2001
New Jersey
HMO Performance Report
Compare Your Choices

Donald T. DiFrancesco
Acting Governor

George T. DiFerdinando, Jr., M.D.
Acting Commissioner
Department of Health and Senior Services

October 2001

Dear Consumers:

We are pleased to present the fifth annual *New Jersey HMO Performance Report.* This report looks at the performance of New Jersey's managed health care plans, how well these plans deliver important health care services, and what members think about the services they receive. This year we have added two new measures that focus on how well the health plans help members manage two common chronic illnesses that affect millions of Americans: controlling high blood pressure and use of appropriate medications for people with asthma.

The report is designed to give both consumers and employers information on the quality of New Jersey's managed health care plans. We believe that you will find this information useful when choosing a health plan for your family or business.

New Jersey has some of the strongest consumer and patient protections in the country. We urge you to become familiar with these protections, which are explained in this report.

We wish you good health and hope this report helps you choose the health plan that best serves you and your family.

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Acting Commissioner
Department of Health and Senior Services

The New Jersey Department of Health and Senior Services developed this report with the cooperation of the New Jersey health plans. The Department was guided by an advisory group representing health plans, health care purchasers, providers and consumers.

This report includes information on New Jersey commercial health plans' health maintenance organization (HMO) and point-of-service (POS) products. The report includes all such health plans, currently marketed in New Jersey that had at least 2,000 members in both 1999 and 2000. For most plans the information combines plan performance for the HMO and POS products. For Horizon Health Care, One Health Plan and WellChoice, only the HMO product is included. *See page 20 for more information about the distinction between HMO and POS products.*

This report does not cover the performance of health plans that serve Medicare beneficiaries or beneficiaries of Medicaid and other New Jersey Department of Human Services programs. *See page 19 for ways you can obtain information on these plans.*

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 experts in health care. It includes measures collected by the health plans and measures collected through member surveys. All measures are verified by independent auditors.

This report contains information on the following health plans:

- **Aetna USHC—HMO/POS**
  (Aetna U.S. Healthcare–New Jersey)
- **AmeriHealth—HMO/POS** *(AmeriHealth HMO)*
- **CIGNA—HMO/POS** *(CIGNA HealthCare of New Jersey)*
- **Horizon—HMO** *(Horizon Healthcare of New Jersey)*
- **One Health—HMO** *(One Health Plan of New Jersey)*
- **Oxford—HMO/POS** *(Oxford Health Plans–New Jersey)*
- **PHS—HMO/POS**
  *(Physicians Health Services of New Jersey)**
- **United—HMO/POS** *(United Healthcare of New Jersey)*
- **University—HMO/POS** *(University Health Plans)*
- **WellChoice—HMO** *(WellChoice HMO of New Jersey)^*

*Physicians Health Services has applied to use the name Health Net.
^WellChoice was formerly known as Empire HealthChoice.

For information on contacting these and other New Jersey health plans, see page 16.

For additional copies of this report, please contact the Office of Research and Development, New Jersey Department of Health and Senior Services, P.O. Box 360, Trenton, New Jersey, 08625-0360; telephone (800) 418-1397, fax (609) 292-6523. There is a charge for multiple copies.

This report is also available on the Department's Web site:
www.state.nj.us/health
or can be requested by e-mail:
hmo@doh.state.nj.us

Contents

Important Questions About Quality You Should Consider

What do you know about the quality of New Jersey health plans?

This report provides information about:

- How consumers rated their health plans and doctors
- How easily consumers got the care they needed
- How well health plans provided preventive care, such as immunizations and mammograms, to help people stay healthy
- How well health plans cared for people who are ill, such as managing the cholesterol level of people with heart disease

Why is the quality of health care important?

Not all health plans are the same. Health plans differ in how well they keep people 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 health plan may influence your health and your family's health.
- **If you are an employer,** the quality of care provided by your health plan may influence absenteeism, employee productivity and your company's health care costs.

What should you consider when choosing your health plan?

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

When choosing a health plan, consider:

- Whether your doctor or health care provider is available in the plan
- Whether the plan offers the benefits you want
- How much the plan will cost you (look at both monthly premiums and out-of-pocket expenses such as copayments, coinsurance and deductibles)
- How well the plan performs in areas most important to you

Look at Quality— See the next page for health plan performance

How New Jersey Health Plans Perform Overall

This chart summarizes New Jersey health plan performance in four broad areas by comparing each plan's performance to the statewide plan average. Each broad area is made up of several performance measures, which are further described on the following pages.

Higher than average scores mean better performance.

Performance Compared to the Average	
	● **Higher** than the New Jersey health plan average
	◓ **About the Same** as the New Jersey health plan average
	○ **Lower** than the New Jersey health plan average

	Overall Performance See the following pages for more detail			
HEALTH PLAN	**Service and Access** See pages 4 & 5	**Doctors and Medical Care** See pages 6 & 7	**Staying Healthy** See pages 8 & 9	**Getting Better/Living with Illness** See pages 10–13
Aetna USHC—HMO/POS	●	●	●	●
AmeriHealth—HMO/POS	●	●	●	◓
CIGNA—HMO/POS	◓	○	●	◓
Horizon—HMO	◓	◓	◓	◓
One Health—HMO	○	○	○	Not Calculated
Oxford—HMO/POS	◓	◓	●	●
PHS—HMO/POS	◓	◓	◓	○
United—HMO/POS	◓	○	◓	◓
University—HMO/POS	○	◓	○	Not Calculated
WellChoice—HMO	◓	●	Not Calculated	Not Calculated

Not Calculated—Insufficient information was reported by health plan for calculation of the score.

Are members satisfied with their health plan's services?

This section (pages 4 and 5) shows how the health plans compare to the New Jersey plan average in providing service to their members.

