

CONSUMER PROTECTIONS:

What are your rights if you enroll in an HMO?

by Pam Silberman, JD, DrPH

INTRODUCTION

North Carolina law requires that health insurance and health maintenance organization (HMO) products or insurance policies sold in the state provide certain consumer protections. These protections generally fall a variety of categories as described as described here. *Unless otherwise stated, these protections do not apply to groups that are self-funded ERISA plans or otherwise exempt from state law.*

Each section below provides a reference to the North Carolina Statutes (NCGS), which are the laws and regulations that govern North Carolina. The regulations that govern insurance companies and HMOs are found in the North Carolina Administrative Code (NCAC). There is also a glossary at the end of this document.

Throughout this guide, *insurance companies* and *HMOs* are referred to collectively as *health plans*. When a law or provision refers specifically to an insurance company or an HMO, these terms are used. Also, individuals insured by or covered under a health plan are referred to as members. Other documents may refer to *members* as *enrollees*, *patients* or *beneficiaries*.

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Emergency Services

Health plans must provide coverage for emergency medical services needed to screen and to stabilize a person. Prior authorization cannot be required if an ordinary person (prudent layperson) acting reasonably would have believed that an emergency medical condition existed. The member may obtain emergency-related services from a non-network provider if the person reasonably believes that the delay in seeking care from a network provider would worsen the emergency. The health plan may charge its regular coinsurance, copayments or deductibles but may not charge additional cost-sharing amounts for using a non-network provider (NCGS 58-3-190).

Mammograms & Pap Smears

Health plans must provide coverage for periodic pap smears and mammograms. Coverage of pap smears will be provided once a year or more often if recommended by a physician. Mammograms must be covered according to the following schedule:

- One or more mammograms a year, as recommended by a physician, for any woman who is at risk of breast cancer;
- One baseline mammogram for any woman 35-39 years of age;
- A mammogram every other year for any woman 40-49 years of age or more frequently upon a physician's recommendation; or

- A mammogram every year for any woman 50 years of age or older.

Health plans may not impose higher copayments on pap smears or mammograms than it does on other similar screening tests (NCGS 58-67-76; 58-51-57, 58-65-92).

Prostate-Specific Antigen Test

Health plans must cover prostate-specific antigen (PSA) tests or other tests for the presence of prostate cancer. A physician must order a PSA test in order for it to be covered. PSAs must be covered at the same level as other similar services (NCGS 58-67-77; 58-51-58; 58-65-93). In other words, plans may not impose higher copayments on PSA tests than it does on other similar screening tests.

Diabetes Self-Care

Health plans must also provide coverage for diabetes outpatient self-management training, equipment, supplies, medications and laboratory procedures used to treat diabetes. The insurer may decide who shall provide and be reimbursed for the outpatient self-management training and educational services (NCGS 58-67-74, 58-51-61, 58-65-91).

Cancer Treatment

Health plans that cover the medication cost for the treatment of one type of cancer must, under certain circumstances, also cover the costs of that medication for the treatment of

another type of cancer. For this protection to apply, the following standards must be met:

- The drug must be approved by the US Food and Drug Administration (FDA);
- It must have been proven effective; and
- It must be accepted for the additional use by the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Drug Information.

Coverage may be denied if the medication is experimental or investigational or if the FDA finds that the drug should not be used to treat the other type of cancer (NCGS 58-67-78, 58-51-59, 58-65-94).

Maternity Care

Health plans are not required to provide maternity coverage. When the company does provide coverage, benefits must be the same as for other services (NCGS 58-3-170). In other words, plans may not impose higher copayments on maternity care than it does on other similar care. Regardless of whether the policy provides maternity coverage, a complication of pregnancy must be treated similarly to other illnesses or sicknesses covered under the health plan's contract. A non-elective cesarean section is considered a com-

plication of pregnancy (11 NCAC 12.0323). Health plans may not deny maternity coverage to an unmarried woman if the coverage is available to married women.

Also, any health benefit plan that provides maternity coverage must pay for inpatient care for a mother and her newly born child for at least 48 hours after vaginal delivery or 96 hours after a cesarean section (NCGS 58-3-169, 58-3-170).

Reconstructive Breast Surgery

Health plans that cover mastectomies must also cover reconstructive breast surgery following a mastectomy (NCGS 58-67-79, 58-51-62). The decision to discharge a patient following a mastectomy must be made in consultation by the attending physician and the patient (NCGS 58-3-168).

Chemical Dependency Treatment

Health plans must offer groups coverage for the treatment of chemical dependency. If the health plan provides the group total annual benefits for all services in excess of \$8,000, then that plan must provide a minimum of \$8,000 for the necessary care and treatment of chemical dependency. The plan must provide a lifetime maximum of no less than \$16,000. While health plans are required to offer this coverage, groups may reject it (NCGS 58-67-70; 58-51-50; 58-65-75).

Temporomandibular Joint Treatment

Health plans must provide coverage for diagnostic, therapeutic or surgical procedures involving bones or joints of the jaw, face or head, including the temporomandibular joint (TMJ), if the procedure is medically necessary. These insurers must provide coverage if the condition is caused by congenital deformity, disease, or traumatic injury (NCGS 58-3-121).

Tax-Supported Institutions

Insurance companies must provide the same coverage for services provided in a tax-supported institution, such as a state psychiatric institution, as the company provides for services in other public or private health care facilities. This provision *only* applies to *group* coverage, and does *not* apply to HMOs (NCGS 58-51-40, 58-65-65).

Public Health Measures

HMOs and local health departments are required to collaborate and cooperate to protect the public health. For example, HMOs and local health departments could jointly sponsor a local health promotion or disease prevention activity (NCGS 58-67-66).

Prescription Contraceptive Drugs or Devices

Beginning January 1, 2000, health plans that provide coverage for prescription drugs or devices must also cover contraceptive drugs and devices. Coverage must include the

insertion and removal of contraceptive devices as well as contraceptive examinations. The health plan must apply the same cost sharing or copayment on the contraceptive drugs and devices as it imposes for prescription drugs. Religious employers may exclude coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets (NCGS 58-3-176).

Non-Formulary Medications

Beginning January 1, 2000, health plans that use a closed formulary must have a process to allow exceptions to the formulary. To obtain coverage of a non-formulary drug, a participating provider must notify the health plan that:

- the drugs on the formulary have been ineffective in treating the patient's condition or
- the drugs on the formulary are reasonably expected to cause a harmful reaction in the patient.

In addition, the drug must be prescribed in accordance with the health plan's clinical protocol. Health plans may not charge patients any additional cost-sharing or a higher copayment for using non-formulary medications when they meet the requirements for an exception to the formulary (NCGS 58-3-221).

