HealthShop

Your Health Plan

Issue Highlights

In-network vs. Out-of-network Providers

The term “in-network” refers to using a health care provider who participates in your health plan’s provider network. Many health plans structure their benefits to encourage members to use providers who are in-network to help ensure continuity of care and reduce members’ out-of-pocket expenses. Using these in-network providers saves you and your health plan money; these physicians have agreed to provide services to the health plan’s members at a reduced rate.

The term “out-of-network” refers to using health care providers who do not participate in your health plan’s provider network—meaning they have no formal agreement to

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Managed Care 101

The health care system in the United States can be confusing and complex. By knowing how to navigate this increasingly intricate system, you can make more informed decisions and ultimately receive better care.

Historically, the U.S. health care system consisted of a large number of independent health care providers who owned their own practices. These were either solo practices or joint practices owned by multiple physicians who practiced together in a group setting. In addition, most communities had independent, nonprofit hospitals.

As the managed care philosophy began to take hold of the health care system, physicians, hospitals and other health care providers became contractually grouped into networks. When providers join a network, they agree to provide care to health plan members at fees established by the network. In general, managed care differs from traditional health care in the following ways:

Selecting a Provider – With traditional insurance, consumers can choose any physician they want, including specialists. Managed care plans require members to choose a physician from the in-network list they are given.

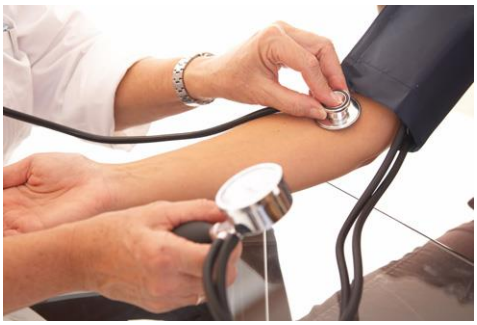
Quality of Care – Traditional insurance holds consumers responsible for determining if their provider is qualified to provide the kind of care they need. Managed care plans usually assess a physician’s qualifications before he or she can join the network. These plans also conduct regular patient surveys and monitor clinical outcomes.

Paying for Care – Under a traditional insurance plan, providers are paid on a “fee-for-service” basis, meaning that the insurance company pays the provider for each appointment or service. Typically, the patient pays up front and the insurance company later reimburses. Managed care plans pay providers in a variety of ways. The central tenet is that managed care payment practices do not encourage providers to perform unnecessary tests or overly expensive procedures. Managed care also encourages patients to focus on preventive care and to maintain a healthy lifestyle. ◊

How Does Managed Care Control Costs?

Managed care plans employ a variety of strategies to control health care costs. These strategies vary by organization and type of health plan.

Managed care plans have become the predominant model for health insurance in America. While the system has managed to deliver some measure of cost savings over the traditional fee-for-service model, the health care system overall is still challenged by rising costs.



Critics of managed care are also quick to point out several disadvantages of the system. In extreme cases, it has limited the services and providers available to patients.

In addition, managed care has provided no help for the ailments of millions of Americans who are without health coverage, or those in rural areas where the population and risk pool are too small to allow a managed care plan to operate successfully.

Managed care plans are believed to be responsible for the growing emphasis on individuals taking responsibility for their own health care and making wiser choices based on the cost of care.

Some common ways that managed care plans attempt to reduce costs are:

- ✓ Contracting with providers to provide care for a certain volume of members at reduced rates.
- ✓ Sharing with providers the financial risk of providing care.
- ✓ Setting criteria for selecting providers and establishing provider networks.
- ✓ Establishing programs that monitor the amount and quality of care being administered (utilization review).
- ✓ Focusing on preventive care and health promotion in order to reduce the incidence of disease and the costs associated with treating it. ◊

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Using In-network vs. Out-of-network Providers provide services to the plan's members at a specified cost. Most health maintenance organizations (HMOs) provide limited or no coverage for services from out-of-network providers except for in emergency situations. Most preferred provider organizations (PPOs) or point-of-service plans (POS plans) provide coverage for out-of-network providers, but members usually pay additional out-of-pocket expenses. ◊

Health Care Terms You Should Know

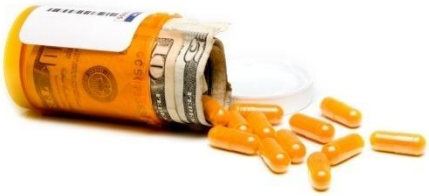
Coinsurance – The money that an individual is required to pay for services after a deductible has been paid; often a specified percentage of the charges.

Copayment – An arrangement where an individual pays a specified amount for various services and the health plan pays the remainder. The copayment usually needs to be paid at the time of service, and is most often a specific dollar amount.

Exclusions and limitations – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

Medically necessary – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Most health plans will only pay for treatment deemed medically necessary.

Out-of-pocket maximum – The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services for the rest of that calendar year. ◊



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