It’s Your Choice

Are Medicare HMOs right for you?
This publication should be used as a guide only.

Health maintenance organization (HMO) policies and coverage vary widely. Your HMO must give you a complete explanation of covered benefits, complaint-handling policies and any rules that members must follow to obtain full coverage.

If you have questions about your HMO, call your plan’s member services department.
About this publication

It’s Your Choice: Are Medicare HMOs right for you? has been created by Consumer Action. In 1997, Consumer Action wrote a similar booklet to help employee-group HMO members get the most out of their plans.

As the first effort was publicized and distributed during 1997, it became evident that there was another group of health insurance consumers — Medicare recipients — who could benefit from the same kind of educational publication. The need was especially urgent because the Balanced Budget Act of 1997 rolled out changes in Medicare, designed to give recipients new options and new rights. But the new law and the program it creates, Medicare+Choice, could bring with it uncertainty for beneficiaries, who may find the government’s mandates to expand Medicare managed care confusing and in some cases unsettling.

Consumer Action was fortunate to include the expertise of two influential national groups, the Gray Panthers and the National Consumers League. These organizations provided invaluable peer review and reinforcement for the objective to create a unique and truly informative publication for Medicare beneficiaries. We note special thanks to Timothy Fuller (National Executive Director) of the Gray Panthers, and Linda Golodner (President) of the National Consumers League. We would also like to thank Glendale Johnson (Director, Consumer Information Network) and Jean Polatsek (Director of Health Policy) of the National Council on the Aging for their comments and suggestions.

Consumer Action is a pioneering non-profit advocacy and education organization that has served consumers since 1971. Consumer Action’s switchboard provides free, non-legal advice and referrals on a wide range of issues, in Chinese, English and Spanish. Each year, Consumer Action distributes more than one million free consumer education publications nationwide. Many are available in Cambodian, Chinese, English, Korean, Laotian, Spanish, Tagalog and Vietnamese, as well as Braille, large type and audiocassette. (Please see the back cover for information on how to contact Consumer Action.)
**Gray Panthers** is an intergenerational organization of advocates and activists — Age & Youth in Action. For almost three decades, the Gray Panthers has influenced and promoted progressive policy on national issues as well as projects in local communities nationwide. Its mission is to organize people of all ages to fight for social and economic justice. The Gray Panthers works with community partners and leaders through its more than 50 chapters across the country. Its *NETWORK* newsletter is distributed bimonthly to members and subscribers. The organization’s information and referral service (1-800-280-5362) offers information to the public regarding advocacy on health care, Social Security, workers’ rights and other issues. A list of publications is available on request. Write to: Gray Panthers, 733 15th St., N.W., Suite 437, Washington, DC 20005; 202-737-6637 fax 202-737-1160; www.graypanthers.org.

**The National Consumer League (NCL)**, the oldest non-profit consumer organization in the United States, is a membership organization dedicated to representing consumers on issues of concern including financial services, fraud, fair labor standards, food and drug safety and telecommunications. Since 1899, NCL’s three-pronged approach of research, education and advocacy has made it an effective representative and source of information for consumers and workers. The *NCL Bulletin* newsletter is distributed bimonthly to members and subscribers. The NCL’s National Fraud Information Center (1-800-876-7060 or www.fraud.org) was established in 1992 to fight the growing menace of telemarketing fraud by improving prevention and enforcement. For more information about NCL and the other projects and programs that it conducts, write or visit the organization’s website: NCL, 1701 K. St., N.W., Suite 1200, Washington, DC 20006; 202-835-3323; fax 202-835-0747; www.nclnet.org.

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Changes are taking place in Medicare, and new health care options for seniors and others eligible for Medicare benefits are now available. You can still choose between original Medicare which allows you to choose any doctor who accepts Medicare patients and Medicare-contracting managed care plans, such as health maintenance organizations (HMOs). HMOs offer additional benefits because you use their network of doctors and hospitals. This booklet explores options available to seniors and all other Medicare beneficiaries, including how Medicare works, new developments in Medicare and whether Medicare HMOs are right for you.

Astronomical increases in health care costs have encouraged private and government health insurers to look for ways to contain costs. Although health care costs continue to increase, HMOs have had some success in containing overall treatment costs by coordinating all aspects of their member’s health care to avoid waste and duplication of medical services. HMOs emphasize preventive services like checkups and screenings, because it is cheaper to prevent illness than to treat it. By carefully managing the care they provide, HMOs have won favor with employers.

1 HMO’s that contract with HCFA to provide health care benefits will be referred to as Medicare HMOs.

and the government by keeping medical insurance costs in check. Eighty-
five percent of workers at firms with 10 or more employees, are now
receiving health care through managed health plans.²

Medicare HMOs — health care companies that contract with the federal
government to provide managed care services to Medicare beneficiaries
are growing rapidly. As of January 1998, more than 6 million Medicare
beneficiaries were enrolled in managed care plans, accounting for nearly
16% of the total Medicare population. That represents a 156% increase in
managed care enrollment since 1992. (Source: Health Care Financing
Administration.)