Bone Mass Measurements

Beginning January 1, 2000, health plans must provide coverage of bone mass measurements for individuals who are at risk of developing osteoporosis or low bone mass. Coverage must include bone mass measurements at least every 23 months and more frequently if follow-up measurements are medically necessary. Coverage for the bone mass measurements shall be the same as for other similar services. Individuals who qualify for coverage of bone mass measurements include those with:

- estrogen-deficiency and risk of osteoporosis or low bone mass;
- radiographic osteopenia anywhere in the skeleton;
- long-term steroid therapy;
- primary hyperparathyroidism;
- monitoring to assess their response to osteoporosis drug therapies;
- histories of low-trauma fractures; or
- other known conditions or on medical therapies known to cause osteoporosis or low-bone mass. (NCGS 58-3-174, 58-50-155).

CONSUMER INFORMATION

False & Misleading Advertisements

Consumers have certain protections to ensure that they receive accurate information. For example, health plans are prohibited from using false and misleading advertisements. They also have protections against misleading incentives to purchase health insurance policies. False and misleading advertisements and inducements are prohibited as an unfair method of competition. Health plans are required to include information about major coverage limitations prominently in all of their advertisements. Consumers who think they have been harmed by false and misleading advertisements should contact the Consumer Services Division of the NC Department of Insurance for more information about their rights at: 1-800-662-7777 or 1-800-546-5664 (NCGS 58-67-65, 58-63-1 et. seq., 58-2-65, 58-2-70, 11 NCAC 12.0518-0536).

Materials Must Be Understandable

State law requires that all materials given to consumers be understandable at a ninth grade reading level. This means that the member handbooks (Evidence of Coverage or insurance policies) should be understandable to those with a high school reading level (NCGS 58-38-35, 58-38-1 et. seq., 58-66-1 et. seq.). However, the state allows each health plan to assess the readability of its consumer materials. Health plans can exclude medical terminology in their assessment of the readability level. In

effect, insurance materials are often difficult for the average person to understand.

Evidence of Coverage

Health plans must provide members with an explanation of the services or benefits covered under the insurance plan. Many plans refer to this document as the Evidence of Coverage (EOC) while other insurance companies refer to similar documents as member handbooks, subscriber contracts or insurance policies. (NCGS 58-67-50(a)(3)(a), 58-65-60).

Health plans have specific requirements for what information must be included in the evidence of coverage or insurance policy. These documents must include a description of:

- The health services or other benefits covered under the plan;
- Any limitations on the services or benefits covered;
- Any required cost sharing;
- The total amount of payment for health services that the member must pay;
- A description of the health plan's method to resolve member complaints;
- A detailed explanation of appeal and grievance procedures;
- Explanation of information that is available to members and prospective members upon request and instructions on how to obtain this information;
- Definition of medical necessity;
- Coverage that is available for out-of-net-

- work services;
- Information about the utilization review process; and
- A description of the reasons, if any, that a health plan can terminate a member's enrollment.

(NCGS 58-67-50(a)(3)(b), 58-38-30, 58-38-35, 58-65-60, 58-50-62, 58-50-61, 58-3-191(b), 58-3-200(b)(d)). Health plans must give members or prospective members a copy of these documents, upon their request (NCGS 58-3-191(b)).

How Will the Health Plan Treat Certain Health Conditions

Health plans that offer managed care products must provide members and prospective members certain information, upon their request. A current or prospective member has the right to request information about:

- How his or her health condition would be treated under the plan (called the health plans' review criteria or treatment protocol);
- A list of the health plan's drug formulary, and how to request drugs outside the formulary; and
- The procedures the health plan uses in determining whether a specific procedure, test or treatment is considered experimental or investigations.

This information is especially important for

people with pre-existing health problems or special health needs (NCGS 58-3-191(b)).

Health Plan Comparisons

HMOs and PPOs are required to report certain information to the NC Department of Insurance. Some of this information may be useful to consumers in comparing health plans. These data include:

- *Grievances*: HMOs and PPOs must report information about member grievances. Grievances may include problems with accessibility or quality of services, claims payments, questions about covered benefits, or other complaints. Health plans must provide information on the number of and reasons for the grievances, and how the grievances were resolved.
- *Participants and groups that withdraw from the health plan*: HMOs and PPOs are required to report the number of groups (generally employer-based plans) and individual members that left the health plan. In addition, the health plans must report data on the numbers of providers who left a plan voluntarily and involuntarily. (NCGS 58-3-191(a)(2)(3)).
- *Provider Network Adequacy Information*: The health plans are required to report information on the number of providers who are in their network by type (primary care, cardiology, chiropractors, der-

matology, ENT, neurology, OB/GYN, orthopedics, psychiatrists/mental health/substance abuse professionals, other physicians, hospitals, other facilities, and other providers). In addition, the health plans must report information on their average driving distances. This information is available by plan for Asheville, Charlotte, Fayetteville, Goldsboro, Greenville, Hickory/Morganton, Jacksonville, Rocky Mount, Triad, Triangle, Wilmington and for non-metropolitan areas. (NCGS 58-3-191(a)(4)).

- *Utilization review and appeal data:* HMOs and PPOs are required to report information on the types of the number of different utilization reviews performed and how many of these reviews resulted in a denial of services (non-certifications). In addition, health plans must also provide information on the number of appeals, and the outcome of these appeals. (NCGS 58-3-191(a)(4)(f)).

- *Provider compensation data:* HMOs are required to submit information on the percentage of providers paid according to different payment arrangements, including capitation, discounted fee-for-service, or salary. In addition, the HMOs must also report about the range of compensation paid under a withhold or incentive system (NCGS 58-3-191(a)(5)).

- *Health Plan Employer Data and Information Set (HEDIS®):* HMOs are required to report HEDIS® data to the state. HEDIS® is a standardized set of performance measures that consumers and other purchasers can use to compare health plans. HEDIS® covers seven general areas of performance: effectiveness of care, access to and availability of care, member satisfaction, health plan stability, use of services, cost of care and health plan information. (NCGS 58-67-11(e)). PPOs are not required to collect or report HEDIS® data.

All of the information except the HEDIS® data is available in a publication called *Managed Care Plan Handbook: A Comparison Guide for North Carolina Consumers*. This document is available in the NC Department of Insurance's website: NCDOI.com, or can be ordered through the Consumer Services Division at: 1-800-546-5664. The HEDIS® data is available in a separate document entitled HMO Performance Report.

CONFIDENTIALITY

Confidentiality of Medical Records

In general, HMOs may not disclose any medical information of a member or applicant without his or her prior consent. There are some limited circumstances when the consent of the patient is not needed. HMOs can release medical information by court order. HMOs can also release medical information in the event of litigation between the HMO and member if the information is relevant to the case. Medical information can be shared within the HMO so that the HMO can assess the appropriateness of the care provided or monitor quality. Any organization, which the HMO contracts with to help in these activities, is subject to these confidentiality provisions (NCGS 58-67-180, 11 NCAC 20.0408, 11 NCAC 20.0509, 11 NCAC 12.0916(a)).

