



PacifiCare Health Watch

Managed Care Terms

HMO/MCO/POS

Knowing and understanding the different roles and responsibilities of the parties within a managed care system will help you get the most value from your health plan. As always, our goal is to keep you informed and up-to-date.

A **Health Maintenance Organization (HMO)** or, as called in some states, Managed Care Organization (MCO) is a system for providing health care services to its members. HMOs are responsible for financing health care as well as contracting with the providers who deliver medical care to their members. An HMO benefit plan is a form of prepaid health insurance that generally includes comprehensive health care benefits with a focus on wellness and preventive care.

HMO benefits include most immunizations, routine physicals and well baby care. Every HMO member selects a Primary Care Physician (PCP) responsible for directing the member's care, including referring members to specialists and hospitals as needed. An HMO member's PCP is in charge of the member's total health care.

A **Point-of-Service (POS) health care plan** offers members the flexibility to choose how to receive health care services at the point of service. Through the POS plan, services are generally covered at two levels: In-Network provides coverage similar to standard HMO coverage, featuring comprehensive health care services with lower Out-of-Pocket costs. Out-of-Network provides more flexibility but with higher Out-of-Pocket costs.

Capitation: A predetermined dollar amount that is paid to HMO providers on a monthly basis. This capitated payment is made to providers regardless of whether or not a member accesses care.

Questions?

Call the

Customer Service

department

toll-free at

1-800-531-3341.

Coinsurance: An employee's share of the medical expenses after satisfying the deductible. Coinsurance is usually expressed as a percentage.

Copayment: A nominal, standard fee charged to HMO members for each office visit or prescription.

Credentialing: The process of reviewing potential health care providers' credentials to determine if they meet the standards of the Medical Group and PacifiCare.

Deductible: A fixed dollar amount a member must pay before the health care plan begins to cover costs.

Fee-for-Service: Traditional method for paying providers based on the fee for each service, without any negotiated discounts.

Fee Schedule: A comprehensive listing of fees used as a standard to reimburse physicians and other health care providers.

Independent Physician Association (IPA): Independent physicians who work in their own practices and see fee-for-service patients as well as HMO members. IPA physicians receive capitated payments for all HMO members who designate them as their PCP.

Open Enrollment: A time period, usually held once per year, during which a company allows employees/retirees to enroll in, or make changes to, their health plan or benefits.

Out-of-Pocket Costs: The amount of payment made by a member for health care services (not including health care premiums paid by the employee or employer).

Participating or Contracting Provider: A medical facility, physician, or pharmacy with a PacifiCare contract to provide health services to its HMO or POS members.

Preventive Care: Health care that places a high priority and emphasis on maintaining the health of members, featuring early detection of illness and disease through routine physicals, regular health screenings, immunizations, and well baby care, among others.

Primary Care Physicians (PCP): The first doctor the member sees for medical treatment. The PCP is responsible for managing and directing all of the member's health care needs.

Primary Medical Group (PMG): A group of health care providers that have joined together to share resources and the financial risk of providing health care to members.

Provider: A supplier of health care services, i.e. physician, pharmacist, home health services, etc.

Reasonable and Customary (R&C): The usual and customary physician fees for like services in the same geographical area. Can also be called Usual, Customary and Reasonable (UCR).

Referral: An authorization to see a specialist given to an HMO or POS member by his/her PCP.