HMOs are not for everyone. There are important factors for each individual
to consider before making the decision to join a Medicare HMO, stay in
original Medicare or look at one of the new options. For instance, those
beneficiaries who have a strong relationship with their primary doctor and
specialists, who travel extensively or are in a treatment program for an
ongoing condition, should weigh their options carefully.

Beneficiaries who are satisfied with Medicare HMOs cite several key
advantages. Many like the lower out-of-pocket costs and hardly any
paperwork (claim forms, bills), virtually no deductibles and no 20%
coinsurance payments. Beneficiaries also are attracted by the additional
benefits HMOs may offer that are not part of traditional Medicare,
especially prescription drug benefits and eyeglasses (limitations may
apply). And Medicare enrollees who join HMOs don't need to buy
Medicare supplemental (Medigap) insurance, because out-of-pocket costs
are lower and additional benefits are normally covered.

Joining an HMO is purely voluntary. And if you do join, you're free to leave
the plan at any time to switch to another HMO or return to traditional
Medicare, effective on the first day of the month after the month of receipt
of your written disenrollment request. As enacted in the 1997 Balanced
Budget Act, in 2002 you will only be able to disenroll from an HMO, or
switch HMOs, during certain periods once or twice per year.
Who is eligible for Medicare?

When you reach age 65 (or if you become disabled at a younger age), you are eligible for Medicare coverage. Medicare is a federal government health insurance program that helps seniors and people with disabilities pay for medical, hospital, nursing and home health care. It is funded by Social Security taxes, and in most cases is limited to people (you and/or your spouse) who have paid into Social Security for at least 10 years. (Your working years do not have to be consecutive.) When you sign up for Medicare, you become a beneficiary, meaning that you are entitled to all the benefits Medicare offers.

Traditionally, Medicare insurance has had two parts, Part A and Part B:

- **If you already are getting Social Security or Railroad Retirement Board benefits, Part A and Part B coverage is automatic.** Part A picks up the bill for care received in hospitals. You must pay a certain amount (your deductible) before full Part A coverage becomes available. Part A also covers care received in skilled nursing facilities, hospice services for the terminally ill and home health care. For hospital and skilled nursing facility stays, full coverage is limited to a certain number of days, called a benefit period. (Most people do not have to pay a premium for Part A coverage.)

- **Part B coverage is voluntary and you must pay a premium that is usually deducted from your Social Security check.** Part B covers care by doctors (including chiropractors), lab tests, X-rays, ambulance services, and the rental of durable medical equipment such as wheelchairs, walkers and hospital beds for use at home. If you are not automatically enrolled in Part B when you turn 65, you must sign up at your local Social Security office.
Medicare+Choice: Expanding your options

You may have begun to hear about Medicare Part C, known as Medicare+Choice (Medicare Plus Choice). This is the government's name for a program intended to expand health care options for Medicare beneficiaries. Medicare+Choice was created by the federal Balanced Budget Act of 1997. This law is designed to give beneficiaries new options in the way they receive health care, increase competition among companies providing Medicare services, provide new patient protections for Medicare beneficiaries and rein in government spending.

These changes will be phased in over a four-year period. Some are already in effect. As of Jan. 1, 1999, Medicare beneficiaries can choose to remain with original Medicare, or to enroll in new Medicare+Choice options, including HMOs, provider-sponsored organizations and medical savings accounts. (See pages 7-8 for more information on these options.) If you are a member of a Medicare HMO (health maintenance organization) and wish to stay with it, you don't have to do anything. Your membership will continue automatically and you will probably notice few changes, if any, in your HMO's services.

Present and future Medicare options

Prior to 1999, your options for receiving Medicare included original fee-for-service and managed care plans, such as HMOs. Depending on where you live, the point-of-service and preferred provider options mentioned below might be available, too. During 1999, new options will become available.

- **Original Medicare** allows you to choose any doctor or medical service provider who accepts Medicare patients. Original Medicare does not cover prescription drugs, eyeglasses, dental exams, cosmetic
surgery, acupuncture or preventive programs to help you lose weight, get fit, improve your nutrition or stop smoking. (Medicare does cover some periodic preventive screenings designed to detect disease at its early stages or to prevent some illnesses.)

Under original Medicare, most Part B services are reimbursed at 80% of the cost of treatment and you pay the remaining 20% out of your own pocket (coinsurance). Under original Medicare it is up to the beneficiary to make sure coinsurance bills are paid. Other out-of-pocket costs include:

**Your Part B premium.** In 1999 it is $45.50 per month, increasing to an estimated $67 by 2002. (Source: Deloitte & Touche)

**Deductibles,** the amount you must pay for services before original Medicare reimbursement kicks in ($100 per year for medical services (Part B) and $768 in 1999 for hospital stays (Part A) per benefit period). A benefit period begins the day you are admitted to a hospital. It ends when you have been out of a hospital, or other facility primarily providing skilled nursing or rehabilitation services, for 60 straight days.

