

# Managed Care in South Florida

## A Consumer's Guide



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## Introduction

The Health Council of South Florida, Inc. is pleased to present this *“Managed Care in South Florida -- A Consumer’s Guide.”* As part of our ongoing mission of education and advocacy, the Health Council of South Florida, Inc. has published this guide to assist you in better understanding managed health care in Miami-Dade and Monroe Counties, District XI. We believe that an educated consumer is the most effective force in bringing forth valuable changes to health care and in improving its quality.

*“Managed Care in South Florida - A Consumer’s Guide”* is designed to assist YOU, the South Florida health care consumer, to “navigate” the complicated and often confusing “waters” of managed care coverage options. The Guide addresses the following key areas:

- ◆ South Florida Trends in Managed Care
- ◆ Available Health Plan Choices
- ◆ Plan Selection and Usage
- ◆ Quality and Evaluation
- ◆ Miami-Dade Health Plan Statistics
- ◆ Current Issues in Managed Care
- ◆ Special Populations and Managed Care Issues

## What is Managed Care?

Managed Care is a general term used to describe the various ways physicians, hospitals and other health care providers have organized into health care delivery networks with the goal of better managing cost, quality and access to care. Prior to managed care, the most common system was “fee-for-service” whereby physicians and hospitals were reimbursed based on their charges for services. Under this model, patients could choose any doctor and/or hospital they wanted, and health care providers were free to perform as many services or tests as they thought necessary without being monitored. Over the years, the fee-for-service system led to escalating health care costs and over-utilization of resources, which resulted in the need for a more structured, cost efficient approach to health services delivery.

There are many types of managed care organizations or health plans. This guide discusses the major types of health plans including • Health Maintenance Organizations (HMOs), • Preferred Provider Organizations (PPO’s), and • Point of Service (POS) plans.

## **What Does “Managed Care” Mean to You?**

There is a variety of managed care plans from which you can choose to cover your health care needs and the needs of your family. The main types of health insurance coverage are: Indemnity insurance or traditional health plans; Health Maintenance Organizations (HMOs); Preferred Provider Organizations (PPOs); and Point of Service (POS) plans.

### **Indemnity Coverage (Traditional Health Insurance)**

Traditional insurance is still common. Usually, you pay a monthly premium to the insurance company for the selected plan. As the subscriber or “insured,” you have complete freedom of choice when selecting a provider. The insurance company pays all or a portion of the bill directly to the provider or to you. The insurance plan's primary function is to pay the bill. The company does not choose the physician. The insurance company will pay based on actual charges or on a "usual, customary and reasonable" schedule, which may be less than or more than the actual charge. You are responsible for any deductibles, co-payments, co-insurance, or charges in excess of usual, customary and reasonable amounts.

### **Health Maintenance Organizations (HMOs)**

Health Maintenance Organizations have increased in popularity over the past decade or so. According to the Federal HMO Act, an entity must be an organized system for providing health care or otherwise assuring health care delivery to a geographic area, have an agreed upon set of basic and supplemental health maintenance and treatment services, and have a voluntarily enrolled group of people in order to call itself an HMO. Under an HMO plan, you pay a monthly premium. You then select doctors or providers from a list provided to you by the HMO. The HMO will assume responsibility for any medical expenses, provided that you use the medical professionals and facilities on the list. The HMO may deny benefits if you use a doctor or hospital outside the HMO without proper approval. If this is the case, you are responsible for payment of the medical bills.

Upon joining an HMO you must ordinarily choose a primary care physician (PCP). This is the doctor who will oversee your medical treatments and referrals to specialists. Therefore, you need to consult the primary care physician first, every time a health-related problem occurs. Normally, you are not able to see a specialist unless your PCP has approved the visit.

### **Preferred Provider Organizations (PPOs)**

The Preferred Provider Organization (PPO) also requires the payment of a premium. By choosing a doctor who participates in the PPO, you will pay less out-of-pocket for care. In contrast to an HMO, you have a choice of providers. You can choose an out-of-network provider for an additional payment.

## **Point of Service (POS)**

Point of Service (POS) plans also offer you out-of-network benefits. Like the PPO, if you seek care outside of the POS network, you increase your financial responsibility. Unlike the PPO, a POS plan provides you with the following three choices:

- ◆ Seek care through the PCP for full HMO coverage;
- ◆ Seek care within the network, but without a referral; or
- ◆ Seek care outside of the network without a referral.

If as a POS member you choose to bypass the health plan's guidelines, you are responsible for an increased portion of the bill (deductibles and coinsurance). If you wish to directly self-refer to a specialist without seeking a referral from the PCP, you are subject to reduced reimbursement by the health plan and in turn, increase your financial responsibility, even within the designated provider network. Finally, you have some limited coverage outside of the provider network, but you are responsible for a larger portion.

## How Do HMOs and PPOs Compare?

HMOs, PPOs, and POSs are different in terms of benefits, out of pocket costs, freedom of choice, access to specialty care and the paperwork involved. The following table outlines the differences of each plan and compares each of these managed care options to traditional/indemnity health insurance:

**A Comparison of HMOs, PPOs, POSs, and  
Traditional/Indemnity Insurance Plans by Key Features**

	<b>HMO</b>	<b>PPO</b>	<b>POS</b>	<b>Traditional/ Indemnity</b>
<b>Provider Selection</b>	Generally, you must use doctors and hospitals that are part of the plan or “network.” Coverage is limited to that network.	You can choose providers outside the network if you prefer. Reimbursement will be at a lower percentage.	In network same as HMO. Out of network same as traditional.	There are no restrictions on your choice of doctor or hospital.
<b>Access to Specialists</b>	In most cases, you must get approval from your Primary Care Physician (PCP) to see a specialist unless your plan has an “open access” policy for specialty care.	In general, you do not need approval to see a specialist. However, if the specialist you choose is not a provider on your health plan or network, reimbursement will be lower.	In network same as HMO. Out of network same as traditional.	You can see a specialist without prior approval.
<b>Benefits</b>	Comprehensive benefits may include prescription drugs, dental and vision care, preventive care services such as health classes on nutrition, weight loss and smoking cessation.	Typically less comprehensive than HMO. Benefits may be somewhat more comprehensive in the network, including preventive care. In general, do not cover health education classes.	In network same as HMO. Out of network same as traditional, usually with some additional exclusions and limitations (e.g. limits on transplant and mental health services)	Benefits may be less comprehensive and typically do not include preventive care or health education classes.
<b>Maximum Lifetime Benefits</b>	Typically unlimited.	Usually limited to a fixed amount. For example, \$1 million, \$2 million, \$5 million.	In network same as HMO. Out of network same as traditional.	Same as PPO.

**A Comparison of HMOs, PPOs, POSs, and  
Traditional/Indemnity Insurance Plans by Key Features (continued)**

	<b>HMO</b>	<b>PPO</b>	<b>POS</b>	<b>Traditional/ Indemnity</b>
<b>Paperwork</b>	No claims to file except for emergency treatment.	In the network, you have little paperwork. Outside the network, you pay the bill, then submit the claim to your health plan for reimbursement. Some providers may accept assignment of benefits (i.e. they bill the insurance company directly).	In network same as HMO. Out of network same as traditional.	In general, you pay your own medical bills, then submit a claim form to your insurance company for reimbursement. Some providers may accept assignment of benefits (i.e. they bill the insurance company directly).
<b>Annual Premiums</b>	Tend to be lower.	Tend to fall in between the HMO and traditional options.	Tend to fall in between the HMO and PPO.	Tend to be higher.
<b>Deductible and/or Cost Sharing</b>	No annual deductible required. You pay a fixed copayment for each service. For example, typical copayments for a physician office visit range from \$0 to \$20; for hospitalization, from \$0 to \$1,500.	Two patterns: (a) fixed copayment for network physician visit and/or prescription, with deductible and co-insurance for all other services; or (b) deductible and co-insurance for all services. Coinsurance percentage is higher out of network.  <i>Note: Refer to the Traditional/Indemnity column for more information on deductible, co-insurance, insurer's fee scales, and balance billing..</i>	In network same as HMO. Out of network same as traditional.	Coverage does not begin until you pay annual deductible, which can vary from \$250 to \$10,000. Thereafter, you pay coinsurance based on a percentage of charges, which can vary from 10% to 50%, until a cap is met (the "out-of-pocket").  Insurer's fee scales vary from a set amount per service ("scheduled plan") to "90 <sup>th</sup> percentile UCR" (acceptable as full payment to 90% of physicians).  You may be responsible for the balance if your doctor charges more than the amount your insurance company pays.

*Source: ACC Hall International, Inc.<sup>1</sup>*

<sup>1</sup> ACC Hall International, Inc. specializes in U.S. and global insurance coverage for medical, dental, life, disability and retirement plans.

## **How Do You Pay for Your Health Plan?**

### **Premium**

A premium is the required periodic payment to the insurance company to keep the policy in effect. Normally, premiums are due monthly. When your employer sponsors or pays for your health insurance, it pays your premium in whole or in part. You are usually responsible for paying the premium for your family members.

### **Co-insurance**

Traditional/indemnity insurance policies require that you share in the cost of health care services. This sharing of health care costs, or co-insurance, is normally a certain percentage of the total cost of a treatment or procedure. Your insurance company will specify the amount. For example, the insurance company may require you to pay co-insurance of 20 percent for a visit to the doctor. If that visit costs a total of \$100, then \$20 will be the co-insurance amount. The insurance company will pay the remaining \$80.

Some types of policies require a co-payment of a specific dollar amount to receive health care services. Under most policies with a co-payment feature, the amount of the co-payment is usually between \$10 and \$20. For example, if the co-payment is \$10, you will need to pay \$10 for each doctor visit. It is important to note that, according to your provider's contract with the health plan, you cannot be charged by a participating provider any amount in excess of the copayment for any covered service or treatment.

### **Deductible**

Certain types of health insurance policies require that you pay a deductible. A deductible is the amount of money paid out-of-pocket by you before the insurance company begins paying for health care services. For instance, for an insurance policy with a \$250 deductible, you must pay \$250 from your own funds before the insurance company will begin paying its share.

## **Paying for Health Care with an HMO or PPO**

### **HMO**

Let us take Neil and his situation as an example. Under his HMO plan, Neil pays a monthly premium of \$180 and he has no annual deductible. Neil's HMO provides him with a list of participating providers from which he chooses a primary care physician. He must also use the hospitals that are part of the plan or "network." When Neil sees his primary care physician, (PCP) he pays a fixed copayment for each visit, usually \$5 to \$15 depending on the health plan. If Neil needs to see a specialist, he must obtain a referral from his PCP and pay a fixed copayment for each visit to his specialist, usually \$10 to \$20 depending on the health plan. Neil's physician bills are covered by his health plan.

## **PPO**

Let us take Neil and his situation as an example. Under his PPO plan, Neil has a \$100 deductible with an out-of-pocket limit of \$1,000. Neil visits a physician, whom he has selected from a list of participating providers. Because he has chosen a participating provider, Neil's co-insurance is 20 percent, until he has paid \$1,000 out of pocket. He must continue seeing his PCP for ongoing treatment of a medical condition. Neil has not yet paid into his deductible this year, and each visit to his doctor costs a total of \$100. Under his policy, Neil will be responsible for paying the full amount of his first doctor's visit, in order to satisfy his deductible. Once Neil meets his deductible, he will have to pay 20 percent of \$100 per visit, or \$20. In order to reach his \$1,000 out of pocket maximum, Neil would have to visit his doctor 50 times within the year (50 visits at \$20 each = \$1,000). If he did so, then the insurance company would usually begin paying 100 percent of the medical expenses that follow.

## **How Do You Choose a Health Plan that is Right for You?**

Whether you are a Medicare subscriber, an employee or an individual wishing to purchase a managed health care plan, financial issues are of great importance when you are deciding whether to choose between HMO and PPO coverage. As a rule, if you choose a PPO you will pay higher premiums and pay more out of pocket when you receive service. This is true particularly at the beginning of obtaining health care. For instance, compare an individual covered with a PPO (Susan) to an individual covered under an HMO (Bob). Susan's deductible is \$200 per year. Every year, she will have to pay \$200 before her insurance company begins paying any benefits. Just one doctor's visit may cost her \$60; once her deductible is satisfied, she will have to continue paying co-insurance until she meets her out of pocket limit of \$1,500. Bob, on the other hand, pays a co-payment of \$10 per doctor's visit. With this arrangement, Bob will visit his doctor 6 times before he pays the \$60 that Susan has paid for one doctor's visit.

