Health Maintenance Organizations



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Get help from TDI

For insurance questions or for help with an insurance-related complaint, call the **Texas Department of Insurance (TDI) Consumer Help Line** at **1-800-252-3439** or visit our website at **tdi.texas.gov**.

Visit **HelpInsure.com** to shop for automobile, homeowners, condo, and renters insurance. Visit **TexasHealthOptions.com** to learn more about health insurance and your options for coverage.

A health maintenance organization (HMO) is a type of health insurance plan that provides care to members through a network of doctors, hospitals, and other providers. The providers in an HMO's network have agreed to treat HMO members at a discounted rate. This allows the HMO to control costs, so out-of-pocket costs are generally lower in an HMO than in other types of health insurance.

How HMOs work

HMOs contract with doctors, hospitals, and other health care providers to provide care within specific geographic service areas. To be a member of an HMO, you must live or work in its service area. Except for emergencies, you generally must use providers in your HMO's network.

To learn whether an HMO is available in your area, call the Texas Department of Insurance (TDI) Consumer Help Line at 1-800-252-3439 or visit our website.

Your primary care physician

When you join an HMO, you must choose a doctor to oversee your care. This doctor is called your primary care physician, or PCP. Your HMO will give you a list of

doctors to choose from.

If you need to see a specialist or another doctor, you must usually get a referral from your PCP. However, you don't need a referral for emergency care or obstetrician/gynecologist visits.

Approved prescription drugs and step therapy exception requests

Each HMO has a list of prescription drugs that its doctors may prescribe. This list is called a formulary.

If a drug isn't on your HMO's list, your doctor may prescribe a similar drug. Most HMOs must cover any prescription drug that your doctor prescribes for a chronic, disabling, or life-threatening illness, even if it's not on the list.

If an HMO drops a drug you're taking from its list, it must continue to cover the drug until your plan's next renewal date.

HMO group plans must tell you whether they use a formulary, how it works, and which drugs are on it. You can also call the plan to ask whether a specific drug is on its formulary. The HMO must answer within three business days.

Some HMO's use a step-therapy protocol for prescriptions. Under step therapy, your doctor will prescribe cheaper, less risky drugs first. The doctor will prescribe more expensive, riskier drugs only if the first drugs are ineffective. Your doctor may ask for an exception to a step-therapy protocol, however. HMOs must respond to step therapy exception requests within 72 hours for a nonlife-threatening condition or within 24 hours for a life-threatening condition. If the HMO doesn't respond within the deadlines, the step therapy exception

request is automatically approved. If an HMO denies your doctor's request, your doctor may appeal the denial. Your doctor may ask that the appeal be expedited.

Coverage for mental health conditions and substance use disorders

HMOs must cover mental health conditions and substance use disorders in the same way it covers medical or surgical services. HMOs may not make it harder to get treatment for mental health conditions or substance use disorders. If you think your HMO is making it hard to get treatment, file a complaint with TDI.

HMO costs

What you pay

- **Premiums.** Premiums are monthly fees you pay to participate in the HMO. If you belong to an HMO through your job, your employer usually takes your premium from your paycheck each month. Some employers might pay all or part of your premium.
- **Copayments.** Copayments are amounts you pay for a covered health service, usually when you get the service. For instance, you will typically pay a copayment each time you fill a prescription. Copayments may vary by the service and are usually more expensive for emergency or specialized care. HMOs may not ask you to pay more than 50 percent of the total cost of services. If the amount of copayments you paid in a calendar year is more than 200 percent of your annual premium, the HMO can't charge you a copayment for the rest of that calendar year.
- **Deductibles.** A deductible is the amount you must pay out of pocket before your health plan will pay.

Although most HMOs don't have deductibles, some do. You'll probably have a deductible if you're in a consumer choice or high-deductible health plan. You might also have to meet a deductible for any care you get outside your network.

Federal law limits the amount you have to pay out of pocket in a policy period (usually one year). In 2019, the maximum out-of-pocket limit is $7,900 for an individual plan and $15,800 for a family plan. Once you reach the limit, you won't have to pay copayments for the rest of that policy period. You still must pay premiums, and the premiums don't count toward the out-of-pocket limit.

What the HMO will pay

HMOs pay the difference between your copayment and the cost of your health care. For example, if your HMO requires a $20 copayment for a doctor visit and the doctor's rate is $80, you would pay the $20 copayment, and the HMO would pay the remaining $60.

Doctors and hospitals in the plan's network may bill you only for copayments. They may not bill you for covered services that the HMO didn't pay or only partially paid. For example, say the doctor's normal rate for an office visit is $100, but the doctor has agreed to a rate with the HMO of $75. You would pay your $20 copayment, and the HMO would pay the remaining $55 of the contracted rate. The doctor may not bill you for the $25 difference between the normal rate and the contracted rate.

However, be aware that a hospital in your network might use radiologists, anesthesiologists, pathologists, assistant surgeons, emergency room doctors, or neonatologists that aren't in your network. Out-of-network providers may bill you for their services, even if the hospital where they treated you is in your HMO's network. If you get a bill from an out-of-network provider, call your HMO. If you

have to go to the hospital, find out whether the providers that will treat you are all in your network. If some are not, ask whether an in-network provider can be assigned. If not, find out in advance how much they will bill you.

