2010

New Jersey

HMO Performance Report

Compare Your Choices

Chris Christie, Governor

Thomas B. Considine, Commissioner

November 2010

Dear Consumers:

We are pleased to present the fourteenth annual *New Jersey HMO Performance Report,* the fifth produced exclusively by the New Jersey Department of Banking and Insurance. This report contains information on the performance of New Jersey's health maintenance organizations (HMOs), and how well these HMOs deliver important health care services.

The report is designed to provide information on the quality of New Jersey's HMOs and the coverage they provide. We hope you find this information useful when choosing health coverage for your family or business.

New Jersey is a leader in providing comprehensive, strong consumer and patient protections. We urge you to become familiar with these protections, which are explained in this report.

By providing you with this report, our goal is to help you make the best health care choices for yourself, your family or your employees.

Chris Christie
Governor

Thomas B. Considine
Commissioner
Department of Banking and Insurance

The format for this report was originally developed by the New Jersey Department of Health and Senior Services (DHSS), when it issued the first HMO performance report in 1997 with the cooperation of an advisory group representing HMOs, health care purchasers, providers and consumers. The New Jersey Department of Banking and Insurance (DOBI) assumed responsibility for providing the HMO Performance Report from DHSS in August 2005. All regulatory and oversight matters concerning managed health care in the state are now consolidated in DOBI.

This report includes information on all commercial products currently marketed in New Jersey by HMOs that had at least 2,000 members enrolled in commercial products in both 2008 and 2009. For most HMOs the information combines plan performance for the HMO and POS products.

The following HMOs and products are included in this report:

- **Aetna-HMO/POS** (Aetna Health Inc. – a New Jersey corporation)
- **AmeriHealth-HMO/POS** (AmeriHealth HMO, Inc. – New Jersey)
- **CIGNA-HMO/POS** (CIGNA HealthCare of New Jersey, Inc.)
- **Horizon-HMO** (Horizon Healthcare of New Jersey, Inc.)
- **Oxford-HMO/POS** (Oxford Health Plans of New Jersey)

This report does not include HMO performance related to any HMO's Medicare or Medicaid business or an HMO's business related to other New Jersey Department of Human Services programs. *See page 18 for ways you can obtain information on these programs.*

This report is based on a measurement system called HEDIS®, which was developed by the National Committee for Quality Assurance (NCQA) through the combined efforts of many health care experts. It includes measures collected by the HMOs and measures collected through member surveys. All measures are verified by independent auditors.

In prior reports, we included ratings of member satisfaction with HMO services. Now you can find summary measures of customer satisfaction by visiting the NCQA's website (see page 14 for more details).

For information on contacting these and other New Jersey HMOs, see page 15.

This report is also available on the Department's web site:
http://www.state.nj.us/dobi/lifehealthactuarial/hmo2010/

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

New Jersey HMO Performance Report

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Quality Matters

Why is the quality of health care important?

Not all HMOs are the same. HMOs differ in how well they keep members healthy and care for them when they become sick. That's why learning about health care quality is important.

- **If you are a consumer**, the quality of care provided by your HMO may influence your health and your family's health.
- **If you are an employer,** the quality of care provided by your HMO may influence absenteeism, employee productivity and your company's health care cost.

This report provides information about how well HMOs:

- Provided preventive care, such as immunizations and mammograms, to help members stay healthy, and
- Cared for members who are ill, such as managing the cholesterol level of people with heart conditions.

You can use this report, along with cost and benefit information available from your employer or the HMO, to choose the right plan for your health care needs.

When choosing an HMO, you should consider:

- Whether your doctor or health care provider is available in the HMOs network,
- Whether the HMO offers the benefits you want,
- How much the HMO will cost you (look at both monthly premiums and out-of-pocket expenses, such as co-payments, coinsurances and deductibles), and
- How well the HMO performs in the key areas most important to you.

Staying Healthy

Does the HMO help members stay healthy and avoid illness?

HMOs should work with doctors to provide important preventive services that help members stay healthy. HMOs reported on the percentage of their relevant membership who received the following services:

- Testing for breast cancer
- Testing for cervical cancer
- Testing for colorectal cancer
- Immunizations for children

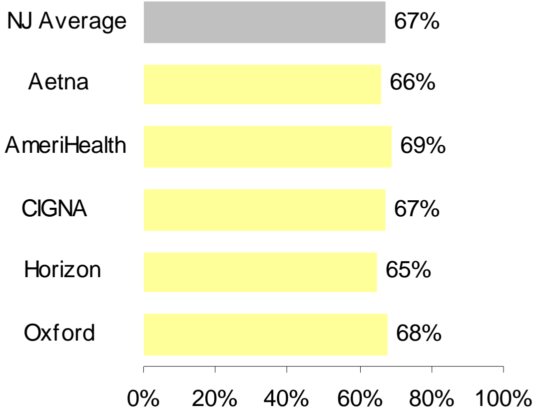
The following tables show how well each HMO did and how well HMOs in New Jersey performed on average.