Another important factor is flexibility in choosing a provider. In order to obtain benefits from an HMO, you must use providers affiliated with the HMO. Also, HMOs require you to obtain a referral from your primary care physician before seeing most specialists. Despite this general rule, and according to State law, you may access certain specialists directly such as dermatologists, podiatrists and gynecologists. Your health plan directory should describe this process in more detail. Most PPO policies allow you to select an unaffiliated provider for care. However, you would probably have to pay a higher co-insurance. PPOs, in contrast, allow you to see a specialist directly. Under this type of plan, you do not have to go to a primary care physician for approval.

### **Medicare Plans**

If you are a Medicare beneficiary, you may be concerned about several other issues when choosing to enroll in an HMO. For example, before enrolling in a managed care plan, you should find out whether your plan has a “risk” or a “cost” contract with Medicare. The following describes each of these two types of plans:

#### **Risk Plans**

If your plan has a “risk” contract with Medicare, then you must generally receive all covered care through the plan or through referrals from the plan. Neither Medicare nor your health plan will pay for services that you receive without having prior authorization. This “lock-in” requirement has only a few exceptions. The only exception that is made by all Medicare-contracting plans occurs when you need to receive emergency services, which may be received anywhere in the United States, or when you are outside of the plan’s service area and you are in urgent need of medical services. Some Medicare risk plans do offer another exception – the POS option. Under this option, if you receive certain services outside of your plan’s provider network, then the plan will pay a percentage of the charges. Generally, you would pay 20 percent of the bill.

**Cost Plans**

Under this type of plan, as a Medicare subscriber you can receive services from health care providers affiliated with the plan or you can receive services outside of the plan. Generally, the plan will not pay for those services that you receive outside of the plan. Although Medicare will pay for approved charges, you are still responsible for paying Medicare's co-insurance, deductibles and other charges. This type of plan is similar to receiving care under the fee-for-service system. This plan is especially beneficial if you travel frequently, live in different parts of the country throughout the year, or you want a provider that is not affiliated with your health plan.

**Medicaid Plans**

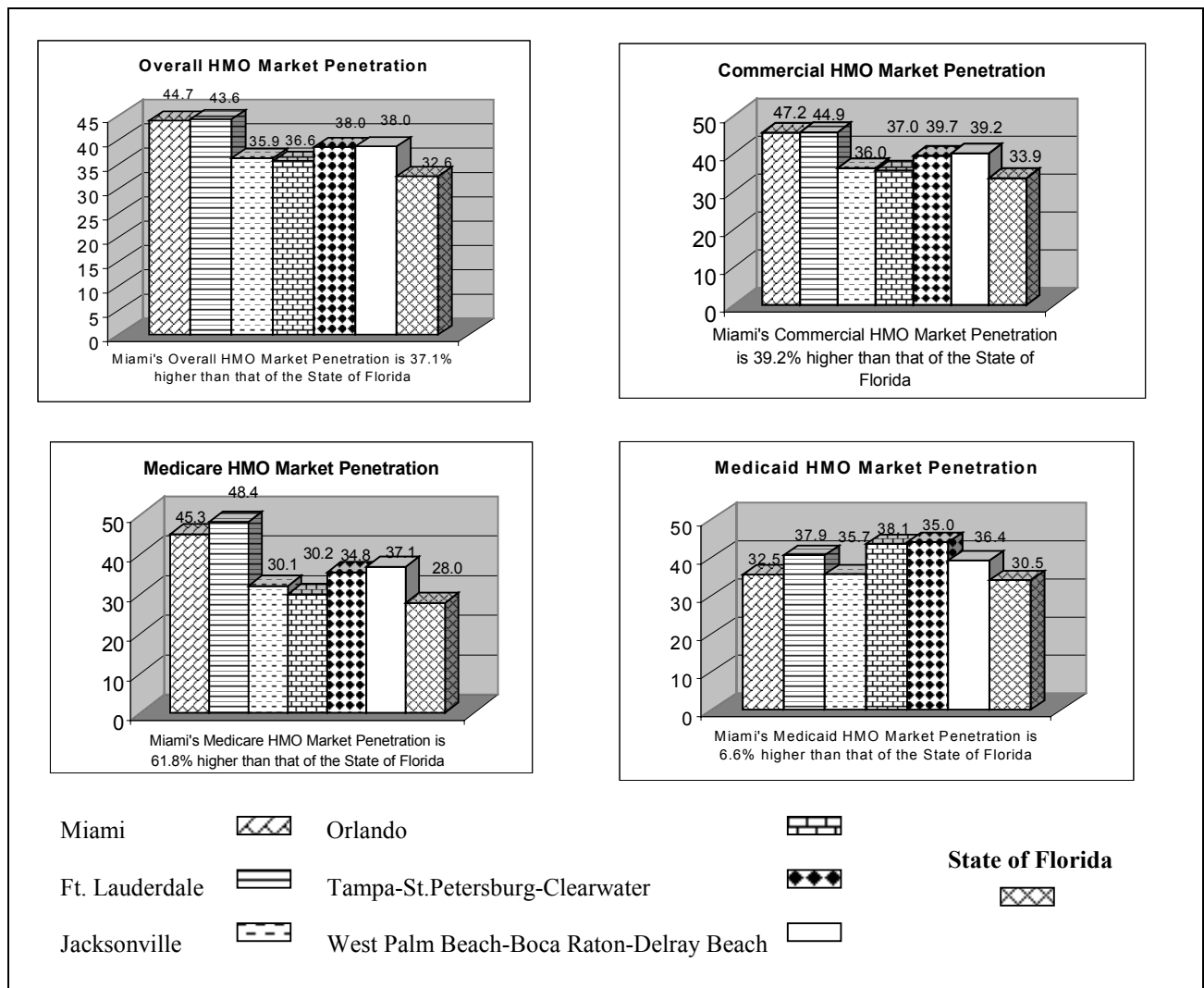
If you are a Medicaid beneficiary, you may be concerned about several other issues when choosing to enroll in an HMO. For example, before enrolling in a managed care plan, you need to decide if you would like to enroll either with a MediPass Provider or in a Medicaid health maintenance organization (HMO). Please refer to the section: "Medicaid and Managed Care" on pages 43-44 for a description of these two types of managed care programs.

*(For additional information, see the subsection "Provider Sponsored Organizations (PSOs)" on page 22.)*

## South Florida Trends in Managed Care

Approximately one out of two people in South Florida is enrolled in a Health Maintenance Organization or “HMO.” Miami has a higher percentage of HMO members than the State of Florida overall among all types of health plans. The most significant differences are within the Medicare and Commercial markets, where, as of June 30, 1999 the proportion of Miami residents enrolled in an HMO versus the State of Florida is more than 61 percent higher. When compared to other metropolitan areas in Florida, Miami has the highest overall HMO enrollment, 44.7 percent, followed by Ft. Lauderdale, which has an overall HMO enrollment rate of 43.6 percent. Miami’s Medicare HMO enrollment rate is 45.3 percent, surpassed only by Ft. Lauderdale which is 48.4 percent. Finally, almost a third, or 32.5 percent of Miami’s Medicaid recipients are enrolled in HMOs, a figure comparable to the rest of the State, at 30.5 percent.

### HMO Market Penetration as of First Quarter 1999 Miami and Other Metropolitan Areas\* In the State of Florida with Populations over 1 Million



Source: “Eye on the Market,” HMO Market Share Report July 1999, Florida Hospital Association.  
(\* Note: The report cited uses Metropolitan areas, not counties, as its geographic unit of measurement.)

HMOs are classified into four different model types. Most HMO's in Miami-Dade are classified as Independent Practice Associations (IPA's). In this type of managed care model, health plans contract directly with individual providers in their own practices to form a "network." A network model HMO can also contract with two or more independent group practices to form a network of care. A health plan is referred to as a Group Model when the HMO contracts with one group practice to service as the plan's health delivery system. When a health plan employs the providers who give care to the members, it is referred to as a Staff Model. A survey conducted by the American Association of Health Plans in 1997 found that nearly 38 percent of HMOs licensed in 41 states over the past two years were provider owned. In the state of Florida, health care providers own 12 percent of HMOs.

HMOs have specific guidelines which must be followed or benefits may not be extended. For example, HMOs most commonly require a Primary Care Physician (PCP) or "gatekeeper" to manage or coordinate all health needs of the member. "Gatekeeper" refers to the PCP who controls access to specialist care and other procedures and services. In most circumstances, you are required to consult your own PCP prior to seeking specialty care or stay within a designated network.

The concept of "gatekeeping" has swept across America and is now very common in South Florida with the growth of managed care organizations in our region. Proponents of the gatekeeping concept support its ability to control costs and improve quality of care through coordination of services. As gatekeeper, the Primary Care Physician may be able to reduce duplication of services or prevent inappropriate or unnecessary care. On the other hand, critics of managed care say that the gatekeeper model results in unnecessary and costly barriers to care, and you may indeed be denied access to services that you may need. This perception has resulted in a backlash against managed care organizations and several legislative initiatives have been sponsored at the state and federal levels. (Please see the section: "Current Issues in Managed Care" on pages 22-24.)

## **Your Rights and Responsibilities**

### **HMOs and Your Rights**

If you are insured by a Health Maintenance Organization (HMO), you have rights and responsibilities with regard to your insurance. According to the Florida Agency for Health Care Administration, the following information is an outline of these rights and responsibilities to help you better understand HMOs and your role as an HMO member.

### **Your Contract**

You have a right to receive a contract, a certificate or a member handbook which clearly specifies the services and limitations of your membership. You have a right to a written translation of that contract in the language used to negotiate the contract. If you are no longer eligible for group coverage, you have the right to convert to an individual contract. In addition, if your company has more than 20 employees, you may have certain rights under the national Consolidated Omnibus Budget Reconciliation Act laws.

### **Your Premiums**

You have the right to fair rates, and you have at least 10 days from the due date to pay your premium.

### **Service**

You have the right to accessible health care, including convenient locations, reasonable hours of operation, adequate staffing and provision of after hours care. You have the right to receive a list of all hospitals and primary care physicians contracted under your benefit plan. The HMO must provide quality emergency care and pay for at least 75 percent of the cost of your medically necessary emergency care, even if it is rendered outside your HMO's service area without prior notification or approval. The HMO may require you to pay a co-payment not to exceed \$100 per claim.

### **Grievances**

Each health plan must have an internal grievance process for you and your provider to utilize if there is a complaint. When you or your provider has a complaint, this process should be employed for resolution.

If you are unable to resolve the complaint in a satisfactory manner through this process, you can file a grievance, which is a formal written complaint, with the Statewide Subscriber Assistance Program. The Statewide Subscriber Assistance Program then has its Statewide Subscriber Assistance Panel review the case. The Panel is comprised of six members: three from the Florida Department of Insurance and three from the Florida Agency for Health Care Administration. In addition to reviewing specific cases, the Panel makes policy recommendations at the State level. If you are a Medicare or Medicaid HMO Member, you can also utilize this service.

The Statewide Subscriber Assistance Program's address is as follows: Agency for Health Care Administration, Bureau of Managed Health Care, P.O. Box 12800, Tallahassee, Florida 32317-2800. They can also be contacted at (850) 921-5458.

In accordance with Florida legislation, if you are a Medicare subscriber and your appeal is denied by your health plan's internal review, it automatically goes to an independent review organization that contracts with Medicare. Medicare implemented its appeals program in 1989. According to a report published by the Kaiser Family Foundation in November of 1998, Medicare, which had approximately 5.5 million beneficiaries enrolled in HMOs in 1997, averaged only 1.6 external reviews per 1,000 HMO enrollees that year.

If you are a Medicaid subscriber, you also have the right to a Medicaid fair hearing in addition to your health plan's grievance procedure. You may pursue this action by contacting the Florida Department of Children and Family Services at (850) 488-1429 or by writing to them at the Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 1, Room 309, Tallahassee, Florida 32399-0700.

If you are a Medicare or Medicaid subscriber and you have complaints about the quality of care that you have received from your doctor, hospital, nursing home, or Medicare/Medicaid health plan, you have the right to an immediate review by the Peer Review Organization (PRO) of your state. For example, a PRO should be utilized when you believe that you are being discharged too soon from a hospital. During the immediate review, you may be able to stay in the hospital at no charge and the hospital cannot discharge you prior to the PRO's decision. Florida's PRO is Florida Medical Quality Assurance.

The Florida Medical Quality Assurance number for Medicare Members is (800) 844-0795. Medicaid Members can reach the Florida Medical Quality Assurance at (800) 595-2811.

Florida's PRO for Medicare Members is contracted through the Health Care Financing Administration (HCFA) and Florida's PRO for Medicaid Members is contracted through the Florida Agency for Health Care Administration.

