2018

New Jersey HMO & PPO Performance Report

Compare Your Choices

Phil Murphy, Governor
Sheila Oliver, Lt. Governor

Marlene Caride, Commissioner

Table of Contents

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO BOX 325
TRENTON, NJ 08625-0325

Phil Murphy
Governor

Sheila Oliver
Lt. Governor

Marlene Caride
Commissioner

June 2019

Dear Consumers:

We are pleased to present a combined Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) Performance Report for 2018. The report contains information collected and reported by New Jersey's HMOs and PPOs, which is verified by independent auditors, on their performance and how well these health plans deliver important health care services.

The report is designed to provide information to consumers and employers on the quality of New Jersey's HMO and PPO health plans and the available coverage. We believe that you will 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, we strive to empower you to make the best health care choices for you, your family or your employees.

Marlene Caride
Commissioner

Introduction

This report was developed by the New Jersey Department of Health. 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 the New Jersey Department of Health in August 2005. Regulatory matters concerning managed health care in the state are now DOBI's responsibility.

In 2014, DOBI expanded this report on health plan performance by including data for PPOs. DOBI has compiled a single performance report to show side-by-side results for both HMOs and PPOs, making the publication more meaningful to employers, employees, and individual purchasers of health insurance.

This report includes information on all commercial managed care products currently marketed in New Jersey by HMOs or PPOs that had at least 2,000 members enrolled in these products in both 2016 and 2017. For HMOs, the information combines plan performance for the HMO and Point of Service (POS)* products for those HMOs who have both products. For PPOs, the information combines plan performance for all PPO and Exclusive Provider Organization (EPO) products for those PPOs that have both products.

This report contains information reported by the following HMO and PPO carriers:

- **Aetna - HMO/POS & PPO/EPO** (Aetna Health Inc.; Aetna Life Insurance Company)
- **AmeriHealth - HMO/POS & PPO/EPO** (AmeriHealth HMO, Inc.; AmeriHealth Insurance Company of New Jersey)
- **Cigna - PPO** (Cigna HealthCare of New Jersey, Inc.; Cigna Health and Life Insurance Company)
- **Horizon - HMO & PPO/EPO** (Horizon Healthcare of New Jersey, Inc.; Horizon Healthcare Services, Inc.)
- **Oxford - HMO/POS** (Oxford Health Plans (NJ), Inc.; Oxford Health Insurance, Inc.)
- **United - PPO/EPO** (UnitedHealthcare Insurance Company)

This report does not include performance for the New Jersey Department of Human Services program (NJ FamilyCare). *See page 37 for ways you can obtain information on this program and others.*

This report uses a measurement system called HEDIS®, which was developed by the National Committee for Quality Assurance (NCQA). It includes measures collected and reported by the HMOs and PPOs. All measures are verified by independent auditors.

Reports through 2008 included ratings of member satisfaction with HMO services. You can find summary measures of customer satisfaction by visiting the NCQA's website (see page 33 for more details).

This report is available on the Department's web site:
https://www.state.nj.us/dobi/lifehealthactuarial/hmo2018

*A Point of Service (POS) plan has some of the qualities of HMO and PPO plans with benefit levels varying depending on whether care is received in or out of the carrier's network of providers.

Quality Matters

Why is the quality of health care important?

Not all HMOs and PPOs are the same. HMOs and PPOs 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 or PPO may influence your health and your family's health.
- **If you are an employer,** the quality of care provided by your HMO or PPO may influence absenteeism, employee productivity and your company's health care costs.

This report provides information about how well HMOs & PPOs:

- 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 or PPO, to choose the right plan for your health care needs.

When choosing an HMO or PPO, you should consider:

- Whether your doctor, health care provider, or preferred hospital is available in the HMO's or PPO's Network;
- Whether the HMO or PPO offers the benefits you want;
- How much the HMO or PPO 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 or PPO performs in the key areas most important to you.

Staying Healthy

Does the HMO or PPO help members stay healthy and avoid illness?

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

- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Childhood immunizations
- Well-child visits in the third, fourth, fifth and sixth years of life
- Immunizations for adolescents
- Adolescent well-care visits

The following table shows how well each HMO and PPO performed. The bar graphs on the next pages show each HMO and PPO compared to the New Jersey average.

HMO/POS & PPO	Breast cancer Screening %	Cervical cancer Screening %	Colorectal cancer Screening %	Childhood Immunizations %	Well-child visits from ages 3-6 %	Immunizations for adolescent %	Adolescent's well-care visits %
HMO							
Aetna - HMO/POS	70	77	60	76	80	86	56
AmeriHealth - HMO/POS	66	70	52	75	84	86	62
Horizon - HMO	70	77	63	77	86	83	63
Oxford - HMO/POS	67	79	56	51	82	77	64
PPO							
Aetna - PPO/EPO	69	80	59	72	86	77	65
AmeriHealth - PPO/EPO	67	78	56	69	86	87	61
CIGNA - PPO	70	78	57	74	87	80	67
Horizon - PPO/EPO	66	78	57	76	82	84	61
Oxford - PPO/EPO	67	78	57	69	84	80	65
United - PPO/EPO	70	80	62	76	88	83	68

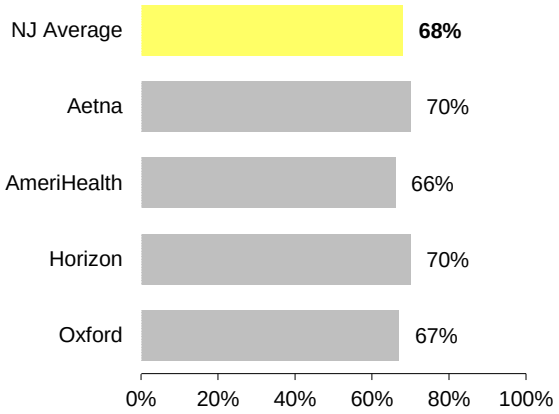
See next page for more information →

Breast cancer screening

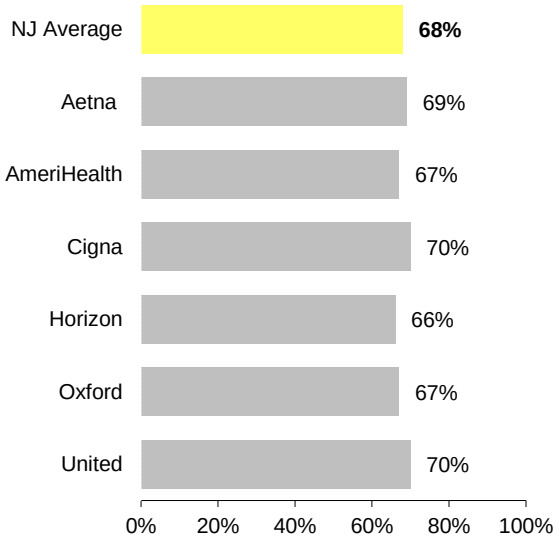
Mammograms are recommended for detection of breast cancer. The bar graphs show the percentage of women ages 52–74 who received a mammogram within the past two years.

A higher percentage rate is better for the breast cancer screening measure. It shows that more women got a mammogram.

HMO



PPO

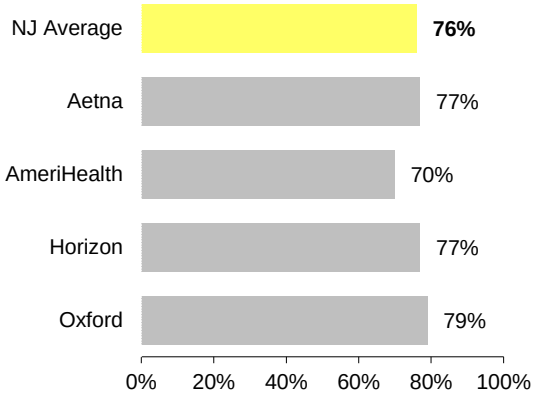


Cervical cancer screening

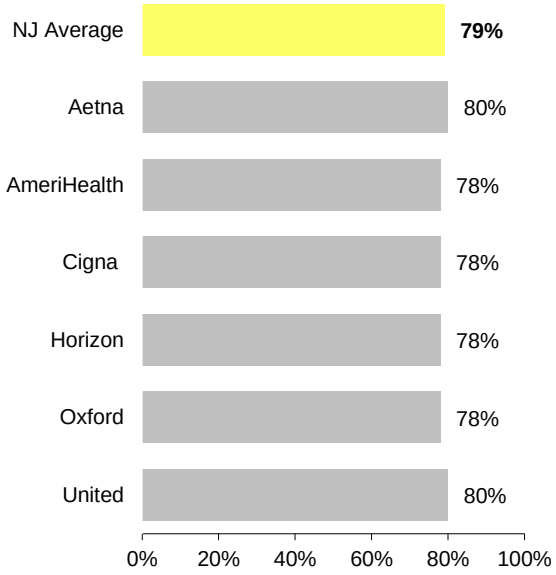
Pap smears are recommended for detection of cervical cancer. The bar graphs show the percentage of women ages 21–64 who received a Pap test within the past three years.

