

## **Making Informed Decisions: Medicare Health Maintenance Organization (HMO)**

Medicare HMOs are one of the Medicare Advantage program's coordinated care plans. They agree to provide all the Medicare-covered benefits a person would receive under Medicare Parts A and B, and sometimes cover additional benefits. HMOs receive a monthly payment from Medicare for each person who enrolls. Some charge enrollees an additional monthly premium. People who join HMOs usually must receive services from doctors, hospitals, and others who belong to the HMO's provider network. A primary care physician or physician assistant coordinates the care enrollees receive. HMOs often require these "gatekeepers" to seek approval from the plan before the HMOs pay for visits to specialists. By using network providers and following the HMO's rules for prior approval and referrals, plan members often have reduced costs for covered services. The HMO generally will not pay for out-of-plan services except in emergencies or urgent situations.

While Medicare HMOs may work well for many people, they are not for everyone. It is important to understand what the rules mean for your access to health care and your budget before you enroll. Take some time to get answers to the questions below. Use the space provided to jot down the names of plan contacts and the answers they give.

**A. About Access to Care in (name of HMO):** \_\_\_\_\_

1. How important is it for you to go to any doctor you choose? How important is it for you to see your current doctor(s)? Do they belong to the HMO's provider network? Do you often see specialists?

In Original Medicare, you can go to any doctor or hospital in the country that accepts new Medicare patients. In a Medicare HMO, you will be limited in most cases to using the primary care physicians and specialists in the HMO's network. If you see a provider outside of the network, you will have to pay the full amount for that care, except in emergencies and urgent care situations.

**Action step:** Call your doctors to ask if they belong to the HMO's provider network.

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2. Does the HMO have network hospitals, diagnostic centers, pharmacies, and other facilities that are conveniently located for you?

Medicare HMOs need not include all of the hospitals in your community in their provider networks. If you go to hospital that is not in the network, the HMO may not pay for the services you receive. You could owe the entire bill. Original Medicare will pay for care at nearly all hospitals in the U.S.

**Action step:** Ask the HMO if the hospital you want to use is in its provider network.

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3. How often do you travel outside of the HMO's service area? How long are your absences from the area?

To enroll in a Medicare HMO, you must live in the plan's service area for most of the year. If you need non-urgent care while you vacation or spend a season outside the service area, a Medicare HMO may not pay for the care you need. Original Medicare covers you in all fifty states, the District of Columbia, and the U.S. Territories.

**Action step:** Ask the HMO about its rules and procedures for covering care outside of its service area.

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4. What rules does the plan use to approve costly tests, specialty care, and surgery? Are you comfortable with these rules and the limits they may place on your access to some providers and services?

HMOs often require your doctors to ask the plan to approve diagnostic and surgical procedures. Without prior approval, the HMO will not pay for the services. Sometimes HMOs do not approve a procedure or course of treatment that doctors recommend, even when there is a medical need for it. HMOs contain costs through these prior approval rules. Original Medicare pays for medically necessary services without prior approval rules.

**Action step:** Ask the HMO to describe how its prior approval process works, and to give some examples of the kinds of medical services that are subject to prior approval.

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**B. About Out-of-Pocket Costs in (name of HMO):** \_\_\_\_\_

1. Does the HMO have a cap on annual out-of-pocket spending? Does it have separate caps for medical and prescription drug coverage? Are you prepared financially to cover out-of-pocket costs up to the cap (or beyond)?

A reasonable out-of-pocket limit is about \$2,500 to \$3,000. This is the amount you would spend for the year. Note that some Medicare HMOs do not have caps on your annual spending. In some medical situations, you could owe many thousands of dollars in combined co-payment and coinsurance charges.

**Action step:** Ask the HMO about which services apply to the annual limit or cap.

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**The plan's annual out-of-pocket limit is:** \_\_\_\_\_.

2. Are you prepared to cover the HMO's co-payments for hospital stays?

Co-payments of \$150 to \$200 per day for the first five days--or more--of a hospital stay are common. Ten days in a hospital could cost in excess of \$1,500. Original Medicare's annual deductible for hospital stays is \$1,068 (2009). Most supplement insurance policies cover the cost in Original Medicare, but not for an HMO.

**Action step:** Check the HMO's total out-of-pocket cost for an inpatient hospital stay.

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3. What are the co-payments for Skilled Nursing Facility (SNF) care and Home Health care? Do the costs count toward the annual out-of-pocket limit?

Original Medicare pays the whole cost of the first 20 days of skilled nursing facility care. It also pays the whole cost of medically necessary home health nursing and therapy visits without a set limit on the number of visits. There is no 20 percent coinsurance charge. Many HMOs, however, have co-payments for these same services.

**Action step:** Check the HMO's co-payments for SNF and Home Health care.

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4. What are the HMO's co-payments for outpatient surgery and other outpatient medical procedures? Do these costs count toward the annual out-of-pocket limit? Are you prepared to cover the out-of-pocket costs for multiple hospitalizations, physical therapy treatments, and ambulance trips?

Many surgical, medical, and rehabilitation procedures routinely occur in an outpatient setting. Co-payments for each outpatient service are \$150 or more at some HMOs. The co-payments for a series of outpatient visits, as physical therapy after a stroke, can quickly add up to thousands of dollars. Also, some HMOs do not count the co-payments for services like ambulatory surgery toward the annual cost-sharing limit.

**Action step:** Ask the HMO about co-payments for outpatient hospital services, including day surgery and rehabilitation. Ask about the services that do not count toward the limit.

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5. Which covered benefits have a fixed co-payment? Which have coinsurance charges, that is, a percent of the total cost of an item or service? Does the HMO use a coinsurance to calculate your share of the cost for medical equipment, supplies, and Part B drugs, such as chemotherapy medications? Are you prepared to cover the coinsurance charges for expensive services or items?

Some HMOs apply a coinsurance charge, often 20 percent, to durable medical equipment (such as wheelchairs and oxygen equipment), medical supplies, prosthetics, and some drugs. These include chemotherapy and other drugs involved in cancer treatment. The coinsurance charges for chemotherapy drugs can be very high. With chemotherapy costing as much as \$100,000, your 20 percent share of the cost would be \$20,000 (if the plan has no annual cap on out-of-pocket costs).

**Action step:** If you use medical equipment like wheelchairs, hospital beds, or oxygen tanks, ask the HMO what you would owe in monthly coinsurance charges. You could also ask what your cost would be for specific Part B drugs you have used.

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6. Are you enrolled in your state's Medicaid program or the Qualified Medicare Beneficiary (QMB) program?

In some states, the Medicaid program does not work with Medicare HMOs to cover plan co-payments and other out-of-pocket costs. Instead, Medicaid works with Original Medicare. Your Medicaid benefits could be worthless if you join an HMO.

**Action step:** Call Medicaid to ask how it works with Medicare HMOs.

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