

Benefit Fact Sheet

What is it?

HMOs provide comprehensive medical services from a closed panel of providers. Generally, coverage is not provided if an insured receives care outside of the network or without prior approval. HMOs use primary care physicians (PCPs) as gatekeepers to coordinate the care of members to maximize efficiency and effectiveness in the delivery of care.

Under this model, providers contract with an HMO to receive more patients and in return usually agree to provide services at a discount. This is often done through a system called capitation, where certain providers (usually PCPs) receive a fixed payment per member per month and in return provide certain services, charge participants only limited copays and do not require claims forms. This arrangement allows the HMO to charge a lower monthly premium, which is an advantage over other medical plans (e.g. PPO, Indemnity) provided that its members are willing to abide by the additional restrictions.

Why offer it?

- HMOs are usually the least expensive form of group health coverage.
- HMOs provide initial and ongoing review with respect to the quality of providers and the care they deliver.

What types of employers offer it?

Employers who wish to provide employees with less expensive, comprehensive medical benefits.

What size employers offer it?

All sizes of employers offer HMOs.

What are the critical underwriting or participation requirements?

- Minimum of two employees (varies by HMO).
- Employer location and industry.
- Employee demographics.
- Past claims experience may apply, depending on employer size and carrier requirements.
- HMO offering may require coordination with other HMO or non-HMO plans offered by employer. Plans may impose specific requirements to ensure all plans are offered on equal standing in terms of benefits and employer funding. Some plans may decline to underwrite under certain circumstances.

What's new in this area?

- To remain competitive, insurers have redesigned HMO products to offer consumers more choice. To achieve this, many insurers have relaxed pre-authorization requirements, eliminated specialist referral requirements for specific services, and expanded their provider networks.
- Financial instability at the medical group level has led to numerous closures of medical groups, in many instances disrupting patient care. Many medical groups have not been able to reposition themselves to capture the growing number of PPO enrollees. Furthermore, health plans are increasingly linking compensation to performance and administration, causing smaller medical groups with less sophisticated administrative systems to fall behind. Many medical groups have merged into larger organizations with stronger negotiating leverage and more stable financial foundations.

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- Taking their cue from the success of tiered pharmacy co-payments, some insurers have rolled out tiered networks where hospitals are designated as higher -- or lower -- cost facilities. Members are then subject to higher copays or deductibles for services at higher-cost hospitals. Insurers hope this will help involve members in making more cost-conscious health care choices, and positively affect medical inflation trends. In a similar attempt, some insurers are introducing HMO plans paired with employer funded HRAs. These HMO plan designs also incorporate coinsurance and high copayments or high deductibles for services. Insurers intend to incentivize conscious consumerism while offering the familiarity of the basic HMO model accompanied by the financial support of an HRA.

How much does it cost?

Average 2009 monthly premium costs (source: [Kaiser Family Foundation](#)):

- Employee Only: \$402
- Family: \$1,114.58

Informational link(s)

- [Health Maintenance Organization](#) (Wikipedia)
- [HMO's Explained](#) (CBS)

Pros and cons

Pros

- Comprehensive benefits at relatively low cost
- No claim forms
- Promotes preventive care and wellness

Cons

- PCP care coordination can be restrictive
- Network changes can be disruptive to members

This Fact Sheet is designed to provide a general overview of the benefit program, service, or regulatory act it describes. The information included in this document is not a substitute for legal or professional opinion relative to a plan sponsor's particular fact pattern. Your ArlenGroup consultant can answer more specific questions relative to its application for your organization. A menu of additional topics is available online at: www.arlengroup.com/facts.