HMO	Testing for breast cancer %	Testing for cervical cancer %	Testing for colorectal cancer %	Immunizations for children %
Aetna - HMO/POS	66	76	58	77
AmeriHealth - HMO/POS	69	72	58	81
CIGNA - HMO/POS	67	77	65	77
Horizon - HMO	65	67	52	72
Oxford - HMO/POS	68	80	56	68

See the next page for each HMO's scores →

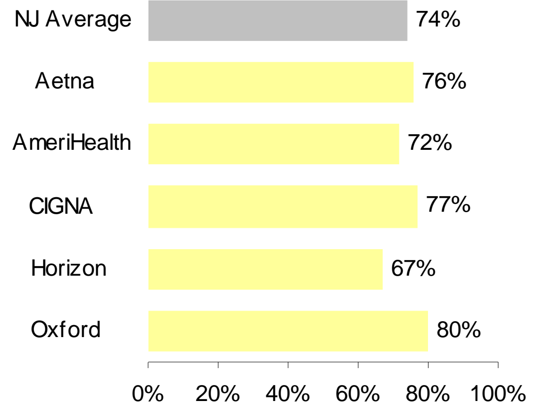
Testing for breast cancer

Mammograms are recommended for detection of breast cancer. Percentage of women aged 42–69 who received a mammogram within the past two years:



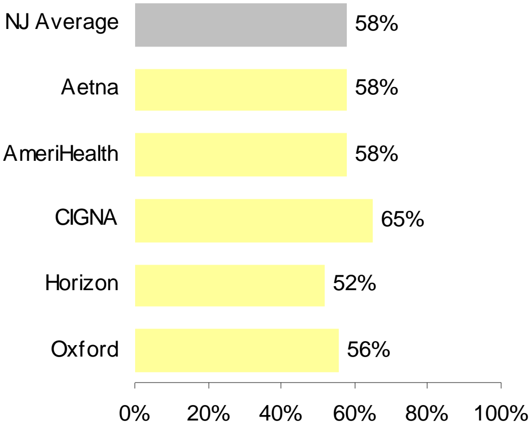
Testing for cervical cancer

Pap smears are recommended for detection of cervical cancer. Percentage of women aged 21–64 who received a Pap test within the past three years:



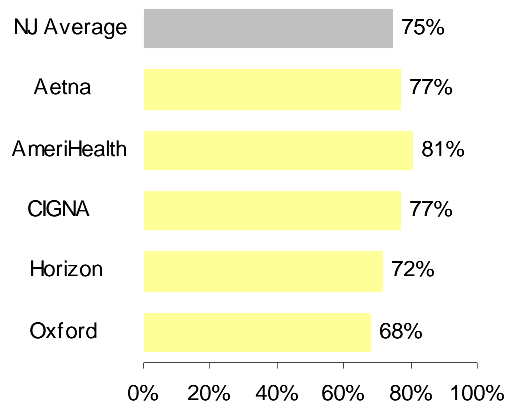
Colorectal Cancer Screening

Colonoscopy is used to look for early signs of colorectal cancer. Percentage of members 50-75 who had appropriate screening for colorectal cancer:



Immunizations for children

Immunizations prevent childhood diseases such as polio, measles, mumps, rubella and whooping cough. Percentage of children who received recommended immunizations by age two:



Respiratory Conditions

How well does the HMO help members with respiratory conditions?

HMOs should work with doctors to provide important services that help improve the health of members with respiratory conditions. HMOs reported on the percentage of their relevant membership who received the following services:

- Testing children with pharyngitis for strep
- Treatment for children with upper respiratory infection (URI)
- Avoidance of antibiotic treatment in adults with acute bronchitis
- Use of spirometry testing in the assessment and diagnosis of Chronic Obstructive Pulmonary Disease (COPD)

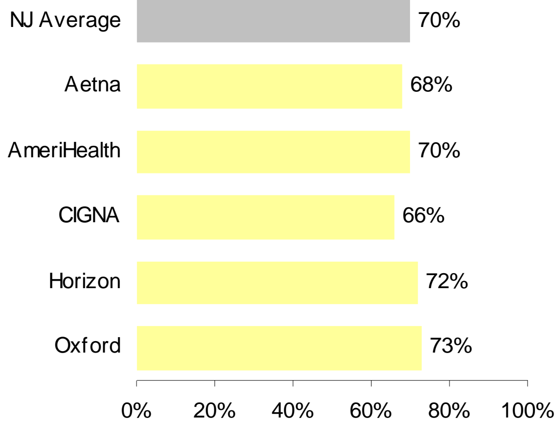
The following tables show how well each HMO did and how well HMO's in New Jersey performed on average.

