HOW WELL DOES NORTH CAROLINA PROTECT ENROLLEES IN HMOs?

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with support from
The Robert Wood Johnson Foundation
State Initiatives Program
(Grant No. 026181)

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Prepared in collaboration with the
North Carolina Institute of Medicine

April 29, 1997
Chapel Hill, North Carolina

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EXECUTIVE SUMMARY

Introduction

This research is a summary of a larger analysis of the adequacy of North Carolina's consumer protections in the managed care market. Between 1993 and 1995, there was a rapid increase in the number of insured individuals who received their health care through managed care organizations as employers shifted to managed care plans to save costs. By the end of 1995, nearly three-quarters of the insured population in the United States received their medical care from some type of managed care organization. Almost one million North Carolinians were enrolled in full-service HMOs by the end of 1996. Thus, the issue of how well the state of North Carolina protects consumers in managed care is especially relevant. This research was funded in part by a grant from the Robert Wood Johnson Foundation, Reforming States Initiative.

Managed care, including Health Maintenance Organizations, Preferred Provider Organizations (PPOs), and Point-of-Service plans (POS) integrate, to varying degrees, the financing and organization of a health care delivery system. More tightly developed forms of managed care, such as HMOs, are also characterized by the use of primary care gatekeepers to manage patient care, and payment systems which shift part or all of the costs of care to the health care providers (through capitation, withholds or bonuses).

Health maintenance organizations are the focus of this study. The study is limited to the state's oversight of HMOs (and to a lesser extent, POS plans) for a number of reasons: first, HMOs are a radical departure from the traditional fee-for-service indemnity model that characterized most people's health care coverage for the latter part of this century. Individuals no longer have total freedom to choose health care providers. Enrollees can only choose from among the providers listed in the provider network; and access to specialists is further limited. Second, HMOs shift the risk of caring the patient onto the providers through capitation, withholds or bonuses--which may provide an incentive to providers to withhold necessary care. Thus, the risk to consumers may be greater within an HMO system than within PPOs or other forms of managed care. Third, the state collects more information about HMOs than about traditional managed indemnity plans or PPOs. PPOs, for example, only need to be registered with the state whereas HMOs need to be licensed and undergo much more extensive evaluation by the Department of Insurance. Thus, there are more data available to examine the working of HMOs than with other forms of managed care plans.

Health maintenance organizations (HMOs) and other forms of managed care are subject to many different, and often complementary, systems to protect consumers. Consumer protections are typically designed to protect consumers from harm, ensure the efficient operation of the market, or set minimum quality standards. Consumer protection mechanisms exist in both the public and private sectors and include, for example, state and federal regulations, voluntary accreditation organizations, purchasers exerting pressures to extract greater protections and the media acting as a "watchdog." Protections have been implemented

on both a reactive and proactive basis--to both remedy past problems and to prevent future ones from occurring.

Although a variety of mechanisms are needed to adequately protect consumers in managed care, this study focuses on the state's role for three reasons: First, regulation of insurance has historically been left to the state by the federal government. Second, the state has set up an extensive regulatory structure in North Carolina; and has therefore assumed the responsibility of ensuring that consumers are protected from harm. Third, the alternative systems of oversight are not as well developed in North Carolina as in other parts of the nation. Market-based systems to ensure quality, such as voluntary accreditation by the National Committee for Quality Assurance (NCQA), are not prevalent in North Carolina. Only six of the carriers have obtained NCQA accreditation. Eleven of the carriers reported that they collected data for the Health Plan Employer Data Information Set (HEDIS), but only five of the plans submitted the data to NCQA to be released to the public as part of the NCQA *Quality Compass* project. This research, therefore, focuses on state level oversight of HMOs.

HMOs Are Growing Rapidly in North Carolina

North Carolina has experienced an explosion in the growth of HMOs and managed care companies in this state. Between June 1994 and November 1996, the number of licensed full-service HMOs grew from 10 to 23, with several HMOs license applications pending review (Cohen, 1997). As the number of licensed plans increased, so did the number of people enrolled in managed care plans. Enrollment in HMOs grew steadily in the early part of this decade, with annual increases of between 50,000 and 100,000 people. Beginning in about 1994, the HMO enrollment started to escalate, with the largest jump occurring between 1995 and 1996. There were 954,967 people enrolled in HMOs or POS plans by the end of 1996.

Methodology for this Study

This study has four major components: 1) an analysis of North Carolina's current regulatory system to protect consumers; 2) an analysis of the operation of the six largest HMOs in North Carolina to discern whether problems currently exist, including Blue Cross Blue Shield of North Carolina Personal Care Plan line of business, Healthsource North Carolina, Kaiser Foundation Health Plan of North Carolina, PARTNERS National Health Plan, PHP (United HealthCare of North Carolina) and Prudential Health Care Plan; 3) an analysis of how well the state enforces its own laws; and 4) a modified cost-benefit analysis to assess the feasibility of implementing additional consumer safeguards. The study concludes with a set of policy recommendations to enhance consumer protections for managed care enrollees.

Findings

In general, the North Carolina Department of Insurance does a relatively good job enforcing current state HMO laws. However, North Carolina lacks an adequate array of laws to ensure that consumers are fully protected. For example, compared to

other states or model acts proposed by the National Association of Insurance Commissioners, North Carolina has less extensive consumer protections in the areas of access standards, quality assurance systems, complaint and grievance procedures, data collection and information disclosed to the public, provider protections, and consumer participation mechanisms.

The information that is available to consumers about competing plans is relatively sparse. Consumers can obtain financial information about the operation of the plans, but little information about consumer satisfaction, the adequacy of the carrier's process for delivering care, or health care outcomes. Nor does the state require plans to disclose information about financial risk sharing arrangements, drug formularies, treatment of specific conditions, coverage of experimental or investigation procedures, or the clinical review criteria used to review the medical necessity of a particular condition or disease. This information is especially useful for individuals with special health care needs who need to choose from competing health plans. Unlike most other states, North Carolina has no requirements to involve consumers in the governance or operation of the plans. Similarly, North Carolina provides few protections to providers.

The analysis of the six largest HMOs in North Carolina also uncovered several problems. In general, all of the plans covered basic health care services, including physicians' services, hospitalizations, some preventive care and some ancillary services. However, the benefit packages were not all comprehensive. Some of the carriers excluded any mental health coverage (unless purchased separately as a rider), and all of the carriers limited therapy services to conditions which were expected to show significant improvement on a short-term basis. Further, the Certificates of Coverage (the member handbook) which should explain the covered benefits and exclusions were incomplete and often confusing. Plans also used technical language which made some of the descriptions of covered or excluded services unintelligible. Further, the appeals mechanisms were not uniform across plans; several failed to provide adequate due process protections.

Limited information was available about the accessibility of network providers or services, or access to plan personnel. Although carriers are required to establish internal access guidelines, they are not currently required to report this information to the state or how well the carriers are meeting their own performance targets.

The six HMOs appeared to be doing a good job of establishing internal quality assurance and utilization review systems. All of the plans had more extensive systems for monitoring quality than required under state regulation. However, little information was available about the quality of care provided by the plans (structure, process or quality measures). Some of the plans report this information on a voluntary basis to the National Committee for Quality Assurance (NCQA), but the information is not readily available to consumers. Similarly, the plans all had extensive utilization review mechanisms, especially geared at monitoring overutilization and inappropriate use of services. Information on overutilization was used by some of the carriers as grounds for sanctions. If utilization was within plan parameters, plans used this information to pay bonuses.

Only four of the six plans reported that they examined potential underuse of services. However, none of the plans reported that they looked at inappropriate underutilization of services in the provider evaluation process or to trigger provider sanctions.

The state collected extensive financial information from plans, as well as some enrollment and very limited utilization data. The usefulness of financial data was limited since two of the plans were not required to submit the same information as other carriers. The enrollment data was useful, and helped provide information about the growth and stability of the plans. However, disenrollment data, which could highlight potential quality of care or access problems, was not required to be reported. Information about consumer complaints, grievances filed against the plans, and malpractice claims could potentially provide useful information about the quality of a plan. However, the usefulness of this data was limited because the required reports were not collected, or the state failed to collect detailed enough information to be able to discern the nature of the underlying problems.

Overall, the Department of Insurance appeared to be doing a good job ensuring that the HMO follows applicable state laws and regulations, but specific improvements are needed: the member materials were not always complete or understandable; the Department failed to track problems over time; the Department did a more thorough job monitoring network adequacy and accessibility in the past; and the Department did not follow up with the carriers that failed to submit some of the required reports to the state. In addition, the Department did not consistently include information in the Market Practices and Market Compliance Examination reports which could be particularly useful to consumers, such as the number or nature of the internal consumer complaints filed with carriers, or the plan's compliance with its own accessibility standards. There was also some indication that the Department lacked the staff needed to properly monitor the growing managed care industry in the state. The Department of Insurance faces another problem which lessens its ability to enforce state laws and regulations. While North Carolina has many of the same regulatory enforcement mechanisms included in other states, most of the HMO enforcement mechanisms are limited to egregious violations of the law.

Recommendations:

The policy recommendations emerging from this analysis generally fall into seven broad areas: improving access, ensuring basic due process rights, expanding the service package, ensuring quality, requiring additional disclosures, involving enrollees in the policy and operational oversight of the plans, and ensuring the adequacy of the Department's oversight capabilities. Some of these recommendations are aimed at correcting specific problems identified during the research. In other areas, such as accessibility of services or providers, the data were so sparse that little information was available about the extent to which current practices adversely affect consumers. The recommendations in these areas are more proactive, and are designed to reduce the risk of harm to consumers.

Ensuring Reasonable Access to Providers:

1. The state should require carriers to report their internal access targets and how well the carriers are meeting these goals to the Department on an annual basis. The state should expand its access targets to include additional NAIC requirements. In addition, carriers should be required to report on how well they meet access standards by service area, not the state as a whole.

2. The access plan and performance report should be made available to purchasers (employers and prospective enrollees), who could then be able to use the information in choosing health plans.

3. All plans should be required to provide purchasers, prospective enrollees, and current enrollees a directory of participating providers who are *currently accepting* new members.

4. Carriers should be required to provide enrollees at least three choices of primary care providers and two choices of specialists within an appropriate travel and time distance (to be determined by the Department of Insurance in consultation with the N.C. Office of Rural Health and Resource Development).

5. OB/GYNs should be allowed as primary care providers.

6. Plans that do not have sufficient contracting providers able to meet the needs of the members should be required to pay for care provided outside the network (as well as reasonable travel costs).

7. The Department of Insurance should be directed to study the referral and gatekeeper arrangements that carriers use to care for the chronically ill and those with complex medical needs; and should be given the authority to adopt regulations to address this issue if additional protections are needed.

8. All plans should be required to continue coverage of services at the contract price for a minimum of 120 calendar days (or through post-partum care) in cases in which it is medically necessary for the enrollee to continue care with the terminated provider. Plans should be required to establish similar arrangements for new enrollees.

Ensuring Basic Due Process Rights

1. The state should establish minimum due process requirements which all carriers must follow. Basic due process includes a) notification of the appeals mechanism in all member handbooks and Certificates of Coverage, as well as all notices of adverse action; b) the consumer, his or her representative or the provider may file an appeal on the enrollees behalf; c) appropriate time limits to ensure prompt resolution of appeals; d) expedited appeals process; e) notice of adverse determinations that include the principle reasons for the determination, the clinical review criteria used to make the determination and a description of

the appeals mechanism; f) review by appropriate personnel not involved in the previous determinations and with no financial conflict of interest; for medical issues reviews should be conducted by clinical peers--health professionals who have the same or similar specialty as the medical issue being contested; g) right to appear at the hearing during at least one level of review; h) continuation of benefits when continued stay in a hospital is being challenged; i) at least two levels of review; and j) notice of the right to contact the Commissioner's office for assistance in every notice.

2. The state should also consider implementing an Ombuds program to help enrollees mediate the system and resolve complaints.

Expanding the Service Package Offered to HMOs

1. Full coverage of mental health and substance abuse services in parity with other medical services should be required.

2. Carriers should also be required to cover services rendered in an emergency room if the enrollee had a reasonable belief that an emergency existed (prudent layperson standard).

3. The Department of Insurance should be directed to assess the need and the potential costs in expanding therapy services to cover habilitative as well as rehabilitative care.

Ensuring Adequate Quality

1. The state should require carriers to enhance their quality assurance systems and follow the provisions in the NAIC Quality Assurance Model Act. In addition, the state should require carriers to report on sentinel events and adverse patient outcomes, malpractice suits, disenrollment data, complaints filed with the plan, and the utilization review and appeals activity reports.

2. Carriers should be required to report all licensed providers who show a persistent pattern of inferior care to appropriate licensing agencies. A similar law already applies to physicians, but not to other licensed providers. Without this requirement, plans may sanction or terminate providers who have shown a persistent pattern of inferior care, leaving the practitioner free to continue treating other patients.

3. The state should have the authority to require carriers to undergo an external quality assessment if sufficient quality of care concerns are raised.

4. Carriers should be required to coordinate and communicate with public health agencies (and visa versa). Given the transitory nature of enrolled populations, carriers stand as much to gain by helping improve the health status of the community as it does investing in clinical health promotion and disease prevention activities which are unlikely to yield positive results until years down

the road.

5. The state should amend its current anti-gag clause provision to provide greater protections for providers who appeal on a patient's behalf, provide information about financial incentives to their patients, help patients choose from competing health plans, or those who file complaints with regulatory or accreditation bodies. In addition, North Carolina should ensure that all carriers have an appeals mechanism for providers who have had their practice privileges in the plan reduced, suspended or terminated.

Enhanced Disclosure Requirements to Improve the Operation of the Market

1. Carriers should be required to report generic physician compensation information, including the number and percentage of physicians paid salary, fee for service, or capitation; the range of withholds and bonuses; and the services included under capitation to ensure that providers are not subject to excessive financial incentives to withhold needed care. Individual providers should also be allowed to disclose individual financial incentives to their individual patients without fear of being sanctioned.

2. Health plans should be required to submit HEDIS data to the state (as many carriers are already collecting this information, little additional work should be required in submitting the information to the state). The Department of Insurance should require carriers to independently audit the data if the state has reason to suspect its reliability. The state should also be given the authority to require carriers to submit different or additional data if there is a particular state health issue that needs to be monitored. In addition, health plans should be required to submit a record of the number and types of complaints filed inside the plan, and to submit their annual utilization review and appeal activity reports.

3. Carriers should also be required to provide prospective enrollees, upon request, information about their drug formularies, treatment protocols for specific cases, treatments or procedures considered experimental and underlying utilization review criteria. In addition, plans should be required to give prospective enrollees copies of the Evidence of Coverage, which contains more detailed information about the benefits included and excluded.

4. Carriers should also be required to minimize the use of medical language and test whole documents for readability.

5. The Department of Insurance or an independent nonprofit agency should be required to develop an annual consumer guide for health plan selection that compares different features of competing health plans.

6. Current law does not provide sufficient protection to prevent risk-segmentation practices by health carriers. The law should be changed to prevent carriers from discriminating against certain providers in their network development who are likely to treat high-risk patients.

7. The Department's authority to review marketing materials should also be expanded to allow the Department to require a health carrier to change its marketing strategy if the marketing materials, *taken as a whole*, suggest efforts to segment the risk to attract only healthy enrollees.

Involve Enrollees More Directly in Policy and Operational Oversight of Plans

1. Require plans to establish separate mechanisms so that consumers can give input into policy matters.

2. The state should also establish a Managed Care Policy Board, including consumers, providers, purchasers, carriers and health service researchers and public health representatives. The Board would funnel problems and suggestions to the Department of Insurance, help the Department develop an annual guide comparing different health plans, recommend what, if any, additional information should be collected, and suggest changes in the Department's regulations and oversight procedures.

Ensure the Adequacy of the Department of Insurance's Oversight Capabilities

1. Standardize market conduct examinations. Ensure that the Department provides consistent information about the plans, including how well the plans meet internal access standards, complaint rates and reasons for the underlying complaints, adverse patient outcomes and what steps the plan has taken to correct the problems. The Department should also track problems over time.

2. Collect more detailed information about the number and nature of complaints filed with the Department of Insurance.

3. Require carriers to submit comparable data including financial information, utilization review and appeals activity reports, and utilization data. Monitor plans to ensure data is submitted.

4. Enhance the Department's enforcement powers to ensure that it has sufficient authority to require plans to correct all types of problems.

5. Allow the Department to deem compliance with certain licensing requirements if the plan is accredited by an independent agency that has the same or higher standards (as determined by the Department).

6. Hire additional staff to ensure that the Department can meet its oversight responsibilities.

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INTRODUCTION

The research examines the adequacy of North Carolina's consumer protections[1] in the managed care market. In 1996, nearly three quarters of the insured population in the United States received their medical care from some type of managed care organization. By the end of 1996, almost one million North Carolinians were enrolled in full-service HMOs. The recent growth in managed care has begun to raise greater concerns among both providers and consumers in North Carolina. According to press reports, the largest single issue aired at a public hearing before the N.C. Health Care Reform Commission held in the summer of 1996 "was dissatisfaction with fast-growing managed care companies" (Clabby, 1996). Thus, the issue of how well the state of North Carolina protects consumers in managed care is especially relevant today. This research was funded in part by a grant from the Robert Wood Johnson Foundation, Emerging States Initiative.

Managed care, including Health Maintenance Organizations,[2] Preferred Provider Organizations (PPOs),[3] and Point-of-Service plans (POS)[4] integrate, to varying degrees, the financing and organization of a health care delivery system. More tightly developed forms of managed care, such as HMOs, are also characterized by the use of primary care gatekeepers to manage the patients care, and payment systems which shift part or all of the costs of care to the health care providers (through capitation, withholds or bonuses).

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[1] Consumer protection laws serve many functions (Lehman, 1997). Certain laws, for example, are enacted to protect consumers from harm, including the laws governing product or drug safety. Other laws are enacted to ensure the efficient operation of the market and to prevent sellers from exercising undue influence over buyers. Antitrust laws, which prohibit businesses from engaging in price fixing, boycotts or other tactics which injure competition, are examples of laws enacted to ensure the efficient operation of the market. In addition, unfair trade practices laws help balance the power between the buyers and sellers of goods by preventing sellers from engaging in unethical, fraudulent or misleading behaviors. Other consumer protections have been enacted to ensure minimum quality of care. Professional licensing laws, such as those governing physicians and lawyers, establish minimum standards to ensure the competency of the practitioners. These laws do more than just protect consumers from harm; they also provide a level of quality by ensuring that the practitioners have a basic understanding of their profession. Further, the government need not wait until harm has occurred to enact consumer protections. Laws are passed to both remedy past problems and to prevent future ones from occurring.

[2] Health maintenance organizations organize the financing and delivery of health care services. HMOs typically have exclusive provider networks and will not pay for services obtained outside the authorized network of providers. The primary care provider usually acts as a "gatekeeper" who is responsible for authorizing treatment by specialists, for ancillary care, or for non-emergency hospitalizations.

[3] Preferred provider organizations are typically found within a traditional insurance plans (i.e., comprehensive major medical insurance plans which pay a fixed percentage of the health care costs). PPO plans manage medical costs by contracting with cost-efficient providers. Patients can choose any health care provider, but will have to pay more out of pocket if the enrollees uses a provider who is not part of the PPO network.

[4] Point-of-Service plans are generally HMOs that give the patient a choice of providers. Patients who use the HMO network of providers pay less than patients who see providers outside the network. In other states, POS plans often require gatekeepers to authorize use of providers outside the network in order for the services to be covered; but in North Carolina, POS products must give the enrollees the option of choosing in or out-of-plan covered services each time services are obtained. [11 NCAC 12.1403]

Because of the rapidly rising health care costs which were endemic to the late 1980s and early 1990s, many businesses turned to managed care organizations to reduce costs. HMOs have been shown to be successful in reducing health care costs, especially among large employers (Freudenheim, 1996a; Winslow, 1996). While it is still open to debate as to whether these savings represent one-time savings due to the shift from indemnity plans to other forms of managed care (Levit, 1996), businesses have nonetheless jumped onto the HMO/managed care bandwagon. As of 1996, approximately 28% of U.S. workers are enrolled in HMOs, another 20% are enrolled in point-of-service plans, and 25% are enrolled in PPOs (Jensen, 1997). The total number of Americans enrolled in HMOs, for example, has increased from 36.5 million in 1990 (Carlson, 1996) to approximately 58 million in 1996 (Freudenheim, 1996b). Enrollment in PPOs and other less tightly controlled forms of managed care has grown to approximately 81 million (Freudenheim, 1996b).

HMOs generally provide more preventive tests and health promotion activities than traditional indemnity plans; reduce hospital admission rates and length of stays; use fewer expensive procedures, tests or treatments; and provided roughly comparable quality of care for a wide range of conditions, diseases or interventions (Zelman, 1997; Miller, 1994; Trends in Health Insurance, 1994). Further, HMOs and other forms of network based care offers the potential of greater coordination of care through the use of gatekeepers (Franks, 1992), and reduced financial barriers by cutting copayments and deductibles (Rodwin, 1996). Despite these generally positive findings, concerns about the quality of care provided in HMOs and other forms of managed care remains.

The HMO industry, which has its roots in the non-profit prepaid health care plans of Kaiser and Group Health of Puget Sound, has largely been converted to a for-profit industry. In 1982, for example, 18% of HMOs were proprietary (Carlson, 1996). By 1996, 69%, or 398 of 574 HMOs around the country were for-profit organizations. The increased emphasis on cost-containment, coupled with the transformation of the managed care industry from a largely non-profit industry into one controlled by billion-dollar corporate giants, raises a concern that the managed care industry will turn from an industry focused on managing health care services to one focused primarily on reducing health care costs.

Observers argue that the payment methodology employed by many HMOs, which shifts the risk of caring for patients onto the provider, gives providers a financial incentive to withhold necessary care (Hillman, 1987; Kassirer, 1995; Council on Ethical and Judicial Affairs, 1995). Managed care also restricts patients' choice of providers, which reduces their ability to "vote with their feet" if they have concerns about the quality of care being delivered (Rodwin, 1996). Other potential problems with managed care include institutional bureaucracy, which may hinder a large organization's ability to respond to consumer needs, and the potential conflict in managed care where the needs of the patient may be pitted against the needs of the organization or the shareholders' desire to make a profit.

Health maintenance organizations (HMOs) and other forms of managed care are subject to many different, and often complementary, systems to protect consumers. These systems are part of both the public and private sectors. The state,

for example, protects consumers through a vast array of laws and regulations and enforces these laws through reporting requirements, complaint investigations and periodic inspections. The federal government plays a role in protecting enrollees in managed care, especially those enrolled in Medicaid or Medicare HMOs by establishing minimum quality and accessibility standards. The private sector also has a role to play in protecting consumers through such measures as individual appeal and grievance systems, voluntary accreditation systems, and media scrutiny. Competition among carriers sometimes leads to enhanced consumer protections. Large purchasers of care have the purchasing power to demand higher quality standards or enhanced services from managed care organizations--beyond those required under state licensure laws.

