UNDERSTANDING MANAGED CARE:

Answers to Frequently Asked Questions

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NORTH CAROLINA INSTITUTE OF MEDICINE

Citizens dedicated to improving the health of North Carolinians

INTRODUCTION

Most Americans are now enrolled in some form of managed care. Yet many of us don't understand what managed care is or how it works. This guide provides an explanation of basic managed care concepts and other information that can help make you a more informed health care consumer.

This Guide has seven sections. Each section includes a series of questions and answers. Most of the questions are asked in relation to HMO coverage. However, much of this information is applicable to other forms of managed care. Throughout this guide, HMOs and health insurance companies are referred to as *health plans*. 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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DIFFERENT TYPES OF MANAGED CARE

What Is Managed Care?

Managed care is a generic term that applies to different types of health care insurance arrangements. The goal of a managed care system is to provide members with needed health care services at the lowest possible cost. Some managed care plans also focus on prevention, trying to keep members healthy. Managed care systems typically combine the financing and delivery of health services. They do this by covering some or all of the costs of health care services (financing), while encouraging members to obtain services from the organization's network of providers (delivery system). In some managed care arrangements, members must seek care from within the health plan's network of providers. In other arrangements, members can obtain services from any provider, but the health plan will pay more of the bill if the patient obtains care from a network provider.

Two of primary components of a managed care plan are systems that oversee the amount and type of health care services being used (utilization review) and provider reimbursement methods that discourage unnecessary care. Managed care organizations often require members to get approval *before* obtaining certain services. Some managed care organizations also give providers financial incentives to eliminate unnecessary care. Some of the most common managed care arrangements are:

- **Preferred Provider Organizations (PPOs):** PPOs seek to manage medical costs by contracting with a network of providers who are willing to accept lower reimbursement rates. These providers often must also meet other requirements, such as utilization review. Members can choose any health care provider but members will have to pay additional money if they use a provider who is not part of the PPO network. PPOs are frequently used by traditional insurance companies.

- **Health Maintenance Organizations (HMOs):** HMOs have exclusive provider networks. They may also use primary care providers (PCP) as gatekeepers. Gatekeepers are responsible for arranging a patient's referral to a specialist or admission to a hospital. While most HMOs use gatekeepers, some HMOs have open access plans. These plans allow the patient to choose any PCP or specialist in the network without a referral. Many HMOs also use reimbursement systems to encourage providers to be

more cost conscious. HMOs may contract directly with physicians in the community, or may contract with networks of physicians. This arrangement is called a network or IPA model HMO. HMOs may have their own physicians on salary or in an exclusive contractual arrangement. This is called a group- or staff-model HMO.

- **Point-of-Service (POS):** POS plans give members the opportunity to see providers outside the network. Members who use a provider in the HMO's network pay less than members who see providers outside the network. The HMO may still require the use of a gatekeeper to authorize in-network services, but no referral is needed for out-of-network services.

- **Primary Care Case Management (PCCM):** Primary care case management programs only operate within the Medicaid program. In PCCM programs the Medicaid agency pays a primary care provider (PCP) a monthly management fee to manage the member's care. However, physicians are reimbursed for the services they provide on a fee-for-service basis. The PCP acts as the patient's gatekeeper and must authorize all non-emergency visits to the hospital and all referrals to specialists.

How Are Managed Care Plans Different from Traditional Fee-For-Service Plans?

In a traditional fee-for-service system, the insurance company pays the bills but the patient has freedom to choose the provider. In most managed care arrangements the company limits the network of providers. Managed care organizations usually give members a financial incentive to obtain care from within the network.

HMOs are the most different from traditional insurance plans. They offer both advantages and potential disadvantages over other forms of health insurance. For example, HMOs emphasize prevention and are more likely to cover annual physicals or well child check-ups than are other insurance carriers. In addition, the HMO industry has made greater efforts to measure the quality of care provided to members. While HMOs offer advantages over traditional insurance plans, there are also potential disadvantages. HMO members must obtain care from health care providers who are in the HMO's network. This limits choice of providers. Typically, HMO members also are required to obtain approval from their PCP before receiving care from a specialist. In addition, HMOs sometimes give physicians or other health care providers' financial incentives to be more efficient managers of care. While these payment mechanisms provide an incentive to reduce unnecessary care, some people worry

that these payment mechanisms also may provide incentives to withhold necessary care. In contrast, some people were concerned that traditional fee-for-service gave physicians incentives to providing unnecessary care.

What Is the Difference between an HMO, POS or PPO?

- **Health maintenance organizations (HMOs)** have exclusive networks of providers. If you are in an HMO it will not usually pay any part of your bill if you choose a provider outside of the HMO's network without prior authorization. HMOs do not require their members to pay a deductible although there may be a copayment each time you receive services.

- **Point-of-service plans (POS)** permit members to see providers outside the network. The HMO will help pay part of the bill but will not pay as much as it would if you go to a provider within the network. For example, if you see a physician inside the network, the HMO will pay all of the costs except any required copayment. If you choose to see a physician outside the network, then the HMO may only pay 70-80% of the costs. You would be responsible for paying the physician the remaining 20-30% of the costs. In addition, you may also have to meet a deductible for out-of-network services, and will usually have to pay a higher premium. Under state law, HMOs can exclude coverage for preventive services if you obtain care from a non-network provider.

- **Preferred provider organizations (PPOs)** are more like traditional insurance companies. Once you meet the deductible, the insurance company will pay a certain percentage of the health care bill. However, you must go to one of the network providers to get the highest level of coverage. A PPO will pay a smaller percentage of the bill if you go to a provider outside of the network. For example, the insurance company may pay 80% of the costs if you seek care from an in-network provider, but only 50-60% of the costs if you seek care from a non-network provider.

Does My Health Plan Operate Differently Because I Am in a Self-Insured or ERISA Plan?

Some employers purchase health insurance coverage directly from an insurer or HMO. In these instances the employer pays the monthly premium and the health plan pays for the medical services. The insurance company or the HMO assumes the financial risk for paying for all of your needed services. In other instances, the employer "self-insures." This means the employer is at risk for the

health care costs of covered employees and dependents. If an employee incurs $1 million in covered health care costs, the employer will pay these costs directly instead of paying a monthly premium to a third party insurer for accepting this risk and paying the cost. The employer retains the financial liability for paying for all covered services. These plans are typically called self-funded, or self-insured plans.

A federal law called ERISA (Employee Retirement and Income Security Act) sets up rules that apply to self-funded plans. Companies that "self-fund" are exempted from state consumer protection laws. For example, self-funded companies do not need to provide coverage for mammograms or pap smears. Nor do they have to provide state appeal and grievance procedures. While self-funded companies are not subject to the state's consumer protection laws, they are subject to federal laws that protect consumers. In 1996, Congress passed a law that prohibits insurance companies or health plans from excluding people based on their health status. This is known as the Health Insurance Portability and Accountability Act (HIPAA). These federal laws apply to both traditional insurance plans and self-funded plans.

