

How does my Medicare HMO plan work?

Health maintenance organizations, HMOs, are a type of **provider network** that requires beneficiaries to obtain care through that **network** except in cases of emergencies, making the plans more restrictive but less expensive than other health plans. With an average Premium cost \$0 HMOs are the most cost effective for your pocketbook, they have provider networks (Medical Group) available within the health insurance plan you choose. But you must still **pay your Premium for Part B Medicare** Insurance (2023 \$164.90) premium to keep your plan active whether it be a Medicare Advantage plan (HMO/PPO) or and Medicare Supplement plan (NO Network Freedom plan).

- [What is an HMO Health Insurance Plan?](#)
- [Differences between HMO health insurance networks and other networks](#)
- [PPO vs. HMO](#)
- [Supplement or Advantage plan](#)
- [How much does an HMO health insurance plan cost?](#)
- [Choosing a plan](#)

What is an HMO health insurance plan?

HMO networks contract with primary care physicians (PCPs) and specialists, as well as hospitals and specialty clinics, enabling HMO insurance plans to provide an array of services across the entire spectrum of care and thus focus on prevention, wellness and care coordination.

Most major insurance providers offer HMO insurance plans, usually as less expensive alternatives to other insurance plan options such as PPOs and Supplements, making them highly affordable.

It is important to remember that HMOs are governed by strict rules designed to better control utilization, costs, and the management of care. Not only are beneficiaries required to access care specialists within their provider network, but they must also **obtain referrals** from their PCPs in order to see a specialist, a practice known as prior authorization. The PCP is responsible for managing the patient's overall care while helping the patient navigate the HMO health insurance system.

With most HMO insurance plans, beneficiaries must live or work within the HMO's geographic **service area**, making it easier for HMOs to determine and set fees based on the service area's population, you usually cannot cross county lines. HMOs, like other health plans, have advantages and disadvantages. Below we have provided some of these pros and cons:

Pros:

- Lower costs in the form of cheaper premiums, deductibles, and copays.
- Easy access to PCPs, who act as health care navigators, managing the patient's overall care while helping the patient navigate the HMO health insurance network.
- Access to integrated and coordinated care that prevents fragmented, episodic care.
- A seamless and less complicated billing and claims processing system because nearly all claims are handled by your in-network Medical Group.
- Some HMO health insurance plans do not charge deductibles, freeing beneficiaries from having to meet financial thresholds before coverage kicks in.

Cons:

- Beneficiaries are required to obtain care within the **HMO network** except in emergency situations, curtailing choice, and flexibility.
- PCP **referrals are required** to see specialists, creating the possibility that beneficiaries could be denied needed specialty care in some situations.
- Some HMOs require beneficiaries to live or work within the HMO plan area, with access only to the doctors within your plans network.

Differences between HMO health insurance networks and other networks (supplements)

- Costs (HMOs being the least expensive of the plans)
- Requires referrals from the PCP
- Where you can access care (HMOs being more restrictive than other plans)
- Restricts you to only in-network specialists
- Gives you extra benefits like vision, hearing, dental, gym membership and over the counter benefits (Supplements do not offer)
- Most Advantage plans include prescription drugs at a lower cost and often with no deductible. Make sure your agent runs a medication list every year to keep your medication costs low
- Remember you can change PCP any time of year, so if your PCP is not doing their job, you can fire them and choose a different PCP. Not all Medical groups are the same some are more difficult to work with than others

What follows are brief descriptions of other types of provider network plans:

Preferred Provider Organization: A type of health insurance plan where you access care inside or outside of the plan's network of providers, though you will pay more for accessing care outside of the plan network. You can also see specialists without having to obtain a referral. These plans provide more flexibility than other plans, but they are **more expensive**.

PPO vs. HMO

The ability to see a specialist is easier with a preferred provider organization (PPO). Referrals are not needed. With a PPO, it is also possible to go outside of the plan network to receive care, though you pay a higher cost to go out-of-network. Going outside of a plan network does not exist with HMO insurance plans except in emergency situations.

Beneficiaries choosing a PPO may like the flexibility of the plans even though they are more expensive. By choosing a PPO, you are, in effect, paying for more options and flexibility.

Medicare Supplement and Medicare Advantage: 6 Key Differences

We've touched on some of the differences you'll see between these two types of plans, but let's lay out the key differences between the two.

First, Medicare Supplement plans will usually have a **higher premium** than Medicare Advantage plans, but they will not usually have a co-pay as the Advantage plans will. I usually recommend Plan G which has a one-time deductible of \$226 per year (2023). All Supplements increase the Premium as you age, so it will get more expensive over time.

Second, Medicare Supplement plans give their members the **FREEDOM to choose any provider**. Medicare Advantage plans usually limit members to receiving care from a specific network of providers the customer chooses.

Third, you will **NOT need a referral** to see a specialist if you are enrolled in a Medicare Supplement plan. You will need a referral in most Medicare Advantage plans.

Fourth, Medicare Advantage plans offer coverage for non-Medicare covered routine dental, vision, and hearing services. **Most Medicare Supplement plans do not offer these additional benefits.**

Fifth, Your Medicare Supplement just supplements Original Medicare, therefore you must purchase a separate Prescription Drug program. They range in Premium from \$8 per month to \$165 per month, the less expensive ones usually have a \$505 deductible, and all have a tiered share of cost for the prescription drugs depending on expense of the medication. Make sure your agent runs a Medication list every year to keep your medications affordable.

Finally, Medicare Supplement members have **coverage across the ENTIRE United States** if the provider accepts Medicare assignment (85% of providers across the USA). **Medicare Advantage HMO** members may only receive care for emergency services if they are outside of their network (and don't want to pay out-of-pocket).

How much does an HMO plan cost?

HMO health insurance plans (Advantage plans) pay designated providers (Medical Groups) fixed fees for delivering a range of services to HMO beneficiaries. By restricting access to in-network providers, the HMO insurance plan can provide lower costs and care coordination, usually resulting in less expensive premiums, deductibles, and co-pays for their customers.

Choosing a plan

The choice between HMOs and other health plans often comes down to price and flexibility, given that quality is the same among the health care plans. HMO network plans are cheaper than Supplements and most PPO Advantage plans, but they are less flexible, providing fewer options and more restrictions.

Many beneficiaries do not like the restrictive nature of HMOs, believing they should have more control over choosing their providers and determining whether they can see specialists without having to obtain approval from a PCP. These policyholders are generally willing to **pay more for this flexibility** and freedom.

However, some beneficiaries like the convenience of an HMO, having an array of services available to them at one location, including a PCP who manages their care and makes referrals as needed.

In choosing a plan, if flexibility is your main concern, then an HMO should not be your first choice. But if cost is an overriding concern, then an HMO can be an attractive option, especially when considering that prevention, wellness and coordinated care are hallmarks of HMO health insurance plans.

Please save your EOB Explanation of Benefits with your tax information; these are the documents we use to protect you in case a doctor or hospital try to overcharge or fraudulently take advantage of you.

Remember when traveling outside the USA you are not covered, please protect yourself and buy travel insurance. Some plans reimburse will you.

Tamie Mongold (951) 795-1943 - Sierra Mongold (951) 313-0267