HMOs, like all insurance carriers, are also subject to the Insurance Information and Privacy Act (NCGS 58-39-1 et. seq.). This statute sets rules for the collection, use and disclosure of medical information involving insurance transactions. For example, health plans may seek information about your medical history before offering you certain types of non-group health insurance. Applicants and members have the right to examine this information for accuracy. Also, you can find out the reason why a health plan decides not to offer you insurance coverage (NCGS 58-39-5).

NON-DISCRIMINATION

Health Status

Health plans have certain rules that prevent them from discriminating against people because of their health status. There are different rules for people enrolled in group plans, (typically employer-sponsored plans), and those who are seeking coverage in the individual market (non-group plans).

- *Group plans*: Health plans may not exclude individuals from coverage or refuse to renew coverage because of their health status, medical condition, claims experience, genetic information, disability or use of health care services. In addition, the health plan may not charge any individual covered under a group plan a higher premium on the basis of that person's health. However, health plans may charge the group (as a whole) higher premiums based on that group's use of health services (NCGS 58-68-35).
 - ⊕ Had 18 or more months of prior health insurance coverage;
 - ⊕ Do not have access to another group or government-sponsored health plan;
 - ⊕ Did not lose prior health insurance coverage

because of nonpayment of premiums or fraud; and

- ⊕ Elected continuation coverage if it was offered, and if so, continued the coverage until the guaranteed time period ran out.

Insurers are not required to offer individuals coverage under all the health insurance policies they sell in the non-group market. At a minimum, plans must offer the two most popular non-group plans, such as the policies with the largest premium volume. While plans have to offer coverage to certain individuals in the non-group market, there is no limit on the premiums that can be charged (NCGS 58-68-60 et. seq.).

Race, Color or National Origin

Health plans are prohibited under state law from limiting coverage, refusing to insure, refusing to continue coverage or for charging different premium rates because of a person's race, color or national or ethnic origin (NCGS 58-67-65(e)(f), 58-3-25(c), 58-65-85).

Gender or Marital Status

No health plan can limit the coverage, refuse to issue or refuse to continue coverage because of a person's sex or marital status. However, the plan may charge different premiums and may take marital status into account when determining a person's eligibility for dependent coverage. For example, a plan could not deny health insurance coverage to women working part-time if men working similar part-time jobs could obtain coverage. A plan also may not deny dependent coverage to

husbands of female employees when dependent coverage is available to the wives of male employees. Similarly, plans may not restrict, reduce or modify benefits payable for disorders of the genital organs of only one sex (NCGS 58-67-65(b); 58-63-1, 11 NCAC 4.0317).

Newborns, Adoptive Children and Foster Care Children

Health plans must provide coverage for newborn infants and foster children from the moment of the child's birth or on the day that the foster child is placed in a foster home. The plan shall provide the same coverage for congenital defects or anomalies that are provided for most sicknesses or illnesses (NCGS 58-51-30). The plan must also cover adopted children upon placement with a person who has insurance coverage, and may not impose preexisting-condition exclusions (NCGS 58-51-125).

Coverage of Children

No children may be denied coverage because the child was born out of wedlock, was not claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the health plan's service area. In addition, the plan must allow a parent to enroll a child when required to do so by court or administrative order. This is true even if it is outside the normal enrollment period (NCGS 58-51-120).

Children with Developmental Disabilities or Other Disabilities

Health plans cannot refuse to enroll a child in an

insurance plan that covers physical illness or injury because of that child's physical disability or mental retardation (NCGS 58-51-35). Insurance companies must continue coverage for dependent children who are mentally retarded or have physical disabilities after the child reaches the age that coverage would normally terminate. This applies if the child is incapable of self-supporting employment and is chiefly dependent upon the policyholder for support and maintenance (NCGS 58-67-65(e), 58-51-25, 58-65-2, 58-67-171).

Sickle Cell Trait or Hemoglobin C Trait

Health plans cannot refuse to enroll an individual in an insurance plan that covers physical illness or injury because of that person's sickle cell or hemoglobin C trait (NCGS 58-67-65(e), 58-51-45, 58-65-70, 58-67-171). In addition, insurers are prohibited from charging higher premiums because of these health conditions.

Blindness or Deafness

Health plans cannot refuse to enroll an individual, limit coverage or charge higher premiums because the member is fully or partially blind or deaf (NCGS 58-67-65(e), 58-3-25).

People with Mental Illness or Chemical Dependency

Individuals with mental illness or chemical dependence enrolled in group contracts covering 20 or more employees are given limited protections. Health plans may not refuse to enroll an individual in a health plan that covers physical illness or injury because the person has a mental ill-

ness or chemical dependence. Similarly, health plans may not charge these individuals a higher premium or reduce the coverage for physical illness or injury (NCGS 58-67-75, 58-51-55; 58-65-90).

Additional protections are available to individuals enrolled in group contracts covering 50 or more employees. Large group plans that cover both physical illness/injury and mental illness cannot impose a lesser lifetime or annual dollar limit on mental health benefits than for the physical illness/injury benefits.¹ However, health plans may still charge higher copayments or have lower limits on provider visits or days of coverage for mental health benefits. Health plans and insurance companies need not offer any coverage for mental illness (NCGS 58-67-75(b1)).

Acquired Immune Deficiency Syndrome & Human Immunodeficiency Virus

Human Immunodeficiency Virus (HIV) infection and Acquired Immunodeficiency Virus (AIDS) must be covered as any other illness or sickness in health insurance policies. Health plans may *not* write plans excluding coverage of AIDS or HIV (11 NCAC 12.0324).

Medicaid Coverage

Health plans are also prohibited from taking into account the fact that an individual is receiving

Medicaid coverage in insuring the person or making payments under the health benefit plan (NCGS 58-51-115). In other words, health plans may not exclude individuals or services because they are already covered by Medicaid.

Genetic Information

Recent laws prohibit health plans from discriminating against members on the basis of genetic information (NCGS 58-3-215(c)). Specifically, health plans may not raise either the group premium rates or the premium rates for any specific individual in the group, and may not refuse to issue a policy because of genetic information obtained about one of the prospective members.

¹ Employers that can demonstrate that the cost of providing the same annual and lifetime limits would exceed 1% of the cost of the plan can obtain an exemption from this requirement (NCGS 58-67-75(b1)(6)).

ACCESS TO PROVIDERS

Network Adequacy

Health plans that operate network-based plans (like HMOs or PPOs) must have systems to ensure the adequacy of the network. Health plans must set their own access standards and monitor how well they meet these internal standards. For example, the health plan's access standards should include information about how long members must travel to access primary care, specialty care, hospital-based services and other facilities. Health plans must also monitor waiting times to find out how long it takes to get an appointment to network providers (NCGS 58-3-191(a)(4)(c)).