A higher percentage rate is better for the cervical cancer screening measure. It shows that more women got a Pap test.

HMO



PPO

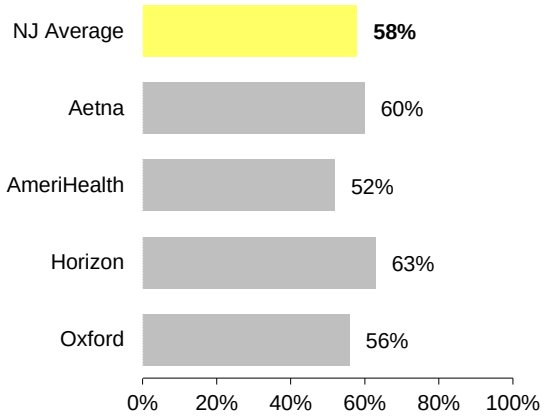


Colorectal cancer screening

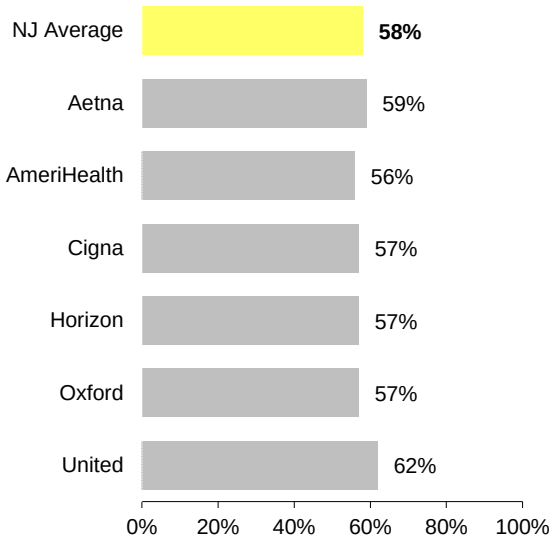
A colonoscopy is recommended to look for early signs of colorectal cancer. The bar graphs show the percentage of members ages 51-75 who had appropriate screening for colorectal cancer.

A higher percentage rate is better for the colorectal cancer screening measure. It shows that more adults were screened for colorectal cancer.

HMO



PPO

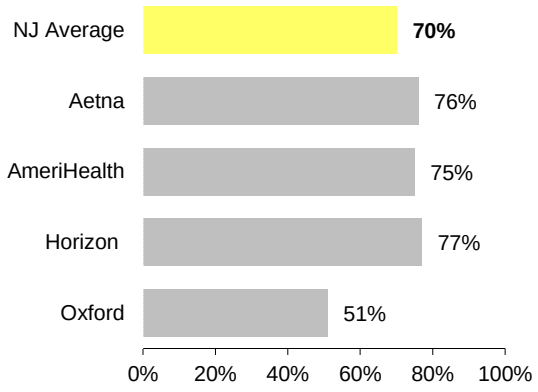


Childhood immunizations

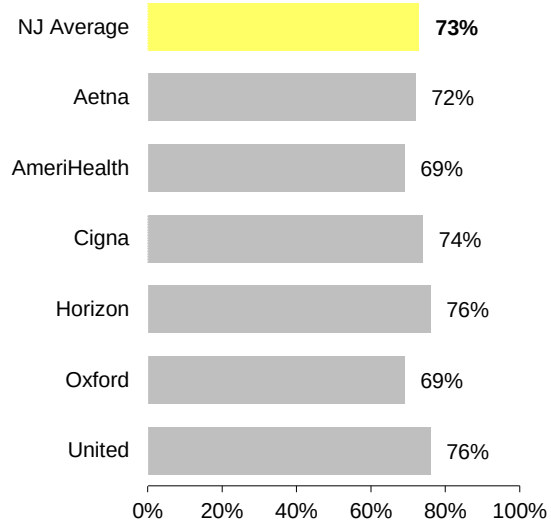
Immunizations prevent childhood diseases such as polio, measles, mumps, rubella and whooping cough. The bar graphs show the percentage of children who received recommended immunizations by age two.

A higher percentage rate is better for the childhood immunization status. A higher percentage shows that more children received all of the required immunizations.

HMO



PPO

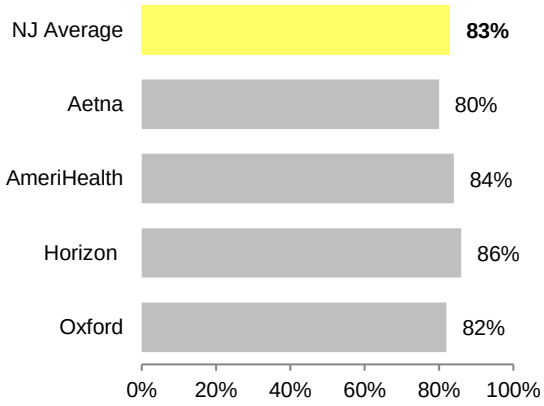


Well-child visits in the third, fourth, fifth and sixth years of life

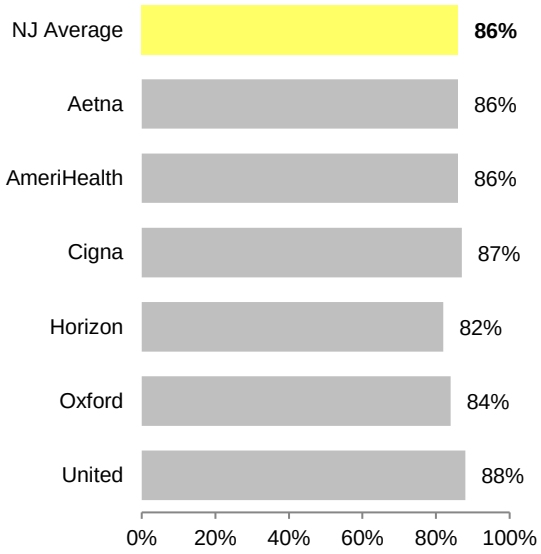
This bar graph shows the percentage of children ages 3-6, who had one or more well-child visits with a primary care provider (PCP) during the measurement year 2017.

For this measure, a higher percentage is better, which means that more young children had one or more well-child visits to a primary care provider and that fewer young children had zero visits.

HMO



PPO

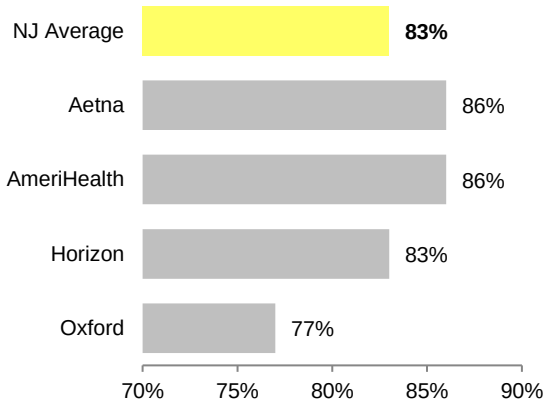


Immunizations for adolescents

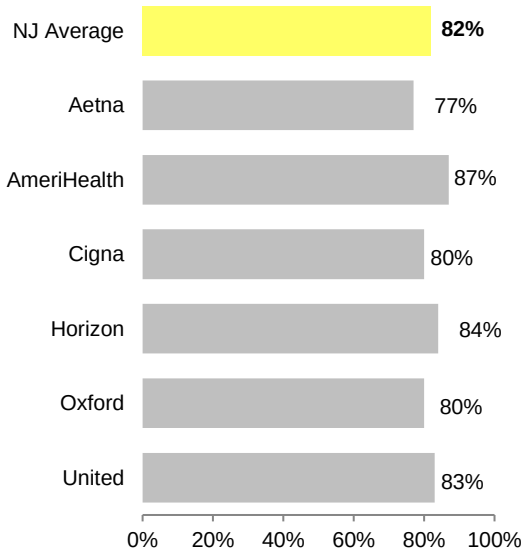
Adolescent immunizations prevent adolescent diseases such as meningococcal, tetanus, diphtheria toxoids and acellular pertussis. The bar graphs show the percentage of adolescent children who received recommended immunizations by age 13 in the measurement year 2017.

