1999

New Jersey HMO Performance Report

Compare Your Choices

Christine Todd Whitman
Governor

Christine Grant
Commissioner
Department of Health and Senior Services

Dear Consumer:

As managed care gains a greater foothold in New Jersey, it's important for health care consumers to learn as much as possible about the performance of their plans. To help consumers make more informed choices, we are pleased to present our third annual report card.

This report card looks at the performance of eight commercial health maintenance organizations and seven point-of-service plans, a type of managed care plan that allows consumers to go outside the network. You'll see how well these plans deliver preventive care, and how plan members view the services they receive.

We've added some new measures to this year's report card, such as the percentage of heart attack patients treated with beta blockers to prevent future heart attacks, and the percentage of heart patients who get their cholesterol checked.

As you use this guide, remember that New Jersey has some of the strongest managed care protections in the country. We urge you to become familiar with these protections, which are listed in this report.

We wish you good health, and hope this report helps you choose the right health plan for you and your family.

Christine Todd Whitman
Governor

Christine Grant
Commissioner,
Department of Health
and Senior Services

To obtain additional copies of this report, please contact the Office of Managed Care, Department of Health and Senior Services, P.O. Box 360, Trenton, New Jersey 08625-0360, phone (888) 393-1062, fax (609) 633-0807. There is a charge for multiple copies. The report is available on the Department's web site: www.state.nj.us/health or can be requested by e-mail: hmo@doh.state.nj.us.

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.

There are two types of health plans presented in this report—health maintenance organizations (HMOs) and point-of-service (POS) plans. See page 18 for details about how HMOs and POS plans work.

This report contains information on the following health plans:

Health Plan	Shown in this Report
Aetna U.S. Healthcare-New Jersey	Aetna USHC HMO Aetna USHC POS
AmeriHealth, Inc.	AmeriHealth HMO AmeriHealth POS
CIGNA HealthCare of New Jersey, Inc.	CIGNA-NJ HMO CIGNA-NJ POS
Horizon Healthcare of New Jersey, Inc. [1]	Horizon HMO
Oxford Health Plans-New Jersey, Inc.	Oxford HMO Oxford POS
Physicians Health Services of New Jersey, Inc. [2]	PHS-NJ HMO PHS-NJ POS
Prudential HealthCare-New Jersey	Prudential HMO Prudential POS
United Healthcare of New Jersey, Inc.	United-NJ HMO United-NJ POS

1 Previously known as HMO Blue.

2 Physicians Health Services of New Jersey, Inc. merged with First Option Health Plan of New Jersey, Inc. on January 1, 1999. The PHS measures also include First Option members.

This report covers the performance of HMOs and POS plans in New Jersey with large commercial enrollments. These plans cover 97 percent of the State's total commercial enrollment. This report does not cover the performance of health plans that serve Medicare or Medicaid beneficiaries. See page 19 for ways to get information on Medicare and Medicaid plans.

New Jersey HMO Performance Report

Table of Contents

Quality Matters

Why is the quality of your health plan 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. The State of New Jersey produced this report so that you can compare how well health plans across the state perform.

- **If you are a consumer,** the quality of care provided by your health plan may affect you and your family's health.
- **If you are an employer,** keeping employees healthy means reduced absenteeism and increased productivity.

For example, consider how well your health plan, or those that you offer to your employees, performs when it comes to:

Cholesterol screening after a heart attack

490,000 Americans die from coronary artery disease each year, making it the leading cause of death in this country. The annual national costs from this condition are estimated to be $47 billion. Health plans that appropriately control cholesterol can reduce a person's chances of dying from a heart attack by as much as 40 percent.

Making sure kids are immunized

Approximately 35,000 of New Jersey's young children do not receive recommended immunizations to protect them against dangerous diseases. Health plans that regularly immunize children help protect them from the harmful effects of such childhood diseases as polio, German measles, mumps and whooping cough.

Finding breast cancer early

Breast cancer is the second most common type of cancer among American women. Approximately 6,000 new cases are reported each year in New Jersey alone. Health plans that regularly provide women with mammograms, a test to detect breast cancer, can save lives. Early detection through mammograms has been shown to reduce death from breast cancer by 20 to 40 percent in women aged 50 and older.

This report gives you information on the performance of New Jersey plans regarding these and other important areas of health care.

Your choice of health plan can influence how healthy you are.

Health Plan Choices

How should you choose your health plan?

Choosing the right health plan is important. It can also be difficult. Today, there are more choices and more kinds of health plans than ever before. Use this report, along with cost and benefit information available from your employer or the health plan to choose the best health plan.

Consider the following questions:

1. Is your preferred doctor or health care provider available in the health plan?

- If you have a doctor or other type of provider you want to see, find out if he or she participates in the health plan. To get this information, review the health plan's provider directory and call the provider's office or the health plan to confirm this information.
- If you are looking for a new doctor, review the list of doctors in the health plan's provider directory for someone that appeals to you. Are there other providers or facilities you think you may need?

2. Does the health plan offer the benefits you want?

- Based on what you know about your family's health, does the plan cover health services your family will need?

3. How much will it cost?

- The amount of your monthly premium and other out-of-pocket expenses will depend on how you get your insurance coverage.
- Look at monthly premiums and copayments, as well as charges you might have to pay if you decide to go outside your health plan's provider network.
- While it's tempting to choose the health plan that costs less, it's important to look for quality first.

4. Which health plans performed best in this report?

- From the health plans that seem to best fit your needs, check their performance in this report.
- Pay the most attention to issues that are most important to you and your family. For example, if you have a young child, you might be most interested in the performance measures in the Care for Kids section.
- Also, do not make decisions based on small differences that are not meaningful. Look at all factors that contribute to a health plan's performance, not just results for a single measure.