No Penalty for Going Outside a Network if Insufficient Providers

Health plans may not charge members more money or otherwise penalize members for using out-of-network providers, if the health plan lacks sufficient network providers to meet the health care needs of the patients without unreasonable delay (NCGS 58-3-191(a)(4)(b), 58-3-191(a)(4)(c)(2)(d), 58-3-200(d)).

Pharmacies

Health plans may not restrict members from selecting a pharmacy if the pharmacy has agreed to participate in the health benefit plan according to the terms offered by the insurer. Health plans may *not* charge higher cost sharing that would affect the members' choice of a pharmacy (NCGS 58-51-37).

Obstetricians and Gynecologists

Health plans must allow female members 13 years or

older to obtain the services of a contracting obstetrician-gynecologist (OB/GYN) without prior referral for obstetrical or gynecological related services (NCGS 58-51-38).

Continuing Care Retirement Communities

Health plans must allow residents of continuing care retirement communities who need nursing home care to obtain the care from a facility within the continuing care retirement community. However, the facility must be a Medicare-certified skilled nursing home and must agree to be reimbursed at the same rate negotiated with similar providers. The nursing home must meet the health plan's billing, quality assurance, utilization review, confidentiality, nondiscrimination, grievance and appeal procedures (NCGS 58-3-200(f)).

Optometrists, Podiatrists, Dentists, Chiropractors, Psychologists, Clinical Social Workers, Nurse Practitioners & Physician Assistants

Insurance plans may not deny payment or reimbursement for any service which is within the scope of practice of a licensed optometrist, podiatrist, dentist, chiropractic, psychologist, clinical social worker, advanced practice nurse (such as a nurse practitioner or nurse midwife) or physician assistant. The goal is to give the member a choice of providers (NCGS 58-65-1; 58-65-36, 58-50-30, 58-50-26, 135-40). This provision does *not* apply to HMOs.

Provider Hold-Harmless Provisions

Providers are prohibited from charging HMO members for covered services other than the allowable coinsurance, copayments or deductibles. The

providers may not charge patients for these services, even if the HMO fails to pay the provider (11 NCAC 20.0202). The patient can, however, agree to pay for *non-covered* services out-of-pocket. This protection only applies to members in HMOs.

Standing Referrals to Specialists

Beginning January 1, 2000, all health plans that require patients to obtain referrals before they can see a specialist must have new procedures to allow certain patients to obtain standing or extended referrals. Health plans must have a process to allow patients with chronic, degenerative, disabling or life-threatening diseases or conditions to obtain extended or standing referrals to in-network specialists. The standing referrals will not exceed 12 months, and shall be part of a treatment plan coordinated with the primary care physician, specialist and the health plan (NCGS 58-3-223).

PROVIDER PROTECTIONS

Non-Discrimination Against Certain Health Professionals

Health plans cannot discriminate against providers who are located in geographic areas that contain high-risk populations. Nor can they discriminate against providers who treat patients that present a risk of higher-than-average claims or use of health care services (NCGS 58-3-200(e)). This section is intended to ensure that health plans do not intentionally exclude certain providers from their networks because they are more likely to treat high-risk populations.

Gag-Clauses Prohibited

Health plans may *not* limit a provider's ability to discuss clinical treatment options with their patient, whether or not these options are covered under the benefit package. Health plans may not limit providers' professional responsibilities to patients (NCGS 58-3-176(a)). Physicians and other providers have an ethical duty to explain all treatment options to their patients, regardless of whether the health plan will pay for the treatment.

Providers Protected From Retaliation When Filing Appeals on Behalf of Members

Health plans are prohibited from discriminating against providers who appeal a plan's decision affecting the availability, delivery or quality of health care services. For example, an HMO cannot retaliate against a physician who appeals the HMO's decision to deny or limit care (NCGS 58-50-62(j)).

UTILIZATION REVIEW PROVISIONS

Medical Necessity

Any plan that limits coverage to medically necessary services and supplies must use the state statutory definition of medical necessity. The state law defines medical necessity as services or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease;
- Not for experimental, investigational or cosmetic purposes;
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms;
- Within generally accepted standards of medical care in the community; and
- Not solely for the convenience of the insured, the insured's family or the provider.

A health plan may examine cost-effectiveness when choosing between two or more services or supplies that are medically appropriate for the condition. However, a health plan may not consider cost-effectiveness in determining whether a service or supply is medically necessary (NCGS 58-3-200(b)).

Assessing Utilization of Health Services

Each HMO must have a utilization review system that collects data and assesses the use of health care services. Specifically, the system must have mechanisms to evaluate medical necessity, as well as the appropriateness, effectiveness and efficiency of health services. The utilization review criteria must be based on sound, up-to-

date clinical criteria and must be applied consistently in all appropriate reviews. HMOs must monitor health care to see if providers are providing unnecessary care (overutilization) or withholding necessary care (underutilization). Any problems identified in the utilization review process should be used to improve the system (NCGS 58-50-61(c)).

Who Conducts Utilization Reviews

Qualified health professionals such as nurses must make all initial utilization review determinations. These reviewers act under the direction of one of the HMO's physicians. An HMO medical physician must also review all decisions to deny requested services. The person making the utilization review decisions may not be paid on the basis of the numbers of services or treatments denied or the money saved (NCGS 58-50-61(d)).

The HMO can conduct utilization review procedures in-house or it can contract these functions to another body called a utilization review organization. Whether it does its own review or contracts with another organization, the HMO has overall responsibility to ensure that the review process meets state law (NCGS 58-50-61(b)).

Time Limits for Review

The HMO also has certain time limits to make utilization review determinations. HMOs must make all prospective and concurrent review determinations within three business days after the insurer obtains all necessary information about the admission, requested procedure or health care service (NCGS 58-50-61(f)). Reviews of services and supplies that are conducted after the services have been provided (retrospective review) must be conducted within 30 days of the time the HMO

receives the necessary information to make the determination.

Utilization Review Procedures

HMOs and other utilization review organizations must notify members and prospective members about the review procedures, including the procedures to appeal denials of care. HMOs must have a toll-free telephone number for members to use in seeking prior authorization, and must include this number on its membership cards (NCGS 58-50-61(e)(3), (m)). In addition, insurers must make sure the utilization review staff is accessible by telephone by monitoring the average speed of answer and call abandonment rates on at least a monthly basis.

APPEAL & GRIEVANCE PROVISIONS

Plan members have two separate appeal routes. One takes place when the member contests a decision to deny or limit health care services (non-certification decision). This is called an appeal.² The other appeal route occurs when a member is unhappy with other aspects of the plan's operations. A complaint about other operations of the plan is called a grievance.

