

HEDIS Report

Annual Report and Analysis of 2006 Activity

North Carolina Department of Insurance



Jim Long,
Insurance Commissioner

Table of Contents

I. Glossary of Managed Care Terms.....	3
II. Frequently Asked Questions.....	4
III. Choosing a Managed Care Plan	5
IV. Member Satisfaction	6
V. PREVENTIVE & CHRONIC CARE.....	15
VI. YOUR RIGHTS AND RESPONSIBILITIES	34
VII. ABOUT THE NORTH CAROLINA DEPARTMENT OF INSURANCE	35

ALL DATA REPORTED IN THIS REPORT ARE FOR THE 2006 CALENDAR YEAR, UNLESS OTHERWISE NOTED.

Dear Managed Care Consumer:

Whether you are currently enrolled in a managed care plan (an HMO or a PPO), are shopping for health insurance or just wish to learn more about managed care, this guide was designed to help you become a more informed consumer. Inside you will find answers to many common questions about managed care, as well as useful information about the managed care companies licensed to operate in North Carolina.

I encourage you to learn as much as you can about your health insurance options and your rights as a health insurance consumer. To help you in that effort, your Department of Insurance offers this guide, as well as other health plan information, including a general guide to health insurance and a booklet outlining your rights to health plan appeals and grievances. You can find these and other helpful publications on the Department's website www.ncdoi.com. You may also request additional information or assistance resolving a problem with your health plan by calling our Consumer Services Division at 1-800-546-5664.

Sincerely,
Jim Long, Commissioner of Insurance

I. Glossary of Managed Care Terms

Appeal - A written request for a plan to reverse its utilization review decision to deny coverage of a requested service.

Grievance - A written complaint (other than an appeal) from a member about an insurer's decisions, policies or actions related to the availability, delivery or quality of healthcare services, claims payment or handling, reimbursement for services or the contractual relationship between a member and the plan.

HEDIS® - The "Health Plan Effectiveness and Information Set," a set of standardized performance measures and data collection methods developed by the National Committee for Quality Assurance (NCQA), designed to help consumers compare HMOs. By July 1 of each year, North Carolina HMOs are required to report certain HEDIS measures to the Department of Insurance Consumer Services Division, which then publishes the data for public review and use.

HMO (Health Maintenance Organization) - A health plan that provides or arranges for the delivery of healthcare services to members through a designated provider network, for a fixed, pre-paid monthly premium.

Member - A person covered under a managed care plan.

NCQA Accreditation - The National Committee for Quality Assurance (NCQA) evaluates and reports on the quality of HMOs across the nation. HMO participation in the NCQA accreditation program is voluntary.

Noncertification - A formal decision, made through a plan's Utilization Review process, to deny coverage for a requested service.

POS/HMO (Point-of-Service HMO Plan) - A type of HMO plan that allows members to receive care for some services from any provider they choose, with the member bearing a higher out-of-pocket cost, such as a higher copayment.

PPO (Preferred Provider Organization) Benefit Plan - A health plan that offers members lower out-of-pocket costs when they receive care from providers in the plan's network. For a higher out-of-pocket cost, PPO plan members can receive care from out-of-network providers at any time for all covered services.

Provider Network - The doctors, hospitals and other health care professionals and facilities under contract with a health plan. These are called "in-network" or "participating" providers.

Primary Care Provider (PCP) - Doctors who provide general health care services. PCPs usually include family practitioners, general practitioners, pediatricians and internists. Some HMOs require members to obtain authorization from their PCP to obtain specialty care.

Utilization Review (UR) - The process by which a managed care plan assesses whether requested health care services are medically necessary and appropriate. The review is sometimes conducted prior to the services being rendered, so that the plan can approve or disapprove coverage in advance ("prospective review" or "preauthorization"). The review can also occur during the course of treatment ("concurrent review") or after treatment is completed ("retrospective review").

II. Frequently Asked Questions

What is a Managed Care Plan?

A managed care plan is a health plan that utilizes a variety of techniques to manage the use of health care services in order to control costs, improve the quality of healthcare and the health outcomes of its members, or both. The goal of the most effective managed care plans is to deliver the right care at the right time, in the most cost-effective setting.

Which providers can I see?

A managed care plan arranges for the delivery of health care services to its members through a designated network of providers (doctors, hospitals and other health care practitioners) that have agreed to charge specified rates. A member typically pays a fixed copayment each time he or she obtains a medical service or fills a prescription. Members of HMOs are generally required to receive their services from the plan's network providers, while members of HMO Point of Service (POS) plans and PPO benefit plans may choose to see non-network providers. Members who choose to utilize non-network providers typically pay a higher copayment in addition to any charges over and above the amount the plan reimburses the provider. Thus, the freedom to choose any provider comes at a higher out-of-pocket cost.

- Member cost is greater for care received outside of the plan network, but the difference between in-network and out-of-network benefits can vary from plan to plan.
- HMO plans require use of network providers in order for benefits to be paid.

- HMO Point-of Service (POS) plans must provide reimbursement for most covered services when received out-of-network, but the member's out-of-pocket cost is higher.
- PPO plans must reimburse for all covered services when received out-of-network, but the member's out-of-pocket cost is higher.
- For emergency services, health plans cannot require use of a network provider or require the member to pay more out-of-pocket for use of a non-network provider in an emergency.

What if I need to see a specialist?

Many managed care plans have removed requirements that obligated a member to obtain a referral to a specialist from his or her Primary Care Physician (PCP). Plans with no referral requirements are called "open access" plans. Referral requirements are more common in HMO plans. If a referral is necessary, the PCP is expected to make the referral to a physician in the plan's network; however, members should always make certain that the specialist is a network provider. Female members age 13 and older must be allowed direct access to obstetrician-gynecologists without prior referral from another physician.

Who chooses my plan's coverage and benefit limits?

Most Americans are covered under "group" coverage through an employer. The employer reviews coverage options and costs with the health plan and makes decisions about plan design. These decisions identify covered and non-covered services, the member's copayment, coverage limits (dollars per year, visits per year, etc.) and other plan features.

A word of advice: There are many things to consider when choosing a health plan. You should base your decision on those factors that are most important to you and your family. Since everyone's needs are different, what is right for someone else may not be right for you.

III. Choosing a Managed Care Plan

Which Health Plan is Right for Me?

Before selecting a health plan, you should review plan documents carefully, call the plan for information if needed and talk with your coworkers and friends about their experiences. Health plans are required by law to honor your request for a copy of the policy or evidence of coverage, coverage criteria for specific conditions and information on prescription drug formularies and coverage of experimental procedures, even before you enroll.

These are some things to consider when choosing a health plan:

- Are your doctors, including specialists, in the plan’s network?
- Will you need to obtain a referral in order to see a specialist?
- What will your out-of-pocket costs be for premiums, copayments and deductibles?

- If someone in your family has a chronic condition, does the plan have a program to monitor that condition?
- What services are covered, and what services are not covered?
- Are the prescription drugs that you take included on the plan’s list of preferred drugs (drug formulary)? If not, how much will you have to pay to obtain those drugs if a preferred drug cannot be substituted?
- How can you obtain care when you are out of town?
- Is the plan accredited by an independent agency, such as the National Committee for Quality Assurance (NCQA), the American Accreditation HealthCare Commission/URAC, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Foundation for Accountability (FACCT)?

North Carolina law does not require HMOs or PPO plans to obtain independent accreditation, and this alone is not necessarily an indication of which plan is best for you.

Figure 1	Benefits	Family Physician	Other Providers	Customer Service	Affordability
Why It Matters	Exclusions (services and treatments not covered) vary from plan to plan and may include treatments recommended by your doctor.	Your family physician is your primary source of medical treatment and advice. In many plans, your primary care physician also acts as a "gatekeeper" who determines whether and when you will be referred to a specialist and also coordinates your care.	These include specialists, hospitals, pharmacies and other providers from which you may be required to receive your care. Plans are only required to refer you to out-of-network providers when they do not have a qualified network provider reasonably available to you.	Just as with other businesses, the flexibility, concern and responsiveness shown by your health plan can be important factors in determining your satisfaction. Service can vary greatly between plans, and some plans are more service-oriented than are others.	Consider both the monthly premium and the out-of-pocket expenses associated with a particular plan. Out-of-pocket expenses include deductibles, coinsurance and copayments. If you routinely require a particular medication or treatment, these costs can add up quickly.
How to Find Out More	Request a copy of the plan's evidence of coverage and drug formulary. Note which treatments, services and supplies are covered and which are not.	Request a copy of the plan's provider directory (some plans have more than one). Determine whether your current providers are in the network or whether there are network providers that will suit your needs. Determine which providers are convenient to your home and/or work. Call several providers to verify their continued participation, determine whether they are accepting new patients and determine typical waiting times for sick and well appointments.		Call the customer service department and note how you are treated. Is the person courteous and knowledgeable?	Review the premium information contained in the pre-enrollment materials provided by the plan or your employer. Review the evidence of coverage and summary of benefits for out-of-pocket expense information.

IV. Member Satisfaction

Since HMOs have rules on how, when and where a member can obtain services, every HMO should make it easy and convenient for its members to obtain needed services. One way to tell how well HMOs meet their members' needs is to see how members rate their plans in areas such as quality of care and customer service.

North Carolina law requires HMOs to measure member satisfaction every year, using the Consumer Assessment of Health Plans Survey (CAHPS), which is part of the Health Plan Employer Data and Information Set (HEDIS). The HMO must

hire an independent survey firm to select a sample of members and administer the survey. Because all of the surveyed members respond to the same survey questions, comparisons between plans are more reliable.

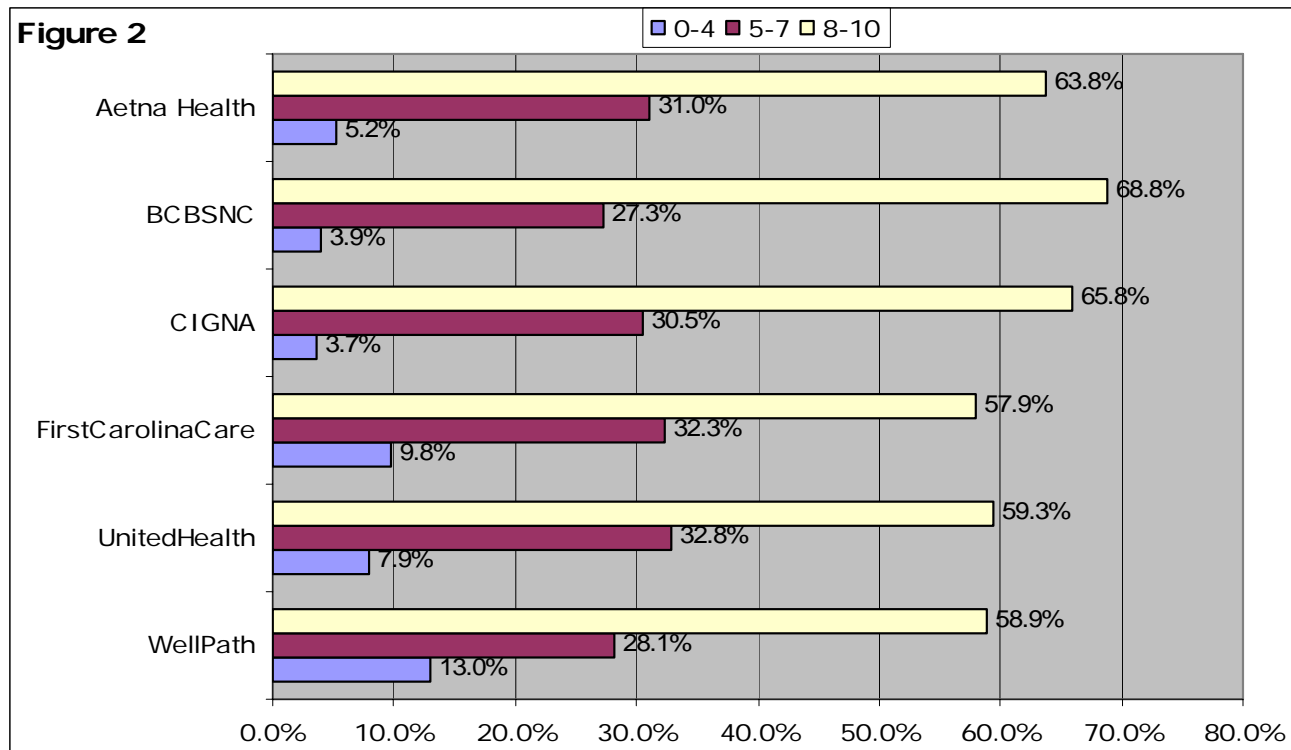
North Carolina law does not require PPO plans to conduct the CAHPS member satisfaction survey, so these plans are not represented in this section. Data included reflects each HMO's fully insured business only.

