# Health maintenance organization

From Wikipedia, the free encyclopedia

*"HMO" redirects here. For other uses, see HMO (disambiguation).*

A **health maintenance organization** (**HMO**) is a type of managed care organization (MCO) that provides a form of health care coverage in the United States that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract. The Health Maintenance Organization Act of 1973 required employers with 25 or more employees to offer federally certified HMO options.[1] Unlike traditional indemnity insurance, an HMO covers only care rendered by those doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines and restrictions in exchange for a steady stream of customers.

## Contents



**Health care in the United States**

**Public health care**

- Federal Employees Health Benefits Program
- Indian Health Service
- Medicaid
- Medicare
- Military Health System / TRICARE
- State Children's Health Insurance Program (SCHIP)
- Veterans Health Administration

**Private health coverage**

- Consumer-driven health care
  - Flexible spending account (FSA)
  - Health reimbursement account
  - Health savings account
  - High-deductible health plan (HDHP)
  - Medical savings account
- **Health maintenance organization** (HMO)
- Managed care
- Medical underwriting
- Preferred provider organization (PPO)

**Health care law**

- Emergency Medical Treatment and Active Labor Act (1986)
- Health Insurance Portability and Accountability Act (1996)
- Medicare Prescription Drug, Improvement, and Modernization Act (2003)
- Patient Safety and Quality Improvement Act (2005)

**State/municipal level reform**

## Operation

Most HMOs require members to select a primary care physician (PCP), a doctor who acts as a "gatekeeper" to direct access to medical services. PCPs are usually internists, pediatricians, family doctors, or general practitioners (GPs). Absent a medical emergency, patients need a referral from the PCP in order to see a specialist or other doctor, and the gatekeeper cannot authorize

that referral unless the HMO guidelines deem it necessary.

"Open access" HMOs do not use gatekeepers - there is no requirement to obtain a referral before seeing a specialist. The beneficiary cost sharing (e.g., co-payment or coinsurance) may be higher for specialist care, however.[2]

- Healthy Howard
- Healthy San Francisco
- Massachusetts health care reform
- Oregon Health Plan

HMOs also manage care through utilization review. That means they monitor doctors to see if they are performing more services for their patients than other doctors, or fewer. HMOs often provide preventive care for a lower copayment or for free, in order to keep members from developing a preventable condition that would require a great deal of medical services. When HMOs were coming into existence, indemnity plans often did not cover preventive services, such as immunizations, well-baby checkups, mammograms, or physicals. It is this inclusion of services intended to maintain a member's health that gave the HMO its name. Some services, such as outpatient mental health care, are limited, and more costly forms of care, diagnosis, or treatment may not be covered. Experimental treatments and elective services that are not medically necessary (such as elective plastic surgery) are almost never covered.

Other Choices for managing care are case management, in which patients with catastrophic cases are identified, or disease management, in which patients with certain chronic diseases like diabetes, asthma, or some forms of cancer are identified. In either case, the HMO takes a greater level of involvement in the patient's care, assigning a case manager to the patient or a group of patients to ensure that no two providers provide overlapping care, and to ensure that the patient is receiving appropriate treatment, so that the condition does not worsen beyond what can be helped.

# Cost containment

Although businesses pursued the HMO model for its alleged cost containment benefits, some research indicates that private HMO plans don't achieve any significant cost savings over non-HMO plans. Although out-of-pocket costs are reduced for consumers, controlling for other factors, the plans don't affect total expenditures and payments by insurers. A possible reason for this failure is that consumers might increase utilization in response to less cost sharing under HMOs. [3]

# History

The earliest form of HMOs can be seen in a number of *prepaid health plans*. In 1910, the Western Clinic in Tacoma, Washington offered lumber mill owners and their employees certain medical services from its providers for a premium of $0.50 per member per month. This is considered by some to be the first example of an HMO. However, Ross-Loos Medical Group, established in 1929, is considered to be the first HMO in the United States; it was headquartered in Los Angeles and initially provided services for Los Angeles Department of Water and Power (DWP) and Los Angeles County employees. Approximately 500 DWP employees enrolled at a cost of $1.50 each per month. Within a year, the Los Angeles Fire Department signed up, then the Los Angeles Police Department, then the Southern California Telephone Company, (now at&t) and more. By 1951, enrollment stood at 35,000 and included teachers, county and city employees. In 1982 through the merger of the Insurance Company of North America (INA) founded in 1792 and Connecticut General (CG) founded in 1865 came together to

become CIGNA. Ross-Loos Medical Group, became now known as CIGNA HealthCare. Also in 1929 Dr. Michael Shadid created a health plan in Elk City, Oklahoma in which farmers bought shares for $50 to raise the money to build a hospital. The medical community did not like this arrangement and threatened to suspend Shadid's licence. The Farmer's Union took control of the hospital and the health plan in 1934. Also in 1929, Baylor Hospital provided approximately 1,500 teachers with prepaid care. This was the origin of Blue Cross. Around 1939, state medical societies created Blue Shield plans to cover physician services, as Blue Cross covered only hospital services. These prepaid plans burgeoned during the Great Depression as a method for providers to ensure constant and steady revenue.