Although a variety of mechanisms are needed to adequately protect consumers in managed care, this research focuses on the state's role. There are a number of reasons to focus on the state: First, regulation of insurance has historically been left to the state, since the enactment of the McCarran-Ferguson Act in 1945. Second, the state has set up an extensive regulatory structure in North Carolina; and has therefore assumed the responsibility of ensuring that consumers are protected from harm. Third, the alternative systems of oversight are not as well developed in North Carolina as in other parts of the country. Market-based systems to ensure quality, such as voluntary accreditation and performance measurements by the National Committee for Quality Assurance (NCQA),[5] are not very prevalent in North Carolina. Only six of the carriers have obtained NCQA accreditation.[6] Eleven of the carriers reported that they collected data for the Health Plan Employer Data Information Set (HEDIS),[7] but only five of the plans submitted the data to NCQA to be released to the public as part of the NCQA *Quality Compass* project.[8] This research, therefore, focuses on state level oversight of HMOs.

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[5] The National Committee for Quality Assurance is a non-profit organization which assesses and reports on the quality of managed care plans, including HMOs. NCQA was formed in 1979 through a joint effort of the two principal managed care associations: the American Managed Care and Review Association and the Group Health Association of America (which later merged and became the American Association of Health Plans "AAHP") (Iglehart, 1996). NCQA became independent from its trade association connections in 1990, and is now governed by a board of directors which includes employers, consumer and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine. NCQA is principally involved in accreditation of managed care organizations and performance measurement (report cards)(NCQA, 1997).

[6] Kaiser and PruCare received full accreditation, Blue Cross Blue Shield, PCP Line of Business and PCP, Inc (subsidiary of BCBSNC) received a one-year accreditation, Healthsource and Partners received provisional accreditation (NCQA, 1996a). None of the other plans have obtained accreditation from other private accrediting bodies (such as JCAHO).

[7] The most recent HEDIS version (3.0) collects data on eight areas of HMO performance: effectiveness of care, accessibility and availability of care, consumer satisfaction, health plan stability, use of services, costs of care, informed choice, and health plan descriptive information.

[8] Aetna, Blue Cross Blue Shield PCP line of business, Healthsource,, Kaiser, Maxicare, Partners, Personal Care Plan, Inc., United Healthcare (PHP), Principal Health Care, Prudential Health Care, and U.S. Healthcare of the Carolinas reported collecting HEDIS data in a managed care survey conducted by the N.C. Department of Insurance (N.C. Department of Insurance, 1997). However, only five carriers reported the data to NCQA to be included in the *Quality Compass* data released to the public in August 1996 or in February 1997. The first *Quality Compass*, released in August 1996, included 1995 HEDIS 2.5 measures and accreditation information for 226 health plans (NCQA, 1996c, 1997a).

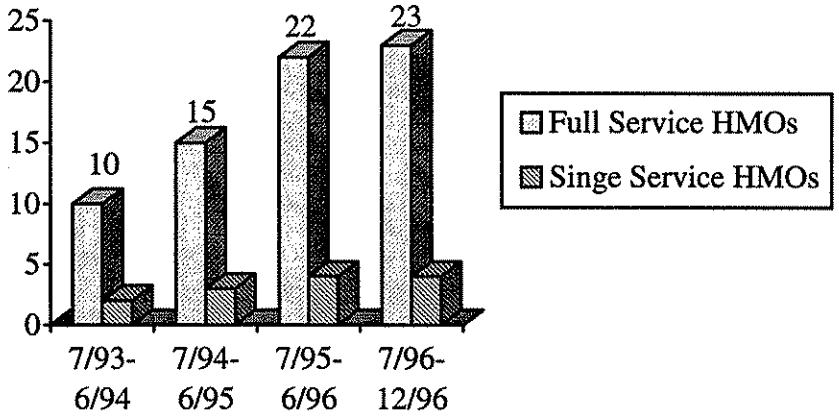
Health maintenance organizations are the focus of this study for a number of reasons: first, HMOs are a radical departure from the traditional fee-for-service indemnity model that characterized most people's health care coverage for the latter part of this century. Individuals no longer have total freedom to choose health care providers. Enrollees can only choose from among the providers listed in the provider network; and access to specialists is further limited. Second, HMOs shift the risk of caring for the patient onto the providers through capitation, withholds or bonuses--which may provide an incentive to providers to withhold necessary care. Thus, the risk to consumers may be greater within an HMO system than within PPOs or other forms of managed care. Third, the state collects more information about HMOs than about traditional managed indemnity plans or PPOs. PPOs, for example, only need to be registered with the state whereas HMOs need to be licensed and undergo much more extensive evaluation by the Department of Insurance. Thus, there is more data available to examine the working of HMOs than with other forms of managed care plans.

This research has four major components: 1) an analysis of North Carolina's current regulatory system to protect consumers; 2) an analysis of the operation of the six largest HMOs in North Carolina to discern whether problems currently exist; 3) an analysis of how well the state enforces its own laws; and 4) policy recommendations to address problems identified through the first three analyses.

HMOS ARE GROWING RAPIDLY IN NORTH CAROLINA

North Carolina has experienced an explosion in the growth of HMOs and managed care companies in this state. Between June 1994 and November 1996, the number of licensed full-service HMOs grew from 10 to 23, with several HMOs license applications pending review (Cohen, 1997). In addition to the full service HMOs, there are currently four single service HMOs (primarily covering dental services) licensed in the state.

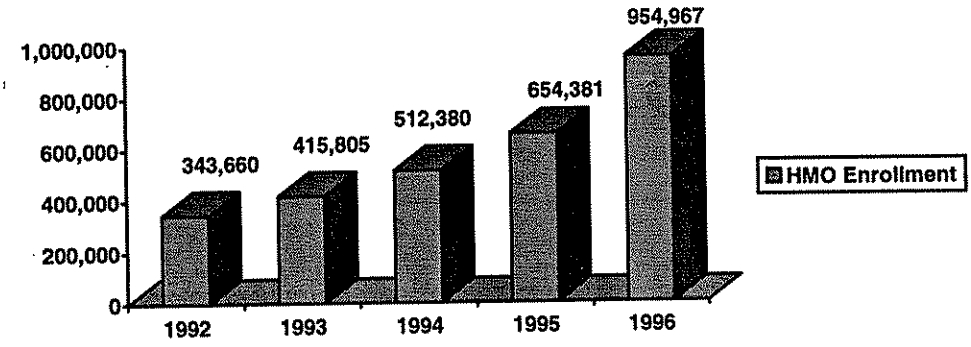
The Numbers of HMOs are Growing in North Carolina



(Cohen, 1997; Burke, 1996b).

As the number of licensed plans increased, so did the number of people enrolled in managed care plans. Enrollment in HMOs grew steadily in the early part of this decade, with annual increases of between 50,000 and 100,000 people. Beginning in about 1994, the HMO enrollment started to escalate, with the largest jump occurring between 1995 and 1996.

Enrollment in Full-Service HMOs has Grown (1992-1996)



(N.C. Department of Insurance, 1997; Cannady, 1997)

The HMO industry in North Carolina is relatively homogenous. With the exception of two HMOs (Blue Cross Blue Shield and Kaiser), all the HMOs in the state are for-profit. Enrollment in the for-profit plans accounted to approximately 63% of the North Carolina market. Five HMOs are mixed group and Independent Practice Association (IPA)[9] models (Aetna, Doctors, Kaiser, PruCare, and Wellpath), all the other plans are pure IPA/network models (N.C. Department of Insurance, 1997).[10] Only one of the plans, United HealthCare (PHP) offers an open access HMO, which permits enrollees to self-refer to any specialist in the network. Otherwise, the plans are all gatekeeper models, which require a primary care provider to authorize treatment by specialists, ancillary services or non-emergency hospitalizations. PruCare is the only company that is not incorporated in North Carolina--all the other HMOs are incorporated in North Carolina (although most of these are subsidiaries of larger national corporations).

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[9] Traditionally, if the HMO is considered an IPA, the HMO contracts with an independent legal entity (the Independent Practice Association) which then contracts with individual providers to provide services either on a capitation or fee-for-service basis (Kongstvedt, 1995). Network model HMOs are health plans that contract with multiple physician groups to deliver care to members. In practice, there is little difference between IPA and network model HMOs, as many of the HMOs in North Carolina that call themselves IPAs contract directly with the providers (N.C. Department of Insurance, 1997). Generally, an HMO's contract with an IPA or network provider is non-exclusive, that is, the physician can contract with multiple HMOs. Staff model HMOs employ the providers directly. Group model HMOs typically have a contract with a major medical group that provides most of the medical care needed by the enrolled population. HMOs usually have exclusive relationships with providers in either the group or staff model HMOs.

[10] PruCare was trying to sell its medical groups to another health care organization, which would turn PruCare into a pure IPA model HMO (Jamieson, 1996f).

Only five of the plans (Kaiser, Maxicare, PARTNERS, PCP, Inc. and PruCare) are also federally-qualified HMOs (N.C. Department of Insurance, 1997), which subject the carriers to heightened consumer protection requirements.[11] Two of the HMOs have been approved to offer Medicare-risk products (PARTNERS and Qual Choice)(N.C. Department of Insurance, 1997; Cueny, 1997), although Blue Cross Blue Shield, Kaiser Healthsource and WellPath are also considering entering the Medicare risk market (Jamieson, 1997). Three companies market managed care plans to the individual market: Kaiser, PARTNERS, and The Wellness Plan (N.C. Department of Insurance, 1997).

COMPARISON OF NORTH CAROLINA LAWS TO OTHER STATES

Methodology:

North Carolina's HMO laws were reviewed and compared to the consumer protections available to individuals who have major medical plans through commercial health insurers or Blue Cross Blue Shield (See Appendix A for comparison of statutory cites). In addition, North Carolina HMO laws were compared to model acts proposed by the National Association of Insurance Commissioners (NAIC) and the Consumer Coalition for Quality Health Care (CCQHC). In addition, North Carolina laws were compared to the managed care laws enacted in other states, the NCQA accreditation and HEDIS 3.0 data collection requirements, and the contractual obligations imposed on the HMOs participating in the Medicaid managed care program currently operating in Mecklenburg County.[12]

The analysis of N.C. laws was broken down into the following areas: marketing and procedural protections, benefits, access standards, quality assurance standards, credentialing standards, utilization review procedures, complaint and grievance systems, provider protections, data collection requirements and methods to provide relevant information to the public, mechanisms for consumer participation, oversight of premium rates, financial solvency requirements, and accountability and enforcement mechanisms.

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[11] To be a federally-qualified HMO, the HMO must meet certain statutory requirements. When the federal HMO Act was passed in 1973, HMOs that met the federal qualifications could qualify for certain grants, loans and contracts, and also had greater access to the large employer market. Most of the benefits of being a federally-qualified HMO have since been repealed.

[12] In general, the NAIC and CCQHC model acts and laws enacted by other states are intended to serve the same purpose as the HMO laws enacted in North Carolina. State licensure laws are often used to establish a floor--standards which must be met before the HMO can operate in a state. Employers and other large purchasers of care can, however, exert their purchasing power to extract additional quality assurances or services. The NCQA accreditation standards and the Medicaid managed care contract provisions are attempts to establish heightened quality and benefit standards. For these reasons, the NAIC model act and the laws enacted in other states are the most appropriate models to use in judging the adequacy of North Carolina's regulatory oversight system. The NCQA accreditation and Medicaid contracts can be used to view the range of consumer protections that are available to the state if it chose to establish higher standards than the minimum requirements usually demanded by state regulators. HEDIS, as a data gathering tool, is somewhat separate from the other models just discussed. HEDIS can be useful to both regulators and purchasers of care.

Findings:

In general, North Carolina's marketing and procedural protections, utilization review, credentialing and financial solvency requirements were similar and in some cases more extensive than those found in other states. In addition, North Carolina's laws contained similar protections to those suggested by the National Association of Insurance Commissioners and the Consumer Coalition for Quality Health Care's Model Legislation. The two major exceptions are that N.C. does not require carriers to cover emergency services when a prudent layperson had a reasonable belief that an emergency existed; and North Carolina does not prohibit plans from discriminating against providers serving high risk populations (recommended in the NAIC and CCQHC model legislation).

North Carolina has less extensive consumer protections in the areas of access standards, quality assurance systems, complaint and grievance procedures, data collection and information disclosed to the public, provider protections, and consumer participation mechanisms. While North Carolina has some laws requiring plans to examine the adequacy and accessibility of their provider networks, in establishing quality assurance systems, and in providing due process protections to enrollees, these laws were generally much less detailed than those found in other states or suggested by the NAIC or CCQHC model acts.

The biggest gaps in consumer protections uncovered during this analysis were in the area of data collection, information available to the public, provider protections and consumer participation mechanisms. The information that is available to consumers about competing plans is relatively sparse (See Appendix B for a comparison of information required to be reported to NCQA as part of the HEDIS (3.0) reporting requirements versus the information required to be submitted to the N.C. Department of Insurance). Consumers can obtain financial information about the operation of the plans, but little information about consumer satisfaction, the adequacy of the carrier's process for delivering care or health care outcomes. Nor does the state require plans to disclose information about financial risk sharing arrangements, drug formularies, treatment of specific conditions, coverage of experimental or investigation procedures or the clinical review criteria used to review the medical necessity of a particular treatment or service. This information is especially useful for individuals with special health care needs who need to choose from competing health plans. Further, North Carolina has no requirements to involve consumers in the governance or operation of the plans. Unlike most other states, North Carolina carriers are not required to give enrollees the opportunity to participate in policy and operational matters. Similarly, North Carolina provides few protections to providers. Provider protections are especially important to enable providers to aggressively advocate for their patients during the appeals process and to ensure that providers are not inappropriately sanctioned for providing patients with high-cost, but medically necessary, health care services.

ANALYSIS OF SIX LARGEST HMOS IN NORTH CAROLINA

Methodology:

This research included an analysis of the operation of the six largest HMOs in North Carolina: Blue Cross Blue Shield of North Carolina Personal Care Plan line of business, Healthsource North Carolina, Kaiser Foundation Health Plan of North Carolina, PARTNERS National Health Plan, PHP (United HealthCare of North Carolina) and Prudential Health Care Plan. These six plans account for 90% of the HMO enrollment in the state. BCBSNC, Healthsource,[13] Kaiser, PARTNERS, PHP (United HealthCare)[14] and PruCare also are among the oldest HMOs operating in the state, each dating back to the early or mid 80s. Blue Cross Blue Shield and Kaiser are non-profits, the remaining HMOs are for-profit. All operate a gatekeeper HMO, although PHP also operates an open-access plan. With the exception of PruCare, all of the HMOs are domiciled in North Carolina, although Healthsource, Kaiser, and PHP are subsidiaries of larger national corporations.

The HMOs' evidence of coverage, provider contracts, plans for quality assurance, utilization management systems, utilization review activity and appeal reports (describing the grievances filed with the plan), financial reports, market conduct examinations and complaints filed with the Department of Insurance were examined. A comparison of selected provisions of the six carriers is attached as Appendix C. The comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the health policy purchased. A more detailed analysis of each of the six plans is available from the author.

This review provides information about the policies and operation of these managed care organizations in order to determine whether additional protections are needed. In addition, reviewing the documents that are required to be filed with the state helps to identify documents which may be helpful to consumers wishing to compare the quality, accessibility and price of competing health plans.

Findings:

In general, all of the plans covered basic health care services, including physicians services, hospitalizations, some preventive care and some ancillary services. However, the benefit packages were not all comprehensive. Some of the carriers limited mental health coverage, and all of the carriers limited therapy services to conditions which were expected to show significant improvement on a short-term basis. Although women could access OB/GYN services directly (without a referral)

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[13] At the time of this publication in 1997, CIGNA was in the process of purchasing Healthsource. However, the organization will be referred to as Healthsource throughout the dissertation since all of the analysis was conducted when these two companies were separate entities.

[14] United HealthCare purchased PHP in 1996. However, most of the documents reviewed were when PHP was still a separate organization. Thus, most of the references in this dissertation cite PHP rather than United HealthCare.

for women's health related needs, OB/GYNs were generally not allowed to act as primary care providers for a full range of primary care services.

The Certificates of Coverage, which should explain the covered benefits and exclusions, were incomplete and often confusing. Several of the plans failed to describe covered preventive services, although they were required to provide these services under state law. Plans also used such technical language as to make the description unintelligible. For example, Healthsource had a provision which excluded:

> "Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column"

(Healthsource, Certificate of Coverage, 1996). Without some health care training, few consumers would understand that Healthsource was limiting chiropractic care or spinal manipulation. In addition, the descriptions of covered and excluded services varied, making comparisons between plans difficult.

Little information was available about the carriers' access standards. Only two of the carriers used extensive travel or distance standards at the time of their last Market Practices Examinations. Information was only available for one of these plans to determine how well the carrier met its internal standards (the carrier was meeting its standards in geographic areas in which it had long-standing operations, but not in its expansion areas). No information was available about how well the other carrier was meeting its time or distance standards. In the area of appointment wait times, information was available about the carrier's internal guidelines for when patients should be seen, but generally not on how well the plan was meeting its internal standards. More information was available about whether consumers could reach the plan by telephone. Most of the carriers were failing to meet their internal telephone accessibility standards at the time of their last Market Practices Examinations. No information was available about whether the plans have complied with the new regulations, effective October 1, 1996, requiring plans to develop internal access targets. The plans are not required to report these internal standards to the state.

All of the plans had more extensive systems for monitoring quality than required under state regulation. Most of the plans included focused quality of care studies, routine on-site reviews of medical records, investigating member complaints, review of sentinel events and certain adverse patient outcomes, and provider and member satisfaction surveys. Some of the plans also noted that they had sought NCQA accreditation and/or were collected HEDIS data. However, no information was available about the outcomes of these internal quality monitoring systems. Further, none of the plans listed any attempts to coordinate their activities with local or state public health (as suggested by NAIC).

The plans all had extensive utilization review mechanisms especially geared at monitoring overutilization and inappropriate use of services. Information on overutilization was used by some of the carriers as grounds for sanctions or to pay bonuses. Four of the six plans reviewed also examined potential underuse of services. Inappropriate underutilization of services did not appear to trigger provider sanctions. With the exception of PARTNERS, none of the plans appeared to have submitted the required utilization review and appeal activity report to the state. This report is required to be submitted on an annual basis to the Commissioner and includes the results of utilization reviews, whether benefits were denied or reduced by the payer, the number and results of any appeals, and any complaints filed in court regarding the results of the utilization review process.

The appeals mechanisms used by the carriers were confusing at best. Kaiser had one system that applied to all types of appeals (although Kaiser argued that it did not need to have an appeals mechanism). PruCare had four separate appeals mechanisms, but the materials available to consumers to describe these procedures were incomplete and confusing. BCBSNC had different time standards depending on the level of review. Four of the six plans permitted the member to appear at some level during the appeals process, but this was not uniform across carriers.

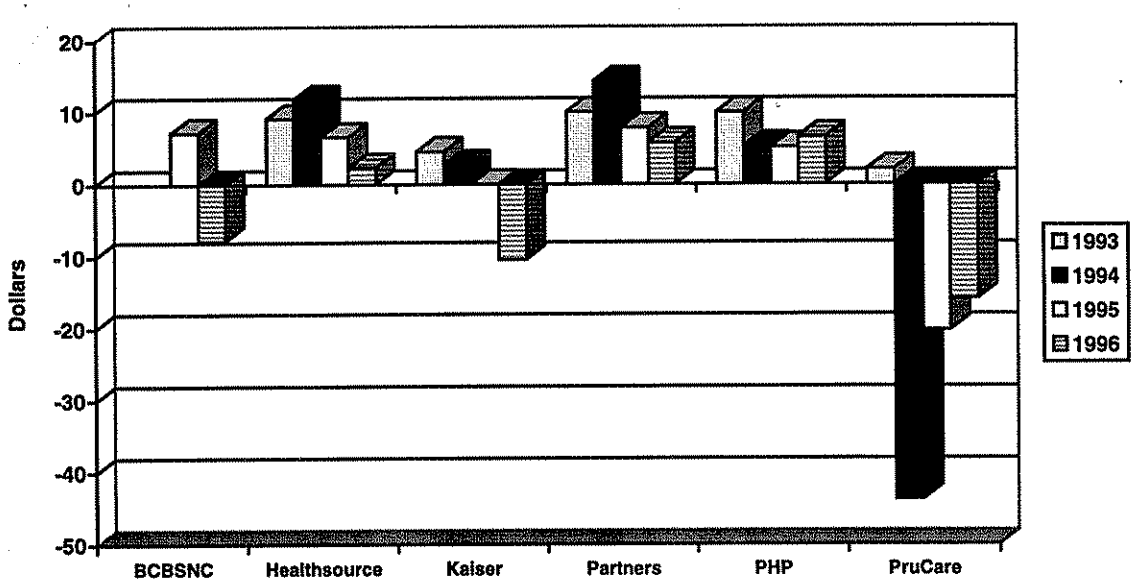
The state collected extensive financial information from plans, as well as some enrollment numbers and utilization data. The financial information may be useful to sophisticated purchasers to determine the financial solvency of the plans. There are two ways to measure a plan's financial stability: net income per member per month (i.e., is the plan generating sufficient income from all sources to cover member expenses); and secondly, operating profit margins (whether the plan is generating enough premiums to cover expenses).

PruCare had the worst financial showing of any of the six HMOs examined. PruCare lost money in North Carolina in the last three years (with a net income PMPM of -$43.80 in 1994, -$20.28 in 1995 and -$15.88 in 1996). Both Kaiser and BCBSNC showed a negative operating profit margin but a positive net income per member per month in 1995; which indicates that they had to rely on other non-operating income (such as investments) to meet operating expenses. However, both organizations showed a negative operating profit margin and net income in 1996. A negative operating profit margin may be due to a variety of reasons--for example, the plan may have chosen to artificially deflate the premiums to increase enrollment (Kaiser, for example, decreased its premiums per member per month for two consecutive years between 1994 and 1996; BCBSNC decreased premiums between 1995 and 1996), or expenses may be high due to inappropriate utilization or additional spending to expand the plan's infrastructure.