While self-funded plans are not required to provide the same consumer protections as other state-regulated insurance plans or HMOs, many employers do so voluntarily. The federal ERISA laws give employees certain protections. Health plan administrators must give employees a Summary Plan Description (SPD) which includes a summary of the benefits covered under the plan.[1] In addition, employees who are covered by self-funded plans also have limited appeal provisions. Basically, an employee who is dissatisfied with a health benefits decision can appeal to the health plan administrator. If that is unsuccessful, then the member can file a lawsuit in federal court.[2]

If you have any questions or concerns about an ERISA plan, you can contact the US Department of Labor, which oversees ERISA plans. Contact information for the Department of Labor is at the back of this booklet.

It is often difficult to know whether your company is operating an ERISA plan or buying a traditional insurance plan or HMO coverage. You may get an insurance card that looks like you are enrolled directly in an HMO or insurance company even though your employer is still retaining the financial

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[1] The US Department of Labor proposed new rules that would expand the type of information that would be provided to enrollees in their Summary Plan Description. The proposed regulations can be found at 63 Fed Reg 48376-48387 (September 9, 1998).

[2] The US Department of Labor has proposed new rules that would ensure more timely benefit determinations, and expand the protections to ensure fair hearings. The proposed regulations can be found at 63 Fed Reg 48389-48409 (September 9, 1998).

risk for paying for all the health care claims. The easiest way to find out whether you are enrolled in a self-funded ERISA plan or whether you are enrolled directly in the state-regulated HMO or insurance company is to ask your employer.

Remember that the ERISA laws only apply to self-funded employer sponsored health plans. If you buy your health insurance directly from an insurance company or non-group plan HMO, or if you receive health insurance coverage through a church, professional association, or the government, you are not enrolled in an ERISA plan.

How Do I Know What Type of Plan I Am In?

The easiest way to know what type of managed care plan you are in is to look at your Evidence of Coverage or Policy Contract, which is the booklet that explains your health plan. It should state whether you are in an HMO, POS, or PPO. Finding out if you are in a state-regulated HMO or in a self-funded plan may be more difficult. You generally will need to ask the employer who provides your health insurance coverage.

HOW TO CHOOSE A MANAGED CARE PLAN

What Should I Look for when Selecting a Health Plan?

Not everyone has a choice of health plans. However, if you are offered a choice of different health plans you may want to consider the following factors:

- **Health Care Providers:** Find out if your physician is part of the HMO or managed care network. You should also check to see what specialists, hospitals, specialized treatment centers and other practitioners are included in the network. This is especially important if you have chronic or special health problems. For example, if you have a child with special health needs you may be interested in finding which pediatricians are included in the network. You may also want to know whether the provider network includes pediatric specialists who can address your child's health condition. If you want to continue your care with a provider who is not in the network, you may want to consider enrolling in a PPO or a POS if given that choice.

- **Services:** Check to see what services are covered or excluded under the plan. You will be given a Summary of Benefits which summarizes the covered services. If you have a special health need, ask to see the Evidence of Coverage which lists the covered and excluded services in more detail. It also lists any limitations in services. For example, many plans limit the number of physical or occupational therapy sessions, or how often a patient can have durable medical equipment replaced. Check the Evidence of Coverage for more specific information about the limitations in covered services. Also check to see where the services are offered and whether they are available in your area of the state. If you have a choice of plans, you may want to talk with your provider to determine which service package best meets your needs.

- **Treatment of Certain Health Conditions:** If you have special health needs, you may want to find out how the HMO or insurance company typically treats other people with the same health condition. New state laws give you a right to request certain information from an HMO or insurer before you choose to join. You can ask the HMO or other managed care company for:

  - *Clinical Review Criteria:* The criteria, guidelines or protocols the health plan uses in deciding what types of services or treatments are appropriate given the symptoms and diagnosis. For example, you might want to find out what services the HMO would authorize to treat members with asthma, diabetes, congestive

heart failure, sickle cell anemia, inflammatory bowel disease, infertility, autism or severe mental illness.

- *Referrals:* You should check the HMO's prior authorization and referral process, especially if you have a health condition that requires you to see your specialist frequently. Some HMOs may only authorize referrals to specialists for a limited number of visits, with a requirement that you obtain your primary care provider's (PCP's) authorization for additional visits. Other HMOs may give standing referrals which allow you to see your specialist for the full course of treatment. Beginning January 1, 2000, all HMOs must have procedures to allow standing referrals for certain people with chronic or disabling health conditions. You may also want to check whether the HMO will let you use your specialist as your PCP. For example, you may want to have your specialist serve as your PCP, if you have received a transplant, have sickle cell anemia, HIV or kidney failure (End Stage Renal Disease).

- *Centers of Excellence:* Some health plans contract with Centers of Excellence for certain services such as transplants. You may be required to travel to other cities or states to obtain those services. It is important to find out where the services are provided, as well as whether the health plan will pay for transportation and lodging costs if the Center is located outside your immediate area. Also check whether the plan will pay the transportation and lodging costs of the parent if a child is required to travel outside of the service area for care.

- *Case Management Protocol*: You may want to see if the HMO has someone who can help you or your family member coordinate all the needed health care services. It is important to realize that a health plan's case manager is not necessarily the same as a patient advocate. A case manager who is employed by the health plan may help you obtain and coordinate health care services, but may also have a responsibility to the HMO to try to reduce health care costs.

- *Formulary*: Usually, there are several different drugs that could be used to treat a specific illness, such as asthma, depression, high blood pressure, high cholesterol, or ulcers. Sometimes, health plans limit their coverage of drugs for an illness. Ask your health plan if your specific medication is covered on their formulary. If it is not, talk with your provider to see whether another medication that is covered will work just as well as the one that is not on the formulary. In addition, find out whether the health plan has a process to obtain prescription drugs that are not on the formulary. On January 1, 2000, North Carolina

law began reqiring all health plans to have a process to cover drugs that are not on their formularies. Your physician will need to explain to your plan why the drug on the formulary is not adequate to treat your health care need.

  - *Experimental or Investigational Treatments*: Most health plans will not cover investigational or experimental treatments. These treatments include services, drugs or procedures that are still being tested to determine their efficacy as part of a clinical trial and have not yet been approved by the Food and Drug Administration (FDA) for use in the general public. However, people who are covered under the State Employees Health Plan, or an HMO that contracts with the state, have better access to clinical trials. These plans must pay for participation in clinical trials if the medical condition is life-threatening, the investigational treatment is superior to other available treatments or the investigational treatment is the *only* treatment currently available for the condition.

- **Quality:** There are many different ways to judge the quality of health plans. Some of the factors to look at include:

  - *Accreditation:* Has the health plan been accredited by a national accreditation organization?

