HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

DEFINITION

An HMO plan is a managed care system where comprehensive health care services are offered to its members through a network of health care providers. It is designed to provide it members with affordable medical care since costs are controlled by restricting one's care to providers within the HMO network.

HOW THEY WORK

Each member selects a primary care physician (PCP) who acts as a gatekeeper as he or she is the one who refers the member to specialists within the HMO system. All physician referrals, prescriptions and other services must first be approved by the HMO in order to be covered.

The costs for these plans are generated in two ways. First, each member pays a premium and in exchange, the HMO provides comprehensive care including physician visits, lab tests, x-rays, therapy, surgeries, emergency care, etc. Second, copayments are typically required for each doctor visit as well as for prescriptions and other services.

ADVANTAGES

- These plans tend to have lower premiums than other managed care programs since the cost of care is spread out among its members.
- Since HMOs are profitable when its members are healthy, they promote preventative care and regular checkups. Also, they have programs and informational guides to promote healthier lifestyle choices and good health.
- For members that are healthy and requiring mostly routine care, an HMO provides great care at lower costs than other managed care programs.

DISADVANTAGES

- Since HMO plans only cover visits with doctors within the HMO network, if a member wants to see a physician or specialist outside of the HMO network, these will not be covered by the HMO and must be paid out-of-pocket by the member.
- A member's medical care is managed by the PCP so all questions and concerns must first go through them in order to potentially be referred to a specialist. This can cause additional time delays.
- Since HMOs have an incentive to keep its members healthy, this could also result in an incentive to restrict care which could then lead to a member being denied care and/or services that he or she wanted.