Insurance Company Abbreviation key for the following charts:

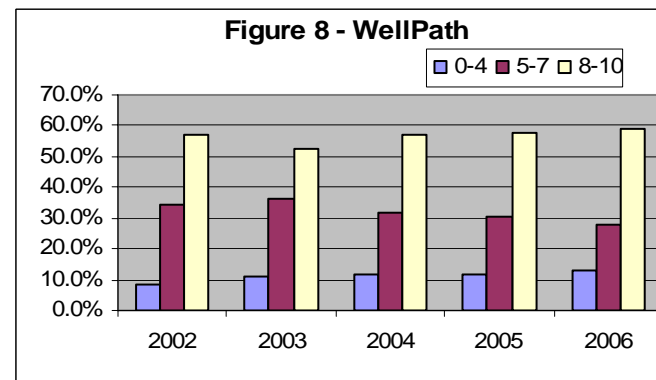
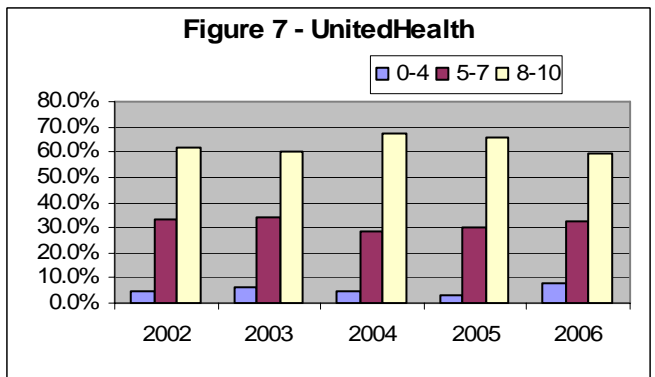
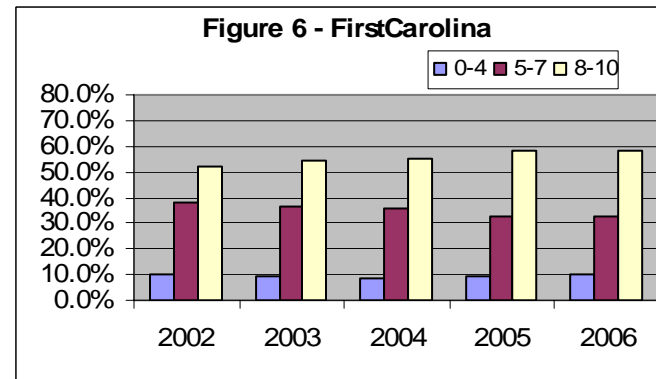
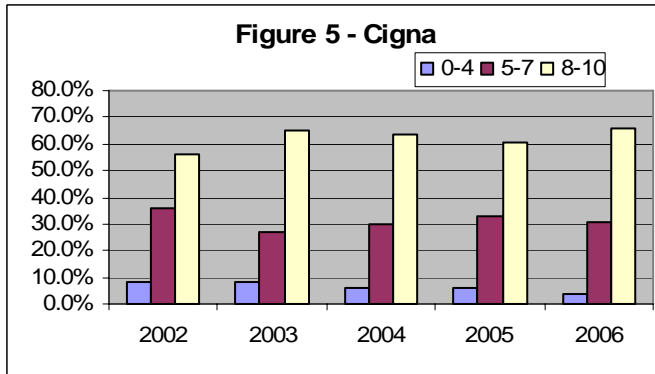
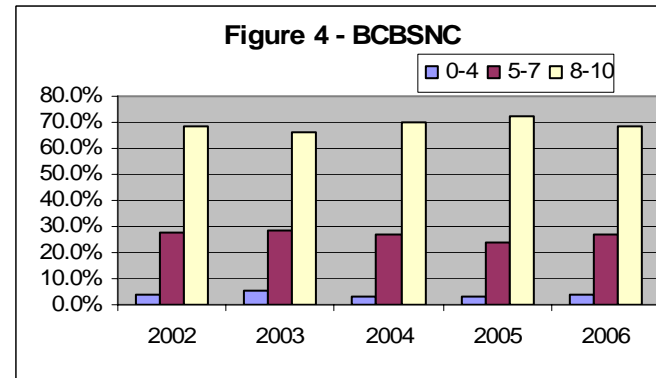
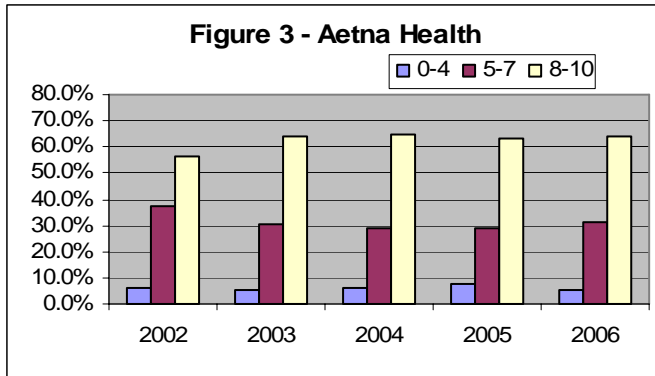
Aetna Health = Aetna Health of the Carolinas Inc.
BCBSNC = Blue Cross & Blue Shield of North Carolina
CIGNA = CIGNA HealthCare of North Carolina, Inc.
FirstCarolinaCare = FirstCarolinaCare, Inc.
UnitedHealth = UnitedHealthCare of North Carolina, Inc.
WellPath = WellPath Select, Inc.

Overall Satisfaction with Plan: Adult Members

The CAHPS survey asked a sample of HMO members to give their plans overall ratings on a scale of zero (“worst plan possible”) to 10 (“best plan possible”). Figure 2 shows the percentage of sampled members who rated their plans within the ranges of 0-4, 5-7 or 8-10. Figures 3 - 8 show the percentages by plan for 2002 - 2006.



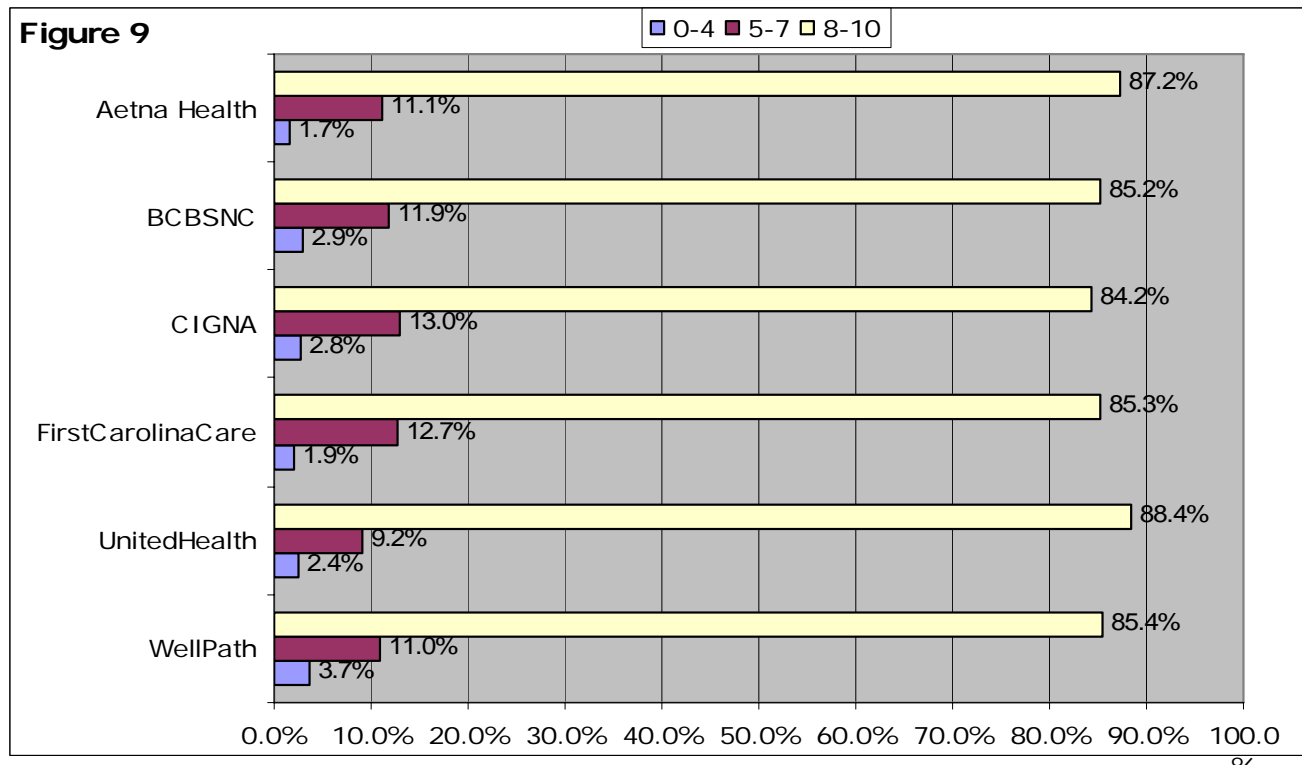
Source: Consumer Assessment of Health Plans Survey (CAHPS)



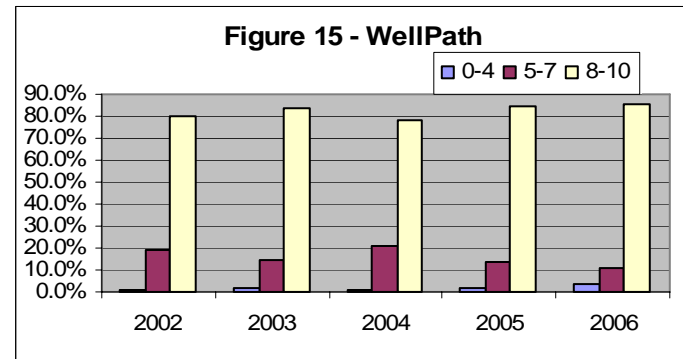
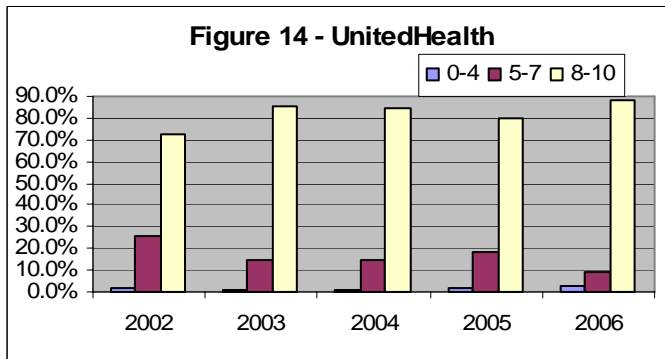
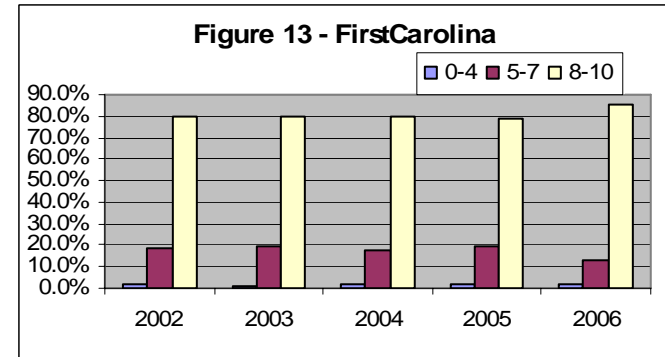
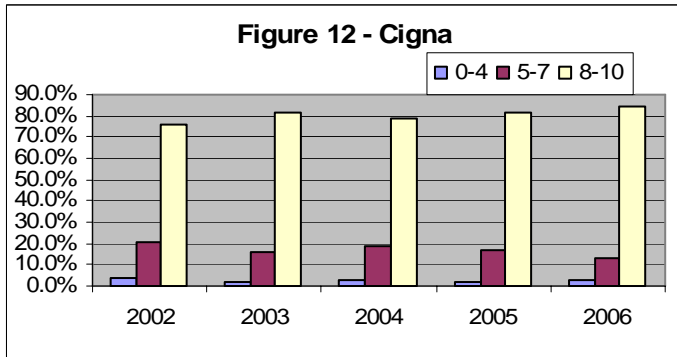
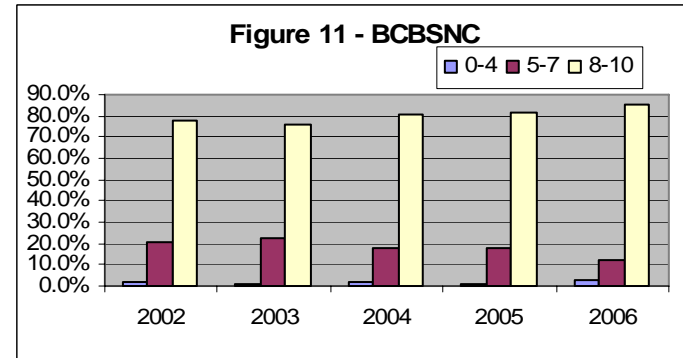
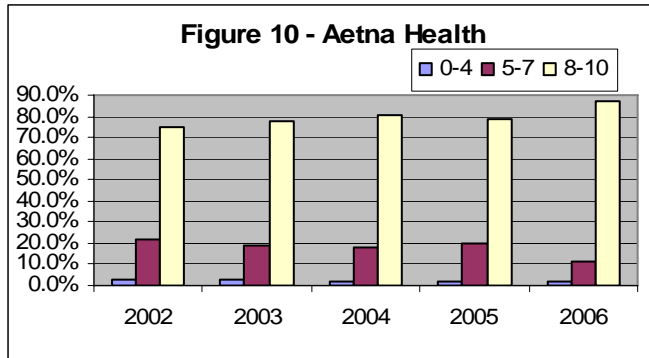
Source: Consumer Assessment of Health Plans Survey (CAHPS)

Satisfaction with Primary Care Physician: Adults

The CAHPS survey asked a sample of HMO members to rate their primary care physicians overall, on a scale of zero (“worst provider possible”) to 10 (“best provider possible”). Figure 9 shows the percentage of sampled members who rated their primary care physicians within the ranges of 0-4, 5-7 or 8-10. Figures 10 - 15 show the percentages by plan for 2002 - 2006.