Healthsource, PARTNERS and PHP had both positive net income and operating profit margins over the last four years; however the amount of their income and profit has varied considerably. Healthsource and PARTNERS have experienced a downward trend in their profitability. For example, both organizations had lower net income and operating profit margins in 1996 than they had in 1995 or 1994. This may be due to the carrier's decision to decrease premiums per member per month in 1996 (Healthsource) or larger than expected expenses (PARTNERS). PHP

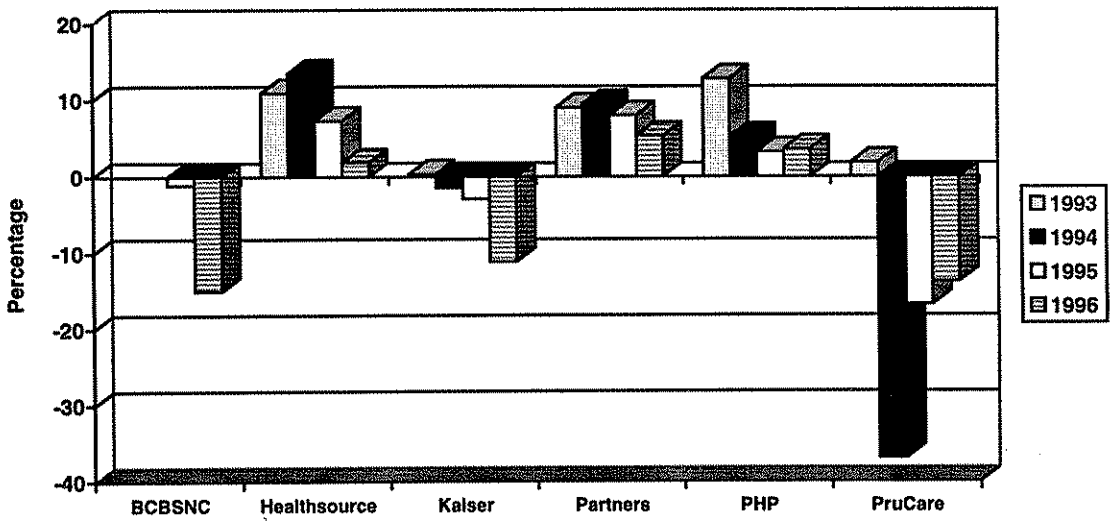
is the only one of the six carriers to have made more money in the last year. PHP had a greater net income per member per month and slightly larger operating profit margin in 1996 than in 1995.

Net Income Per Member Per Month 1993-1996 (reported in dollars)



(BCBSNC, Annual Financial Statement, 1995, 1996; Healthsource, Annual Financial Statement, 1994, 1995, 1996; Kaiser, Annual Financial Statement, 1994, 1995, 1996; PARTNERS, Annual Financial Statement, 1994, 1995, 1996; PHP, Annual Financial Statement, 1994, 1995, 1996; PruCare, Annual Financial Statement, 1994, 1995, 1996).

Operating Profit Margin 1993-1996 (reported in percentages)

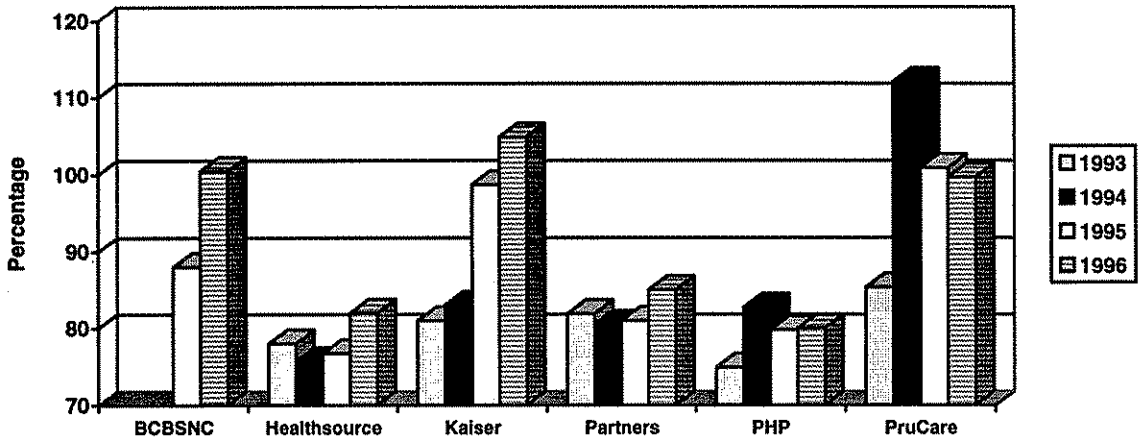


BCBSNC, Annual Financial Statement, 1995, 1996; Healthsource, Annual Financial

Statement, 1994, 1995, 1996; Kaiser, Annual Financial Statement, 1994, 1995, 1996; PARTNERS, Annual Financial Statement, 1994, 1995, 1996; PHP, Annual Financial Statement, 1994, 1995, 1996; PruCare, Annual Financial Statement, 1994, 1995, 1996).

Net income and operating profits are useful in determining the financial viability of a plan. However, these indicators do little to tell consumers how much money is being spent on medical expenses. In theory, plans may be profitable by denying needed medical care, thereby artificially decreasing expenses. One way to examine the amount of money being spent on medical expenses versus administrative costs or profits is to look at the medical loss ratio. The medical loss ratio is defined as the total medical and hospital expenses over the premiums collected.[15]

Medical Loss Ratios 1993-1996
(reported in percentages)



(BCBSNC, Annual Financial Statement, 1995, 1996; Healthsource, Annual Financial Statement, 1994, 1995, 1996; Kaiser, Annual Financial Statement, 1994, 1995, 1996; PARTNERS, Annual Financial Statement, 1994, 1995, 1996; PHP, Annual Financial Statement, 1994, 1995, 1996; PruCare, Annual Financial Statement, 1994, 1995, 1996).

Over the years, the medical loss ratio has varied from as low as 74.9 (PHP, 1994) to 112.03 (PruCare, 1994).[16] Most of the plans operated with a medical loss ratio in the 75-88% range over the last four years, meaning that 12-25% of premiums have gone into profit or administrative overhead rather than medical expenses. Healthsource and PHP have consistently had the lowest medical loss ratios. In the

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[15] Medical and hospital expenses include physician services, other professional services, outside referrals, emergency room and out-of-area service costs, occupancy, depreciation and amortization associated with medical services, inpatient hospital costs, incentive pools and withhold adjustments, aggregate write-in for other medical and hospital expenses, reinsurance expenses net of recoveries, copayments and coordination of benefits and subrogation income. Medical and hospital expenses should not include expenses for medical personnel time devoted to administrative tasks. Administrative expenses are those associated with the overall management and operation of the HMO and include compensation; interest expenses; occupancy, depreciation and amortization, marketing and aggregate write-ins for other administrative expenses (NAIC, 1995).

[16] PruCare spent more than 100% of its premiums on medical expenses in 1994 and 1995, as did Kaiser and BCBSNC in 1996, a fact which is reflected in their negative operating margin.

years that they had the lowest medical loss ratio, they also had their highest operating profit margin. For example, in 1993 PHP spent 74.9% of its premiums on medical expenses; during that same year PHP made a 12.8% operating profit margin. In 1994, Healthsource spent 75.7% of its premiums on medical expenses; during that same year Healthsource made 13.5% operating profit margin. The relationship was not as clear for the other plans.

While medical loss ratios are useful in determining the amount of premiums spent on medical care, it is not sufficient to determine the adequacy of care provided under the plan. Without some independent examination of utilization, access and quality, an outside observer would have a hard time determining whether the low medical loss ratio was an indication of appropriate utilization management skills or access barriers causing artificial underuse of services. Theoretically, utilization information could assist the public in monitoring the accessibility of services provided by plans; however, the information available in the state's Annual Financial Report was totally meaningless. The measures are crude (only capturing physician and non-physician ambulatory visits), and the definitions are so ambiguous that plans could easily record the same data differently.

The usefulness of financial data was further limited since two of the plans were not required to submit the same information as other carriers. The enrollment data was useful, and helps provide information about the growth and stability of the plan. However, disenrollment data, which could highlight potential quality of care or access problems, were not required to be reported.

Most of the plans included the provider contract provisions required under state law, although again, some problems were uncovered. For example, three of the carriers failed to provide a full description of the grounds used to sanction providers. On the other hand, all of the carriers included consumer protections not required by law, including requirements that providers continue to provide care to members upon contract termination until reasonable and medically-appropriate alternative arrangements have been made. A couple of carriers also included additional consumer protections not required by law. Prudential, for example, provided more extensive coverage of health services to members who are temporarily out of the service area than did other carriers.

Potentially, information about consumer complaints, grievances filed against the plans, and malpractice claims could provide useful information about the quality of a plan. However, the usefulness of this data was limited because the required reports were not collected, or the state failed to collect detailed enough information to be able to discern the nature of the underlying problems.

EVALUATION OF N.C. DEPARTMENT OF INSURANCE'S ENFORCEMENT EFFORTS

Methodology:

The public documents filed by the HMOs and the Department's examination reports were reviewed for two reasons. First, to gain insight into whether any

additional laws were needed to adequately protect consumers enrolled in North Carolina HMOs (discussed previously). And second, to gain some insight into how well the state enforces its own laws. If the Department was failing to meet its oversight responsibilities, reviewing the documents and publicly filed information should have uncovered numerous instances in which the plans were out of compliance (for example, failing to file required documents or documents that included illegal provisions).

Findings:

While a review of publicly filed information is useful, it is difficult to ascertain exactly how well the Department is meeting its responsibilities absent an independent review of internal HMO documents. Nonetheless, there are some tentative conclusions which can be drawn from this analysis.

Overall, the Department appeared to be doing a good job ensuring that the HMO follows applicable state laws and regulations. The Department of Insurance has many systems to monitor and oversee the operations of an HMO. The Managed Care and Health Benefits Division conducts on-site examinations and has mechanisms to review significant modifications of the HMOs operations (such as significant changes in provider contract forms, group contract forms, provider networks, HMO's health care delivery model). The Financial Evaluation Division reviews annual and quarterly filings of financial statements. In addition, the Life and Health Division monitors marketing materials and member handbook materials; and the Consumer Affairs Division investigates and helps resolve consumer complaints. The analysis only identified a few instances in which HMOs appeared to be operating in contravention with current laws that were not already identified by the Department. Despite the Department's generally good record enforcing current laws, specific improvements are needed:

- Member materials were not always understandable. Health carriers are permitted to conduct their own test of readability and to exclude specific medical terminology in the analysis. In addition, carriers only need review selected passages on a page, rather than the whole document if the document is long. The effect of these provisions is to allow carriers to use language that is not easily understood by an average consumer. Another problem was the sufficiency of the information provided in the member materials. PruCare's description of their appeal procedures, for example, was so vague that it would be difficult for a consumer to understand their appeal rights.

- Information provided in the Market Practices Examination and Market Compliance Examination reports was inconsistent and lacked specific information which could be used by consumers. The Department did not consistently report on a carrier's internal access standards or how well the carrier met its internal standards; the number and reasons for consumer complaints filed by members of the plans; or specific information about adverse patient outcomes (when noted by the Department).

- The Department did not appear to track problems over time. Issues were raised in market conduct examinations that had previously been raised in earlier market conduct examinations; but there was no indication in the written report that the department was tracking these problems over time.

- The Department did not have a good system to report and categorize consumer complaints. The Department collects and investigates consumer complaints. However, there was no information available about the nature of the underlying complaints filed with the Department. While DOI planned on upgrading its computer capacity to collect information about the reasons for the complaints and the dispositions, the categories to be collected were very broad and would not enable the Department or the public to identify trends or specific problem areas (Dorman, 1996b). For example, the new computer system will collect whether the consumer was complaining about coverage questions, access to care or quality of care; but would not enable the Department to computerize more specific information about the nature of the access or coverage questions.

- The Department did a more thorough job monitoring network adequacy and accessibility in the past than it has more recently. For example, in the early 1990s, the Department attempted to determine the adequacy of Healthsource's provider network and Kaiser's access and use of mental health services by comparing the carrier's provider network and/or use of services to external standards. After 1993, however, the Department stopped independently reviewing the adequacy of the provider networks or utilization of services to identify potential access barriers.

- The Department monitors the carrier's process for delivering care--not the actual quality of care provided. The Department monitors the plan's internal processes for monitoring quality (including the quality assurance and risk management systems), but does not directly review patient outcomes. Plans may choose to participate in externally-established quality monitoring systems (such as the NCQA accreditation process) or report performance measures (for example, HEDIS), but are not required to do so.

- The Department appears to be understaffed to adequately monitor the growing HMO industry in the state. The number of licensed full-service HMOs in North Carolina has grown from ten in June 1994 to 23 by December 1996. While the number of staff has also increased, the Managed Care and Health Benefits Section appears to have insufficient staff to meet all its regulatory requirements. The Department has requested six new staff members (five professional and one clerical) for the Managed Care Section in its 1997 expansion budget request (Burke, 1997b). The new staff are needed just to keep up with current regulatory oversight requirements, but would not be available to handle new responsibilities, such as analyzing data and preparing reports for the general public.

POLICY RECOMMENDATIONS TO ENHANCE THE STATE'S CONSUMER PROTECTIONS FOR ENROLLEES IN HMOS

The research identified 14 areas in which the state failed to adequately protect consumers: 1) ensuring that the provider network was adequate; 2) ensuring that consumers had an adequate choice of providers; 3) ensuring that consumers had access to specialists; 4) ensuring that certain enrollees in an active course of treatment could continue care with current health care providers; 5) ensuring that all carriers included a simple, understandable, and timely appeals mechanism that provided basic due process protections; 6) ensuring that carriers offered a basic benefit package that met essential health care needs; 7) ensuring high quality care; 8) disclosing and/or minimizing potential conflicts of interest; 9) involving health plans in efforts aimed at improving the health of the community; 10) protecting providers for aggressively advocating on a patient's behalf; 11) providing information to consumers to enable them to make an informed choice between competing health care plans; 12) minimizing the ability of health plans to "cherry pick" healthy patients; 13) involving consumers more directly in policy and operational oversight of the plans; and 14) ensuring the sufficiency of the Departments enforcement capabilities.

The research identified potential policy recommendations for each of these problem areas. While these recommendations are couched in terms of additional protections for enrollees in HMOs, many of these same protections should be afforded to all insured individuals. Thus, similar protections should be built into the commercial health insurance laws and the laws governing nonprofit hospital and medical corporations (BCBS).

1) Ensuring the Adequacy of the Provider Network

Problem: HMOs and other forms of network-based care have a greater burden to ensure access to providers than traditional insurance companies. Historically, indemnity insurance paid for health care but left the choice of providers to the consumer. Managed care organizations, including HMOs and PPOs, have assumed the responsibility of organizing a network of providers, in effect, limiting the patients' choice of providers. Some HMOs and, in other states, POS plans, use gatekeepers to restrict the patients' access to providers, and most managed care organizations impose significant cost barriers to obtaining care outside the network.[17] Therefore, ensuring the adequacy of the provider network is critical for managed care enrollees.

North Carolina's regulations aimed at ensuring the sufficiency of the provider network are not as extensive as those found in other states or the NAIC model Act. For example, North Carolina has no minimum access requirements, such as maximum travel distances or provider-to-patient ratios. Instead, North Carolina requires carriers to establish their own access performance targets and to measure their own compliance with these targets. NAIC also requires carriers to establish

[17] Individuals are always free to seek care from a provider outside the prescribed network; but the extent to which such care will be covered by the plan is limited. With a few exceptions, HMOs do not pay for care outside the network; PPOs and POS will pay for care outside the network, but will impose higher cost sharing on the enrollee.

internal access targets, but its requirements for what carriers must include in their access targets are more extensive than required under N.C. regulations. North Carolina does not require carriers to submit their access plans or how well the carrier is meeting its access targets to the Department or to make these plans available to the public; although both the NCQA and CCQHC model acts do so. Further, the language of North Carolina's regulations are broad enough that a carrier could develop access targets for its whole service area, which could mask particular access problems in rural areas.

The review of the six North Carolina HMOs provided little insight into the adequacy of the provider networks. Because the regulation requiring plans to establish access targets was new, little information was available about the adequacy or accessibility of the carriers' provider network. Several of the plans had internal telephone accessibility standards which were often not being met, and some of the plans had internal appointment time standards. However, the Department's reporting of the underlying standards and how well the carrier was meeting these standards was inconsistent. The Department did not try to independently judge the adequacy of provider networks or accessibility of services as it had in the past. Thus, little information is available to the public to compare the adequacy of provider networks or general accessibility of the plan.

Recommendations: The current Department regulations are insufficient to ensure adequacy of the provider network. Plans are only required to develop access plans, not report them to the state. The elements which HMOs must consider in determining accessibility are not comprehensive. Further, plans are not required to report how well they are meeting their own access targets, or to make this information available to the public. Therefore, consumers cannot rely on the market to ensure adequate oversight of access standards. Even though there is no current evidence of widespread problems with access to providers in HMOs, given the importance of this issue and the perception of a chronic problem of access to care for selected populations, both insured and uninsured (N.C. Health Planning Commission, Report of the Advisory Committee on Rural and Urban Medically Underserved Areas, 1994), the state should take a proactive position to ensure adequate access.

The state should require carriers to report their internal targets and how well the carriers were meeting these goals to the Department on an annual basis. The state should expand the elements of the access targets to include additional NAIC requirements, such as requiring plans to examine the amount of specialty and technological services needed to serve the health care needs of covered persons and the process that plans will use to ensure coordination and continuity of care for insured's referred to specialty physicians. In addition, carriers should be required to report on how well they meet their access standards by service area, not the state as a whole. Otherwise, a carrier that offers services statewide may be able to mask particular access problems in rural areas by providing statewide information about average driving distances, travel time or appointment availability. The access plan and performance report should be made available to purchasers (employers and prospective enrollees), who would then be able to use the information in choosing health plans. Annual reporting also provides the Department with more immediate feedback about the adequacy of a health plan's internal access targets. The state can

monitor a plan more frequently than once every three years if the annual report or enrollee complaints suggest access barriers.

Specific access thresholds (such as maximum travel distances or provider-to-patient ratios) would arguably provide greater protection to consumers. However, setting specific requirements in statute limits a health plan's flexibility in how it will ensure the adequacy of the provider network. Minimum statutory thresholds would also necessitate legislative action every time the standard needed to be changed. Further, this is an area where the market is likely to force needed changes. Providing information to the public comparing the adequacy of different provider networks is likely to force the carriers with the less comprehensive provider networks to improve their standards in order to compete with other carriers.

2) Ensuring a Choice of Providers

Problem: Consumers want to have a choice of health care providers. Data suggests that choice of doctors is one of the most important criteria used in selecting health plans (Chakraborty, 1994), in deciding whether to join an HMO or stay with an traditional indemnity plan (Thompson, 1993; Goldsmith, 1979), and in overall satisfaction with the plan (Davis, 1995). Lack of choice was found to be strongly related to satisfaction with health plans in one study of HMO enrollees in three cities across the country. Because consumers have been so concerned with lack of choice in closed network HMOs, more health plans are offering point-of-service plans or open-access panels in which patients can self-refer to any provider within the network (Freudenheim, 1997). Point-of-service plans are the fastest growing segment of the managed care market (Jensen, 1997). In North Carolina, for example, traditional HMO enrollment grew 15% from 1994 to 1995, while point-of-service plans grew 142%. By June 30, 1996, 26% of N.C. managed care enrollees were enrolled in point-of-service plans (up from 18% at the end of 1995) (N.C. Department of Insurance, 1997; Cohen, 1997).

Consumers are interested in a choice of primary care providers as well as specialists (Emanuel, 1995). North Carolina does not currently require plans to provide purchasers, prospective enrollees, or enrollees with a directory of participating providers who are currently accepting new members, although in practice, most plans use their provider directories as part of the marketing materials (Cueny, 1997). The issue is not only one of the number of providers available from which to choose, but also what type of provider can act as gatekeeper. For example, half of the plans reviewed specified that only providers with a specialty in general internal medicine, pediatrics, family medicine or general medicine could serve as a primary care provider (BCBSNC, Group Insurance Benefits, 1996; Healthsource, Member Certificate, 1996; PruCare, Certificate of Group Health Coverage, 1996) for general primary care services. Only one of the HMOs reviewed specifically listed Obstetricians/Gynecologists (OB/GYNs) within their definition of primary care providers, although two others had language in their Evidence of Coverage which gave

the HMOs the discretion to authorize other providers to serve as primary care providers.[18]

Not only is choice a matter of personal preference or convenience for the consumer. Allowing the patient to choose his or her primary care provider and specialist is a critical dimension of the ideal physician-patient relationship (Emanuel, 1995). Establishing a trusting relationship, which is influenced by the ability to choose one's doctor, plays a role in the patient's adherence to a treatment plan and satisfaction with care (Safran, 1996; Emanuel, 1995).

Recommendations: Our current laws do not guarantee individuals a choice of providers. In some parts of the state, individuals may be forced to join a plan by his or her employer and then be given little, if any, choice of primary care or specialty providers. Ensuring an adequate choice of providers is critical to the success of a managed care system, and impacts on the quality of care provided.

There are three ways in which consumers can be provided a more meaningful choice of providers. First, carriers should be required to provide enrollees at least three choices of primary care providers and two choices of specialists within an appropriate travel and time distance (to be determined by the Department of Insurance in consultation with the N.C. Office of Rural Health and Resource Development). While this requirement may require some additional expenditures, most plans already meet this requirement. Second, all plans should be required to provide purchasers, prospective enrollees, and current enrollees a directory of participating providers who are *currently accepting* new members. Most plans already meet this requirement, thus little if any additional costs would be incurred. This requirement helps ensure that prospective purchasers can make a meaningful choice among competing health plans based on the providers in the carrier's network. Third, OB/GYNs should be allowed to act as a woman's primary care provider. Allowing OB/GYNs to serve as primary care providers would improve access to the nearly 10% of women who rely on OB/GYNs for all their care, without a noticeable increase in utilization or costs to the plans (Bartman, 1996).

Enacting an any-willing-provider law would force a health plan to open up its provider network to any provider who meets the credentialing criteria, is willing to accept the plan's compensation arrangements and follow the carriers' quality assurance, utilization review and other administrative requirements. This option would provide individual consumers the greatest choice of providers, but would also make it more difficult for carriers to negotiate volume discounts with providers and would require greater oversight of the quality of care and utilization by providers. Further, any willing provider laws are likely to increase costs--some reports suggest that prices could increase by as much as 30% (NC HMO Assoc., Issue No. 11), potentially forcing some individuals to drop coverage. Although any-willing-provider laws could significantly expand the number of participating providers, it was not included as a recommendation because of the potential costs involved. Requiring HMOs to offer point-of-service or open-access plans to employers is less

[18] North Carolina has a law which authorizes women to obtain services from an OB/GYN directly, without need for a referral from a primary care provider for obstetrical and gynecological services. [G.S. 58-51-38] However, the law does not authorize OB/GYNs to serve as primary care providers.

onerous, but there is no guarantee that these options would be picked and offered to the employees. Employers who are interested in these options can already purchase open-access or point-of-service plans in the market. Further, providing individuals a choice of point-of-service or open-access plan does little to expand choice of providers for individuals or families with lower incomes who cannot afford the additional costs associated with POS or open-access plans. The policy options recommended above should be implemented and monitored to determine whether they provide a meaningful choice to enrollees before moving to more intrusive regulatory requirements (such as mandatory any-willing-provider laws or required point-of-service plans).