**Excess charges,** the difference between a doctor's fee and the approved amount that Medicare considers reasonable for the treatment you need. (You can avoid these charges by finding a doctor who agrees to accept assignment of Medicare's approved amount.) However, the Medicare limiting charge prohibits doctors from asking Medicare beneficiaries to pay more than 15% above Medicare's approved amount. Your doctor can ask you to pay your share of the charges including any unpaid portion of your annual $100 deductible at the time of the office visit, or can bill you later. If you are overcharged, the amount must be refunded to you.

As a result of the Balanced Budget Act of 1997, Medicare rules were changed to allow Medicare beneficiaries to sign a private contract with a physician exempting both parties from Medicare regulations and canceling the doctor's right to seek Medicare reimbursement.
Physicians who enter into such an agreement also may not bill Medicare for any other patients for two years. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation.

- **Medicare supplemental (Medigap) policies** are private insurance policies that help traditional Medicare enrollees pay for co-payments, deductibles and excess charges, as well as for services that are not covered by Medicare, such as prescription drugs. These are also called Medigap policies, because they cover the gaps in Medicare coverage.

- **Health Maintenance Organizations (HMOs)** use a system that provides all of your health care services through a coordinated network of contracting doctors, hospitals and other medical service providers in a limited geographical area. Medicare pays the HMO a flat fee to administer the medical care of each covered individual. HMO plans include all Part B services and usually cover some additional benefits, such as prescription drugs (although limits may apply). In addition, you will not have to pay any money for your Part A services except for your Medicare premium and possibly a small plan premium, co-payment, or for a skilled nursing care facility which is limited to 100 days per benefit period (see page 22). When you enroll in an HMO plan, normally neither you nor your doctor will be reimbursed by Medicare if you consult doctors or other health care providers that are not part of the HMO network. An exception is made if you need emergency treatment, urgent care while you are away from the HMO’s service area and urgent care in-area in unusual circumstances. If you decide to disenroll from your HMO, just notify the plan, Social Security, or the Railroad Retirement office in writing. You will automatically return to original Medicare on the first day of the month following the receipt of your disenrollment request. However, if you have dropped your Medigap policy, it may be difficult and expensive (and maybe even impossible) to get another one, depending on your age and your health.

**There are different types of HMOs.** One type is the staff model — the HMO uses its own salaried physicians and its own facilities. (Kaiser
Permanente was founded on this model.) However, the majority of HMOs use the network model partnership of doctors or a corporation that is responsible for providing services and paying the affiliated providers. Group model HMOs contract with doctors, other medical professionals and institutions to provide their members’ health care.

- **Point-of-service (POS) plans and preferred-provider organizations (PPOs)** give their members the option of seeing doctors outside the health insurer’s own physician network. These options may be offered as a part of some HMO plans; others are stand-alone. If you consult an outside doctor, you will have to pay more than if you had stayed in the network.

- **Provider-sponsored organizations (PSOs)** are a new form of managed care available in 1999. They are similar to HMOs but are owned and run by doctors, medical partnerships, clinics and/or hospitals instead of health insurance companies. Medicare+Choice promotes the creation of PSOs in order to give all Medicare beneficiaries more choices. PSOs are a new form of managed care. Make sure you evaluate any PSO or health plan carefully before deciding to join.

- **Medical savings accounts (MSAs)** are a new concept under Medicare+Choice that will be tested among a limited enrollment group. MSAs usually combine a limited-use individual savings account with a high-deductible insurance policy to protect you from high-cost health catastrophes. You can use the money deposited in your Medicare MSA to pay for medical expenses.

You can choose a high-deductible health insurance policy approved by the Medicare program. The policy’s deductible may not be more than $6,000 in 1999. You also choose the bank or financial institution where your MSA is set up, and it, too, must be approved by and registered with Medicare. At the beginning of the year, Medicare makes an annual deposit into your account. You use the money deposited in your Medicare MSA to pay for medical expenses not covered by the high-deductible insurance policy. Money can be withdrawn from a
Medicare MSA for non-medical expenses, but that money will be taxed. Any unused funds are rolled over from year to year, including interest.

Medicare MSAs have been criticized because they have the potential to leave Medicare beneficiaries unprotected in the event of unexpectedly high health care costs. In their early years, MSAs may not contain enough funds to meet the deductibles, and recipients may be forced to pay out-of-pocket for health care services.

How Medicare HMOs work

The federal government enters into contracts with HMOs, requiring them to provide all Medicare-covered services. You are guaranteed not to lose any Medicare benefits when you join an HMO and that you will receive all basic health care services provided by original Medicare. Most Medicare HMOs offer additional services as well, such as prescription drug services, eyeglasses and preventive health programs (although limitations may apply on all additional services). However, you must continue to pay your Part B Medicare premium.

You also may have to pay a monthly premium to your Medicare HMO usually ranging from $10 to $50 per month. Monthly premiums vary by state and county. Depending on where you live, you even might have access to zero premium plans, which means you don’t have to pay the HMO a monthly fee to be a member.

As an HMO member, you may be asked to pay a small fee, usually $5 to $15, each time you see the doctor. This is called a co-payment.