Members have the right to two levels of review, for both appeals and grievances. The first level of review has a different name and a slightly different process depending on whether it is a first-level appeal or first-level grievance review. However, the second-level

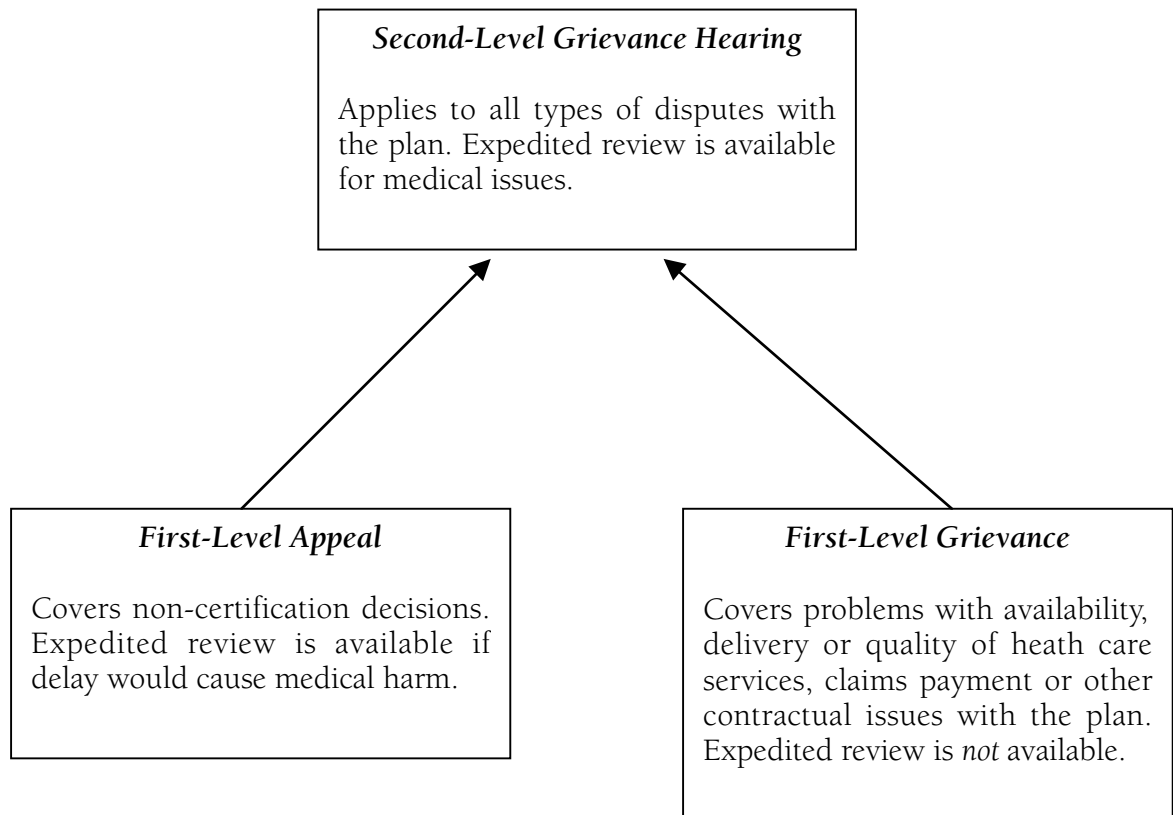
review is the same regardless of whether the dispute is a denial of services or another problem with the plan's operation. This is referred to as a second-level grievance hearing.

Members who contest non-certification decisions (denials of services or procedures) have a right to ask for expedited review if the normal time limits could hurt the person's health. Otherwise the normal time limits apply. There is not an expedited process for first-level grievance decisions, because first-level grievance hearings do not deal with non-certification decisions (these are handled at the first level appeals).

Appeals of Non-Certification Decisions

- *Denial Notices:* When health plans deny care, they must send the covered member a non-certification letter explaining why the requested service or procedure was denied. The notice must include the clinical reasons for the non-certification as well as instructions on how to appeal the plan's decision (NCGS 58-50-61(h)). *Members should always ask for a copy of the clinical review criteria used in making the decision.* This provides a more complete explanation for why the requested treatment, procedure or admission was denied.
- *First Level Appeals:* Members can file an appeal on their own behalf. In addition, a physician or other person acting on the member's behalf can file an appeal (NCGS 58-50-61(j)). All plans must

² The appeals procedures do not apply to any non-certification given solely on the basis that a health benefit plan does not provide coverage for the health care services being requested if the exclusion of the specific service requested is clearly stated in the Evidence of Coverage (NCGS 58-60-61(a)(13)).



offer at least two levels of appeals. A physician who was not involved in the original decision must hear the first appeal. Normally the physician has 30 days to decide the appeal.

- *Expedited Review*: Member can request an expedited appeal if their health would be harmed by the 30-day delay. In an expedited appeal, the physician has up to four days to make a decision. However, members can request the decision be made immediately if there is a more immediate health care need (NCGS 58-50-61(k), (l)). Members will have their health services covered until the member is notified of the expedited review decision, if the appeal involves concurrent review such as continued stay in a hospital. Members are not entitled to expedited review if the health care services have already been provided and the issue is whether the care was appropriate (retrospective review).
- *Notice of Decision*: Each health plan or utilization review organization must provide a written decision to the member and the member's provider. The decision should contain the qualifications of the person reviewing the appeal, the reviewer's decision including the medical rationale and evidence used as the basis for the decision, and instructions on how to file a second-level grievance hearing (NCGS 58-50-61(k)).

First-Level Grievance Reviews

- *Reasons to File a Grievance*: Members have a right to file a grievance any time they are dissatisfied

with any of a plan's policies, decisions or actions. For example, members can file grievances if they are unhappy with the quality of care or the availability of health care services. Similarly, they can file grievances if the health plan fails to reimburse them for certain out-of-pocket payments that should have been covered by the plan (NCGS 58-50-62(b), 58-50-61(a)(6)).

- *First Level Grievance Reviews*: The member, his or her representative or the provider may submit a first-level grievance. The HMO must provide the member with information on how to submit written materials within three business days after receiving notice of the grievance. The person reviewing the grievance cannot be the same person who initially handled the grievance. If the issue is a clinical one, at least one of the reviewers must be a medical physician with appropriate expertise. The HMO must make a grievance decision within 30 days after receiving the complaint. The notice of the decision must include the same information as provided in first-level appeal decisions (NCGS 58-50-62(e)).

Second-Level Grievance Hearings

- *Hearing Procedures*: HMOs must also have second-level grievance reviews for members who are dissatisfied with the decision of the noncertification appeal or first level grievance review. The HMO must notify the member of the name and telephone number of the grievance coordinator, as well as information about the second-level grievance process within 10 days of receiving a request

for a second-level grievance. Members have more extensive due-process rights at the second-level grievance review. Specifically, a member can attend the second-level grievance-hearing, request and receive all information relevant to the case in order to prepare for the hearing. A member may present his or her case to the review panel, submit supporting materials before and at the review meeting, ask questions of any member of the review panel and bring another person to help in the review hearing (such as a family member, employer representative or attorney). If the member chooses to bring an attorney, then an attorney may also represent the HMO (NCGS 58-60-62(f)(1)b).