A higher percentage rate is better for the adolescent immunization status. A higher percentage shows that more adolescent children who turned 13 years of age during the measurement year had received all of their required immunizations.

HMO



PPO

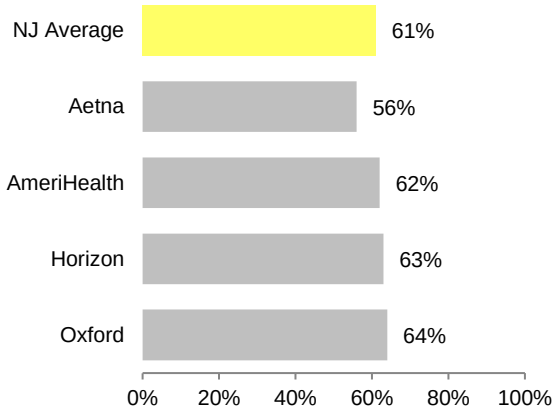


Adolescent well-care visits

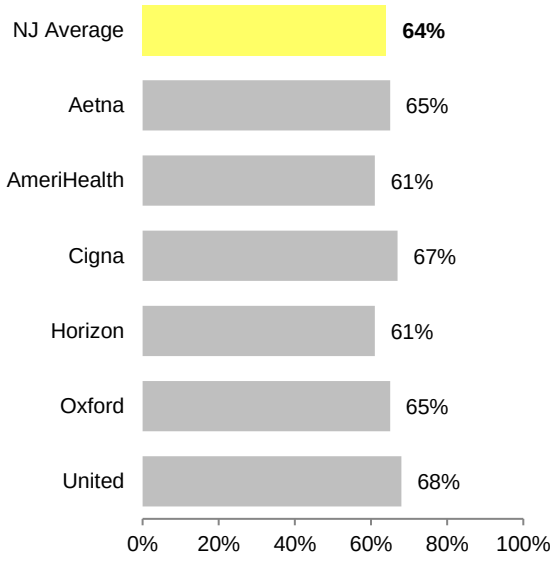
The bar graphs show the percentage of adolescents ages 12-21 who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year 2017.

A higher percentage is better for this measure. A higher percentage shows that more individuals in the 12-21 age group had one or more well-care visits to a PCP or an OB/GYN.

HMO



PPO



Respiratory Conditions

How well does the HMO or PPO help members with respiratory conditions?

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

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

The following table shows how well each HMO and PPO performed. The bar graphs on the next pages show the HMOs and PPOs compared to the New Jersey average.

HMO/POS & PPO	Appropriate testing for children with Pharyngitis %	Appropriate treatment for children with Upper Respiratory Infection %	Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis %	Use of Spirometry testing in the assessment and diagnosis of COPD %
HMO				
Aetna - HMO/POS	91	95	73	51
AmeriHealth - HMO/POS	90	93	16	41
Horizon - HMO	86	91	22	50
Oxford - HMO/POS	93	90	18	78
PPO				
Aetna - PPO	92	92	24	48
AmeriHealth - PPO	89	93	21	43
CIGNA - PPO	91	92	24	51
Horizon - PPO	87	90	21	45
Oxford - PPO	89	90	24	45
United - PPO	87	90	22	50

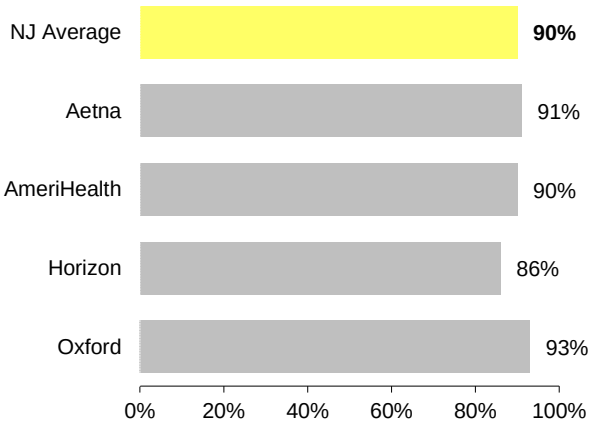
See the next page for more information →

Appropriate testing for children with pharyngitis

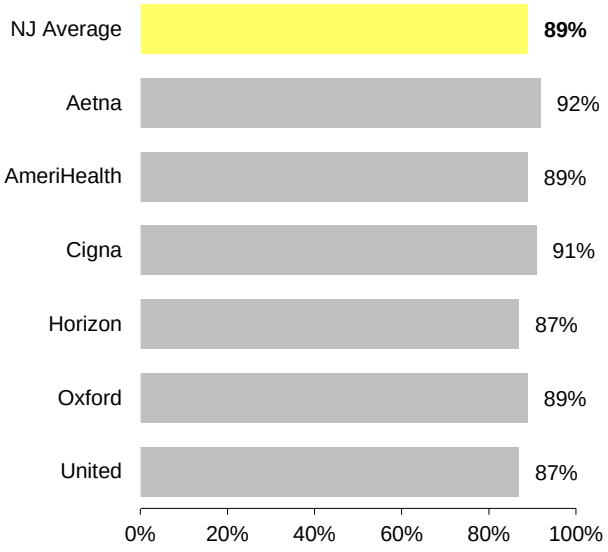
Strep testing is recommended for the detection of pharyngitis. The bar graphs show the percentage of children ages 3-18 who received a strep test to diagnose pharyngitis and then were given an antibiotic.

A higher percentage rate is better for this health measure. A higher percentage shows that more children received an appropriate strep test before getting an antibiotic prescription medication to treat pharyngitis.

HMO



PPO

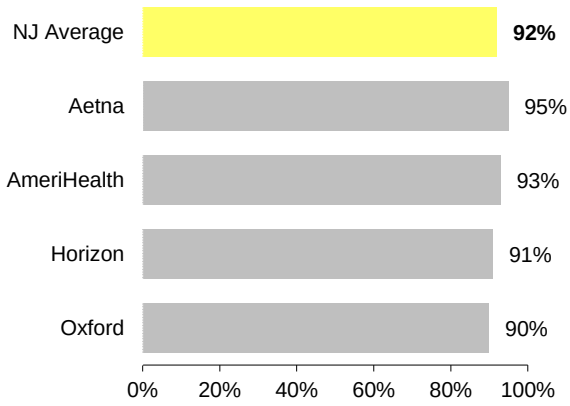


Appropriate treatment for children with upper respiratory infection (URI)

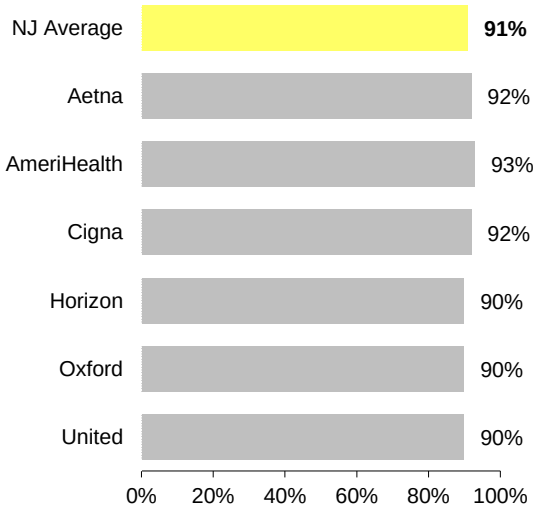
An upper respiratory infection (URI) is one of the most common illnesses, resulting in more doctor visits than any other illness every year. The use of antibiotic* medication is usually not an appropriate treatment for URI. The bar graphs show the percentage of children 3 months to 18 years of age with a diagnosis of URI and who were not dispensed an antibiotic.

A higher percentage rate is better for this health measure. It means more infants, children and adolescents were not prescribed possibly unnecessary antibiotic medication.