  - *Performance Measurement*: How does the plan compare to other plans on certain performance data?

  - *Disenrollment*: Are large numbers of members, groups or members or physicians leaving the plan in large numbers?

  - *Member Satisfaction*: Are member satisfied with the plan?

  - *Utilization Review*: How often the plan reviews requests for medical services and how often these reviews are denied and appealed?

  - *Grievance Reports*: Other complaints that members have with the plan.

  - *Inspections*: When was the last Department of Insurance inspection and how did the plan do on the inspection?

  Some of these measures examine the quality of the services provided to members. Other measures focus on the health plan operations, and how easy it is for members to obtain needed services. These measures are described in more detail in the **Quality** section.

- **Costs:** Find out how much you will have to pay for care from the different health plans. To do this, look at the monthly premiums and out-of-pocket

costs in the form of deductibles, co-insurance or copayments, covered and excluded services, and annual or life-time limits. An HMO with a higher monthly premium may cost less money on a yearly basis after consider-ing all costs. However, this depends on the types of services you need and how often you need them. It is impor-tant to evaluate the costs of each plan separately. You should also find out if both plans cover the same services. If the same services are not covered in both plans, you may have to pay for some services out-of-pocket.

Example A

Mary Jones is given a choice to enroll in Insurance Company A or HMO B. Insurance Company A charges a $185 a month in premiums. The plan has a $250 deductible, after which it will pay 80% of all other health care services. HMO B charges $200 a month in premiums, but only requires a $10 copayment per visit to the physician. Mary's annual health care costs will depend on her use of health services and the costs incurred. Even though Insurance Company A's premiums are less expensive, Mary may spend less money on a yearly basis with the HMO if she needs frequent visits to the physician. For example, it would be less expensive for Mary to join the HMO, if she sees the physician three times a year, assuming an average cost of $125 a visit. In this example, Mary would have to pay $2,495 per year for Insurance Company A, but only $2,430 for HMO Company B.

	Insurance Co. A (Fee-For-Service)	**HMO B**
Premiums	$2,220 ($185 premium for 12 months)	$2,400 ($200 premium for 12 months)
Deductible	$250	$0
Physician visits	$25 Once she meets her deductible, Mary must pay 20% of the remaining $125 of the doctor's cost and the insurance company will pay the remaining 80%	$30 Mary pays a $10 copayment for each of her 3 visits
Total	$2,495	$2,430

How Do I Know What Services My Plan Will Cover?

Your Evidence of Coverage (member handbook) describes the services that are covered and excluded in your plan. You should receive a copy of the Evidence of Coverage when you enroll or your employer enrolls you in the HMO. The Evidence of Coverage includes information on:

- Covered services, including any limitations;
- Excluded services;
- Cost sharing or coverage differences for in- and out-of-network services;
- Total payment for health services that the member must pay;
- Reference information available to members and prospective members upon request;
- Definition of medical necessity;
- How to request pre-authorization for services and the toll-free number to call for pre-authorization;
- Coverage that is available for out-of-network services;
- The health plan's method for resolving member complaints;
- Appeal and grievance procedures; and
- Reasons, if any, that an HMO can terminate a member's enrollment.

Look at the sections in your Evidence of Coverage that describe the services covered as well as limitations or exclusions. Most plans will not cover experimental services or long-term institutional care. In addition, many plans limit physical, speech or occupational therapy services and durable medical equipment, and some limit mental health or substance abuse coverage.

Note: It is very important to read the Evidence of Coverage carefully. Your HMO is required to send you another copy of your Evidence of Coverage if you cannot find your original copy.

What If I Have a Pre-Existing Condition?

Under certain circumstances, health plans are allowed to limit coverage of people with pre-existing conditions. Pre-existing conditions are mental or physical conditions for which you sought medical advice, care or treatment within six months prior to your enrollment. Health plans, both HMOs and insurance companies, can limit coverage for up to 12 months. With certain exceptions, a person who enrolls late—after the normal enrollment period—can be excluded from coverage for pre-existing conditions for some people for up to 18 months. However, individuals who enroll late because they lost other health insurance coverage are generally not considered late members. Therefore, they can only be subject to a maximum of 12 months pre-existing condition limitation.

A patient who has a pre-existing condition may be excluded from coverage for the services needed to treat that condition. The health plan will cover other services that are unrelated to

the pre-existing condition. For example, if a person has cancer or a heart condition, the health plan can exclude coverage for those conditions, but will still be required to pay for other health services unrelated to the heart condition or cancer. The reason that health plans are allowed to limit coverage for pre-existing conditions is to discourage individuals from waiting until they are sick before purchasing health insurance coverage.

Once you meet the 12- or 18-month pre-existing condition limitation period or are enrolled in a health plan for at least 12 months, you are given additional protections. You can not be subject to a pre-existing coverage limitation if you later develop health problems. In addition, you will not be subject to a pre-existing coverage limitation if you change health plans and enroll in your new plan within 63 days of ending your prior health insurance coverage. If you met part of an exclusionary period, you must be given credit for that time when enrolling in a new health plan. For example, if you received health insurance through ABC insurance company, and met six months of a 12-month exclusionary period, you must be given credit for that six months if you enroll in XYZ insurance company within 63 days of leaving ABC.

QUALITY

How Can I Judge the Quality of My Health Plan?

There is no easy way to assess the quality of care provided by different health plans. However, some information is available to help consumers.

Nationally there are two organizations that accredit HMOs or other managed care organizations: The National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). While most HMOs that seek accreditation do so from NCQA, some HMOs are beginning to seek accreditation from JCAHO. In North Carolina, all of the health plans that have sought accreditation have done so from NCQA. The accreditation status of a managed care organization can be obtained from NCQA's web site.

NCQA looks at five categories in its accreditation process: access and services, qualified providers, staying healthy, getting better, and living with illness. An HMO seeking accreditation is evaluated on how well it meets NCQA's standards in each of these areas. Once a review is completed, a health plan will be given an accreditation decision. Health plans that exceed NCQA's standards receive an *Excellent* status. HMOs that fully meet NCQA's standards receive a *Commendable* status. Those that meet most of NCQA standards receive an *Accredited* status. *Provisional* accreditation may be given for plans that meet some, but not all, of NCQA's standards. Health plans that fail to meet NCQA's requirements during the review will have their accreditation request *Denied.*

In North Carolina, the following health plans have received NCQA accreditation:

- **Blue Cross and Blue Shield of North Carolina Personal Care Plan** (Commendable)
- **Cigna HealthCare of North Carolina** (Commendable)
- **Healthsource of North Carolina** (Commendable)
- **Partners National Health Plan of North Carolina** (Commendable)
- **Prudential Health Care—Charlotte** (Provisional*)

  *Previously earned one-year accreditation but currently under review due to merger of Charlotte and Raleigh operations.
- **United HealthCare of North Carolina** (Commendable)

What does it mean if a health plan is not accredited?

