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MEDICARE AND MANAGED CARE

CHOICE FOR PEOPLE ON MEDICARE

1. WHAT IS A MANAGED CARE HEALTH PLAN?

A managed care plan, sometimes referred to as a Managed Care Organization (MCO) or a Health Maintenance Organization (HMO), can be thought of as a combination insurance company and health care delivery system all in one company. Managed care companies provide health care to individuals or groups of individuals for a fixed, prepaid price. Because managed care plans deliver health care services for a fixed price, they use various methods to control costs.

2. HOW DOES A MANAGED CARE HEALTH PLAN DELIVER SERVICES?

People normally think of an HMO in the group-model type where all the physicians (primary and specialists) are housed under one or more centrally located health facilities and the patient goes to the HMO facility to receive all care. Although the group-model exists, a common variant is the network-model, where the HMO contracts with various doctors or groups of doctors in the community to provide care. In addition, the HMO contracts with specific hospitals, nursing homes, home health care organizations and laboratories to provide full service care to all members of the HMO. The HMO is simply a company that collects fixed fees from its members (usually monthly) and then contracts with various health care providers to deliver health care when the members require services.

3. WHAT IS THE DIFFERENCE BETWEEN A FEE-FOR-SERVICE INSURANCE PLAN AND A MANAGED CARE PLAN?

The traditional health insurance policy is a fee-for-service plan or indemnity plan. You choose any licensed physician and then may use the services of any hospital, health care provider, or facility. A fee is paid each time a service is used. Either your insurance plan or Medicare pays a share of your hospital, doctor, and other health care expenses. You are responsible for certain deductibles, and coinsurance payments - the portion of the bill Medicare does not pay. Usually Medicare beneficiaries purchase supplemental health insurance plans (Medigap policies) to cover the deductible and copayments that Medicare does not cover. When you join a managed care plan, you pay a monthly premium and sometimes a small copayment each time a service is used. Usually there are no additional charges by the plan, no matter how many times you visit the doctor, are hospitalized, or use other covered services.

4. HOW DOES A MANAGED CARE PLAN CONTROL COSTS?

Under a fee-for-service plan, you decide which doctor or specialist you want to see and how many times you want to see them. Under a managed care plan, you must use the doctor, specialist, and hospital covered under the plan. The managed care plan also restricts access to specialty care, tests, and medication much more frequently than the fee-for-service plans. In a managed care plan, you must get approval from your primary care physician before going to a specialist or laboratory covered under the plan. Basically, under the managed care plan, you have less choices, but you also have less out of pocket expenses.

5. HOW CAN I JOIN A MANAGED CARE PLAN IF I AM A MEDICARE BENEFICIARY?

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. The only requirement is that you continue to pay the Part B monthly premium. Medicare, in turn, pays the managed care company a fixed amount of money each month for providing you health care. These plans contract with Medicare beneficiaries cannot be denied membership because of poor health or a disability. Many managed care plans offer additional services, such as preventive care, prescription care, and eyeglass care. The managed care plan may charge a small monthly premium to cover other costs and usually requires a small copayment every time you receive a service. Thus instead of Medicare paying a portion of your health care costs each time you see a doctor, Medicare pays the HMO a fixed amount of money each month, whether you need health care services or not.

6. DO I NEED MEDIGAP INSURANCE IF I JOIN A MANAGED CARE PLAN?

Don't confuse joining a Managed Care Plan under Medicare with a Medigap policy. They are not the same. When you enroll in a managed care plan you will not need Medigap insurance. However, you may want to retain your Medigap insurance until you have tested the plan for a few months. If you later disenroll from the plan and return to traditional Medicare and try to purchase your former Medigap policy, the policy may charge you higher monthly fee and may now exclude coverage from any pre-existing illnesses you may have.

7. WHAT ARE THE ADVANTAGES OF JOINING A MANAGED CARE PLAN?

Medicare managed care plans have a number of benefits:

You will not have to pay Medicare deductibles and copayments.

You will not need Medigap insurance to supplement your Medicare coverage.