In 1970, the number of HMOs declined to less than 40. Paul Ellwood, often called the "father" of the HMO, began having discussions with what is today the U.S. Department of Health and Human Services that led to the enactment of the Health Maintenance Organization Act of 1973. This act had three main provisions:

- Grants and loans were provided to plan, start, or expand an HMO
- Certain state-imposed restrictions on HMOs were removed if the HMOs were federally certified
- Employers with 25 or more employees were required to offer federally certified HMO options alongside indemnity upon request

This last provision, called the dual choice provision, was the most important, as it gave HMOs access to the critical employer-based market that had often been blocked in the past. The federal government was slow to issue regulations and certify plans until 1977, when HMOs began to grow rapidly. The dual choice provision expired in 1995.

In 1971, Dr. Gordon K MacLeod MD developed and became the director of the United States' first federal Health Maintenance Organization (HMO) program. He was recruited by Elliot Richardson, former secretary of the U.S. Department of Health, Education and Welfare.

### Switzerland

Since 1990, Switzerland has funded several HMOs, covering 10 percent of the Swiss population as of March 2006; most HMOs are located in cities. The percentage would be much higher if there were HMOs in all regions. There are mountainous regions where the population density is too low to support HMOs. Insurances grant premium reductions to people who visit HMOs instead of their normal doctor; but this, at the same time, lures younger and healthier people into HMO insurance schemes, thus negating some of the financial benefits for the overall healthcare system. Switzerland, in stark contrast to the US, has an obligatory health insurance in effect, and thus Swiss HMOs are more complex entities than in the United States.

## Types of HMOs

HMOs operate in a variety of forms. Most HMOs today do not fit neatly into one form; they can have multiple divisions, each operating under a different model, or blend two or more models together.

In the **staff model**, physicians are salaried and have offices in HMO buildings. In this case, physicians are direct employees of the HMOs. This model is an example of a closed-panel HMO, meaning that

contracted physicians may only see HMO patients.

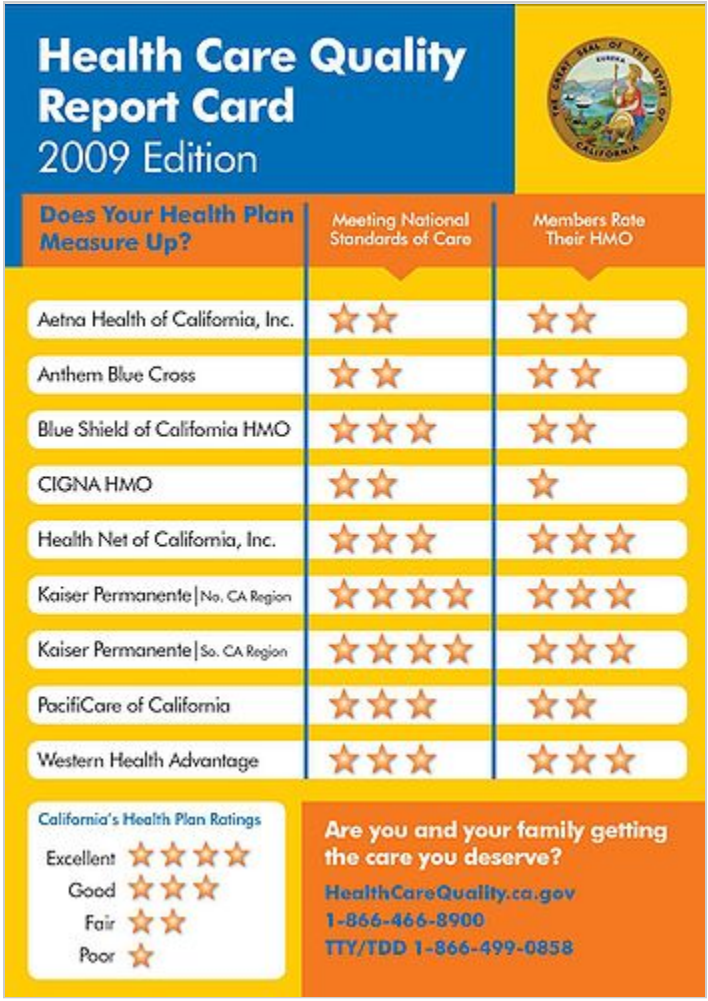
In the **group model**, the HMO does not employ the physicians directly, but contracts with a multi-specialty physician group practice. Individual physicians are employed by the group practice, rather than by the HMO. The group practice may be established by the HMO and only serve HMO members ("captive group model"). Kaiser Permanente is an example of a captive group model HMO rather than a staff model HMO, as is commonly believed. An HMO may also contract with an existing, independent group practice ("independent group model"), which will generally continue to treat non-HMO patients. Group model HMOs are also considered closed-panel, because doctors must be part of the group practice to participate in the HMO - the HMO panel is closed to other physicians in the community.[4]

Physicians may contract with an **independent practice association** (IPA), which in turn contracts with the HMO. This model is an example of an open-panel HMO, where a physician may maintain their own office and may see non-HMO members.