If you get care from a doctor or hospital outside the HMO's network, you'll have to pay the full cost of the care yourself, except in these situations:

- You went to an emergency room for a medical emergency. Understand how your HMO defines a medical emergency and whether there are any procedures you must follow. For instance, you might have to tell your HMO within a certain amount of time after you get emergency care.
- You need a covered service that isn't available from network doctors.
- You have a point-of-service option. This allows you to go to out-of-network doctors if you're willing to pay more of the cost.

HMO members rarely have to file claims or wait for reimbursements. But sometimes, you might have to pay for services when you get them. For example, an out-of-network emergency room might require you to pay for your care up front. You'd then submit a claim to your HMO for reimbursement.

Choosing an HMO

When deciding whether to join an HMO, there are several things you should consider.

First, make sure that there's an HMO in your area. You'll have to live or work in an HMO service area to join. To search for HMOs by county, visit our Data Lookup page at apps.tdi.state.tx.us/sfsdatalookup/StartAction.do.

Also visit TDI's Listing of HMO Profiles at www.tdi.texas.gov/hmo/profiles/index.html. You can also call TDI's Consumer Help Line.

Remember that while your overall costs will be lower in an HMO, your choices of doctors and hospitals will be limited. You must usually use doctors and hospitals in your HMO's network.

Also consider the HMO's customer service record. You can learn an HMO's complaint history by calling TDI's Consumer Help Line or by using the Company Lookup feature on our website.

Also talk to an HMO representative or your employer's benefits coordinator and ask these questions:

- Are my doctors in the HMO's network?
- Which hospitals and specialists are in the network?
- Where are the network's doctors and hospitals located?
- What will my expenses (premiums and copayments) be?
- What is the maximum amount I'll have to pay out of pocket?
- Do I have to pay a deductible for emergency care outside the HMO's network?

HMO report cards

The National Committee for Quality Assurance (NCQA) is an independent health care monitoring organization that accredits HMOs. Each year, NCQA issues a report card evaluating HMO performance. To learn more about an HMO, call **NCQA** at **1-888-275-7585** or visit its website at **ncqa.org**.

The Texas Office of Public Insurance Counsel issues two annual reports that compare and evaluate HMOs in Texas:

- Comparing Texas HMOs includes results of a survey asking members to rate their HMOs, the quality of care they receive, and their doctors. This report also provides the number of customer and doctor complaints against HMOs. Find it online at www.opic.texas.gov/health/comparing-texas-hmos.
- Guide to Texas HMO Quality compares the quality of care delivered by HMOs in the state. Find it online at www.opic.texas.gov/health/guide-to-texas-hmo-quality.

For more information about **OPIC**, call **512-322-4143** or visit **opic.texas.gov.**

You can view financial reports and complaint data for HMOs online at www.tdi.texas.gov/reports/report2.html.

Denials of services, treatments, or medications

HMOs will pay only for services, treatments, and prescription drugs that are medically necessary. The process they use to decide whether something is medically necessary is called utilization review.

HMOs usually do utilization reviews before you receive a service. However, an HMO may review a service after you received it if it didn't know about it beforehand.

HMOs must have a process for you to appeal decisions to deny coverage for a treatment or service. You may also appeal an HMO's decision to deny a prescription drug because it's not on the approved list.

If you lose your appeal, you can ask an independent

review organization (IRO) to review the denial. The HMO must comply with the IRO's decision. If you have a life-threatening condition or need a prescription drug or intravenous infusions, you don't have to go through the HMO appeal process. You may ask for an immediate review by an IRO.

You can ask for an IRO review if the HMO decides that the covered service or treatment isn't medically necessary or is experimental or investigational. You can't ask for an IRO review if your HMO denied the treatment because the HMO doesn't cover it.

Not all health plans are required to participate in the Texas IRO review process. For questions or more information about IROs, call **TDI's Managed Care Quality Assurance Office** at **1-866-554-4926** or visit the MCQA web page at **www.tdi.texas.gov/wc/wcnet/index.html**.

Your rights in an HMO

HMOs must have a process to resolve complaints. They may not cancel or retaliate against an employer, a doctor, or a patient who files a complaint or appeals an HMO decision.

HMOs may not prevent doctors from talking to you about your medical condition, available treatment options, and terms of your health care plan, including how to appeal an HMO's decision. An HMO also may not reward doctors for withholding necessary care.

If an HMO doesn't pay or only partially pays for a covered service, network doctors and hospitals may not bill you for the amount that the HMO didn't pay. If you think a doctor or other health care provider has billed you inappropriately, talk to your HMO. You may also call TDI's Consumer Help Line to learn your options.

Texas law requires HMOs to have adequate personnel and facilities to meet the needs of their members. HMOs also must make health care services available within a certain distance of your home and workplace. The law also requires HMOs to:

- allow referrals to out-of-network doctors and hospitals when medically necessary services aren't available within the network,
- allow members to change a PCP up to four times a year, and
- pay for emergency care if not getting immediate medical care could place your health - or the health of your unborn child if you're pregnant - in jeopardy. If you get emergency treatment at a hospital outside the HMO's network, you may be transferred to a network doctor or hospital after your condition is stabilized.

Filing a Complaint

If you have a problem with an HMO, first file a complaint through the HMO's complaint process. If you can't resolve your problem with the HMO, TDI might be able to help.

TDI investigates complaints about HMO claims, billing, enrollment, and appeals. Use the Online Complaint Portal at www.tdi.texas.gov/consumer/complfrm.html to file a complaint online or call the Consumer Help Line for help.

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Texas Department of Insurance
PO Box 149091 | Austin TX 78714-9091
1-800-252-3439 | **TDI.texas.gov** | **@TexasTDI**

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