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Performance Compared to the Average

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- ○ **Lower** than the New Jersey health plan average

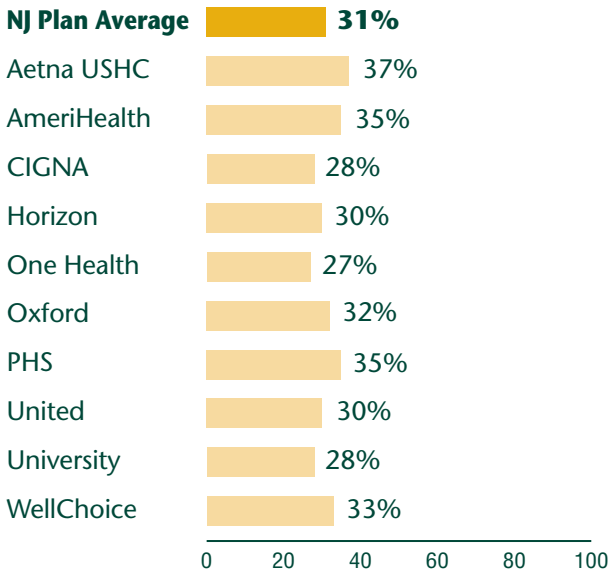
HEALTH PLAN	Rating of health plan	Getting needed care	Claims processing	Customer service
Aetna USHC—HMO/POS	●	●	●	●
AmeriHealth—HMO/POS	◓	●	●	●
CIGNA—HMO/POS	◓	◓	◓	◓
Horizon—HMO	◓	◓	◓	◓
One Health—HMO	◓	○	○	○
Oxford—HMO/POS	◓	◓	◓	◓
PHS—HMO/POS	◓	◓	◓	◓
United—HMO/POS	◓	◓	○	◓
University—HMO/POS	◓	○	○	○
WellChoice—HMO	◓	◓	◓	◓

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.

See the next page for each health plan's scores

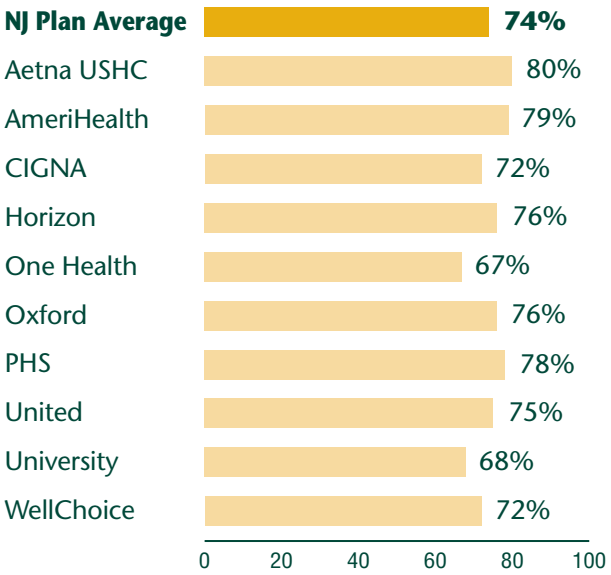
Rating of health plan

Percent of members who rated their health plan a 9 or 10 on a scale from 0 (worst possible) to 10 (best possible):



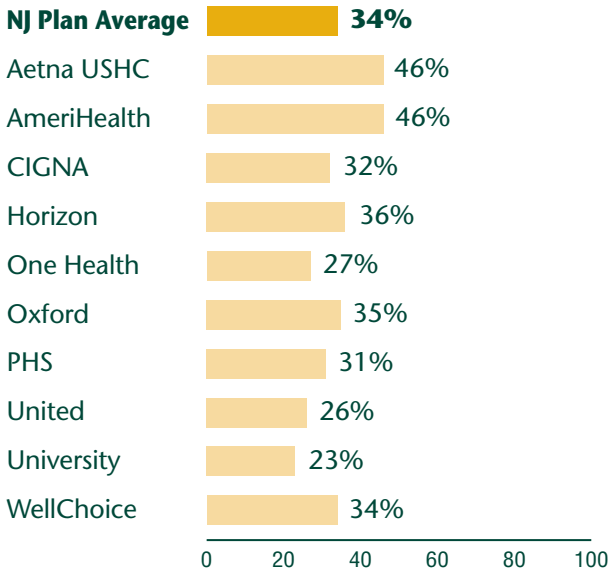
Getting needed care

Percent of members who said they had *no problem* obtaining • a personal doctor they like • a referral to see a specialist • necessary care • timely approvals for care:



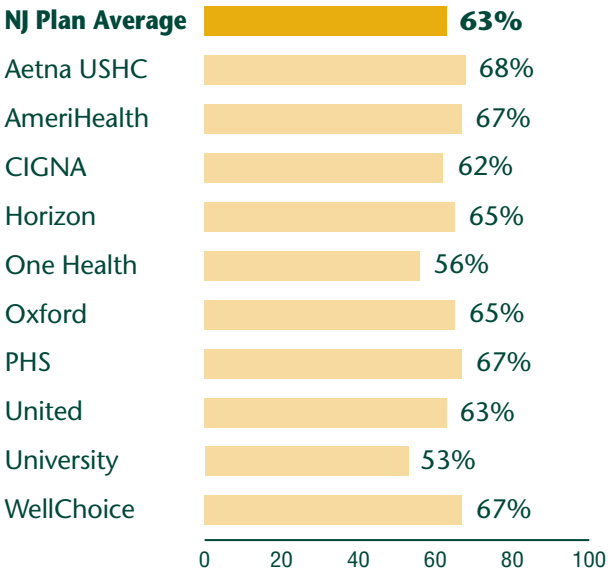
Claims processing

Percent of members who said their plan *always* handled their claims • in a reasonable amount of time • correctly:



Customer service

Percent of members who said they had *no problem* • finding or understanding written information • getting needed help from customer service • completing paperwork:



Are health plan members satisfied with their doctors and medical care?

This section (pages 6 and 7) shows how the health plans compare to the New Jersey plan average in working with doctors to provide high quality medical care to their members.

Higher than average scores mean better performance.

Performance Compared to the Average

- ● **Higher** than the New Jersey health plan average
- ◓ **About the Same** as the New Jersey health plan average
- ○ **Lower** than the New Jersey health plan average

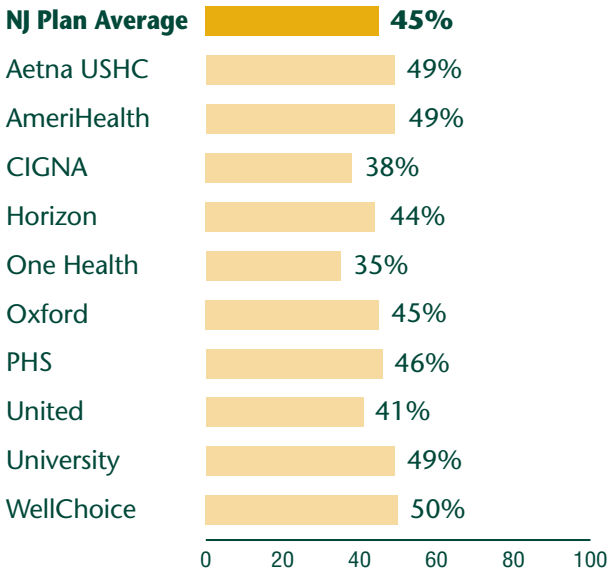
HEALTH PLAN	Rating of health care	Getting care quickly	Rating of personal doctor	How well doctors communicate
Aetna USHC—HMO/POS	◓	◓	●	●
AmeriHealth—HMO/POS	◓	●	●	●
CIGNA—HMO/POS	○	◓	○	○
Horizon—HMO	◓	◓	◓	◓
One Health—HMO	○	○	○	○
Oxford—HMO/POS	◓	◓	◓	◓
PHS—HMO/POS	◓	◓	●	◓
United—HMO/POS	◓	○	◓	○
University—HMO/POS	●	◓	◓	●
WellChoice—HMO	●	◓	◓	●

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.