In Miami-Dade County the local Alliance for Aging has an HMO Patient Advocate Program that can also help you address unresolved issues if you are a Medicare HMO subscriber. This is a free service. You may contact the Alliance for Aging HMO Patient Advocate Program at (305) 670-6500.

*(For additional resources, see the section: "Who Can You Call for More Information on Managed Care?" on pages 49-50.)*

## **HMOs and Your Responsibilities**

Since HMOs may differ with regard to the responsibilities that they expect from you, you should refer to their benefits materials and become familiar with how their health care plan works. You are responsible for knowing how to properly utilize the services offered by your health plan. For further inquiries or concerns about your responsibilities, you should contact your plan's Member Services.

## **Member Information**

Your health care plan should be notified of any changes in your address, phone number, enrollment status, family size, etc.

## **Premiums**

You have the responsibility to make premium payments on time if they are not paid directly by your employer. These premiums must be paid even if you are involved in a financial dispute with your HMO. The HMO can cancel your membership and stop paying for medical services any time a premium payment is not made.

## **Services**

You have the responsibility to keep scheduled appointments and to immediately notify the physician's office if you will not be able to keep an appointment. You must present your ID card prior to receiving services and pay for all applicable co-payments at the time services are rendered. You may also be liable for paying any ensuing charges for missed appointments and/or non-covered services.

## **Treatment**

You and your PCP should establish a relationship where you can express your opinions, concerns or complaints in a constructive manner. You are responsible for providing honest and complete information to those providing care. You should know what medications you are taking, why you are taking them, and adhere to the prescribed regimen. You should also follow your PCP's advice and consider the consequences that may occur if you do not follow it. You should also schedule a new-patient appointment with any new PCP.

## Key Health Care Consumer Questions

When offered a choice of managed care plans, it is important for you to consider many factors. Here are some other important questions to ask when you are choosing a managed health care plan for you and your family:

- ◆ Can you afford the health plan premiums and co-payments?
- ◆ Is your personal physician part of the network?
- ◆ If your physician is not part of the network, is there one on the plan who is satisfactory for your needs?
- ◆ How easy is it for you to change your primary care physician?
- ◆ Are the specialty providers and hospitals located close to your home or work for easy access?
- ◆ What special health services do you utilize and are they listed as covered benefits on the plan?
- ◆ Does the National Committee on Quality Assurance (NCQA) accredit the health plan? *Other accrediting bodies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC).*
- ◆ Does the HMO have wellness benefits, such as fitness discounts or smoking cessation programs?
- ◆ How is a physician compensated?
- ◆ What services are covered without first obtaining a referral?
- ◆ What is the phone number for customer service? Are they available 24 hours each day?
- ◆ What happens if you receive notification of a denied claim?
- ◆ If you have a complaint or grievance, how is it handled?
- ◆ Does the health plan offer coverage or discounts for alternative/complementary medical treatments such as chiropractic, acupuncture, massage therapy, among others?

## What You Need to Know about Quality

One of the most important issues that you need to consider when choosing a managed care plan is how the HMO or PPO stacks up in terms of quality. Here are some helpful hints for you as you make your decision:

### NCQA Accreditation

The National Committee for Quality Assurance (NCQA) is an independent, non-profit organization that assesses and reports on health plans. Through accreditation reviews and standardized measures of health plan performance, NCQA holds health plans accountable for the quality of care and service they deliver. NCQA's mission is to provide information that lets you, as a consumer of managed health care, to distinguish among plans based on quality and allows you to make more informed choices. NCQA Accreditation is a comprehensive evaluation process of how the health plan ensures that you receive high quality care.

Health plans are evaluated by accreditation surveyors who are trained health care experts, including physicians. The NCQA survey team thoroughly evaluates how well a plan does on all dimensions – systems, processes and outcomes of care. This information is used by employers, state governments, and other purchasers of health coverage in compiling comparative report cards about health plans. NCQA accreditation is divided into five levels which indicate different strata of achievement or compliance for the health plan: • Excellent Accreditation (3 years); • Commendable (3 years); • Accredited (1 year); • Provisional Accreditation (1 year); and • Denial (1 year). When choosing a health plan, you should find out what level of accreditation the health plan has achieved. The following table provides a breakdown of the possible Accreditation levels:

### NCQA Accreditation Levels

<b>Excellent</b>	This is NCQA's highest accreditation status and is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve The Health Plan Employer Data and Information Set (HEDIS®) results that are in the highest range of national or regional performance.
<b>Commendable</b>	This accreditation level is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
<b>Accredited</b>	Health plans that earn the 'Accredited' designation must meet most of NCQA's requirements for consumer protection and quality improvement.
<b>Provisional</b>	Provisional accreditation indicates that a health plan's service and clinical quality meet some, but not all, of NCQA's requirements for consumer protection and quality improvement.
<b>Denied</b>	Denied is an indication that a health plan did not meet NCQA's requirements during its review.

*Source: NCQA Accreditation Summary Reports*

Note: NCQA Accreditation statuses are available by calling 1-888-275-7585 or on the World Wide Web at [www.ncqa.org](http://www.ncqa.org).

## JCAHO Accreditation

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit organization whose mission is to improve the quality of health care provided to the public through the process of health care accreditation and related services which support performance improvements in health care organizations. The Joint Commission evaluates and accredits hospitals and health care organizations that provide managed care (including health plans, preferred provider organizations and integrated delivery systems), home care, long-term care, behavioral health care, laboratory and ambulatory care services.

The standards set forth by JCAHO address a health care organization’s level of performance in specific areas related to both what the organization actually does and what it is capable of doing. JCAHO standards are developed through the collaborative effort of health care experts, providers, measurement experts, purchasers, and consumers. These standards are usually updated every two years or as needed to improve clarification and reduce duplication.

The following table provides a breakdown of the possible Joint Commission on Accreditation of Healthcare Organization Accreditation of the Healthcare Organization levels:

### JCAHO Accreditation Levels for “Managed Care Organizations”

<b>Accreditation with Commendation</b>	The highest accreditation decision. Organization demonstrates exemplary performance in complying with JCAHO standards.
<b>Accreditation</b>	Organization demonstrates acceptable compliance with JCAHO standards in all performance areas.
<b>Accreditation with Type I Recommendations</b>	Organization receives at least one recommendation addressing insufficient or unsatisfactory compliance in a specific performance area. Recommendations must be resolved within set time frames.
<b>Provisional Accreditation</b>	Organization demonstrates satisfactory compliance with the selected standards applied during the organization’s initial survey under the Early Survey Policy. A second survey is conducted about six months later so that the organization is able to demonstrate a track record of performance. The organization may then receive one of the other official accreditation decisions.
<b>Conditional Accreditation</b>	Organization is not in substantial compliance with JCAHO standards but is thought to be capable of achieving acceptable standards compliance within a set time period OR the accredited organization is found by JCAHO to have one or more adverse events that potentially affect patient care or safety and/or potentially reflect underlying systems problems.
<b>Preliminary Non-accreditation</b>	An organization is preliminarily denied accreditation due to significant noncompliance with JCAHO standards or its accreditation is initially withdrawn by JCAHO for other reasons.
<b>Non-accreditation</b>	An organization is denied accreditation because of significant noncompliance with JCAHO standards, when its accreditation is taken away by JCAHO for other reasons, or when the organization voluntarily withdraws from the accreditation process.

*Source: Joint Commission on Accreditation of Healthcare Organizations.*

Note: JCAHO statuses are available at Quality Check™ on the World Wide Web at [www.jcaho.org](http://www.jcaho.org).

## **AAAHC Accreditation**

The Accreditation Association for Ambulatory Health Care (AAAHC) is a private, not-for-profit organization that assists ambulatory health care organizations in improving the quality of care they provide to their patients. This end is accomplished by setting standards, measuring performance, providing consultation and education where needed, and ultimately by awarding accreditation to those organizations that are found to be in compliance with its standards. AAAHC is an approved HMOs accrediting body in the state of Florida.

In April of 1997, AAAHC adopted specific standards for professional services delivered by managed care organizations. These standards of measurement evaluate providers of care working within managed care organizations as well as an organization's compliance with outlined standards. The standards set forth by AAAHC evaluate an HMOs communication mechanisms used with patient members, its grievance resolution system, consumer information, appeals procedures, and utilization management.

## Statewide Association

### **Florida Association of HMOs**

1415 East Piedmont Drive  
Tallahassee, Florida 32312  
Phone: (850) 386-2904

Membership in the Florida Association of Health Maintenance Organizations (FAHMO) is open only to HMOs licensed in accordance with Chapter 641 of the Florida Statutes. FAHMO assists its members in recognizing and fulfilling the needs of its subscribers and provides technical support in the development of public policy positions that are later advocated to the Legislature, regulatory agencies and the general public. As the major communicator for the HMO industry, FAHMO supports legislation and proposes new laws that are in the best interest of the public as well as the HMO industry. By offering Continuing Medical Education/Continuing Education short courses, forums, seminars, conferences, and workshops FAHMO assists HMO executives to keep abreast of the latest techniques and ideas related to specific areas within the HMO industry.

## Florida Regulation

### **Florida Department of Insurance**

Dade and Monroe County Offices  
401 NW 2<sup>nd</sup> Avenue, Suite N307  
Miami, FL 33128-1700  
Phone: (305) 377-5235

### **Florida Agency for Health Care Administration**

Division of Quality Assurance  
Bureau of Managed Health Care  
2727 Mahan Drive  
Tallahassee, FL 32308  
Phone: (850) 922-6830

In Florida, the Department of Insurance in conjunction with the Bureau of Managed Health Care of the Agency for Health Care Administration (AHCA) screens Florida HMOs for quality of care and for financial stability. AHCA is responsible for issuing operating licenses to managed care organizations licenses to operate and for providing oversight for a variety of managed care entities.

AHCA is also responsible for monitoring accreditation surveys and investigating quality of care complaints that involve managed care organizations. Specifically, the Bureau of Managed Health Care manages a Hotline and an Assistance Panel, which investigates consumer and plan complaints in order to resolve potential problems.

ACHA's Hotline number is (800)-226-1062 and their Assistance Panel is available through their Statewide Subscriber Assistance Program at (850) 921-5458.

According to AHCA, examples of consumer difficulties that the Agency can assist with include:

- ◆ Difficulty in scheduling appointments
- ◆ Difficulty getting referrals to specialists
- ◆ Denials of service; and
- ◆ Concerns about quality of health care received.

## **Current Issues in Managed Care**

As a consumer, you need to be aware of the key issues surrounding managed care and how policy makers at the local, state and federal level may be making changes to the laws that govern managed care organizations.

### **Cost Cutting & HMOs**

Current research into the ordering practices of laboratory tests by physicians who practice in areas with multiple HMOs suggest that these physicians may be ordering fewer tests and conducting less complicated procedures on patients, regardless of insurance type. Findings also suggest that physicians are altering their treatment practices for all patients.

### **Direct Access to Specialists**

Though gatekeeping arrangements serve as the foundation for HMOs, direct access to frequently utilized specialists is also on the rise. Examples of exceptions to the “gatekeeper” rule as mandated by Florida Statutes include dermatological visits, chiropractic services, podiatry services, and annual gynecological exams for female subscribers. If you are a female member, an HMO or other managed care provider must allow you “direct patient access” to an obstetrician or gynecologist. This permits you direct access to a contracted OB-GYN for one annual visit and medically necessary follow-up care. In this manner, you have the ability to obtain services without a referral or other authorization before receiving services.

### **Consumer Bill of Rights**

In 1998, the President endorsed a Bill of Rights proposed by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Since then, Congress has yet to pass a Patient’s Bill of Rights of this nature, but it remains on the congressional agenda.

### **Experimental Procedures**

Many managed care plans do not cover procedures that have not been approved by the Federal Food and Drug Administration (FDA) or are experimental. This issue deserves more study and it is expected that managed care plans will revisit guidelines for coverage in the future.

### **Length of Stay**

Lengths of stay laws are now in place for maternity care. According to federal law (PL-104-204), hospitals may not discharge you any sooner than two days for a normal vaginal delivery and three days for a cesarean section, unless you and your baby are medically cleared to leave before that time.

### **Provider Sponsored Organizations (PSOs)**

This type of health care plan is administered by physicians and other providers rather than by an insurance company. Under this type of plan, a group of doctors, hospitals, and other health care providers agree to provide care to Medicare subscribers in exchange for a fixed amount of money from Medicare every month.