3) Ensuring Access To Specialists

Problem: People with chronic illnesses have consistently shown less satisfaction with care in HMOs, particularly in how managed care affects their access to providers (Robert Wood Johnson 1995; Davis, 1994). Access to specialists is a major source of contention for all enrollees in managed care plans. In 1996, Sachs/Scarborough Health Plan conducted a survey of 85,000 health plan members in 27 cities and found that 30% of the respondents said that they were dissatisfied with their ability to get a referral to specialists (Freudenheim, 1997).

In addition, recent studies suggest that the health outcomes for certain chronically ill patients may fare worse within a managed care setting. For example, a recent study suggested that the elderly and poor chronically ill had worse physical health outcomes in HMOs than in fee-for-service plans, although mental health outcomes varied by site and patient characteristics (Ware, 1996). Although no reason is given for this difference, one possibility may be access barriers to specialty care. Another study suggested that some patients have a better survival rate when treated by specialists than by primary care providers. The one-year survival rate for Medicare patients admitted to the hospital for myocardial infarction by cardiologists was 12% higher than those admitted by a primary care provider (Jollis, 1996). An earlier study suggested that individuals with special needs may have less access to specialized services needed to improve functioning or quality of life unless the specialized services would lead to direct cost savings through reduced use of hospital services (Fox, 1994). Fox and her colleagues found that HMOs did a good job of providing primary care and needed preventive services to children with special needs enrolled in Medicaid managed care plans, but that these managed care organizations made few efforts at early identification or treatment of developmental, behavioral, or emotional problems unless it could specifically offset future hospital costs.

North Carolina regulations currently require health carriers to set access targets which address the number of specialists needed to cover the needs of the patient population and also to establish a method to arrange or provide health care services outside the service area when providers are not available in the area. NAIC's provisions go a step further. A health plan's access goals should include the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Carriers shall ensure that covered persons can obtain all covered benefits offered from participating providers,

or if insufficient number of participating providers are available, then the plans must ensure that covered persons can obtain the covered services at no greater cost. In addition, carriers must show how they ensure coordination and continuity of care for covered persons referred to specialty physicians or using ancillary services (including social services and other community resources) and appropriate discharge planning.

Issues arise with current North Carolina regulations when enrollees are unable to find appropriate providers inside the network. For example, the N.C. Health Access Coalition, in a letter to Barbara Morales Burke (the head of the Managed Care and Health Benefits Division of the Department of Insurance), reported the experience of one member who had an infant daughter diagnosed with dysphagia. According to the Coalition,

> "The health plan referred this infant to an adult speech therapist to provide assistance with the dysphagia. Although the adult speech therapist treated stroke victims and adults with head traumas with dysphagia, he had never treated an infant with this condition. In fact, he felt that he did not have the training necessary to treat this condition in infants because it manifests itself differently for infants than it does for adults...The carrier had no pediatric speech therapists on the plan; yet still penalized the member for going outside of the plan for necessary services." (N.C. Health Access Coalition, 1996b).

Health care plans can require enrollees to seek authorization from a primary care provider for every visit to a specialist, even if the patient is in the midst of an active course of treatment which necessitates a number of visits (for example, chemotherapy). North Carolina has no provisions to require carriers to allow for standing referrals to specialists, to allow specialists or multidisciplinary teams to serve as the coordinator and/or gatekeeper for services for certain patients with chronic health conditions, or to require carriers to develop "plans of care" with the primary care physicians and appropriate specialists for the treatment of chronically ill or disabled members. Several other states, notably, New York and New Jersey, have enacted laws to facilitate access to specialists. In addition, at least one of the larger national HMOs (Oxford) recently announced its move to allow specialists to coordinate the care of certain patients with chronic or high-cost conditions (Winslow, 1997).

Recommendations: Plans that do not have sufficient contracting providers able to meet the needs of the members should be required to pay for care provided outside the network (as well as reasonable travel costs). This ensures that individuals with unique medical needs will have their health care needs met, and provides an incentive to plans to ensure that it has a comprehensive provider network so that it does not have to pay for services by out-of-network providers.

Carriers should also be required to establish procedures for standing referrals, allowing specialists or multidisciplinary teams to serve as gatekeepers, or establishing plans of care for certain enrollees with complicated health needs. However, it is difficult to establish blanket policies that apply to all cases. Carriers have the authority under existing law to implement these special referral or

gatekeeping arrangements, but are not required to do so. Further study of this issue is needed. The Department of Insurance should be directed to study the referral and gatekeeper arrangements that carriers currently use to care for the chronically ill and those with complex medical needs; and should be given the authority to adopt regulations to address this issue if needed.

4) Ensuring that Certain Enrollees in Active Course of Treatment Can Continue Care with Current Health Care Providers

Problem: Continuity of care is often disrupted when an individual joins a new HMO or has his or her provider leave the HMO (Families USA, 1996). This can pose significant problems to individuals who are undergoing treatment for a life-threatening medical conditions or a degenerative and disabling condition, or for women who are pregnant. North Carolina has no laws to address this problem.

The problem manifests itself in two ways. First, HMO enrollees undergoing an active course of treatment can be harmed if the provider leaves the network (or the plan refuses to renew his or her contract). All six of the HMOs reviewed for this dissertation had provider contract provisions requiring the providers to continue to provide care to the patient (even after the contract ends) until alternative arrangements can be made. In these instances, the provider continues to be paid at the former HMO contractual rate.

NAIC requires carriers to describe their plan for providing continuity of care in the event of contract termination with participating providers. Other states have developed more extensive requirements (Families USA, 1996). For example, Kansas, Maryland, Texas, Virginia and New York all have requirements that HMOs continue to pay the provider upon contract termination for up to 120 days, or through post-partum care for pregnant women. New York also allows new HMO enrollees to continue to see their provider for 90 days from the date of enrollment (or through postpartum care) if the enrollees are in an ongoing course of treatment and the provider agrees to accept the HMO payment rate and meet other HMO quality of care standards. These continuation provisions are usually limited to individuals with life-threatening or disabling or degenerative conditions or pregnant women in their second or third trimester.

Recommendations: The six plans reviewed all had provider contract provisions which require providers to continue care to individuals in an ongoing course of treatment until alternative arrangements can be made. These continuation of care provisions lasted between 90 days in one plan to a year in another. While mandating continuation of care may be unnecessary for these six plans; legislating this requirement provides assurance that all plans provide similar protections. All plans should be required to continue coverage of services at the contract price for a minimum of 120 calendar days (or through post-partum care) in cases in which it is medically necessary for the enrollee to continue care with the terminated provider. Requiring plans to establish similar arrangements for new enrollees seems equally appropriate.

5. Ensuring that All Carriers Includes a Simple, Understandable, and Timely Appeals Mechanism that Provides Basic Due Process Protections

Need: Managed care, with the use of gatekeepers and other utilization review mechanisms, imposes procedural obstacles for enrollees seeking care. Further, the payment structure which shifts part or all of the risk to the providers, gives providers a financial incentive to undertreat. Therefore, appeal mechanisms to ensure the prompt and fair resolution of disputes involving access to care, denial of services or quality of care is needed (Stayn, 1994).

North Carolina's laws require carriers to establish mechanisms to handle all types of consumer complaints. However, the regulatory appeals mechanisms, including time standards, notice requirements, and review procedures only apply to noncertification decisions. North Carolina's laws do not require plans to allow members to appear in person at a hearing (four of the six plans reviewed allow for in-person appeals). In addition, North Carolina does not currently require carriers to continue to provide care pending the outcome of an appeal of a concurrent stay decision (decision to discharge the patient from the hospital), as has been suggested in the NAIC model act. North Carolina's laws do not require plans to notify enrollees of their right to contact the Commissioner's office for assistance, and there are no appeal mechanisms outside of the plan.

While the laws set out specific appeals mechanisms for noncertifications--in practice each HMO employs a different appeals mechanism. The appeal process also varies within plans--Kaiser has one appeal mechanism for all types of appeals (and has argued that the state rules do not apply to it), others have multiple appeal processes depending on the type of appeal. Knowing which appeals process applies in a particular circumstance is not always easy.

Internal appeals processes serve an important function in ensuring that enrollees have access to and coverage for necessary health services. As one HMO administrator noted, many of the initial denials are overturned on appeal because further information is presented to the carrier to justify the needed services (Cueny, 1996). PARTNERS, the only plan for which the required utilization review and appeals activity report was available, also showed a significant reversal rate for the appeals submitted[19] (PARTNERS, 1995 Report on Utilization Review, 1996).

Recommendations: The state should establish minimum due process requirements which all carriers must follow. Basic due process includes a) notification of the appeals mechanism in all member handbooks and Certificates of Coverage, as well as all notices of adverse action; b) the consumer, his or her representative or the provider may file an appeal on the enrollees behalf; c) appropriate time limits (not to exceed 30 calendar days) to ensure prompt resolution

[19] Partners completely denied 34 hospitals admissions, of these seven were appealed and seven reversed (100% reversal rate). Partners partially denied 18 hospital admissions, of these 13 were appealed and 13 were reversed in the enrollee's behalf (100% reversal rate). In addition, there were 22 other appeals submitted to the second level of the appeals process; of these 13 were reversed and paid (59%) (Partners, 1995 Report on Utilization Review, 1996).

of appeals; d) expedited appeals process (the hearing to be held within 72 hours, with notice within one day thereafter, or more quickly when warranted) when a delay could potentially harm the health of the member; e) notice of adverse determinations that include the principle reasons for the determination, the clinical review criteria used to make the determination, and a description of the appeals mechanism; f) review by appropriate personnel not involved in the previous determinations and with no financial conflict of interest; for medical issues reviews should be conducted by clinical peers--health professionals who have same of similar specialty as the medical issue being contested; g) right to appear at the hearing during at least one level of review; h) continuation of benefits for concurrent case reviews; [20] i) at least two levels of review; and j) notice of the right to contact the Commissioner's office for assistance in every notice.

The state should also consider implementing an Ombuds program to help enrollees mediate the system and resolve complaints. North Carolina already has an Ombudsprogram to help nursing home and rest home residents and their families resolve complaints, and to provide information about these facilities to the general public. Ombudsprograms have been implemented in nine states in the Medicaid program, and have been generally be viewed positively by the state, consumers and health plans (Perkins, 1996). The General Accounting Office found that the Ombuds program and county health care advocates in Minnesota helped resolve problems between beneficiaries and plans before they became grievances, and as a result, Minnesota's Medicaid managed care plan had a low number of formal appeals (Mark, 1995). Ombuds programs have worked successfully in other settings to resolve consumer problems (IOM, 1995). Implementing an Ombuds program for all managed care enrollees would help all enrollees understand and exercise their appeal rights; help resolve consumer complaints before rising to the level of a formal grievance; and would be a centralized repository of consumer complaints to determine if there were consistent quality concerns or access barriers within or across plans.

Consumers do not stand as much to gain by establishing an independent appeals process external to the plans which would operate as a substitute for an internal process. Since many consumer complaints can be resolved easily once the carrier is presented with additional information, there is little need to start initially with an independent appeals process. However, the Department should study the need for an external appeals process once the internal process is completed.

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[20] In Goldberg v. Kelly, 397 U.S. 254 (1970) the Supreme Court held that a pretermination hearing is required to provide welfare recipients with adequate due process. The interests of welfare beneficiaries in the uninterrupted receipt of assistance, which helps pay for needed food, clothing and medical care, coupled with the state's interest in ensuring the eligible individuals are not erroneously denied assistance, outweighs the state's interest in decreased fiscal and administrative costs. Such hearings need not be full scale trials, but recipients must be provided with timely and adequate notice detailing the reasons for termination, an opportunity to confront adverse witnesses and present his or her own arguments. The decision maker must be impartial and should not have participated in making the determination under review. The extent to which procedural due process must be afforded depends on the extent to which the recipient may be forced to suffer grievance loss. While the fourteenth amendment requires states to provide basic due process rights within the context of public programs, a similar policy argument about the basic necessity of pretermination appeal rights can be made within the context of a health care system.

6) Requiring Insurance Companies to Offer a Basic Benefit Package that Meets Essential Health Care Needs.

Problem: The federal HMO Act requires plans to provide physicians services, inpatient and outpatient hospital services; medically necessary emergency services; short-term (not to exceed 20 visits), outpatient evaluative and crisis intervention mental health services; medical treatment and referral services for the abuse of or addiction to alcohol or drugs; diagnostic laboratory and diagnostic and therapeutic radiological services; home health services; and preventive health services including immunizations, well-child care from birth, periodic health evaluations for adults, voluntary family planning services, infertility services, and children's eye and ear screenings.[21] Only five HMOs in North Carolina are federally-qualified HMOs,[22] so a minority of the state's plans are subject to the federal requirements (N.C. Department of Insurance, 1997). Further, North Carolina is only one of two states that does not require HMOs to provide a core array of services. Most states require HMOs to cover inpatient hospitalizations, emergency services, physician services, outpatient medical care, preventive services, diagnostic lab and radiological services (CHCR, Vol. 2, 1995). Many other states require coverage of mental health services.

Because 10% of the people consume more than 70% of the resources (Berk, 1992), health carriers have a strong financial incentive to design benefit plans to appeal to healthier patients and deter patients with ongoing medical needs (Hoy, 1996). The Wisconsin Employee Trust Fund moved to a standardized benefit product for its state employees largely as a result of this problem. "HMOs were required to offer identical benefit structures so that plans can no longer design for risk selection, employees can better understand coverage and compare value and the [state] can better evaluate plans' efficiency." (Hoy, 1996).

Mental health coverage may be one area in which plans are attempting to segment risk through product variation. Some plans exclude mental health coverage altogether unless purchased separately in a rider (Healthsource, PARTNERS); others place different variations on the number of visits, overall dollar limits or when services will be authorized. The Department singled out the risk segmentation practices of Kaiser in its 1992 market conduct examination:

> "The patients that are the most in need of mental health services are in fact the patients that are the most likely to be denied coverage. According to one file that was examined, one KFHPNC member was denied mental health benefits because he suffered from 'an extremely severe, chronic mental illness.' Multiple diagnoses (were) involved, including a diagnosis of chronic and persistent suicidal ideation. Denial of care in such cases can pose serious ethical concerns and an increased exposure to the potential for legal liability... [A] public policy issue is raised when individuals participating in an HMO that received its [Certificate of Authority], based in part upon a

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[21] 42 USC 300e-1.

[22] Kaiser Foundation Health Plan of North Carolina, Maxicare North Carolina, Partners National Health Plan, Personal Care Plan of NC and Prudential Health Care Plan are the only federally qualified HMOs operating in North Carolina. These plans account for 33% of the market.

> comprehensive benefit plan, are denied needed mental health care and are referred to already overburdened community mental health centers and state/county operated and financed mental health inpatient and substance abuse facilities and programs. The practice of denying enrollees needed mental health benefits because their condition is chronic or considered to be not responsive to short term therapy and has no written policies and/or protocols that offer guidance to practitioners, is an unusual practice that has a potential for (1) inconsistent application, (2) the denial of medically necessary, mental health and substance abuse services, (3) an increased exposure of the HMO to unfavorable publicity and of litigation, and (4) a heightened concern relating to the "dumping" of patient on state and local government tax supported programs to which the HMO in question (being nonprofit and paying no taxes) is exempt from supporting."
>
> (DOI, Market Practices Examination of Kaiser, 1992).

Another problem that is evident from a review of the carriers' contract provisions is coverage for emergency care. All of the plans have language in their Certificate of Coverage which give the carriers the authority to exclude coverage for services provided in the emergency room for conditions which are not later shown to be true emergencies. For example, Blue Cross Blue Shield holds the member responsible for all charges if the primary care provider determines that the condition did not constitute an emergency (PCP, Group Insurance Benefits, 1996). PARTNERS will not cover emergency care provided inside the service area unless the condition, following a review of the medical records, was determined to be an emergency at the time the services were rendered (PARTNERS, Certificate of Coverage, 1995). Other states have responded to this problem by enacting laws which ensure that the HMOs pay for the emergency services provided unless the enrollees reasonably should have known that an emergency did not exist.

Coverage of therapy services is also limited. While all plans covered speech, physical and occupational therapies, coverage was limited to conditions expected to show significant improvement on a short-term basis. This excludes all habilitative coverage of therapy services (for example, to prevent deterioration of care or to enhance quality of life). Further, the number of visits covered varied from 20 days coverage (PHP) to 60 days coverage (PruCare); plans also differed in the criteria used to determine medical appropriateness of such services.

Recommendations: Additional consumer protections are needed in the area of mental health coverage and emergency services. Two of the plans reviewed had no coverage of mental health services unless purchased separately as a rider. Failing to cover mental health services is one way to segment the market--because individuals with mental illnesses will be less likely to choose that particular plan. While disclosure of the lack of coverage is important from the individual consumers perspective (so an individual with mental health needs can choose a plan that meets his or her needs), disclosure will actually exacerbate risk-segmentation. Therefore, the state cannot rely solely on disclosure mechanisms to protect the consumers and to level the playing field among plans. A minimum mental health benefits package is needed. Most carriers offer some coverage of mental health services, so the

additional costs would be marginal. Optimally, all health plans and indemnity insurers should be required to offer mental health coverage on parity with other medical illnesses; so that diseases of the brain are treated no differently than diseases of the body. The same argument can be made for parity in the coverage of substance abuse treatment. Given the relatively low per member per month costs ($3.34) involved in requiring comprehensive mental illness and substance abuse coverage (Bachman, 1997), and the increased benefits to individuals and society by reducing the effects of substance abuse and mental health disorders (N.C. Health Planning Commission, Report of the Benefits Advisory Committee, 1994), full coverage of mental health and substance abuse services in parity with other medical services should be required.

Similarly, some additional coverage of therapy services is probably warranted. However, there was less information available about the possible increased costs or how to define a reasonable benefit package. Therefore, rather than immediately mandate that additional therapy services be provided; the Department of Insurance should be directed to assess the need for expanded coverage of therapy services.

Carriers should also be required to cover services rendered in an emergency room if the enrollee had a reasonable belief that an emergency existed. Individuals are not trained as medical professionals, so should not be expected to understand which conditions are true emergencies and which are less serious conditions. Carriers who are uncomfortable applying a reasonably prudent person standard can cover all services provided in the emergency room and charge a higher copayment to deter unnecessary emergency room use.

7) Ensuring High Quality Care

Problem: The move towards managed care has largely been spurred by the need to control rising health care expenditures. "Without an emphasis on quality, health plans and providers may be driven to cut necessary services instead of cutting out unnecessary care, excess administrative costs or other waste in the system" (N.C. Health Planning Commission, 1994).

North Carolina regulations currently require carriers to establish quality assurance systems. However, the regulations contain little specificity about what must be included in the quality assurance system. The only requirements in state regulations are that HMOs must employ a variety of quality management tools that assess the quality of all types of medical care, administrative and utilization management decisions. In addition, carriers must have a method of aggregating, categorizing and analyzing quality of care complaints related to provider performance or HMO policies or procedures. North Carolina looks at the carriers adherence to its own quality assurance process during the triennial market conduct examinations, but does not conduct its own investigation into the quality of care provided enrollees.

NAIC and many other states have far more extensive requirements. NAIC, for example, requires carriers' quality assurance system to include systemic collection, analysis and reporting of data. The system must: include a description of the

priority diagnoses and treatments to be reviewed (the health carrier shall focus on practices and diagnoses that affect a large number of the plan's covered persons or that could place covered persons at serious risk); use a range of methods to analyze quality including information on over- and under-utilization of services, and outcomes evaluations (including health status measures); document both the satisfaction and grievances of covered persons; compare findings with past performance and internal/external standards; measure the performance of participating providers and conduct peer review activities; take steps to correct deficiencies; utilize treatment protocols and practice parameters with appropriate clinical input; and evaluate access to care for covered persons. The plan must involve providers in the development of the plan and include a system to allow members to comment on the quality assurance process. NAIC also requires carriers to provide a summary of the quality assurance process in its marketing materials and make the findings of the quality assurance program available to the public. NAIC and NCQA both require carriers to have a system to report providers who have provided inferior quality care to the appropriate licensing agency. North Carolina only requires HMOs to report doctors to the licensing board, but does not have a similar reporting requirement for other licensed providers such as psychologists (Storie, 1997) or pharmacists (Work, 1997).

While North Carolina laws are particularly sparse in what must be included in the quality assurance system, all of the six plans reviewed had more extensive quality assurance systems. The quality assurance departments were charged with carrying out such activities as focused quality of care studies, routine on-site review of medical records, investigating member complaints, reviewing sentinel events and certain adverse patient outcomes, and conducting provider and member satisfaction surveys. No information is available about the quality assurance systems for the remaining carriers which were not reviewed for this dissertation.

North Carolina collects little outcome data. The state does not require the carriers to submit any process or outcomes data (such as HEDIS data), nor does it require mandatory reporting of sentinel events or adverse outcomes which could indicate quality of care problems. The state requires carriers to report on malpractice claims filed against the plan, but the carrier need not provide detailed information about the underlying nature of the complaints.

Carriers are not required to report to the Department on the number of complaints it receives or the underlying reasons for complaints. Instead, the carrier must keep a copy of the internal complaints for at least three years (which enables the Department to review the complaints during its triennial market review). However, with the exception of Kaiser, the Department did not examine (or at least failed to report) during the triennial market practices examination on the number of complaints filed with the plan or reasons for the underlying complaints. Unlike general consumer complaints, carriers are required to submit information about the numbers and results of utilization review appeals and any complaints filed in court regarding the results of the utilization review process ("utilization review and appeals activity report"). However, only one of the six plans submitted the required utilization review and appeal activity report; the Department failed to enforce this provision with the other five plans.

Market-based systems to ensure quality, such as external accreditation or data reporting (HEDIS), are not very well developed in North Carolina. Only six of the carriers have obtained NCQA accreditation. Eleven of the carriers reported that they collected HEDIS data, but only five of the plans submitted the data to NCQA to be released to the public as part of the NCQA *Quality Compass* project.

Recommendations: Current state law already requires carriers to establish internal quality assurance systems, but has few requirements for what must be included in these systems. The state, for example, does not currently require carriers to examine underuse of services, although managed care payment methodologies provides incentives to withhold necessary care. Further, little information is reported to the state; none of the information reported to the state is made readily available to consumers or purchasers. Therefore, maintaining current law is not sufficient to adequately ensure the quality of care provided enrollees.