Accreditation is just one way to assess the quality of a health plan. However, not all health plans seek accreditation. The accreditation process is very expensive and some plans choose not to participate. This does not necessarily mean that the HMO is bad, but it does make it more difficult to judge the quality of care provided by the plan.

- **Health Plan Employer Data and Information Set (HEDIS®):** HEDIS® is a standardized set of performance measures that consumers and other purchasers can use to compare health plans. Information about HEDIS® can be found on NCQA's website: www.ncqa.org. In 1998, HEDIS® covered 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. In general, accreditation standards examine the health plan's process for providing care and the HEDIS® reporting requirements examine the health plan's actual performance.

  A new North Carolina law requires that each HMO report its HEDIS® data to the Department of Insurance beginning in July of 1999. Information is available from the NC Department of Insurance or its web site (see back of this booklet for contact information).

- **Disenrollment**: In theory, disenrollment numbers, or the numbers of members and providers who leave a plan, may give an indication of satisfaction—or dissatisfaction—with a health plan. If large numbers of members leave a health plan, for example, it may indicate dissatisfaction with customer service or problems with the quality of care delivered by a plan. This is also true if a large number of providers leave a health plan.

  HMOs are required to submit data to the Department of Insurance on the number of individuals and groups that withdraw from their health plan. HMOs are also required to report data on the numbers of providers who left a plan voluntarily or those who were terminated from the plan by the HMO. However, the number of people or providers who leave an HMO may be misleading. HMOs with greater numbers of members will likely have more people leave in a given year than a plan with fewer members. It is important to compare disenrollment rates (ie, the number of people who left in a year divided by average number of members enrolled during the year) in order to compare numbers across plans. Disenrollment information is available in the NC Department of Insurance's *1999 Managed Care Handbook* which can be obtained from the NC Department of Insurance or its web site.

  Disenrollment figures should be read with caution. People may leave health plans for a variety of reasons. For example, a health plan may have raised its premiums, forcing an employer or individual members to choose a lower-cost plan. An HMO may stop covering a particular part of the state, forcing some members to choose another plan. Physicians may leave the plan because they are unhappy with the HMO's reimbursement rate. So, disenrollment numbers by themselves are often an inadequate way to measure quality. They are best used in conjunction with other measures listed here.

- **Member Satisfaction:** Each HMO is required to submit member satisfaction survey data to

the NC Department of Insurance. HMOs must collect this data using similar methods so that the results should be comparable.This information is also available from the NC Department of Insurance.

In general, most HMOs have relatively high member satisfaction levels. But these numbers may not be good indicators of the experiences of people with special health care needs. Most HMO members, and consequently, most of the people who respond to the member satisfaction surveys, are relatively healthy. A member who is healthy and rarely uses health services will have fewer interactions with the HMO, and thus are likely to have fewer problems within the system. A better way to assess the plan would be to survey the members who have greater health care needs. However, this information is not currently collected.

- **Utilization Review and Appeal:** The NC Department of Insurance collects information about the number of utilization reviews conducted by each health plan. Utilization review is a mechanism HMOs use to evaluate the appropriateness of certain procedures, providers or tests. Utilization review can include precertifications, concurrent reviews or retrospective reviews. Precertification systems require members to obtain prior approval or preauthorization from the plan before being admitted to the hospital or obtaining certain health care services. Concurrent reviews are usually done when the members are in the hospital. This is the method used to review the proposed length of stay or prescribed course of treatment for appropriateness. Retrospective reviews occur after services are provided, and is used to assess whether the services that were provided were appropriate.

The Department of Insurance collects information on the number of requests for coverage of services or treatment that were denied. HMOs must also report the number of noncertification appeals filed with a plan and whether the member won or loss the appeal.

North Carolina began collecting information about the types of services examined by utilization review in March 1999. These include inpatient hospitalizations, outpatient procedures, referrals to specialists, prescriptions, inpatient mental health or substance abuse admissions, outpatient mental health and substance abuse services. The data also include the number of noncertifications, whether these noncertifications were appealed, and the results of the appeal. Utilization review and appeal information is available in the NC Department of Insurance's *1999 Managed Care Handbook* which is available from the Department or its web site.

Consumers should look at more than the numbers of reviews, noncertification decisions and appeals because again, some health plans have more members than others. Consequently, large plans usually have more reviews and more noncertfications. In addition, plans differ in

their policies about when prior authorization is required. A better approach is to look at the review, noncertification and appeal rates, such as the number of reviews divided by the average number of HMO members. As previously stated, this information cannot be used in isolation. Review and noncertification rates may demonstrate how stringent a plan's review systems is; however, this information may not apply to your particular medical needs.

- **Grievance Reports:** HMOs are required to report information about all written correspondence from members expressing dissatisfaction with the plan. Grievances include:

  - Problems with the insurer's policies or actions related to delivery, quality or availability of health care services;
  - Problems with claims payments or reimbursement for services;
  - Issues related to the contractual relationship between the member and the insurer, including questions about covered benefits;
  - Requests to further review the decisions of first level noncertification appeals.

  The data include the number of grievances filed by reason, and the outcomes of these grievances. Again, look at grievance rates, that is, the number of grievances divided by the average number of members, before comparing plans. These data, used with the utilization review or disenrollment numbers, may be useful in identifying plans with more problems. Grievance and appeal information are available in the NC Department of Insurance's *1999 Managed Care Handbook*. This publication is available from the Department or its web site.

- **Department of Insurance Market Practice Examination Reports**: The NC Department of Insurance inspects each HMO at least once every three years. The Department's review covers 11 areas: company overview, management and control, general administration, delivery system and provider relations, utilization management, quality management, claims administration, member services, sales and marketing, premium rate setting and underwriting, and services which the HMO delegates to another organization. This report is often the best source of information about a health plan's internal operations. However, these reports are not always current. They are generally released about six months after the inspections have been conducted. The Department conducts follow-up inspections when necessary. These inspections are called compliance examinations and are conducted one year after the initial inspection to determine if the health plan has corrected the problems. These compliance reports also take about six months to be released to the public. You may obtain a copy of the report from the NC Department of Insurance.

CHOOSING YOUR PHYSICIAN

How Should I Choose My Primary Care Provider (PCP)?

HMOs give you an opportunity to choose your own primary care provider (PCP). You will receive a list of participating providers when you first enroll. Some HMOs have their current provider lists on the internet (*See* **For More Information**). Check to see if your current PCP is already a participating provider. If so, you can designate him or her as your PCP. If not, you should call the HMO and your provider and tell them you would like your provider to enroll in the HMO's network.