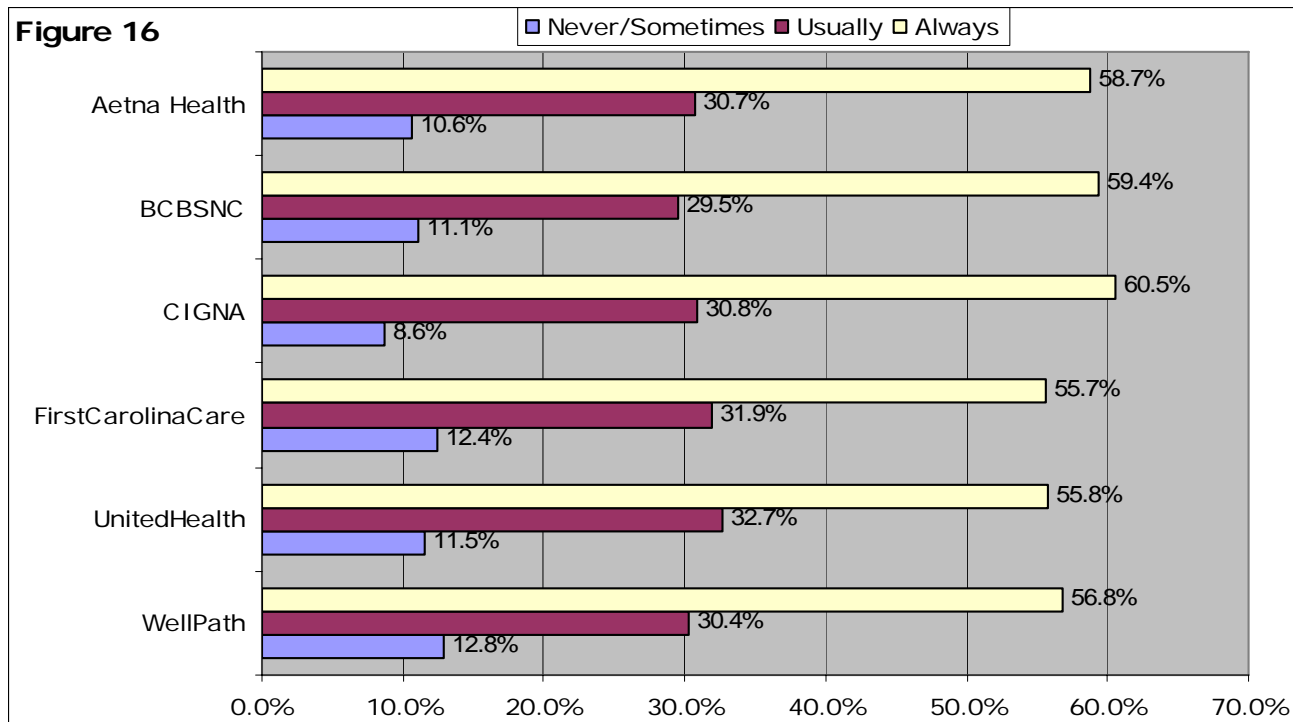
Source: Consumer Assessment of Health Plans Survey (CAHPS)



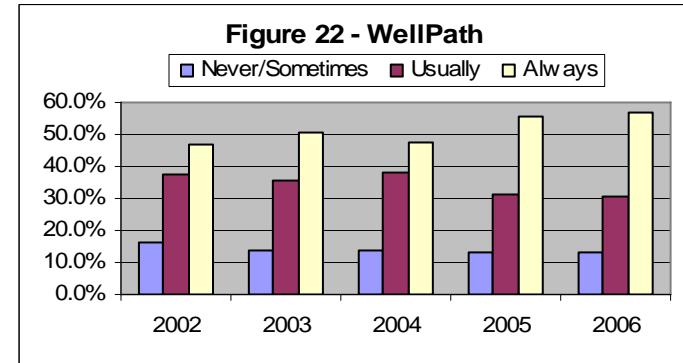
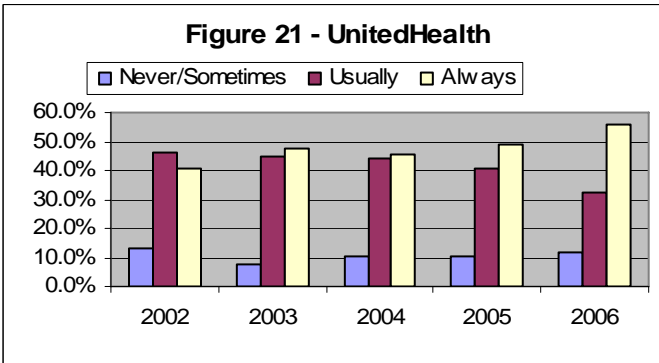
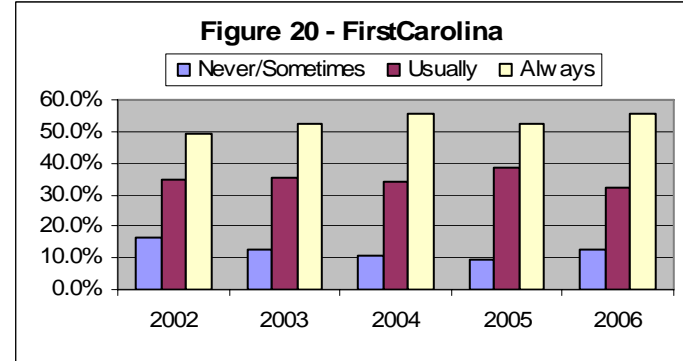
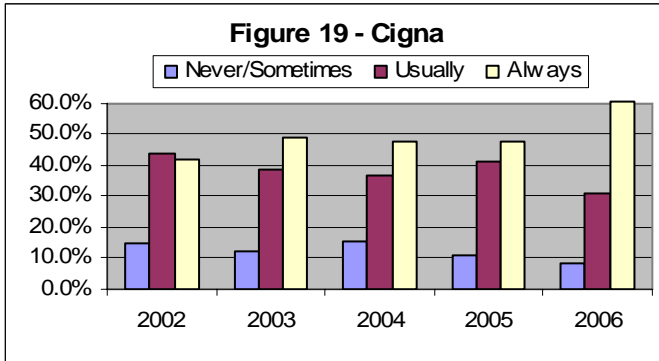
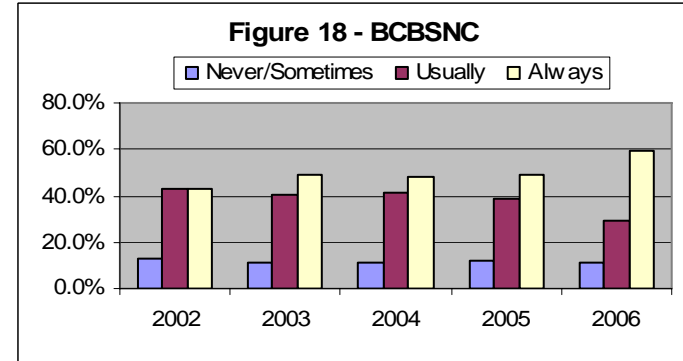
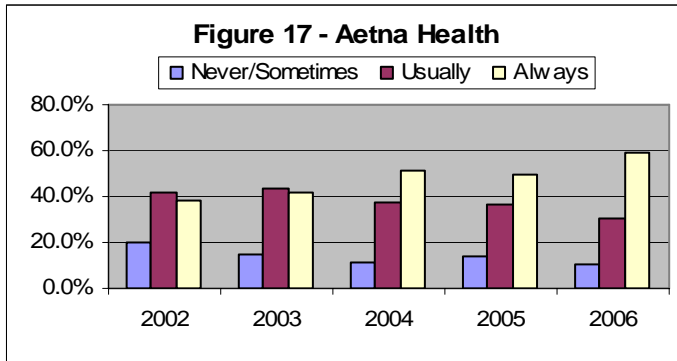
Source: Consumer Assessment of Health Plans Survey (CAHPS)

Routine Appointment Availability: Adults

The CAHPS survey asked a sample of HMO members to report how often (within the previous 12 months) they had been able to get routine medical appointments within the desired time frame. Possible responses were "Never," "Sometimes," "Usually" and "Always." Figure 16 shows the percentage of each HMO's sampled members who reported that routine appointments with their providers had "Never," "Sometimes," "Usually" or "Always" been available within the desired time frame. *Note: The "Never" and "Sometimes" responses are combined into a single category.* Figures 17 - 22 show the percentages by plan for 2002 - 2006.



Source: Consumer Assessment of Health Plans Survey (CAHPS)

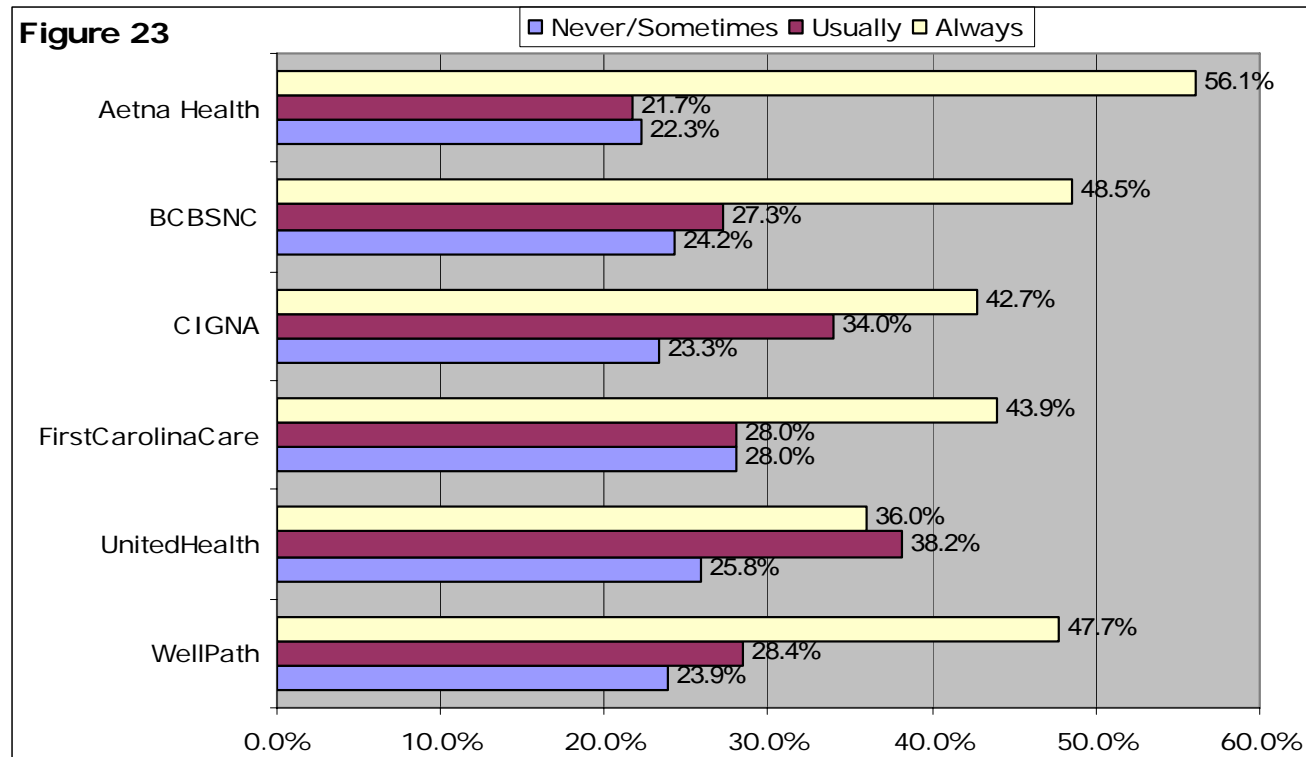


Source: Consumer Assessment of Health Plans Survey (CAHPS)

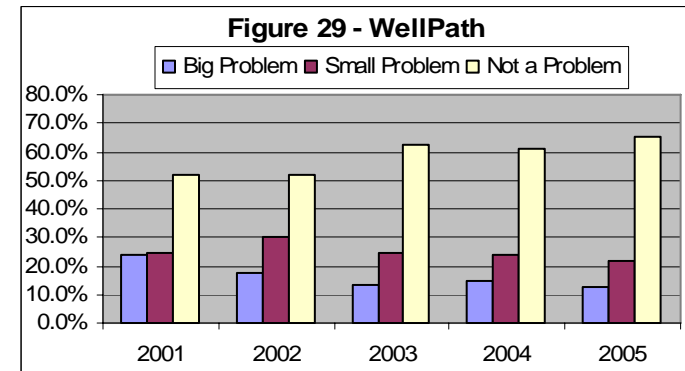
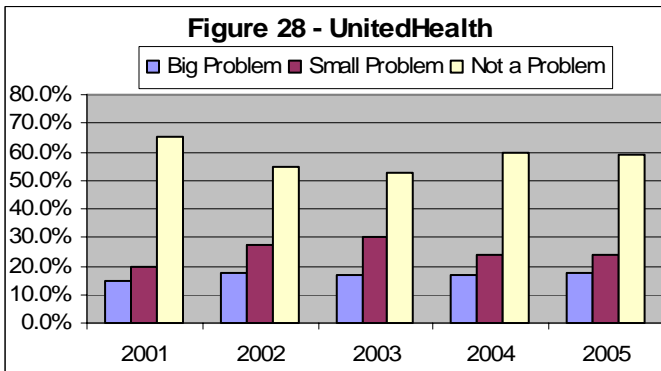
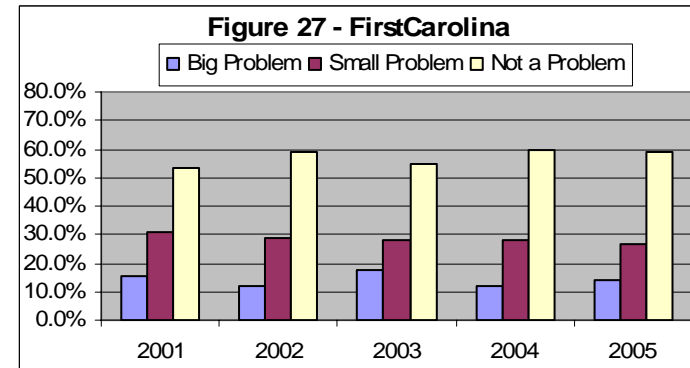
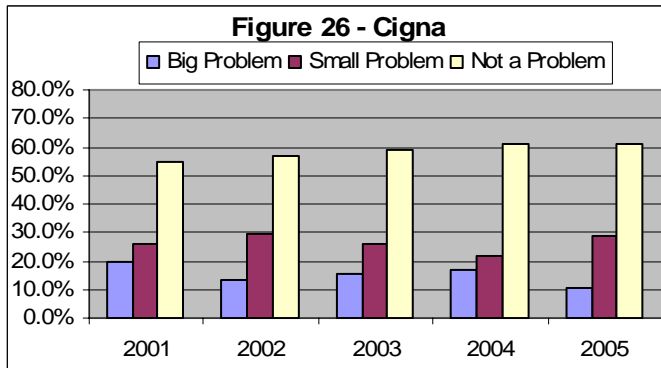
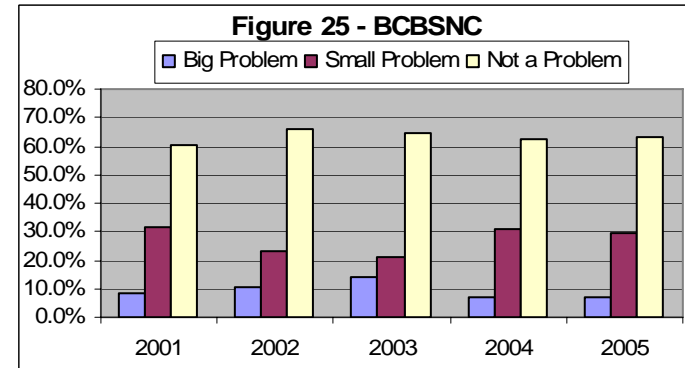
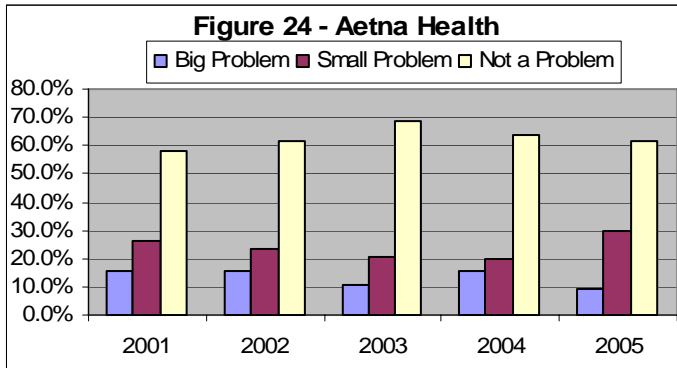
Satisfaction with Customer Service: Adults