See the next page for each health plan's scores

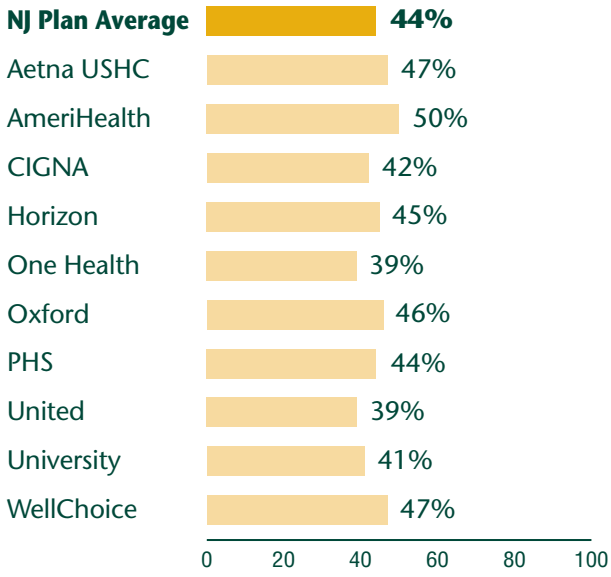
Rating of health care

Percent of members who rated their quality of care a 9 or 10 on a scale from 0 (worst possible) to 10 (best possible):



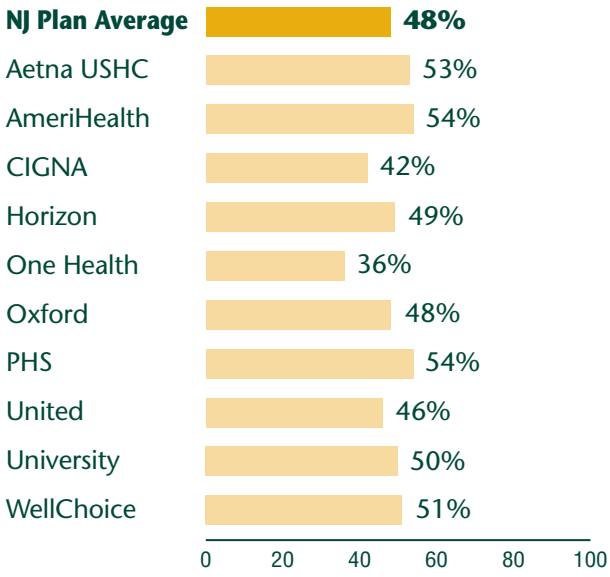
Getting care quickly

Percent of members who said they • *always* were able to obtain advice, get timely appointments and get care for an illness or injury • *never* had to wait over 15 minutes past appointment time to see a provider:



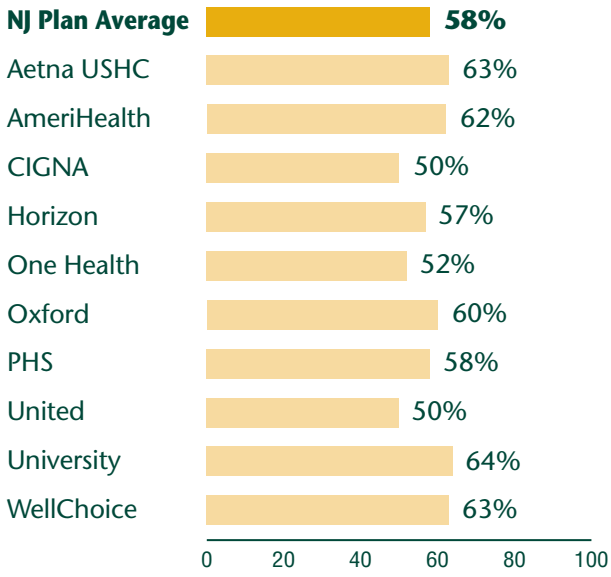
Rating of personal doctor

Percent of members who rated their personal doctor a 9 or 10 on a scale from 0 (worst possible) to 10 (best possible):



How well doctors communicate

Percent of members who said their doctor *always* • listened carefully • explained things clearly • showed respect • spent enough time with them:



Does the health plan help members stay healthy and avoid illness?

This section (pages 8 and 9) shows how the health plans compare to the New Jersey plan average in working with doctors to provide important preventive services that help members stay healthy.

Higher than average scores mean better performance.

Performance Compared to the Average

- ● **Higher** than the New Jersey health plan average
- ◓ **About the Same** as the New Jersey health plan average
- ○ **Lower** than the New Jersey health plan average

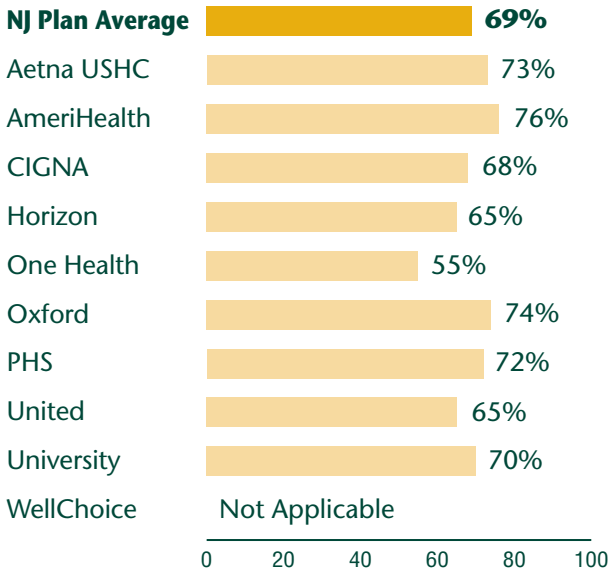
HEALTH PLAN	Testing for breast cancer	Testing for cervical cancer	Check-ups for new mothers	Immunizations for children
Aetna USHC—HMO/POS	◓	●	●	●
AmeriHealth—HMO/POS	●	◓	●	●
CIGNA—HMO/POS	◓	◓	●	●
Horizon—HMO	◓	◓	◓	●
One Health—HMO	◓	○	○	Not Applicable
Oxford—HMO/POS	●	●	◓	●
PHS—HMO/POS	◓	◓	○	◓
United—HMO/POS	◓	◓	◓	◓
University—HMO/POS	◓	○	◓	○
WellChoice—HMO	Not Applicable	Not Applicable	◓	Not Applicable

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.
Not Applicable—Health plan was unable to report the measure due to the small number of eligible members.