- The HMO will convene a hearing panel to hear second-level grievances. The panel will usually be comprised of people who are not employees of the HMO or utilization review organization, who were not previously involved in the decision, and who do not have a financial interest in the outcome of the review. All of the people reviewing a second-level grievance involving a non-certification or clinical decision should be providers who have appropriate expertise³ in the health issue in dispute. The review panel has up to 45 days to hold the hearing, and up to 15 days thereafter to make a decision. This decision is a recommended decision to the HMO.
- *Expedited Hearings*: Members can request an expedited second-level review if their health could be

harmful because of any time delays (NCGS 58-60-62(i)). Members may request an expedited second-level review even if the first-level appeal or grievance review was not expedited. If necessary, the HMO may conduct the hearing over the phone or through submission of written information.

- *Second-level Hearing Decisions*: Each HMO must provide a written decision to the member and the person's provider (if appropriate). The decision should contain the qualifications of the people reviewing the grievance, the reviewers' decision, including the medical rationale for the decision and the evidence used as the basis for the decision. (NCGS 58-60-62(h)).

Members do not have the right to any further reviews after the second-level grievance hearing. However, a person with an outstanding complaint may still be able to seek help from the Department of Insurance in settling the dispute. The Department of Insurance's Consumer Services Section answers the public's complaints or questions about insurance companies. Sometimes the Department will intervene and try to negotiate a solution with the HMO when it thinks that the consumer has a justified complaint. The Department of Insurance's telephone number is: 1-800-662-7777 or 1-800-546-5664.

³ If the HMO used a clinical peer in the noncertification appeal or a first-level grievance review panel, then the HMO may use one of its employees on the second-level grievance review panel (if the second-level panel consists of three or more people). (NCGS 58-60-62(f)(2)).

QUALITY ASSURANCE

Provider Credentialing Procedures

HMOs must have systems to ensure the minimum competency of the health care providers in their networks. These are called credentialing procedures. The HMO must check physicians' credentials before listing them in its provider directory or other materials given to members (11 NCAC 20.0401 et. seq.). For example, the HMO must check the following information on physicians:

- Personal information;
- Practice information, including the non-work hours that the provider can be contacted (call coverage);
- Education and training history;
- Current provider license, registration or certification. States where the provider has previously been licensed, certified or registered should be listed;
- Drug Enforcement Agency registration and any prescribing restrictions;
- Specialty board certification, professional and hospital affiliation;
- The amount of professional liability coverage and the provider's malpractice history;
- Any disciplinary actions by medical organizations and/or regulatory agencies;
- Any felony or misdemeanor convictions;
- The type of affiliation requested; and
- A statement signed and dated by the applicant attesting to the truthfulness and completeness of the information submitted.

HMOs must also obtain information on health care facilities, including accreditation status from the Joint Commission on Accreditation of Health Care

Organizations, state licensure information, Medicaid and Medicare certification and evidence of current malpractice insurance.

HMOs must verify all information included in the provider's application for credentials and must reverify the provider's credentials not less than once every three years. The HMO is responsible for ensuring that these rules are followed, even if it subcontracts the credentialing process to another organization.

Disciplining Providers Who Provide Inappropriate Care

HMOs must have a mechanism to reduce, suspend or terminate providers from participating in the network if the HMO believes the physician is providing poor quality of care or the physician drops malpractice coverage (11 NCAC 20.0411). In addition, HMOs, like other health care institutions, must report to the Board of Medical Examiners any time it revokes, suspends, or limits a physician's practice privileges or when a physician decides to stop participating in the plan (NCGS 90-14.13). This law was established to ensure that the Board of Medical Examiners is alerted to any potential provider competence issues.

Internal Quality Assurance Systems

HMOs must also have an internal quality assurance system to ensure the overall performance of the HMO and the quality of health care services provided to its members (11 NCAC 20.0501 et. seq.). The HMO must employ a variety of tools to assess the quality of health care services provided in different types of treatment settings. The HMO must also ensure the quality of its internal administrative and utilization review operations. In addition, the system must include procedures to investigate and take corrective action in response to patient complaints about the providers or

HMO decisions. Any HMO that delegates the quality management activities to another organization must ensure that the other organization follows state laws.

POINT-OF-SERVICE PROTECTIONS

Covered Services

Point of Service (POS) plans must make all benefits available for in-plan covered services. But they need not cover preventive services on an out-of-plan basis. Any out-of-plan covered service must also be available on an in-plan covered service basis. POS products must give members the option to choose in-plan or out-of-plan covered services each time the member seeks services. POS products must provide incentives for members to use in-plan services (11 NCAC 12.1403).

Out of Pocket Payments

In POS plans members have the option of seeking care outside of the network. Usually members have to pay deductibles, higher copayments and/or more coinsurance than they would if they received care inside the network. North Carolina laws put limits on the amount that HMOs can charge for using out-of-network providers. For example, coinsurance for out-of-plan covered services may not be more than 30 percent more than coinsurance for in-plan coverage. The deductible may not be more than five times the amount of the annual deductible for in-plan coverage. The deductible may not be more than \$2,000/\$6,000 for individuals/family coverage if the in-plan does not have a deductible. The copayments may not exceed the copayments for in-plan covered services by more than \$50 or 100%, whichever is greater. The annual and lifetime maximum, if any, may not be less than one-half of the amount

of any annual or lifetime maximums for in-plan covered services (11 NCAC 12.1403).

Disclosure of Cost Sharing to Members

All marketing materials, evidence of coverage, member handbooks and other materials must explain the method of reimbursement, applicable cost sharing amounts and any uncovered costs or charges. Materials should also explain covered benefits that a member may receive on an out-of-plan basis and instructions to submit claims for out-of-plan covered services (11 NCAC 12.1404).

PREMIUM RATE OVERSIGHT

Rating Methods

The HMO's premium schedule must be filed with and approved by the Insurance Commissioner prior to use (NCGS 58-67-50(b)(1), 11 NCAC 16.0602(b)(1)).⁴ To be approved, the premium rating method must be based on sound actuarial principles, and not on the health status of an individual member. The premiums may not be excessive, inadequate, or unfairly discriminatory, and cannot be based on an individual's health status.

Periodic Adjustments

The premiums for non-group coverage cannot be adjusted more frequently than once every 12 months and may not become effective unless the HMO has given the members at least 45 days advance notice (NCGS 58-67-50(b)(2)). HMOs may not adjust group rates more frequently than once every six months, although the Department of Insurance is unlikely to approve a rate adjustment in the first 12 months of enrollment.