If your provider is not a participating provider or if you want to choose another provider, you will need to review the HMO's list of participating providers. The list usually includes the names, addresses and phone numbers of the provider, as well as the provider's specialty. The provider directory usually lists PCPs separately from other providers. Most HMOs require that you select a family physician, general pediatrician or general internist as your PCP. Some HMOs allow you to choose a nurse practitioner (NP) or physician's assistant (PA). Some may also allow you to choose an obstetrician-gynecologist (OB-GYN) or other provider as your PCP. If you fail to choose a PCP, some HMOs will choose one for you.

Even though a physician or group practice may be listed in a provider directory it does not necessarily mean that new patients are being accepted. When a physician's practice is full, he or she may stop taking new patients. It is important to call the physician's office to see if new patients are being accepted. You should also ask the office how long it usually takes to get an appointment for both immediate needs and for general check-ups. Ask what hours the office is open. Calling the physician's office will also give you a sense of how easy or difficult it is to reach the office by telephone.

There are other ways to check out prospective physicians. Talk to friends and neighbors about their experiences with a physician's practice. Ask them how easy—or difficult—it is to reach the physician by phone or to schedule appointments, how much time the physician spends with them and how comfortable they feel talking with the physician.

The NC Board of Medical Examiners can tell you if a physician has had any action (including disciplinary action or restrictions) taken against his or her license. A doctor could have his or her license revoked or restricted because of malpractice or inappropriate behavior. Public Citizen Health Resource Group in Washington DC also keeps records of all physicians who have had a disciplinary action by a state Board of Medical Examiners.

How Can I Find the Best Physician if I Have a Special Health Care Need?

If you have a special health care need, such as a disability or chronic illness, or have a child with a disability, you may want to talk to an advocacy or self-help group to find out which physicians are best known for treating your (or your child's) health con-

dition. The HMO should also be able to give you information regarding the educational background and specific interests of in-network PCPs and specialists. It is particularly critical that you find a primary care physician who understands your disability and is willing to work with you in developing a long-term treatment plan. If you do not have specific recommendations for a physician, you may want to consider interviewing potential PCPs once you have selected your health care plan. Ideally, however, this interview process should take place prior to plan selection.

Once your have selected a PCP, it is important to set up an initial appointment or exam with him or her so that you can immediately begin developing a care plan. This appointment will also provide the opportunity to begin establishing a positive long-term relationship with your physician. You should try to meet with your PCP before an emergency situation arises. This will help to avoid some of the possible confusion over emergency care coverage and processes. Having a physician who personally knows you and your condition will also increase your ability to obtain the care you need. Selecting a PCP who will advocate for your needs is crucial in managed care. The PCP can help you navigate the health care system in both emergent and non-emergent situations as well as assist you and your family in transitioning to another health care plan, should the need arise.

What Can I Do If I Don't Like My Primary Care Provider (PCP)?

You do not have to stay with your physician if you do not like the care you receive. Most HMOs let you switch PCPs at least once a year. Some plans allow you to switch whenever you are dissatisfied. Check your member handbook (Evidence of Coverage) about the procedures to switch physicians. You may need to call the HMO to get a new provider directory since participating PCPs can change frequently. Call the PCP you are considering to make sure that he or she is accepting new patients. Once you have selected your new PCP, call the HMO again to change the name of your PCP in its records.

How Much Choice Do I Have in Choosing a Specialist?

If you are enrolled in an HMO, you will usually have to obtain care from network providers, including specialists, hospitals, home health, hospice and other health care providers. Sometimes, you will be given a choice of health care providers—for example, if you need to be referred to a cardiologist there is usually more than one cardiologist to whom you could be referred. At other times, the HMO may limit which health provider you can see. Most of the HMOs in North Carolina contract with specific hospitals for transplant services. If you need a transplant, you may be given no choice of where you can receive these services.

Sometimes your choice of providers may be limited to a subset of providers within the HMO's network. Some HMOs contract with Independent Practice Associations (IPAs). An IPA is a network of providers who contract with the HMO. These IPAs effectively operate as "mini" networks within the HMOs larger network. If your PCP is part of an IPA, then he or she

may only be able to refer you to specialists and other health providers within the IPA's network (in contrast to the larger HMO network). Thus, when you enroll in an HMO, you may or may not have access to all the HMO's network of providers. It is therefore very important to find out whether your physician is part of an IPA, and whether the IPA places restrictions on referrals.

How Is My Physician Paid? Does My Physician Receive Financial Incentives to Withhold Care?

Not all HMOs give providers a financial incentive to efficiently manage care. Some HMO pay providers on a fee-for-service basis and have other mechanisms to control costs. For example, most HMOs have quality assurance and utilization review systems to look at care that was provided to make sure it was appropriate. These systems are used to ensure that a health care provider does not authorize unnecessary services or withhold necessary care.

HMOs sometimes give physicians financial incentives to be cost conscious in the care they provide. They do this through one of three payment mechanisms: capitation, withholds or incentive payments.

A capitation payment is a fixed payment per month that a physician's practice receives to cover a specified set of services. The practice gets a fixed regular payment from the HMO for each member who is served. Under capitation systems, the physician's practice receives the payment whether or not patients receive services in that month. In return, the practice is responsible for providing all the specified services, even if the costs exceed the monthly capitation payment (*See Capitation Description*).

Capitation Description

Dr. Jones' practice receives $20 per member per month to cover the primary care needs of 100 of an HMO's members, (or a total of $2,000 month). If none of the HMO members seek care in a particular month, Dr. Jones' practice gets keeps the full $2,000. However, if the members' health care costs actually exceed $2,000, then the practice will need to pay for those costs from other revenues. In theory, this type of payment system gives Dr. Jones an incentive to keep all the members healthy. If the members are healthy, they would have less need to obtain health care services and the physician's practice would be able to keep more of the capitation payment. However, some people are afraid that a capitation system encourages physicians to withhold care in order to make money.

While some physicians receive capitation payments, other physicians have different payment arrangements. Some physicians receive a salary for their services. Other physicians are paid on a fee-for-service basis, that is, payment for each service provided. HMOs sometimes combine these payments with other methods to discourage unnecessary care. For example, HMOs may combine capitation, salary or fee-for-service payments with withholds or incentive payments.

Under a typical withholding arrangement, the HMO keeps a certain percentage of the physician's regular payment to cover excess medical costs. The physician may receive a refund of the "withhold" at the end of a specified time period if health care services and spending are within allowable limits. Thus, the money a physician receives may depend on how often he or she refers members to specialists, admits members to hospitals or orders expensive tests and procedures.

Another similar system is an incentive payment. Incentive payments are in addition to a physician's ordinary payment and are made on the basis of efficiency. A physician who orders fewer tests and procedures and makes fewer referrals or admissions may get an additional incentive payment or bonus. Both withholds and incentive payments encourage physicians to manage treatment efficiently. However, some people are concerned that these payments may also discourage physicians from referring or admitting members or ordering certain diagnostic tests or medical procedures, when they may be needed.