See the next page for each health plan's scores

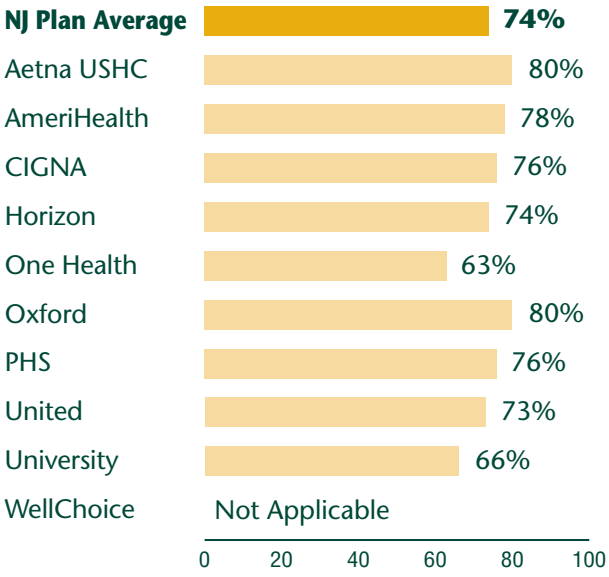
Testing for breast cancer

Women are more likely to survive if breast cancer is found early through a mammogram (x-ray of the breast). Percent of women aged 52–69 who received a mammogram within the past two years:



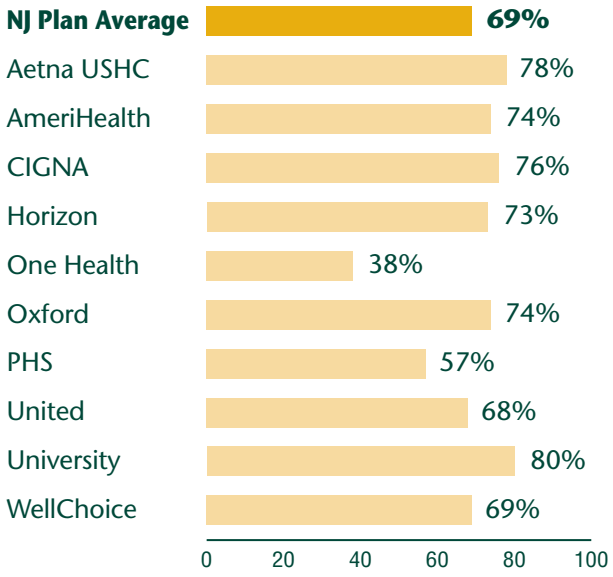
Testing for cervical cancer

Women are more likely to survive if cervical cancer is found early through a Pap test. Percent of adult women who received a Pap test within the past three years:



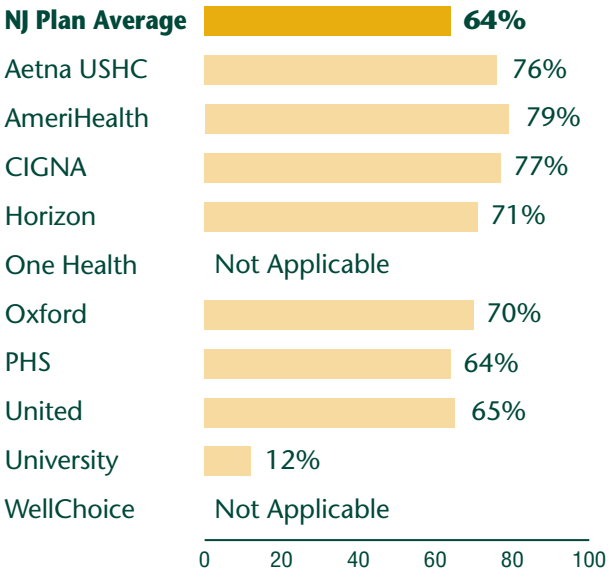
Check-ups for new mothers

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:



Immunizations for children

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



How well does the health plan care for members who are sick?

This section (pages 10–13) shows how the health plans compare to the New Jersey plan average in working with doctors to care for members who are sick or living with chronic illness.

Higher than average scores mean better performance.

Performance Compared to the Average

- ● **Higher** than the New Jersey health plan average
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- ○ **Lower** than the New Jersey health plan average

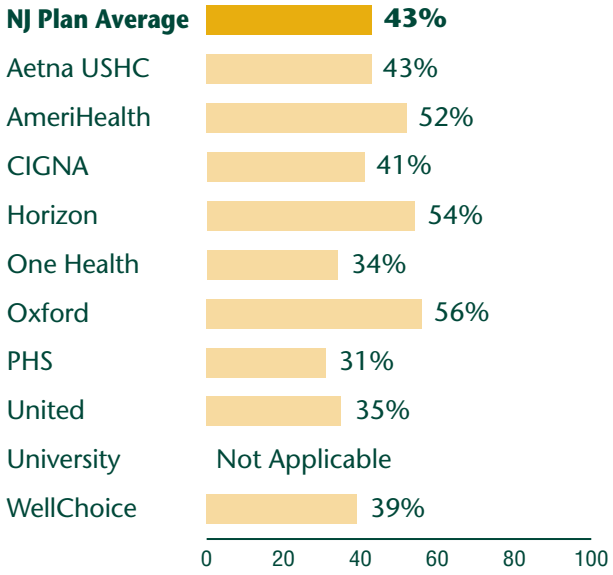
HEALTH PLAN	Controlling high blood pressure	Cholesterol management of heart patients	Beta blocker treatment after a heart attack	Care after hospitalization for mental illness
Aetna USHC—HMO/POS	◓	◓	◓	●
AmeriHealth—HMO/POS	●	◓	●	◓
CIGNA—HMO/POS	◓	◓	◓	◓
Horizon—HMO	●	◓	◓	◓
One Health—HMO	◓	Not Applicable	Not Applicable	Not Applicable
Oxford—HMO/POS	●	●	●	◓
PHS—HMO/POS	○	○	○	○
United—HMO/POS	○	◓	◓	Not Applicable
University—HMO/POS	Not Applicable	Not Applicable	Not Applicable	Not Applicable
WellChoice—HMO	◓	Not Applicable	Not Applicable	Not Applicable

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.
Not Applicable—Health plan was unable to report the measure due to the small number of eligible members.