HMO	Strep testing for children with pharyngits %	Avoidance of antibiotic treatment for children with URI %	Avoidance of antibiotic treatment in adults w/ acute bronchitis %	Use of spirometry testing in diagnosis of COPD %
Aetna - HMO/POS	68	84	21	43
AmeriHealth - HMO/POS	70	81	21	42
CIGNA - HMO/POS	66	87	21	44
Horizon - HMO	72	85	27	44
Oxford - HMO/POS	73	86	23	51

See the next page for each HMO's scores →

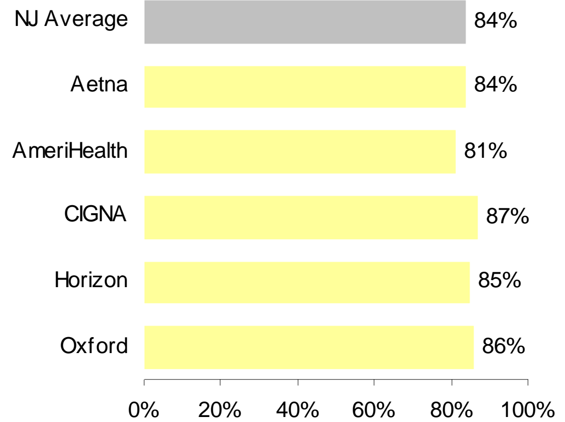
Testing children with pharyngitis for strep

Strep testing is recommended for detection of Pharyngitis. The percentage of children age 2-18 years of age diagnosed with pharyngitis and dispensed an antibiotic who also received a strep test for the episode. A higher rate represents better performance:



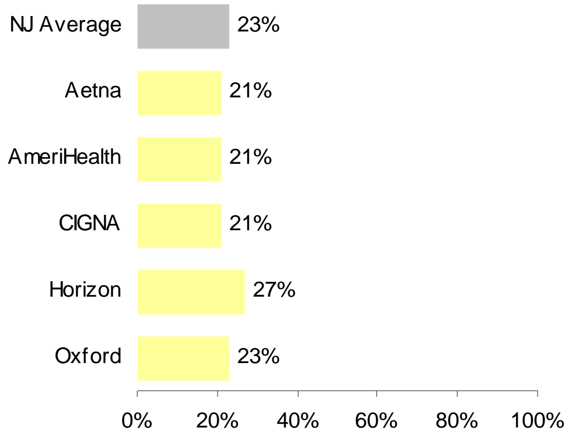
Avoidance of antibiotic treatment* for children with upper respiratory infection (URI)

An upper respiratory infection (URI), is one of the most common illnesses, leading to more doctor visits. The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic:



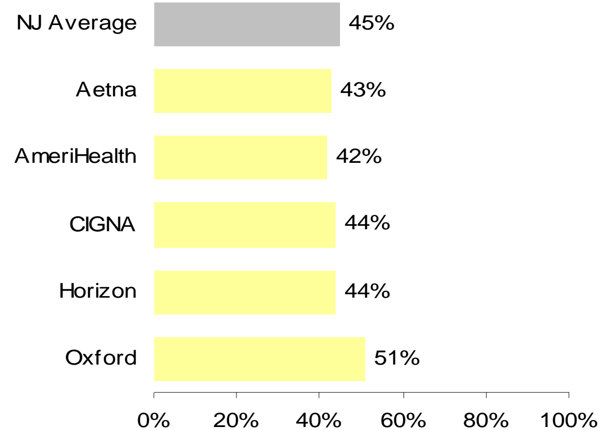
Avoidance of antibiotic treatment* in adults with acute bronchitis

Use of antibiotics usually is not an appropriate treatment for acute bronchitis. The percentage of adult's ages 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (a higher rate indicates lower antibiotic use, which is appropriate):



Use of spirometry testing in the assessment and diagnosis of COPD

Spirometry testing measures air flow through the lungs and can confirm a COPD diagnosis. Members 40 years of age and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis:



* Inappropriate use of antibiotics has been shown to promote resistant bacteria that are more difficult to treat. The Center for Disease Control and other organizations urge physicians to avoid prescribing antibiotics when not medically indicated.

Getting Better/Living with Illness

How well does the HMO care for members who are sick?

HMOs should work with doctors to care for members who are sick or living with chronic illness. HMOs reported on the percentage of their relevant membership who received the following (pages 7-12):

- Management of medicine for depression
- Care after hospitalization for mental illness
- Management of medicine prescribed to treat Attention Deficit Hyperactivity Disorder (ADHD) in Children
- Appropriate medications for treatment of asthma in children

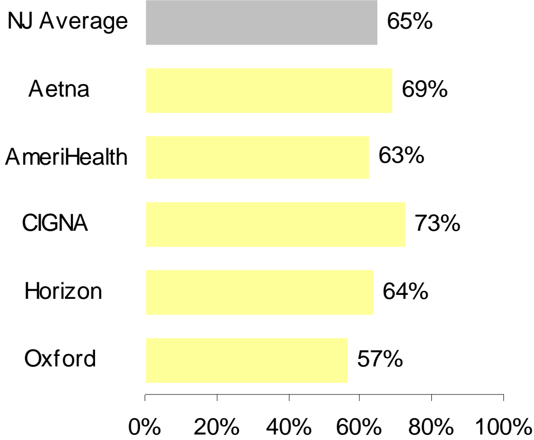
The following tables show how well each HMO performed and HMO average in New Jersey.

