

Understanding insurance-speak

Dear Patient:

The language of healthcare used to be a whole lot simpler. Today, under managed care, new, sometimes bewildering terms seem to crop up every year. If you feel confused, don't worry. You're not alone. We've put together the following glossary of some of the most widely used managed care terms. The definitions are simple and to the point. If you'd like a fuller explanation of anything you see below, please don't hesitate to ask me or a member of my staff.

Access—your ability to see me—or to obtain other healthcare services—whenever necessary.

Ancillary services—services other than mine or another physician's (home healthcare, physical therapy, occupational therapy) that I suggest to help you get better quicker.

Appeal—your right to have a coverage decision by your health plan reviewed. All states require plans to submit appeals to an in-house or *internal* review board. Currently, 42 states and the District of Columbia also permit you to appeal denials to an agency outside the insurance company, once the internal process has been exhausted. In either case, I stand ready to assist you, if necessary.

Capitation—the way some health insurers pay doctors—not on the cost or number of services we *actually* deliver—but on a fixed formula, typically some dollar amount per patient (or “covered member”) per month.

Copayment—a flat, out-of-pocket fee (typically \$10-20) that your health plan requires I collect each time you visit. You will also pay this flat fee for many of the prescriptions your pharmacist fills.

Deductible—a flat amount you must pay before your health plan will pay for any of your care.

Fee schedule—the fee determined by your health plan—and accepted contractually by me—for specific procedures or services. Also known as a *fee allowance*, *fee maximum*, or *capped fee*.

Formulary—a list of drugs that your health plan encourages—and, in some cases, requires—me to prescribe in order to reduce costs. You'll usually have a lower copay for such formulary medications than for other drugs.

Health Maintenance Organization—a health plan that offers a full-range of medical services for a set, prepaid premium. In an *open-panel HMO*, you may receive nonemergency services from a specialist, without first getting approval from your primary care doctor. In a *closed-model HMO*, the doctors you see are all employees of the HMO or belong to a physician group that contracts with the HMO.

Hospitalists—doctors who spend the bulk of their time in a hospital setting and care for the hospitalized patients of primary care physicians. This arrangement allows primary care doctors to spend more time in the office. Be assured that—if I refer you to a hospital-based doctor—I'll be in close contact with him and will still closely monitor your course of treatment.

Medically necessary services—diagnostic or treatment measures that I believe are appropriate given your physical condition. Your health plan may refuse to pay for something, claiming it's not a medically necessary service when, in fact, they may just not cover it because it's too expensive. You have the right to appeal that decision. (See above.)

Network—the group of physicians, hospitals, and other healthcare professionals that a health plan contracts with to deliver medical services to its members. Patients receiving services from providers outside this group are said to be going “out-of-network.”

Point of service plan (POS)—a health plan option that permits you to choose—at the time you need medical services—whether to go to a network doctor or an out-of-network doctor.

Pre-authorization (also called “precertification”)—the approval I must get from your health plan before admitting you to the hospital or providing or referring you for other types of specialty services. Without this approval, your medical care may not be covered.

Preferred provider organization (PPO)—a benefit arrangement that offers you a discount for using designated doctors but that also permits you to use, at a higher fee, physicians that haven't contracted with the PPO.

Usual and customary—the measure insurers use to determine physician reimbursement for a certain medical service within a specific geographical area. To determine usual and customary fees, insurers look at the range of fees doctors in the area charge for the same service. If they choose to reimburse at the lower end of the range, my charge *could* be higher than the “usual and customary” fee because that fee doesn't adequately cover my cost of providing the service.