When you join a Medicare HMO, you are still a Medicare beneficiary. You do, however, agree to obtain all your medical services only from that HMO network’s doctors and hospitals. This is called a lock-in agreement because any services you obtain outside the network will not be covered by Medicare while you are enrolled in a Medicare HMO. Services from a non-network provider are covered in emergency situations, when you need urgent care when you are away from home or traveling, or for urgent care in-area in unusual circumstances.
HMO benefits & out-of-pocket costs vary widely

Throughout the U.S., the Health Care Financing Administration (HCFA) contracts with managed care plans, including Medicare HMOs, to provide health care benefits to Medicare beneficiaries. Medicare contracting HMOs are independent companies that enter into these contracts voluntarily on an annual basis. HCFA pays each contracting HMO a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to the member. The amount that the contracting HMO receives for each enrolled member varies because of certain factors, including age, sex and county of residence, as well as whether the beneficiary:

■ is employed or retired.
■ needs special care, such as skilled nursing.
■ is disabled or over 65 (Medicare entitlement status).

For instance, an HMO may receive a lower payment for a younger disabled beneficiary versus an aged individual.

The amounts paid to HMOs for each enrollee also vary by county. This payment is based on how much it cost to provide fee-for-service Medicare in that particular county in the past. HCFA also allows HMO plans to charge a plan premium to enrolled Medicare beneficiaries.

In some counties, HMOs waive the allowable premium (zero premium) and decide to offer services in addition to Medicare – covered services. So, within the same state and the same HMO, members in one county may pay $50 per month for their plan, and $15 each time they visit the doctor, while in another county, enrollees may have a zero premium plan and pay the doctor only $5 per visit. The same HMO might give its Southern California members extensive prescription drug benefits, while members in parts of Nevada have limited or no coverage at all for drugs.

Contracts are renewed on a calendar year basis. Each HMO may decide to continue its contract, adjust its plan premiums and/or increase or decrease
its additional benefits, extend or reduce its service area or to not renew its contract with HCFA. If your HMO decides not to renew its contract in the county you live in, you will have to join another HMO or return to original Medicare. If you are notified that you will be dropped as of the end of the calendar year (Dec. 31) because your plan did not renew its contract, you have the right to apply for a new Medigap policy governed by certain conditions that are favorable to you. (See Your Rights as an HMO Member, page 20.)

Do you belong in an HMO?

Medicare HMOs offer some advantages, but they are not right for everyone. Consider these points:

- **You might have to switch doctors if you join an HMO.** While many people find that their doctors are affiliated with one or more HMOs, this is not always the case.

- **In certain parts of the country there are no HMOs or very few of them.** If you are to get the most out of a Medicare HMO, its doctors and hospitals must be convenient to you. If participation in your nearest HMO requires you to drive an hour each way to see the doctor or go to the hospital, chances are you will not be satisfied as an HMO member.

- Under original Medicare, you **have the freedom to consult a specialist when you feel you need to.** In an HMO, your primary care physician usually determines when you need to see a specialist. Then an authorization must be obtained from the HMO or medical group. You and your primary care physician may differ on when you need to see a specialist. Before you join an HMO, check to see if your doctor and the specialists you see are affiliated and if they are in the same medical group; it could make the transition to an HMO easier for you.

- **Prescription drug coverage may be limited.** HMOs don’t give you discounts on all drugs approved by the Federal Food and Drug Administration (FDA). To receive full value from your prescription drug
benefits, your doctor might have to switch you to a different drug or you might have to accept a generic drug instead of a name-brand drug. (See Are your prescription drugs covered? on page 16.) However, original Medicare does not provide prescription drug coverage.

- **HMOs usually serve members in a limited geographical area.**
  Do you spend more than one year at a time away from home? Or do you visit family members or take off in your recreational vehicle for twelve months or longer? Do you have dual residences? If so, you probably should not join a Medicare HMO. Because HMO care is provided through a local network of doctors and hospitals, and because your care in an HMO is coordinated by one doctor, you may be better off under original Medicare. (Some HMOs have special programs that cover members when they are living in a different area for longer than one year.)

### Choosing an HMO

Many beneficiaries have a choice of Medicare HMOs. If you do, ask for materials from all of them, and compare the services they offer. To find out more about plans in your area, visit Medicare Compare, an online database on the Internet run by the federal Health Care Financing Administration (www.medicare.gov). If you don’t have a computer with Internet access, your local library, area aging agency or elder care service organization might have one. Specific benefit information can be obtained from the various plans available in your area.

Before making a choice, ask these questions about each plan:

- Is my doctor in your network?

- If not, how many doctors can I choose from within a convenient distance of my home?

- How long does it take to get an appointment?

- Are the hospital, doctor’s office and other network medical providers close to my home?
- Are the prescription drugs I’m taking covered by your plan?
- What benefits does the plan cover in addition to Medicare’s required coverage (such as dental checkups, eye care, prescription drugs, etc.)?
- Are there any limits to these services, such as how often I can use them, or any maximum dollar amount of benefits?
- How many members voluntarily dropped out of the plan last year?
- How much are the monthly premiums and co-payments for doctor visits?
- Do you have any special programs to help me manage particular illnesses or conditions?
- How does your process for handling complaints work? Is there anyone who has the responsibility to help me file a grievance or appeal if I need to?

