physicians, whether they participate in managed care plans or not, tend to be guided by similar training, standards and beliefs. Usually a treatment becomes the “gold standard” for a condition because it works -patients get better. But “gold standards” change over time and, as research has found, can vary greatly from community to community and region to region. So any patient faced with a recommendation for surgery should ask hard questions and do a little research, even in a managed care plan.

Conclusion

Consumers must be prepared to make good decisions in every encounter with the health care system. This article represents a compendium of some of the most important things that consumers don’t know but should to make the best use of there managed care plan (though much of the advice applies to all plans). There’s a lot more, including (but not limited to) consulting specialists; consulting specialists; deciding whether to and when to participate in a clinical trial; and taking charge of one’s own health care through appropriate use of preventive care, second opinions and one’s own research.

We believe that consumers who understand even just this list will be better able to navigate the world of managed care to the benefit of their health and pocketbooks. And in the end, that is what managed care is really about.

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