Withhold or incentive systems may also be based on quality of care measures in addition to efficiency. For example, HMOs may take into consideration patient satisfaction scores or the percentage of members who receive preventive services in paying physicians.

Each HMO and insurance company has different reimbursement rules and oversight systems. Ask your physician directly about your HMO's payment arrangements or internal review mechanisms if you are concerned that the arrangement may affect the care your physician can provide to you.

ASSURING COVERAGE FOR HEALTH CARE SERVICES

Does My Health Plan Have to Cover All the Health Care I Need?

Your health plan does not have to cover all the health care services that you need. No insurance company covers all health care services. The HMO or insurance company is only required to pay for services that are mandated by state law or covered under your health plan contract (described in your Evidence of Coverage). For example, some plans specifically exclude coverage of mental health services or prescription drugs. Health plans are not required to cover these services unless you purchased a rider to cover these services. Similarly, some health plans put limits on the extent of coverage, or the situations when the services will be covered. Some health plans, for example, pay for a limited number of physical, occupational or speech therapy visits. The health plan is not obligated to cover additional services, no matter how much you may need them. However, your physician has an ethical responsibility to discuss all appropriate treatment options regardless of whether the service is covered under the plan.

Note: Health plans are not required to pay for covered services if you fail to obtain a required referral or prior authorization or if the HMO determines that the services were not medically necessary. Therefore, it is very important to always make sure you understand your plan's requirements and follow them.

Do I Need to Get a Referral from My Primary Care Provider (PCP)?

HMOs usually require members to get referrals from their PCP before the health plan will pay for specialty care, high-technology services or non-emergency hospital admissions. Your Evidence of Coverage will specify when you need a referral. As a general rule, your PCP must refer you for most health care services provided outside his or her office. The two notable exceptions are for emergency care and for care related to the female reproductive system from participating OB-GYNs. In addition, referrals to specialists are not usually required if the person is enrolled in an open-access HMO, Point-of-Service plan (POS) or a Preferred Provider Organization (PPO).

Note: It is important to understand exactly what services your referral covers.

People sometimes have problems with their HMO because the referral did not cover all the services that they received. For example, a member may obtain a referral to a specialist and assume that all the diagnostic tests the specialist orders automatically will be covered. However, some health plans may require an additional referral from the PCP or prior authorization from the health plan before covering certain procedures (see below). Other problems can arise when a person is referred to a specialist for on-going care. Some PCPs or HMOs limit the number of visits or length of time a referral will cover. Therefore, it is important to understand what the referral covers and to contact your PCP if an additional referral is needed.

When Do I Need Prior-Authorization?

In addition to the PCP referral requirements, most HMOs require that certain services be approved in advance by the plan. This is called prior authorization or precertification and is necessary before the HMO will pay for the service.

Each HMO has its own rules for which services or procedures require prior authorization. As a general rule, most HMOs require non-emergency hospitalizations, surgery or therapy services be approved in advance. Similarly, many HMOs require prior authorization for certain high-technology (and high-cost) services such as MRIs (Magnetic Resonance Imagings, which are special images or pictures of the inside of the human body). The HMO should specify which services require prior authorization in your Evidence of Coverage. Your membership card should include a toll-free number to call when you need to get prior approval from the HMO.

Some HMOs place the responsibility of obtaining prior approval on your physician or health care provider. In these instances, the HMO will deny payment to providers who fail to obtain the necessary approval. Some HMOs prohibit providers from charging members if it was the provider who failed to get authorization. Other HMOs place the responsibility on the members and allow the physician to charge for services if the member fails to get prior approval.

Note: It is important to always obtain prior authorization when required. Otherwise, the HMO does not have to pay for the services you received even if they are listed in your Evidence of Coverage. If you are not sure if you need to get prior authorization, call your HMO.

My Plan Said It Would Not Cover My Services Because They Are Not Medically Necessary. What is Medically Necessary?

Health plans often limit covered services to those that are medically necessary. If an HMO tries to limit coverage to medically necessary services, it must use the definition that is specified under North Carolina state law. North Carolina defines medical necessity as the services or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and 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;
- Not solely for the convenience of the insured, the insured's family or the provider.

In other words, the health plan will examine whether the treatment or service that you or your physician wants is appropriate to treat your health condition. Experimental treatments are usually not covered. A health plan is allowed to examine the cost-effectiveness of alternative services or supplies when determining which services or supplies will be covered.

Will My Health Plan Pay If I Need To Go to the Emergency Room?

HMOs and other insurance companies must pay for your costs of emergency room services if you reasonably thought that you had a medical emergency when you sought care. You do not need to seek prior authorization to obtain emergency care. The HMO or insurance company will be required to pay for the screening and any services needed to stabilize your condition. If possible, you should seek care from a hospital that is in the HMO's network. This will make it easier for follow-up care once you are stabilized. However, the HMO will still be required to pay for your care if you seek care from a non-network hospital if you thought the delay in going to one of the HMO's network hospitals would worsen your health condition. The HMO or insurance company may charge its regular coinsurance, co-payments or deductibles but may not charge you an additional cost for using a non-network provider.

The North Carolina law does not mean that all visits to the emergency room are covered. You cannot, for example, seek care in the emergency room for a common cold or sore throat, or just because your physician's office was closed. HMOs do not have to pay for non-emergency care that most reasonable people would not think was an emergency. If you are not sure whether you need to seek care in an emergency room and you think the delay will not cause you (or the patient) harm, you should call your PCP or the HMO for prior authorization. If you receive prior authorization, the HMO must cover the care you receive.

APPEAL AND GRIEVANCE PROCEDURES

What Can I Do If My Health Plan Won't Approve Care My Physician Recommends?

You have the right to appeal your HMO's decision to deny coverage of health care services. Most noncertification decisions occur when the HMO does not have enough information about your case. *More than half of all appeals of noncertification decisions are decided in favor of the patient, so be aggressive in pursuing your rights!* Involve your physician in the appeal process because your physician can more easily explain the reason why you need the service in question.

When the HMO denies payment for services, the plan must send you a noncertification letter explaining why the requested services or procedures were denied. The notice must include the underlying clinical reasons for the noncertification as well as instructions on how to appeal the HMO's decision. Ask the HMO to give you a copy of the reasons it used in making the decision. This will provide you with a more complete explanation for why the requested treatment, procedure or admission was denied.

If the HMO denies coverage, you may first want to try to resolve the problem informally. Most HMOs have an informal review process, where you or your physician can call the HMO to see if the problem can be worked out. This process is voluntary. You do not need to seek an informal resolution of the problem before filing a formal appeal, and you can stop the informal process at anytime and file a formal appeal. However, you may be able to resolve the problem more quickly if your physician calls the HMO and explains the need for the requested services.