Sales presentations. If the HMOs in your area hold sales presentations, attending provides a relatively easy way to find out about them. Approach the sales presentation with skepticism. Double-check any important concerns by reading the printed materials from the HMO or calling the HMO member services department. HMO sales and marketing representatives are required by law to give you accurate information about their benefits and services. They cannot offer you gifts, bribes or other inducements like a free trip or dinner at an expensive restaurant to convince you to join the HMO. (Inexpensive promotional items like pens, key chains and refrigerator magnets are okay if everyone gets them.) HMO salespeople cannot come to your home or nursing home unless you have invited them and they have made an appointment with you.

Salespeople or other HMO representatives are not allowed to ask non-members:

- To submit to a physical exam.
- How often you visit the doctor.
- How many times you have been hospitalized.
If you have any conditions that require you to take prescription medication on a regular basis.

If you exercise regularly.

If you smoke.

If you are eligible for Medicare, the HMO you choose must allow you to join, regardless of your age, health or any ongoing medical conditions you are being treated for. Medicare HMOs cannot enroll you if you have end stage renal (kidney) disease, unless you are already belong to its commercial (employer sponsored) plan. (However, kidney disease is covered by original Medicare.)

### Joining an HMO

When you enroll in an HMO, you will receive a membership card — your key to membership services. You will need it when you visit the doctor, or are hospitalized. If you don’t show it, you may not get all the benefits that you are entitled to, or you may have to pay more. The card should have the toll-free number for your HMO member services department. Call it whenever you have a question about your health care coverage.

When you join an HMO, you do not use your Medicare card. Put it away in a safe place — you will need it if you return to original Medicare.

Arrange to have a physical exam soon after you enroll in an HMO. Most plans want you to meet your primary care physician (PCP) right away, so that your health can be assessed. Let your doctor know all about your current and past health concerns, including all the medications you are taking.

Familiarize yourself with your HMO’s preventive services. These include periodic checkups and screenings that are helpful in preventing illness or detecting diseases at early stages when they are most treatable. The preventive services offered by your HMO may also include walking clubs, health education classes, forums on nutrition and healthy cooking, discounts at the local gym or pool and information on how to manage chronic diseases.
Choosing a primary care physician is your most important health care decision. As an HMO member, this choice becomes even more important, because your primary care physician coordinates all your care, from routine and preventive care to visits to specialists and hospital stays. If you join an HMO and find out you cannot continue to see your current doctor, this does not mean you have lost control. The HMO system allows you to choose from among many primary care physicians. Your new primary care doctor can be a family practitioner or an internist (specializing in internal organs) or a gerontologist (specializing in the care of older adults).

Your doctor should know your entire medical history and what is important to you. This knowledge can be crucial to your care should you become critically ill and may reduce the chances of complications during your treatment. You and your doctor must become partners in your health care.

Most HMOs hold their affiliated doctors to quality standards and regular reviews by their medical colleagues (peer review). Having a well-qualified doctor is obviously important. But it is just as important to have a doctor you are comfortable with. Because the relationship between the member and the primary care doctor is key to providing quality health care, HMOs allow members to change primary care physicians.
To choose the best doctor for you, follow these tips:

- **Seek a recommendation** from someone you know who is enrolled in the HMO.

- **Call the HMO member services department and ask for help** in creating a short list of primary care doctors who practice and have operating privileges at hospitals close to your home, who speak your preferred language, and whose office hours are convenient for you. You can further refine the list by asking for doctors who specialize in medical conditions you have. Ask about the educational background and board certification of each doctor. (Doctors who pass special exams in a particular area of medicine are said to be board certified in that specialty.) Also ask how you can verify independently that the doctor's license is up-to-date.

- **Narrow your list to two or three doctors.** Call their offices to make sure they are accepting new patients. Ask if you can arrange a short interview in person or over the phone.

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**Are your prescription drugs covered?**

Prescription drugs can cost thousands of dollars per year. Original Medicare doesn't pay for drugs (unless you're hospitalized), but many Medicare HMOs have prescription drug benefits. However, your HMO prescription drug coverage is no guarantee that the drugs you now take will be covered. There may be substantial limits to your HMO's drug benefits. HMOs do not cover all prescription drugs and usually place an annual dollar limit on covered drugs.

Most HMOs have a formulary — a specific list of drugs they pay for. Ask if the drugs you take are part of the HMO's formulary. If they are not, there may be a comparable drug on the formulary. Make sure your doctor approves any changes in prescriptions. Or, your doctor may ask for special permission, called prior authorization, for drugs he or she can demonstrate
that you need. If you can’t get authorization, in most cases you will have to accept a substitution or pay full price for the drugs.

Your HMO’s formulary probably divides drugs into two categories, generic and name brand drugs. When the exclusive patent on a drug expires, any pharmaceutical company may market it and it becomes a generic drug. This competition usually brings the price down. But while a drug is still under patent only one company markets it, and these name brand drugs tend to carry higher price tags. If a lower cost generic drug alternative is available, your HMO may offer it instead of a name brand. HMOs generally set dollar limits on the amount of name brand drugs a member may be reimbursed for each year.

