

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 2009. The first section of the report illustrates the results of the Consumer Assessment of Healthcare Providers and Systems, Version 4.0H (CAHPS[®] 4.0H). 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 of information and assistance.

The survey results published in the report reflect only answers given by enrollees in a commercial HMO plan. Medicaid and Medicare enrollees were not surveyed as part of the CAHPS[®] 4.0H. 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 126-128 for Medicare and Medicaid contact information. ERISA plans are also excluded. See page 128 for more information on ERISA plans.

Who did the survey?

The CAHPS[®] 4.0H survey was performed by independent survey vendors. Each vendor was certified by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of health care.

The survey comprises the consumer satisfaction measure for the Healthcare Effectiveness Data and Information Set (HEDIS[®]) that Texas HMOs are required to submit annually to the State of Texas.

Who was surveyed?

The CAHPS[®] 4.0H survey was compiled from answers from more than 7,778 adults enrolled in health plans across the state of Texas who had been enrolled in their plan continuously for the 12-month period from January 1, 2009 to December 31, 2009. 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 33%. Of the 27,337 plan members selected and eligible to participate in the survey, 5,776 completed the survey by mail, 1,854 by phone and 148 online. Refer to each region for a list of response rates by plan.

How can the report help you?

This report gives you information about health plan quality from the point of view of people who were enrolled in the plans during 2009.

This report 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 5 and 124-128.

What to consider when choosing an HMO

- *Which are available where you live or work?*
Review the HMOs' membership information or call the customer service departments (see page 124).

- *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 a family member 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 HMOs' 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.

Choosing an HMO

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?

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

- covered services,
- exclusions and limitations,
- prior authorization requirements,
- continuity of treatment,
- approved prescription drugs,
- 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.

The federal Patient Protection and Affordable Care Act (PPACA) and related *Health Care and Education Reconciliation Act*, enacted by Congress in March 2010, include significant insurance market reforms effective for most group and individual health insurance policies. The following health insurance market reforms apply for plan years that begin on or after September 23, 2010:

- Health plans must provide a required set of preventive services to enrollees, waiving applicable in-network deductibles, co-pays and co-insurance,
- Health plans may not require referrals for in-network pediatrician and OB-GYN care,
- Prior approval requirements for emergency care are prohibited,
- Health plans that offer dependent coverage must allow adult children who lack access to their own employer-sponsored coverage to remain on a parent's plan up to age 26,
- Health plans may not deny coverage or apply pre-existing condition exclusions to coverage for children under age 19,
- Health plans may not impose lifetime dollar limits,
- Rescissions of health insurance coverage are prohibited, and
- Consumers have a right to internal and external appeals of claim and coverage denials.

Texas law also provides the following protections:

- 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 to 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,
- requiring hospitals and doctors to provide an itemized statement of billed services and/or an estimate of charges upon request, and
- the right to request a mediation settlement if an enrollee is balance billed for an out-of-network claim.

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/pubs/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 in 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 certain situations. <i>See page 4 for more information.</i> Some HMOs, called open access HMOs, allow you to go to any doctor in the network without a referral.	Most PPOs allow you to go to any doctor in the network without a referral. Some PPOs require you to choose a PCP and get a referral from that doctor before seeing other doctors in 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 in 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 is usual and customary, 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.