See the next page for each health plan's scores

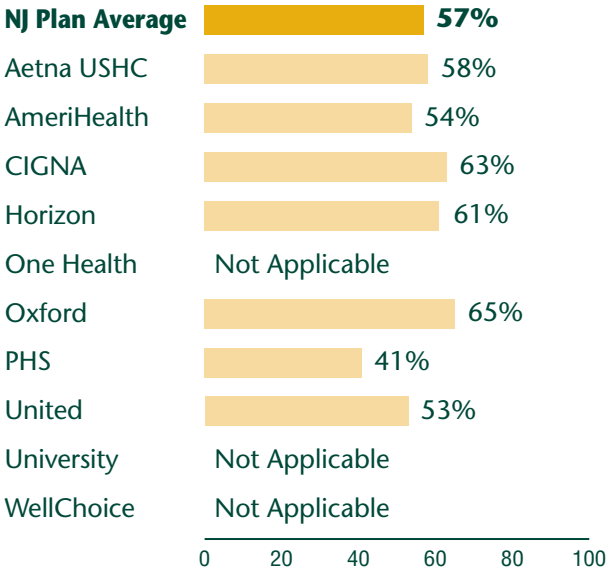
Controlling high blood pressure

High blood pressure (hypertension) is a major risk factor for a number of diseases, and must be closely monitored and controlled. Percent of members aged 46–85 with hypertension whose blood pressure was under control at their most recent medical visit:



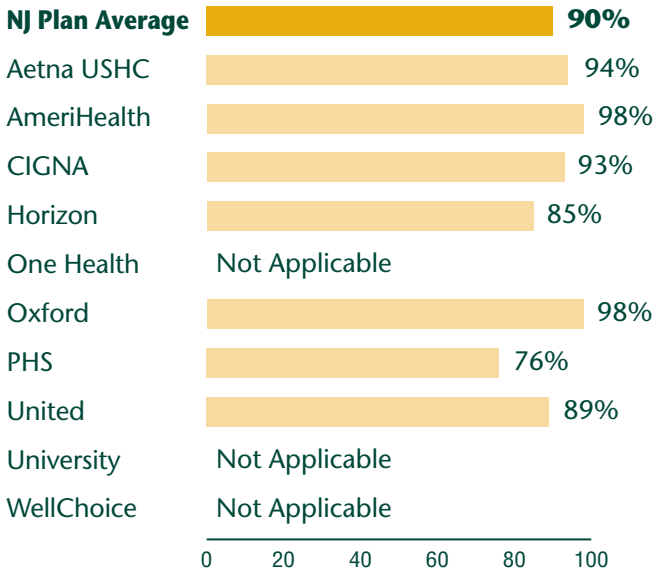
Cholesterol management of heart patients

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



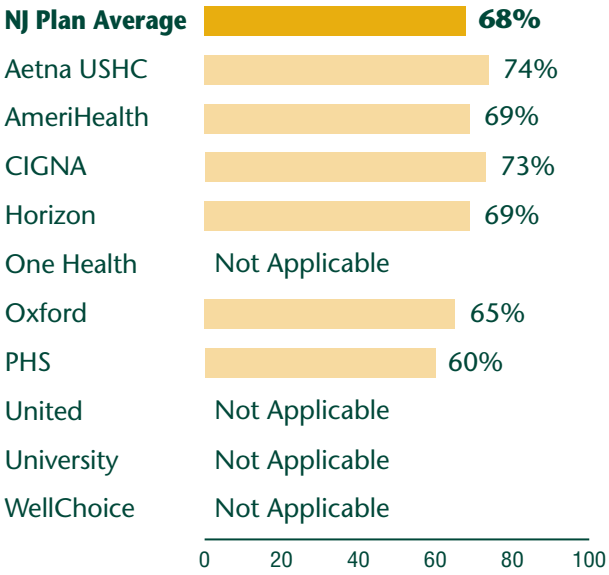
Beta blocker treatment after a heart attack

Beta blockers after a heart attack can help prevent future heart attacks. Percent of members who had a heart attack and received beta blockers:



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:



How well does the health plan care for members who are sick?

This section (pages 10–13) shows how the health plans compare to the New Jersey plan average in working with doctors to care for members who are sick or living with chronic illness.

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Performance Compared to the Average

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- ○ **Lower** than the New Jersey health plan average

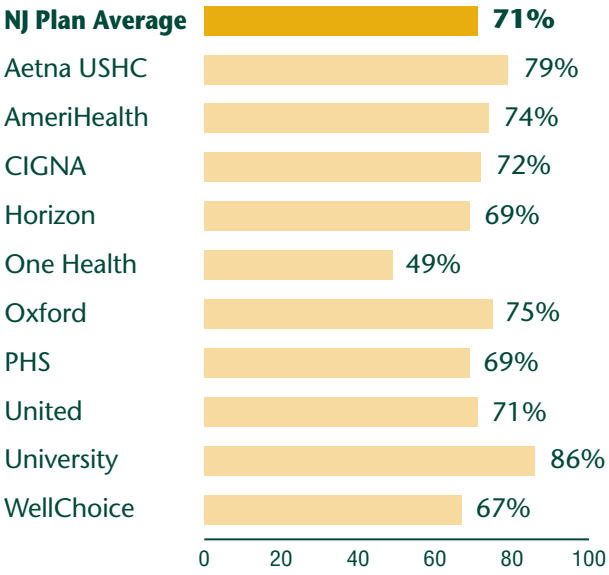
HEALTH PLAN	Blood sugar testing for people with diabetes	Eye exams for people with diabetes	Appropriate medications for asthma (children)	Appropriate medications for asthma (adults)
Aetna USHC—HMO/POS	●	●	◓	●
AmeriHealth—HMO/POS	◓	●	○	○
CIGNA—HMO/POS	◓	◓	◓	◓
Horizon—HMO	◓	●	◓	○
One Health—HMO	○	○	Not Applicable	Not Applicable
Oxford—HMO/POS	◓	◓	●	●
PHS—HMO/POS	◓	○	○	○
United—HMO/POS	◓	◓	◓	◓
University—HMO/POS	●	●	●	Not Applicable
WellChoice—HMO	◓	○	Not Applicable	Not Applicable

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.
Not Applicable—Health plan was unable to report the measure due to the small number of eligible members.

