Alternatives to Medicare Supplement Insurance

Advantages and Disadvantages of HMO Plans

Advantages of Plan Membership

- Getting all services through one source can be easier (for example, doctor's services, hospital care, laboratory tests, X-rays).
- Quality of care may be enhanced because of the coordination of services.
- You can budget medical costs more easily because you know the amount of any premiums in advance, and the other out-of-pocket expenses are likely to be less than under the fee-for services system.
- A beneficiary pays only a nominal copayment when using a service.
- A beneficiary will not need Medigap insurance to supplement Medicare coverage because the plan provides all or most of the same benefits at no additional cost.
- Paperwork is virtually eliminated.
- HMO plans generally must accept all Medicare applicants.

Disadvantages of Plan Membership

- The Medicare beneficiary may not be free to go to any physician or hospital. You generally must use the plan's providers or the plan will not pay, except in emergencies or out-of-area urgently needed care.
- A beneficiary may need to have the prior approval of his or her primary physician to see a specialist, have elective surgery, or obtain equipment or other medical services.
- Disenrollment can take up to 30 days, and you must continue to use the HMO providers until you are disenrolled. You must disenroll in writing.
- If you decide to return to fee-for-service Medicare, depending on your health status, you may not be able to purchase a Medicare Supplement plan.
- You may only change a Medicare Advantage plan once a year from October 15th through December 7th.

Questions to Ask When Considering a Managed Care Plan

- What is covered by the plan? What is not?
- Does it cover dental, podiatry, prescriptions, preventive screenings, hearing aids, and glasses?
- If it covers prescriptions, is there a list of covered prescriptions (formulary) and, if so, does it cover the drugs I use?
- What are the costs and financial arrangements of the plan?
- What physicians and hospitals are available to me through the plan?
- What are the rules on the primary care physician (PCP), and may I change PCP's?
- What may I do if a PCP will not refer me to a specialist I feel I need to see?
- Are physicians/specialists I currently see on the plan and, if so, may I continue to see them?
- How will I feel if they are later dropped by the plan?
- How long does it take to get an appointment with a physician or specialist?
- What do other enrollees think of the health plan?
- How does the plan define "emergency or urgently needed care"?
- How does the plan handle complaints and grievances?