The CAHPS survey asked a sample of HMO members if their HMOs' customer service departments gave them the information or help they needed within the previous 12 months. Possible responses were "Never," "Sometimes," "Usually" and "Always." Figure 23 shows the percentage of each HMO's sampled members who reported that they "Never," "Sometimes," "Usually" or "Always" received the information or help they needed. *Note: The "Never" and "Sometimes" responses are combined into a single category.*

In previous years, HMO members were asked if they had problems getting needed information from their HMOs' customer service departments within the previous 12 months. Possible responses were "Big Problem," "Small Problem," and "Not a Problem." Figures 24 - 29 show the percentages by plan for 2001 - 2005.



Source: Consumer Assessment of Health Plans Survey (CAHPS)



Source: Consumer Assessment of Health Plans Survey (CAHPS)

V. PREVENTIVE & CHRONIC CARE

North Carolina law does not require PPO plans to collect HEDIS data, so PPO plans are not represented in this section.

HMOs encourage wellness among their members by promoting the prevention of diseases and injuries, and by promoting healthier lifestyles in general. HMOs also offer programs to improve the quality of care for members with chronic conditions like diabetes and asthma.

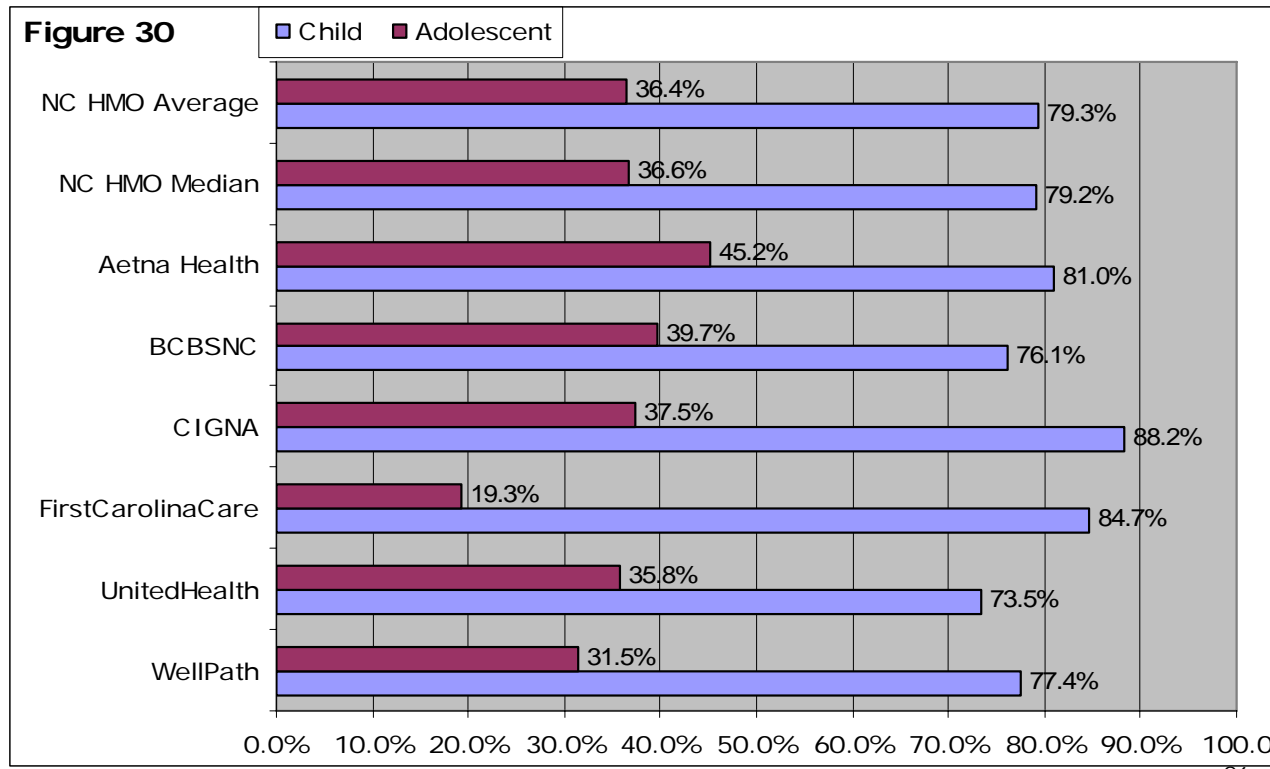
North Carolina law requires all licensed HMOs to collect information on their members' use of preventive and chronic care services, using a data collection tool called the Health Effectiveness Data and Information Set (HEDIS®). The performance measures in HEDIS are related to important health concerns such as cancer, heart disease and diabetes.

The HEDIS data in this booklet were self-reported by the HMOs. The following HMOs provided documentation that their data collection, reporting processes and reported data were audited and validated by independent audit firms (such audits are not required by North Carolina law):

No HMOs provided audit documentation.

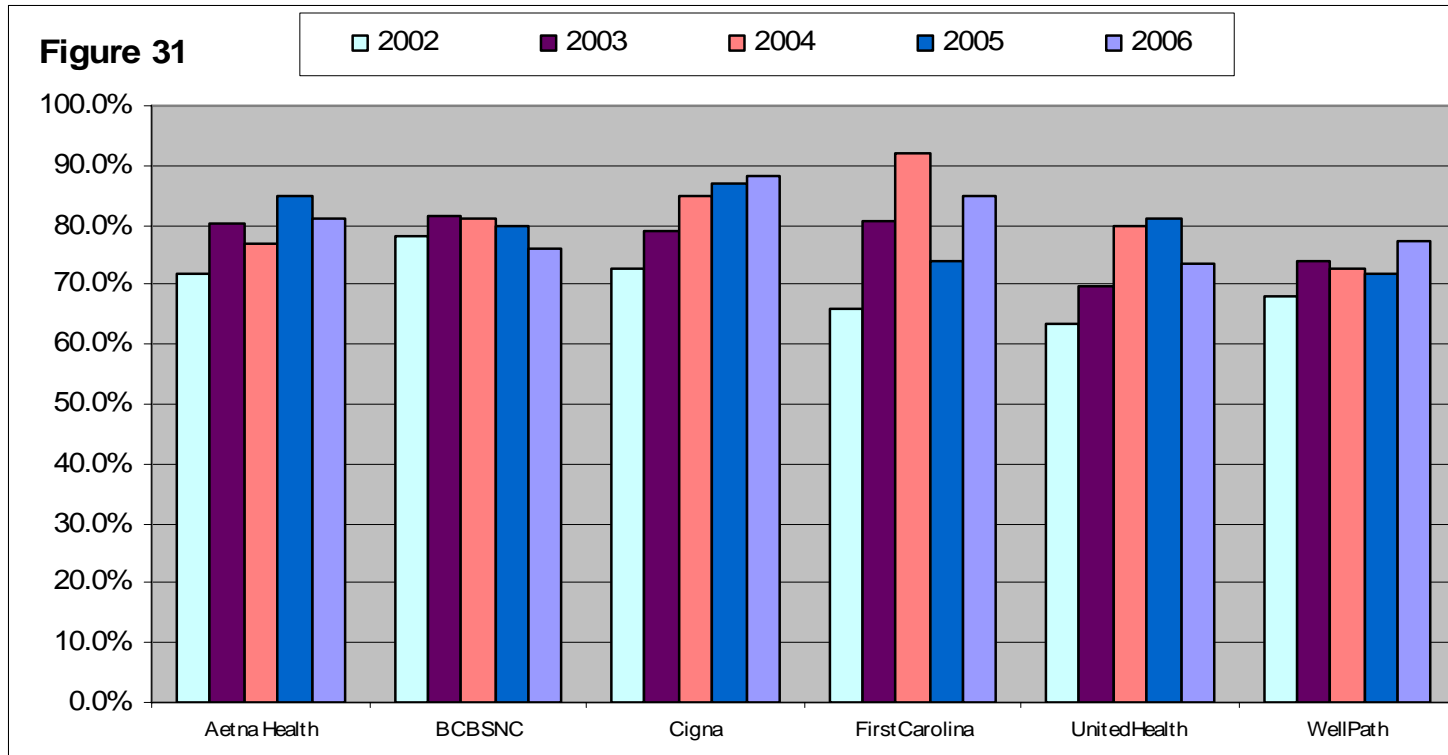
Immunizations for Children and Adolescents

Immunizations are a proven way to prevent diseases of childhood and adolescence such as polio, measles, mumps, rubella, influenza type b, hepatitis b, diphtheria, tetanus, pertussis and others. Figure 30 shows the percentage of each HMO's child members (lower bar) who received recommended vaccinations by age two, and the percentage of adolescent members (upper bar) who received all recommended immunizations by age 13. Figure 31 shows the percentages for each HMO's child members for 2002 - 2006. Figure 32 shows the percentages for each HMO's adolescent members for 2002 - 2006.