HMO	Management of medicine for depression %	Care after hospitalization for mental illness %	Follow-up Care for children prescribed ADHD medications %	Appropriate medications for asthma %
Aetna - HMO/POS	69	77	39	97
AmeriHealth - HMO/POS	63	76	2	93
CIGNA - HMO/POS	73	66	39	96
Horizon - HMO	64	83	31	96
Oxford - HMO/POS	57	74	40	96

See the next page for each HMO's scores →

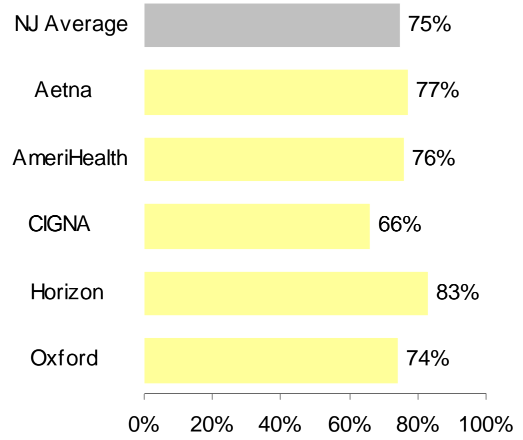
Management of medicine for depression

People taking medicine for depression need to be monitored. Percent of members given medicine for depression who had follow-up visits:



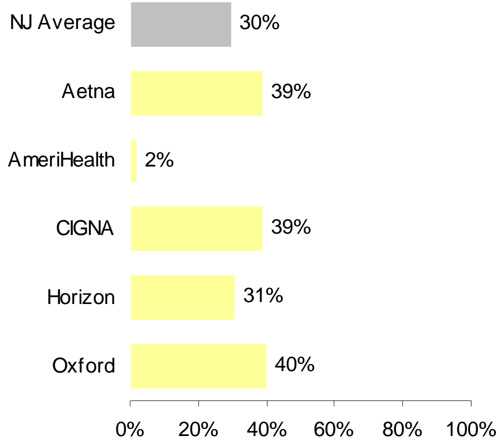
Care after hospitalization for mental illness

Therapy after a hospital stay for mental illness is important for recovery. Percent of members hospitalized for mental illness who received care afterwards:



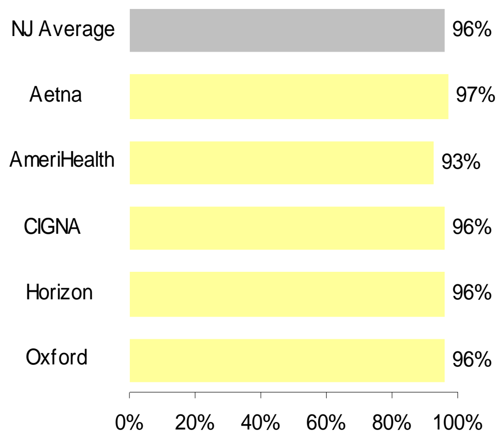
Follow-up care for children prescribed ADHD medications

Children prescribed for ADHD medications need to be monitored. Percent of members given medicine for Initiation Phase of ADHD who had follow-up visit within 30 days of Initiation-Phase:



Appropriate medications for asthma (children)

With appropriate therapies, long term control of persistent asthma can be achieved, resulting in a decrease in hospitalizations and emergency room visits for treatment. Percent of pediatric members aged 5–11 with persistent asthma who received an appropriate therapy in the past year:



Getting Better/Living with Illness (continued)

How well does the HMO care for members who are sick?

HMOs should work with doctors to care for members who are sick or living with chronic illness. HMOs reported on the percentage of their relevant membership who received the following (pages 7-12):

- Cholesterol management (of heart patients)
- Persistence of beta blocker treatment after a heart attack
- Blood sugar testing for people with diabetes
- Eye Exams for people with diabetes

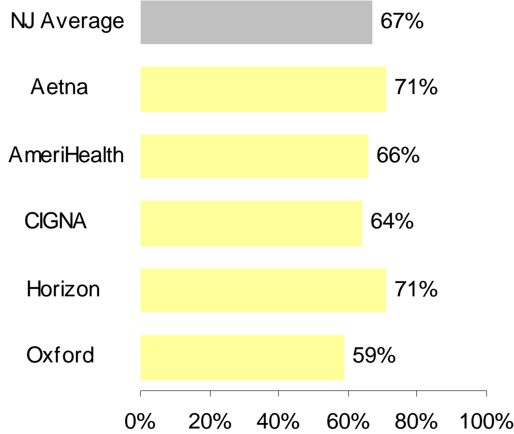
The following tables show how well each HMO performed and HMO average in New Jersey.