See the next page for each health plan's scores

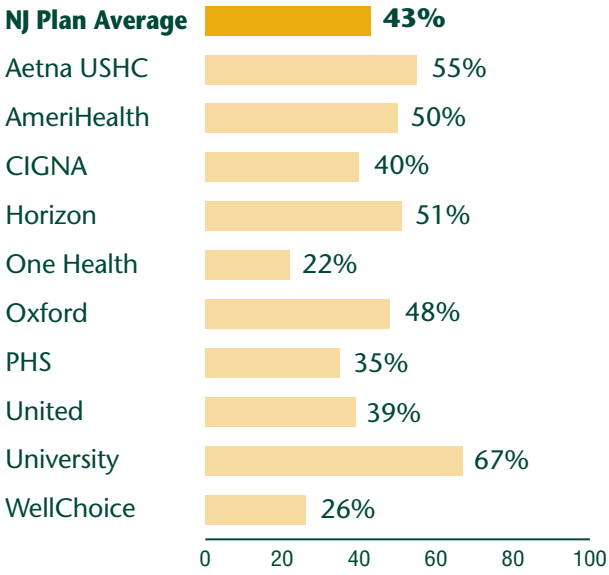
Blood sugar testing for people with diabetes

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



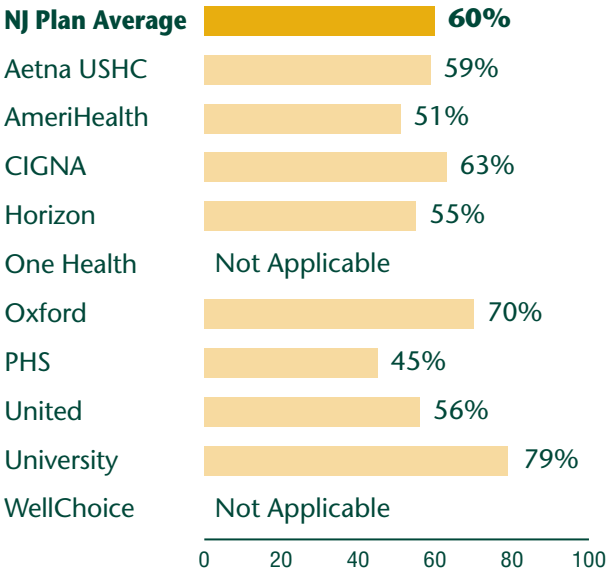
Eye exams for people with diabetes

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



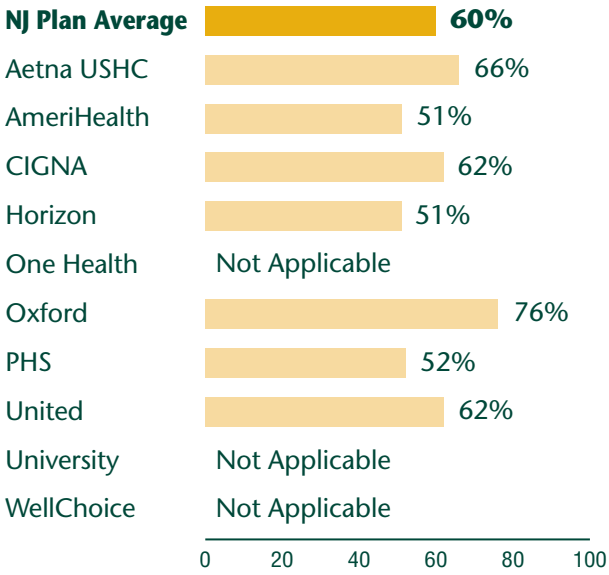
Appropriate medications for children with asthma

Asthma is the most common chronic childhood disease. With appropriate therapies, long term control of persistent asthma can be achieved, resulting in a decrease in hospitalizations and/or emergency room visits for treatment. Percent of pediatric members aged 5–17 with persistent asthma who received one of four acceptable therapies in the past year:



Appropriate medications for adults with asthma

Much of the increasing death and morbidity associated with asthma is avoidable. With appropriate therapies, long term control of persistent asthma can be achieved, resulting in a decrease in hospitalizations and/or emergency room visits for treatment. Percent of members aged 18–56 with persistent asthma who received one of four acceptable therapies in the past year:



Your choice of a health plan can influence your health.

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

Quality of Care and Service

- Look to see how well the plan 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. When comparing plans, look at all the factors that contribute to a health plan's performance and at large differences in the measures.

Choice of Providers

- Make sure that your preferred doctor, hospital and other providers participate in the plan by looking in the plan's directory. You should also call the plan's member services department or the provider directly.
- Decide whether the plan 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 benefits the plan offers by reviewing the member handbook or calling the member services department.
- Consider your special needs and circumstances such as chronic health conditions, elder care needs, frequent travel, language, retirement and starting a family.
- Decide whether there is a good match between the benefits offered by the plan and what you think you may need.
- Find out what types of care or benefits the plan does not offer.

Cost

- Try to get an idea of how much you are likely to pay in premiums, copayments, coinsurance and deductibles each year.
- Find out if the plan covers services by providers outside the network and how much it will cost you 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 plan places limits on the amount of benefits it will pay (annual or lifetime maximum).

Accreditation

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

Getting involved in your health care can help you get the most from your health plan.

Know the Rules

- Understand what services your plan does not cover by reading the member handbook or talking to your employer.
- Know how to choose or change your primary care physician.
- Understand how to schedule appointments for check-ups and when you are sick.
- Know when you need referrals and how to get them.
- Know what you are required to do when using a hospital or emergency room.

Stay Informed

- Be sure to learn about any new policies affecting how the plan works by reading member newsletters and checking the plan's Web site.
- Know the telephone numbers and hours of your physician's office and the plan's member services department.

Keep Records

- Write down your health concerns to help you discuss them with your doctor.
- Set up health files to keep track of the care and services received by you and members of your family.

Take Charge

- Take good care of your health by making appointments for check-ups and preventive care.
- Talk with your doctor about when you need regular health screenings.
- Call member services if you don't understand information that the plan or provider sends you.
- If you don't understand the answers to your questions, ask that they be explained to you.