HMOs change their formularies by adding and dropping drugs, especially when new medications become available. If your drug is discontinued, call your doctor or member services department to learn your options. Ask your doctor if switching to a different name brand drug or generic drug will present a problem.

Any switch, whether generic or name brand, should be approved by your doctor. If your doctor decides to switch you to a different drug, your progress on the new prescription should be monitored closely. The dosage may need to be adjusted or you may experience side effects. If you are not responding to the generic or substituted drug, your doctor can ask your HMO for prior authorization for the drug you need. Some HMOs authorize a high percentage of these requests, but others do not. If the request is not approved you can choose to use a drug on the formulary or pay for the drug yourself. You may also appeal the decision. (See page 27.)

You may even want to consider switching HMOs. Different HMOs have different formularies. Check if competing Medicare HMOs will cover the drug you take if your doctor prescribes it.

Questions to ask about drug benefits:

- Can I have a copy of your list of covered drugs?
- What out-of-pocket costs or co-payments will I be responsible for?
Do you have an annual limit on prescription drug benefits?

What percentage of doctors’ requests for drugs that are not covered are approved for full or partial coverage?

Do you allow members to roll over unused prescription benefits from one year to use them the next year?

**Nursing home & home health care**

Long-term care is one of the biggest costs many older people face. Original Medicare and Medicare HMOs cover nursing facility expenses only if you require skilled nursing care. In a Medicare HMO, this care is usually provided at a network-affiliated institution and is limited to 100 days per benefit period. A benefit period is a way of measuring your use of services under Medicare Part A. A benefit period begins the first day of a Medicare-covered in patient hospital stay and ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty (60) days in a row (including the day of discharge).

**Original Medicare and Medicare HMOs do not cover long-term nursing home or permanent assisted living care** for Medicare beneficiaries who must move into a facility permanently because they are frail or need day-to-day care.
Home health care is covered by original Medicare and Medicare HMOs. To qualify under Medicare, you must be homebound, require part-time skilled nursing assistance, physical therapy or speech therapy and be under the care of a physician. Your care must be reviewed at least every 62 days in order to be re-approved. Under these conditions, Medicare also pays for medical social services, home health aide visits, and durable medical equipment needed by the homebound. This can include up to eight hours of reasonable and necessary care per day for up to 21 consecutive days or longer in certain circumstances.

Medicare HMOs can increase the benefits described above but not decrease them. Policies vary greatly from one HMO to another. Make sure you discuss home health care policies in detail.

Leaving an HMO plan

The law protects you from any effort by the HMO to disenroll you because you need expensive treatments such as heart surgery, transplants or long-term nursing care. This is against the law and should be reported immediately to the Medicare hotline. (See page 27.)

If you decide to leave the HMO, you will be covered by original Medicare on the first day of the next month following the month your written request is received. (However, it will be up to you to arrange for a new Medigap policy, if you want one.) To withdraw from a Medicare HMO, you must write a letter to your local Social Security office, the HMO or the Railroad Retirement Board. By law, the HMO must not delay your request or make it hard for you to leave the HMO.

You may switch from plan to plan or return to original Medicare every 30 days. However, as of 2002, you will only be able to disenroll from an HMO, or switch HMOs, during certain periods once or twice a year. (You may hear this referred to as a lock-in, because you must use the HMO that you enrolled in and its network of physicians.)
Your rights as a Medicare HMO member

As a Medicare HMO beneficiary, you have stronger rights and consumer protections than many members in employer-paid plans. In order for an HMO to be approved to offer managed care services it must follow federal regulations that dictate the coverage provided to Medicare beneficiaries as well as exactly how and how fast it must handle appeals by Medicare HMO members. (See *How to complain*, page 24.)

**Medicare HMO members have the right to request an explanation of how the health plan pays its doctors.** You can ask your HMO or medical group for a summary of physician compensation arrangements.

**You also have the right to ask for information about how the HMO or medical group makes decisions about care** (utilization review), how many grievances and appeals were filed by members and what percentages of appeals were approved or sent to the Center for Health Dispute Resolution for determination. HMOs are not required to disclose grievance and appeals data until January 2000 for the period of April 1, 1999 through September 30, 1999.

**As a Medicare beneficiary enrolled in an HMO, you are entitled to a second medical opinion if you are told you need surgery.** Any surgery is serious, and you owe it to yourself to seek a second opinion. It will not insult your primary care doctor if you ask for one. Most doctors are comfortable with the idea and will cooperate fully. If the second opinion disagrees with your doctor’s original recommendation, original Medicare gives you the right to seek a third opinion.

**Your HMO must provide emergency medical care.** An emergency is a serious illness or injury that needs immediate attention. (See *How to judge a medical emergency*, page 22.)

