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About the Report

The Office of Public Insurance Counsel (OPIC) is an independent state agency that advocates on behalf of insurance consumers as a class in the state of Texas. In 1997 the 75th Texas Legislature directed OPIC to issue annual reports comparing HMOs in the state of Texas.

Comparing Texas HMOs 2011 reflects the experience of Texans enrolled in Health Maintenance Organizations (HMOs) during 2010. Section One of the report offers background information on the report, information on consumer rights, and information on types of health plans. Section Two provides the results of the Consumer Assessment of Healthcare Providers and Systems, Version 4.0H (CAHPS[®] 4.0H) by service area: Central Texas, East Texas, Gulf Coast Texas, North Texas, Panhandle/Plains Texas, South Texas, and West Texas. Section Three contains information on HMO complaints, appeals, and independent review organizations. Section Four provides HMO market share data and financial information, HMO customer service contact information, additional sources of health care information, and information on the survey.

About the Survey

The CAHPS[®] 4.0H survey was performed by independent vendors certified by the National Committee for Quality Assurance (NCQA), a private, non-profit organization.

The survey uses the consumer satisfaction measure for the Healthcare Effectiveness Data and Information Set (HEDIS[®]). Texas law requires HMOs to submit HEDIS[®] measures—including consumer satisfaction data—on an annual basis.

The survey data was compiled from answers from 5,629 adults enrolled in commercial health plans across the state of Texas. The surveyors mailed questionnaires to over 22,000 plan members eligible to participate and followed up by telephone with those who did not respond. Participants answered questions about their satisfaction with the health care services they received in the previous twelve months.

The report does not include data for Medicare, Medicaid, or Employee Retirement Income Security Act of 1974 (ERISA) plans. Pages 118-120 contain contact information for these plans.

About HMOs

Health Maintenance Organizations (HMOs) are managed care plans that provide health care services to members through networks of doctors, hospitals, and other health care providers. An HMO member must select a primary care physician who oversees medical care and provides referrals to specialists. HMOs require members to pay a set copayment for covered services within the network. The table on page 5 provides more information on HMOs and compares HMOs to other types of health plans.

How to Use the Report

Choosing an HMO can feel overwhelming. When you select an HMO, you are not only choosing health plan benefits, but also the network of doctors, hospitals, and other providers who deliver your care as well as the administrators who review and approve recommended care. You can obtain information on service area, benefits, cost, and available providers directly from the HMOs. However, consumer satisfaction information can be difficult to find. *Comparing Texas HMOs 2011* provides this information for you.

Choosing an HMO

When you choose an HMO, you will want to make an apples-to-apples comparison of the plans. This section lists a few points of comparison you may want to consider. This is not an exhaustive list, but it is intended to help you break down a complicated decision into smaller pieces. You may use the table below to take notes on the HMOs you consider.

- **Service Area Availability**
HMOs cover specific service areas. Review the HMOs' membership information to find one with a service area close to where you live or work.
- **Benefits**
Individuals utilize different services based on medical conditions, age, and family needs. Review HMO benefit information for coverage of medications or services that you use. You may need to contact the plans to get all your questions answered.

- **Affordability**
Your overall health care costs will include your premiums as well as other out-of-pocket costs like deductibles, copays, and coinsurance. To compare affordability, estimate your annual health care needs and calculate the total cost you would pay with each HMO.
- **Provider Availability**
Some consumers find it important to receive care from specific doctors or hospitals. Review provider directories for information on in-network providers.
- **Consumer Satisfaction**
The survey data in this report provide an aggregate look at consumer satisfaction for members currently enrolled in HMOs. Review the information in this report to find out how current plan enrollees rate the plan quality of the HMOs you are considering.

HMO	Service Area Availability	Benefits	Affordability	Provider Availability	Consumer Satisfaction

What are Your Rights as a Consumer?

An HMO must provide requested information regarding the terms and conditions of the plan including:

- covered services
- exclusions and limitations
- prior authorization requirements
- continuity of treatment
- approved prescription drugs
- complaint resolution
- the HMO's toll-free telephone number

You have the right to certain consumer protections under federal and state law.