HMO



PPO



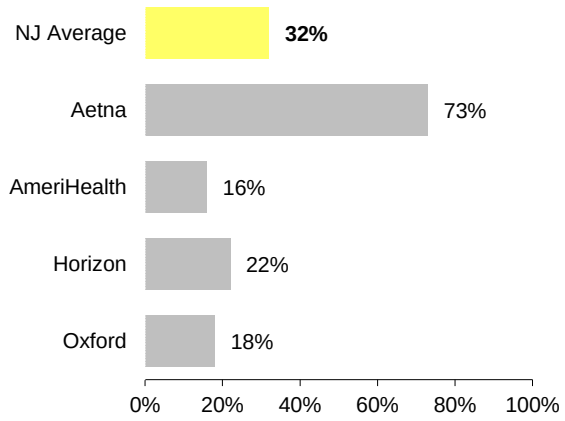
* Inappropriate use of antibiotics has been shown to promote resistant bacteria that are more difficult to treat. The federal Centers for Disease Control and Prevention (CDC) and other organizations urge physicians to avoid prescribing antibiotics when not medically indicated. Since the cause of most URI's is viral, antibiotics are unnecessary.

Avoidance of antibiotic treatment* in adults with acute bronchitis

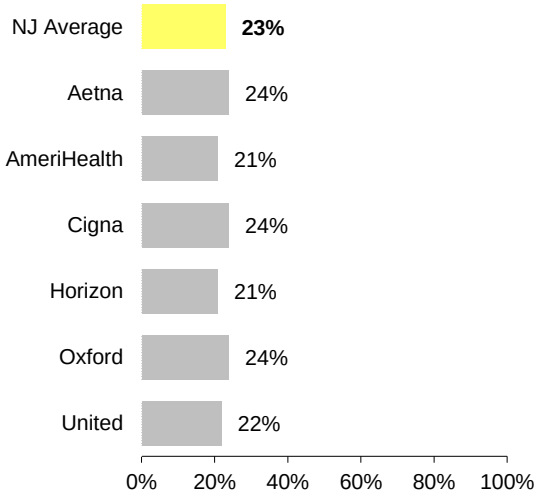
Use of antibiotics usually is not an appropriate treatment for acute bronchitis. The bar graphs show the percentage of adults ages 18-64 with a diagnosis of acute bronchitis and who were not dispensed an antibiotic* prescription.

A higher percentage rate is better for this health measure. A higher percentage rate indicates that more adults with acute bronchitis were not prescribed possibly unnecessary antibiotic medication as part of their treatment.

HMO



PPO



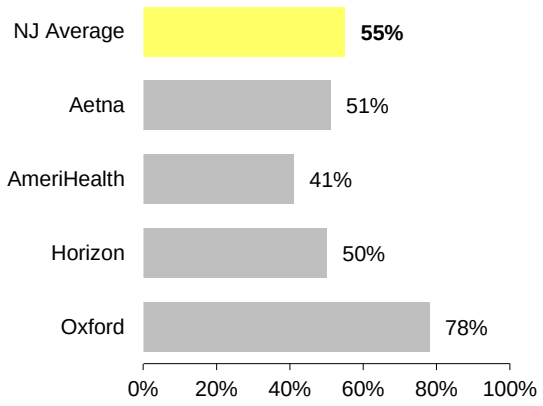
* Inappropriate use of antibiotics has been shown to promote resistant bacteria that are more difficult to treat. The federal Centers for Disease Control and Prevention (CDC) and other organizations urge physicians to avoid prescribing antibiotics when not medically indicated.

Use of spirometry testing in the assessment and diagnosis of COPD

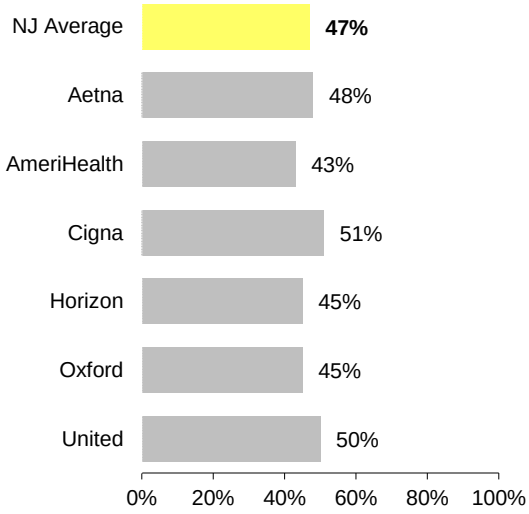
Spirometry testing measures air flow through the lungs and can confirm a COPD diagnosis. The bar graphs show the percentage of members, ages 40 and older, with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

A higher percentage rate is better for this measure. It means that more adults who are 40 and older received the best diagnostic lung function test for COPD.

HMO



PPO



Getting Better/Living with Illness - 1

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

HMOs and PPOs should work with doctors to care for members who are sick or living with chronic illness. HMOs and PPOs reported on the percentage of their relevant membership who received the following:

- Antidepressant medication management
- Follow-up after hospitalization for mental illness, and
- Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication.

The following table shows how well each HMO and PPO performed and the bar graphs on the next pages show the HMO and PPO compared to the New Jersey average.

HMO/POS & PPO	Antidepressant medication management %	Follow-up after hospitalization for mental illness %	Follow-up care for children prescribed ADHD Medication %
HMO			
Aetna - HMO/POS	63	73	38
AmeriHealth - HMO/POS	72	58	42
Horizon - HMO	76	77	45
Oxford - HMO/POS	63	40	38
PPO			
Aetna - PPO	75	77	39
AmeriHealth - PPO	74	57	44
CIGNA - PPO	69	78	38
Horizon - PPO	74	76	36
Oxford - PPO	72	75	39
United - PPO	65	73	49

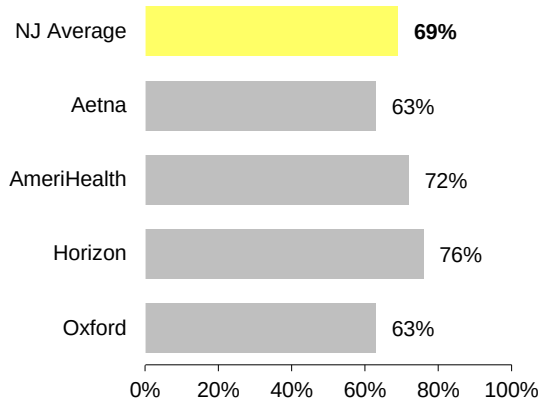
See the next page for more information →

Antidepressant medication management

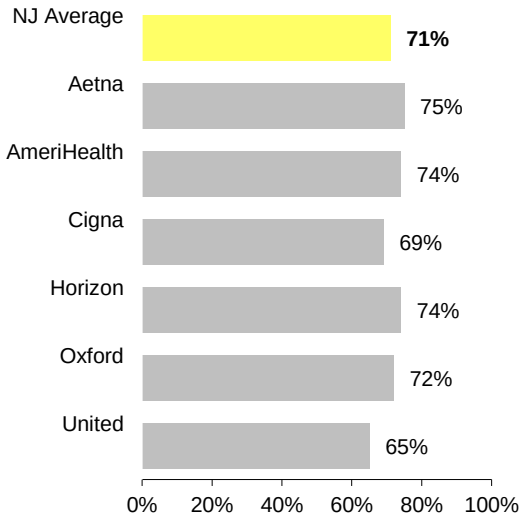
People taking medicine for depression need to be monitored. The bar graphs show the percentage of members given medicine for depression who had follow-up visits during the 12-week acute phase treatment period in the measurement year.

A higher percentage is better for effective treatment. That means more adults with depression were effectively treated when taking antidepressant medications and following up with their physician during their treatment.