The state should require carriers to enhance their quality assurance systems and follow the provisions in the NAIC Quality Assurance Model Act. Since most plans probably meet these requirements, little additional costs will be incurred. In addition, the state should require carriers to report on certain sentinel events and adverse patient outcomes, malpractice suits, disenrollment data, complaints filed with the plan, and the utilization review and appeals activity reports. This information will help enhance the Department's oversight capabilities, as the Department may be alerted to quality of care concerns prior to its regular three year triennial market review. In addition, this information should be released to the public, as quality of care information is useful to prospective enrollees in choosing a health plan.

Carriers should be required to report all licensed providers who show a persistent pattern of inferior care to appropriate licensing agencies. A similar law already applies to physicians, but not to other licensed providers. The NAIC Quality Assurance Model Act and the NCQA accreditation standards require carriers to report to appropriate authorities practitioners with serious quality deficiencies resulting in suspension or termination. This requirement helps protect all consumers from poor quality providers. Without this requirement, plans may sanction or terminate providers who have shown a persistent pattern of inferior care, leaving the practitioner free to continue treating other patients.

Currently, there is no system in place to systematically review the actual quality of care provided by health plans. The Department only reviews the structure and process of delivering care; not the actual quality of care provided. According to the HMO experts consulted for this research, the market will likely force all plans to undergo private accreditation in order to remain competitive in the marketplace. Before these market forces are brought to bear, the state should have the authority to require carriers to undergo an external quality assessment if sufficient quality of care concerns are raised.

8) Disclosing and/or Minimizing Potential Conflicts of Interest

Problem: Physicians historically have had an ethical responsibility to place their patients' care over their own financial interests (Gray, 1997).[23] This heightened responsibility has been considered by many as that of a fiduciary, who is required to exercise discretion and independent judgment solely for the benefit of the another[24] (Rodwin, 1995a; Rodwin, 1995b; Gray, 1997).

Yet, managed care payment methodologies, which compensate providers based on their utilization patterns and the overall financial health of the HMO, create potential conflicts of interest for the physician. Capitation, withholds and other financial bonuses provide a financial incentive to withhold necessary care to increase profits.[25] The specific details of a payment methodology can provide a greater or lesser financial incentive. Presumably, financial incentives which are linked to the care provided to individual patients are more likely to affect a provider's utilization of services in a specific case than are incentives tied to a provider's total patient population. Incentives tied to an individual provider's use of services will have more impact than those which examine the utilization pattern of a group of providers. Similarly, the timing of the incentive payment may have an impact on use of services--the closer in time that the incentive payment is distributed to the care delivered, the more likely the payment will affect the provider's treatment of a particular patient.

The Health Care Financing Administration (HCFA) has attempted to address the potential problems arising from the use of payment methodologies which shift risk to the providers. The Medicare and Medicaid statutes prohibit prepaid health care organizations with Medicare and Medicaid risk contracts from knowingly making incentive payments to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. HCFA, in its regulations implementing this provision, prohibited prepaid health plans from linking financial incentives directly to the care provided any individual patient. HCFA also established additional protections for plans shifting "substantial risk" to providers and imposed a disclosure requirement for other types of financial arrangements.[26] Substantial financial risk occurs if the incentive payment places a physician or physician group at risk for amounts in excess of 25% (including capitation payments, withholds and bonuses), if the risk is based on the use or costs of referral services. In general, the 25% rule applies to physician groups with panel sizes of less than 25,000 patients. If a provider group is subject to substantial risk, the plan must

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[23] Gray (1995) cites an AMA Council on Ethical and Judicial Affairs opinion holding that "under no circumstances may physicians place their own financial interests above the welfare of their patients."

[24] Fiduciaries are defined as: "a person entrusted with power or property to be used for the benefit of another and legally held to highest standard of conduct. Fiduciaries advise and represent others and manage their affairs. They usually have specialized knowledge or expertise. Their work requires judgment and discretion. Often the party that the fiduciary serves cannot effectively monitor the fiduciary's performance. The fiduciary relationship is based on dependence, reliance and trust." (Rodwin, 1995a).

[25] The potential conflicts of interest posed by reimbursement methodologies are not unique to managed care organizations. Physicians, under fee-for-service payment methodologies, had financial incentives to provide excess care, even if not in the patient's best interest.

[26] The federal regulations governing financial incentives in Medicaid and Medicare managed care can be found at: 61 Fed. Reg. 69034-69050 (December 31, 1996).

ensure that the physician or physician group has either aggregate or per-patient stop-loss protection that meets certain regulatory requirements, and the plan must also conduct enrollee surveys.[27]

HCFA also requires all plans participating in Medicaid or Medicare managed care arrangements to disclose: 1) if physicians are at risk for services not furnished by the physicians (if not, no further disclosure is required); 2) the type of incentive arrangement; 3) if the financial arrangement involves a withhold or bonus, the percentage of withhold or bonus; 4) the amount and type of stop-loss protection; 5) the panel size and pooling methods used (if any), 6) if capitation is paid to a primary care physician, the percentage paid for primary care services, referrals to specialists, hospitals or other provider services, and 7) results of the required beneficiary survey. Recipients are entitled to know whether or not the incentive plan covers referral services, the type of incentive arrangement (withholds or capitation), and whether there is adequate stop-loss coverage in place.

NCQA has similar financial reporting requirements as part of HEDIS 3.0. NCQA requires plans to report the number and percentage of physicians who are paid salary, fee-for-service, or capitation; the number and percentage of physicians in each category who are paid a bonus or subject to a withhold (and the range of the withhold or bonus); the services covered by the capitation payment; and the basis for the withhold or bonus (NCQA, 1996a, 1996c).

North Carolina has no laws governing the specifics of incentives payments. Only five of the North Carolina carriers currently have Medicaid managed care contracts, and another two have Medicare risk contracts.[28] Therefore, less than half of North Carolina HMOs are currently subject to HCFA financial disclosure requirements. And unlike many fiduciary relationships, where the potential conflict of interest must be disclosed to the involved parties, North Carolina laws have no mandatory disclosure requirements. Health carriers need not disclose, and in fact may sanction providers for disclosing financial incentives which could conceivably create a conflict of interest for the provider. For example, BCBSNC's contract included provisions that its reimbursement agreements are proprietary and may not be released to any third party, except as required by law (PCPNC, Personal Physician Agreement, 1995).

Recommendations: As fiduciaries, or even quasi-fiduciaries, providers have a responsibility to disclose potential conflicts of interest to their patients. However, some carriers consider this information to be proprietary; providers who disclose

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[27] The U.S. Department of Health and Human Services is not currently requiring plans that operate incentive plans that place physician or physician groups at substantial risk to conduct enrollee surveys for the Medicaid population. Plans may comply with this survey requirement for the Medicare population by using the CAHPS (Consumer Assessments of Health Plans Study) survey instrument developed by the Agency for Health Care Policy and Research. A number of limitation were noted in the federal register about the CAHPS survey. First, the enrollee survey only collects data at the plan, not the provider level. Second, the survey does not collect information from individuals who disenroll from the plan. Finally, the plan does not currently oversample for the chronically ill and disabled, although strategies for doing so are being considered.

[28] Atlantic Health Plans, Kaiser, Maxicare, Optimum Choice and The Wellness Plan are participating in the Medicaid managed care project in Mecklenburg county. Partners and QualChoice offer a Medicare risk plan (Department of Insurance, 1997; Cueny, 1997).

this information could potentially be sanctioned by the plan. Therefore, consumers can not rely on existing law to ensure that potential conflicts of interest are disclosed. As a practical matter, it makes more sense for the carriers rather than the providers be given the reporting responsibility as only 23 reports would be submitted to the state rather than individual reports from thousands of providers. The carrier can report generic physician compensation information, including the number and percentage of physicians paid salary, fee for service, or capitation; the range of withholds and bonuses; and the services included under capitation (NCQA, 1996a). Individual providers should also be allowed to disclose individual financial incentives to their patients without fear of being sanctioned.

9) Involving Health Plans in Efforts Aimed at Improving the Health of the Community.

Problem: In 1994, Governor Hunt and the 15 other members of the N.C. Health Planning Commission, established a set of principles that should govern any future health reform effort. One of the principles directly addressed the need to emphasize improved health status of the population. "The goal of any future health systems should be on improved health status of individuals, with an emphasis on primary care, health promotion, disease prevention and health education" (N.C. Health Planning Commission, 1994).

Over the last hundred years, the greatest improvements in the health of the people have come from public health measures, not from the medical care system. The increase in life expectancy, from less than 50 years in 1900 to more than 75 years in 1990, is largely attributed to clean water and sanitation measures, and the control of infectious diseases (U.S. Public Health Service, 1993). More recent improvements in health status, including a 50% reduction in deaths due to strokes, 40% reduction in deaths due to coronary heart disease, and 25% reduction in overall death rates for children can largely be attributed to health promotion activities initiated in the 1970s. Health promotion and disease prevention efforts offer some of the greatest opportunities to improve the overall health status of communities in the future. Not only are health promotion and disease prevention activities likely to improve health status, they also offer a great opportunity to lower overall health care costs. For example, in 1993, heart disease affected seven million people across the county (HIAA, 1993). That year, 284,000 bypass procedures were performed at an average cost of $30,000 per patient. Thus, for this one procedure alone, the nation spent approximately $8.5 billion. Despite these expenditures, heart disease, largely a preventable condition, claimed the lives of approximately 500,000 people.[29]

[29] According to the Source Book of Health Insurance Data, 1993, from the Health Insurance Association of America, the cost per patient of preventable medical conditions is as follows: heart disease (7 million affected, 500,000 deaths/year, 284,000 bypass procedures/year, $30,000/patient for by-pass surgery); cancer (1 million new cases/year, 510,000 deaths/year, $29,000/patient for lung cancer treatment); stroke (600,000 strokes/year, 150,000 deaths/year, average costs of $22,000/patient); injuries (2.3 million hospitalized/year, 142,500 deaths/year, 177,000 persons with spinal cord injuries, $570,000 lifetime costs for quadriplegia); HIV infection (1-1.5 million infected, 147,525 AIDS cases as of Jan. 1990, $75,000/patient for lifetime treatment); alcoholism (18.5 million persons abuse alcohol, 105,000 alcohol deaths/year, $250,000/patient for liver transplant); drug abusers (1.3 million regular cocaine users, 900,000 IV-drug users, 500,000 heroin users, 375,000 drug exposed babies; $63,000 cost of substance abuse treatment/patient over five years old); low birthweight babies

Although HMOs do a better job covering preventive health services such as adult physicals and well child care than do traditional indemnity plans or PPOs (Trends in Health Insurance, 1994), many HMOs are reluctant to invest in broader health promotion/disease prevention activities because of the additional costs involved. Molloy, in a study of 23 managed care organizations in seven communities across the country, found that many HMO administrators thought that offering individual preventive services had "no payoff" since most enrollees leave the plan within one to three years (Molloy, 1996). Community-focused prevention interventions were viewed more positively by some of the plan administrators because "providing prevention interventions to the entire community may be just as beneficial to the company as is offering prevention services to our own plan members." Another HMO administrator thought that community-wide prevention efforts would be accepted more readily if required of all plans: "When regulators require prevention practices across the board, we will more likely invest in quality prevention programs because they will benefit us just as much as the plan that our clients switch to in two years."

The North Carolina HMO industry has not had much experience working with local public health departments or the state Department of Environment, Health and Natural Resources in North Carolina (Simmons, 1997). This lack of communication between HMOs and public health mirrors the lack of dialogue across the country (Cahill, 1997). However, such communication and coordination is critical. According to the State Health Director,

> "It is critical to include clear and unambiguous language [in the Department of Insurance's proposed 1997 HMO legislation] that requires a formal linkage between managed care organizations and the local public health department in each of the communities where they provide service. For example, whether the linkage between the health department and the managed care organization concerns the continuity of care for a Medicaid patient, the exchange of information on an infectious disease, or the cooperative planning of a community health assessment, the collaboration between the managed care plan and the public health department is critically important. Our experience would indicate that while this important relationship between managed care and public health should occur naturally, the dearth of managed care/public health interactions suggests otherwise." (Levine, 1996)

Further, public health departments, which rely heavily on the funding received from the care of Medicaid patients are at risk of losing a substantial portion of their revenue base as Medicaid managed care siphons off paying patients (Rideout,

1997).[30] The Medicaid revenues are used to pay for other core public health functions, including assessment, policy development and assurance. The lost patient revenues may make it more difficult for public health departments to meet their statutory responsibility to protect the health of the community. Thus coordination and communication between local public health departments and HMOs will become even more critical in the future to ensure that limited public resources can be used most effectively and efficiently to protect the public's health.

Recommendation: Although most of the HMOs are for-profit organizations with a legal responsibility to care for their members rather than the community as a whole, public policy should require a greater investment in the community. In return for granting HMOs limited protection from competition through license restrictions on market entry, the state can require HMOs to serve the greater public good. Requiring carriers to coordinate and communicate with public health agencies (and visa versa) is not only good public policy; it may well help the carrier's bottom line. Given the transitory nature of enrolled populations, carriers stand as much to gain by helping improve the health status of the community as it does investing in health promotion and disease prevention activities which are unlikely to yield positive results until years down the road.

10) Protecting Providers for Aggressively Acting on Patients Behalf

Problem: As noted previously, physicians are often considered fiduciaries for their patients. Anything that compromises the physician's duty to act on behalf of the patients is a potential conflict of interest for the physician. This report has already discussed one type of potential conflict--that arising when the physician's financial interests potentially conflict with the needs of the patient. Providers face another potential conflict stemming from divided loyalties (Rodwin, 1995a). Health care providers, especially those within a managed care context, have a contractual duty to follow the rules and procedures of the health plan. In fact, North Carolina law obligates carriers to have a contract provision requiring providers to follow the utilization review, quality assurance and credentialing requirements of the plan. This contractual duty to follow the carrier's rules can create a conflict of interest when the provider thinks the care authorized under the plan is inappropriate and contrary to accepted professional or ethical standards.

Without a medical education, consumers are ill-equipped to know when needed care is being withheld or how to best advocate for needed health services. Physicians are in the best position to advise patients about appropriate treatment options and to help patients through complex utilization review processes. At least one commentator has suggested that the successful operation of a utilization management program relies on the physician's willingness to speak on behalf of the patient when the patient is being threatened by unsound review decisions (Gray, 1997). Physicians and other health care providers need to be able to advise their

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(260,000 low birthweight babies born each year, 23,000 deaths at an average cost of $10,000 for intensive care) (HIAA, 1993).

[30] Dale Simmons, Leader of the Local Health Department Technical Advisory Program, for the N.C. Department of Environment, Health and Natural Resources reported that more than 50% of a local health department's revenues typically come from Medicaid and Medicare.

patients about available treatment options (whether the option is covered by the plan), and should be able to advocate on the patient's behalf during an appeal process. Similarly, physicians are often in the best position to know when an HMO's internal management practices threaten the health or well-being of the enrollees.

North Carolina laws currently give physicians the right to file appeals in non-certification decisions. In addition, recent regulations prohibit carriers from using credentialing, utilization management, quality assurance or sanction programs to restrict physicians from providing information or assistance to patients. Yet these protections may not go far enough. At least one HMO, CIGNA, is on record as stating that it does not think providers should be able to file appeals on the patient's behalf (CIGNA, 1996). Steve Keene, the Director of Government Relations for the N.C. Medical Society, noted that physicians are afraid of retaliation by the carriers for advocating or filing appeals on the patient's behalf (Keene, 1997). Further, providers who notify state or federal regulators or private accreditation agencies of potential quality of care concerns are not protected from being sanctioned by the plan. The NAIC Network Adequacy Model Act contains more specific protections:

> "A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of a patient or patients within the utilization review or grievance processes established by the carrier or person contracting with the carrier. . . the health carrier shall not penalize a provider who reports to state or federal authorities any act or practice that jeopardizes the patient's health/welfare." (NAIC, Network Adequacy, 1996)

North Carolina, unlike at least eight other states, does not require carriers to allow providers an appeal when the provider's application to participate in the plan is denied or the provider is sanctioned or contract terminated (Families USA, 1997).

Recommendations: North Carolina has some protections allowing providers to inform patients of different treatment options. However, North Carolina's laws are not adequate to fully protect consumers. Current laws do not adequately protect providers who appeal on a patient's behalf; nor do they protect providers who provide information about financial incentives to their patients or those who file complaints with regulatory or accreditation bodies. North Carolina should expand its current anti-gag clause provision to provide greater protections for providers acting on a patient's behalf or provide financial compensation information to their patients. In addition, North Carolina should ensure that all carriers have an appeals mechanism for providers who have had their practice privileges in the plan reduced, suspended or terminated. This will help ensure that providers, for example, those who have higher utilization rates because they treat a disproportionate number of patients with complex medical needs, are not inappropriately sanctioned.

11) Providing Additional Information to Consumers Which Will Help Them Select from Competing Health Care Plans

Problem: Informed consumer choice is a necessary element for the proper functioning of the market (Varner, 1986). Enabling consumers to make informed choices requires the availability of sound, comprehensive, understandable data that compares the features of one plan to another. In the past, the issue of selecting health plans has largely been one left to the domain of the group purchaser (employer). However, in the past few years, a majority of insured workers (62%) have been offered a choice of at least two health plans (Jensen, 1997). Thus, the need for comparative information about plans is becoming more critical for individual consumers.

There have been numerous studies examining what type of information consumers want in selecting health plans. The General Accounting Office found that both consumers and employers want more information than they currently have (GAO, 1995). Consumers and employers want information that emphasizes outcomes rather than process or structure and information that is standardized to allow comparisons among provider and plans. Both consumers and purchasers are interested in access, quality, satisfaction with plans, and health outcomes (Research Triangle Institute, 1995; Edgman-Levitan, 1996). To be most useful, concerns about reliability and validity of the data should be addressed (GAO, 1995). Data should be made available to both employers and directly to the consumers, since few employers share available data with their employees.

Hibbard, in a study of individuals with private insurance, Medicaid, and the uninsured, also found that consumers were interested in access to information that compared the quality of health care plans (Hibbard, 1996). Overall, consumers were most interested in information about specific hospitals and physicians, rather than information about plans. However, even plan level information was useful. Several other studies noted that consumers were interested in how other enrollees evaluated their health plans, particularly evaluations of people in similar circumstances to themselves (Hanes, 1996; Research Triangle Institute, 1995; Edgman-Levitan, 1996). For example, people with chronic illnesses were more likely to rely on the evaluations of other people with chronic illnesses than the evaluations made by a relatively healthy population. Overall, however, consumers seemed most interested in information about cost, availability of one's own physician, quality of physicians and generosity of benefits and coverage (Hanes, 1996; Isaacs, 1996). Issues of plan quality that were most relevant to consumers related to the competence, compassion, and communication skills of individual providers.

Consumers are also interested in general information about how a managed care plan works, including the enrollees' rights, how to choose a doctor, how to switch physicians, what happens if a person needs experimental treatment, where clinics are located and their hours of operation (Edgman-Levitan, 1996).

In the last few years, some of the large purchasers of health care have started producing information to help facilitate consumer choice among competing health plans. Hoy examined the efforts of six major purchasers to produce materials to

help facilitate consumer choice (Hoy, 1996). All six purchasers used common techniques to help facilitate choice and promote competition based on quality and cost-effectiveness. The purchasers: 1) created a standardized benefit package which helped reduce risk segmentation across plans and made it easier for consumers to compare the plans; 2) offered a limited number of plans that met the purchaser's selection criteria; 3) provided comprehensive, reliable and objective consumer information comparing the plans; 4) held plans accountable through uniform reporting of performance data; and 5) augmented the written information with consumer education. No matter how thorough, written materials are not sufficient by themselves to meet the needs of consumers (Hanes, 1996). Consumer information should be augmented by an advice counselor, telephone access or some other mechanism to link the enrollee to a live person.

North Carolina does a particularly poor job in providing enrollees and the public with information about individual health plans. Until recently, the Department produced little information for the public about HMOs. In January, 1997 the Department produced its first report, entitled "HMOs in North Carolina: Status Report & Analysis of 1995 Activity." The report contains information about the numbers of licensed plans, types of HMOs (profit status, IPA or group model, gatekeeper or open-access), product offerings (including point of service and traditional HMO), enrollment information, some financial information (including average premium revenues and expenses per member per month as well as the medical loss ratio), Department of Insurance complaint rates, whether the plan collected HEDIS data or was accredited by NCQA, and some basic utilization data for the industry.[31]

The recent Department of Insurance report is a useful starting point, but lacks certain types of information that consumers want. For example, the state's report does not contain information about the providers covered under the plan (or other access measures), consumer satisfaction, quality of providers within the plan, outcome data or detailed information about the services covered or excluded by the plans. Nor does the plan provide detailed information about the number or nature of complaints filed against the plans, disenrollment numbers or adverse health outcomes. The Department does not currently collect most of this information, so is unable to make this information available to the public.

The Department provides no information comparing the services covered and excluded in the plans. Consumers, faced with a choice of plans, can only make these comparisons with difficulty, as carriers do not use a consistent format for describing the services that are covered or excluded. Prospective enrollees can obtain copies of marketing materials providing a summary description of benefits covered or excluded under the plan, but can not obtain copies of the Evidence of Coverage which provides more detailed information about the benefits covered and excluded, description of appeal rights, and what services require pre-authorization.[32]

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[31] The utilization data was provided by the carriers to an independent actuarial firm and aggregated for all plans. Therefore, no carrier specific information is available.

[32] In conducting the research for this dissertation, two HMOs initially refused to send out a copy of their Evidence of Coverage when requested, stating that the information was only available to enrollees (not prospective enrollees or the general public).

The information that is available is not always understandable.[33] Further, some of the information that would be most relevant to consumers is considered "proprietary" by some of the carriers. For example, all the health plans offered to state employees must provide mental health coverage (State of North Carolina, The Teachers and State Employees Comprehensive Major Medical Plan, 1996). Almost all of the HMOs have provisions which state that "all mental health services must be approved in advance...", otherwise it appears that the mental health benefits are unlimited: "all inpatient, partial hospitalization, residential treatment and intensive outpatient services covered at no charge." While these benefits look the same among plans, the coverage depends on the carrier's mental health utilization review criteria (N.C. Health Access Coalition, 1996b). Without information about the carriers' underlying utilization review criteria, a person with mental health problems will not be able to make an informed choice of plans. Similarly, individuals prescribed certain medications may need information about a carriers' formulary, and individuals with chronic health conditions may want to know more about the carriers' treatment protocols. This information is commonly considered proprietary, and is therefore unavailable to prospective enrollees.

Recommendations: North Carolina does a particularly poor job providing consumers and purchasers with information comparing different health care plans. The state can not rely on the existing data collected to meet consumers' need for information. Although information comparing health plan performance will not, in itself, ensure that services are accessible and high quality; exposing the plans' operations and outcomes to public scrutiny should improve the functioning of the market.