## **Provider Sponsored Networks (PSNs)**

Health care providers offering integrated systems of care to Medicaid recipients operate this type of organized health system. A PSN must be at least 51 percent owned by a hospital, physician group, or consortium of the aforementioned providers. For the remaining 49 percent ownership, the above restriction does not apply. You can be a recipient of the services offered by the PSN if you are an individual who has been determined to be eligible to receive Medicaid benefits.

## **Medical Savings Accounts (MSAs)**

Some individuals enrolled in Medicare + Choice are testing out this concept. At the beginning of each year, Medicare deposits money into a Medicare approved and registered bank or financial institution of your choice. This plan is designed to protect you from high-cost health catastrophes by combining a limited-use individual savings account with a high-deductible insurance policy. In 1999, the policy's deductible may not be more than \$6,000. The deposited funds can then be used for medical expenses not covered by the high-deductible insurance policy. Money withdrawn from the Medicare MSA for non-medical expenses is taxed and those funds that are not used are rolled over from year to year, including interest. This innovative concept has received much criticism because as a Medicare subscriber you may be left unprotected in the event of unexpectedly high health care costs. Also, you may have to pay out-of-pocket for health care services if your MSA contains inadequate funds in their initial years.

## **Alternative/Complementary Medicine**

In 1990, an estimated 425 million Americans visited alternative health care providers, a figure that exceeded the number of visits to allopathic conventional primary care physicians during the same period.<sup>2</sup> There are several reasons for which individuals seek alternative treatments or "unconventional medical therapies." Some patients are dissatisfied with conventional treatments that have persistently proven their ineffectiveness. Others have suffered from the adverse effects of conventional treatments or have found them to be too impersonal and/or costly. By seeking out these alternative recourses, patients may feel that they have more control over their health care decisions.

Many managed care organizations include alternative practitioners such as chiropractors, acupuncturists, holistic healers, herbalists, naturopaths and massage therapists in their health plans. In fact, sixty-seven percent of HMOs offer at least one type of alternative care therapy.<sup>3</sup> It is anticipated that these alternative practices will go "mainstream" and that the market share of alternative practitioners will grow.<sup>4</sup>

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<sup>2</sup> Source: "Why Patients Use Alternative Medicine: Results of a National Study," by John A. Astin, PhD., JAMA, May 20, 1999.

<sup>3</sup> Source: "1999 Nationwide HMO Study of Alternative Care." Medical Benefits, April 30, 1999.

<sup>4</sup> Source: "Issues in Managed Care." On Managed Care: Industry Information for Health Care Decision-Makers, March 1999.

HMOs that offer alternative care have done so for various reasons, the most important ones being that members, employers and groups have asked for it and that they have been required by law to do so. Other factors taken into consideration have included the clinical effectiveness of such alternative care methods, to differentiate the HMOs from their competitors, to meet the competition, and/or to attract members. The most common type of alternative care in 1999 is chiropractic, an option that has been available for the past five to six years and is offered by 65 percent of all HMOs. About 31 percent of HMOs also offer acupuncture and 11 percent offer massage therapy. Within the next two to three years, it has been projected that 31 percent of HMOs will include acupuncture, 31 percent acupressure, 30 percent massage therapy, and 27 percent vitamin therapy.<sup>5</sup>

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<sup>5</sup> Source: "1999 Nationwide HMO Study of Alternative Care." Medical Benefits, April 30, 1999.

## **South Florida's Health Plans**

### **Which HMOs Are Included**

The following section provides information for 13 of 33 HMOs that presently offer coverage in the state of Florida (as of June 30, 1999). The thirteen HMOs included are those that had a commercial enrollment of at least 5,500 in Miami-Dade and/or Monroe Counties as of March 31, 1999<sup>6</sup> and offer health coverage in the two counties. Although many of the HMOs included in this section do offer coverage in other parts of the state, the information presented in this section focuses solely on managed health care offered in South Florida.

### **How the Information Was Collected**

Multiple sources were used to collect the information presented in this section. Initially, HMO market share reports from the Florida Hospital Association as well as other reputable publications were utilized to compile preliminary information. In April 1999, representatives from each HMOs marketing, public relations, provider operations, or member services department were asked to provide the Health Council of South Florida with information that could not be gathered from existing published documents. Representatives were also asked to submit any revisions to the information that had been previously gathered. Revisions were compiled from April to November 1999. Representatives from each HMO were then given the opportunity to review and make any further updates to their compiled service sheet before this document was published in December, 1999.

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<sup>6</sup> Source: FHA Eye on the Market: HMO Market Share Report, July 1999.

## **South Florida's Health Plans**

- ❖ **Aetna**
- ❖ **AvMed**
- ❖ **Beacon Health Plans**
- ❖ **CIGNA Healthcare of Florida**
  - ❖ **Foundation Health**
  - ❖ **Health Options**
- ❖ **HIP Health Plan of Florida**
- ❖ **Humana Medical Plan**
- ❖ **JMH Health Plan**
- ❖ **Neighborhood Health Partnership**
- ❖ **Prudential HealthCare Plan**
  - ❖ **Total Health Choice**
- ❖ **United Healthcare Plans of Florida**

# Aetna, Inc.

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P.O. Box 1125, Blue Bell, PA 19422  
Web Site: [www.aetnaushc.com](http://www.aetnaushc.com)

Tel: 800-282-3517  
Fax: 813-775-0645

**Profit Status:** For-Profit  
**Model Type:** IPA  
**Plan License Date:** 1997  
**Accreditation:** NCQA – Commendable\*

**Managed Care Plans:** HMO & POS  
**Service Areas:** Dade

## Ancillary Services Covered\*\*:

Ambulance, Audiology, Dialysis, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Occupational, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	3348	<b>Available to Medicare Applicants:</b>	No
Specialists	7771	<b>Available to Medicaid Applicants:</b>	No

**Member Satisfaction Surveys:** Yes  
**Commercial Enrollment in Dade County†:** 16,765

Note: \*Status effective as of February 5, 1999; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# AvMed Health Plans, Inc.

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9400 South Dadeland Boulevard, Miami, FL 33156  
Web Site: [www.avmed.com](http://www.avmed.com)

Tel: 800-882-8633  
Fax: 352-337-8745

**Profit Status:** Not-for-Profit  
**Model Type:** IPA  
**Plan License Date:** 5/17/73  
**Accreditation:** NCQA – Commendable\*;  
JCAHO – Full

**Managed Care Plans:** HMO, POS, & Medicare HMO  
**Service Areas:** Dade

## Ancillary Services Covered\*\*:

Ambulance, Audiology, Dental, Dialysis, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Occupational, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	1085	<b>Available to Medicare Applicants:</b>	Yes
Specialists	3325	<b>Available to Medicaid Applicants:</b>	No

**Member Satisfaction Surveys:** Yes  
**Commercial Enrollment in Dade County†:** 102,363  
**Medicare Enrollment in Dade County†:** 12,961

Note: \*Status effective as of March 26, 1999; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Beacon Health Plans, Inc.

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2511 Ponce de Leon Blvd, 5<sup>th</sup> Floor, Coral Gables, FL 33134  
Web Site: [www.beaconhealth.com](http://www.beaconhealth.com)

Tel: 305-460-2000  
Fax: 305-774-2649

**Profit Status:** For-Profit  
**Model Type:** IPA

**Plan License Date:** 8/16/97  
**Accreditation:** AAAHC

**Managed Care Plans:**  
HMO, POS, Medicare, Medicaid

**Service Areas:**  
Dade & Monroe

## Ancillary Services Covered\*:

Ambulance, Audiology, Dental, Dialysis, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Occupational, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Skilled Nursing Custodial Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	Yes
PCP	2000	<b>Available to Medicare Applicants:</b>	Yes
Specialists	5000	<b>Available to Medicaid Applicants:</b>	Yes

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade &amp; Monroe Counties†:</b>	18,674
<b>Medicare Enrollment in Dade &amp; Monroe Counties†:</b>	1,341
<b>Medicaid Enrollment in Dade &amp; Monroe Counties†:</b>	3,466

Note: \*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# CIGNA Healthcare of Florida, Inc.

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6700 Andrews Avenue, North, Suite 300  
Ft. Lauderdale, FL 33309  
Web Site: [www.cigna.com](http://www.cigna.com)

Tel: 800-942-2471  
Fax: 813-282-0356

**Profit Status:** For-Profit  
**Model Type:** IPA

**Plan License Date:** 7/1/91  
**Accreditation:** NCQA – Commendable\*

**Managed Care Plans:**  
HMO, PPO, & POS

**Service Areas:**  
Dade

## Ancillary Services Covered\*\*:

Ambulance, Dialysis, Durable Medical Equipment, Home Health, Hospice, Laboratory Services, Preventive Wellness Care, Radiology, Rehabilitative Services, Skilled Nursing Custodial Care, Vision.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	3,500	<b>Available to Medicare Applicants:</b>	No
Specialists	7,200	<b>Available to Medicaid Applicants:</b>	No

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	5,030

Note: \*Status effective April 14, 1999; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Foundation Health, Inc.

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1340 Concord Terrace, Sunrise, FL 33323  
Web Site: [www.fhfl.com](http://www.fhfl.com)

Tel: 800-441-5501  
Fax: 954-846-8873

**Profit Status:** For-Profit  
**Model Type:** Combination  
**Plan License Date:** 8/25/94  
**Accreditation:** NCQA – Commendable\*

**Managed Care Plans:** HMO, PPO, POS, & Indemnity  
**Service Areas:** Dade

## Ancillary Services Covered\*\*:

Ambulance, Audiology, Dental, Dialysis, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians - Statewide:</b>		<b>Available to Individuals:</b>	Yes
PCP	2,438	<b>Available to Medicare Applicants:</b>	No
Specialists	4,713	<b>Available to Medicaid Applicants:</b>	No

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	30,163
<b>Medicare Enrollment in Dade County†:</b>	7,805
<b>Medicaid Enrollment in Dade County†:</b>	4,508

Note: \*Status effective August 27, 1998; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Health Options, Inc.

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8400 NW 33 Street, Suite 100, Miami, FL 33122-1932  
Web Site: [www.bcbsfl.com](http://www.bcbsfl.com)

Tel: 800-955-3589  
Fax: 305-921-7498

**Profit Status:** For-Profit  
**Model Type:** IPA  
**Plan License Date:** 9/25/84  
**Accreditation:** NCQA – Commendable\*

**Managed Care Plans:** HMO & PPO  
**Service Areas:** Dade

## Ancillary Services Covered\*\*:

Ambulance, Durable Medical Equipment, Home Health Services, Hospice, Laboratory Services, Physical, Prescription Drugs Preventive Wellness Care, Radiology, Rehabilitative Services, Skilled Nursing Care.

<b>Physicians-Statewide***:</b>		<b>Available to Individuals:</b>	Yes
PCP	5,984	<b>Available to Medicare Applicants:</b>	Yes
Specialists	8,790	<b>Available to Medicaid Applicants:</b>	No

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	86,102
<b>Medicare Enrollment in Dade County†:</b>	14,602

Note: \*Status effective May 30, 1997; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
\*\*\* As of May 1999; † Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# HIP Health Plan of Florida, Inc.

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300 South Park Road, Hollywood, FL 33021  
Web Site: [www.hipusa.com](http://www.hipusa.com)

Tel: 800-385-4447  
Fax: 954-986-6204

**Profit Status:** Not-for-Profit  
**Model Type:** IPA  
**Plan License Date:** 9/30/85  
**Accreditation:** NCQA – Commendable\*

**Managed Care Plans:** HMO, PPO & POS  
**Service Areas:** Dade

## Ancillary Services Covered\*\*:

Ambulance, Audiology, Dental, Dialysis, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Occupational, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Skilled Nursing Custodial Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	1215	<b>Available to Medicare Applicants:</b>	Yes
Specialists	2289	<b>Available to Medicaid Applicants:</b>	No

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	42,696
<b>Medicare Enrollment in Dade County†:</b>	4,155

Note: \* Status effective November 12, 1996; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Humana Medical Plan, Inc.