**While you are traveling, your HMO must also reimburse you for emergency care and any urgent health care you needed while you**
were traveling or temporarily out of your HMO’s service area. This applies to travel within the United States and under limited circumstances outside of the United States. An urgently needed medical service is defined by the government as being medically necessary care that is required immediately because of unforeseen illness, injury or other condition occurring under circumstances in which it is not reasonable to obtain the necessary services through your HMO’s network of contracting providers. (Medicare also requires that you be reimbursed for urgently needed medical services obtained outside your HMO network when, under unusual and extraordinary circumstances, you are in your HMO service area, but your contracting medical group is temporarily unavailable or inaccessible.)

If you need urgent care while you are away from home, go to a nearby doctor or medical clinic, pay the bill and save all receipts so that your HMO can reimburse you. You or a member of your family should call your doctor as soon as reasonably possible, or within 48 hours.

To assess the need for medical assistance, ask yourself: Can this wait until I can call my doctor? If you are traveling, ask yourself: Can this wait until I get home? If the answer is no, go immediately to the nearest emergency room or urgent care facility.

If you have received emergency care at an outside facility that is not affiliated with your HMO, you may not be transferred to an affiliated plan provider as long as your transfer would put your health at risk or because the transfer would be unreasonable because of distance and the nature of your medical condition.

If your HMO notifies you that it has not renewed its contract to serve Medicare HMO members in your county, you have the right to buy a new Medigap policy. You will be notified 60 days before the end of the calendar year (Dec. 31) if your HMO has chosen not to renew its contract. You must purchase your new Medigap policy within 63 days of the date your coverage is terminated. Companies selling Medigap policies cannot place conditions on the policy (such as excluding any pre-existing
conditions you might have) or discriminate in the price of the policy because of your health, past claims or whom you choose to provide your health care.

**If you dropped a Medigap policy when you joined your current HMO, you may have the right to get the same policy back if the insurance company is still selling it.** In order to be eligible, you still must be with the HMO you were with when you dropped your Medigap policy and you must have dropped out of the plan less than a year after you joined. You must reapply for the policy within 63 days after you leave the plan. It's a good idea to make sure your old policy is still available from your original insurer before you disenroll from your HMO.

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**How to judge a medical emergency**

Some HMO members have run into problems when they sought care for a medical emergency and later found out that the HMO would not pay for it. To protect HMO patients, the government has come up with a “prudent layperson test” to help you judge if you need emergency medical assistance. Its definition of an emergency is: “A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with the respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or,
- serious dysfunction to a bodily organ or part.”
Stand up for your rights

In recent years, attention has been focused on improving the rights of Medicare HMO members. There is some concern that Medicare beneficiaries who enroll in managed care plans might be shortchanged. In 1996, the government told health plans that they couldn’t curb what doctors tell patients about treatment options (gag clauses). Broader rights of appeal and a faster, 72-hour timetable for processing expedited service requests have been added to the regulations.

The new regulations require that a Medicare member of an HMO may get a 72-hour decision for a service request if their health or ability to function could be seriously harmed by waiting for a standard decision. (See page 25 for more information on fast, 72-hour decisions.)

The new Medicare+Choice directives recognize that there needs to be more information available to help prospective HMO enrollees choose the right plan for them. Whenever possible, supplement the comparisons provided by your HMO by reading information distributed by government agencies such as the Health Care Financing Administration (HCFA), non-profit watchdog organizations and the media.

Medicare HMO members have strong government rules to protect them. But ultimately, your satisfaction level will be higher if you remain informed and stand up for your rights. Here are some tips to help you get the most out of your HMO:

■ **Be your own advocate.** Be persistent in seeking the best health care from your HMO and your physician. Don’t take no for an immediate answer. Ask your doctor: What are my treatment options?

■ **Ask your plan to consider the care you feel is necessary.** Speak up if you feel you need additional treatment. It doesn’t hurt to ask, and doing so may result in improved care.

■ **Document everything.** When you visit the doctor, take notes. When you talk to your doctor’s receptionist or your HMO member services department, note the name of the person you spoke to and the date.
and time of your call. If you are denied care, get the denial in writing and save a copy. These documents will back up your case if you have to file an appeal.

- **Your doctor should be your ally.** Having checkups and following your doctor's advice will show that you are willing to take extra steps for your own health. Find a physician who knows how to work within the system. Your doctor is your caregiver and has the right to seek exceptions to HMO rules when she or he finds it medically necessary.

- **Demand appropriate, necessary care.** People who know what they need are more likely to get what they want. Do research to back up arguments about your care. Clip articles about new treatments from health magazines. Search the Internet for information about your condition.

- **Don't postpone seeking help in a serious medical emergency** because of fear that your HMO won't cover the cost. Know your HMO's rules for emergency situations, but realize that it may be impossible to reach an affiliated hospital in time. Emergency rooms should not serve as a substitute for routine care, but when you are confronted with an emergency or any urgent situation, seek help quickly.

## How to complain

- **If you find yourself in disagreement with treatment decisions,** call your HMO member services department immediately and tell the representative what your problem is. Make sure you are calling your HMO, and not your doctor's medical group. If you are unsure ask — if there is an important difference. Your HMO has specific employees (sometimes called ombudsmen or grievance or appeals managers) whose job it is to help you solve your problem. You can find the number of your HMO member services department on your membership card. It is usually a toll-free number.