FINANCIAL SOLVENCY

Sufficient Financial Resources

North Carolina laws mandate that HMOs have minimum financial resources to protect against insolvency. The statute sets out minimum requirements for working capital, deposits,

net worth and reserves. For example, all HMOs must have a minimum deposit of at least \$500,000 for full-service HMOs, and must maintain a minimum net worth of at least \$1 million. The required contingency reserve is calculated on the basis of the HMO's annual premiums. (NCGS 58-67-20(a), 25, 40, 110).

Additional Insolvency Protections

In addition to these monetary requirements, HMOs must ensure that providers do not collect sums from members that are owed by the HMO. If the HMO does not have this protection in its provider contracts then it must set up an additional special deposit to cover unpaid claims (NCGS 58-67-115). Each HMO must ensure that members can obtain benefits for the duration of the contract period for which premiums have been paid, even if the HMO lacks sufficient funds to continue operating (insolvency). In case of hospitalization, this applies until a member's discharge. HMOs must also have other protections against insolvency that are approved by the Commissioner of Insurance, such as a reinsurance agreement that covers the HMO against excess losses; or any other arrangement that the Commissioner may require (NCGS 58-67-120, 11 NCAC 20.0202).

Obtaining Other Coverage Upon Insolvency

If an HMO does become insolvent, the Insurance Commissioner has the authority to order other carriers to offer a 30-day enrollment period for members of the insolvent plan. HMOs, which previously offered coverage to groups enrolled

⁴ Premiums for individual policies offered by commercial insurers must be filed and approved by the Commissioner prior to use (NCGS 58-51-95(f)). The Commissioner does not have the authority to review the premiums charged by commercial insurers to group policy holders. In these instances, the Commissioner must approve the group policy, but not the premiums or premium rating methodology. However, commercial insurers must provide evidence that the rates are established using sound actuarial principles (NCGS 58-51-85). The Commissioner has the responsibility of reviewing and approving nonprofit medical and hospital corporation (BCBS) premiums and rating methodology for the non-group market (NCGS 58-65-40, 58-65-45), but must only approve the rating methodology for the group market. The Commissioner must approve the methodology for determining adjusted community rates for the small group market (NCGS 58-50-130(b)).

in the insolvent health care plan, are the first that will be required to offer coverage. The Commissioner may allocate the insolvent HMO's group or non-group contracts to other HMOs (NCGS 58-67-125).

DEPARTMENT OF INSURANCE OVERSIGHT

Accountability and Enforcement Mechanisms

The NC Department of Insurance inspects health plans at least once every three years (NCGS 58-2-131, 11 NCAC 19.0006). In addition, the Department can investigate complaints outside of the normal three-year cycle. If the Department finds problems, it can seek corrective action. If the problems are significant, the Department can seek to suspend or revoke the license, issue civil penalties, or seek injunctive relief. (NCGS 58-67-140, 58-67-165, 58-2-60, 58-2-70).

Consumer Services Division

The NC Department of Insurance has a Consumer Services Division that can help address consumer complaints. The Department can investigate the complaint and will intervene on behalf of the consumer if it thinks the health plan is acting improperly. The Consumer Services Division is open from 8:00 am to 4:50 pm Monday through Friday. The Division can be reached at: 1-800-662-7777 or 1-800-546-5664.

GLOSSARY

Ambulatory Review: Review of the appropriateness, necessity, efficacy or efficiency of health care services performed or provided in an outpatient setting. NCGS 58-50-61(a)(17)(a).

Appeal: A request by a member to an HMO to review a non-certification decision—that is, a decision to deny or limit payment of recommended health care procedures, services, or treatments.

Authorization: Approval to obtain health services, see a specialist, obtain care outside of the network, or be hospitalized. A primary care provider (PCP) can often authorize the provision of health services and referrals to specialists. However, the HMO sometimes requires that the member seek prior authorization from the health plan for non-emergency hospital admissions or certain high-cost or high-technology procedures. Also known as Prior Authorization.

Capitation: A fixed payment that an HMO pays to a physician, group practice, hospital or network of providers. The payment is calculated to cover the expected costs of providing certain services to members over a period of time, usually a month. The provider gets the same payment each month (or other fixed time period), regardless of the amount or type of services actually rendered. Capitation payment systems can cover just the cost of providing primary care (primary care capitation), may cover the costs of primary care and some specialty care (partial capitation) or may also include the costs of primary, specialty and hospitalization (full or global capitation).

Certification: A determination by an insurer or its designated Utilization Review Organization that an admission, continued stay in a hospital, or other health care services has been reviewed and satisfies the health plan's requirements for coverage. NCGS 58-50-61(a)(17)(c).

Clinical Guidelines: The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. Clinical guidelines are usually developed by practicing health care providers, and are an attempt to identify the best way to prevent, detect or treat a particular medical condition. Managed care organizations and other health care institutions use clinical guidelines as a way to ensure that practitioners are providing appropriate care, and to standardize care across providers. Also referred to as clinical practice guidelines, clinical protocols, treatment protocols, or medical protocols.

Clinical Review Criteria: The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. May include clinical protocols or practice guidelines used by an insurer to determine the services or treatments that are appropriate and medically necessary for a person with a specific health condition, disease or illness. NCGS 58-50-61(a)(2).

Coinsurance: The percentage of a provider's fee that the patient is expected to pay. For example, many traditional insurance companies pay 80% of a physician's usual, customary and reasonable (UCR) fees. The patient is expected to pay the 20% difference between the physician's UCR fees and what the insurance company pays. The 20% which the patient pays is called the coinsurance.

Concurrent Review: Review conducted during the course of a patient's hospital stay or course of treatment, to determine whether the hospital stay or treatment is still necessary. NCGS 58-50-61(a)(17)(d).

Congenital Abnormality: Physical or mental health problem that develops during pregnancy or the birth of a child.

Copayment (Copay): A fixed payment that must be paid out-of-pocket by a patient upon receiving health care services. In some HMOs, for instance, you pay a \$10 copayment for a physician visit, or a \$5 copayment for a prescription.

Cost Sharing: A generic term used to describe any payment the member must make for covered services. Different cost-sharing methods include deductibles, coinsurance and copayments.

Credentialing: The process that health plans use to ensure that health care providers and institutions meet certain minimum competency and malpractice coverage requirements. Typically, plans verify a professional's medical license, board certification (if any), malpractice history, and educational background.

Deductible: The amount an insured person must pay out-of-pocket each year before the insurance plan begins to cover health care costs. A policy with an individual deductible of \$250 and a family deductible of \$750 means that each individual person in the family must pay \$250 of medical expenses before the policy begins paying benefits for that individual. Once the out-of-pocket expenses of the family reaches \$750, then the insurance company will pay benefits for each family member.

Efficacy: Under *ideal conditions*, how well a treatment, therapy or procedure produces a desired health outcome (cure, alleviation of pain, return of functional abilities).