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3400 Lakeside Drive, Miramar, FL 33027  
Web Site: [www.humana.com](http://www.humana.com)

Tel: 800-521-4882  
Fax: 305-626-5717

**Profit Status:** For-Profit  
**Model Type:** Combination  
**Plan License Date:** 6/1/87  
**Accreditation:** NCQA – Accredited\*

**Managed Care Plans:** HMO, PPO & POS  
**Service Area:** Dade

## Ancillary Services Covered\*\*:

Ambulance, Audiology, Dental, Dialysis, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Occupational, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	3964	<b>Available to Medicare Applicants:</b>	Yes
Specialists	10,435	<b>Available to Medicaid Applicants:</b>	Yes

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	50,942
<b>Medicare Enrollment in Dade County†:</b>	29,078

Note: \*Status effective July 12, 1999; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# JMH Health Plan

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1801 NW 9<sup>th</sup> Avenue, Suite 700, Miami, FL 33136

Tel: 305-575-3700  
Fax: 305-545-5212

**Profit Status:** Not-for-Profit  
**Model Type:** Combination

**Plan License Date:** 9/30/85  
**Accreditation:** AAAHC

**Managed Care Plans:**  
HMO

**Service Area:**  
Dade

**Ancillary Services Covered\*:**

Ambulance, Dental, Durable Medical Equipment, Home Health Services, Hospice, Skilled Nursing Care.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	690	<b>Available to Medicare Applicants:</b>	No
Specialists	2,057	<b>Available to Medicaid Applicants:</b>	Yes

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	22,893
<b>Medicaid Enrollment in Dade County†:</b>	7,710

**Note:** \*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Neighborhood Health Partnership, Inc.

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7600 Corporate Center Drive, Miami, FL 33126

Tel: 800-354-0222  
Fax: 305-715-4696

**Profit Status:** Not-for-Profit  
**Model Type:** IPA

**Plan License Date:** 12/29/87  
**Accreditation:** NCQA – Accredited\*

**Managed Care Plans:** HMO, POS, & Access Option      **Service Areas:** Dade

**Ancillary Services Covered\*\*:**

Ambulance, Audiology, Durable Medical Equipment, Hearing Exams, Home Health Services, Hospice, Laboratory Services, Mental Health Care, Occupational, Optical, Pharmacy, Physical Therapy, Prescription Drugs (by rider), Preventive Wellness Care, Radiology Services, Rehabilitative Services, Skilled Nursing Care, Speech Therapy, Substance, Vision Exams, X-ray.

<b>Physicians-Statewide:</b>		<b>Available to Individuals:</b>	No
PCP	1129	<b>Available to Medicare Applicants:</b>	Yes
Specialists	2476	<b>Available to Medicaid Applicants:</b>	Yes

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	89,106
<b>Medicare Enrollment in Dade County†:</b>	17,697
<b>Medicaid Enrollment in Dade County†:</b>	9,852

**Note:** \*Status effective January 25, 1999; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
† Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Prudential HealthCare Plan, Inc.

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P.O. Box 45064, Jacksonville, FL 32232  
Web Site: [www.prudential.com](http://www.prudential.com)

Tel: 800-628-3801  
Fax: 904-351-5516

<b>Profit Status:</b>	For-Profit	<b>Plan License Date:</b>	12/23/83
<b>Model Type:</b>	Combination	<b>Accreditation:</b>	NCQA – Accredited*

<b>Managed Care Plans:</b>	<b>Service Areas:</b>
HMO, POS, & PPO	Dade

## Ancillary Services Covered\*\*:

Ambulance, Durable Medical Equipment, Home Health Services, Hospice, Laboratory Services, Preventive Wellness Care, Radiology, Rehabilitative Services, Skilled Nursing Care.

<b>Physicians-Statewide***:</b>	<b>Available to Individuals:</b>	No
PCP 2840	<b>Available to Medicare Applicants:</b>	Yes
Specialists 5950	<b>Available to Medicaid Applicants:</b>	No

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	41,319
<b>Medicare Enrollment in Dade County†:</b>	6,732

Note: \*Status effective March 18, 1999; \*\*According to Benefit Plan, coverage varies from Plan to Plan;  
\*\*\*As of July 1, 1999; † Source: FHA Eye on the Market: HMO Market Share Report, October 1999.

# Total Health Choice, Inc.

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P.O. Box 830010 Miami, FL 33283-0010

Tel: 305-408-5700  
Fax: 305-408-5710

<b>Profit Status:</b>	Not-for-Profit	<b>Plan License Date:</b>	1991
<b>Model Type:</b>	IPA	<b>Accreditation:</b>	AAAHC – 3 year

<b>Managed Care Plans:</b>	<b>Service Areas:</b>
HMO	Dade

**Ancillary Services Covered:**  
Information not made available.

<b>Physicians-Statewide:</b>	<b>Available to Individuals:</b>	Yes
PCP NA	<b>Available to Medicare Applicants:</b>	No
Specialists NA	<b>Available to Medicaid Applicants:</b>	No

<b>Member Satisfaction Surveys:</b>	Yes
<b>Commercial Enrollment in Dade County†:</b>	14,988

Note: † Source: FHA Eye on the Market: HMO Market Share Report, October 1999.



**HMO Hospital Affiliations in Miami-Dade and Monroe Counties as of October 30, 1999**

<b>HMO Hospital Affiliations</b>	<b>Aetna</b>	<b>AvMed</b>	<b>Beacon Health Plans</b>	<b>Cigna Health Care of Florida</b>	<b>Foundation Health</b>	<b>Health Options</b>	<b>HIP Health Plan of Florida</b>	<b>Humana Medical Plan</b>	<b>Neighborhood Health Partnership</b>	<b>Prudential Health Care</b>	<b>JMH Health Plan</b>	<b>Total Health Choice</b>	<b>United Healthcare</b>
<b>Ann Bates Leach Eye Hospital</b>		<b>X</b>			<b>X</b>		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>		<b>X</b>
<b>Aventura Hospital &amp; Medical Center</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Baptist Hospital of Miami</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>			<b>X</b>
<b>Cedars Medical Center</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>		<b>X</b>
<b>Coral Gables Hospital</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
<b>Deering Hospital</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>	<b>X</b>	<b>X</b>
<b>Douglas Gardens Hospital</b>													
<b>Fisherman's Hospital - Marathon</b>			<b>X</b>					<b>X</b>					
<b>Healthsouth Doctors' Hospital</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Health Systems - Depoo Campus</b>			<b>X</b>										
<b>Health Systems - Florida Keys</b>			<b>X</b>										
<b>Hialeah Hospital</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Homestead Hospital</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>
<b>Jackson Memorial Hospital</b>		<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>	<b>X</b>		<b>X</b>
<b>Jackson North Maternity Center</b>											<b>X</b>		
<b>Kendall Regional Medical Center</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>			<b>X</b>	<b>X</b>	<b>X</b>
<b>Larkin Community Hospital</b>	<b>X</b>		<b>X</b>		<b>X</b>		<b>X</b>	<b>X</b>				<b>X</b>	<b>X</b>
<b>Mariner's Hospital</b>													
<b>Mercy Hospital - Miami</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>
<b>Miami Children's Hospital</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Miami Heart Institute</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>			<b>X</b>	<b>X</b>	<b>X</b>
<b>Mount Sinai Medical Center</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>
<b>North Shore Medical Center - Miami</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>
<b>Palm Springs General Hospital</b>					<b>X</b>	<b>X</b>		<b>X</b>					

**HMO Hospital Affiliations in Miami-Dade and Monroe Counties as of October 30, 1999**

<b>HMO Hospital Affiliations</b>	Aetna	AvMed	Beacon Health Plans	Cigna Health Care of Florida	Foundation Health	Health Options	HIP Health Plan of Florida	Humana Medical Plan	Neighborhood Health Partnership	Prudential Health Care	JMH Health Plan	Total Health Choice	United Healthcare
	<b>Palmetto General Hospital</b>	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>
<b>Pan American Hospital</b>						<b>X</b>							<b>X</b>
<b>Parkway Regional Medical Center</b>	<b>X</b>		<b>X</b>		<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
<b>South Miami Hospital</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>			<b>X</b>
<b>South Shore Hospital &amp; Medical Center</b>			<b>X</b>		<b>X</b>		<b>X</b>	<b>X</b>			<b>X</b>		
<b>University of Miami Hospital and Clinics</b>		<b>X</b>		<b>X</b>		<b>X</b>	<b>X</b>				<b>X</b>		<b>X</b>
<b>Vencor Hospital - Coral Gables</b>	<b>X</b>		<b>X</b>					<b>X</b>		<b>X</b>			
<b>Westchester General Hospital</b>								<b>X</b>					
<b>Total # of Participating South Florida Hospitals</b>	<b>18</b>	<b>11</b>	<b>22</b>	<b>18</b>	<b>20</b>	<b>19</b>	<b>19</b>	<b>23</b>	<b>11</b>	<b>17</b>	<b>14</b>	<b>11</b>	<b>22</b>

## Directory of Miami-Dade County Hospitals

### **Anne Bates Leach Eye Hospital**

900 NW 17<sup>th</sup> Street  
Miami, FL 33136  
(305) 326-6000

### **Aventura Hospital & Medical Center**

20900 Biscayne Blvd  
Aventura, FL 33180  
(305) 682-7000

### **Baptist Hospital of Miami**

8900 N Kendall Dr  
Miami, FL 33176  
(305) 596-1960

### **Cedars Medical Center**

1400 NW 12<sup>th</sup> Ave  
Miami, FL 33136  
(305) 325-5660

### **Coral Gables Hospital**

3100 S Douglas Rd  
Coral Gables, FL 33134  
(305) 445-8461

### **Deering Hospital**

9333 SW 152<sup>nd</sup> St  
Miami, FL 33157  
(305) 251-2500

### **Douglas Gardens Hospital**

5200 NE 2<sup>nd</sup> Avenue  
Miami, FL 33137  
(305) 751-8626

### **Healthsouth Doctor's Hospital**

**5000 University Drive**  
Coral Gables, FL 33146  
(305) 666-2111

### **Hialeah Hospital**

651 E 25<sup>th</sup> Street  
Hialeah, FL 33013  
(305) 557-1616

### **Homestead Hospital**

160 NW 13<sup>th</sup> Street  
Homestead, FL 33030  
(305) 248-3232

### **Jackson Memorial Hospital**

1611 NW 12<sup>th</sup> Ave  
Miami, FL 33136  
(305) 585-1111

### **Jackson North Maternity Center**

14701 NW 27<sup>th</sup> Avenue  
Miami, FL 33054  
(305) 688-3800

### **Kendall Regional Medical Ctr.**

11750 SW 40<sup>th</sup> St  
Miami, FL 33175  
(305) 223-3000

### **Larkin Community Hospital**

8000 Biscayne Boulevard  
Miami, FL 33143  
(305) 284-7500

### **Miami Children's Hospital**

3100 SW 62<sup>nd</sup> Ave  
Miami, FL 33155  
(305) 666-6511

### **Mount Sinai Medical Center**

4300 Alton Rd, Suite 207  
Miami Beach, FL 33140  
(305) 674-2121

## Directory of Miami-Dade County Hospitals

### **Miami Heart Institute**

4701 N Meridian Avenue  
Miami Beach, FL 33140  
(305) 672-1111

### **North Shore Medical Center**

1100 NW 95<sup>th</sup> Street  
Miami, FL 33150  
(305) 835-6000

### **Palmetto General Hospital**

2001 W 68<sup>th</sup> St  
Hialeah, FL 33012  
(305) 823-5000

### **Palm Springs General Hospital**

1475 W 49<sup>th</sup> Street  
Hialeah, FL 33012  
(305) 558-2500

### **Pan American Hospital**

5959 NW 7<sup>th</sup> St  
Miami, FL 33126  
(305) 264-1000

### **Parkway Regional Medical Center**

160 NW 170<sup>th</sup> St  
North Miami Beach, FL 33169  
(305) 651-1100

### **Mercy Hospital**

3663 South Miami Avenue  
Miami, FL 33133  
(305) 854-4400

### **South Miami Hospital**

7400 SW 62<sup>nd</sup> St  
South Miami, FL 33143  
(305) 661-4611

### **South Shore Hospital and Medical Center**

630 Alton Road  
Miami Beach, FL 33139  
(305) 672-2100

### **University of Miami Hospital and Clinics**

1475 NW 12<sup>th</sup> Avenue  
Miami, FL 33162  
(305) 243-6418

### **Vencor Hospital – Coral Gables**

5190 SW 8<sup>th</sup> St  
Coral Gables, FL 33134  
(305) 448-1585

### **Westchester General Hospital**

2500 SW 75<sup>th</sup> Avenue  
Miami, FL 33155  
(305) 264-5252

## Directory of Monroe County Hospitals

### **Health Systems – Depoo Campus**

1200 Kennedy Drive  
Key West, FL 33040  
(305) 294-5531

### **Fisherman’s Hospital - Marathon**

3301 Overseas Highway  
Marathon, FL 33050  
(305) 743-5533

### **Health Systems – Florida Keys**

5900 College Road  
Key West, FL 33040  
(305) 294-5531

### **Mariner’s Hospital**

91500 Overseas Highway  
Tavernier, FL 33070  
(305) 852-4418

## **SPECIAL POPULATIONS AND MANAGED CARE**

- ◆ **Medicare and Managed Care**
- ◆ **Medicaid and Managed Care**
- ◆ **Florida Employers and Employees**
- ◆ **Recent Immigrants (“New Arrivals”)**
  - ◆ **Children and Managed Care**
  - ◆ **Florida KidCare**

## MEDICARE and MANAGED CARE

More than 80,000 Medicare beneficiaries enroll in health maintenance organizations (HMOs) each month throughout the United States. The majority of beneficiaries who choose the HMO option are in Florida, New York, California, Oregon, Arizona, and Hawaii. In Florida, there are over 750,000 Medicare beneficiaries enrolled in an HMO. Miami-Dade County's Medicare HMO enrollees total 138,977 and the total number of Medicare HMO enrollees in Monroe County is 175.<sup>7</sup>

Despite the tremendous growth in Medicare HMOs, many beneficiaries do not understand the basics of traditional Medicare *or* their current HMO options. According to a government survey, six out of every 10 Medicare beneficiaries report knowing little or nothing about managed care.