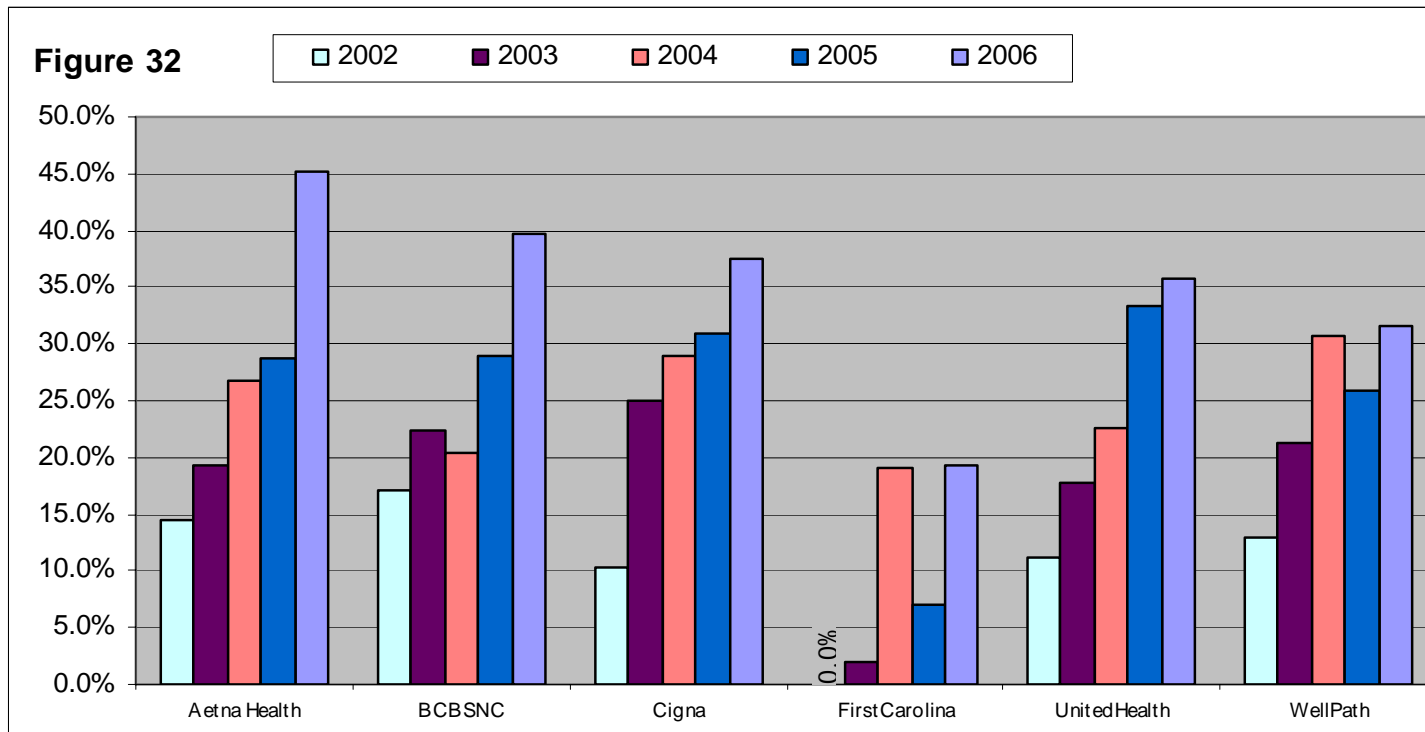
Source: 2006 HEDIS Data

Immunizations for Children



Source: 2002-2006 HEDIS Data

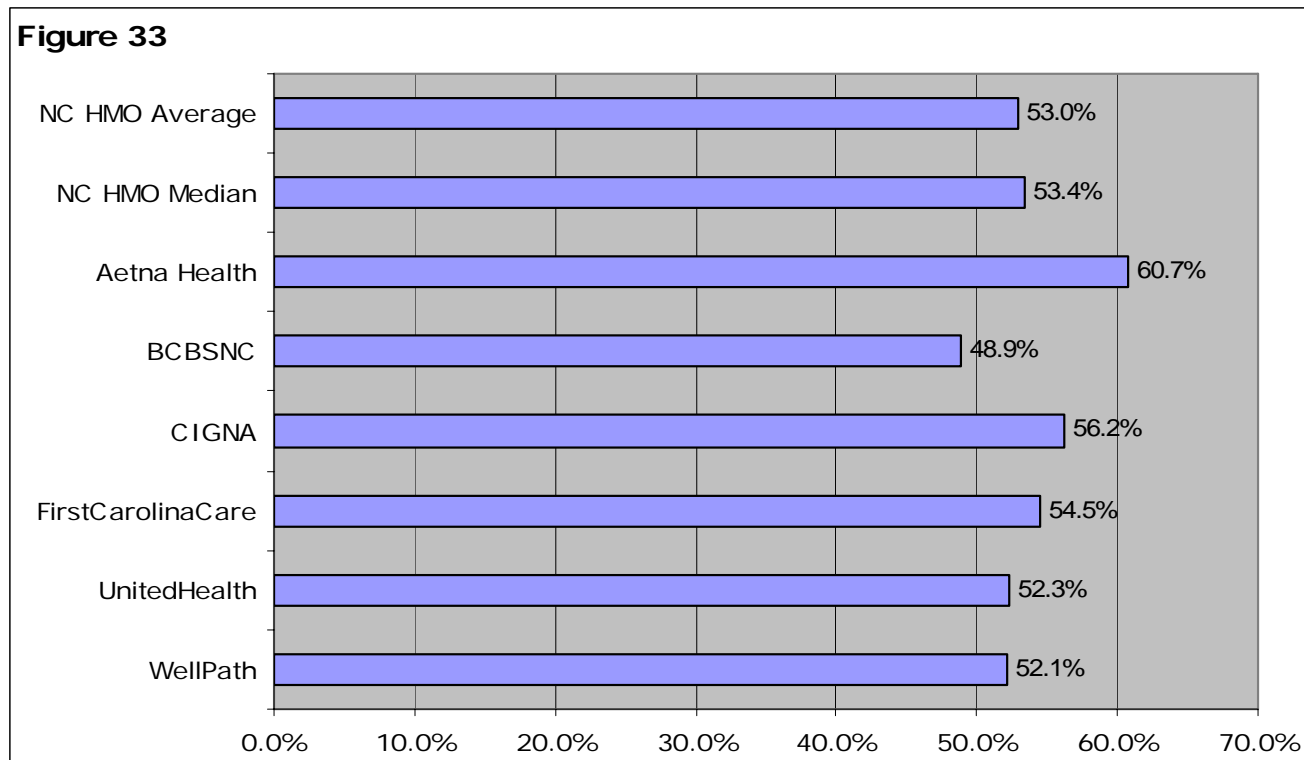
Immunizations for Adolescents



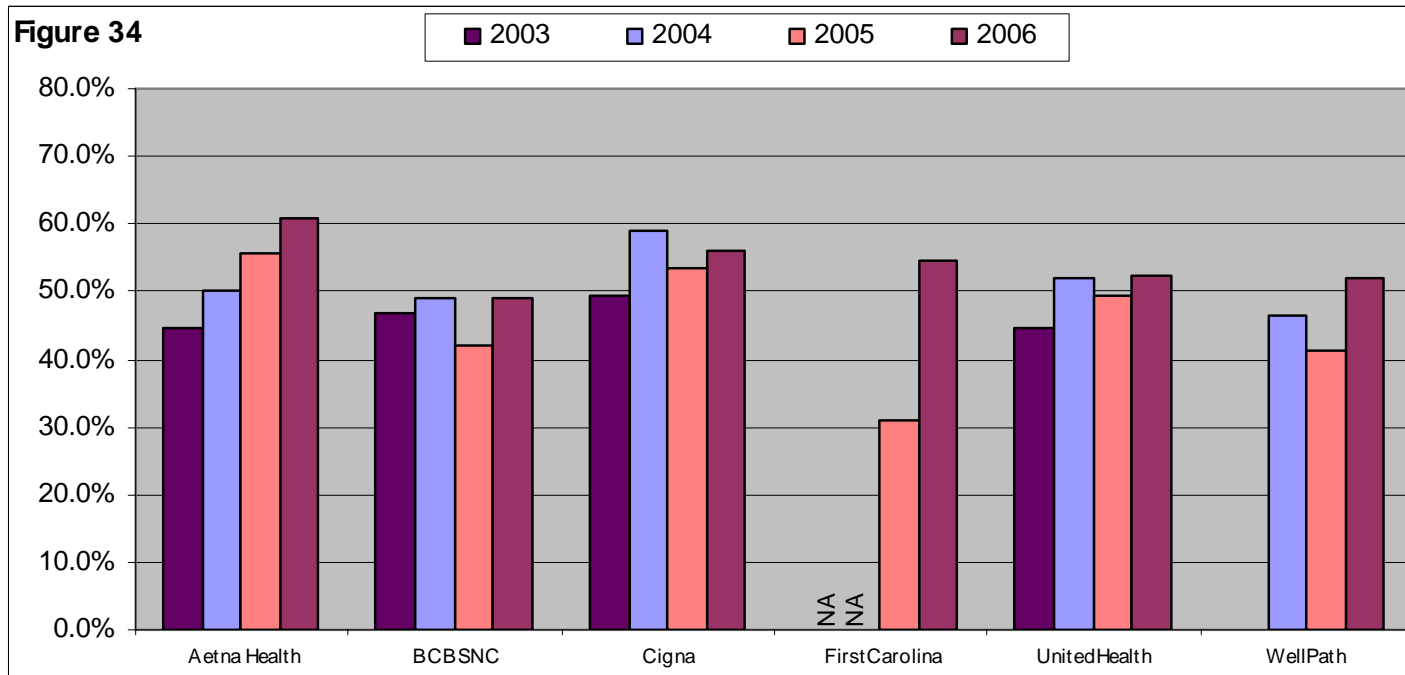
Source: 2002-2006 HEDIS Data

Cholesterol Management after Heart Attack

Figure 33 shows the percentage of each HMO's coronary patients (ages 18-75) who were admitted and discharged for an acute cardiovascular event during 2005 and whose LDL-C levels were below 100mg/dL between 60 and 365 days after discharge. Figure 34 shows the percentages by plan reported for 2003 - 2006.



Source: 2006 HEDIS Data

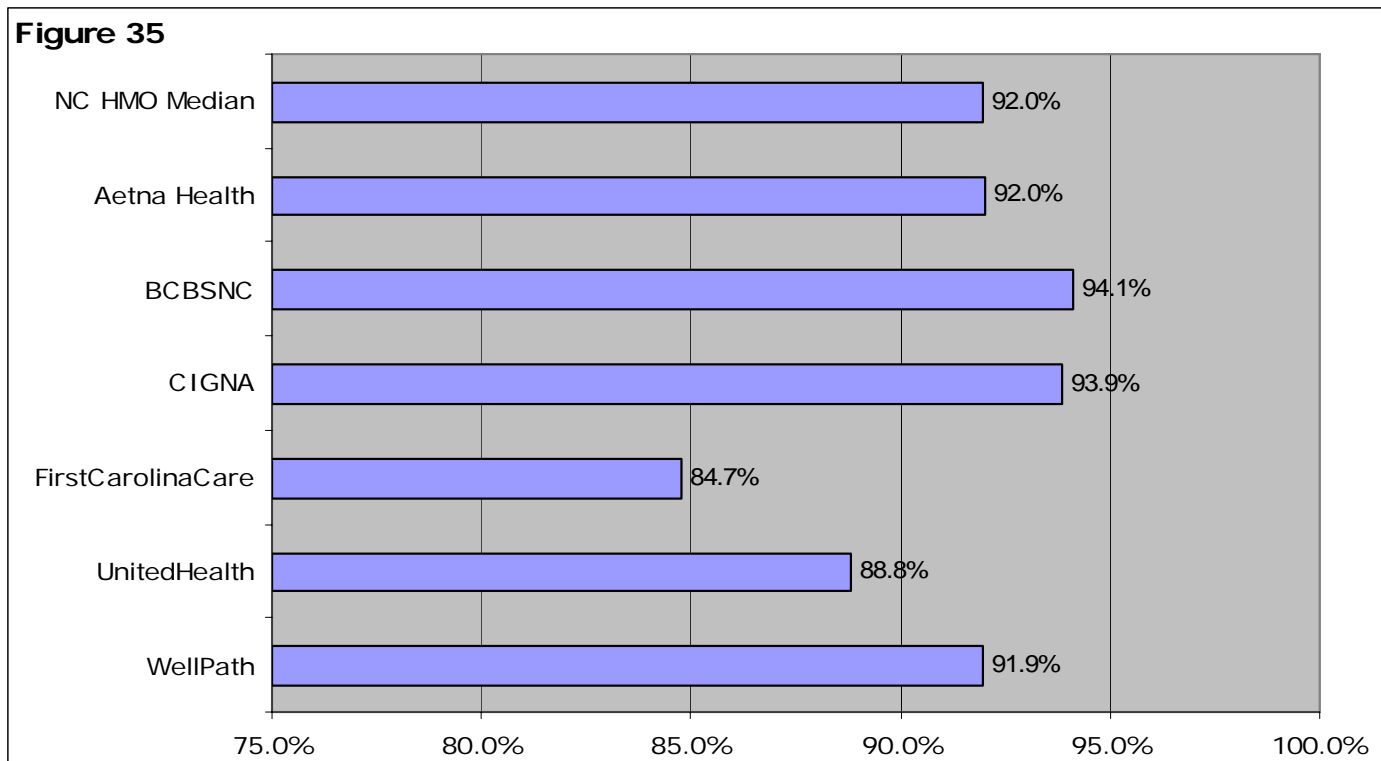


NA: Not applicable (due to small number of members in this category)

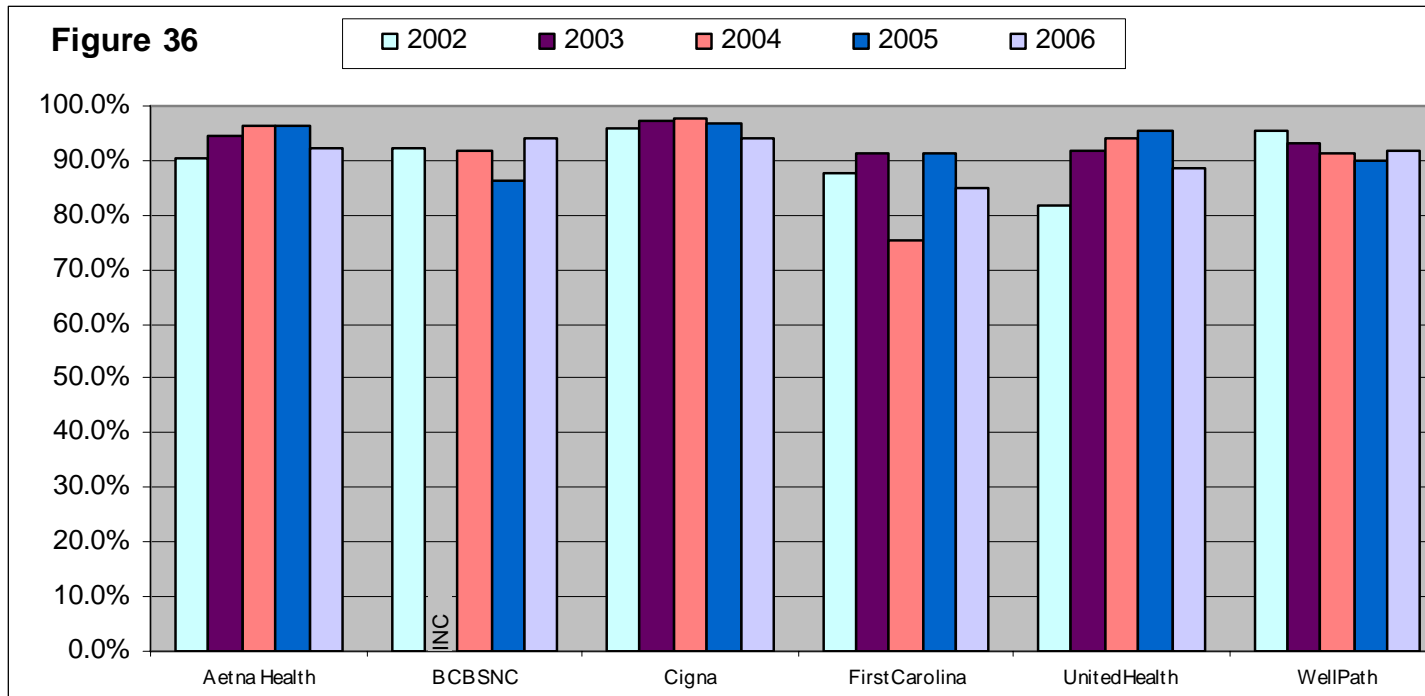
Source: 2003-2006 HEDIS Data

Prenatal Care in First Trimester

Early prenatal care can prevent many serious problems for mother and baby. Figure 35 shows the percentage of each HMO's female members who delivered during 2006, and who had begun prenatal care during the first 13 weeks of pregnancy. Figure 36 shows the percentages by plan for 2002 - 2006.



