

COMPARING TEXAS HMOs 2006

HEALTH PLAN QUALITY
FROM THE
CONSUMER'S POINT OF VIEW



All Regions Included:

Central Texas

East Texas

Gulf Coast Texas

North Texas

Panhandle/Plains Texas

South Texas

West Texas



Prepared by the

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About the report . . .

The **Office of Public Insurance Counsel (OPIC)**

is a state agency, which represents consumers as a class in insurance matters.

The 75th Texas Legislature directed OPIC to issue annual reports comparing HMOs in the state of Texas.

This report reflects the experience of Texans in Health Maintenance Organizations (HMOs) during 2005. The first section of the report illustrates the results of the Consumer Assessment of Health Plans Study, Version 3.0H (CAHPS™ 3.0H). The responses of HMO members are broken down by service area and are compiled to reflect the experience of consumers in each of the following seven regions: Central Texas, East Texas, Gulf Coast Texas, North Texas, Panhandle/Plains Texas, South Texas, and West Texas. The sections following the survey results contain complaint data, market share, and other statewide information collected by the Texas Department of Insurance. The report concludes with additional sources for information and assistance.

The survey results published in the report reflect only answers given by enrollees in an HMO group plan. Medicaid and Medicare enrollees were not surveyed as part of the CAHPS 3.0H™. However, Medicaid information is readily available from the Texas Health and Human Services Commission (HHSC). Medicare information may be obtained from the Centers for Medicare and Medicaid Services (CMS). Refer to pages 115-116. ERISA plans are also excluded. See page 116 for more information on ERISA plans.

Who did the survey?

The CAHPS™ 3.0H survey was performed by independent survey vendors certified by the National Committee for Quality Assurance (NCQA); a not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans.

The survey comprises the consumer satisfaction measure for the Health Plan Employer Data and Information Set (HEDIS®) that Texas HMOs are required to submit annually to the State of Texas.

Who was surveyed?

The CAHPS™ 3.0H survey was compiled from answers from more than 11,000 adults enrolled in 32 health plans across the state of Texas and who had been enrolled in their plan continuously for the 12-month period from January 1, 2005 to December 31, 2005. Those surveyed answered only questions pertaining to health care services they had actually received during the 12 months immediately preceding the survey.

How was the survey done?

The survey was administered primarily by mail, with a telephone follow-up to those not responding to the mailed questionnaire. The survey was voluntary and confidential.

The survey asked HMO members questions about their experiences with their health plans and medical care, such as:

- Were claims handled quickly and correctly?
- Did they get the care they needed?
- Could they get appointments quickly when they needed them?
- Could they get information they needed from the health plan?

What was the response rate?

The average response rate for the survey was 32%. Of the 35,186 plan members selected and eligible to participate in the survey, 19,883 completed the survey by mail, 14,921 by phone and 382 online. Refer to each region for a list of response rates by plan.

How this booklet can help you

This booklet gives you information about health plan quality from the point of view of people who were enrolled in the plans during 2005.

This booklet can help you choose a health plan by showing you how the plans in Texas compare on some important quality topics. Although this report compares plans, it does not tell you which one to choose. You should pick a plan based on what is most important to you and your family.

Why does health plan quality matter?

When you pick an HMO, you are also picking the doctors, hospitals, and other providers you can use. You are also choosing plan administrators, who review and approve or disapprove doctor-recommended care, and provide financial incentives to doctors based on the amount or type of care provided. That is why it is important to consider consumer ratings of health plan quality along with costs and covered services.

For a short description of health maintenance organizations and how to get additional information, see pages 4 and 114-116.

What to consider when choosing an HMO

- *Which are available where you live or work?*
Review the HMO's membership information, or call the customer service departments (see page 113).
- *Which offer the benefits you want or need?*
Review benefit information from your employer or the HMOs. If you use specific medication, check to see if it is covered. You may need to call the plans to get all your questions answered.
- *Which can you afford?*
Review cost information from your employer or the HMOs, including out-of-pocket costs.
- *Which include your preferred doctor, provider and hospital?*
If it is important to you or someone in your family to use a specific doctor or hospital, find out if they are in the networks of the health plans that you are considering. Review the HMO's physician directories and membership information, or call the customer service departments.
- *Which performed well on the consumer ratings of health plan quality in this booklet?*
Review information from the consumer satisfaction survey section of this booklet.

Health Plan (write in name)	Available near work or home	Offers benefits you want	Can afford	Preferred doctor in network	Performed well in consumer ratings	Other important considerations

What are your legal rights?