In the **network model**, an HMO will contract with any combination of groups, IPAs, and individual physicians. Since 1990, most HMOs run by managed care organizations with other lines of business (such as PPO, POS and indemnity) use the network model.

# Regulation in the US

HMOs are regulated at both the state and federal levels. They are licensed by the states, under a license that is known as a certificate of authority (COA) rather than under an insurance license. [5] In 1972 the National Association of Insurance Commissioners adopted the HMO Model Act, which was intended to provide a model regulatory structure for states to use in authorizing the establishment of HMOs and in monitoring their operation.



HMO quality report card by the California Office of the Patient Advocate

## Legal responsibilities

HMOs often have a negative public image due to their restrictive appearance. HMOs have been the target of lawsuits claiming that the restrictions of the HMO prevented necessary care. Whether an HMO can be held responsible for a physician's negligence partially depends on the HMO's screening process.***Citation?*** If an HMO only contracts with providers meeting certain quality criteria and advertises this to its members, a court may be more likely to find that the HMO is responsible, just as hospitals can be liable for negligence in selecting physicians. Despite the fact that the HMO makes medical decisions while controlling the financial aspect of providing care, it is often insulated from malpractice lawsuits. The Employee Retirement Income Security Act (ERISA) can be held to preempt negligence claims as well. In this case, the deciding factor is whether the harm results from the plan's administration or the provider's actions.

## Organizations

- Aetna
- CIGNA
- Kaiser Permanente
- Humana
- Health Net
- Wellpoint

## See also

- America's Health Insurance Plans
- Capitated reimbursement
- Health insurance in the United States
- Managed care
- Medicare (United States)
- Preferred provider organization
- Publicly-funded health care
- Sicko A movie critical of HMOs
- Single-payer health care

# References


1. ^ Joseph L. Dorsey, "The Health Maintenance Organization Act of 1973(P.L. 93-222)and Prepaid Group Practice Plan," Medical Care, Vol. 13, No. 1, (Jan., 1975), pp. 1–9
2. ^ Peter R. Kongstvedt, "The Managed Health Care Handbook," Fourth Edition, Aspen Publishers, Inc., 2001, page 40 ISBN 0-8342-1726-0
3. ^ Jaeun Shin, Sangho Moon, "Do HMO Plans Reduce Expenditure in the Private Sector?", Economic Inquiry, Jan 2007. [1] (http://findarticles.com/p/articles/mi_hb5814/is_1_45/ai_n29387922/pg_1?tag=artBody;col1)
4. ^ Peter R. Kongstvedt, "The Managed Health Care Handbook," 4th edition, Aspen Publishers, Inc., 2001, ISBN 0-8342-1726-0, pages 35–26
5. ^ Peter R. Kongstvedt, "The Managed Health Care Handbook," Fourth Edition, Aspen Publishers, Inc., 2001, page 1322 ISBN 0-8342-1726-0


# External links

- America's Health Insurance Plans (http://www.ahip.org) - a trade organization
- HealthDecisions.org (http://www.healthdecisions.org) - Comprehensive resource for insurance news and information
- Medicare HMO Web Site (http://www.medicarehmo.com/)
- State of California - Health Care Quality Report Card 2009 Edition (http://www.opa.ca.gov/report_card/?utm_source=Wiki-HMO&utm_medium=ExternalLinks&utm_campaign=Wikipedia) . HMO and Medical Group ratings in California. Plans and Medical Groups are scored on meeting national standards and how members rate their plan (patient satisfaction). Also contains ratings on PPOs, Medi-Cal, Healthy Families, and more.
- California's Office of the Patient Advocate -- What's an HMO (http://opa.ca.gov/healthcare/health-plan/what-is-hmo.aspx?utm_source=Wiki-HMO&utm_medium=ExternalLinks&utm_campaign=Wikipedia)
- The high costs of for-profit care (http://www.cmaj.ca/cgi/content/full/170/12/1814) - an article that includes references to the excesses of HMO Chief Executive Officer pay in the U.S.
- Physician Salaries in USA (http://MDsalaries.blogspot.com) - A Snapshot
- What Exactly is an HMO? (http://www.helium.com/items/1316595-what-is-an-hmo)


Categories: Health maintenance organizations | Managed care