If you are a Medicare beneficiary, you may be concerned about several other issues when choosing to enroll in an HMO. A recent focus group study of Medicare beneficiaries noted that there are seven key areas of concern that Medicare subscribers evaluate when choosing an HMO:

- ◆ Choice
- ◆ Cost
- ◆ Coverage
- ◆ Convenience
- ◆ Customer Service
- ◆ Case Management, and
- ◆ Continuity of Care.

Indeed, of these concerns, choice has emerged as the single most important consideration for Medicare enrollees.<sup>8</sup>

The most common type of Medicare HMO is referred to as a "Medicare risk" managed care plan. The at-risk Medicare plan is paid a fixed premium each month by the government to provide all Medicare-covered services needed by the beneficiary. Members are usually "locked in" to the plan's provider network of physicians and hospitals unless they need emergency care or they travel outside the plan's service area. Members of Medicare managed care plans pay a small copayment when they use a service, so out-of-pocket expenses are likely to be less than the traditional Medicare fee-for-service system. In addition, Medigap insurance is usually not necessary because the plan provides the same benefits at no additional cost.

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<sup>7</sup> Source: FHA Eye on the Market: HMO Market Share Report, April 1999.

<sup>8</sup> Source: Navigating the Seven C's of Consumer-Driven Medicare Managed Care Plans," Patrick K. Barry, MS, HEALTH CARE INNOVATIONS, July/August 1996.

Each health plan that offers a Medicare product is required to make marketing materials available to you, which explain the benefits and out-of-pocket costs. Many plans provide additional benefits that are not covered under traditional Medicare, such as:

- ◆ Pharmacy benefits,
- ◆ Vision benefits, and
- ◆ Dental benefits.

If you are a Medicare beneficiary, you should obtain a copy of each plan's materials and compare the benefits and costs. Choosing a Medicare HMO is an important decision. Therefore, based on your particular needs and past use of health care services, you should evaluate the differences between each plan's benefits and out-of-pocket expenses, such as co-payments for a specialist visit and pharmacy costs.

If you are a potential member, you should obtain a list of primary care physicians and specialists that will be available to you and you should ask questions about the plan's quality of care. You should ask about their results from the latest review conducted by the National Committee for Quality Assurance (NCQA) or the Health Care Financing Administration (HCFA). Current or previous members of the plan are a valuable source of information. Consumer surveys are now being conducted and contain the percentage of members that rate the plan as excellent in terms of the following:

- ◆ Access to appropriate care,
- ◆ Communication with physicians about their health status and treatment options, and
- ◆ The quality of care provided.

In addition to the survey results, you should ask to see the percentage of members who have left or "dis-enrolled" from the plan each month.

HCFA is developing the National Medicare Education Program that will provide you with information that will help you evaluate your options. This information is available through a toll free number (1-800-MEDICARE), an Internet site ([www.medicare.gov](http://www.medicare.gov)), and a Medicare handbook of plan comparisons. As your choices of health care plans increase, it becomes increasingly important that you seek as much information as possible about benefits, health plans, and your rights and responsibilities.<sup>9</sup>

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<sup>9</sup> Source: 1998-1999 Managed Care Guide for Northeast Florida, The Health Planning Council of Northeast Florida, Inc., Heritage Publishing, Inc.

## MEDICARE + CHOICE

For further information on Medicare + Choice  
Contact the Health Care Financing Administration at:  
(404) 562-7200  
or  
[www.hcfa.gov](http://www.hcfa.gov)

Across the nation, elders are faced with challenging decisions about their personal health care needs. Medicare + Choice was created in 1997 through the federal Balanced Budget Act. The implementation of Medicare + Choice began in January 1999 and includes the following plan type choices:

- ◆ Health Maintenance Organizations (HMO)  
You are restricted to a specified network of physicians and utilize the gatekeeper concept with all care being coordinated by the Primary Care Physician.
  
- ◆ Preferred Provider Organizations (PPO)  
You may use network or non-network providers for varying levels of reimbursement.
  
- ◆ Provider Sponsored Organizations (PSO)  
A network of physicians administered by hospitals and physicians.
  
- ◆ Medical Savings Accounts (MSA)  
A demonstration project allowing beneficiaries to withdraw from a tax-free medical savings account for incurred medical costs.
  
- ◆ Private Fee-For-Service Plans  
You are not restricted to a network of physicians, but in return pay higher premiums and overall costs for services.
  
- ◆ Religious Fraternal Benefit Society Plans

All plans are required to offer complete Medicare Part A and Part B coverage. Part A includes inpatient hospital care along with other types of services such as hospice and skilled nursing.

Part B includes physician office visits and related services. Some include additional benefits such as vision care and pharmaceuticals.

## **MEDICAID and MANAGED CARE**

Medicaid is the state and federal partnership that provides health coverage for selected categories of people with low incomes – individuals who may otherwise go without medical care for themselves and their children. The total national Medicaid population in 1998 was 30,896,635 - 53.64 percent of which was enrolled in managed care.<sup>10</sup> There are currently about 415,000 Medicaid recipients enrolled in 15 health maintenance organizations (HMOs) throughout the state of Florida.<sup>11</sup> Medicaid offers two managed care programs; Health Maintenance Organizations and the Medicaid Provider Access System (MediPass). The Agency for Health Care Administration (AHCA) is the single state agency responsible for administering the Medicaid program in Florida and the Florida Department of Children and Families Services, Office of Economic Self Sufficiency, in conjunction with the Social Security Administration determines Medicaid recipient eligibility.

According to Florida law, if you are a Medicaid recipient you must enroll within 30 days from the date that Medicaid eligibility begins with either a Medicaid HMO or with a MediPass provider, otherwise the Florida Agency for Health Care Administration (AHCA) assigns you to one. You may change your managed care program at any time. However, service authorizations must be obtained from your current program until enrollment changes take effect – a process that can take anywhere from 15 to 45 days. If you wish to change your managed care provider, you may do so by either contacting your HMO's member services office or the MediPass program office, respectively. HMO enrollment changes may also be requested by calling the Agency's choice hotline directly at 1-888-367-6554.

In Florida, Medicaid has eleven area offices that handle claims resolution, provider relations and training, and manage Early and Periodic Screening, Diagnosis and Treatment (EPSDT). The Area 11 office handles Miami-Dade and Monroe Counties and it can be reached at (305) 499-2000.

### **HMOs**

The Florida Medicaid Program contracts with HMOs to provide prepaid Medicaid services to a defined population of enrolled Medicaid recipients. Contractors must provide the following services: EPSDT; durable medical equipment and medical supplies; family planning; hearing; home health; hospital (inpatient, outpatient and emergency services); laboratory, including independent laboratory services; prescribed drug services; physician services; therapy; vision; and x-rays. Physician services can be rendered by any of the following: licensed physicians;

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<sup>10</sup> Source: Health Care Financing Administration: National Summary of Medicaid Managed Care Programs and Enrollment, June 30, 1998.

<sup>11</sup> Source: FHA Eye on the Market: HMO Market Share Report, Fourth Quarter 1998.

advanced registered nurse practitioners; physician assistants; podiatrists; chiropractors; ambulatory surgical centers; rural health clinics; federally qualified health centers; and/or birthing centers.

In addition to these services, plans are also required to provide benefit enhancements such as smoking cessation, substance abuse, domestic violence, pregnancy prevention, prenatal/postpartum pregnancy programs and children's programs. Dental, transportation, and nursing facilities may also be included. Members must request authorization prior to receiving all services, except for emergency, family planning, chiropractic, podiatric, and some dermatology services. Recipients must use a plan provider for chiropractic, podiatry, and dermatology services.

If you are a Medicaid recipient you cannot also enroll in a Medicaid HMO if you...

- reside in a nursing facility,
- are currently enrolled in a Children's Medical Services,
- are in hospice, a Medicare HMO,
- are enrolled in MediPass, or if you
- receive a Home and Community-Based Waiver (exceptions are made if they receive the Developmental Services, Aged/Disabled Adult Services, or the Supported Living Waiver.)

## **MediPass**

MediPass was established in 1991 and is administered by Florida Medicaid. It is a primary care case management program for Medicaid recipients. MediPass assures that you receive adequate access to coordinated primary care and controls for inappropriate utilization of medical services. As a MediPass recipient you have access to 24-hour care, referral, and authorization for specialty services and hospital care.

MediPass providers or those providers to whom you were referred by a MediPass provider are required to provide the following services: advanced registered nurse practitioner; ambulatory surgical center; birth center; chiropractic, county health department, durable medical equipment and medical supply services, EPSDT, federally qualified health center services, home health, hospital inpatient, hospital outpatient, laboratory, licensed midwife, physician services (including obstetrics), physician assistant, podiatric, prescribed drugs, registered nurse first assistant, rural health clinic, therapy, x-rays (including portable x-rays). In addition to being reimbursed for rendered services, MediPass providers also receive a \$3 monthly patient management fee for each eligible recipient that selects them.

If you receive services from any of the above without a referral from a MediPass provider, Medicaid will not reimburse the service and you may be liable for the charges. However, the following physician services do not require prior authorization from the MediPass provider: ophthalmology, mental health, and family planning. Emergency services do not require prior authorization either.

If you belong to any of the following categories you are eligible to enroll in MediPass: low-income families and children; children in foster care; children in subsidized adoptions; and Supplemental Security Income (SSI) recipients who do not receive Medicare.

For general MediPass information, please call the MediPass office for Miami-Dade and Monroe Counties at either (305) 499-2300 or (305) 499-2158.

## **FLORIDA EMPLOYERS AND EMPLOYEES**

More employers are moving to managed care plans to control costs. Those employers that still offer indemnity plans may require you to share more of the financial burden, thus creating a more costly option. When selecting a managed health care plan, employers may consider the following factors:

- ◆ Access to physicians

Employers can consider the location of where you and your co-workers live and determine if a particular network of physicians will meet this need. In addition, employers may wish to evaluate how many primary care physicians have “open” or “closed” panels. When a physician has a “closed panel”, he/she is no longer accepting new patients in the practice, thus limiting the number of providers from which you can choose. Physician hours, if available, may also be considered.

- ◆ Cost

The cost of premiums is very important to employers and consumers. The fees associated with health plans can be extraordinary. Small businesses in Florida may wish to contact the local Community Health Purchasing Alliance (CHPA). The CHPA specializes in insuring small businesses and may offer lower cost options. For more information, call: 1-800-4MY-CHPA. CHPA’s are coordinated in Miami-Dade County through the following insurance carriers: AvMed, Beacon Health Plan, CIGNA Healthcare of Florida, Connecticut General Life Insurance, Health Options (Blue Cross Blue Shield), Health Plans of America, Inc., HIP Health Plan of Florida, Humana, Neighborhood Health Partnership, JMH Health Plan, Sunstar Health Plan and WellCare HMO.

Employers may wish to consider subsidizing all or part of health care premiums on behalf of their employees. Along with considering the cost of the health plan to the company, employers are urged to seek affordable options for the employee. A plan with premiums that are unaffordable will not increase access for you.

- ◆ Quality Indicators

Employers can review a health plan’s most recent quality indicators to assess overall service. Many plans in Miami-Dade are NCQA accredited. Some health plans publish a Health Plan Employer Data and Information Set (HEDIS). This publication acts as a “report card” and allows you to compare “apples to apples” among health care outcomes data. The information collected includes, but is not limited to:

- Preventive Care (e.g. immunizations, pap smears, mammograms);
- Disease Management (beta blockers in cardiac patients); and
- Customer Satisfaction

Employers may contact NCQA at (888) 275-7585 or the specific health plan for more information on what data is available.