HMO



PPO

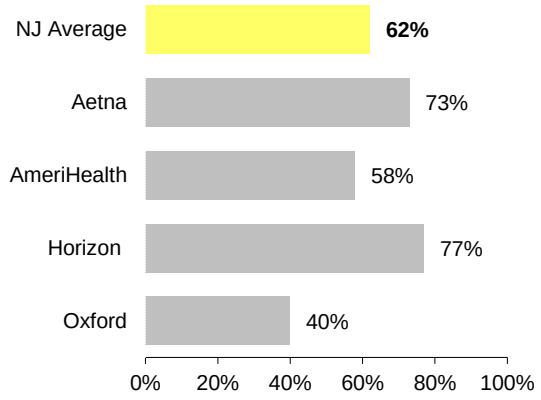


Follow-up after hospitalization for mental illness

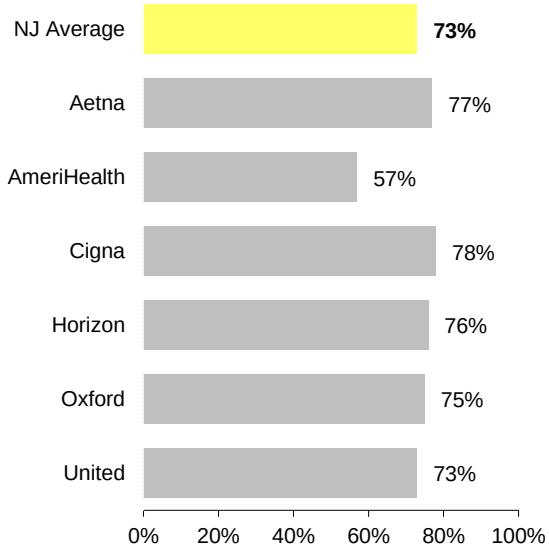
Therapy after a hospital stay for mental illness is important for recovery. The bar graphs show the percentage of members hospitalized for mental illness who received care afterwards.

A higher percentage rate is better. This means that more members who were hospitalized for the treatment of mental health disorders received timely follow up within 30 days of discharge.

HMO



PPO

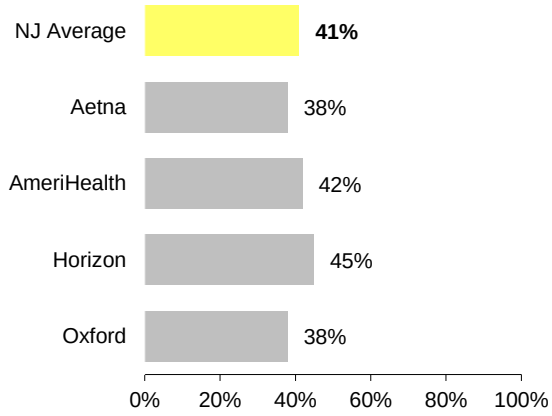


Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication

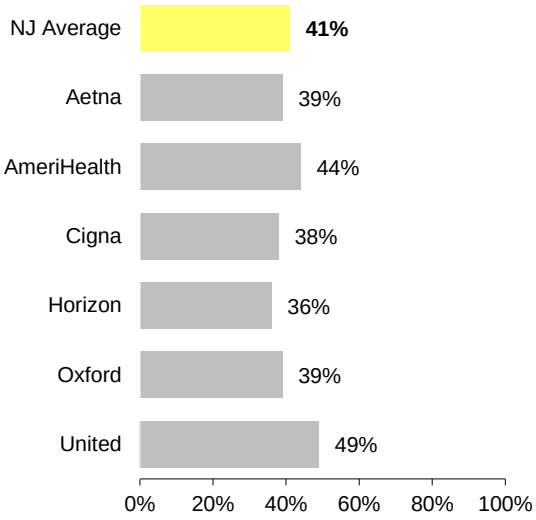
Children prescribed ADHD medications need to be monitored. The bar graphs show the percentage of children given medicine for the Initiation Phase of ADHD who had one follow-up visit within 30 days of the Initiation Phase.

For follow-up care for children prescribed ADHD medications, a higher percentage rate is better. This means that more children received a follow-up visit within 30 days of the Initiation Phase.

HMO



PPO



Getting Better/Living with Illness - 2

How well does the HMO or PPO care for members who are living with illness?

HMOs and PPOs should work with doctors to care for members who are sick or living with chronic illness. HMOs and PPOs reported on the percentage of their relevant membership with the following conditions:

- Controlling high blood pressure,
- Blood sugar testing for people with diabetes,
- HbA1c poor control (>9.0%) for people with diabetes, and
- Eye exams for people with diabetes.

The following table shows how well each HMO and PPO performed. The bar graphs on the next pages show the HMOs and PPOs compared to the New Jersey average.

HMO/POS & PPO	Controlling high blood pressure %	Blood sugar testing for people with diabetes %	HbA1c poor control (>9.0%) for people with diabetes %	Eye exams for people with diabetes %
HMO				
Aetna - HMO/POS	48	87	30	64
AmeriHealth - HMO/POS	53	83	41	39
Horizon - HMO	64	90	23	65
Oxford - HMO/POS	58	90	25	49
PPO				
Aetna - PPO	43	87	35	51
AmeriHealth - PPO	55	83	45	40
CIGNA - PPO	56	91	31	47
Horizon - PPO	64	90	29	59
Oxford - PPO	55	88	30	42
United - PPO	61	90	25	46

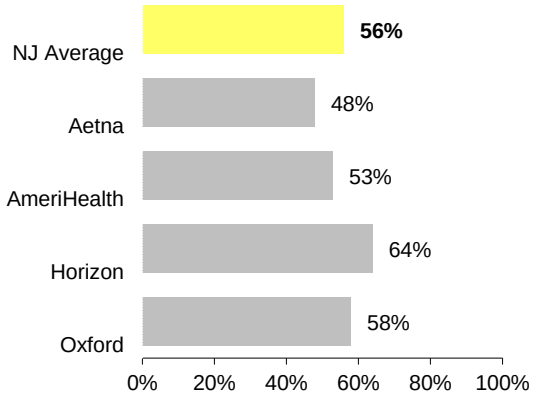
See the next page for more information →

Controlling high blood pressure

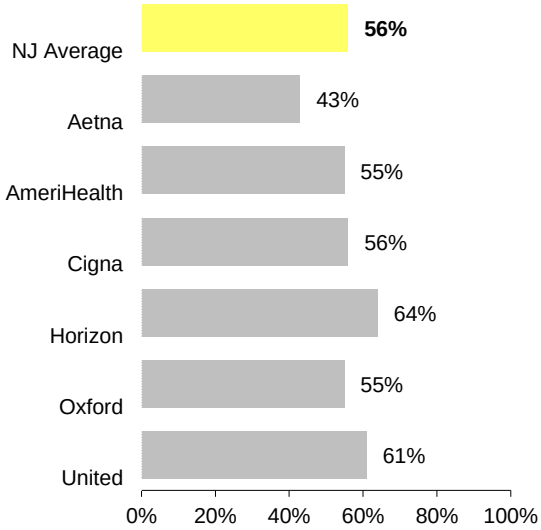
High blood pressure (hypertension) is a major risk factor for a number of diseases. The bar graphs show the percentage of members ages 18–85 with hypertension whose blood pressure was under control at their most recent medical visit.

A higher percentage rate is better for this health measure. A higher percentage shows that more adults with hypertension were able to adequately control their blood pressure through treatment.

HMO



PPO

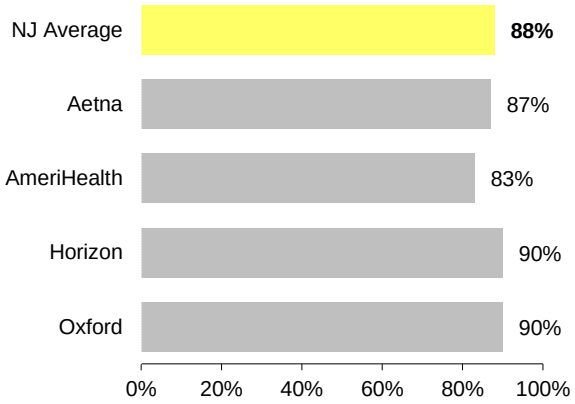


Blood sugar testing for people with diabetes

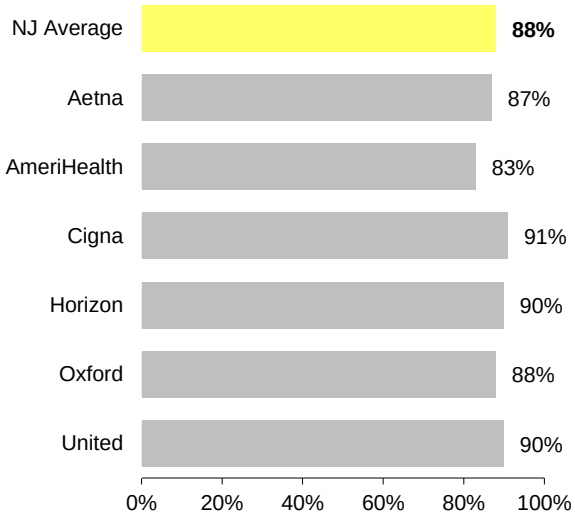
Controlling blood sugar levels can prevent complications from diabetes. The bar graphs show the percentage of members ages 18-75 with diabetes who had a blood sugar (HbA1C) test in the measurement year.