Source: 2006 HEDIS Data



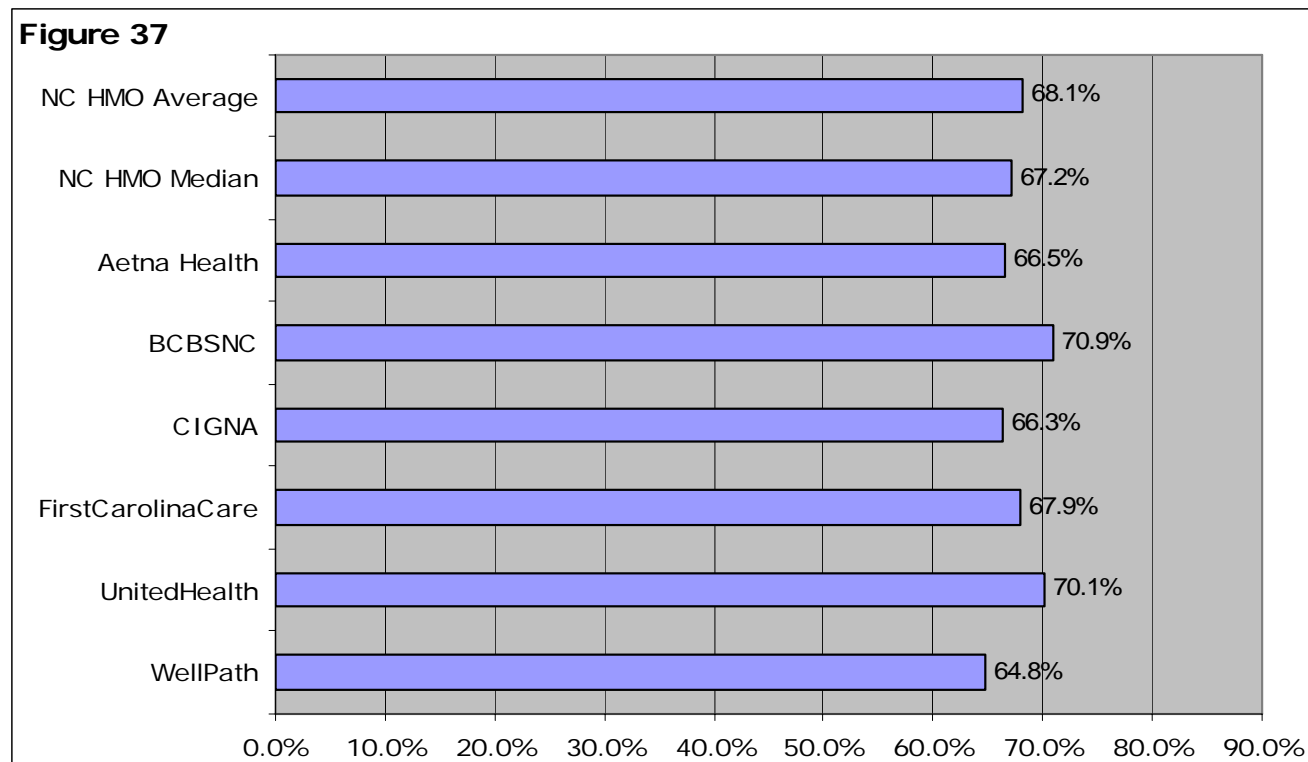
INC: Company failed to report complete data on this performance measure

Source: 2002-2006 HEDIS Data

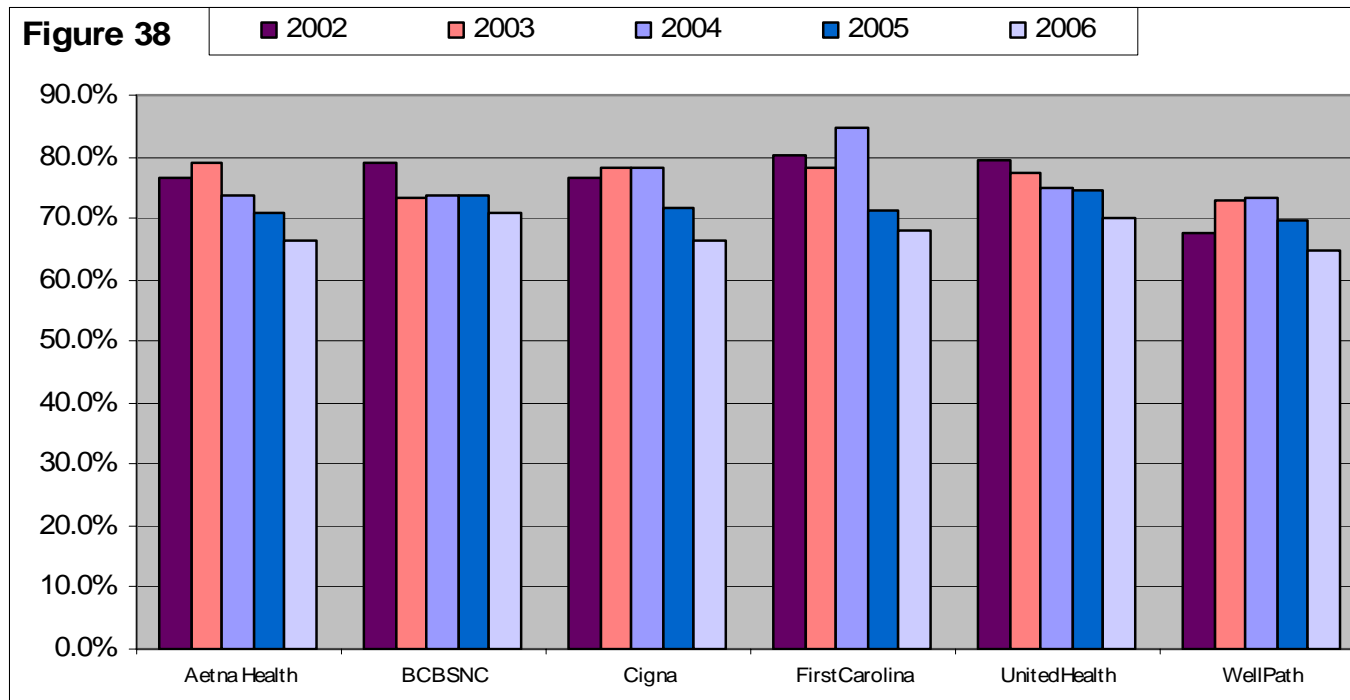
Breast Cancer Screening

Breast cancer is the most commonly diagnosed cancer among women in the United States. An estimated 183,000 U.S. women were newly diagnosed with breast cancer in 2000, and nearly 41,000 women died from the disease (Agency for Healthcare Research and Quality). Women have more treatment options and a better chance of survival if breast cancer is detected early, and mammograms are an effective tool in early detection.

Figure 37 shows the percentage of each HMO's female members between the ages of 52 and 69 who had mammograms during 2005-2006. Figure 38 shows the percentages by plan reported for 2002 - 2006.



Source: 2006 HEDIS Data

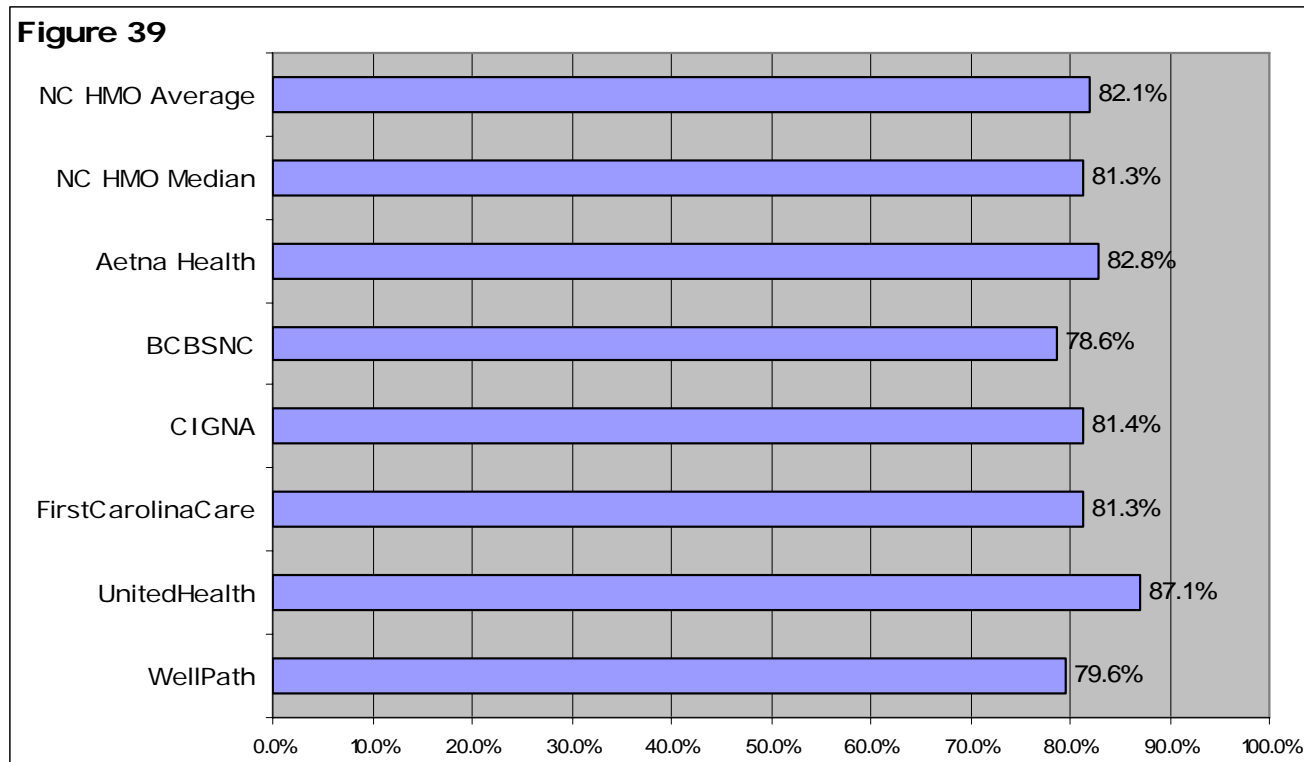


Source: 2002-2006 HEDIS Data

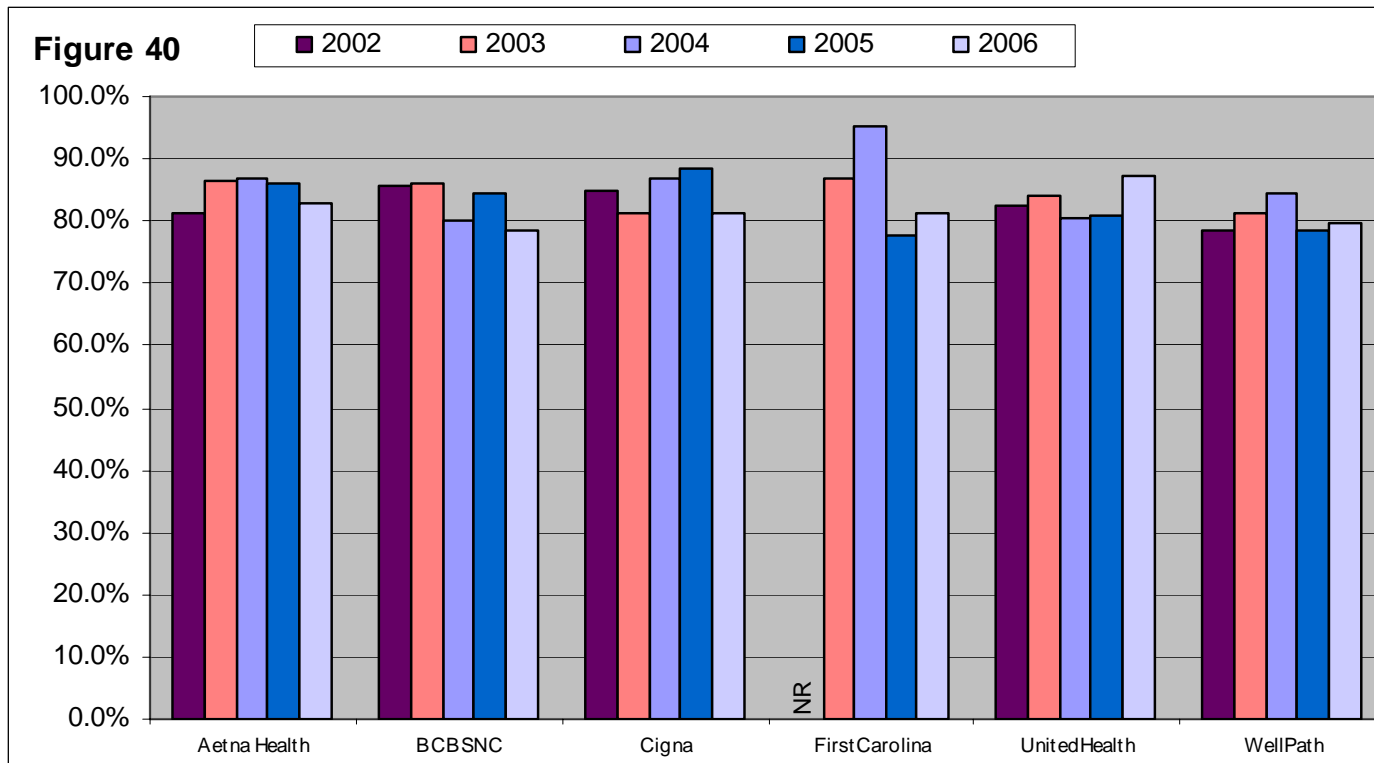
Cervical Cancer Screening

In 1999, there were approximately 13,000 cases of invasive cervical cancer in U.S. women, and about 4,800 women died from the disease. About half of the women with newly diagnosed invasive cervical cancer have not had a Pap test in the previous 5 years. (Agency for Healthcare Research and Quality). A Pap smear is an effective tool in the early detection of cervical cancer.

