Working with your HMO

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Working with your HMO

• Agenda
  • Introduction to HMOs
  • Matching your priorities with services
  • Coverage and cost
  • Problem solving
  • Where to turn for help
Introduction to HMOs
What is an HMO?

- Health Maintenance Organization:
  - A plan offered by an insurance company which provides a comprehensive predetermined medical care package either through prepaid, subcontracted health care providers or through its own providers.
UC-sponsored HMOs

• Health Net
• Kaiser Permanente
Why did HMOs start?

- HMOs promised to reduce costs and deliver quality care if consumers, doctors & hospitals agreed to certain restrictions
- Reduced unnecessary visits by using a gatekeeper
- Emphasized preventive care
- Care based on medical necessity
How do HMOs work?

- Medical Groups are prepaid to provide care
  - Association of medical providers who band together to negotiate with insurance companies as one legal entity

- Closed panel HMO:
  - Care provided by employees of the HMO
  - Kaiser prepays the Permanente Medical Group

- Open panel HMOs:
  - Care provided by prepaid independent medical groups
  - Health Net
How do HMOs work?

- The HMO pays a per capita rate (called capitation) to each Medical Group
  - Medical Group is responsible for your care

- You choose a Primary Care Physician (PCP) who acts as your gatekeeper to care through the Medical Group
How do HMOs work?

You choose primary care physician (PCP)

PCP refers you to x-ray or lab, handles hospital admissions

PCP refers you to specialists

Provider submits claims to HMO through Med Group

PCP requests **authorizations** from the Medical Group
Advantages of HMOs

- Low monthly premiums
- Low copayments
- No claim forms
- No deductibles/coinsurance
- Encourages relationship with PCP
Limits of HMOs

- Must select PCP from available medical groups
- Most specialty care requires PCP referral
- Preauthorization process required
- Must use your Medical Group’s network of specialists/hospitals/labs
- Service area limited to certain zip codes
  - Medical Benefits Summaries:
    - http://atyourservice.ucop.edu

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Medical plan comparison

- HMO
- POS (Point-of-Service)
- PPO (Preferred Provider Organization)
- FFS (Fee-for-Service)

Working with your HMO
Matching your priorities with services
When choosing a plan

- What is important to you?
  - Access to a particular PCP, specialist or hospital
  - Needs of family members
  - Prescription drug benefit
  - Mental health services
  - Monthly premium
Your PCP

- You must have a PCP
  - Belongs to your Primary Medical Group

- Each family member may have a different PCP

- Family member PCPs may be in different Medical Groups
  - Caution: newborns must usually be assigned to a pediatrician in the mother’s Medical Group at first
How to find a PCP

- HMO websites
- Medical Group websites
- More information about choosing a PCP:
  - http://www.hr.uci.edu/hcf
  - Click on “Choosing Your Doctor”
Access to specialists

- PCP referral usually required
- Preauthorization usually required
  - Medical Group’s “Utilization Management” department
- PCP must refer to specialists in same Medical Group
  - Out-of-network referrals are rare
Medical Group

- You can change your Medical Group or PCP by calling your HMO
  - If you call by the 15th you can usually have the new group effective on the 1st of the next month
Hospitals

- Check which hospital you will use when deciding on a PCP/Medical Group
- For planned services, you must use the group’s hospital
- For emergencies, dial 911 or go to the nearest hospital
  - **Important:** follow up with your PCP
Location

- Is the location of the doctor’s office and hospital convenient?
- Are the medical group’s specialists nearby?
- Close to home vs. close to work vs. close to school
What about quality?

- Quality ratings available on some HMO websites
- http://calhospitalcompare.org
- Quality of Care Report Card
  - http://www.opa.ca.gov/report_card
  - Quality ratings on health plans and Medical Groups
Prescription drugs

- List of preferred drugs is a formulary
  - Non-formulary meds have higher co-pay
  - Formulary subject to change
- Some meds have supply limits or may require preauthorization
Mental health services

- Consider both medical and mental health needs before choosing a plan

- Separate mental health provider network: United Behavioral Health
  - No need to get a referral from PCP
  - Call UBH directly
  - Intake specialists will assess and refer
Mental health networks

- Health Net: UBH
- Kaiser:
  - Kaiser providers and/or
  - UBH
Mental health providers

- Services must be authorized
  - No coverage for out-of-network providers

- When given a list of providers, some may not be accepting new patients
  - Private practitioners often do not have office staff
    - If a provider does not return your phone calls in a timely manner, or if you are told that they are not accepting new patients, please report this to UBH

- Search for UBH providers:
  - http://www.liveandworkwell.com
  - Use Access Code 11280
Employee Assistance Program (EAP) can assist Faculty and Staff with referral process

- Cascade Centers:  (800) 433-2320
Coverage and cost
Know what’s covered

- Read your Plan Booklet a.k.a. Evidence of Coverage (EOC)
  - [http://atyourservice.ucop.edu](http://atyourservice.ucop.edu)
  - Look under Forms & Publications

- Medical plan websites
  - Physician search
  - Drug formulary
  - Wellness & discount programs
Know what’s NOT covered

• See your EOC for *exclusions & limitations*
  • Services from non-network providers
  • Out-of-area services (non-emergency)
  • Plans may differ on exclusions
  • Alternative medicine
    • Some plans may offer discounts
What will it cost me?