A higher percentage rate is better for this measure. It means that more diabetic adults received appropriate HbA1c testing.

HMO



PPO

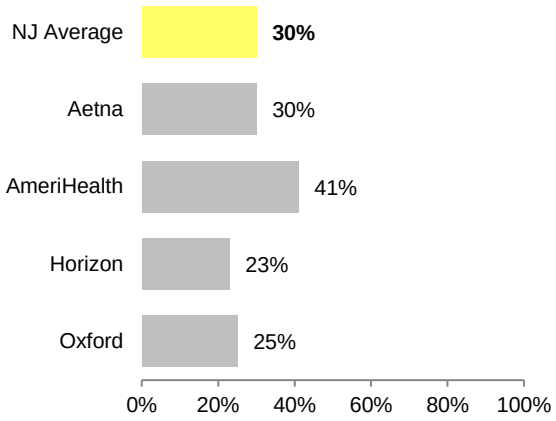


HbA1c poor control (>9.0%) for people with diabetes

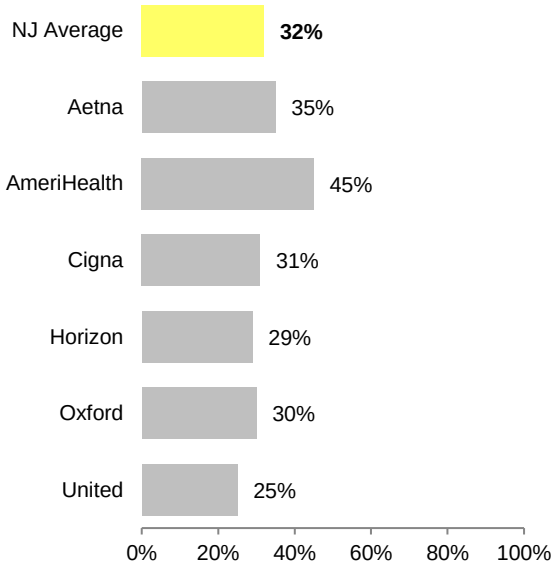
The bar graphs show the percentage of members ages 18 to 75 with type 1 and type 2 diabetes who had HbA1c testing during measurement year 2017 and who displayed poor HbA1c control (> 9.0%).

A *lower* percentage indicates a better performance. It shows better diabetic management, as fewer diabetic adults showed poor control of their HbA1c.

HMO



PPO

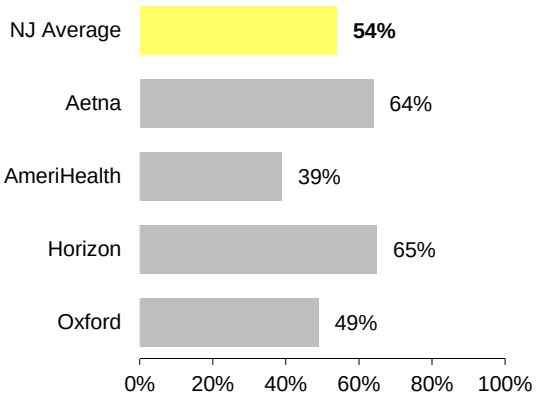


Eye exams for people with diabetes

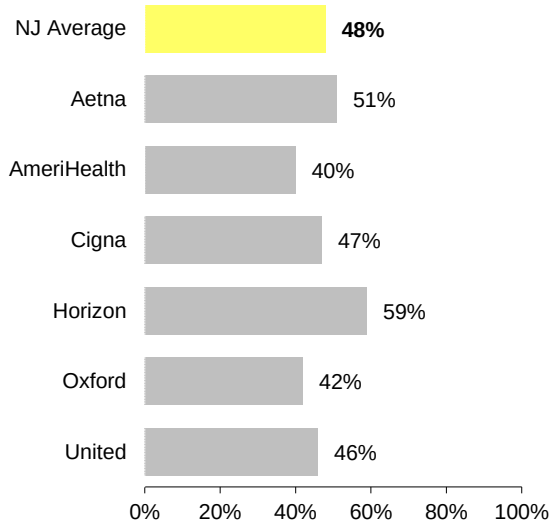
Regular eye exams can reduce the risk of blindness from diabetes. The bar graphs show the percentage of members with diabetes who received an eye exam during the measurement year.

A higher percentage rate is better for this performance indicator. This means that more adults with diabetes received appropriate retinal examination of the eyes.

HMO



PPO



Getting Better/Living with Illness - 3

How well does the HMO and PPO care for members who are living with illness?

HMOs and PPOs should work with doctors to care for members who are sick or living with chronic illness. HMOs and PPOs reported on the percentage of their relevant membership who received the following:

- Persistence of beta blocker treatment after a heart attack,
- Postpartum care,
- Anti-rheumatic drug therapy for rheumatoid arthritis, and
- Use of imaging studies for low back pain.

The following table shows how well each HMO and PPO performed. The bar graphs on the next pages show the HMOs and PPOs compared to the New Jersey average.

HMO/POS & PPO	Persistent of beta blocker treatment after heart attack %	Postpartum care %	Anti-rheumatic drug therapy for rheumatoid arthritis %	Use of imaging studies for low back pain%
HMO				
Aetna - HMO/POS	70	68	69	73
AmeriHealth - HMO/POS	81	59	94	76
Horizon - HMO	93	84	85	76
Oxford - HMO/POS	100	88	94	76
PPO				
Aetna - PPO	87	66	85	73
AmeriHealth - PPO	82	68	90	76
CIGNA - PPO	84	68	86	73
Horizon - PPO	88	78	85	73
Oxford - PPO	75	71	86	74
United - PPO	86	74	86	75

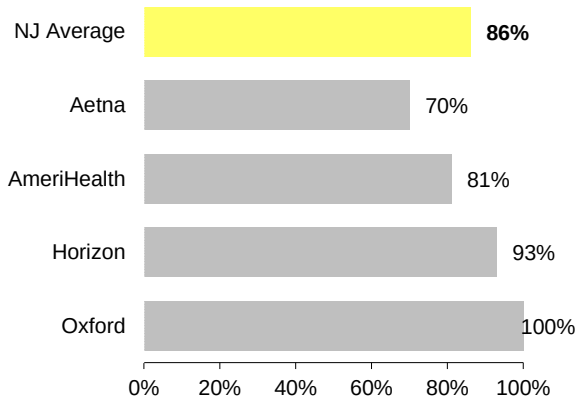
See the next page for more information →

Persistence of beta blocker treatment after a heart attack

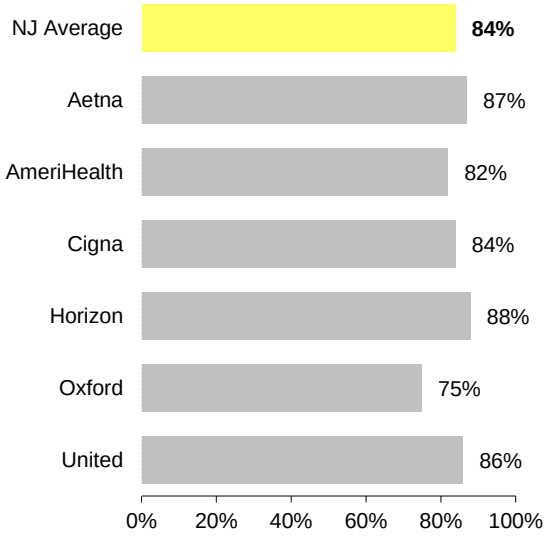
Beta blockers after a heart attack can help prevent future heart attacks. The bar graphs show the percentage of members who received persistent beta-blocker treatment for six months after discharge.

A higher percentage is better for this measure. It means that more adults with a history of having a heart attack received at least six months of persistent beta-blocker treatment.