## **RECENT IMMIGRANTS – “NEW ARRIVALS”**

When newly arrived immigrants enter the United States, they are faced with numerous challenges. One facet of this experience is understanding the health care system. HMOs can be difficult to comprehend.

If you are a new arrival and are offered coverage by through an HMO, you should focus on the following issues:

- ◆ The importance of knowing which services are covered by the health care insurer and adhering to the HMO rules to ensure insurance payment for health services rendered;
- ◆ The importance of understanding that if you go to another doctor without approval from the primary care physician (in most circumstances), the HMO is not obligated to pay the medical bills.
- ◆ Availability of bilingual services.

You are encouraged to take the following steps when enrolling in an HMO:

1. Read the member handbook, rights and responsibilities and covered services to familiarize yourself with what is a covered benefit and what is excluded.
2. If a specialty service is needed, seek a referral from the primary care physician; if the physician indicates a referral is not needed, verify this information with the customer service department of the HMO. (Note: most HMO’s have 24-hour hotlines to provide information).
3. Carry your HMO card at all times.
4. Provide accurate and complete information about present health, past illnesses, hospitalization, medications and other health matters.
5. Arrive on time for all medical appointments.
6. If a medical claim is denied, contact your HMO’s grievance department for assistance in resolving the problem.

## CHILDREN and MANAGED CARE

Today, some 85% of all employed families, as well as a growing number of families covered by Medicaid are in managed health care plans. Children, in particular, are being enrolled in managed care plans at a higher rate than adults, and now represent a disproportionately larger share of all managed care members.<sup>12</sup>

Because your children must rely on you to coordinate their health care, and their needs are complex due to their rapid growth and development, it is important you carefully consider a managed health plan's benefits and potential pitfalls.

According to the Packard Foundation, when choosing a managed care plan that works for children, your family should consider the following important features:

- A “medical home” that provides accessible, continuous, comprehensive, family-centered, coordinated and compassionate care for your children.
- A defined benefit package that is crafted around your child's changing physical and emotional needs.
- Access to appropriate pediatric specialists for your children with chronic or disabling illnesses.
- Coordinated care both within the managed care organizations and among other child and family-serving organizations outside the managed health plan.
- Rewards and encouragement for your active participation of parents.
- Fair reimbursement rates for providers to ensure adequate network coverage, particularly for special needs children.
- Rewards for managed health plans that improve the health of the children they serve.

The State of Florida is committed to improving the health of its children and families, and as such developed an innovative health care insurance program designed to improve access to health insurance and health care services for children who are uninsured or underinsured. Important information on the Florida KidCare program follows.

*(For additional resources and references on children and managed care, see the Reference Section on page 61 of this guide.)*

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<sup>12</sup> Source: Executive Summary, The Future of Children Vol. 8 No. 2 – Summer/Fall 1998. *The David and Lucile Packard Foundation*.

## FLORIDA KIDCARE

In July of 1998, Florida enacted the “KidCare” program, as authorized under the Balanced Budget Act passed in 1997. This insurance program offers various insurance options for uninsured children ages 0-18. Thus, if your families’ income is below 200% of the federal poverty level (FPL), or if your child qualifies for the free or reduced lunch program your child is eligible for some type of free or low cost insurance plan which will not exceed \$15 per month per household. KidCare covers the following types of services:

- ◆ Primary and Specialty Care Visits
- ◆ Hospital Care
- ◆ Prescription Drugs
- ◆ Laboratory Tests
- ◆ Mental Health

**Medicaid** is for children of all ages. Eligibility is based on your families’ income, the number of people within your household and the ages of the children in your family.

**MediKids** is offered for children ages birth to 4. In order for your child to be eligible for MediKids he/she must not be eligible for Medicaid or Children’s Medical Services and have no other form of health insurance. Like the Medicaid program, specific income provisions apply.

**Healthy Kids** is offered for school-aged children 5-18 and their siblings ages 3-5. Your child must be enrolled in Kindergarten through 12<sup>th</sup> grade and not have any other health insurance to apply. Like MediKids, your child must not qualify for Medicaid or Children’s Medical Services to be eligible to receive benefits.

**Children’s Medical Services Network** offers insurance for children 0-18 with special health care needs. Specific income provisions apply.

**The new KidCare application does not ask for the immigration status of parents. A child must be an U.S. citizen or qualified alien to participate, but application questions about citizenship apply only to children, not their parents. The Florida Legal Services may be called for advice at (305) 576-0080.**

Applications for KidCare Available at  
1-888-FLA –KIDS  
(1-888-352-5437)

## **Who Can You Call for More Information on Managed Care?**

For more information about health plan quality, or your specific health plan, please contact:

### **National Committee on Quality Assurance (NCQA)**

2000 L Street, NW, Suite 500  
Washington, D.C. 20036  
Phone: (888) 275-7585  
Fax: (202) 955-3599  
Website: <http://www.ncqa.org>

### **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**

Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
Phone: (800) 944-6610  
Fax: (630) 792-5636  
Website: <http://www.jcaho.org>

### **Accreditation Association for Ambulatory Health Care (AAHC)**

9933 Lawler Avenue  
Skokie, IL 60077-3708  
Phone: (847) 676-9610  
Fax: (847) 676-9628  
Website: <http://www.aaahc.org>

### **Florida Association of HMOs**

1415 East Piedmont Drive  
Tallahassee, Florida 32312  
Phone: (850) 386-2904  
Website: <http://www.fahmo.org>

### **Florida Agency for Health Care Administration (AHCA)**

Division of Quality Assurance - Bureau of Managed Health Care  
2727 Mahan Drive  
Tallahassee, FL 32308  
Phone: (850) 921-5458  
Fax: (850) 994-5418  
Website: <http://www.fdhc.state.fl.us>

There are several additional ways to get more information to help you put together the pieces of the health care insurance puzzle:

**Florida Department of Insurance**

Dade and Monroe County Offices  
401 NW 2nd Avenue (Suite N307)  
Miami, FL 33128-1700  
Phone: (305) 377-5235  
Website: <http://www.doi.state.fl.us>

**Florida Department of Insurance Consumer Helpline**

Phone: (800) 342-2762  
(For the hearing impaired: (800) 640-0886)

For more information on PPO's, contact:

**American Association of Preferred Provider Organizations**

One Bridge Plaza, Suite 325  
Fort Lee, NJ 07024  
Phone: (800) 642-2515  
Fax: (201) 947-3808  
Web Site: <http://www.aappo.org>

For more information on HMOs, contact:

**American Association of Health Plans**

1129 20th Street, NW, Suite 600  
Washington, DC 20036  
Phone: (202) 778-3200  
Web Site: <http://www.aahp.org>

## Other Important Telephone Numbers

Agency for Healthcare Administration - Office of Managed Care.....	(800) 226-1062
• <i>HMO Complaint Hotline</i>	
Alcohol & Drug Help Line.....	(800) 821-HELP
Alliance for Aging Insurance Counseling – SHINE.....	(305) 670-6531
American Association of Retired Persons (AARP).....	(800) 424-3410
Community Health Purchasing Alliance (CHPA).....	(305) 593-5528
Elder Help Line.....	(800) 273-2044
Florida Insurance Consumer Hotline .....	(800) 342-2762
• <i>Free non-emergency information and referral to consumers seeking health care services in South Florida.</i>	
Insurance Consumer Help Line.....	(800) 342-2762
Managed Care (HMO) Complaint Hotline .....	(800) 800-5154
• <i>Consumer complaint is recorded by a confidential voice mail system. The call is either returned or a written reply is sent from a physician.</i>	
Medicaid Resource & Information Unit.....	(305) 499-2100
Medicare Information.....	(800) 638-6833
Mental Health Association of Dade County.....	(305) 379-2673
• <i>Provides information and referral concerning services available for senior citizens.</i>	
South Florida Health Line.....	(305) 825-6269 (800) 624-3365
Statewide Subscriber Assistance Program.....	(850) 921-5458

## GLOSSARY OF COMMON MANAGED CARE TERMS

**Accreditation** - Certification that an organization meets the reviewing organization's standards.

**Accreditation Association for Ambulatory Health Care (AAAHC)** – A private, not-for-profit organization that assists ambulatory health care organizations in improving the quality of care they provide to their patients by setting standards, measuring performance, providing consultation and education where needed, and ultimately by awarding accreditation to those organizations that are found to be in compliance with its standards.

**Alternative Delivery Systems** – Term used to describe all forms of health care delivery except traditional fee-for-service care and includes HMO's, PPO's, and IPA's.

**Application** – The document a person signs to join an HMO. The application includes the names, ages and addresses of the persons to be covered and may ask questions about medical history.

**Authorized HMO** – An HMO that has received a Certificate of Authority from the Department of Insurance. After it has met certain quality of care standards, the Agency for Health Care Administration is responsible for issuing a Health Care Provider Certificate to the HMO.

**Beneficiary** – A person who is eligible to receive benefits under a health benefits plan.

**Board Certified Physicians** – Physicians who have taken an exam and have been certified by medical boards of their respective medical specialty.

**Cancellation** – Termination of the contract between an HMO and a subscriber. By law, HMOs must give a subscriber 45 days' written notice of cancellation (other than for non-payment of premium or termination of eligibility). Reasons for cancellation must also be given.

**Capitation** - Capitation is a payment methodology used by HMO's to pay health care providers typically on a per member per month (pmpm) basis. The provider must then provide or make arrangements for the provision of all necessary care as agreed upon in the contract. The provider is usually at risk for a portion of the expenses for care that exceeds the prepaid amount. Likewise, the provider is entitled to the profits for care that falls below the capitation rate. Providers must balance their medical decision making between under- and overutilization of resources, services, tests, consultants, etc. This payment method was devised to encourage providers to reduce unnecessary utilization of resources.

**Carve-Out** - An arrangement in which an employer or health plan removes coverage for a specific category of services and arranges for coverage through a contract with a separate set of providers. A carve-out service typically involves management of chronic or long-term disorders, other specialty services, such as mental health, prescription drugs or medical equipment.

**Case Management** – Coordination of services to help meet a patient’s health care needs, usually when the patient has a condition which requires multiple services from multiple providers. This term is also used to refer to coordination of care during and after a hospital stay.

**Closed Panel** – Managed care plan that contracts with physicians on an exclusive basis to provide health services to enrollees.

**Community Health Purchasing Alliance (CHPA)** - A CHPA is a non-profit organization that helps small businesses find affordable health insurance. Businesses with less than 50 employees can choose from a variety of low cost plans.

**Consolidated Omnibus Budget Reconciliation Act (COBRA)** - A federal law requiring employers with 20 or more employees and with group health plans to offer participants the opportunity to purchase the continuation of health care coverage for a limited time period after the occurrence of a qualifying event such as termination of employment.

**Consultation** – A discussion with another health care professional when additional feedback is needed during diagnosis or treatment. Usually, a consultation is by referral from a primary care physician.

**Continuity of Care** – Maintaining continuity of care for patients is a quality and risk management issue that includes coordination within a medical team, attending physician/consulting interface, as well as coordination across institutions and care settings.

**Co-payment** - A small fee paid to a medical provider upon receiving services (usually about \$5-10). This can include physician visits, pharmaceuticals and laboratory services. The remainder of payment due is received from the managed care organization, provided the services are covered by the health plan and the patient followed managed care guidelines.

**Covered Services** – Medical services for which the health plan will pay if needed by the patient. Certain procedures or conditions may be excluded by the plan, especially if they are considered experimental.

**Credentialing** – A review of a physician’s background, qualifications and professional standing against a set of criteria. Participation is granted based on hospital affiliations, education, liability history, felony convictions and disciplinary actions. Credentials and performance are periodically reviewed, which may result in a physician’s privileges being denied, modified, or withdrawn.

**Deductible** – The out of pocket amount a person must pay each year before the insurance company will pay the provider for all or part of the remaining cost of covered services.

**Dependent** – A person eligible for coverage under an employee benefits plan because of that person’s relationship to an employee. Spouses, children and adopted children are often eligible for dependent coverage.

**Deductible** – The out of pocket amount a person must pay each year before the insurance company will pay the provider for all or part of the remaining cost of covered services.

**Disenrollment** – A voluntary procedure for terminating one’s membership in a health benefits plan.

**Eligible** – Provisions contained in each health benefits plan that specify who qualifies for coverage under that plan.