If you can not resolve the dispute informally, you can file a formal appeal. You can file an appeal on your own behalf. In addition, a physician or another person acting on your behalf can file an appeal. Usually, the appeal must be in writing. Some HMOs have time limits for filing the initial appeal. Your Evidence of Coverage will describe the HMO's appeal and grievance procedures, including any time limits for filing appeals and where the appeal should be sent. The appeal letter need not be very detailed (*See Sample Appeal Letter*).

All HMOs must offer at least two levels of appeals. A physician who was not involved in the original decision denying your care must hear the first appeal. Normally, the physician has 30 days to decide the appeal but you can request an expedited appeal if your health would be harmed by the 30-day delay. In an expedited appeal, the physician has up to four days to make a decision. You may request that the decision be made immediately if you have a more urgent health care need. If you are still dissatisfied with the HMO's decision after the first review, you can request a second review, called a second-level grievance hearing. You can request a second-level grievance hearing by submitting a letter much like the one you sent for first-level grievances.

Second-level appeals are more structured. You have a right at this hearing to:

- Attend the hearing in person;
- Bring someone else to help you with the hearing, such as a family member or attorney;
- Present your own evidence;
- Request information from the health plan in advance of the hearing;
- Question other people at the hearing.

Sample Appeal Letter

[*Your Name*]
[*Your Address*]
[*Your Phone Number*]
[*Your Member Number*]

[*Date*]

Appeals Coordinator
[*HMO Address*]

Dear Appeals Coordinator:

I am writing to appeal __________ [*HMO name*]'s decision to deny requested health care services. My physician recommended that I obtain the following health care services: ________________ [*describe the services that were recommended*]. The HMO denied those services on __________[*date of denial notice*]. I am writing to request a first-level appeal.

Please send me the clinical review criteria that you used to make your decision to deny the requested services. Also, I would like information about the review process.

[*Add the following if you need an expedited review*]: I am specifically requesting an expedited review. If I do not receive the requested services soon, my health will suffer. _________________ [*Explain why your health may suffer if you go through the normal appeals process*].

If you have any questions, you can contact me or my physician. My physician's name is __________ [*physician's name*], and ______ [he/she] can be reached at: [*telephone number*]. Thank you for your prompt attention to this matter.

Sincerely,

____________ [*Sign Your Name*]

[*Note: You can write a similar appeals letter on someone else's behalf.*]

The HMO will convene a hearing panel to listen to second-level grievances. The panel will usually consist of people who are not employees of the HMO or review organization and who were not previously involved in the decision. If the issue involves a clinical decision, then all of the panelists should be providers who have appropriate expertise in your underlying health problem. The review panel has up to 45 days to hold the hearing and up to 15 days thereafter to make a decision. However, you can request an expedited second-level review if your health could be harmed because of any delay.

In most HMOs, you do not have the right to any further reviews after the second level grievance hearing. However, you may still be able to seek help from the Department of Insurance in settling your dispute. The Department of Insurance's Consumer Services Division answers the public's complaints or questions about insurance companies. If you think you have a justified complaint, they may intervene on your behalf.

Advocacy Tips

- Obtain a copy of the clinical review criteria that the HMO used in denying your request for health care services. These are the guidelines the HMO uses in deciding whether a person with your condition should receive certain health care services or treatments. Show these criteria to your provider. Sometimes your provider will have additional information that shows why your health care needs meet the HMO's clinical review guidelines.

- As mentioned earlier, more than half of the appeals that members filed in 1998 were decided on behalf of the patient. Part of the reason for this high success rate is that members or their providers furnished additional medical information supporting their request for treatment.

- It is also important for both you and your provider to keep copies of all correspondence or notes of conversations (with names and dates) you have had with the HMO. For example, if someone in the HMO approved certain services, the HMO may not later deny payment for that care. These notes may come in handy during your appeal.

- Contact the NC Department of Insurance's Consumer Services Division if you still have a problem with your HMO after exhausting your internal appeals.

Can I Sue My Health Plan If I Was Hurt Because They Would Not Cover Care My Physician Recommended?

Most people have limited ability to sue their HMO or other insurance company. This is particularly true if you want to sue the company for the harm caused by its negligence or malpractice in determining the type of care you should receive. You may have more rights if you are seeking reimbursement just for the cost of the services that you thought should be covered.

However, there are some exceptions to this general rule. For example, state employees and Medicaid and Medicare recipients may have the ability to sue their health plan for malpractice. This is a very unsettled area of the law. Currently there are several bills pending in Congress that would give you the right to sue your health plan for malpractice if you are harmed. If you are considering a lawsuit,

it is wise to check with an attorney who specializes in this area of the law.

What If I am Unhappy with My HMO?

You have the right to file a grievance any time you are dissatisfied with your HMO's policies, decisions or actions. For example, you can file a grievance if you are unhappy with the quality of care or the availability of health care services offered by a health plan. You can file a grievance if the HMO or insurance company fails to reimburse you for certain out-of-pocket payments that should have been covered by the plan. However, before filing a formal grievance, you may want to call the health plan or insurance company to see if you can work out the problem informally. You don't need to call the health plan before filing a grievance, but you may be able to get your problem solved quicker by calling the HMO first.

If you file a formal grievance, you have the right to two levels of review: These are first- and second-level grievance hearings. You, someone acting on your behalf or your physician can file a grievance on your own behalf. The HMO must provide you with information about the grievance process within three business days after receiving notice of the complaint. The person who reviews the grievance may not be the same person who initially handled the matter. If the issue is a clinical one, at least one of the reviewers will be a medical physician with appropriate expertise. The HMO has 30 days to make a decision.

If you are dissatisfied with the HMO's decision, you can request a second-level grievance hearing. 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, 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. This person can be a family member, employer or attorney. However, if the member brings an attorney then an attorney may also represent the HMO.

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 the review organization, who were not previously involved in the decision and who have no financial interest in the outcome of the review. 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 then presented to the HMO. The HMO must provide you with a written notice of the decision, explaining the rationale.

You do not have the right to any further reviews in most HMOs after the second-level grievance hearing. However, you may still be able to seek help from the Department of Insurance in settling your dispute. The Department of Insurance's Consumer Services Division answers public complaints or questions about insurance companies. The Consumer Services Division may intervene on your behalf if they believe you have a justified complaint.