HMO



PPO

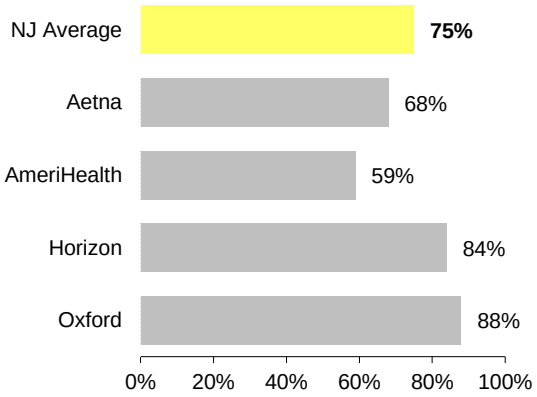


Postpartum care

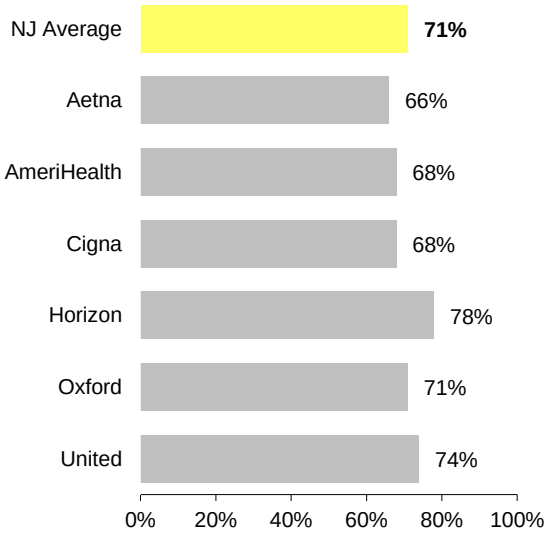
During a visit, providers can check a new mother's recovery from childbirth and answer questions. The bar graphs show the percentage of new mothers who received a check-up within eight weeks after delivery.

A higher percentage is better for this performance measure. This means that more women with live birth deliveries received postpartum care in a timely manner.

HMO



PPO

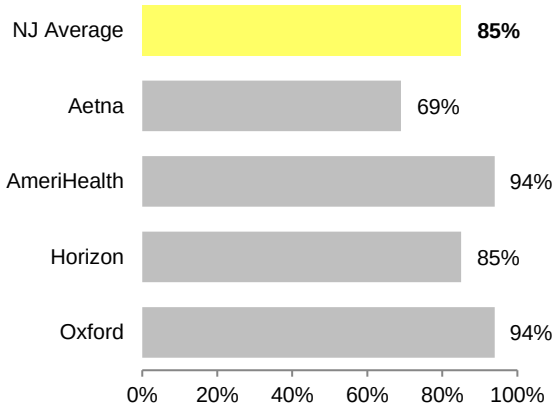


Anti-rheumatic drug therapy for rheumatoid arthritis

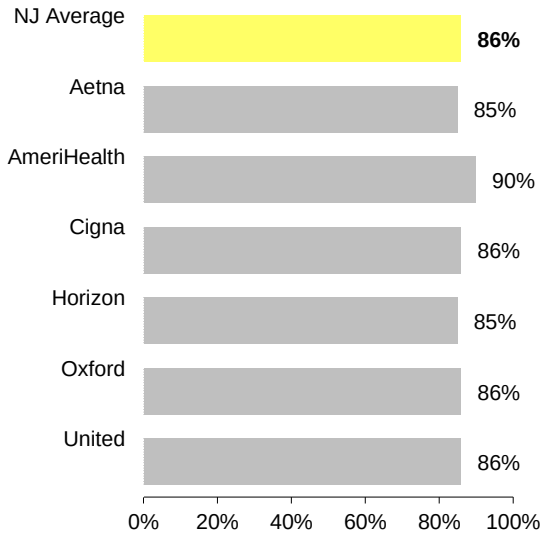
Disease-modifying anti-rheumatic drugs (DMARDs) are proven effective in slowing or preventing joint damage as opposed to just relieving pain and inflammation. The bar graphs show the percentage of members ages 18 and older, who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one DMARD in the measurement year.

A higher percentage is better for this measure. This means that more members 18 years of age and older received DMARD treatment for their RA.

HMO



PPO

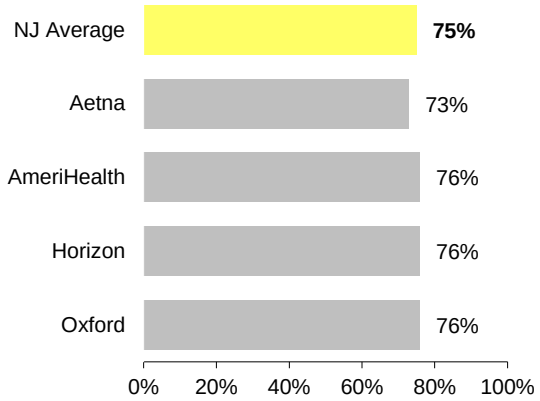


Use of imaging studies for low back pain

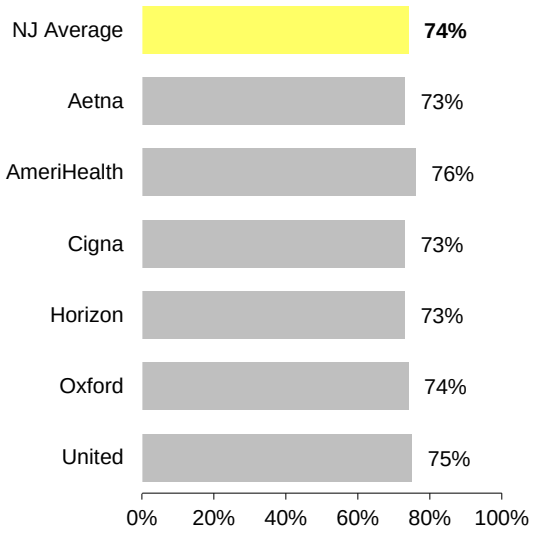
Imaging studies (plain x-ray, MRI, CT scan) are not needed for a primary diagnosis of lower back pain.

The bar graphs show the percentage of members with a primary diagnosis of low back pain who did not have a plain x-ray, MRI, and/or CT scan within 28 days of the diagnosis. A higher rate indicates appropriate treatment of low back pain.

HMO



PPO



Frequencies of Selected Procedures – HMO

This measure summarizes the utilization of two frequently performed procedures - Tonsillectomy and Cardiac Catheterization:

Procedure	Age	Sex	Number of Procedures 2017	Number of Procedures 2018	Procedures / 1,000 Member Years 2017	Procedures / 1,000 Member Years 2018
Aetna						
Tonsillectomy	0-9	Male & Female	128	98	7.14	7.81
	10-19		65	54	2.36	2.74
Cardiac Catheterization	45-64	Male	332	218	10.52	10.16
		Female	189	149	5.40	6.00
	65+	Male	62	58	19.28	22.82
		Female	38	30	13.05	12.99
AmeriHealth						
Tonsillectomy	0-9	Male & Female	13	12	4.09	5.58
	10-19		14	4	3.56	1.45
Cardiac Catheterization	45-64	Male	55	39	8.78	8.29
		Female	20	19	3.53	4.49
	65+	Male	4	7	12.08	25.27
		Female	5	4	20.65	19.55
Horizon						
Tonsillectomy	0-9	Male & Female	595	674	5.76	7.06
	10-19		330	325	2.46	2.62
Cardiac Catheterization	45-64	Male	1428	1376	9.42	9.95
		Female	831	769	4.64	4.76
	65+	Male	422	419	19.64	20.59
		Female	236	220	12.77	12.28
Oxford						
Tonsillectomy	0-9	Male & Female	45	1	4.00	1.29
	10-19		19	1	1.38	0.79
Cardiac Catheterization	45-64	Male	126	5	7.14	5.05
		Female	59	1	3.50	0.93
	65+	Male	20	2	20.75	22.49
		Female	3	1	4.41	13.56

Frequencies of Selected Procedures - PPO

This measure summarizes the utilization of two frequently performed procedures - Tonsillectomy and Cardiac Catheterization:

Procedure	Age	Sex	Number of Procedures - 2017	Number of Procedures - 2018	Procedures / 1,000 Member Years 2017	Procedures / 1,000 Member Years 2018
Aetna						
Tonsillectomy	0-9	Male & Female	470	513	4.83	4.99
	10-19		258	279	2.19	2.22
Cardiac Catheterization	45-64	Male	843	858	6.60	6.25
		Female	517	535	3.71	3.58
	65+	Male	257	293	18.70	19.36
		Female	125	124	10.04	9.56
AmeriHealth						
Tonsillectomy	0-9	Male & Female	37	51	5.90	8.56
	10-19		18	24	2.29	3.03
Cardiac Catheterization	45-64	Male	89	91	8.12	8.08
		Female	40	41	3.48	3.51
	65+	Male	20	18	20.56	19.22
		Female	10	10	12.52	13.52
Cigna						
Tonsillectomy	0-9	Male & Female	222	236	4.77	4.85
	10-19		102	129	1.89	2.28
Cardiac Catheterization	45-64	Male	409	389	6.82	6.21
		Female	176	201	2.92	3.16
	65+	Male	116	126	18.21	18.72
		Female	63	60	11.21	10.25
Horizon						
Tonsillectomy	0-9	Male & Female	354	394	5.04	5.49
	10-19		201	228	2.06	2.32
Cardiac Catheterization	45-64	Male	965	1024	7.64	7.97
		Female	514	580	3.76	4.10
	65+	Male	246	260	18.96	20.68
		Female	142	117	12.14	10.59
Oxford						
Tonsillectomy	0-9	Male & Female	37	86	4.84	4.95
	10-19		22	58	2.12	2.69
Cardiac Catheterization	45-64	Male	72	164	6.34	6.07
		Female	40	66	3.35	2.49
	65+	Male	13	30	10.18	13.18
		Female	3	14	3.23	8.40
United						
Tonsillectomy	0-9	Male & Female	262	257	3.95	3.96
	10-19		147	126	2.09	1.82
Cardiac Catheterization	45-64	Male	416	399	5.75	5.56
		Female	232	235	3.16	3.23
	65+	Male	94	101	17.51	17.68
		Female	29	35	7.01	7.95

Choosing Your HMO & PPO

Your choice of a Managed Care Plan can influence your health.

Looking at HMO & PPO quality, along with a plan's choice of providers, benefits offered, and costs, can help you decide on an HMO or PPO that best meets your needs.

Quality of Care and Service

- Look to see how well the HMO and PPO performs in each section of this report.
- Pay special attention to the health issues that are the 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, and PPOs look at all the factors that contribute to an HMO's or PPO's performance and at large differences in the measures.
- Check the NCQA website for quality and member satisfaction measures of each health plan at:
  https://www.ncqa.org/
  http://healthinsuranceratings.ncqa.org/

Choice of Providers

- Make sure that your preferred doctor, hospital and other providers participate in the HMO's and PPO's network by looking in the HMO's and PPO's provider directory. It is important to confirm your provider's participation by calling the HMO's and PPO's member services department or the provider directly, prior to enrollment. *See page 34 for ways to contact the HMO and PPO.*
- Decide whether the HMO and PPO 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 and PPO offers by reviewing the evidence of coverage, Summary of Benefits and Coverages, the member handbook, or by calling the HMO's or PPO's member services department to find out about the health benefits or services covered.
- Consider your special needs and circumstances such as chronic health conditions, elder care, frequent travel, language, retirement or starting a family.
- Decide whether there is a good match between the health benefits offered by the HMO or PPO and what you think you may need.
- Find out what types of care or services the HMO or PPO 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 or PPO covers services by providers outside the HMO's or PPO'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).
- The HMO and PPO might also have internal limits on specific services, such as, 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: https://www.ncqa.org/

Utilization Review Accreditation Commission (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: https://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: https://www.jointcommission.org/

Contacting Your HMO & PPO

The information in this report only covers the HMOs and PPOs offering commercial HMO/POS and PPO products. The contact information in the chart lists **all** active HMOs and PPOs approved to issue HMO and PPO products in New Jersey. Some of the HMOs are limited to offering Medicare or Medicaid products. Some products are only available in limited service areas. Contact the HMO or PPO to determine their offerings and service areas.

Telephone Numbers & Web Sites

HMO & PPO		
Health Plans	**Telephone**	**Web site**
Aetna Better Health of New Jersey, Inc. **Aetna Health, Inc. - New Jersey Corp.** **Aetna Life Insurance Company**	(800) 872-3862	https://www.aetna.com
AmeriChoice of New Jersey	(800) 941-4647	https://www.uhccommunityplan.com
AMERIGROUP New Jersey	(800) 600-4441	https://www.amerigroupcorp.com
AmeriHealth HMO **AmeriHealth Insurance Company of New Jersey**	(888) 968-7241	https://www.amerihealth.com
CIGNA HealthCare of New Jersey **CIGNA Health & Life Insurance Co. of New Jersey** **Connecticut General Life Insurance Company**	(800) 345-9458	https://www.cigna.com
Horizon Healthcare of New Jersey **Horizon BCBS of New Jersey**	(800) 355-2583	https://www.horizonblue.com
Oxford Health Plans - New Jersey **Oxford Health Insurance Co.** **UnitedHealthCare Insurance Co.**	(800) 444-6222	https://www.uhc.com
WellCare Health Plan of New Jersey	(866) 687-8570	https://www.wellcare.com

CARRIERS AS OF THE DATE OF THIS REPORT.

Appeals and Complaints

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 or PPO's Decision

Your HMO or PPO 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 or PPO that the services are not medically necessary. Such decisions are called "adverse utilization management (UM) determinations."

Review the services covered by your HMO or PPO 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 or PPO's adverse UM determination.

Stage 1

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

Stage 2

If you are dissatisfied with the results of the Stage 1 appeal, you can request in writing, that the HMO or PPO have your appeal reviewed by a panel of doctors and other health care professionals. You will receive notice of the panel's decision. Consumers enrolled in an individual health benefits plan do not have to file a Stage 2 appeal and may proceed directly to Stage 3 appeal.

Stage 3

If you are dissatisfied with the carrier's decision on your Stage 2 appeal, you can file an appeal with the Department of Banking and Insurance within four months after receiving the carrier's Stage 2 decision, or if you are enrolled in an individual health benefits plan you can file within four months of receiving the carrier's Stage 1 appeal decision. You will receive the form and instructions needed to file a Stage 3 appeal from your HMO or PPO at the same time you receive the Stage 2 appeal decision, or the Stage 1 appeal decision if you are enrolled in an individual health benefits plan. Your case will be reviewed by independent experts under contract with the State through the Independent Health Care Appeals Program (IHCAP). Decisions made by the IHCAP are binding on the HMO or PPO and the covered person, except to the extent that other remedies are available to either party under State or Federal law.

For appeals involving urgent circumstances, the HMO or PPO is required to respond within 72 hours at Stages 1 and 2 of the appeal process.

FOR MORE INFORMATION ABOUT HOW TO APPEAL SEE THE DEPARTMENT'S GUIDE at:

https://www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf

To File a Complaint against an HMO or PPO

In addition to the appeal process for adverse UM determinations, you also have the right to complain to the HMO or PPO about any aspect of its operations. The carrier 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 carrier's business and marketing practices. The HMO or PPO 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 carrier'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

https://www.state.nj.us/dobi/division_insurance/managedcare/index.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 35.

For Medicare and Medicaid managed care appeals refer to page 37.

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 on the previous page (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.

New Jersey 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: https://www.state.nj.us/dobi/division_insurance/

You may also request information by calling (609) 633-1882 and pressing option "3". DOBI monitors the compliance of HMOs and PPOs with New Jersey rules through in-depth reviews and targeted examinations. DOBI investigates consumer complaints about HMOs and PPOs 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 https://www.state.nj.us/dobi/division_insurance/managedcare/index.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 and PPOs as well as other information on health carriers. This information can be found at: https://www.state.nj.us/dobi/division_insurance/lhactuar.htm

Medicare

For information on managed care options for Medicare in New Jersey, call the New Jersey Division of Aging Services, State Health Insurance Assistance Program (SHIP) at (800) 792-8820, or call (800) MEDICARE. You can also visit https://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.

NJ Family Care

For information on NJ Family Care and Medicaid HMO options, quality information and complaints, call the New Jersey Department of Human Service NJ FamilyCare program at: 1-800-701-0710 (TTY: 1-800- 701-0720), or visit: http://www.njfamilycare.org/default.aspx https://www.njconsumeraffairs.gov/

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: https://www.njconsumeraffairs.gov/bme

Additional Health Care Information

The Department of Health 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: https://www.state.nj.us/health/healthfacilities/reportcards.shtml

A price comparison registry for many prescription drugs can be found at: https://www20.state.nj.us/LPSCA_DRUG/index.jsp

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: https://www.dol.gov/agencies/ebsa

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

https://www.state.nj.us/dobi/lifehealthactuarial/hmo2018/