The Department needs to significantly increase the data that is collected and distributed to the public. To the extent feasible, the state should collect data that health plans are already collecting for other purposes (in order to minimize the additional reporting requirement on the plans). Eleven health plans stated in a recent report that they collected HEDIS data, so HEDIS is a good starting point for data to be submitted to the state. However, DOI should require carriers to independently audit the data if the state has reason to suspect its reliability. The state should also be given the authority to require carriers to submit different or additional data if there is a particular state health issue that needs to be monitored. In addition, health plans should be required to submit a record of the number and types of complaints filed inside the plan. The Department should also enforce current laws which mandate that carriers and utilization review organizations submit annual utilization review and appeal activity reports.

Carriers should also be required to provide prospective enrollees, upon request, information about their drug formularies, treatment protocols for specific

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[33] Although state law requires that Certificates of Coverage and other marketing materials be readable at the ninth grade level (Flesch test), medical terminology is specifically excluded in calculating the Flesch readability score (Shackelford, 1997). Further, carriers can select specific passages from longer documents in determining readability. The entire document must be reviewed for readability for documents that contain less than 10,000 words. Two 200 word sections per page must be reviewed for longer documents. Carriers conduct their own Flesch tests to determine the readability of the materials available to the public.

cases, treatments or procedures considered experimental and underlying utilization review criteria. In addition, plans should be required to give prospective enrollees copies of the Evidence of Coverage, which contains more detailed information about the benefits included and excluded. Many individuals need this information in order to make an informed choice and pick the plan that will best meet their medical conditions. Carriers should also be required to minimize the use of medical language and test whole documents for readability--to ensure that information provided directly to consumers is understandable.

12) Minimizing Ability of Health Plans to "Cherry Pick" Healthy Patients

Problem: As noted earlier, ten percent of the population uses more than 70% of the resources. Because so much of the health care resources are consumed by such a small number of people, health insurers and HMOs have a strong financial incentive to "cherry pick" healthier patients. As Alain Enthoven noted,

> "Unlike sellers of goods, sellers of health insurance have good reason to care about who buys their product. Medical expenses are distributed very unevenly. About 72 percent of annual national expenditures are spent on the 10 percent of the population with the highest costs. To survive in an unregulated market and to protect those who buy insurance from high costs, an insurer must seek to cover persons who are unlikely to need much care (good risks) and to avoid covering those who are likely to need care (bad risks)... Risk-avoidance strategies have led to high transaction costs in the individual and small-group markets, refusal to cover high-risk people, or coverage only at very high prices." (Enthoven, 1995).

The impact of adverse selection on a health plan can be staggering. For example, in 1989, the actuarial values of nine Federal Employee Health Benefit Plans (FEHBP) studied varied by no more than 35%, but the premium difference between the lowest and highest-cost plan was 246% (Jones, 1996). This difference was due primarily to risk selection, with the more comprehensive benefit plan attracting sicker patients.

There are a number of ways which health plans can attempt to segment the market to encourage healthy people to enroll and discourage unhealthy people. Changes in the benefit package to exclude certain services known to be used more heavily by high-risk enrollees, is one method already discussed. Plans can also avoid high-cost recipients by excluding providers who have traditionally served the highest cost patients (The Impact of Managed Care on Doctors Who Serve Poor and Minority Patients, 1995; Horn, 1995). For example, the GAO noted that one former health plan official reported that the health plan she worked for identified a specific provider who had a significant number of AIDS patients (GAO, 1996a). The plan dropped the provider from its panel in favor of an AIDS treatment clinic and saw its AIDS caseload decrease. GAO reported that this example demonstrated health plans' ability to identify specific providers as "magnets for high-cost recipients" and to reduce the carrier's costs by dropping or replacing certain providers. In addition, carriers can make it difficult to prospective enrollees to find out which specialty

providers are included in the network, use selective marketing strategies to attract healthy patients, establishing utilization review protocols that create barriers to the receipt of necessary high-cost care, pay providers and hospitals in ways that pass on to them increasing amounts of risk or remain silent about new treatment approaches such as successful ways to treat asthmatics (GAO, 1996a; Jones, 1996). The threat of risk-segmentation may be even greater if more of the risk is shifted to providers. "As physicians and other providers assume more and more of the risk, they are likely to have to develop their own set of practices for demarketing to the chronically ill, a frightening thought, given providers' better knowledge of which individuals in their practice are likely to be high-cost" (Jones, 1996).

While exhaustive research in this area has not been conducted, there is some anecdotal information to suggest that some of these practices have occurred in North Carolina. In a recent op-ed piece published in the Charlotte Observer, Aluko, an African-American cardiologist practicing in Charlotte noted that less than 15% of the 150 African-American members of the Charlotte Medical Society (an association of African-American and other minority physicians) have been included in an organized fashion in any of the area hospital physician network panels (Aluko, 1997). African-American physicians have a history of treating minority populations, who tend to be poorer and less healthy than the general population (Impact of Managed Care on Doctors Who Serve Poor and Minority Patients, 1995; Horn, 1994). Even those plans that have participated in Medicaid managed care programs have excluded minority physicians from their panels. Further, excluding physicians with experience serving higher cost patients could lead to a decline in the overall quality of care provided to these patients.

NAIC addressed this issue by limiting a health carriers' provider selection criteria:

> "The selection criteria shall not be established in a manner: (a) that would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or that would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care utilization." (NAIC, Network Adequacy, 1996)

In addition, some plans are known to be engaging in selective marketing strategies. The Department of Insurance noted a change in Blue Cross Blue Shield's marketing strategy which attempts to target a younger, healthier population: "In the past, BCBSNC had not targeted specific audiences and relied on a global approach to reach potential members, but recently this strategy has changed. For example, a special advertising campaign has been segmented to the Charlotte area only and focuses on value and stability and is targeted at a younger audience" (N.C. Department of Insurance, Market Practices Examination of Blue Cross Blue Shield, 1995).

Recommendations: Current law does not provide sufficient protection to prevent risk-segmentation practices by health carriers. Already there are some suggestions that plans exclude certain services likely to appeal to high cost users (for example, care for the chronically mentally ill), engage in selective marketing practices aimed at the young and healthy, and exclude certain providers who have historically treated high-cost patients.

The law should be changed to prevent carriers from discriminating against certain providers in their network development who are likely to treat high-risk patients. Although difficult to enforce, this provision would give providers a basis for appeal if they think that were excluded because of the patients they treat. The Department's authority to review marketing materials should also be expanded to allow the Department to require a health carrier to change its marketing strategy, if the marketing materials, *taken as a whole*,[34] suggest efforts to segment the risk to attract only healthy enrollees.

13) Involving Consumers More Directly in Policy and Operational Oversight of the Plans

Problem: Neither government regulators, the market, or employers can be counted on to completely protect the interests of consumers. State regulators may lack the resources or the legal authority to fully protect consumers; employers and large purchasers of care may have financial interests which conflict with the interest of particular employees; and market forces are unlikely to be useful exacting changes applicable to small numbers of enrollees. Physicians also have competing interests, between serving the needs of individual patients and maintaining good standing with a particular plan. Only consumers--individual enrollees--can be counted on to consistently represent their own interests.

Compared to other states, North Carolina consumers have relatively few official avenues to participate in the governance of the HMOs in this state. For example, North Carolina laws do not require enrollee representation on HMO governing boards, nor do they give enrollees the opportunity to participate in policy and operation matters. Most HMOs have a Member Services department that will record consumer complaints--but few plans involve consumers directly in establishing policy.

The N.C. Medical Society suggested the creation of an independent Commission or Institute with broad representation from providers and the general public to establish standards for the operation of managed care plans which affect patient services and provider contracts; help establish and operate a data driven monitoring system that evaluates quality and value of services provided; receive complaints and adjudicate grievances between patients, providers of care and managed care organizations; provide advice to the Commissioner about initial and continued

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[34] Individual marketing efforts could continue to be directed to different segments of the population, as long as the carriers entire marketing effort was not directed to young, healthier individuals.

licensure; and support the inclusion of health promotion and disease prevention as a condition of initial and continuing licensure of managed care organizations (Values in Medicine Task Force, 1996).

Recommendations: Unlike a majority of other states, North Carolina laws provide consumers no opportunity to participate in the development of an HMO's policy or operations. Although HMOs have Members Services sections, there is no guarantee that the carrier will consider consumer input. Requiring plans to establish separate mechanisms so that consumers can give input into policy matters would also not guarantee that carriers consider the input provided. However, the heightened publicity given by enacting such a provision might encourage plans to more seriously consider enrollee suggestions. Further, there is little downside to enacting such a provision.

The state should also establish a Managed Care Policy Board. The Board could serve many functions. First, it could act as the eyes and ears for different interest groups, and funnel problems and suggestions to the Department of Insurance. Second, it could help the Department develop an annual guide comparing different health plans and determine what, if any, additional information should be collected. The Policy Board could also suggest changes in the Department's regulations and oversight procedures. The Policy Board could also act as an independent, binding appeals board, to hear and make recommendations for certain HMO grievances. Alternatively, the Policy Board could serve in a non-binding role, following the external appeals process implemented in Florida and New Jersey. This is more palatable to the HMO industry (Rowan, 1997) and produces much of the same desired results as the industry usually follows the advisory board's rulings. Finally, the Board could help facilitate a dialogue among different interest groups.

14) Ensuring Sufficiency of Department of Insurance's Oversight Capabilities

Problem: While the Department appeared to be doing a good job overall monitoring HMOs for compliance with current law, some problems were identified. Specifically, the member materials were not always complete or understandable; the Department failed to track problems over time; the Department did a more thorough job monitoring network adequacy and accessibility in the past; and the Department did not follow-up with the carriers that failed to submit some of the required reports to the state. In addition, the Department did not consistently include information in the Market Practices and Market Compliance Examination reports that could be particularly useful to consumers, such as the number or nature of the internal consumer complaints filed with carriers, or the plan's compliance with its own accessibility standards. There was also some indication that the Department lacked the staff needed to properly monitor the growing managed care industry in the state. The Department of Insurance faces another problem which lessens its ability to enforce state laws and regulations. While North Carolina has many of the same regulatory enforcement mechanisms included in other states, most of the enforcement mechanisms are limited to egregious violations of the law.

Recommendations: Changes should be made to enhance the Department's oversight capabilities and make the data that is collected and reported more uniform

and useful to consumers and purchasers of care. The Department should be required to modify internal oversight mechanisms to ensure that market conduct examinations are standardized, that the Department tracks problems over time, and that the market reports contain consistent information. The Department should also use the consumer complaints it currently receives in the market conduct examinations and should provide more detailed information about the number and nature of underlying complaints to the public. The Department should also monitor the information reported by the carriers to ensure that all the required reports and data are submitted and that the data that carriers are required to report are comparable across plans.

The state needs an array of enforcement options to enable it to remedy all violations of the law, even when the violation is not egregious. Additional staff appear to be needed to meet the Department's ongoing monitoring and enforcement responsibilities, and to expand the Department's capacity to analyze data and prepare reports for the public comparing selected aspects of different plans. One way to expand the ability of the Department to meet its enforcement responsibilities with a more limited staff is to allow the Department to deem compliance with certain licensure requirements if the plan is accredited by an private accrediting body with the same or higher standards. In addition to relieving the state from some of its oversight responsibilities, this provision would also encourage more plans to seek private accreditation. Deeming should be limited to those plans that obtain full accreditation (as opposed to one year or partial accreditation), and only if the accrediting agency has the same or higher standards.

CONCLUSIONS

This research analyzed the extent to which the state of North Carolina protects HMO enrollees by examining current consumer protections, comparing North Carolina laws to other protections enacted or proposed elsewhere, reviewing the practices of the six largest HMOs in the state and the Department of Insurance's enforcement of current laws to identify potential problem areas, and analyzing different policy options. The recommendations were developed after considering the potential costs and benefits (or strengths and weaknesses where cost data were not available) of different policy options.

This report examines general consumer protections available to HMO enrollees, rather than remedies for specific health issues or conditions. The policy recommendations were constructed in a way that would recognize the need to ensure the adequacy of the process of delivering care, rather than trying to legislate specific health care practices. Many states have enacted or are considering legislation to regulate specific health care practices (such as requiring plans to provide hospital care for a certain length of time after a mastectomy or delivery). Although these bills address specific problems in the managed care industry; there is an inherent problem in taking a piecemeal approach to consumer oversight. It is impossible to anticipate and enact legislation covering all the different HMO health care practices that may adversely affect enrollees. In addition, health care practices are constantly changing. Enacting legislation to require health insurers or providers to follow

specific health care procedures is a cumbersome process and not responsive to rapid changes in the medical sciences. A more holistic approach is needed.

Few industries readily seek out or encourage greater regulation, yet some regulation and oversight is needed--both to protect consumers and ensure the efficient operation of the marketplace. The policy recommendations suggested in this report were intended to enhance the operation of the marketplace through greater disclosure of information about competing plans, build on reporting requirements already required by NCQA or HCFA, and substitute voluntary accreditation processes to meet some of the state licensure requirements. However, there were instances in which disclosure was inadequate or potentially misleading, or where disclosure could exacerbate risk segmentation across plans. In these instances, other mechanisms were suggested to protect consumers. In general, the most costly policy options--for example, those with the greatest potential to drive up premium costs or to significantly reduce HMO flexibility-- were rejected in favor of less onerous recommendations to the industry. It is also worth repeating that while this research focused on consumer protections available to HMO enrollees, most of these recommendations are equally appropriate for other managed care organizations, including PPOs, point-of-service plans and provider sponsored networks that integrate the financing and delivery of care.

The growth of HMOs in North Carolina has reached a critical stage. Enrollment in managed care organizations will continue to grow, as will the number of plans competing to enroll members. As the managed care industry becomes more competitive, and HMOs fight to lower prices in order to gain market share; an increased emphasis may be placed on cutting "costs" rather than providing appropriate and accessible services. Consumers may have an even harder time accessing needed services or receiving appropriate quality of health care services without an adequate array of consumer protections. Rather than wait for a crisis--like the one that occurred in the mid 80s in North Carolina with the collapse of two HMOs--the state should take a proactive approach and add additional protections to prevent harm from occurring.

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APPENDIX A:

Comparison of North Carolina HMO Laws with the Same or Similar Provisions in Commercial Health Insurance and Nonprofit Hospital and Medical Corporation Acts

Comparison of North Carolina HMO Laws with the Same or Similar Provisions in Commercial Health Insurance and Nonprofit Hospital and Medical Corporation Acts[35]

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
General statutory references:	58-67-1 et. seq	Scattered throughout Ch. 58	58-65-1 et. seq.
License Provisions (Certificate of authority)	58-67-10	58-2-125	58-2-125; 58-65-50, 58-65-55
• Filing requirements	58-67-10	58-2-125; 58-28-5; 58-16-5	58-65-50
• Notice and approval of significant modifications	58-67-10(d)(1), 11 NCAC 20.0601, 20.0602	58-8-5	58-65-125; 58-65-130; 58-65-155
• Grounds for approving license	58-67-20(a)	58-2-125	58-65-55
Powers of health insurer/HMO	58-67-35		
Evidence of Coverage:			
• Must be approved prior to use	58-67-50	58-51-85	58-65-40
• May not be deceptive	58-67-50		
• Required information	58-67-50(a)(3)b		58-65-60
• Must be readable at 9th grade level	58-38-35(a)(2)	58-38-1 et. seq.	58-65-60; 58-66-1 et. seq.
Consumer Protections			
Accurate information required:			
• No misleading or deceptive info.	58-67-65(a).	58-63-15(2); 58-63-15(9); 58-51-95; 11 NCAC 12.0518-.0536 (advertising)	58-63-15(2); 58-63-159(9)(history note includes Art. 65 and 66); 11 NCAC 12.0518-.0536 (advertising)
• Unfair trade practices prohibited	58-67-65(b)(makes HMOs subject to G.S. 58-63-1 et. seq.)	58-63-1 et. seq.	58-2-70; 58-2-65; 58-63-15 (history note includes Art. 65 and 66)
• Can't charge enrollee deductible/copayment based on charges when HMO pays discounted rates	11 NCAC 12.0561		

[35] Even if the statute does not expressly apply, insurance, HMO or nonprofit hospital or medical service corporations may still provide same protections.

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
• Policies/contracts/evidence of coverage must be understandable/readability test	58-38-35	58-38-1 et. seq.	58-66-1 et. seq.
• Misleading information intended to induce policy holders to terminate/surrender policies prohibited	58-67-65(b) makes Art. 67 subject to Art. 63; 58-2-70	58-3-115	58-3-115
• Fraudulent acts prohibited	58-2-171	58-2-171	58-2-171
Procedural protections:			
• Grace period to pay premiums	DOI takes position HMOs subject to same standards as commercials	58-51-15(a)(3)	DOI takes position nonprofit hospital/ med. subject to same standards as commercials
• 10 day free look period	Not addressed in statute; DOI takes position that HMOs held to same standards for non-group coverage only	58-51-10	58-51-10
• Time limits on defense--can't cancel policy more than 2 yrs from date of issue/reissue for misstatement unless fraud	Not addressed in statute; DOI takes position that HMOs held to same standard	58-51-15	58-65-25
• No evidence of insurability for groups of 50 or more; max. 12 mo. preex. cond. exclusion; prior time must be credited	58-67-85	58-51-80	58-65-60(e)
• Must issue standard and basic plans to small groups with guarantee to issue; max. 12 mo. preex. cond. exclusion (18 mo. for late enrollees); prior time must be credited; adjusted community rating	58-50-100 et. seq.	58-50-100 et. seq.	58-50-100 et. seq.
• May not exclude conditions through riders, must guarantee renewal with limited exceptions	58-3-173; 58-50-130	58-3-173; 58-50-130	58-3-173; 58-50-130
• Continuation and conversion provisions	58-53-1 et. seq.	58-53-1 et. seq.	58-53-1 et. seq.

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
• Can't cancel for employers' failure to make payroll deduction to pay premium unless advance notice to insured	58-50-40 Class H felony	58-50-35	58-50-40 Class H felony
• Insurance fiduciaries can't willfully fail to pay premiums, must give 45 days advance notice of termination of coverage	58-50-40	58-50-40	58-50-40
Non-Discrimination Provisions:			
• May not cancel/renew coverage because of deterioration in health	58-67-65(c)	58-50-130(a)(3)	58-65-25
• May not refuse to enroll employees/no medical underwriting	58-67-65(e), 58-50-130(a)(6)(small group)	58-50-130(a)(6) (small group), 58-51-80(a)(2) (large groups)	58-50-130(a)(6) (small group), 58-65-60(e)(1) (large groups)
• May not discriminate on basis of race/national origin	58-67-65(f)	58-3-25(c)	58-65-85
• May not discriminate on basis of gender or marital status	Although not directly prohibited, Dept. of Insurance would take this position based on G.S. 58-67-65(e)	11 NCAC 4.0317	11 NCAC 4.0317
• Auto. coverage for newborns/foster children, coverage for congenital defects	58-51-30	58-51-30	58-51-30
• Auto. coverage for adoptive children	58-51-125	58-51-125	58-51-125
• Coverage of children with mental retardation or physical handicap	Although not directly prohibited, Dept. of Insurance would take this position based on G.S. 58-67-65(e)	58-51-35	58-51-35
• Continuation of coverage for children who are mentally retarded or physically handicapped after reaching dependent age limits	Although not directly prohibited, Dept. of Insurance would take this position based on G.S. 58-67-65(e)	58-51-25	58-51-25

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
• Can't discriminate because child born out of wedlock, does not reside with parent, or court orders enrollment outside of normal enrollment period	58-51-120	58-51-120	58-51-120
• Protections for mentally ill or chemically dependent in groups of 20 or more	58-67-75	58-51-55	58-65-90
• Can't refuse to insure, renew, limit coverage or charge different premiums because of whole/partial blindness or deafness	Although not directly prohibited, Dept. of Insurance would take this position based on G.S. 58-67-65(e)	58-3-25	58-3-25
• Can't discriminate against individuals with sickle cell trait or hemoglobin C trait	Although not directly prohibited, Dept. of Insurance would take this position based on G.S. 58-67-65(e)	58-51-45	58-65-70
• Must provide same coverage of services provided in tax-supported institutions as covered for services provided in other public/private facilities		58-51-40	58-65-65
• Cannot consider Medicaid coverage in enrollment/covered services	58-51-115	58-51-115	58-51-115
• HIV/AIDS treated as any other illness	11 NCAC 12.0324	11 NCAC 12.0324	11 NCAC 12.0324
Mandated Benefits:			
• Pap smears and mammograms	58-67-76	58-51-57	58-65-92
• PSA tests	58-67-77	58-51-58	51-65-93
• Cancer medications	58-67-78	58-51-59	58-65-94
• Maternity care not less favorable; 42/96 hour coverage	58-3-170; 11 NCAC 12.0323	58-3-170; 11 NCAC 12.0323	58-3-170; 11 NCAC 12.0323
• Treatment of chemical dependency	58-67-70	58-51-50	58-65-75
• Bones, joints of jaw, face or head	58-3-121	58-3-121	58-3-121

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
Choice of providers:			
• Choice of pharmacy	58-51-37	58-51-37	58-51-37
• Optometrist, podiatrists, dentists, chiropractor, psychologists, fee-based practicing pastor counselors, clinical social workers, advance practice nurses		58-50-30	58-65-1
• Obstetrician-gynecologists without prior referral	58-51-38	58-51-38	58-51-38
Provider Accessibility and Availability			
• Performance targets which address number and types of providers, proximity of providers, average wait times, etc.	11 NCAC 20.0301, 20.0302		
Utilization Review and Appeals Provisions:			
• Must meet UR requirements or contract with entity meeting requirements	11 NCAC 12.0903	11 NCAC 12.0903	11 NCAC 12.0903
• Must make initial determination no later than two days after initial contact by insured	11 NCAC 12.0904	11 NCAC 12.0904	11 NCAC 12.0904
• Notice requirements for noncertifications	11 NCAC 12.0910	11 NCAC 12.0910	11 NCAC 12.0910
• Appeal provisions (30 days generally, 72 hours expedited)	11 NCAC 12.0914	11 NCAC 12.0914	11 NCAC 12.0914
• Standards and procedures used in utilization review decisions, available to Commissioner	11 NCAC 12.0905, 12.0909, 12.0918	11 NCAC 12.0905, 12.0909, 12.0918	11 NCAC 12.0905, 12.0909, 12.0918
• Records/reports of complaints, appeals and outcomes of appeals	11 NCAC 12.0915, 12.0917	11 NCAC 12.0915, 12.0917	11 NCAC 12.0915, 12.0917
• Telephone access to utilization reviewers	11 NCAC 12.0907	11 NCAC 12.0907	11 NCAC 12.0907
• Can't reimburse utilization review organizations on basis of amounts saved	11 NCAC 12.0916	11 NCAC 12.0916	11 NCAC 12.0916
• 10 day determination of eligibility for transplant coverage		58-3-102	58-3-102

