HMO Reference Binder

- **What is HMO?**
    - Stands for Health Maintenance Organization
    - Made up of a certain number of providers that have agreed to participate in this network and charge a certain price for any of the services they provide, helping to control costs for their members
    - Patients are only covered under the HMO plan if they see a provider within the HMO network. There are few opportunities to see someone outside the network.
    - Usually restricting on how many number of visits, tests, and treatments you can do that's covered under the plan
    - Can either be a public or private entity
- **Key points of HMO**
    - May require you to select a primary care physician who will determine what treatment you need. May also need their referral when you need to get special treatment
    - Might require you to live or work in the area to be eligible for a certain HMO
    - No coverage when seeing a doctor outside of an HMO network
    - Usually lower premiums and no deductible/a low one (because of agreed upon payment and because healthcare providers are able to have their patients go directly to them instead of someone else). Usually have lower copays and coinsurance (at time of visit), great option for people who are looking for something affordable and don't need anything more than basic checkups and immunizations
    - The Department of Managed Health Care (DMHC) oversees all HMOs in California
    - Claims won't have to be filed as often if you are receiving in network care
- **Main types of HMO**
    - Staff Model
        - Healthcare professionals are directly employed by HMO and only will see patients under HMO
    - Group model
        - Healthcare professionals not directly employed by HMO but have contracts to provide care for a fixed rate. Only sees patients enrolled with HMO
    - Network model
        - Healthcare professionals not directly employed by HMO and HMO have contracts with multiple physician groups. Healthcare professionals can see patients with HMO as well as with other types of insurance
- **Advantages of HMO**
    - Preventative care: HMO plans encourage people to seek medical treatment early and to have annual checkups. Having a more long-time, established relationship with a PCP helps to coordinate care (potentially better understanding of patients' profiles from longer relationships) and PCPs encourage preventative services.
    - Cost friendly: Is the least expensive health insurance. Members don't pay deductibles, but instead pay monthly premiums and small copayments for medical services/treatments regardless of what medical treatment a member needs

    - No lifetime maximum payout: The plan pays for as long as you are part of the plan
    - Less complicated billing: Usually less confusion and problems when members need to pay
- **Disadvantages of HMO**
    - Strict definitions within the HMO plans that tend to limit what kind of care you will receive
    - Patient Quotas: physicians who are a part of HMOs are usually required to see a minimum number of patients each day which can limit the time they can spend with someone
    - Many HMos require that diagnostic tests be approved before payment which can delay healthcare treatment until the paperwork is resolved
- **HMO covered services:**
    - Preventative care (physical exams, immunizations, lab tests, cancer screening)
    - Office visits
    - Surgery
    - Urgent/emergency care
    - Hospital care
    - Family planning
    - Speech therapy
    - Hearing aids
    - Medical equipment/medical supplies
    - Each HMO has a list of prescription drugs that its doctors may prescribe
        - If the drug isn't on the list, the doctor can prescribe a similar drug
        - Most HMOs have to cover any prescription drug for chronic, disabling, or life-threatening illness even if it's not on the list
    - Pharmacy
        - Usually HMO members have access to in network pharmacies, depending on your plan, where you may have to pay a certain amount of copay and limitations/restrictions may apply (preferred cost sharing)
        - Going out of the network is possible but results in higher costs/and might need to pay the full amount. You would have to submit a prescription drug claim form to receive any reimbursement for going out of network
- **Exceptions to the rule of having to stay in network**
    - HMO Point-of-Service (HMOPOS) plans are plans within the HMO that may allow you to get out of network services, but you will need to pay a higher copayment/coinsurance. These can include:
        - Life threatening emergencies
        - Out of area urgent care
        - Temporary out-of-area dialysis
    - HMO doesn't provide service you need
        - If this happens, a network gap exception might be granted, which means that because the provider isn't capable of providing the healthcare service that you

need, you are allowed to get treatment from an out-of-network provider while still paying in network costs
    - When you are in the middle of a complex treatment when you become an HMO member and your specialist isn't part of the HMO
        - Whether or not you will be able to finish with your current provider is on a case-by-case basis
- **Examples of HMO's in California**
    - Kaiser Foundation Health Plan Inc
    - Sharp Health Plan
    - Aetna Health of California Inc
    - Blue Cross of California dba Anthem Blue Cross
    - Blue Shield of California

Sources

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