You will receive coverage for services that Medicare does not cover, such as preventive care services, vision care, hearing care, and prescription drug coverage.

Quality of care may be enhanced because of the coordination of services.

You will have much less paperwork.

8. WHAT ARE THE DISADVANTAGES OF JOINING A MANAGED CARE PLAN?

Medicare managed care plans have disadvantages also:

You are not free to go to any physician or hospital you choose. The only exception is when you need emergency or unforeseen, out-of-area, urgent care service. Otherwise, you are ALocked-in@ and must use the managed care=s providers and facilities.

You must obtain prior approval from your primary physician to see a specialist, have surgery, or receive other medical services.

If you are out of the managed care plan=s service area, you will not receive coverage for your care, except in emergency and urgent care situations. If you take long trips frequently or spend part of the year outside the managed care plan's area, joining a managed care plan may not be for you.

9. IF I DECIDE I DON'T LIKE BEING IN A MANAGED CARE PLAN UNDER MEDICARE, CAN I RETURN TO THE BASIC FEE FOR SERVICE MEDICARE PLAN?

You have the right to disenroll from the managed care plan and switch back to Medicare. Your Medicare coverage begins on the first day of the month following your disenrollment from the HMO. For example, if you disenroll from the HMO on March 5, then on April 1, you will no longer be the HMO. However, until April 1, you must continue to use the HMO for health care services.

10. HOW DO I DISENROLL FROM THE MANAGED CARE PLAN?

In order to disenroll, you may either notify the HMO in writing or go to your Social Security Office and provide a written statement of your request to disenroll from the plan. It is probably best for you to actually inform Medicare of your disenrollment by both visiting your local Social Security Office and writing to the HMO by certified mail, return-receipt requested, so that you have proof that the HMO received your letter.

11. WHAT SHOULD YOU CONSIDER BEFORE JOINING A PARTICULAR MANAGED CARE PLAN UNDER MEDICARE?

Before signing any HMO materials, you should review the HMO materials and find out the answers to the following questions:

Where do you go for care? To a central location? To an individual doctor's office? Is it convenient?

What doctors and other health care providers are affiliated with the managed care plan? Can you change physicians within the plan if the physician you initially select is not satisfactory? If you want to make a change, how long must you wait?

Are participating primary physicians accepting new patients? (This is especially important if you are interested in a particular physician).

How is an emergency defined? Where do you go for emergencies, particularly after hours or on weekends? What if you're out of town? How soon do you have to notify the plan that you've received emergency care?

If drugs are offered in the plan, which prescription drugs are offered, and are the drugs that you need offered under the plan?

What skilled nursing homes are covered under the plan? With what home health care agency does the plan contract?

What percentage of the HMO's members have disenrolled this year and why have they disenrolled?

How much are the copayments and do they vary between a primary physician and a specialist? Does the plan require you to pay any premiums? If so, how much? What controls are placed on the doctors, in terms of delivering services to members? If you have a unique ailment requiring special attention, will the plan provide you with the care you need?

12. CAN I APPEAL A DECISION OF NONPAYMENT OR NONCOVERAGE MADE BY THE MANAGED CARE PLAN?

Just as you have a right under Medicare to appeal a decision, you have the right to appeal a decision made by the HMO that you believe was wrongly decided. By law, HMOs are required to have appeal procedures in place. You may appeal an HMO decision not to pay for your emergency or urgent care. Don't confuse the formal appeal system with making a complaint to the HMO. The appeal goes to Medicare not simply to the HMO. The membership materials should give you details on your appeal rights. Legal Services of Northern Virginia is available to help explain to

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IMPORTANT

Everyone's situation is different and most every rule has exceptions. The information above is intended only for general informational purposes in the State of Virginia. It may not apply to your individual situation. Therefore, it is advisable to discuss your particular situation with a lawyer.

If you need legal help, call the Legal Services Branch that serves the city or county in which you live to make an appointment. To be helped by Legal Services, you must meet financial eligibility requirements. These guidelines will be explained to you when you call.