23. Health Maintenance Organizations

Introduction

Since the 1980s, enrollment in health maintenance organizations (HMOs) has greatly increased. HMO advocates believe HMOs offer great potential for controlling health care costs while maintaining quality medical care. HMOs provide a wide range of services to subscribers and their dependents on a prepaid basis. Subscribers purchase HMO coverage for a contract period by paying a fixed periodic fee (typically annual). HMOs generally emphasize preventive care and early intervention. Because HMOs are contractually obligated to provide all covered medical services for a fixed dollar amount, they have an incentive to provide care early, before illnesses become more serious. At the same time, HMO members tend to have lower rates of hospitalization than persons covered by traditional fee-for-service insurance plans.

The first HMO was established in 1929. The number of HMOs has risen dramatically since then. As of July 1, 1995, there were an estimated 593 pure and open-ended HMOs covering 53.4 million people (InterStudy, 1995). InterStudy projects that by 1997 the number of individuals enrolled in a pure HMO will increase from 58.5 million to 66.0 million. According to the Bureau of Labor Statistics’ employee benefit surveys, in survey years 1992 and 1993, 20 percent of full-time employees in private industry and state and local governments who participated in an employment-based health plan were enrolled in an HMO (U.S. Department of Labor, 1994a and 1994b). As of July 1, 1995, 3.4 million older Americans were enrolled in HMOs through Medicare (Marlowe and Childress, 1995).

How HMOs Work

HMOs both finance and deliver health care services. Instead of paying a health care provider each time a service is delivered, HMO subscribers agree to pay periodic fees (typically annual). In turn, HMOs provide for virtually all of their subscribers’ covered health care needs. (Subscribers may be required to make a modest copayment for some HMO services.) Each HMO develops its own rates and benefits, although certain HMOs that are regulated by federal law must provide at least the basic health services required by law. HMOs accept the risk of providing covered health care services. Thus, they have an economic incentive for monitoring utilization and costs.

HMOs’ basic functions are to provide comprehensive health care services to subscribers, contract with or employ physicians and other health care professionals who will provide the covered medical services, and contract with one or more hospitals to provide covered hospital care (a few HMOs own and operate hospitals).

Because HMOs both finance and provide health care services, their role is different from that of commercial insurers or a Blue Cross and Blue Shield plan. Conventional insurance plans simply reimburse health care providers whom the patient has to locate, usually under a fee-for-service arrangement. However, commercial insurers, self-insured employers, and Blue Cross and Blue Shield plans are increasingly using preferred provider organization (PPO) arrangements and other managed care arrangements to encourage employee use of certain designated health care providers.

Types of HMOs
Currently, there are five different HMO models: staff, group, network, independent practice association, and mixed model. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to manage services and costs.

- **Staff Model**—In a staff model, the HMO owns its health care facility and employs health care providers on a salaried basis. Patient choice is limited: enrollees are restricted to network providers and are required first to see a primary care physician, who then refers them to specialists within the HMO when it is considered medically necessary and appropriate.

- **Group Model**—In a group model, the HMO contracts with a single independent group practice to provide services to the HMO participants. The practice is managed independently and is usually paid on a capitated basis. Group model HMO providers usually spend most of their time with HMO participants but may spend some time in private practice.

- **Independent Practice Associations (IPAs)**—IPAs are groups of physicians in private practice who provide some services to HMO participants but primarily provide services to patients not enrolled in an HMO. The IPA may contract with more than one insurer or HMO. The non-HMO patients are treated on a fee-for-service basis. IPA providers working with HMOs are generally paid on a fee-for-service basis; therefore, they do not have strong incentives to provide cost-effective care. However, there has been a movement toward reimbursing IPAs on a discounted fee-for-service basis or on a capitated basis. The advantage of an IPA is that contracting with physicians practicing in their own offices allows the HMO to offer services in a broader geographic area, requires less capital investment than a staff or group model HMO of similar size, and generally offers patients more choice among providers.

- **Network Model**—In the network model, the HMOs contract with two or more independent physician groups that often provide general and specialty services. These groups are typically paid on a capitated basis by the HMO, but they also spend some time in private practice operating on a fee-for-service basis.

- **Mixed Model**—A mixed model HMO initially adopts one type of model, such as a staff model, and then expands its capacity and/or its geographic region later by adding another type of model such as an IPA.

**Health Maintenance Organization Act of 1973**

The Health Maintenance Organization Act of 1973 was intended to encourage the growth of HMOs. In addition, it established requirements for an entity seeking designation as a federally qualified HMO. Under these requirements, HMOs must offer certain benefits and satisfy federal regulations for administrative, financial, and contractual arrangements. The U.S. Department of Health and Human Services administers the act and oversees federal qualification of HMOs. A federally qualified HMO must meet uniform standards for service delivery, quality assurance, marketing practices, and financial standing.

The federal HMO law and regulations also include the following provisions. The HMO’s solicitation to the prospective employer customer must be in writing, and it must be directed to a managing official at the solicited location. The written request must be extended at least 180 days before renewal or expiration of the employer’s regular health benefit contract or collective bargaining agreement. Additionally, the HMO must satisfy other requirements before it will be considered as an optional employer plan (e.g., information must be available on the HMO’s ownership and control,
facilities, hours of operation, service areas, and rates). In actual practice, most employers who offer HMOs do so voluntarily (i.e., not as a result of the formal solicitation process). For more information on federal legislation, see section on Dual Choice Requirement.