**Emergency Services** - The procedures for accessing twenty-four (24) hour emergency service are outlined below. A medical emergency is the sudden and unexpected onset of a health condition where the symptoms are severe enough to make a prudent lay person believe that immediate medical care is required. Emergency medical conditions may include, but are not limited to, situations where: (a) a person’s health is in significant jeopardy; (b) serious bodily impairment may impact a bodily function; (c) serious dysfunction may impact any bodily organ or part; (d) there is inadequately controlled pain; or, (e) a pregnant woman is having contractions. Failure to get treatment for a medical emergency could put a person’s life in danger or cause serious harm. HMO’s must pay for emergency services without prior approval or authorization by the Primary Care Physician.

**Enrollment Period** – The period of time for which a subscriber is a member of a health benefits plan.

**EPSDT** – Early and Periodic Screening, Diagnosis, and Treatment Program. Designed to improve primary health benefits for children with emphasis on preventive care that has been a part of the federal Medicaid program since its beginning in the late sixties. After a Medicaid review in 1989, Congress moved to increase the services of EPSDT through the Omnibus Budget Reconciliation Act. States must now cover regular and periodic exams for all eligible children under the age of 21. They must also provide any medically necessary services prescribed by the exams, even those not covered in a state’s Medicaid plan. This includes many assistive devices and services for individuals that are under 21 which have been excluded under the regular Medicaid program in the past. Note: Individuals within the manage care programs contract their service providers for more information.

**Exclusive Provider Organization (EPO)** - EPO is a health care plan in which members receive benefits only when they select from a limited network of providers.

**Explanation of Benefits** – Statement sent to health plan enrollee by their health plan showing services provided, amount billed, and payment made.

**External Appeals** – The right of patients to seek independent third-party reviews of health plan’s decision to deny coverage of doctor-recommended treatment.

**Federal Qualification** – Federal requirements as established by federal law and regulation. All HMOs providing Medicare services must be approved by the Health Care Financing Administration, a part of the U.S. Department of Health and Human Services.

**Fee-for-service** – The traditional method of payment for health care services based on each visit or service rendered. Traditional health coverage where the patient or insurance company is billed for services provided.

**Florida KidCare** - A low cost health insurance program for children, which includes Medicaid, MediKids, Healthy Kids and Children’s Medical Services. Program information and eligibility requirements can be obtained by calling 1-888-FL-KIDS.

**Gatekeeper** - A primary care provider who monitors a patient’s care and decides if tests or specialists are needed. Generally, to be covered for specialty care, your primary care physician must refer you to a specialist.

**Group Model HMO** – This type of HMO contracts with doctors organized as a partnership, professional corporation or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting hospitals for care for their patients.

**Health Financing Administration (HCFA)** – Federal agency responsible for administering Medicare and supervising the states’ administration of Medicaid.

**Health Maintenance Organization (HMO)** - A prepaid managed health plan utilizing the gatekeeper concept. Members must coordinate all care through the primary care physician. Referrals are needed for most specialty care of non-emergent hospitalizations. It is a form of comprehensive health insurance through which members receive care provided by certain doctors, hospitals and other health care providers who are affiliated with the HMO. These partnerships create a coordinated system of patient care called a network.

**Health Maintenance Contract** – Any contract entered into by a health maintenance organization with a subscriber or group of subscribers to provide comprehensive health care services in exchange for a fixed, prepaid sum. The health maintenance contract must outline the responsibilities of the HMO and the subscriber.

**HMO Member Handbook** – An easy-to-read booklet that explains an HMO’s services, benefits, limitations and exclusions.

**Health Maintenance Services** – Any health care service or program that helps maintain a person’s good health. Health maintenance services include all standard preventive medical practices, such as immunizations and periodic examinations, as well as health education and special self-help programs.

**The Health Plan Employer Data and Information Set (HEDIS®)** – A core set of performance measures developed through the collaborative effort of the National Committee for Quality Assurance (NCQA), employer groups and health care purchasers. HEDIS is a registered trademark of the National Committee for Quality Assurance.

**ID card** – Identification cards are provided to all participants for proper identification under their group health plan. ID card information helps providers verify patient eligibility for coverage.

**Indemnity Insurance** – Health insurance plan providing a predetermined amount of covered services. Traditionally, payment is made on a fee-for-service basis with no involvement by the insurer in the actual delivery of health care services.

**Independent Practice Association (IPA) HMO** – The HMO contracts with an association of medical professionals to provide medical services in return for a negotiated fee. The IPA in turn contracts with physicians who continue in their existing individual or group practice.

**Individual Converted Contract (Conversion)** - A contract that has been converted from a group contract to an individual contract. If you are an HMO member under a group contract for at least three months and your coverage is terminated, you can elect to transfer coverage from the group policy to an individual contract under certain circumstances. Refer to the member handbook for complete information.

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** – An independent, not-for-profit organization whose mission is to improve the quality of care provided to the public through the process of health care accreditation and related services which support performance improvements in health care organizations. The Joint Commission evaluates and accredits hospitals and health care organizations which provide managed care (including health plans, preferred provider organizations and integrated delivery systems), home care, long-term care, behavioral health care, laboratory and ambulatory care services.

**Lock-in Provision** – The requirement that members use only HMO doctors and facilities for all medical care, except for emergency care or urgently needed care while temporarily away from the service area.

**Long Term Care Insurance** – Long-term care insurance usually covers skilled nursing, intermediate-care, personal care, home care, or eldercare facilities.

**Managed Behavioral Healthcare Organization (MBHO)** – A managed care company specializing in managing the mental health or behavioral health benefit for an insurance company or employer. These benefits are typically separate or “carved out” from the basic health or medical insurance benefit.

**Managed Care** - A type of health insurance generally utilizing the “gatekeeper” concept. All health care needs are coordinated through the primary care physician with the exception of some specialties, which by state mandate must be accessible without a referral (e.g. obstetrics/gynecology, dermatology, podiatry, and chiropractic). Examples of managed care organizations include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Managed care plans generally require a “co-payment” at the time medical care is sought.

**Medicaid** - A state and federal health insurance program for residents below state designated income levels. Medicaid was established in 1965 as part of the Social Security Act. It is a separate program in each State and territory. Medicaid pays for health care for people with low incomes. Without Medicaid many people would not have access to medical care for themselves and their children. In order to receive Medicaid in the State of Florida, you must be a U.S. Citizen, a resident alien or a permanent U.S. resident under the law. You must also be a Florida resident; have or apply for a Social Security card; and assign medical insurance payments to HRS. Your income and assets must be below certain limits. Medicaid pays for hospital stays, doctor bills, clinic visits and prescriptions.

**Medicare** - A federal health insurance program primarily for residents over the age of 65. Medicare is a federally funded health insurance program for people age 65 or older. Certain disabled people under 65 and people of any age who have permanent kidney failure are also eligible. Medicare provides basic protection against the cost of health care. It does not cover all medical expenses. Medicare has two parts, hospital insurance and medical insurance. Hospital insurance or “Part A” is financed by part of the payroll tax that pays for Social Security. It pays for inpatient hospital care; inpatient care in a skilled nursing facility; home health care; and hospice care. A benefit period starts the day of admission into the hospital or other facility, and ends when the patient has been out of the hospital or other facility for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. Monthly premiums paid by enrollees finance medical insurance. It helps pay for doctor’s services. It also pays for other medical services and supplies not covered by hospital insurance. Medicare medical insurance begins paying for coverage after an annual medical deductible is met.

*Special Medicare Programs or Initiatives Medicare Choices* – two year demonstration project sponsored by the Health Care Financing Administration (HCFA) which is intended to test the receptivity of Medicare beneficiaries to a broad range of health care delivery system options, gauge the viability of alternative payment methods and evaluate the suitability of such options for the Medicare program.

*Medicare Select* - originated with the passage of OBRA '90 as a demonstration allowing insurers in 15 states the opportunity to offer the 10 standardized Medigap policies with a preferred provider panel. Legislation passed in June 1995 expanded its sales to all 50 states. The plan is responsible for covering only those services rendered in-network that exceed the benefit level covered under Medicare. HCFA will make payments for all Medicare covered services both in-network and out-of-network. The restricted panel and the financial disincentives associated with going out of the network drive down the price of a SELECT policy between 15 percent and 25 percent to that of the comparable Medigap policy.

**Medicare Part A** – Hospital insurance provided by Medicare that can help pay for inpatient hospital care, medically necessary inpatient care in a skilled nursing facility, home health care, hospice care and end-stage renal disease treatment.

**Medicare Part B** – Medicare-administered medical insurance that helps pay for certain medically necessary practitioner services, outpatient hospital services and supplies not covered by Part A hospital insurance of Medicare coverage. Doctors’ services are covered under Part B even if they are provided to a member in an inpatient setting. Part B can also pay for some home health services when the beneficiary doesn’t qualify for Part A.

**Medigap Insurance** – “Medigap” insurance is private health insurance. It pays for some of the expenses that Medicare does not cover, for example, deductibles and co-payments. State or federal governments do not offer Medigap policies. However, state insurance departments must approve Medigap policies offered by private companies.

**Member** – An individual covered by an HMO contract. The person can be the subscriber or eligible dependent(s).

**National Committee on Quality Assurance (NCQA)** - A nonprofit accrediting organization for managed care organizations. It assesses quality, credentialing, utilization management, customer rights, preventive health services, and medical records.

**Network** – A group of health care providers under contract with a managed care company within a specific geographic area.

**Network Model HMO** – A health care model in which the HMO contracts with more than one physician group and may contract with single and multi-specialty groups. The physician may share in utilization savings, but may not necessarily provide care exclusively for HMO members.

**Open Access** – Self-referral arrangement (also called open panel) allowing members to see participating providers for specialty care without a referral from a primary care doctor.

**Open enrollment** – A period when eligible persons can enroll in a health benefits plan.

**Outpatient care** – Any health care service provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor’s office, clinic, the patient’s home or hospital outpatient department.

**Out of Pocket Maximum** – A limit on the insured’s total out of pocket expenses, including deductibles and co-payments. Once out of pocket maximum is reached, the insurance company will begin to pay 100% of covered charges.

**Participating Providers** – An HMO or PPO Provider Directory usually includes a listing of participating network providers, including PCP and Specialists. Pharmacies and other specialty or “carve-out” providers are also listed in the directory. Physicians are listed by geographic location and specialty such as family practice or pediatrics.

**Physical Hospital Organization (PHO)** – A PHO encourages cooperation between hospitals and physicians by enabling both groups to make patient care decisions in a capitated environment. (See Capitation.)

**Point of Service (POS)** - A managed care plan with both “in-network” and “out-of-network” coverage. Members may seek care through their primary care physician and receive full benefits with responsibility for a copayment; members may choose to pay a deductible and coinsurance to receive out-of-network services. A POS insurance plan allows members to choose any provider. For greater savings, they can utilize a Primary Care Physician (PCP). This PCP then manages their care and service referrals.

**Policyholder** – The group or individual to whom an insurance contract is issued.

**Provider** – A provider is a doctor, hospital, or any other individual or facility licensed to provide health care services in the state.

**Provider Network** – A selected group of physicians, hospitals, laboratories and other health care providers who participate in a managed care plan’s health delivery program and agree to follow the plan’s procedures.

**Provider Sponsored Organization (PSO)** – A group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. This type of managed care plan is run by the providers and doctors themselves, rather than by an insurance company.

**Quality Assurance** – Formal set of activities within health plans to protect or improve the quality of patient care, administrative and support services. Involves evaluating treatments and procedures, correcting problems, and monitoring corrective actions.

**Quality of Care** – The nature of the care received by a subscriber. By law, an HMO must ensure that the health-care services it provides are consistent with the community’s current professional standards of medical practice. The Agency for Health Care Administration monitors HMOs to ensure that providers (doctors, hospitals, etc.) furnish appropriate and safe health care to HMO members.

**Referral** – If a primary care physician determines that a participant has a condition, which requires the attention of a specialist, the physician makes a referral to a specialist. Under some benefits plans, a referral by the primary care physician is required to obtain services from other providers.

**Service Area** – The geographical area covered by a network of health care providers.

**Specialists** – Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), a specific age group (e.g., pediatrician), or specific procedures (e.g., oral surgery).

**Staff Model HMO** – A health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

**Status Change** – A lifestyle event that may cause a person to modify their health benefits coverage category. Examples include, but are not limited to, the birth of a child, divorce, or marriage.

**Subscriber** – The individual, group or employer to whom the HMO issues a health maintenance contract.

**UCR** – Usual, Customary, and Reasonable.

**Utilization Review** – Program designed to reduce unnecessary hospital admissions and control the length of inpatient stays through the use of pre-admission certification, second surgical opinions, concurrent inpatient evaluations and/or discharge planning.

**Withholds** – Compensation given to a provider by an HMO when certain utilization and quality goals are met.

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