Choose a Doctor Carefully

- Ask for recommendations from medical societies, health care providers, referral services, hospitals, family members and friends.
- Get information about the doctor's training and experience from the plan or the doctor.
- Ask if the doctor is board certified in his or her specialty area.
- Check whether prospective doctors have had any disciplinary actions issued against them. For information on New Jersey physicians, including disciplinary actions, call the New Jersey State Board of Medical Examiners at (609) 826-7100 or visit www.state.nj.us/lps/ca/bme/docdir.htm.

Contacting Your Health Plan

The information in this report covers the commercial HMO and POS products in New Jersey. This chart lists all active health plans approved to provide HMO and POS products in New Jersey. The chart shows if the health plan offers commercial coverage and if it participates in Medicare or Medicaid. It also shows the counties that each plan is authorized to serve. A plan may not offer Medicare or Medicaid in all the counties in its service area. Look at the chart notes to find the counties where a plan participates in Medicare or Medicaid.

Use the telephone numbers and Web sites to learn more about the health plans that interest you.

Telephone Numbers, Web Sites

HEALTH PLAN	TELEPHONE #	WEB SITE
Aetna U.S. HealthCare—New Jersey	(800) 323-9930	www.aetnaushc.com
AmeriChoice of New Jersey	(800) 941-4647	www.americhoice.com
AMERIGROUP New Jersey	(800) 600-4441	www.amerigroupcorp.com
AmeriHealth HMO	(800) 877-9829	www.amerihealth.com
CIGNA HealthCare of New Jersey	(800) 345-9458	www.cigna.com/healthcare
Coventry Health Care	(800) 727-9951	www.chcde.com
Horizon Healthcare of New Jersey	(800) 355-2583	www.horizon-bcbsnj.com
One Health Plan of New Jersey	(800) 663-8081	www.onehealthplan.com
Oxford Health Plans—New Jersey	(800) 444-6222	www.oxhp.com
Physicians Health Services of New Jersey*	(800) 441-5741	www.phshealthplans.com
United Healthcare of New Jersey	(800) 357-0942	www.uhc.com
University Health Plans	(800) 564-6847	www.uhpnet.com
WellChoice HMO of New Jersey^	(888) 476-6986	In Development

PRODUCT LINE AND SERVICE AREA INFORMATION AS OF JULY 1, 2001

*Physicians Health Services has applied to use the name Health Net.

^WellChoice was formerly known as Empire HealthChoice.

NOTES:

1. AmeriChoice Medicare is available only in Essex, Passaic and Union (North); and Camden (South).
2. AmeriHealth Medicare is available only in Mercer and Monmouth (Center); and Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem (South).
3. Oxford Medicare is available only in Essex, Hudson, Morris and Union (North); and Middlesex (Center).
4. Physicians Health Services Medicaid is available in Essex, Hudson, Passaic and Union (North); Mercer, Middlesex, and Somerset (Center); and Burlington, Camden, Cumberland, Gloucester, Ocean and Salem (South).
5. University Health Plan Medicaid is available in Bergen, Essex, Hudson, Morris, Passaic and Union (North); Hunterdon, Mercer, Middlesex, Monmouth and Somerset (Center); and Burlington, Camden, Gloucester and Ocean (South).

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

Product Lines and Service Areas

PRODUCT LINES		
COMMERCIAL	MEDICARE	MEDICAID
✔	✔	
	✔[1]	✔
		✔
✔	✔[2]	
✔		
✔		
✔	✔	✔
✔		
✔	✔[3]	
✔		✔[4]
✔		
✔		✔[5]
✔		

SERVICE AREAS		
NORTH	CENTER	SOUTH
✔	✔	✔
✔	✔	✔
Bergen, Essex, Hudson, Morris, Passaic, Union, Warren	Hunterdon, Mercer, Middlesex, Monmouth	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean
✔	✔	✔
✔	✔	✔
		Camden, Cumberland, Gloucester, Salem
✔	✔	✔
✔	✔	Burlington, Camden, Gloucester, Ocean
✔	✔	✔
✔	✔	✔
✔	✔	✔
✔	✔	✔
✔	✔	

Steps you can take if you have been denied covered medical benefits or want to file a complaint

To Appeal a Health Plan Decision

Your plan is required to have an appeal process that gives you an opportunity to resolve disagreements about denial of a covered benefit:

Preliminary Stage
Review the services covered by your plan and the explanation of the appeal process in the plan's member handbook. You or your doctor, acting with your consent, have the right to file an appeal.

Stage 1
Inform the plan, either verbally or in writing, that you disagree with the plan's decision to deny or limit services you believe are covered.

Stage 2
If you are dissatisfied with the results of the initial communication with the plan, you can request, either verbally or in writing, that the plan have your appeal reviewed by a panel of doctors and other health care professionals not involved in your case.

Stage 3
If you are dissatisfied with the plan's decision on your appeal, you can file an appeal with the Department of Health and Senior Services within 60 days of receiving the plan's Stage 2 decision. You will receive the form and instructions needed to file a Stage 3 appeal from your health plan at the same time you receive the plan's 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). Beginning in 2001, decisions made by the IHCAP became binding on the health plans.

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

To File a Health Plan Complaint

In addition to the appeal process for denial of a covered benefit, you also have the right to complain to the health plan about any aspect of its operations. Your plan 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 a plan's business and marketing practices. The plan is required to respond to your complaint within 30 days. The plan's member handbook contains a description of the process and contact information for resolving complaints. If you are dissatisfied with the outcome of the plan's complaint process, contact the appropriate State agency:

For complaints about quality of care, choice of providers or access to network providers:

NJ Department of Health and Senior Services
Office of Managed Care
P.O. Box 360
Trenton, NJ 08625-0360
(888) 393-1062
www.state.nj.us/health/hcsa/hmocompl.pdf.

For complaints about business practices such as claims payment, member enrollment or termination of coverage:

NJ Department of Banking and Insurance
Division of Enforcement and Consumer Protection
P.O. Box 329
Trenton, NJ 08625-0329
(800) 446-7467
www.naic.org/nj/complain.pdf.

The process for appealing a decision or filing a complaint is different if you belong to a "self-insured" plan. Check with your employer or health plan and refer to page 19.

For Medicare and Medicaid managed care appeals refer to page 19.

Health Care Carrier Accountability Act

Signed into law in the summer of 2001 by Acting Governor Donald T. DiFrancesco, this legislation gives HMO members the right to sue their HMO if the member believes that the HMO's decision to delay or deny care has or will result in serious harm to the member. In most cases members will first appeal the HMO's decision through the external appeal process described above. However, the external appeal process can be bypassed in cases where serious harm to the member has already occurred or is imminent.