Figure 39 shows the percentage of each HMO's female members aged 21 to 64 that had at least one Pap smear during 2004-2006. Figure 40 shows the percentages by plan reported for 2002 - 2006.



Source: 2006 HEDIS Data



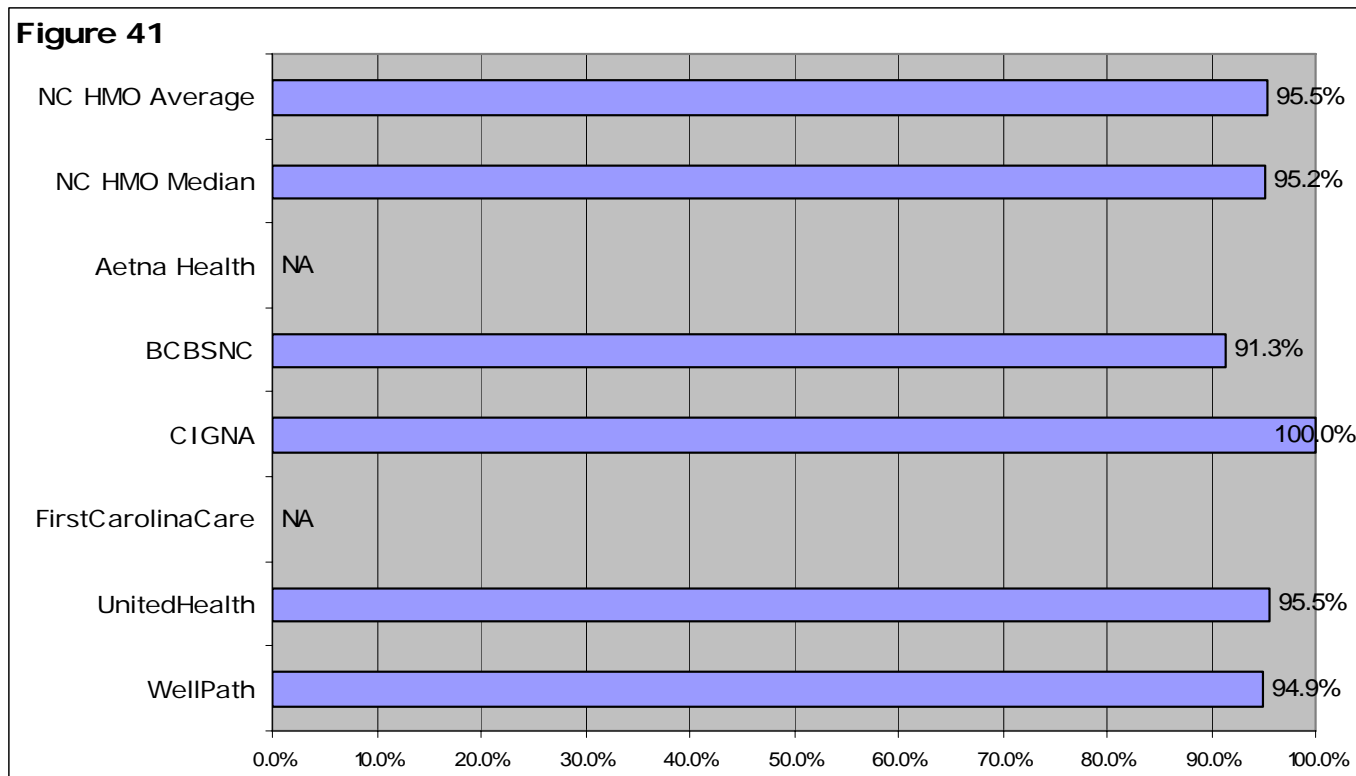
NR: Not required (HMO did not have membership during entire measurement period)

Source: 2002-2006 HEDIS Data

Beta Blockers after Heart Attack

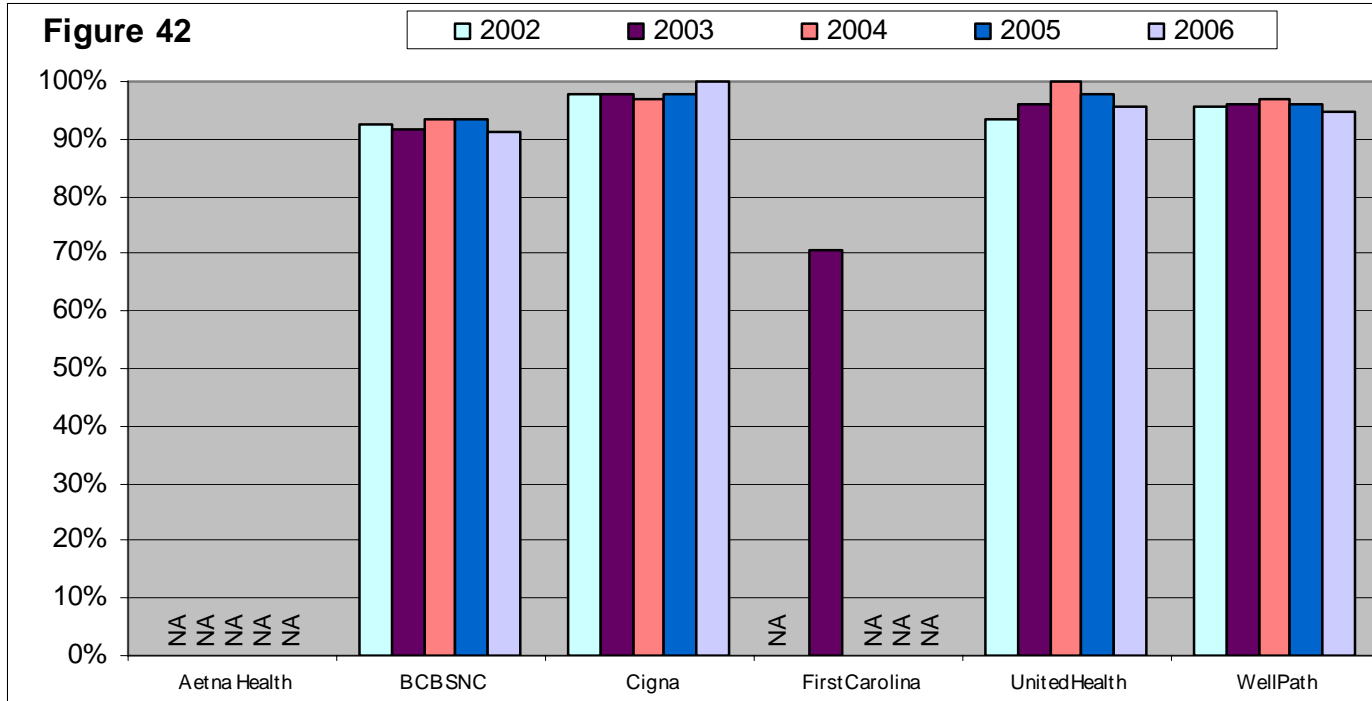
Coronary heart disease is the leading cause of death in the United States, claiming more than 500,000 American lives every year (American Heart Association). Treatment with "beta blocker" drugs has been shown to significantly reduce illness and deaths associated with heart disease and to reduce heart disease illnesses, chance of a second heart attack, and deaths.

Figure 41 shows the percentage of each HMO's members aged 35 and older who were hospitalized and discharged (with a diagnosis of acute myocardial infarction) during 2006 and who received a prescription for beta-blockers on an ambulatory basis, any time between 30 days before admission and 7 days after discharge. Figure 42 shows the percentages by plan for 2002 - 2006.



NA: Not applicable (due to small number of members in this category)

Source: 2006 HEDIS Data



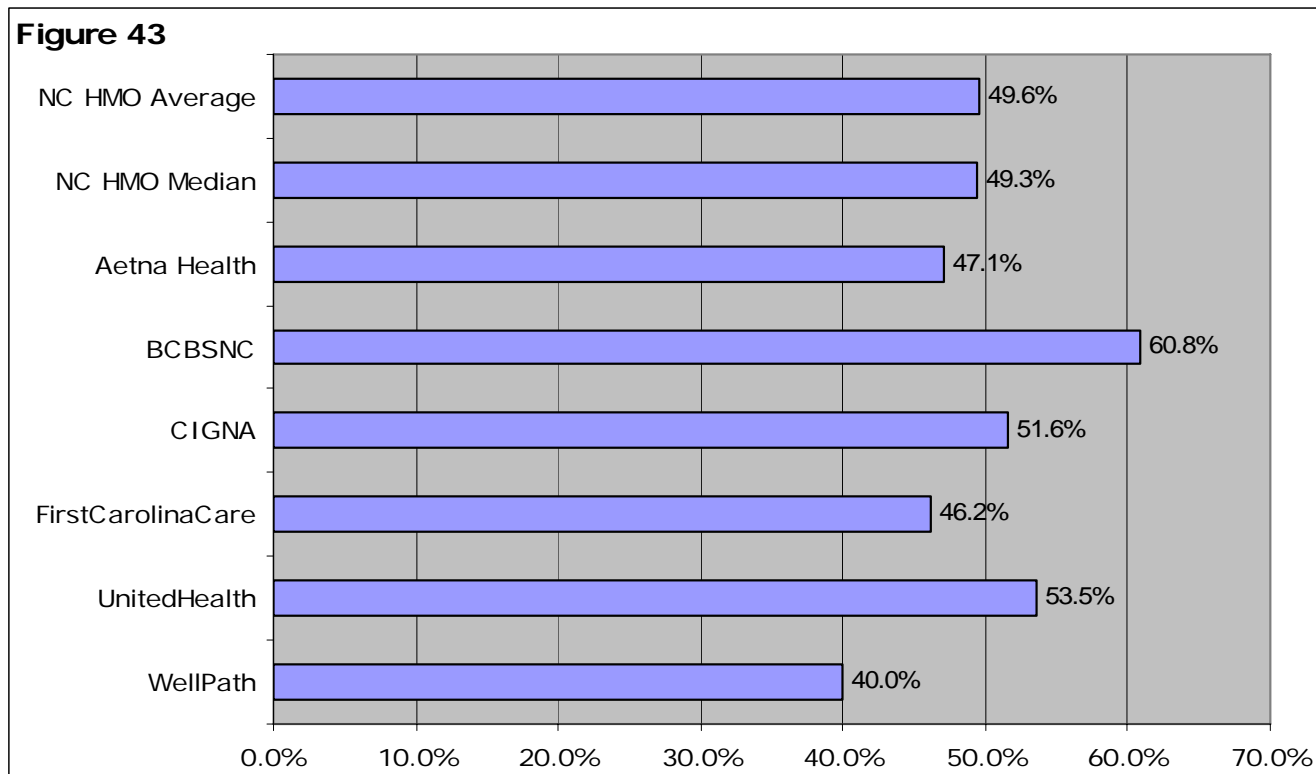
NA: Not applicable (due to small number of members in this category)

Source: 2002-2006 HEDIS Data

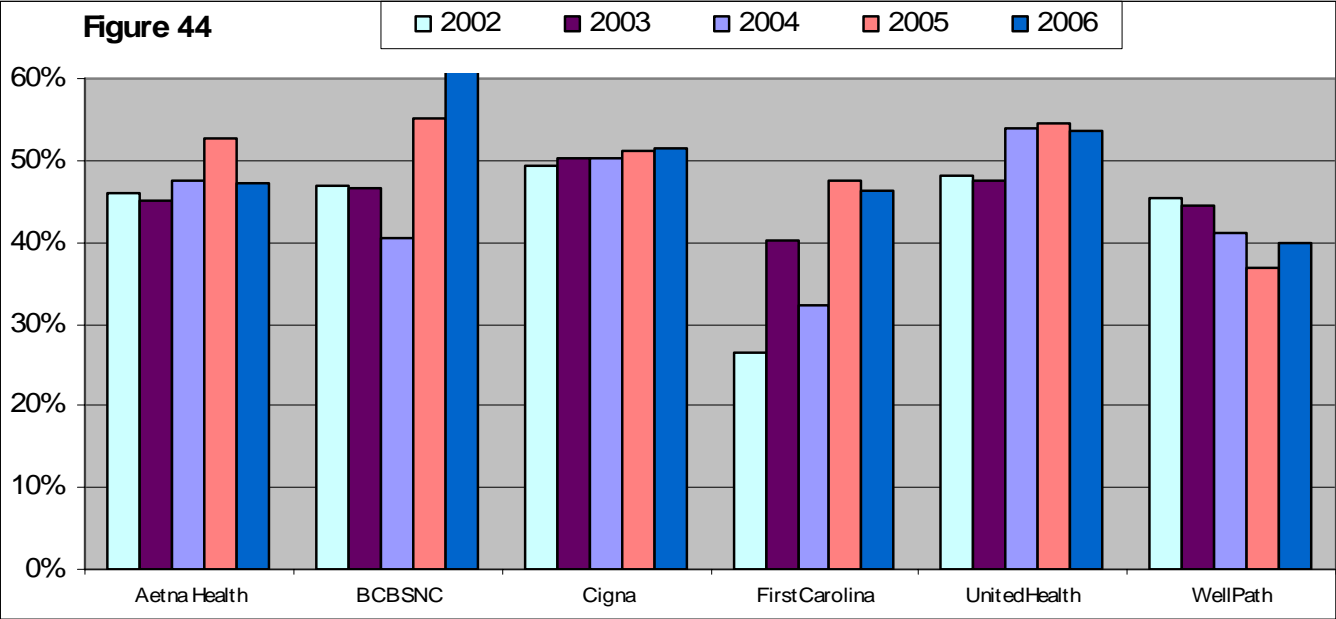
Eye Exams for Adults with Diabetes

Diabetes is the leading cause of adult blindness in the United States. Blindness may be prevented if changes in the retina of the eye are detected and treated early.