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
Confidentiality of Medical Records:			
• Medical info. confidential	58-67-180, 11 NCAC 20.0408 (provider credentialing proc.), 20.0509 (QA activities)		
• Utilization review activities confidential	11 NCAC 12.0916(a)	11 NCAC 12.0916(a)	11 NCAC 12.0916(a)
• Insurance information and privacy act	58-39-1 et. seq.	58-39-1 et. seq.	58-39-1 et. seq.
• Medical info. collected by Commissioner confidential	58-2-105	58-2-105	58-2-105
Quality Assurance:			
• Must have QA plan to monitor, evaluate services and HMO	11 NCAC 20.0501 through 20.0503		
• Plan must include procedures to investigate and take corrective action over patient complaints, must be carried out by medically qualified staff	11 NCAC 20.0502, 11 NCAC 20.0505		
• When problems found, must take corrective action	11 NCAC 20.0507		
• Must maintain records for three years/next triennial review	11 NCAC 20.0510		
• If delegate QA activities, must review	11 NCAC 20.0506		
• Must report providers who have been sanctioned/removed from network to Bd. of Medical Examiners	G.S. 90-14.13		
Provider Credentialing:			
• Must credential providers before listing them in provider directory	11 NCAC 20.0401 through 20.0403		
• Information to be verified in professional credentialing	11 NCAC 20.0404(a)		
• Information to be verified for facility credentialing	11 NCAC 20.0404(b)		
• Recredentialing at least once every three years	11 NCAC 20.0407		

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
• Must have mechanism to remove providers from network	11 NCAC 20.0411		
• If delegate credentialing, must monitor	11 NCAC 20.0410		
Provider Contracts:			
• Provider contracts must be in writing, approved before use	11 NCAC 20.0201, 20.0205		
• Material changes must be reviewed and approved	11 NCAC 20.0203		
• Required provisions in provider contract	11 NCAC 20.0202		
• Authority to approve/ disapprove individual providers contracting with intermediaries to participate in HMO network	11 NCAC 20.0204		
• Uniform claims forms	58-3-171	58-3-171	58-3-171
• Must notify insured, and in certain instances, the providers if claim denied	58-3-172, 11 NCAC 4.0319(5)	58-3-172, 11 NCAC 4.0319(5)	58-3-172, 11 NCAC 4.0319(5)
Data Collected			
• Annual and quarterly reports	58-67-55; 11 NCAC 11C.0312	58-2-165	58-65-100; 11 NCAC 11C.0312
• Info. collected by DOI must be accessible to the public	58-2-100	58-2-100	58-2-100
• Cost and utilization info. for group contracts of 100 enrollees or more	58-67-55(e)		
Premium Rates:			
• Schedule must be filed and approved	58-67-50(b)(1), (c), (d); 11 NCAC 16.0601	58-51-85, 11 NCAC 16.0201-.0206	58-65-40; 58-65-45; 11 NCAC 12.0539
• Periodicity schedule for readjusting rates	58-67-50(b)(2) (nongroups)	58-51-80(g)	58-65-45 (nongroups), 11 NCAC 12.0539
Financial Solvency			
• Working capital	58-67-20(a)	58-7-75	
• Minimum deposits	58-67-25	58-5-55	
• Minimum net worth	58-67-110	58-7-75	
• Contingency reserves	58-67-40		58-65-95
• Consumer protections against insolvency (i.e., reinsurance, continuation of benefits)	58-67-115; 58-67-120; 58-67-125	58-62-1 et. seq. (guarantee assoc.)	58-62-1 et. seq. (guarantee assoc.)

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
• Allowable investments	58-67-60; 58-7-160 through 58-7-200	58-7-160 through 58-7-200	58-7-160 through 58-7-200
• Unearned premium reserves		58-3-71	58-65-95
• Directors or officers who collect or disburse funds must act in fiduciary relationship to enrollees	58-67-45	58-50-45	58-50-45
Accountability and Enforcement Mechanisms			
• Consumer Services Section investigation of complaints	11 NCAC 11-4.0115	11 NCAC 11-4.0115	11 NCAC 11-4.0115
• Commissioner must examine no less than once every three years	58-67-100	58-2-131	58-2-131
• Examination requirements	11 NCAC 19.006	58-2-131 through 58-2-133; 11 NCAC 19.006	58-2-131 through 58-2-133; 11 NCAC 19.006
• Hazardous financial condition	58-67-105	58-30-60	58-30-60
• Right to suspend or revoke license	58-67-140	58-3-100	58-65-125
• Rehabilitation, liquidation or conservation	58-67-145; 58-30-1 et. seq.	58-30-1 et. seq.	58-30-1 et. seq.
• Summary revocation in emergencies	58-2-70(h)	58-2-70(h)	58-2-70(h)
• Civil penalties or restitution, negotiate agreements	58-67-165(a); 58-2-70	58-2-70	58-2-70
• Cease and desist orders	58-67-165(d),(e)	58-30-60	58-30-60
• Restraining orders	58-2-60	58-2-60	58-2-60
• Criminal provisions	58-67-165(b)	58-2-60(b)	58-2-60(b)
Point of Service/PPOs			
• Commissioners rule making authority	58-67-35	58-50-55	58-65-140
• Differential for in-network and out-of-network care	11 NCAC 12.1403	58-50-55	58-65-140
• Marketing materials must explain method of reimbursement, applicable cost sharing, uncovered costs or charges, covered benefits	11 NCAC 12.1404		
• Provider accessibility and availability standards	11 NCAC 20.0300 et. seq.	11 NCAC 20.0101(a)(1); 11 NCAC 20.0300 et. seq.	11 NCAC 20.0101(a)(1); 11 NCAC 20.0300 et. seq.

Statutory Provisions	HMO Laws	Commercial Health Insurance	Non Profit Hospital and/or Medical and/or Dental Corp.
• Provider credentialing criteria	11 NCAC 20.0400 et. seq.	11 NCAC 20.0101(a)(1); 11 NCAC 20.0400 et. seq.	11 NCAC 20.0101(a)(1); 11 NCAC 20.0400 et. seq.
• Provider contract provisions	11 NCAC 20.0202 et. seq.	11 NCAC 20.0101(a)(1); 11 NCAC 20.0202 et. seq.	11 NCAC 20.0101(a)(1); 11 NCAC 20.0202 et. seq.
Miscellaneous			
• Forms (contracts, policies, evidence of coverage), must be preapproved by Commissioner	58-67-85 (master group contracts)	58-3-150, 58-51-1, 58-51-85, 58-51-95	58-65-40
• Provisions controlling governing boards			58-65-20
• Fees for filing documents	58-6-5(5); 58-67-160	58-6-5(5)	58-6-5(5)
• Insurance regulatory charges		58-6-25	
• Mergers and consolidation requirements			58-65-155, 58-65-160
• Group coverage available to local boards of education to cover students	58-51-81	58-51-81	58-51-81

APPENDIX B:

Comparison of HEDIS 3.0 Reporting Requirements to HMO Data Required to be Submitted to the N.C. Department of Insurance

Comparison of HEDIS 3.0 Reporting Requirements to HMO Data Required to be Submitted to the N.C. Department of Insurance

HEDIS 3.0 Requirements	HMO Documents Filed with Department of Insurance
Effectiveness of care, including information on childhood immunization status, adolescent immunization status, flu shots for older adults, breast cancer screening, cervical cancer screening, prenatal care in the first trimester, low birth weight babies, check-ups after delivery, treating children's ear infections, beta blocker treatment after a heart attack, eye exams for people with diabetes, follow-up after hospitalization for mental illness, how effectively the plan helps elderly people maintain high quality of life.	No information available
Accessibility and Availability of Care,[36] including information on appointment access, telephone access, adults' access to preventive and ambulatory health services, availability of primary care providers, availability of mental health/chemical dependency providers, availability of obstetrical and prenatal providers, initiation of prenatal care, low birth weight deliveries at facilities for high-risk deliveries and neonates, and availability of language interpretation services.	Some information available through Market Practices Examination Report about internal access standards; little information available about how well plans meeting standards.

[36] In addition to the data required to be reported for all HMO enrollees, the following information is also required for Medicaid enrollees: children's access to primary care providers, annual dental visits, availability of dentists.

HEDIS 3.0 Requirements	HMO Documents Filed with Department of Insurance
Satisfaction with Experience of Care, including an annual member health care survey and survey descriptive information.	No standardized information available; plans may conduct consumer satisfaction surveys, but not required to use standardized instrument or report results to the Department.
Health Plan Stability, including information on disenrollment, physician turnover, years in business, total membership, performance indicators, narrative information on rate trends, financial stability and insolvency protections.	Most of the HEDIS 3.0 financial stability information can be obtained from HMO financial report filed annually; however, information about members or providers who disenroll from the plan is not available.
Use of Services, including well-child visits in the first 15 months of life, well-child visits in the third, fourth, fifth and sixth year of life, adolescent well-care visit, frequency of selected procedures, inpatient utilization (general hospital/acute care), ambulatory care, inpatient utilization (non-acute care), discharge and average length of stay for females in maternity care, cesarean section and VBAC rate, births and average length of stay for newborns, mental health utilization (inpatient discharges and average length of stay), mental health utilization (percentage of members receiving inpatient, day/night and ambulatory services), readmission for specified mental health disorders, chemical dependency utilization, readmission for chemical dependency, outpatient drug utilization, frequency of ongoing prenatal care (Medicaid only).	Detailed utilization information is not available; plans are only required to report total annual physician visits, non-physician visits, and hospital patient days.

HEDIS 3.0 Requirements	HMO Documents Filed with Department of Insurance
Cost of Care, including information on high-occurrence/high cost DRGs and rate trends.	Rate trends (expenses PMPM, premiums collected PMPM) available; discharges, length of stays for high occurrence/high cost DRGs not available.
Informed Health Care Choices, including information on language translation services, and new member orientation/education materials.	No information available.
Health Plan Descriptive Information, including information on providers' board certification/residency completion, provider compensation, physicians under capitation, case management, utilization management and risk management systems, quality assessment and improvement, recredentialing, preventive care and health promotion, arrangements with public health, educational and social service entities, total enrollment, enrollment by payer, unduplicated count of Medicaid members, cultural diversity of Medicaid members, weeks of pregnancy at time of enrollment, pediatric mental health network, chemical dependency services, and family planning.	Carriers must provide information about quality assurance, utilization management, credentialing and grievance procedures, but it need not be updated when changed. Enrollment information is required to be reported separately by type of plan (i.e., Medicaid, Medicare, commercial, non-group). No information provided about number of providers who have completed residency and/or board certified; little information available about plan's compensation arrangements; no information available about the number of members who participated in health promotion/education programs or coordination with other public agencies.

(NCQA, 19996a, 1996c).

APPENDIX C:

Comparison of Selected Aspects of BCBSNC, Healthsource, Kaiser, PARTNERS, PHP and PruCare Health Plans

Comparison of Selected Aspects of BCBSNC, Healthsource, Kaiser, PARTNERS, PHP and PruCare Health Plans

Issue Area	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
General Information						
Plan Type	Non-profit, IPA gatekeeper model. Domiciled in NC.	For-profit, IPA gatekeeper model. Domiciled in NC; wholly owned subsidiary of Healthsource Management Inc.	Non-profit, group and IPA gatekeeper model. Domiciled in NC; wholly owned subsidiary of Kaiser Permanente Medical Care Program.	For-profit, IPA gatekeeper model. Domiciled in NC.	For-profit company, domiciled in NC, recently purchased by United HealthCare. PHP has both an open access and a gatekeeper plan. IPA model HMO.	For-profit corporation located in Texas. IPA and group model. Uses gatekeepers.
Received Certificate of Authority	1981	1986	1984	1986	1985	1985
Primary Care Providers	Family Practitioner, Pediatrician or General Internist.	Family Medicine, Pediatrics, Internal Medicine or General Practice, and OB/GYN for purposes of obstetrical or gynecological services only.	Family Medicine, Pediatrics or Internal Medicine unless otherwise agreed to by Carolina Permanente Medical Group.	Any provider who satisfied PARTNERS requirements to serve as a PCP, who has elected to be designated as PCP, and who is responsible for providing or coordinating care.	Family practice, general internal medicine, pediatrician, OB/GYN, or gynecologist.	General Internal Medicine, Pediatrics, Family Medicine, and OB/GYN for purpose of obstetrical or gynecological services only.

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Preventive Services	Well-baby care and routine office visits, immunizations, periodic health checks, certain screenings covered.	Covers well child care, physical examinations, pap smears, mammograms, PSA tests, immun. and health education programs.	Covers routine examinations and immunizations, some screenings.	Covers periodic examinations, pediatric and adult immunizations, screenings and inoculations.	Well child, annual medical and vision examinations.	Covers routine health assessments, including but not limited to: mammograms, pap smears, PSA tests and immunizations.
Therapy Services	Speech, physical, occupational and respiratory therapy (if expected to show significant improvement in short term). Combined inpatient and outpatient visits limited to 30 days for each type of therapy, other therapy services including dialysis treatments, radiation therapy and chemotherapy covered. Long-term rehabilitative therapy excluded.	Covers short-term physical and occupational therapy or speech therapy (if expected to show significant improvement within 60 day period); pulmonary and cardiac rehabilitation programs. Speech therapy only available to correct speech disorders that are result of diagnosed medical illness, surgery or accidents.	Covers physical therapy, chiropractic services, speech therapy, occupational therapy, and rehabilitation services if expected to show improvement within 2 months (subject to visit or length of time limits). Speech therapy limited to speech impairments of specific organic origin. Occupat'l therapy limited to services to achieve and maintain improved self-care. Long-term therapy or rehabilitation services excluded.	Covers cardiac or pulmonary rehabilitation (up to 3 months); short term physical therapy (up to 24 visits if expect to result in significant improvement) , speech therapy when significant improvement expected within predicted period of time. Excludes long term rehabilitative therapies or therapy for chronic condition which will not result in significant improvement, speech therapy unless accident or disease related.	Physical, occupational and speech therapy (limited to 20 visits per member per year.) Speech therapy for children of school age must be provided through the school system per P.L. 94-142 and will not be covered by PHP. Covers up to $500 for rehabilitative services.	Covers rehabilitative services, including physical, occupational and speech therapy for a condition that is subject to significant improvement through short-term therapy (services are limited to 60 days). Also covers inhalation therapy. Speech therapy only available to restore speech after loss or impairment of a demonstrated previous ability to speak, or therapy to develop or improve speech to correct a birth defect that impaired the child's ability to speak.

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Mental Health	Mental health services including outpatient care (individual and group therapy visits), inpatient facility care, and inpatient doctor care (limited number of inpatient and outpatient visits covered; only for purposes of short term evaluation and crisis intervention).	Excluded unless purchased in a rider.	Covered. Limited to evaluation, crisis intervention and short-term treatment which are responsive to short-term therapy. Excludes services which would not be subject to therapeutic management, including: chronic psychosis (except acute episodes if member is responding favorably to treatment plan); chronic organic brain syndrome (acute episodes are covered); intractable personality disorders (unless the member is responded favorably to treatment plan); mental retardation; court ordered mental health services unless medically necessary.	Excluded unless purchased as a rider. Excludes religious, marital, family and sex counseling.	Covers outpatient mental health and chemical dependency services, individual therapy services, group therapy services, intensive chemical dependency rehabilitation, inpatient mental health and chemical dependency services. Mental health and chemical dependency services are limited to a lifetime maximum of $25,000. Excludes mental health services beyond a short term evaluation or crisis intervention; marriage or family counseling; or for psychoanalysis.	Covers treatment for mental health, psychoneurotic and personality disorders including physicians' visits (or the equivalent), hospital inpatient stays and intermediate care facility services, subject to certain visit and day limits.

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Learning disorders	Excludes treatment for conditions related to developmental delay and/or learning differences.	Excludes evaluation and treatment of learning disabilities, delayed speech and stuttering.	Excludes psychological testing; court ordered testing, testing for ability, aptitude, intelligence or interest; and psychological testing for children with learning disabilities.	Excludes treatment for attention deficit/ hyperactivity disorder unless covered by a rider. Services, treatment or diagnostic testing of behavioral disorders, mental retardation, developmental or learning disorders excluded as are educational testing or training.	Excludes services beyond the period necessary for the evaluation and diagnosis for learning disabilities, behavior disorder and mental retardation.	Excludes services determined to be educational (including training in the activities of daily living, treatment of learning disabilities, or used to improve scholastic skills or preparation for an occupation; however not excluded if directly related to treatment for a sickness or injury that resulted in a loss of a previously demonstrated ability to perform those activities).
Substance Abuse	Covers chemical dependency services, including outpatient care, inpatient facility care, and inpatient doctor care (day limits); limited to $8,000 yearly maximum and $16,000 lifetime maximum.	Excluded unless purchased in a rider.	Substance Abuse (extent of coverage depending on group contract provisions).	Excluded unless covered by a rider.	See Mental Health Section for description of covered services. Chemical dependency services are limited to $8,000 yearly maximum and $16,000 lifetime maximum.	Detoxification and treatment of illnesses which are a result of alcoholism or drug abuse. Does not cover rehabilitative services.

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Transplants and Dialysis	Covers organ, tissue, bone marrow transplants, including cornea, heart, combined heart and lung, lung, kidney, simultaneous pancreas and kidney, liver and bone marrow for certain types of cancer.	Covers organ and bone marrow transplants if condition meets Healthsource's coverage criteria (i.e., sufficient evidence that the health intervention can be expected to produce its intended effects on health outcomes, the expected benefits outweighs the harms, and most cost-effective method available to address member's health condition); services provided at Healthsource approved facility; donor's expenses covered up to $10,000.	Covers transplants and dialysis including kidney, heart, heart-lung, liver, lung, cornea and simultaneous pancreas-kidney transplants; certain bone marrow transplants for children; and dialysis. Non-human and artificial organs are not covered; bone marrow transplants with high dose chemotherapy for germ cell tumors and neuroblastomia in children are covered, bone marrow transplants for other solid tissue tumors are not covered.	Covers organ transplants including heart, heart/lung, cornea, pediatric and neonatal heart, kidney, bone marrow, liver, lung, and pancreas when certain diagnosis and specific selection criteria met.	Unclear what type of transplants covered. Excludes transplants for cancer or those involving mechanical or animal organs. Excludes high dose chemotherapy with autologous or allogenic bone marrow transplant, except that this treatment will be covered for non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma (if at least one year old) , acute lymphocytic leukemia, and acute non-lymphocytic leukemia. PHP limits high dose chemotherapy with autologous or allogenic bone marrow transplants to one per lifetime.	Covers some transplants, but unclear what types of transplants covered.

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Reconstructive Surgery	Excluded: surgery and related services intended to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies and from which no significant improvement in physiological function could be reasonably expected.	Covers reconstructive surgery (intended to restore normal physiologic functioning).	Covers surgery that will result in significant improvement in physical function or will correct a significant disfigurement as a result of a non-congenital injury or medically necessary surgery, or treatment of congenital anomalies.	Covers plastic and reconstructive surgery needed to correct the results of a disease or injury. Surgery must be necessary to correct functional impairment, although breast reconstruction subsequent to mastectomy covered.	Covers when needed to repair a defect caused by an injury, infection or disease or congenital anomaly which result in functional impairment.	Covers surgery to correct the result of an injury, to treat a condition that impairs the function of a body organ or congenital defect, or reconstructive surgery after surgery for the treatment of a disease.
Health Promotion	Not listed in Member Certificate.	Covers health education services, specific services not specified.	Covers health education for high blood pressure, cholesterol, child and adult weight management, diabetes control, and stress reduction.	Nutritional counseling covered when approved (up to 3 visits per 12 months). Excludes printed health education materials.	Covers disease prevention, health promotion, community health programs and demand management for employer groups, diabetes education.	Covers instruction in personal health care.
Family Planning	Covers family planning services. However, contraceptives (other than legend oral or injectable contraceptives and diaphragms) excluded.	Covers family planning services (including vasectomies and tubal ligations, diaphragms, IUDs, Norplant, Depo-Provera).	Counseling, information on birth control, voluntary sterilization. Excludes outpatient contraceptive drugs and devices.	Covers family planning services but excludes contraceptives (unless covered by a rider). Covers voluntary sterilizations.	Subdermal birth control implants covered (limited to one insertion and removal per year).	Covered (does not specify if it covers contraceptives).

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Infertility Treatment	Covers some infertility services (including artificial insemination).	Excludes expenses for diagnosis or treatment of infertility (unless covered by a rider).	Artificial insemination is covered except for the cost of collection, storage, and processing of donor semen and donor eggs (other services for conception by artificial means are excluded). Drugs for infertility depend on contract.	Covers diagnosis. Excludes artificial conception procedures.	Covers infertility testing and initial diagnosis. Excludes health services related to the treatment of infertility including artificial insemination or fertilization methods.	Covered, but excludes infertility services and supplies (infertility treatments involving harvesting, storage and/or manipulation of eggs and sperm and certain drug therapies).
Abortions	Excludes elective abortions after 16th week of pregnancy.	Covered.	Elective abortions are not covered in some contracts.	Abortions limited to one per lifetime.	Covered.	Not specified.
Alternative Therapy	Covers biofeedback for certain specified conditions, otherwise excluded.	Covers biofeedback treatment.	Acupuncture and biofeedback (inclusion and extent of coverage dependent on group contract provisions).	Covers biofeedback (limited to 60 day period if approved by plan). Acupuncture is excluded.	Covers biofeedback training (for the treatment of headaches). Treatment, services, and supplies for acupuncture are excluded.	Not specified.
Prescription drugs	Covered.	Excluded unless purchased by a rider.	Inclusion and extent of coverage dependent on group contract provisions.	Excluded unless purchased by a rider.	Covered.	Not covered unless purchased separately as a rider.
Vision	Vision examinations, eye glasses covered only if purchased as a rider.	Excluded unless purchased by a rider.	Inclusion and extent of coverage dependent on group contract provisions.	Covers vision screening (for members up to age 18), other vision services excluded.	Excludes eye glasses, contact lenses or fittings for eyewear, radial keratotomy and other refractive eye surgery excluded.	Covers vision screening (for members up to age 18); Excludes eye exams and surgery, eyeglasses or lenses.