HMO	Controlling high blood pressure %*	Cholesterol management of heart patients %	Blood sugar testing for people with diabetes %	Eye exams for people with diabetes %
Aetna - HMO/POS	71	58	86	61
AmeriHealth - HMO/POS	66	66	84	47
CIGNA - HMO/POS	64	63	90	57
Horizon - HMO	71	58	88	62
Oxford - HMO/POS	59	55	86	41

See the next page for each HMO's scores →

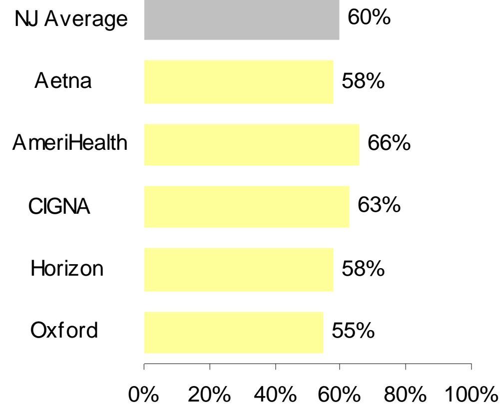
Controlling high blood pressure

High blood pressure (hypertension) is a major risk factor for a number of diseases. Percent of members aged 18–85 with hypertension whose blood pressure was under control at their most recent medical visit:



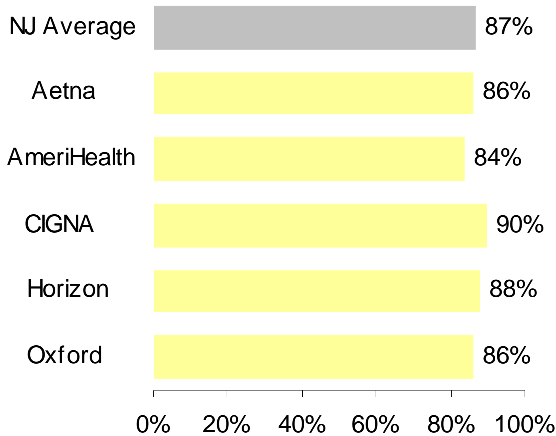
Cholesterol management of heart patients

Reducing cholesterol lowers the chances of having a heart attack. Percentage of members with heart conditions who had their cholesterol level controlled:



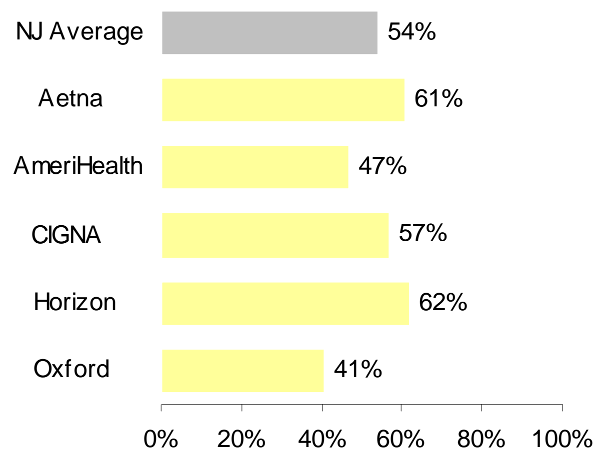
Blood sugar testing for people with diabetes

Controlling blood sugar levels can prevent complications from diabetes. Percent of members with diabetes who had a blood sugar (HbA1C) test:



Eye exams for people with diabetes

Regular eye exams can reduce the risk of blindness from diabetes. Percent of members with diabetes who received an eye exam:



Getting Better/Living with Illness

How well does the HMO care for members who are sick?

HMOs should work with doctors to care for members who are sick or living with chronic illness. HMOs reported on the percentage of their relevant membership who received the following (pages 7-12):

- Persistence of beta blocker treatment after a heart attack
- Check-ups for new mothers
- Use of imaging studies for low back pain
- Frequencies of selected procedures

The following tables show how well each HMO performed and HMO average in New Jersey.

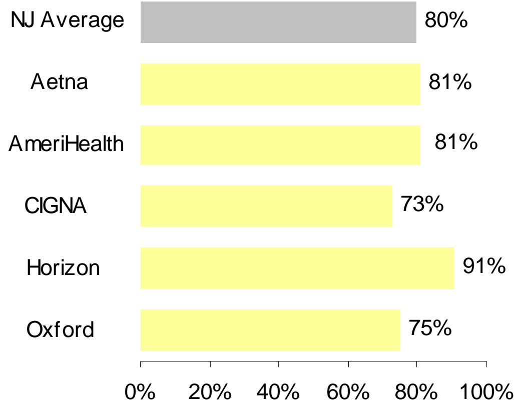
HMO	Persistence of beta blocker treatment after heart attack %	Check-ups for new mothers %*	Use of imaging studies for low back Pain %	Frequencies of selected procedures %
Aetna - HMO/POS	81	89	77	See page 13
AmeriHealth - HMO/POS	81	85	80	,,
CIGNA - HMO/POS	73	84	75	,,
Horizon - HMO	91	82	78	,,
Oxford - HMO/POS	75	75	72	,,

* Only AmeriHealth used 2009 data for this measure; other health plans have used 2008 data for Postpartum Care.