Services that federally qualified HMOs must provide include primary and specialty physician care, inpatient and outpatient hospital care, emergency care, short-term outpatient mental health care, medical treatment and referral for alcohol/drug abuse and addiction, diagnostic laboratory services, diagnostic and therapeutic radiology services, home health care, and preventive health care. At its discretion, a federally qualified HMO may also provide a broad range of supplemental health care services, such as intermediate and long-term care (e.g., institutional or home health care); adult vision care; dental care; long-term or inpatient mental health care; long-term physical therapy and rehabilitation services; and prescription drugs. These supplemental services can be offered on a fee-for-service basis. For more information on dental care, prescription drug, and vision care plans, see chapters 20, 21, and 22, respectively.

Employers who offer HMOs must provide for annual group enrollment periods, during which employees can choose either the HMO or the regular health insurance plan without waiting periods, exclusions, or restrictions due to health status. As of January 1, 1995, 270 HMOs were federally qualified; these HMOs provided health care services to 70.3 percent of all HMO subscribers (InterStudy, 1995).

Some HMOs are not federally qualified because they do not meet the HMO act’s requirements or because they have not applied for qualification. However, all HMOs must be state certified. HMOs generally provide more comprehensive services than are covered by commercial insurance plans or Blue Cross and Blue Shield plans. For example, federally qualified HMOs must provide routine examinations, and their allowable copayments are limited.

HMO Act Amendments of 1988

Responding to employer concerns about selection bias and HMO pricing, Congress enacted the 1988 amendments to the HMO Act (P.L. 100-517) on October 24, 1988. The new law relaxed some regulations applying to federally qualified HMOs, allowing employers to negotiate HMO rates and coverage more easily.

**Dual Choice Requirement**—One of the major provisions of the 1973 HMO act was a requirement that most employers offer their employees a qualified HMO, in addition to a traditional health plan, if requested to do so by such an HMO. The 1988 amendments repealed the dual choice requirement, effective October 24, 1995.

**Equal Contribution Requirement**—Regulations provided under the original act had interpreted the dual choice provision to require that mandated employers contribute the same dollar amount to federally qualified HMOs as they contribute to their highest cost non-HMO health plan. The 1988 law eases this requirement and states that any contribution made by a mandated employer to a qualified HMO must be in an amount that does not “financially discriminate” against an employee enrolled in the qualified HMO. A contribution is considered not financially discriminatory “if the employer’s method of determining the contributions on behalf of all employees is reasonable and is designed to assure all employees a fair choice among health benefit plans.”

**Community Rating Requirement**—The original HMO act required that federally qualified HMOs community rate their services. A community rating system determines rates based on the HMO’s total membership experience rather than on the experience of each subscriber group. The 1988 amendments allow employers to negotiate group rates on the basis of an estimate of how much it is likely to cost to provide services to the employee
group. This type of pricing is similar to the experience rating used in fee-for-service insurance plans, except that HMOs are not permitted to adjust premiums retroactively if the estimates prove inaccurate. Employers with fewer than 100 employees can be charged no more than 110 percent of the community rate.

**HMO Growth and Competition**

Since the passage of the 1973 HMO act, some observers have indicated that HMOs have been an important influence in restructuring the U.S. health care system and slowing rising health care costs. However, the growth of HMOs was relatively slow during the 1970s for a number of reasons, including physician reluctance to leave fee-for-service medical practice and beneficiary reluctance to accept restrictions on freedom of provider choice. Additionally, there was some initial confusion over the 1973 HMO act. The act has been amended several times, in part to alleviate this confusion and, in 1988, to promote competition among HMOs for employers' business, which in turn could lower employers' cost of providing health coverage to employees.

Sustained growth in HMO membership since the 1980s suggests increasing employer, consumer, and government interest in HMO arrangements and increased acceptance by providers and employees. Employers, unions, and insurance companies have been more involved as direct sponsors and organizers of HMOs. Government policies increasingly encourage enrollment in managed care programs of Medicare/Medicaid populations and government employees. Also, hospital managers and private practice physicians have become more interested in HMOs as well as other types of alternative health care delivery systems.

**Conclusion**

Despite HMOs' growth and increasing acceptance, some observers question their ability to stem rising health care costs. Several studies have been conducted on the impact of HMOs on health care costs. More recent studies have shown that, in markets with a high penetration of HMOs, hospital costs are lower than in markets with low HMO penetration. (Gaskin and Hadley, 1995). One of the main points on which HMOs are criticized is that their cost savings result primarily from selection bias, i.e., healthy, young individuals are more likely to enroll in HMOs than relatively older unhealthy individuals. Yet research into the selectivity bias in HMOs has shown little or no conclusive evidence of selectivity bias.

Recent studies do indicate that, while HMO costs continue to increase, they are increasing at a slower rate than traditional fee-for-service plan costs. One study indicates that between 1992 and 1995, HMO medical plan costs increased from $3,075 to $3,255 per employee, an average annual growth rate of 1.9 percent, while traditional fee-for-service medical plan costs increased from $3,268 to $3,650 per employee, an average annual growth rate of 3.8 percent. Thus, despite continued debate regarding the optimal system for health care delivery, given continued health care cost inflation, the role of HMOs is likely to grow.

**Bibliography**


### Additional Information

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A pure health maintenance organization (HMO) is an organization that offers prepaid, comprehensive health coverage for both hospital and physician services. Members are required to use participating providers and are enrolled for specified periods of time. An open-ended HMO, also known as an HMO point-of-service, is an organization in which the patients are prepaid enrollees who may receive services from providers who are not members of the HMO's panel. There usually is a substantial deductible, copayment, or coinsurance requirement for use of nonpanel providers. These products are governed by state HMO regulations (InterStudy, 1995).