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Hearing	Excludes hearing aids and supplies, or hearing examinations excluded.	Excludes fitting or purchasing hearing aids (except if covered under rider).	Inclusion and extent of coverage dependent on group contract provisions.	Covers hearing screening (for members up to age 18). Excludes hearing aids, cochlear implants.	Excludes hearing aids, cochlear implants, and related services to correct hearing excluded.	Covers hearing screening (for members up to age 18). Excludes other hearing exams, hearing aids, cochlear implants.
Emergency room or urgent care	Emergency defined as "a sudden or unexpected onset of a condition requiring immediate medical or surgical care such that in the absence of care the Member could reasonably be expected to suffer serious physical impairment or death." Members must pay a copayment for emergency services unless admitted to the hospital. PCP will not pay for any follow-up care or treatment unless requested by the personal physician and determined to be medically necessary by the	Emergencies are defined as "an unforeseen illness or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. Follow-up care is covered only if provided by a member primary care provider or consulting specialist with referral from a PCP and prior authorization. Urgent Care includes "services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or	Emergency services are medical necessary medical and ambulance services that are required for unforeseen illness or injury when the onset of symptoms is both sudden and so severe to require immediate medical or surgical treatment. Emergencies include accidental injuries or unforeseen medical emergencies of a life-threatening nature, or which would result in a serious impairment to bodily functions if treatment were not provided	Emergencies are unforeseen illness or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or unforeseen medical emergencies of a life-threatening nature, or which would result in the serious impairment of bodily functions if treatment were not rendered immediately. PARTNERS does not cover emergency care provided inside the service area unless the	Emergencies are defined as serious medical conditions that are sudden or unexpected and require immediate medical or surgical care. In the absence of such medical care, the member could suffer serious physical impairment or death. The emergency room copayment will be waived if the patient is admitted to the hospital. For continued care to be covered by the plan, the care must be approved by PCP. PHP will pay for emergency or urgent care services provided outside of	Emergency medical services covered under the plan are those services provided to a person whose sickness or injury is of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to the person's bodily function. Emergency room services are subject to a copayment. Term deliveries (36 weeks or more) are not considered emergencies. Continued care provided after authorization for a medical emergency must be approved

This comparison of covered and excluded services is based on the benefits covered under one or more of the carriers' most commonly purchased policies. A particular service described in this comparison may or may not be covered, depending on the policy purchased.

Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Emergency Services	plan. Urgent care will be covered if outside of the service area. If, in the judgment of PCP, the condition did not constitute an emergency or require urgent care, then the member is responsible for all charges.	treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer an extended illness, prolonged impairment, or require more hazardous treatment." Further, care which could have been foreseen before leaving the immediate area, such as deliveries beyond the 35th week of pregnancy, dialysis or scheduled medical treatment, is not covered.	immediately. Copayment waived if admitted. Kaiser will cover the usual, customary and reasonable charges for out-of-plan emergency services for members who become ill or are injured while outside the service area. However, delivery after the end of the 34th week of pregnancy will not be covered.	condition, following review of the medical records, were determined to have been emergencies or urgent care services at the time services were rendered. Care provided outside the service area is covered if the member could not have reasonably anticipated the need for such services and supplies prior to leaving the service area and delay in receiving services and supplies would prove hazardous to the Members' life or health. Out of area care which could reasonably have been foreseen, such as routine maternal care and delivery, are not covered.	the service area. To be covered, an urgent medical need must be so serious that the health of the member would be risked if taken to a PHP provider or must be provided when a member is unable, because of his or her condition, to request treatment from a PHP provider.	by the primary care provider.

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Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Experimental or Investigational Therapies excluded	Excluded. PCP will rely on the following in determining whether a service or supply is investigational: 1) Services or supplies require federal or other governmental body approval, do not have unrestricted market approval from the FDA or final approval from any other governmental regulatory body for use in treatment of a specific condition; 2) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit evaluation of the therapeutic value; 3) There is inconclusive evidence that the service or supply	Excluded if there is insufficient evidence to draw conclusions about the health intervention's effects on health outcomes; the evidence does not demonstrate that the health intervention can be expected to produce its intended health outcomes or studies show that the adverse effects outweigh the expected benefits. Healthsource does not consider whether a member has tried other more conventional therapies without success in making the determination as to whether to cover certain "experimental" procedures.	Excluded if services cannot be legally marketed in the United States without FDA approval; are subject of a current new drug or device application on file with the FDA; are provided as part of a research trial; are provided pursuant to a written protocol that lists evaluation as part of its objectives; are subject to the approval or review of an Institutional Review Board or similar body; are provided pursuant to informed consent that describe the service as experimental or investigational; or the prevailing opinion among experts is that the use of the service should be substantially	Excluded if: 1) not generally accepted or endorsed by health care professionals in the general medical community as safe and effective in treating the condition, illness or diagnoses for which their use is proposed, or 2) not proven by scientific evidence to be safe and effective in treating the condition, illness or diagnosis for which their use is proposed.	Excluded if: (1) not generally accepted by informed health care professionals in the United States as safe and effective in treating the condition, illness or diagnosis for which its use is proposed, or (2) not approved by the FDA to be lawfully marketed for the proposed use; or (3) subject to federal law requiring Institutional Review Board review and approval for the proposed use; or (4) the subject of ongoing FDA-regulated Phase I, II or III Clinical Trials; or (5) not demonstrated through sufficient peer-review medical literature to be safe and effective for the proposed use.	Excluded if services or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy (including phase I, II and III clinical trials); prevailing opinion is that the service or supply needs further evaluation for the particular diagnosis; a drug, device or other supply that is subject to FDA approval does not have FDA approval or has approval only under its treatment investigational new drug regulation or is being used for an indication or at a dosage that is not accepted off-label use (with certain exception for drug prescribed for cancer treatment); the service or supply is subject to Institutional Review Board approval; the

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Selected Services	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Experimental or Investigational Therapies excluded	has a beneficial effect on health outcomes; 4) The service or supply is not as beneficial as any established alternative.		confined to research settings or further research is necessary to determine its safety, toxicity or efficacy of the service.		The fact that experimental service or treatment is only available treatment will not result in coverage.	informed consent or research protocol indicates that the service or supply is experimental or investigational.
Other unusual provisions	Excludes inpatient admissions primarily for diagnostic studies, prescription drugs for smoking cessation.	Excludes "care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column" unless purchased by a rider.		Excludes routine maternity care for dependent children, free standing birthing centers.	Excludes: Health services rendered as part of a covered treatment program that was terminated for patient noncompliance; General patient education programs except when medically necessary and approved in advance by PHP; Health services and associated expenses for megavitamin therapy, psychosurgery, nutritional-based therapy for alcoholism or other chemical dependency; services and supplies for smoking cessation.	

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Access Standards	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Accessibility (i.e., travel or distance standards)	No accessibility standards listed in materials reviewed.	No accessibility standards listed in materials reviewed.	No travel time standards listed in materials reviewed. However, service areas are linked to geographic areas which are no more than 30 miles from Kaiser's medical offices.	There was no information available in materials reviewed about Partner's internal access, waiting time, provider sufficiency standards.	Primary care and general hospital services had to be available within 20 minutes in metropolitan areas, within 30 minutes or 30 miles (whichever less) for suburban areas, and within 50 minutes or 45 miles (whichever less) in rural areas.	85% of members enrolled in PruCare should have a choice of at least two internists, pediatricians or family physicians within 10 miles (urban areas) or 15 miles (non-urban areas).
Appointment wait times:	Appointment standards: Urgent (within the same office day); Regular appointments (within two weeks for pediatrics or adult sub-acute problems, within four weeks for adult chronic care problems). Time in waiting room: generally no longer than 30/60 minutes but patient given option to reschedule earlier if scheduled appt.	Healthsource has developed appointment availability standards as well as wait time standards although the internal guidelines were not provided in the documents reviewed.	For primary care: urgent (24 hours), routine (30 days), physical exams with PCP (90 days), physical exams any provider (30 days). For specialty care: routine initial consult (30 days), routine visit (30 days).	Not included in materials reviewed.	Patients should not have to wait more than 30 minutes in the provider's office. Same day appointments were required for emergency and urgent care situations. PHP did not have guidelines regarding waiting times for routine appointments in 1995.	Members should have immediate access to an appointment for life threatening conditions, within 24 hours for urgent care, two weeks for routine or non-urgent medical care appointments, and 8 weeks for routine physical appointments.

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Access Standards	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Telephone answering response goals:	Maximum telephone abandonment rate of 5 percent; 90% of calls must be answered within 30 seconds.	Maximum telephone abandonment rate of 3%, average answer and holding time less than 30 seconds.	Telephone advice line: 100 seconds, no more than 10% abandonment rate. Member Services phone accessibility: answer within 90 seconds, no more than 8% abandonment rate.	Not provided in materials reviewed.	Member services: abandonment rate of no more than 5%. All calls must be answered within 30 seconds.	Member services: at least 85% of incoming calls answered within 30 seconds, with 5% or less abandonment rate.
Number of providers needed to serve enrolled population	PCP had not adopted a methodology to determine network adequacy, but was in the process of developing baseline criteria for network adequacy by geographic region.	Healthsource in 1995 did not use any statistical standards, such as patients per physician or travel times; relying instead on feedback from employers and Member Relations for determining need.	Kaiser established a provider staffing guidelines which was based on the assumption of three office visits per member per year; providers being "in-clinic" 70% of paid time; an average of 12 patients seen per four hour session in adult primary care (i.e., average 20 minutes per adult patient); 14 patients seen per four hour session in pediatrics (average 14 minutes per child).	Not provided in materials reviewed.	PHP has its own internal goals for how many primary care providers, specialists, other health care providers and facilities are needed to serve its enrolled population (although these internal goals were not available in any of the reports filed at the Department of Insurance; nor were the goals described in the Department's market practices examination).	Not provided in materials reviewed.

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Quality Assurance and Utilization Review Procedures	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Focus on underutilization	Not mentioned in materials reviewed.	Practice deviations, including underutilization, may trigger quality assurance study.	Looked at both under and overutilization.	Not mentioned in materials reviewed.	PHP looked for both over and underutilization of services.	PruCare looked for both over and underutilization of services.
UR time standards	BCBSNC failed to make all initial precertification determinations within two days in 1995.	Met appropriate standards in 1993.	Met appropriate standards in 1995.	Met appropriate standards in 1993.	In 1995, initial certification decisions took longer than the two days allowed in the regulations (PHP took six days to two weeks to make decisions)	Met appropriate time standards in 1994.
Appeal and Grievance Procedures						
Procedures	Informal appeals to member services. Noncertification appeals have three level appeals process. Member has right to appear at second level hearing. Expedited reviews available if member's health would be adversely affected by delay or if length of stay reduced or terminated. Other appeals have four levels of review;	Informal appeal to Member Services. Noncertification appeals have three levels. Member can appear at 3rd level. Expedited review available when regular process would be detrimental to health of member. Other appeals have 2 levels of appeal. Member can appear at third level of noncertification decision (not	Three levels of appeal for all types of appeals. Right to appear in person at second level. Expedited review allowed if need urgent care.	Enrollees are encouraged to first try to resolve their concerns informally, by contacting participating providers or plan staff members. Noncertification appeals have two levels of review. PARTNERS appeal provisions do not specifically authorize member or provider to attend hearing.	Enrollees are encouraged to first call the Customer Services Department to resolve complaints about the provision of health services for noncertification or benefits under the contract. Two formal internal grievance levels; member can appear at second level.	Informal appeal to Member Services. Administrative appeals (membership, eligibility, etc.) have four levels of appeal. Noncertification issues have one level of appeal. Other medical issues have three levels of appeal. Expedited review available in certain cases (criteria for expedited review

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Appeal and Grievance Procedures	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Procedures	member has chance to appear at 2d level review.	other appeals).		Other appeals have one review (with the plan). Members may file expedited appeal when regular appeals process would cause delay detrimental to the health of the member.	Expedited appeal available when the regular appeals process would cause delay detrimental to the member's health. After two internal levels of appeals, Certificate of Coverage notifies member about appeal rights to Commissioner of Insurance.	not given in materials reviewed). No right to appear at any hearing noted in the materials.
Time Standards	Noncertification: decision rendered within 30 days at each level of review; other appeals, decision rendered between 14 days (1st level) and 45 days (4th level). Expedited hearings within 72 hours of request, decision within one day of receiving all information.	Noncertification: decision within 30 days for first two levels; at 3rd level, hearing set within 30 days, decision within 5 business days thereafter. Expedited review within 72 hours; decision next business day after receipt of all necessary info. Other appeals, decisions (30 days 1st level, 10 days 2nd level).	Decision at first level appeal to Member Services Committee made within 30 days. No other time standards for resolving appeals (expedited or otherwise).	All decisions made within 30 days of request for review and receipt of necessary information. Expedited appeals reviewed within 72 hours of request; decision within one working day of receipt of all necessary information.	1st level decision within 30 days; 2nd level hearing within 30 days, decision within five days thereafter. PHP will review expedited appeals within 72 hours after request; and make a decision within one business day after receipt of all necessary information.	Generally 30 day time standard for rendering decision at each level. No time standards given for expedited review.

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Financial Information	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
1996 Enrollment	222,870	194,302	131,606	137,312	126,225	57,487
1996 Premiums Per Member Per Month	$111.94	$125.18	$122.94	$138.82	$130.51	$119.22
1996 Operating Profit Margin	(14.96%)	1.87%.	(11.11%)	5.31%.	3.63%	(13.73%)
1996 Medical Loss Ratio	100.5%	82.0%	104.9%	85.0%	80.0%	99.6%
Utilization Information						
1996 Ambulatory Encounters per 1,000 member months	278.45 physician visits (non-physician visits not listed)	348.29 ambulatory encounters	319.82 ambulatory encounters	453.82 ambulatory encounters	Not provided in financial report	249.8 ambulatory encounters
1996 Hospital Days per 1,000 members	276.1 days	233.2 days	225.7 days	292.6 days	220.4 days	258.6 days
Provider Contract Provisions						
Sanctions	No information was available based on the documents reviewed to determine BCBSNC's provider sanction policies (other than termination policies for failure to meet credentialing standards or for risk to health).	Providers may be placed on probation and/or assessed an increased amount of withhold or financial sanction, after approval by the Quality Assurance or Utilization Review Committee. Causes for such action may include, but not be limited to: inappropriate referrals by the	Providers, who fail to cure a non-compliance with the Carolina Permanente contract may be terminated within 30 days after the notice of such non-compliance. Immediate termination allowed if fails to meet credentialing standards or for risk to health.	Sanctions may be implemented if the Utilization Review Committee identifies continued problems with the physician practice patterns and/or excessive utilization. All the examples listed in PARTNERS utilization management document are examples of	Any provider identified with utilization pattern problems may be sanctioned. Noncompliance with performance requirements are identified through claims records, health services departments and customer services. In 1995, sanctioning was based on a point	No information was available based on the documents reviewed to determine PruCare's provider sanction policies (other than termination policies for failure to meet credentialing standards, risk to members health or releasing proprietary information).

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Provider Contract Provisions	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Sanctions		physician; inpatient or outpatient utilization patterns which exceed plan norm for specialty; noncompliance with Healthsource stated policies and procedures; or submission of claims requiring additional review for appropriateness or correctness of billing. Providers may appeal a decision to sanction or suspend their participation in the plan.		overutilization or inappropriate use; none of potential underuse of services. PARTNERS may terminate a physician contract pursuant to the performance review process, for failure to meet credentialing standards or other selected reasons.	system. New physicians (who have not joined existing practices) were exempt for the first 12 months to give them time to learn the PHP policies; thereafter, physicians were allowed five sanctions per year. However, PHP planned on modifying this system to include a weighted point system based on the severity of noncompliance; the ability to impose monetary fines; and accumulating points from year to year (which would allow PHP to track problems over time).	

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Provider Contract Provisions	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Primary Care Reimbursement	Primary care providers paid a capitation payment based on the member's age and sex. Primary care providers who have less than 100 members are paid the lesser of the physician's normal charges or fee schedule, plus a monthly management fee.	Paid on a fee-for-service basis the lesser of the physician's usual and customary fees or a maximum allowable charge (set by the plan). Alternatively, Healthsource will pay providers an age-sex adjusted capitation payment or based on other mutually agreed upon payment methodology. Compensation for laboratory covered services provided to members is paid on a fee-for-service or capitated basis.	The Carolina Permanente Medical Group is paid a fixed per capita rate based on the number of members enrolled at the beginning of each month (DOI, Market Practices Examination of Kaiser, 1995). Contracting providers (i.e., IPAs, community providers) are paid on a capitation basis, which covers the diagnosis, evaluation, management and treatment, laboratory and radiology services and other related ancillary services.	Paid on a fee-for-service basis in the amount of recognized charges. Recognized charges are the lesser of the fees billed by the physician or the maximum fee set by PARTNERS.	Physicians are paid the lesser of their customary charge for health services or fee maximums set by the plan.	Paid the lesser of the usual and customary charges billed by the physician or a maximum specified by Prudential.
Withholds and incentives	Primary care providers are not subject to a withhold, but may receive incentive payments at the option of PCPNC.	Healthsource may withhold 5% from primary care providers and 10% from consulting specialists to establish a risk	Not mentioned in materials reviewed.	Physicians are subject to withholds; the particular amount is determined by PARTNERS. A different withhold	The withhold varies from 5 to 15 percent, depending on the provider's contract. The Board has sole discretion of	Unknown from materials reviewed.

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Provider Contract Provisions	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
		reserve fund to meet the financial requirements of the plan. Healthsource may distribute these funds, in its sole discretion, based on a methodology looking at the cost and/or utilization of services provided to members by individual physicians and/or any group of physicians.		percentage may be applied to different physicians or different categories of physicians. PARTNERS may either increase or decrease the percentage withheld based on its needs. PARTNERS has total discretion over distribution of withholds. The board will determine whether to return the withheld amounts, based on quality, utilization, cooperation with medical management, experience, patient relationships and patient satisfaction, and adjustment for catastrophic cases. PARTNERS may also provide additional incentives.	whether to disburse the reserved funds (i.e., the withholds), depending on the carrier's net income, medical expense budget, individual physician cost effectiveness and other criteria. The Board of Directors may also distribute incentive payments, which may be based on utilization and cost-effectiveness criteria of individual providers.	

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Provider Contract Provisions	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Continuation of care when provider contract terminates	Personal Physician shall remain obligated to continue to provide medical care to Members that are receiving ongoing care until PCP-NC can arrange for the Member to select another Personal Physician. Limited to period of up to an additional ninety (90) days.	Physicians are required to continue to provide covered services to members until reasonable and medically appropriate arrangements are made for the continued care for the member (with reasonable compensation from the plan).	Carolina Permanente will not terminate a contract without cause with a community physician that has at least 1,500 members prior to the first anniversary of the renewal date of all members enrolled in the contract, or the renewal date of all members enrolled with the provider which occurs after the expiration date of the contractual agreement. In the event of termination with other providers, the provider will provide services to the Members until the medical group has made alternative arrangements or services are no longer necessary.	If provider contract terminated, provider must continue to provide services to the member until a course of treatment is completed or until PARTNERS makes medically appropriate arrangements for another provider to provide services.	Physicians are required to continue to provide treatment to members who are receiving active treatment at the time that the physician stops participating in the plan, until the course of treatment is complete or PHP makes a medically appropriate arrangement with another provider. This provision applies regardless of the cause of the provider termination.	Providers will, if asked by Prudential, continue to provide health care services for existing covered persons until alternative care is arranged, but not longer than one year.

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Provider Contract Provisions	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Other Unusual Contract Provisions	BCBSNC has a provider contract provision affirmatively mandating providers to seek review if provider thinks medical care being provided or denied is inappropriate and contrary to accepted professional or ethical standards of medical practice.	Healthsource includes a provision in its hospital contract prohibiting hospitals from entering into direct contracts with employer-sponsored health plans unless provided under a fully insured health benefit plan, or if this non-competition provision is legally prohibited. Hospital contract includes anti-disparagement clause (modified "gag-clause") which prohibits hospitals from saying anything that might disparage Healthsource, the quality of services offered or would otherwise damage the relationship between Healthsource and Members or employer groups.				PruCare has a special portability provision for members who require non-routine, non-elective ambulatory medical care while temporarily away from service areas. PruCare also has a contract provision allowing contract holders a 31 day grace period.

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Grievances, Complaints and Malpractice	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
Utilization Review Activity Report	Utilization review activity and appeal report for the last three years not on file with the Department of Insurance.	Utilization review activity and appeal report for the last three years not on file with the Department of Insurance.	Utilization review activity and appeal report for the last three years not on file with the Department of Insurance.	In 1995, 34 acute hospital admissions were completely denied for various reasons (7 were appealed, all 7 denials were reversed and paid). 18 acute hospital admissions were partially denied (13 appealed and reversed). There were 22 appeals presented to the second level of appeals process seeking reconsideration of noncertification issues. Of these, 13 were reversed and paid; 9 remain denied. No complaints were filed in court.	Utilization review activity and appeal report for the last three years not on file with the Department of Insurance.	Utilization review activity and appeal report for the last three years not on file with the Department of Insurance.
Complaints with the Department of Insurance (per 100,000 member months)	Information about PCP (BCBSNC's line of business) not available.	1993 - 2.67 1994 - 3.05 1995 - 2.59	1993 - 1.84 1994 - 1.99 1995 - 2.07	1993 - 1.9 1994 - 2.2 1995 - 1.2	1993 - 1.37 1994 - 2.07 1995 - 2.57	1993 - 1.8 1994 - 1.9 1995 - 2.4

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Grievances, Complaints and Malpractice	BCBSNC	Healthsource	Kaiser	PARTNERS	PHP	PruCare
1995 Malpractice Claims	Information not provided in 1995 Financial Report.	None.	5 legal claims processed, 3 claims settled without legal proceeding, 7 claims closed with payout, 2 closed without payout.	None.	None.	None in North Carolina
Sources of Information	Annual Financial Report, 1994-1996; Provider Contracts, 1995 Market Practices Examination, Group Insurance Benefits A92P73-000F 1996.	Annual Financial Report, 1994-1996; Provider Contracts, 1995 Market Compliance Examination, 1993 Market Practices Examination, Member Certificate, 1996, CPHP Internal Grievance Procedure, Quality Assurance Program.	Annual Financial Report, 1994-1996; Provider Contracts, Group Evidence of Coverage 1996, 1997 Group Medical and Hospital Service Agreement, 1995 Market Practices Examination, 1992 Market Practices Examination.	Annual Financial Report, 1994-1996; Provider Contracts, 1993 Market Practices Examination, 1993 Market Compliance Examination, 1995 Report on Utilization Review, 1995 Certificate of Coverage, 1994 Quality Assurance Charter, Utilization Management Plan.	Annual Financial Report, 1994-1996; Provider Contracts, 1995 Market Practices Examination, 1992 Market Practices Examination, 1996 Certificate of coverage #COC94-1, Quality Management Program, Utilization Management Program.	Annual Financial Report, 1994-1996; Provider Contracts, 1995 Market Compliance Examination, 1993 Market Practices Examination, 1996 Certificate of Group Health Care coverage, Description of Quality Assurance Program, Grievance Procedures, Utilization Review Program.

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