Under Federal Law:

- 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 pediatric and OB-GYN care.
- Health plans may not require prior approval for emergency care.
- Health plans that offer dependent coverage must allow adult children who lack access to employer-sponsored coverage the option of remaining 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.
- Health plans may not rescind health insurance coverage.
- Consumers have a right to internal and external appeals of claim and coverage denials.

Under Texas State Law:

- Health plans must provide access to specialist care and prescription drugs.
- Health plans must provide access to regular physical examinations.
- Health plans must provide emergency care, including care at out-of-network hospitals.
- Health plans must provide continuity of care when your doctor leaves the network.
- Health plans must provide a procedure for complaints, appeals, and independent review of adverse determinations.
- Health plans may not provide financial rewards to doctors for withholding necessary care.
- Health plans must allow members to change primary care physicians at least four times per year.
- Health plans may not prohibit doctors from discussing treatment options with patients.
- Health plans must provide covered health care services within a certain distance of a consumer's home.
- Consumers have the right to request a mediation settlement if balance billed for an out-of-network claim.
- Consumers may take legal action against a non-ERISA HMO plan for harm caused by its treatment decisions.
- Providers may not bill patients for covered services if the HMO fails to pay.
- Hospitals and doctors must provide an itemized statement of billed services and/or an estimate of charges upon request.

The Texas Department of Insurance publishes a brochure describing your rights entitled "Health Maintenance Organizations." You may access this document on TDI's website at <http://www.tdi.texas.gov/pubs/consumer/cb069.html> or by calling 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 in-network doctors, hospitals and specialists.	<u>Open Network</u> You may use in-network doctors, hospitals, and specialists or go outside the network.	<u>Open Network</u> You may use in-network doctors, hospitals, and specialists 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 you to choose a primary care physician (PCP) from the HMO's network. With some exceptions, you must obtain a referral from your PCP before seeing other doctors in the network. Some HMOs, called open access HMOs, allow you to go to any doctor in the network without a referral.	Many PPOs permit you to see any doctor in the network without a referral from your PCP. However, some PPOs do require you to choose a PCP and obtain a referral from that doctor before seeing other doctors in the PPO's network. Verify referral requirements with your PPO before making an appointment with a doctor.	Generally, you are required to choose a PCP and obtain a referral from that doctor before making an appointment with other doctors in the network.	No limitations.
Incentives to use network doctors	Except in emergency situations, an HMO will not cover services provided by out-of-network providers. If your employer only offers an HMO health plan option, it must include an HMO/POS option. (This does not apply to small employer plans.)	The PPO will typically reimburse a higher percentage of the cost of your health care services if you use in-network providers.	The HMO/POS will typically reimburse a higher percentage of the cost of your health care services if you use in-network doctors.	Not applicable.
Payment for services	When you access the HMO network, you pay designated copays for doctor visits, prescription drugs, emergency visits and inpatient hospital stays. Generally, you will not be responsible for a deductible (an amount you must pay each year before the health plan begins to cover your health care costs) or co-insurance (a percentage of the charges). An in-network provider cannot bill you for any balance after the copay is met.	When you access the PPO network, you typically pay a copay for covered services. You may pay a percentage of the overall cost of the service as well. When you use an out-of-network provider, you will pay a deductible and a percentage of the charges. The PPO will base its reimbursement percentage on the usual and customary amount—the amount it typically contracts with providers to pay for the service. You will be responsible for your percentage plus any remaining balance charged by the health care provider.	When you access the HMO network, you will be responsible for copays. When you use an out-of-network provider, you will pay a deductible and a percentage of the charges. The reimbursement will be based on the usual and customary amount. You will be responsible for your percentage plus any remaining balance charged by the health care provider.	Fee-for-Service insurance plans partially pay for the medical services you receive. Unlike managed care plans, FFS insurers do not negotiate contract amounts with providers. Instead, the insurer bases its reimbursement percentage on the usual and customary charges for the service. You will be responsible for your percentage plus any remaining balance charged by the health care provider.