- **When you call your HMO,** write down the person's name, the date and time you called and what was said. Do not allow yourself to be hurried. Make sure you understand everything you are told. Make a file
for your complaint, so you can keep all your notes, correspondence and other paperwork associated with it in one place.

- **Your HMO has to notify you in writing about any denial** or termination of services or benefit change. The notice should describe in detail the appeals process that is available to you. If you do not receive this notice, call your HMO member services department.

- **Recently, Medicare beneficiaries’ rights to appeal were significantly expanded.** You begin the appeals process by writing to the plan that you want a reconsideration of its decision. Describe your complaint fully. If your health or ability to function could be seriously harmed by waiting for a standard decision, the HMO must make its service determination and notify you by phone within 72 hours. (A follow-up letter will also be sent to you within two days of your notification by phone.) If your condition is serious, ask that your request be expedited — the use of this word will give notice to the plan that you want an answer within 72 hours or less because you believe a delay could harm your health. An expedited review can be requested by writing, calling or faxing your plan with the request.

- **If you do not win the appeal, it will automatically go to the Center for Health Dispute Resolution,** an agency that contracts with Medicare to review HMO denials nationwide. If the review body also decides against your appeal, you may request a hearing before an administrative law judge of the Social Security Administration.

- **For help in deciding whether or not to appeal,** call your state’s federally funded Health Insurance Counseling and Assistance Program (HICAP) for Medicare beneficiaries. To find the phone number of your local HICAP office, call 1-800-638-6833.

- **If you are going to be discharged from the hospital before you are ready,** ask for an immediate review by the peer review organization (PRO), physicians organizations that contract with Medicare to review the quality of care provided to Medicare beneficiaries in HMOs. If you request the review before noon on the day after you receive notice of your discharge, you will be allowed to stay in the hospital at no extra
charge until a decision is made. You are not financially liable for hospital charges during the PRO review. To obtain the phone number of the PRO in your state, call 1-800-638-6833.

- **If you have service complaints about long waits to see the doctor or for appointments**, or about rude staff members, you can complain directly to your HMO and file a grievance. Ask or read in your HMO’s Evidence of Coverage how long the HMO has to answer your grievance, and call back at that time if you haven’t heard anything.

- **Ask your HMO members services department if it offers case management services.** Some HMOs have a case manager who can help you explore community-based assistance programs, such as non-profit organizations that help seniors with housekeeping or provide hot meals, or even provide donations to help you pay for medical care, prescription drugs or skilled nursing services that are not covered by traditional Medicare or your HMO.

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**Comparing Medicare HMOs**

Do you want to know more about your HMO and how it compares to others? One way to find out about good plans is to ask your friends and acquaintances. In addition, there are several sources of help:

- **The National Committee for Quality Assurance (NCQA)** is a non-profit review organization that runs the only national program to evaluate the quality of health care provided by HMOs. The process, called accreditation, is voluntary. The NCQA worked with employers, doctors, medical institutions and HMOs to develop its evaluation standards. Key areas include quality and appropriateness of managed care, the credentials of doctors and other medical providers, member rights and responsibilities, preventive care services and medical record keeping. To check if your HMO has received NCQA accreditation, call 1-888-275-7585.

- **Ask your health plan for its NCQA accreditation status**, member satisfaction survey results and report card of itself and its network providers.
The Health Care Financing Administration (HCFA) offers Medicare Compare, an online computer database you can use to compare HMO benefits in your area. Look it up on the Internet at www.medicare.gov. You will be asked to enter your zip code and the computer program will pull up all Medicare HMOs near you. Early in 1999, HCFA will incorporate the results of quality-of-care and member satisfaction surveys to further help Medicare beneficiaries compare health plans.

The agency in your state that is responsible for overseeing HMOs may release data to help the public evaluate HMOs. (In many states, the regulatory agency is the insurance department.)

Many comparisons of HMOs are published by the media and non-profit groups each year. For instance, Newsweek, U.S. News & World Report and Consumer Reports magazines have published national HMO comparisons. Each survey uses different criteria in evaluating plans. The comparisons can be found at your local library or on the Internet.

**Improper practices**

If you believe your HMO is not meeting its obligations under its Medicare contract, or is violating your rights by creating unreasonable delays, blocking your access to health care or making you leave the hospital before you are fully recovered, call your local Health Insurance Counseling and Assistance Program (HICAP). The program helps Medicare beneficiaries resolve problems about Medicare. To find your local HICAP office, call 1-800-638-6833.

To report suspected Medicare fraud or other improper practices, call either:

- The Office of the Inspector General’s toll-free hotline at 1-800-HHS-TIPS (1-800-447-8477), or
- The Medicare hotline at 1-800-638-6833.

These agencies do not resolve individual complaints, but calling them may prompt an investigation of suspected fraud or other improper practices.
Consumer Action
717 Market St., Suite 310
San Francisco, CA 94103

523 West Sixth St., Suite 1105
Los Angeles, CA 90014

Consumer Action Assistance Switchboard
Northern California: (415) 777-9635
Southern California: (213) 624-8327
www.consumer-action.org

For more copies or information: 1-800-929-1606