Texas has some of the most comprehensive patient protection laws in the nation.

HMOs are required to provide you information you request about the terms and conditions of the health plan including:

- ***covered services,***
- ***exclusions and limitations,***
- ***prior authorization requirements,***
- ***continuity of treatment,***
- ***complaint resolution, and***
- ***the HMO's toll-free telephone number.***

This information can be vitally important in helping you decide whether or not to enroll in an HMO.

Upon request the HMO also must tell you whether a specific drug is on the HMO's list of approved prescription drugs (formulary) within 3 business days of your request.

Some other rights covered by Texas law are:

- Access to specialist care – in and out of the network
- Access to prescription drugs – formulary, non-formulary, and off-label uses
- Access to regular physical examinations
- Payment for emergency care, including care at out-of-network hospitals
- Continuity of care when your doctor leaves the network
- Complaints, appeals, and independent review of adverse determinations
- Prohibiting network providers from billing patients for covered services if the HMO fails pay
- Prohibiting financial rewards to doctors for withholding necessary care
- Allowing members to change primary care physicians at least four times per year
- Legal action against a non-ERISA HMO plan for harm caused by its treatment decisions
- Prohibiting contractual limitations on treatment options doctors can discuss with patients
- Covered health care services available within a certain mileage

The Texas Department of Insurance publishes a brochure describing your rights entitled Health Maintenance Organizations. Access this document on TDI's web site at www.tdi.state.tx.us/consumer/cb069.html or call 1-800-252-3439 to request a copy.

Types of health plans...

	HMO <i>Health Maintenance Organization</i>	PPO <i>Preferred Provider Organization</i>	HMO/POS <i>Health Maintenance Organization with Point of Service Option</i>	Traditional Insurance <i>Fee-for-Service</i>
Type of Network	<u>Closed Network</u> You must use doctors, hospitals and specialists who are members of the HMO's network except in an emergency.	<u>Open Network</u> You may use doctors, hospitals, and specialists who are members of the PPO's network or go outside the network.	<u>Open Network</u> You may use doctors, hospitals, and specialists who are members of the HMO's network or go outside the network.	<u>No Network</u> You may use any doctor, hospital, or specialist you choose.
Limitations on your choice of doctors	HMO plans typically require that you choose a primary care physician (PCP) from the HMO's network. Before seeing other doctors on the network, such as specialists, you must get a referral from your PCP. However, HMOs must allow women to choose and see a network gynecologist without a referral. The law also allows direct access to specialists in other situations. <i>See page 4 for more information.</i> Some HMOs, called open access HMOs, allow you to go to any doctor on the network without a referral.	Most PPOs allow you to go to any doctor on the network without a referral. Some PPOs require you to choose a PCP and get a referral from that doctor before seeing other doctors on the PPO's network. This requirement, if applicable, does not affect your ability to go to doctors outside the network.	Generally, you are required to choose a PCP and get a referral from that doctor before seeing other doctors on the HMO's network. This requirement does not affect your ability to go to doctors outside the network.	No limitations.
Incentives to use network doctors	Generally, the HMO will not pay unless you use its doctors (except emergency care). If your employer offers only an HMO, it must include a point of service option. This provision does not apply to small employer plans. <i>See HMO/POS.</i>	The PPO will pay a greater portion of the charge if you use its doctors who are in the network.	The HMO/POS will pay a greater portion of the charge if you use its doctors who are in the network.	Not applicable.
Payment for services	You pay designated copayments for doctor visits, prescription drugs, emergency visits and inpatient hospital stays. Generally you do not pay a deductible (an amount you must pay each year before the health plan begins to pay) or co-insurance (a percentage of the charges). A doctor in the HMO network cannot bill the patient for any balance after the copay is met.	When you use the PPO network, you usually pay copayments similar to an HMO. A PPO may also require you to pay a percentage of the doctor's charge. When you go outside the network, you pay a higher percentage of the charges and a deductible. These charges may be substantially higher than the discounted rates charged by preferred providers or network providers. The PPO bases its percentage on what it considers reasonable, leaving you to pay your percentage share and any balance.	When you use the HMO network, you pay copayments as described under HMO. When you go outside the network, you pay a percentage of the charges and a deductible. The HMO/POS bases its percentage on what is usual and customary, leaving you to pay your percentage share and any balance.	Generally, you pay a deductible and a percentage of the doctor's charge (co-insurance). The insurer bases its percentage on what is usual and customary, leaving you to pay your percentage share and any balance.