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

Department of Health and Senior Services

The Office of Managed Care in the New Jersey Department of Health and Senior Services monitors the compliance of managed health care plans with New Jersey rules through annual examinations and in-depth reviews of each plan conducted every three years. The office investigates consumer complaints and oversees the Independent Health Care Appeals Program (IHCAP). For information, call the Office of Managed Care toll-free at (888) 393-1062 or visit the Web site, www.state.nj.us/health.

Managed Health Care Consumer Assistance Program

This new program sponsored by the Department gives information and assistance to individuals regarding managed health care and educates health plan members about their rights and responsibilities. It explains the complaints, grievance, and appeal processes that are available to members and helps individuals to determine the process that is most appropriate to their specific situation. The program can also provide help in obtaining and completing the required forms. The toll-free number for the program is (888) 838-3180. It can also be reached on the Web at www.managedcarehelpline.org.

Self-Insured Plans

Large employers and unions often assume financial responsibility for their health benefits instead of buying insurance. Employers may contract with outside organizations to administer their self-insured health benefits plans. Questions or complaints about these self-insured plans can only be addressed by the federal Department of Labor's Pension and Welfare Benefits Administration. The main number is: (202) 219-8776 ext. 10. The Web site is: www.dol.gov/dol/pwba.

Department of Banking and Insurance

The New Jersey Department of Banking and Insurance (DOBI) publishes Buyer's Guides for individual and small employer coverage. You may obtain a copy of the Buyer's Guide for individuals at (800) 838-0935 and for small employers at (800) 263-5912. These are also available at DOBI's Web site: www.njdobi.org.

DOBI also publishes a Managed Care Compendium each year. This contains information on enrollment by county, premiums, expenses, hospital utilization, net worth and profitability for all New Jersey HMOs as well as summary information on other managed care companies. Information about this Compendium and related matters are available at the DOBI Managed Care Web site: www.naic.org/nj/managed.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 Senior Affairs, 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.

Medicaid

For information on Medicaid health plan options, quality information and complaints, call the New Jersey Department of Human Services at (800) 356-1561 or visit www.state.nj.us/humanservices.

How HMO and POS Products Work

In HMO (Health Maintenance Organization) and POS (Point-Of-Service) products, you usually get care from doctors and hospitals that are part of the plan's provider network. This differs from fee-for-service insurance, which permits you to get care from any doctor or hospital, but may have higher out-of-pocket costs.

This table compares HMO, POS plans and fee-for-service insurance. The table presents general information, which may not apply to your plan. Be sure to check with your health plan or employer to verify information.

HMO	POS	Fee-for-Service
Can you get covered services from providers who are not in the network?		
No. The HMO pays for covered services only if you use network providers.	Yes, but you usually pay more than if you go to a network provider.	Yes. You may get care from any provider.
How do you pay for services?		
You are charged a copayment (usually between $5 and $25) for a doctor's office visit and most other services. There is no deductible. You usually do not need to fill out claim forms.	If you use a provider who is in the network, you pay a copayment, but no deductible. You do not have to fill out claim forms. If you use a provider who is not in the network: after you pay a deductible, you pay coinsurance (usually 20–40%) and the insurer pays the rest *up to the insurer's allowed amount.* If your provider bills more than the allowed amount, you also must pay the difference between the billed and allowed charges ("balance billing"). You may need to fill out a claim form.	After you pay a deductible, you pay coinsurance (usually 20–30%) and the insurer pays the rest *up to the insurer's allowed amount.* If your provider bills more than the allowed amount, you also must pay the difference between the billed and allowed charges ("balance billing"). You will need to fill out a claim form.
Do you need to choose a Primary Care Provider (PCP)?		
You usually need to choose a PCP from the network, who takes care of most of your medical needs.	You usually need to choose a PCP from the network.	You can get care from any doctor.
Do you need a referral from your PCP to go to a specialist?		
You usually need a referral, although in many HMOs some types of specialists may be available without a referral. Some HMO products allow visits to most specialists in the network without a referral.	Depends. You usually need a referral only if you want to see a specialist and receive in-network benefits. Some POS products allow visits to in-network specialists and provide in-network benefits without a referral. If you use a provider who is not in the network, you usually do not need a referral, but you will pay more than if you go to in-network providers.	You do not need a referral to go to a specialist.

Consumer Bill of Rights

Members of HMOs, POS plans and any health plan that manages the use of services through provider networks have important consumer rights:

The Right to Information about Your Plan and How it Works

- The right to information on what health care services are covered and any limitations on that coverage
- The right to obtain a current directory of doctors within the network
- The right to know how your managed care plan pays its doctors so you know if financial incentives or disincentives are tied to medical decisions

The Right to Ask Questions and to File Complaints, Appeals and Lawsuits

- The right to no "gag rules"—doctors are allowed to discuss all treatment options even if they are not covered services
- The right to know the reason your managed care plan denied a covered service requested by you or your doctor
- The right to file appeals with the managed care plan concerning denials or limitations of a covered service
- The right to file complaints with the managed care plan regarding any aspect of the plan's health care services, including quality of care, choice, accessibility of providers and network adequacy
- The right to receive no retaliation against you or your doctor for filing complaints or appeals
- The right to independent review of the plan's decision to deny or limit covered services; if you have exhausted the managed care plan's internal appeal process, you have the right to appeal that decision through the Independent Health Care Appeals Program *(see page 18 for more details)*
- The right to sue your HMO for losses if you or a covered member of your family sustain serious injury or death that you believe is the result of the HMO's denial or delay of approval of medically necessary covered services

The Right to Appropriate Treatment

- The right to have a doctor—not an administrator—make the decision to deny or limit coverage
- The right to change primary care providers without having to wait more than two weeks
- The right to access a primary care provider 24 hours a day, 365 days a year for urgent care
- The right to call 911 in a potentially life-threatening situation without prior approval
- The right to go to an emergency room without first contacting the HMO when it appears to the member that serious harm could result from not obtaining immediate medical treatment
- The right to coverage of a medical screening exam in a hospital emergency room to determine whether an emergency medical condition exists
- The right to a choice of participating specialists for referrals
- The right of a consumer with a chronic disability to be referred to an experienced specialist
- The right to coverage of certain preventive care, including childhood immunizations, lead screening, certain cancer screenings, testing for glaucoma, cholesterol and blood glucose levels
- The right to a minimum amount of time in the hospital after giving birth or having a mastectomy
- The right to receive continued coverage from a doctor who stops being part of the network for up to four months, and longer for certain medical conditions

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