• Copayments
  ▪ Physician office visit: $15
  ▪ ER: $50
  ▪ Inpatient hospitalization: $250
  ▪ Mental health outpatient: $0-$15
  ▪ Mental health inpatient: $250
What will it cost me?

- **Generic Rx:** $10/30-day supply
  - Kaiser: 100-day supply
- **Brand name Rx:** $20/30-day supply
  - Kaiser: 100-day supply
- **Non-formulary Rx:** $35/30-day supply
  - Kaiser: not covered
What will it cost me?

- **Mail-order Rx:**
  - 90-day supplies for 2 copayments
  - Kaiser: 100-day supplies for 1 copayment

- **UC pharmacies:**
  - 90-day supplies for 2 copayments
  - Health Net
What will it cost me?

- **Maximum Copayment Liability**
  - When you’ve reached the maximum, you pay no more copays for services
  - **Important:** save your receipts
  - Does not include Rx
  - Does not include non-severe behavioral health

- HMOs have no overall **Lifetime Maximum** that they will pay
Problem solving
Troubleshooting tips

• Make the most of time with your PCP
  • Write down symptoms
  • Share your hunches as to what’s wrong
  • Bring a short list of important questions
  • Take notes/write down what you learned after the appointment
Troubleshooting tips

- Be sure that your referral is authorized
  - Did you get a letter/authorization number?

- Ask for a Second Opinion
  - Not getting better
  - Test results aren’t clear
  - Questions about the necessity of a surgery
Troubleshooting Rx

- Generics may be substituted automatically
  - Unless “do not substitute” written on prescription

- Bring a copy of your plan’s drug formulary when you see the doctor

- Bring a list of the drugs that you take w/ dosage

- Be sure to use a HMO-approved pharmacy

- Mail order/UC pharmacies will save you money
  - Ask for a 90-day prescription with refills
  - Order your refill 3 weeks prior to running out

Working with your HMO
If you get a bill

- You should not get any bills for services received through an HMO
  - A bill usually means “something is wrong”
  - Don’t throw things away
  - Follow up with health plan immediately
    - May need to re-direct bill to the correct payer
    - May need “retroactive authorization” from group
- Note: if you get a letter that says “this is not a bill” – it isn’t a bill (Explanation of Benefits)
What if you need services that are not covered?

- HMOs are low cost because of their limited flexibility
- Consider a more flexible plan (Blue Cross/CIGNA)
  - PPO plans may cost more to use
  - You can change plans only under certain circumstances
- Expect to pay out of pocket for some expenses
  - Use the Health Flexible Spending Account (Health FSA) for planned expenses
Health FSA

- Allows you to set aside money on a pre-tax basis for qualified health expenses

- For expenses not covered by health insurance
  - **Yes:** copayments, deductibles, even some over-the-counter medications
  - **No:** insurance premiums, care not “medically necessary” e.g. massage or plastic surgery
Health FSA

- Contribute up to $5,000 by payroll deduction
- **Caution:** Use it or lose it
  - Expenses must qualify under IRS rules
- Enroll during Open Enrollment
- Debit/credit card
- **Caution:** Save your receipts
- Administered by CONEXIS
What if you leave your HMO service area?

- **Short-term (vacation):**
  - Covered for urgent/emergency care
  - Ask pharmacist for “vacation override” for meds

- **Long-term (move):**
  - If out of service area for more than 2 months, you can change plans (Blue Cross/CIGNA)
  - Must change address with UC system
Changing plans

- Open Enrollment (November)
  - New plan effective the following January 1
- Addition of new eligible family members
- HMO Transfer Program
Provider disruption

- What can you do?
  - HMO Transfer Program
    - Medical group disruption
  - Open Enrollment
  - If undergoing treatment when changing plans, request “Continuity of Care” from new plan
    - A.K.A. Transition Assistance
  - Choose a new doctor
What does the future hold?

- Networks/service areas expand & contract
- Medical group consolidation/bankruptcy
- Some doctors are leaving HMOs
- Nationally, HMO enrollment has decreased to 21% (kff.org Employer Health Benefits 2007 Annual Survey)
- As of 2007, 47% of Californians in HMOs (statehealthfacts.org)
- 88% of UC Davis/UCDHS employees in HMOs

Working with your HMO
What does the future hold?

- Costs continue to rise
- Stay aware of alternative UC plans
  - Blue Cross PLUS/Blue Cross PPO
  - CIGNA Choice Fund PPO
- Disease Management efforts
  - Your plan may contact you with a special program for asthma, diabetes, heart disease, etc.
What if you can’t get services you need?

- Know your rights and responsibilities
  - Read your EOC
  - [http://www.calpatientguide.org](http://www.calpatientguide.org)

- Each plan has a process for:
  - **Grievances**: a.k.a. “complaints”
    - Dissatisfaction with a service or access to care
  - **Appeals**:
    - Requests for the reversal of a plan decision (usually a denial of service)
Where to turn for help
Help is available

- Your PCP or specialist
- Your medical group
- Customer Service at your HMO
- The California Department of Managed Health Care (DMHC)
  - http://www.hmohelp.ca.gov

Write down who you speak to and when
Help is available

Health Care Facilitator Program

- Glenn Rodriguez
  - (949) 824-9065
  - glenr@uci.edu
  - http://www.hr.uci.edu/hcf

- Benefits Office
  - (949) 824-5210

Working with your HMO
For more information

http://www.opa.ca.gov/english/about/consumer_information/HMO_Guide.aspx

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Thank you!