See the next page for each HMO's scores →

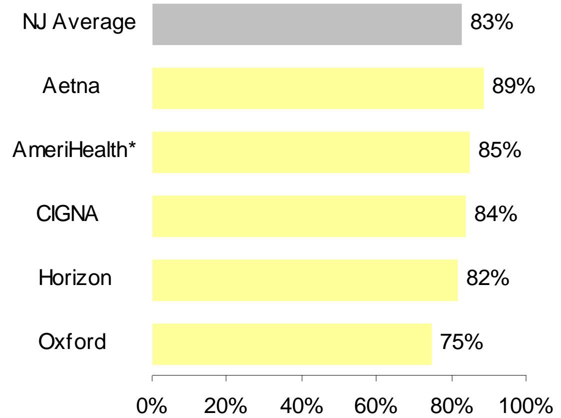
Persistence of beta blocker treatment after a heart attack

Beta blockers after a heart attack can help prevent future heart attacks. Percent of members who received persistent beta-blocker treatment for six months after discharge:



Check-ups for new mothers

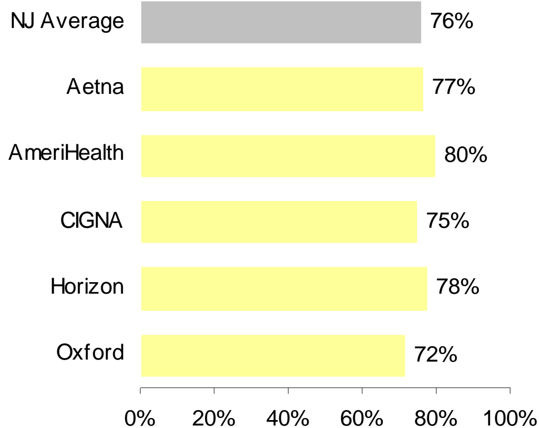
During a visit, providers can check a new mother's recovery from childbirth and answer questions. Percent of new mothers who received a check-up within eight weeks after delivery:



* AmeriHealth's rate for Postpartum Care is based on 2009 data but other rates for Postpartum Care are based on 2008 data.

Imaging Studies for Low Back Pain

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis. A higher rate indicates appropriate treatment of low back pain:



Frequency of Selected Procedures

See page 13 for frequencies of selected procedures

Frequencies of selected Procedures

This measure summarizes the utilization of frequently performed procedures:

Procedure	Age	Sex	Number of Procedures	Procedures / 1,000 Member Years
Aetna				
Tonsillectomy	0-9	Male & Female	512	7.45
	10-19		304	3.16
Cardiac Catheterization	45-64	Male	993	10.45
		Female	713	7.06
	65+	Male	195	23.33
		Female	131	18.47
AmeriHealth				
Tonsillectomy	0-9	Male & Female	75	10.22
	10-19		24	2.75
Cardiac Catheterization	45-64	Male	113	10.83
		Female	77	7.29
	65+	Male	19	20.90
		Female	8	10.48
CIGNA				
Tonsillectomy	0-9	Male & Female	79	6.40
	10-19		43	3.02
Cardiac Catheterization	45-64	Male	143	11.29
		Female	81	6.20
	65+	Male	36	24.17
		Female	25	20.24
Horizon				
Tonsillectomy	0-9	Male & Female	204	6.60
	10-19		123	3.28
Cardiac Catheterization	45-64	Male	483	10.76
		Female	365	7.33
	65+	Male	87	31.70
		Female	34	14.01
Oxford				
Tonsillectomy	0-9	Male & Female	107	5.74
	10-19		50	2.61
Cardiac Catheterization	45-64	Male	178	8.71
		Female	103	4.86
	65+	Male	24	19.86
		Female	14	15.32

Choosing Your HMO

Your choice of an HMO can influence your health.

Looking at HMO quality, along with choice of providers, benefits offered, and costs, can help you decide on an HMO that best meets your needs.

Quality of Care and Service

- Look to see how well the HMO performs in each section of this report.
- Pay special attention to the health issues that are most important to you and your family.
- Do not focus on small differences in a single measure that may not be meaningful. To compare HMOs, look at all the factors that contribute to an HMO's performance and at large differences in the measures.
- Check the NCQA website for a quality and member satisfaction measures of each health plan at: www.ncqa.org or http://reportcard.ncqa.org/plan/external/plansearch.aspx

Choice of Providers

- Make sure that your preferred doctor, hospital and other providers participate in the HMO's network by looking in the HMO's provider directory. It is important to confirm your provider's participation by calling the HMO's member services department or the provider directly, prior to enrollment. *See page 15 for ways to contact the HMO.*
- Decide whether the HMO has enough of the kinds of doctors you are likely to need and whether they are located near your home or work.
- Once you have selected a provider, make sure the doctor has office hours and a location convenient for you and your family.

Benefits

- Find out what types of health benefit plans the HMO offers by reviewing your evidence or member handbook or calling the member services department.
- Consider your special needs and circumstances such as chronic health conditions, elder care, frequent travel, language, retirement and starting a family.
- Decide whether there is a good match between the health benefits offered by the HMO and what you think you may need.
- Find out what types of care or services the HMO does not cover.

Cost

- Try to get an idea of how much you are likely to pay in premiums, co-payments, coinsurance and deductibles each year.
- Find out if the HMO covers services by providers outside the HMO's network and how much it will cost for these services.
- See if there are any limits on how much you are responsible for paying in case of major illness (out-of-pocket maximum).
- Find out if the HMO places limits on the amount of benefits it will pay (annual or lifetime maximums).
- The HMO might also have internal limits on specific services, such as dollar, day or visit limits for specific services.