Figure 43 shows the percentage of each HMO's members with diabetes, aged 18-75, who received an eye exam during 2006. Figure 44 shows the percentages by plan for 2002 - 2006. *Note: Screening rates below 100 % are not necessarily an indication of poor performance since some diabetics can safely be screened less frequently than once a year.*



Source: 2006 HEDIS Data

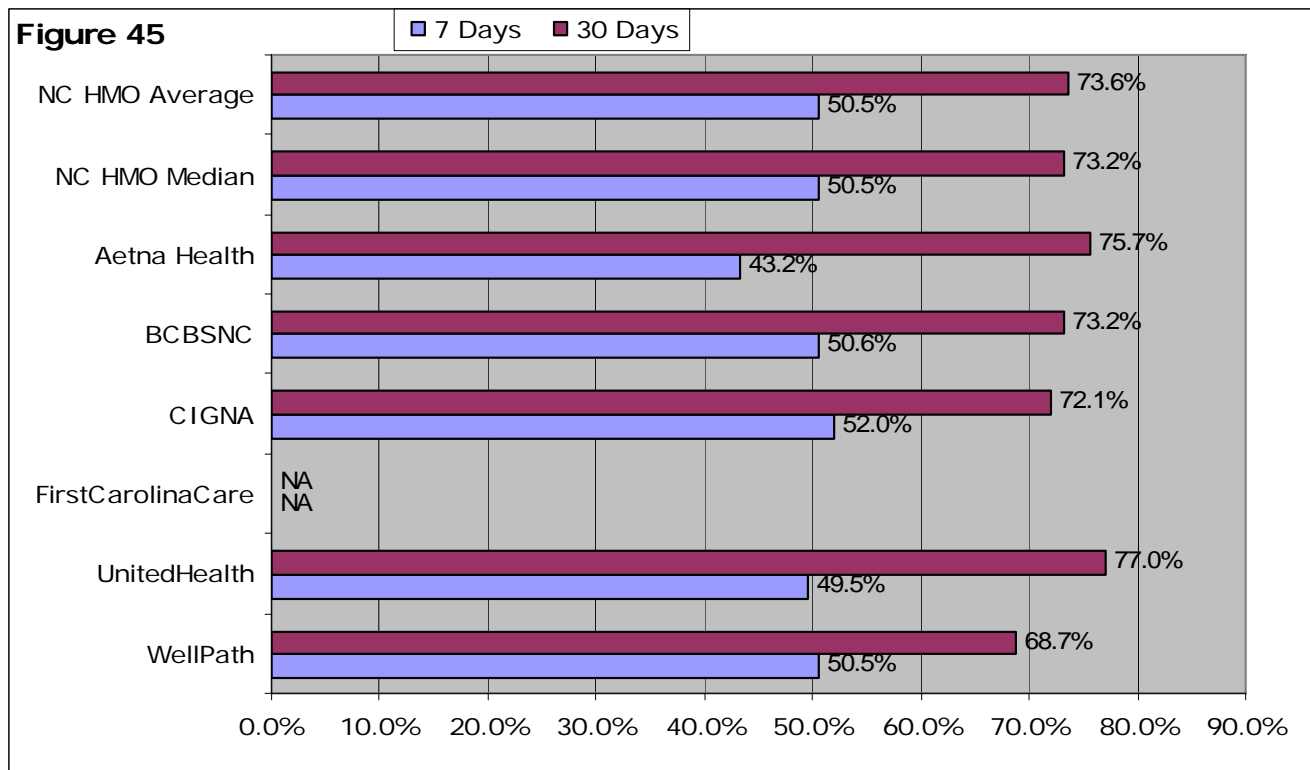


Source: 2002-2006 HEDIS Data

Follow-up after Hospitalization for Mental Illness

A visit with a mental health practitioner following hospitalization for mental illness is recommended to detect any problems with the transition back to home, school or work.

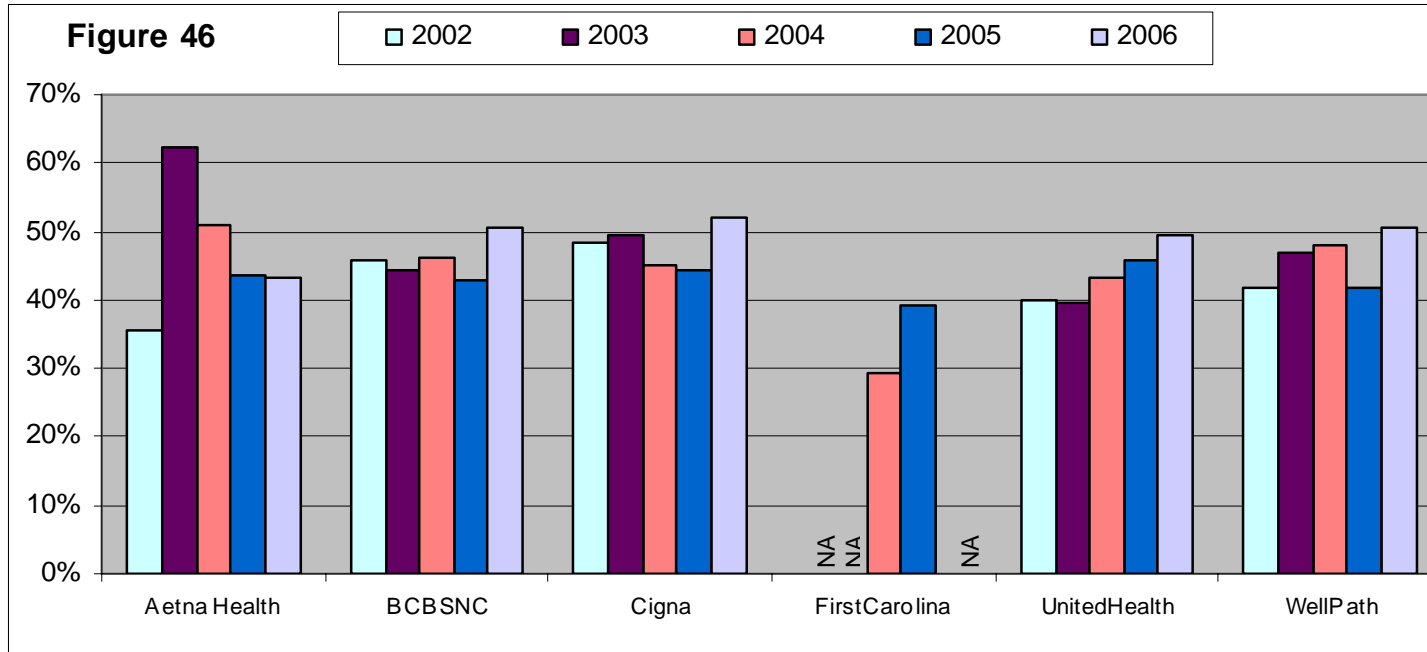
Figure 45 shows the percentage of each HMO's members aged 6 years and older who were hospitalized for treatment of selected mental health disorders during 2006, and who were then seen by a mental health provider within 7 days (lower bar) and/or 30 days (upper bar) after discharge. Figure 46 shows the follow-up within 7 days percentages by plan for 2002 - 2006. Figure 47 shows the follow-up within 30 days percentages by plan for 2002 - 2006.



NA: Not applicable (due to small number of members in this category)

Source: 2006 HEDIS Data

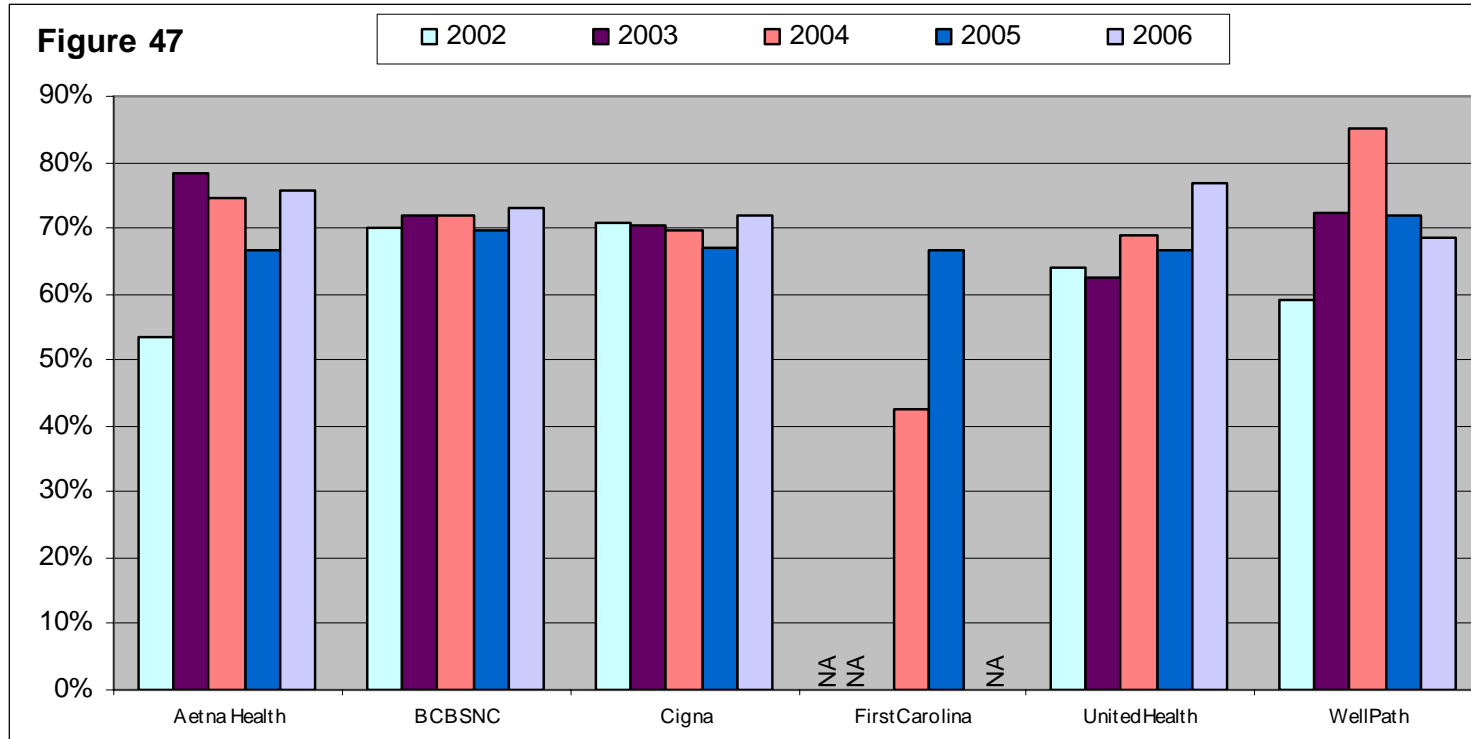
Follow-up after Hospitalization for Mental Illness - 7 Days



NA: Not applicable (due to small number of members in this category)

Source: 2002-2006 HEDIS Data

Follow-up after Hospitalization for Mental Illness - 30 Days



NA: Not applicable (due to small number of members in this category)

Source: 2002-2006 HEDIS Data

VI. YOUR RIGHTS AND RESPONSIBILITIES

As a healthcare consumer, you have the RIGHT to:

- Obtain a copy of the plan's evidence of coverage (policy), even before you enroll.
- Obtain an explanation of a plan's utilization review criteria for specific conditions, even before you enroll.
- Obtain information about a plan's prescription drug formularies and prior approval requirements for drugs, even before you enroll.
- Seek treatment from the closest facility available, regardless of whether it is in your plan's network, whenever a prudent person would believe your symptoms indicate an emergency medical condition.
- Request that your plan allow you to obtain care from non-network providers, at network benefit levels, when your plan does not have qualified network providers reasonably available to you.
- Obtain the medical review criteria on which your plan's noncertification decision is based.
- Appeal your plan's denial of reimbursement for a covered service, including a second-level hearing before a panel of doctors (if your first appeal isn't successful). When warranted by your medical condition, you have a right to an expedited appeal.
- Contact the Department of Insurance for assistance when you feel your plan has not properly handled your appeal or grievance.
- Receive information and advice from your health care provider without constraint, whether or not the treatment options discussed are covered under your plan.
- Have your confidentiality protected at all times.

As a healthcare consumer, you have the RESPONSIBILITY to:

- Carefully review all member materials, including the evidence of coverage, before obtaining care.
- Familiarize yourself with the services, treatments and supplies covered under your plan.
- Select and establish a relationship with a PCP you trust to coordinate your care.
- Understand and follow your plan's requirements for referrals to specialists and inpatient care.
- Thoroughly discuss all treatment options and your treatment preferences with your doctor.
- Before receiving services, confirm that your provider continues to participate in your plan's network, by calling your plan or asking the provider.
- Understand your copayment obligations and how they may vary based on when, where and how services are provided.
- Secure prior approval for services, including non-formulary drugs hospitalizations and surgery, in accordance with your plan's requirements.
- Question your health plan and your doctor about any policies, requirements or treatments you don't completely understand.
- Notify all of your providers right away whenever you change to a different health plan.

VII. ABOUT THE NORTH CAROLINA DEPARTMENT OF INSURANCE

The North Carolina Department of Insurance serves the citizens of North Carolina through the regulation of all insurance business conducted in the state. Our mission is to ensure that consumers can readily purchase insurance at fair prices, from financially sound and responsive companies.

The Department's Consumer Services Division is dedicated to assisting consumers with questions or problems about their insurance coverage. Other publications about health insurance are available upon request, including:
Guide to Appeals and Grievances - Contains information about your rights as a health insurance consumer.
Guide to Health Insurance - Contains general information about managed care and traditional indemnity insurance.

How to Contact the Department of Insurance

If you need more information regarding your appeal and grievance rights, or if you have a complaint about your health plan that you cannot resolve, you may contact the North Carolina Department of Insurance by writing or calling:

N.C. Department of Insurance
Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

(800) 546-5664
(919) 807-6750
Monday through Friday, 8 a.m. to 4:50 p.m.

VISIT THE NCDOI WEBSITE!

This guide and other information about all types of insurance can be found on the North Carolina Department of Insurance website, at <http://www.ncdoi.com>.