FOR MORE INFORMATION

Federal Resources

US Department of Labor
ERISA Questions
Pension and Welfare Benefits Administration
US Department of Labor
Sam Nunn Federal Center
61 Forsyth St., SW
Suite 7B54
Atlanta, GA 30303
404-562-2156
http://www.dol.gov/dol/pwba/

US Department of Health and Human Services
http://www.dhhs.gov

Health Care Financing Administration
http://www.hcfa.gov

Medicare
http://www.medicare.gov

Medicaid
http://www.hcfa.gov/Medicaid/

Child Health Insurance Programs
http://www.hcfa.gov/init/children.htm

State Resources

NC Department of Insurance
Market Practice Examination Reports
Guide to Appeals and Grievances, Your Rights as a Health Insurance Customer
Managed Care Plan Handbook: A Comparison Guide for North Carolina Consumers
HMO Performance Report: A Comparison of Health Maintenance Organizations in North Carolina
1-800-443-9354 (for information from SHIIP)
1-800-546-5664 (for all other publications)
http://www.ncdoi.com

NC Department of Insurance Consumer Services Division
HMO Complaints
1-800-662-7777

NC Division of Medical Assistance
Medicaid
1985 Umstead Dr.
PO Box 29529
Raleigh, NC 27626-0529
919-857-4011 (phone)
919-733-6608 (fax)
http://www.dhhs.state.nc.us/dma/

CARELINE
Information and referrals about state-funded NC DHHS programs (Medicaid, NC Health Check or NC Health Choice)
1-800-662-7030

NC Health Choice
NC's Child Health Insurance Program, insurance coverage for children in families below 200% of federal poverty guidelines
http://www.dhhs.state.nc.us/dma/cpcont.htm

NC Family Health Resource Line
Information about NC Health Choice and NC Health Check (Medicaid coverage for children under the age of 21)
1-800-367-2229

Children with Special Needs
Information on Health Choice services for children with special needs.
1-800-737-3028

State Employees Health Plan
1-800-422-4658
http://statehealthplan.state.nc.us

NC Board of Medical Examiners
Disciplinary actions or restrictions on physicians practicing in NC
919-326-1100
http://www.docboard.org

Managed Care Resources

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
Hospital and managed care accreditation
http://www.jcaho.org

National Committee for Quality Assurance (NCQA)
Managed care accreditation
http://www.ncqa.org

Aetna US Healthcare
http://www.aetnaushc.com

Blue Cross Blue Shield of North Carolina
http://www.bcbsnc.com

Cigna HealthCare of North Carolina
http://www.cigna.com

Doctors Health Plan
http://www.dhpcares.com

Generations
http://www.fammplan.com

Optimum Choice/MAMSI
http://www.mamsi.com

Partners National Health Plan of North Carolina
http://www.partnershealth.com

Principal (web site for parent company)
http://www.chcc.cuty.com

Prudential Health Care
http://www.aetnaushc.com/pruhealthcare/

Qualchoice
http://www.qualchoicenc.com

The Wellness Plan
http://www.twpnc.com

United HealthCare of North Carolina
http://www.uhc.com/northcarolina

Wellpath
http://www.wellpathchp.com

Other Resources

Public Citizen Health Resource Group
Records of physicians who have received disciplinary action by a state Board of Medical Examiners
Washington, DC
202-588-1000

GLOSSARY

Accreditation: A quality review process by an outside agency that looks at how well an organization provides services to its members and works to continuously improve those services. The National Committee for Quality Assurance (NCQA) conducts many of the reviews of HMOs. In order for hospitals and other health care facilities to be accredited they must go through a separate review process, often conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Accreditation can be distinguished from state licensure, as accreditation is a voluntary process. Further, the accrediting bodies lack the enforcement mechanisms needed to ensure that the plans provide the required quality of, and access to, care.

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).

Annual Limits: The maximum amount of money that the insurer or HMO will pay for a member's health care services in a given year. The insurer can have an annual limit for all health care services, or may have separate annual limits for specific services (for example, prescription drugs or durable medical equipment). Some insurers also have lifetime limits, which is the maximum amount of money the insurer or HMO will pay during the lifetime of a particular member.

Appeal: A request by a member to an HMO to review a noncertification 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).

Case Management: A coordinated set of activities to manage the health care services provided to patients with serious, complicated or prolonged health conditions. NCGS 58-50-61(a)(17)(b).

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).

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.

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.

Discharge Planning: The process used to determine how a patient's ongoing health care needs will be coordinated and managed after being discharged from a hospital or other health care facility. NCGS 58-50-61(a)(17)(e).

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 insurance carriers or HMOs. 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 health plan'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 noncertification decision. NCGS 58-50-61(a)(6).

Health Insurance Portability and Accountability Act (HIPAA): Passed by Congress in 1996, it established minimum standards for access, portability and renewability of coverage for all health plans, including self-funded or ERISA plans. Most of the protections apply to large and small group purchasers and certain individuals leaving or changing group coverage. Provisions of the bill include guaranteed issue, guaranteed renewability, limits on preexisting condition waiting periods, nondiscrimination based on health status, portability and special enrollment periods.29 USC §§ 1001-1461.

Independent Practice Association (IPA) Physician Network: A legal entity comprised of independent physicians that contracts with HMOs for the physicians in the association. Physicians in the IPA retain their independence, ability to contract individually with other organizations and work out of their own offices. By forming an IPA, these independent physicians gain leverage for negotiating contracts and attain administrative economies of scale, thus reducing costs. Also referred to as Independent Physician Associations or Independent Provider Associations.

Lifetime Limits: The maximum amount of money that the insurer or HMO will pay for care over the member's lifetime. The insurer can have a lifetime limit for all health care services, or may have separate lifetime limits for specific services. Some insurers also have annual limits, which is the maximum amount of money the insurer or HMO will pay for the member during a particular year.

Medicaid: A governmental health insurance program that provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population.

Medicare: The national health insurance program provided primarily to older adults (65 or older) and some disabled people who are eligible for Social Security benefits. Medicare has three parts: Part A, which is hospital insurance, Part B, which covers the costs of physicians and other providers, and Part C (Medicare Plus Choice), which expands the availability of managed care arrangements for Medicare recipients.

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).

Open-Access Plan: An HMO that allows members to see any provider within the network without a referral from a primary care provider (PCP). Open-access plans are distinguished from gatekeeper plans, which usually require a PCP to authorize all visits to specialists

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, prior approval, pre-authorization.

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).

Rider: A health insurance or HMO policy that supplements regular coverage. For example, some insurers exclude prescription drugs or mental health coverage. These services are not included in the comprehensive policy but may be purchased separately through a rider.

Second Opinion: An examination by a second physician or health provider before obtaining treatment. Second opinions allow patients to compare the recommendation of the second provider with the recommendation of the first provider. Second opinions are more common if the patient has complex medical conditions, the diagnosis is not clear, multiple treatment options exist, or a treatment or therapy is expensive.

Self-Insured or Self-Funded Plans: Health plans in which the employer is actually the insurer and is responsible for paying the medical bills of those insured through the plan. Even though the employer may contract with an HMO, insurer or other third-party administrator to administer the coverage and pay the claims, the employer retains responsibility for paying all the medical claims. These plans are governed by federal ERISA laws rather than state insurance regulations, and are sometimes called ERISA plans.

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.

Third-Party Administrator: Company hired to handle only the non-clinical aspects of a health plan's business, such as billing, collecting premiums and paying physicians.

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).

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

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