Accreditation

NCQA, the National Committee for Quality Assurance, is a non-profit organization committed to assessing, reporting on and improving the quality of care provided by the nation's carriers offering managed care health benefits plans. To find out if your carrier is NCQA accredited, call toll-free (888) 275-7585 or visit the web site: www.ncqa.org.

URAC, the American Accreditation HealthCare Commission is a non-profit organization originally focused on the accreditation of utilization review programs. URAC now provides accreditation services for many types of health care organizations, including HMOs. For information on URAC's accreditation services, visit the web site: www.urac.org.

JCAHO, the Joint Commission on Accreditation of Healthcare Organizations, is an independent, non-profit organization that evaluates and accredits various types of health care networks including health carriers, hospitals, home health care organizations and others. For more information on JCAHO's accreditation services, visit the web site: www.jcaho.org

Contacting Your HMO

The information in this report only covers the HMOs offering commercial HMO and POS products in New Jersey. The contact information in the chart lists **all** active HMOs approved to issue HMO and POS products in New Jersey. The chart shows if the HMO offers commercial coverage and if it participates in Medicare or Medicaid. It also shows the counties that each HMO is authorized to serve. An HMO might not offer Medicare or Medicaid in all the counties in its service area. Look at the chart notes to find the counties where an HMO participates in Medicare or Medicaid.

Telephone Numbers, Web Sites

HMO		
Health Plans	**Telephone**	**Web site**
Aetna Health, Inc. - New Jersey	(800) 872-3862	www.aetna.com
AmeriChoice of New Jersey	(800) 941-4647	www.americhoice.com
AMERIGROUP New Jersey	(800) 600-4441	www.amerigroupcorp.com
AmeriHealth HMO	(866) 681-7368	www.amerihealth.com
Bravo Health Pennsylvania, Inc.	(800)-235-9188	www.bravohealth.com
CIGNA HealthCare of New Jersey	(800) 244-6224	www.cigna.com
Healthfirst Health Plan of New Jersey, Inc.	(866) 635-1521	www.healthfirstnj.com
Horizon Healthcare of New Jersey	(800) 355-2583	www.horizonblue.com
Oxford Health Plans - New Jersey	(800) 444-6222	www.oxhp.com
WellCare Health Plan of New Jersey	(866) 687-8570	www.wellcare.com

PRODUCT LINE AND SERVICE AREA INFORMATION AS OF JULY 1, 2010

Use the telephone numbers and web sites to learn more about the HMOs that interest you.

Service Areas	Counties
NORTHERN:	Bergen, Essex, Hudson, Morris, Passaic, Sussex, Union, Warren
CENTRAL:	Hunterdon, Mercer, Middlesex, Monmouth, Somerset
SOUTHERN:	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean, Salem

Product Lines and Service Areas

HMOs	PRODUCT LINES			SERVICE AREAS		
Health Plans	**COMMERCIAL**	**MEDICARE**	**MEDICAID**	**NORTH**	**CENTER**	**SOUTH**
Aetna Health, Inc. NJ	✓	✓		✓	✓	✓
AmeriChoice of NJ		✓1	✓	✓	✓	✓
AMERIGROUP NJ		✓2	✓2*	✓	✓	✓
AmeriHealth HMO	✓	✓		✓	✓	✓
Bravo Health Pennsylvania, Inc.		Burlington, Camden, Gloucester				✓
CIGNA HealthCare of NJ	✓			✓	✓	✓
Healthfirst Health Plan of NJ Inc.		✓3	✓3*	Bergen, Essex, Hudson, Passaic, & Union		
Horizon Healthcare of NJ	✓	✓	✓	✓	✓	✓
Oxford Health Plans - NJ	✓	✓4		✓	✓	✓
WellCare Health Plan of NJ		✓		Essex, Hudson, Passaic, & Union	Middlesex	Camden

Notes:

1. AmeriChoice Medicare is available only in Atlantic, Bergen, Burlington, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic and Union counties. 2. AMERIGROUP Medicare is available in Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean and Union Counties only. 2*. AMERIGROUP Medicaid is available statewide except Salem County (South). 3. Healthfirst Medicare is available in Bergen, Essex, Hudson, Passaic, and Union counties. 3*. Healthfirst Medicaid is available in Bergen, Essex, Hudson, Morris, Passaic, Somerset, Sussex and Union counties. 4. Oxford Medicare is available in Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, and Union counties.

These are the steps you can take if you have been denied covered medical benefits or want to file a complaint.

To Appeal an HMO's Decision

Your HMO is required to have an appeal process that gives you an opportunity to resolve disagreements about denials, limitations and terminations of covered services (or benefits for such services) resulting from a decision by the HMO that the services are not medically necessary. Such decisions are adverse utilization management (UM) determinations.

Review the services covered by your HMO and the explanation of the appeal process in your evidence of coverage or member handbook. You or your doctor, acting with your consent, have the right to file an appeal of an HMO's adverse UM determination.

Stage 1

Inform the HMO, either verbally or in writing, that you disagree with the HMO's decision to deny or limit services you believe are covered and medically necessary. A different doctor at the HMO will consider your request for services. You will receive notice of whether the HMO is revising or upholding the initial decision.

