For information
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LegCo Panel on Health Services
Regulation of Health Maintenance Organizations in overseas jurisdictions

This paper outlines the regulation of Health Maintenance Organizations (HMOs) in five selected overseas jurisdictions, namely, the United Kingdom, Singapore, Canada (Ontario), Australia (New South Wales), and the United States.

General landscape

2. In the United States, HMO is generally defined as an organization which directly or through contracts with providers furnishes comprehensive health care services on a prepaid basis to enrolees in a designated geographic area. The US is the pioneer of HMO, and so far HMOs have taken the strongest hold in the United States. The healthcare system of the US is unique among the developed countries in that it is largely insurance-based and employer-financed. Around 174m Americans get health coverage from their own employers or those of their spouses or parents, another 124m Americans either buy health insurance on their own or are covered by Medicare[1] and Medicaid[2] programmes. Healthcare services are mainly delivered by private providers. While HMOs are major providers for employer-financed healthcare, they also provide services on Medicare and Medicaid contracts. In this connection the US is also unique among the developed countries in that it has an elaborate regulatory system specific to HMOs.

3. In contrast, the United Kingdom, Canada and Australia have largely tax-based public healthcare systems, which provide relatively inexpensive medical services to their citizens. Singapore also has a significant public healthcare delivery system subsidized by government revenue. While there exists a private healthcare sector complementing the public sector, in our understanding these countries do not have regulatory regimes specifically targeting at HMOs. Instead, there are general regulatory regimes that regulate medical units, such as hospitals, clinics and nursing homes.

[1] Publicly funded medical benefits for the elderly and the disabled.
[2] Publicly funded medical benefits for the poor.

The United Kingdom

4. As far as we know the UK does not single out any HMO-like organizations for specific regulation.

5. Under the Care Standards Act 2000, as amended by the Health and Social Care (Community Health and Standards) Act 2003, the Commission for Healthcare Audit and Inspection (CHAI) is statutorily tasked to register and inspect both public and independent healthcare providers. Registration requirements apply to independent healthcare providers, which include hospitals and clinics, as well as local authorities service providers.

6. When a medical unit applies for registration, CHAI would assess the suitability or 'fitness' of personnel, premises and service for operation. Independent medical units are required to follow the National Minimum Standards. The Core Standard is embodied in guidelines on quality of treatment and care, management and personnel, complaints management, premises, facilities, equipment, information provision, risk management procedures, records and information management, etc. The Core Standard is supplemented by service-specific standards. Failure to comply with the regulations may trigger legal/disciplinary actions by CHAI, such as attaching conditions to the registration, imposing an injunction to stop an offence, or revoking the registration.

7. Under the Private and Voluntary Healthcare (England) Regulations 2001, CHAI is empowered to obtain information as it may require in order to consider the financial viability of the establishment, including annual accounts and bank references.

Singapore

8. There is no specific legislation targeting at HMOs in Singapore. The Private Hospital and Medical Clinics Act 1980 (revised in 1985 and 1999) provides for the control, licensing and inspection of private hospitals, medical/dental clinics, clinical laboratories, nursing and maternity homes, healthcare establishments, and for purposes connected therewith. The Licensing and Accreditation Branch under the Health Regulation Division of the Ministry of Health is responsible for the licensing and accreditation.

9. The licensing and renewal requirements for medical and dental clinics cover, among other aspects, the following -

- Services provided to patients
- Drugs storage

- Medical records
- Layout of premises
- Facilities (including availability of hand washing and hand drying facilities, and requirements pertaining facilities for surgery, anaesthesia and resuscitation)
- Equipment (including compliance of licensing requirements for certain types of equipment such as lasers, ultrasound and x-ray machines, laboratory service, radiology service)
- Infection control practices and notification of infectious diseases

Canada and Australia

10. The situations in Ontario, Canada and New South Wales, Australia are more or less similar. Non-public health facilities are required to be registered. The relevant pieces of legislation are Private Hospitals Act 1990 and Independent Health Facilities Act 1990 in Ontario, and Private Hospitals and Day Procedure Centres Act 1988 in New South Wales.

The United States

11. As explained above, the situation in the US is quite different from that in the other jurisdictions as its healthcare relies heavily on private financing and private delivery systems. In the US, HMOs are subject to regulation at the federal and state levels.

Federal level

12. At the federal level, the Department of Health and Human Services, acting primarily through the Health Care Financing Administration (HCFA), serves not only as a regulator of health plans, but also as a purchaser of health care coverage for Medicare beneficiaries to enrol in an HMO or preferred provider organization. The HMO Act of 1973, regulated by HCFA, sets standards for HMOs relating to benefits, delivery systems, fiscal soundness, and other key aspects of plan design and operations. Although the decision to seek federal qualification is voluntary, such qualification serves to provide a seal of approval.

13. "Federally qualified" HMOs have an obligation to provide a package of "basic health services" which includes hospital services, physician services, emergency services, short-term outpatient services, crisis intervention mental health services, services for treatment of alcohol and drug abuse, diagnostic laboratory and radiology services, therapeutic radiology services, home health services and preventive health services.

14. The spirit of the HMO Act 1973 is to facilitate the growth of HMOs as much as to regulate them. In addition to providing for the setting up of the regulatory regime, the Act provided grants and loans to facilitate start-up or expansion of HMOs, and required large employers providing medical indemnity benefits to offer the option of enrolment in HMO plans to their employees.

State level

15. At the state level, health plans are regulated by more than one agency in a state – usually the Department of Health (which regulates the health care delivery system, including oversight on access and quality of care) and the Department of Insurance (which oversees the financial aspects of health plan operations). HMOs may be required to be licensed in some states. States may require their Medicaid beneficiaries to enrol in HMOs or other prepaid plans, and the states pay for the health benefits. States agencies therefore become directly involved in setting standards for HMOs who seek Medicaid contracts.

Private accreditation

16. Independent accrediting organizations also set standards for managed health care plans, and although these standards do not have any legal binding effect, increasing numbers of large employers and other purchasers are seeking external validation of health plans with which they contract. One of the national private accrediting organizations which have more extensive involvement with health plans is the National Committee for Quality Assurance, which reviews and accredits various aspects of HMO operations, most of which are related to quality of care.

17. Members are invited to note the content of this paper.

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