Effectiveness: Under *real life* conditions, how well a treatment, therapy or procedure produces a desired health outcome (cure, alleviation of pain, return of functional abilities).

Employee Retirement Income Security Act (ERISA): A Federal law that prevents states from enacting laws or regulations that have an impact on employer welfare plans, including employer

sponsored health benefits. States can regulate health plans. If an employer purchases a regulated health plan, then the members are covered by the state consumer protection laws. However, employers that pay directly for all of health services (self-funded or self-insured plans) are not subject to the same state laws.

Emergency Medical Condition: North Carolina state law uses a prudent layperson definition of emergency medical condition. That is, state law considers certain acute symptoms to be emergency medical conditions if a prudent layperson, possessing an average knowledge of health and medicine, thinks that in the absence of immediate medical attention, the medical condition is likely to place him or her (or in the case of a pregnant woman, her unborn child) in serious jeopardy, or cause serious impairment to bodily functions or bodily organs. NCGS 58-50-61(a)(4).

Emergency Services: Health care items and services needed to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available in the emergency department. NCGS 58-50-61(a)(5).

Evidence of Coverage (EOC): The document given to HMO members that describes the covered benefits and exclusions, utilization review requirements, cost-sharing, and other coverage provisions. The evidence of coverage is similar to a policy contract that other insurers issue.

Experimental: A new treatment developed from research that is different from the commonly provided standard of care for a given disease, illness or condition. Experimental or investigational drugs, treatments or procedures are typically not approved for use by the FDA, and may be the subject of clinical trials to test toxicity, efficacy or effectiveness.

Fee-for-Service (FFS): Payments to providers based on the specific services rendered. Fee-for-service systems are typically distinguished from capitation payments, which involve a fixed periodic payment per individual regardless of what services are provided. Under a fee-for-service system, the provider is paid each time he or she provides a different service.

Formulary: List of drugs and other pharmaceuticals that the health plan will cover. A formulary may limit the type and number of medications available for a physician to select from when treating any given disease, illness or condition.

Gatekeeper: In managed care systems, a primary care provider (PCP) who is responsible for authorizing treatment by specialists or non-emergency hospitalizations. If you are in a managed care system that uses gatekeepers you must see your gatekeeper before visiting a specialist (for example, a cardiologist).

Grievance: A written complaint submitted by a member which challenges any of the following: the insurer's decisions, policies or actions related to availability, delivery or quality of health care services; claims payment or handling; reimbursement for services; the contractual relationship between the member and the insurer; or the outcome of an appeal of a non-certification decision. NCGS 58-50-61(a)(6).

Group Insurance Plan: Health benefits purchased to cover individuals who are grouped together for purposes other than purchasing health insurance coverage. Employers often sponsor group insurance plans for their employees. Group plans tend to be less expensive than individual non-group plans because the health plan can spread the administrative costs and health risks over more individuals. Unions and churches may also sponsor group insurance plans.

Non-Certification: A decision by an insurer or its designated utilization review organization to deny, reduce or terminate a requested service, treatment or procedure. The denial must be based on a review and a decision that the requested service, treatment or procedure does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. NCGS 58-50-61(a)(13).

Non-Group Insurance Plan. A health insurance plan that is purchased separately, and not part of a group. Non-group plans are sometimes referred to as plans purchased in the individual market. Individuals or families who purchase health insurance directly from a health insurer, and not through an employer, church or association, are usually purchasing non-group insurance plans.

Out-of-Network: Care delivered by health care providers who are not a part of the managed care organization's network. Some plans allow members to seek care out of the network, but at a higher out-of-pocket cost and/or deductible to the member (POS and PPO plans). HMOs generally do not cover any costs for care obtained out of network, unless contracting health care providers are unavailable to meet the health needs of the insured without unreasonable delay.

Pre-Certification or Pre-Admission Screening: Authorization that must be obtained from the health plan before inpatient care is provided in order for the plan to pay for the hospitalization. Pre-admission screening reviews the appropriateness of the requested care, while pre-certification may specify the allowable length of stay in addition to what services/procedures will be covered.

Primary Care Providers (PCP): Generally, most plans allow family physicians, pediatricians or general internists to serve as

primary care providers. Sometimes, obstetricians or gynecologists (OB-GYNs), nurse practitioners (NPs), certified nurse midwives (CNMs) or physician assistants (PAs) can be PCPs. Primary care is distinguished from specialty care, which is often concerned with a particular health condition. Examples of specialists include oncologists, who deals with cancer, or cardiologists, who specialize in hearts.

Prior Authorization: The health plan's approval that a requested hospital admission, treatment or procedure is a covered service and is medically necessary and appropriate. Also known as pre-authorization or prior approval

Prospective Review: Review conducted before an admission or a course of treatment. Prospective review includes pre-authorization and pre-certification requirements that may be needed before a patient can be admitted to a hospital or obtain certain health care. NCGS 58-50-61(a)(17)(f).

Referral: Physician recommendation to a patient to see another physician for further evaluation or treatment. In HMOs that use gatekeepers, services provided by specialists or other practitioners usually require a referral by the patient's PCP in order for the health plan to cover the cost of the care.

Retrospective Review: Review of services and supplies already provided to a patient to determine whether they were medically necessary or appropriate. NCGS 58-50-61(a)(17)(g).

Stabilize: Provision of medical care that is appropriate to prevent the person's health condition from deteriorating. NCGS 58-50-61(a)(16).

Standing Referral: A referral from a primary care provider (PCP) to a specialist for a specified period of time (often to cover a

course of illness). Health plans must have a process to allow members with chronic, degenerative, disabling or life-threatening illnesses or conditions to obtain extended or "standing" referrals to in-network specialists. The standing referrals can not exceed 12 months, and must be part of a treatment plan coordinated with the primary care physician, specialist and health plan.

Utilization Review (UR): A system designed to monitor the use of, or evaluate the medical appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Utilization review may include ambulatory review, case management, certification, concurrent review, discharge planning, prospective review, retrospective review or second opinions. NCGS 58-50-61(a)(17).

Withholds: A payment system in which the HMO withholds a portion of the provider's payment. This may be refunded based on a set of performance criteria. For example, a provider or group of providers may have a withhold fund established to help offset all or part of the costs of specialty care. If funds remain in the specialty fund at the end of the quarter (or year), the funds may be redistributed back to the providers.

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N.C. Consumer Guide to Health Plan Selection: <http://www.nciom.org/hmoconguide>

ABOUT THE NORTH CAROLINA INSTITUTE OF MEDICINE

Chartered in 1983 by the North Carolina General Assembly, the North Carolina Institute of Medicine (NC•IOM) is an independent, nonprofit organization that serves as a non-political source of analysis and advice on issues of relevance to the health of North Carolina's population. The Institute is a convenor of persons and organizations with health-relevant expertise, a provider of carefully conducted studies of complex and often controversial health issues, and a source of advice regarding available options for problem solution.