Stage 2

If you are dissatisfied with the results of the Stage 1 appeal, you can request, either verbally or in writing, that the HMO have your appeal reviewed by a panel of doctors and other health care professionals. You will receive notice of the panel's decision.

Stage 3

If you are dissatisfied with the HMO's decision on your Stage 2 appeal, you can file an appeal with the Department of Banking and Insurance within 60 days after receiving the HMO's Stage 2 decision. You will receive the form and instructions needed to file a Stage 3 appeal from your HMO at the same time you receive the Stage 2 appeal decision. Your case will be reviewed by independent experts under contract to the State through the Independent Health Care Appeals Program (IHCAP). Decisions made by the IHCAP are binding on the HMO.

For appeals involving urgent circumstances, the HMO is required to respond within 72 hours in Stages 1 and 2.

To File a Complaint against an HMO

In addition to the appeal process for adverse UM determinations, you also have the right to complain to the HMO about any aspect of its operations. The HMO is required to have a system to resolve complaints about such things as quality of medical care, choice of doctors and other health care providers, and difficulties with processing claims or disputes about an HMO's business and marketing practices. The HMO is required to respond to your complaint within 30 days. Your evidence of coverage or member handbook contains a description of the process and contact information for resolving complaints. If you are dissatisfied with the outcome of the HMO's complaint process, contact:

NJ Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329, Trenton, NJ 08625-0329
(888) 393-1062
http://www.state.nj.us/dobi/managed.htm

The process for appealing a decision or filing a complaint is different if you belong to a "self-funded" plan. Check with your employer or health plan and refer to page 18

For Medicare and Medicaid managed care appeals refer to page 18

Health Care Carrier Accountability Act

Signed into law in the summer of 2001, this legislation gives consumers covered under managed care contracts the right to sue their carrier if the consumer believes that the carrier's decision to delay or deny care has or will result in serious harm to the consumer. In most cases, consumers will first appeal the carrier's decision through completion of the external appeal process described above (Stage 3). However, the external appeal process can be bypassed in cases where serious harm to the consumer has already occurred or is imminent.

Other Important Resources

When you are making decisions about health care, consider other sources of information and assistance.

Department of Banking and Insurance

Buyers Guides and other information are available for individual and small employer coverage. This information is on the New Jersey Department of Banking and Insurance's (DOBI) web site at http://www.state.nj.us/dobi/division_insurance/ihcseh/index.html. You may also request information by calling (609) 633-1882 and pressing option "3". DOBI monitors the compliance of HMOs with New Jersey rules through in-depth reviews and targeted examinations. DOBI investigates consumer complaints about HMOs and other carriers offering managed care health benefits plans, and oversees the Independent Health Care Appeals Program (IHCAP) and the program for Independent Claims Payment Arbitration (PICPA), an arbitration mechanism that became operational in July 2007 to address certain claims disputes between health care providers and carriers. Certain data regarding complaints, the IHCAP and PICPA is available. For information, visit www.state.nj.us/dobi/managed.htm or call the Office of Managed Care toll-free at (888) 393-1062.

DOBI also posts information on enrollment by county and line of business, net worth and profitability for New Jersey HMOs, as well as other information on health carriers. This information can be found at www.state.nj.us/dobi/lhactuar.htm

Medicare

For information on managed care options for Medicare in New Jersey, call the New Jersey Department of Health and Senior Services, Division of Aging and Community Services, State Health Insurance Assistance Program (SHIP) at (800) 792-8820, or call (800) MEDICARE. You can also visit www.medicare.gov. If you have a complaint about a Medicare managed care plan, refer to your member services handbook for detailed information about where to submit your complaint based on the type of complaint you have.

NJFamilyCare/Medicaid

For information on NJ Family Care and Medicaid HMO options, quality information and complaints, call the New Jersey Department of Human Services at (800) 701-0710 or visit: www.state.nj.us/humanservices.

Physicians

For information on New Jersey physicians, including disciplinary actions, call the New Jersey State Board of Medical Examiners at (609) 826-7100 or visit http://www.state.nj.us/lps/ca/bme/index.html

Additional Health Care Information

The Department of Health and Senior Services publishes a number of reports and other data, such as indicators of hospital performance, and long-term care facility performance. This information is found at: www.state.nj.us/health/reportcards.shtml. A price comparison registry for many prescription drugs can be found at: www.njdrugprices.nj.gov

Self-Funded Plans

Large employers and unions often assume financial responsibility for employee health benefits instead of buying insurance. Employers may contract with outside organizations to administer their self-funded health benefits plans (sometimes referred to as "self-insured" plans). These plans are not bound by New Jersey's statutory or regulatory requirements, but rather by federal rules. Roughly half of all New Jersey health benefits through employers are in self-funded plans. Questions or complaints about these self-funded plans can only be addressed by the federal Department of Labor's Employee Benefits Security Administration. The main number is: (866) 275-7922. The web site is: www.dol.gov/ebsa.

New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625-0325

www.state.nj.us/dobi/lifehealthactuarial/hmo2010/