To get additional information from the health plans you are most interested in joining, telephone numbers for health plans are listed on page 19.

How to Read This Report

The information in this report is based on a survey of plan members done by the Department of Health and Senior Services and audited information from health plan records.

- Charts with circles summarize results and give you the big picture of how the health plans compare.
- Bar graphs show each health plan's actual scores.

Access and Service

Do members have access to the care and service they need?

Circles compare each health plan's score to the average for New Jersey health plans. Higher than average scores mean better performance. Bar graphs on the next page show scores for each plan on these topics.

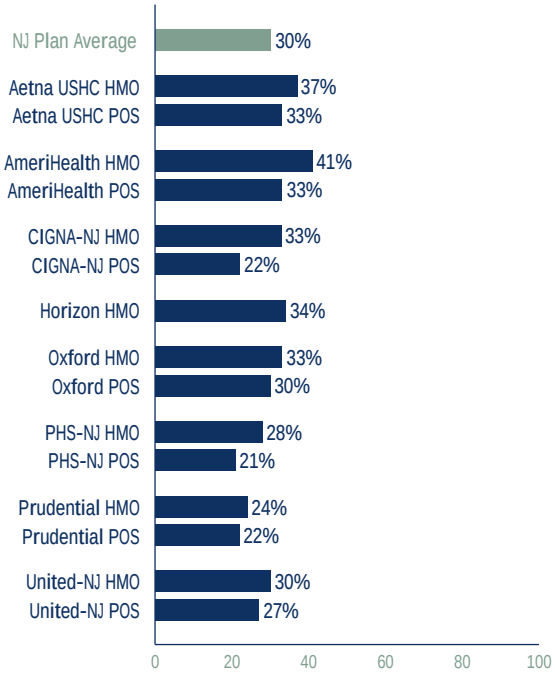
Performance Compared to the Average

- ● **Higher.** Score for plan is *above the average* score for New Jersey health plans.
- ◓ **Average.** Score for plan is *neither higher nor lower* than the average score for New Jersey health plans.
- ○ **Lower.** Score for plan is *below the average* score for New Jersey health plans.

Health Plan	Rating of health plan	Getting needed care	Getting care quickly	Customer service
Aetna USHC HMO	●	●	◓	●
Aetna USHC POS	◓	◓	◓	●
AmeriHealth HMO	●	●	●	●
AmeriHealth POS	◓	◓	●	◓
CIGNA-NJ HMO	◓	◓	◓	◓
CIGNA-NJ POS	○	○	○	○
Horizon HMO	●	◓	◓	●
Oxford HMO	◓	◓	◓	◓
Oxford POS	◓	◓	◓	◓
PHS-NJ HMO	◓	◓	◓	◓
PHS-NJ POS	○	○	◓	◓
Prudential HMO	○	◓	◓	○
Prudential POS	○	◓	◓	○
United-NJ HMO	◓	◓	◓	◓
United-NJ POS	◓	○	○	◓

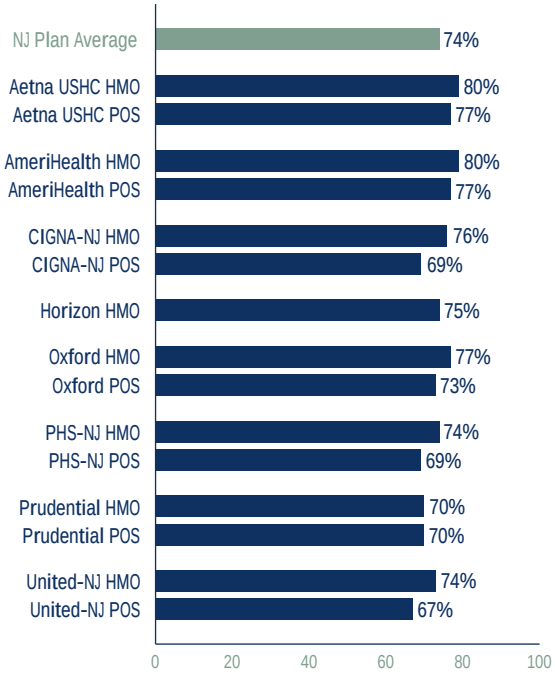
Rating of health plan

Percent of members who rated their health plan a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



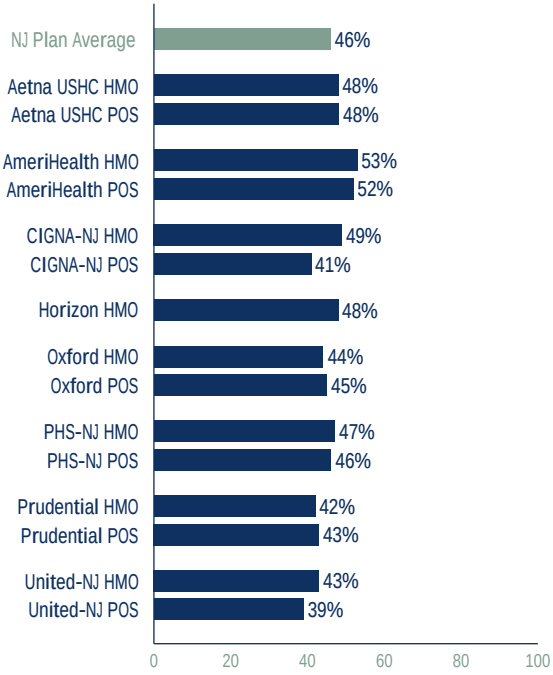
Getting needed care

Percent of members who responded "not a problem" when asked about obtaining: a personal doctor they are happy with • a referral to see a specialist • necessary care • timely approvals for care.



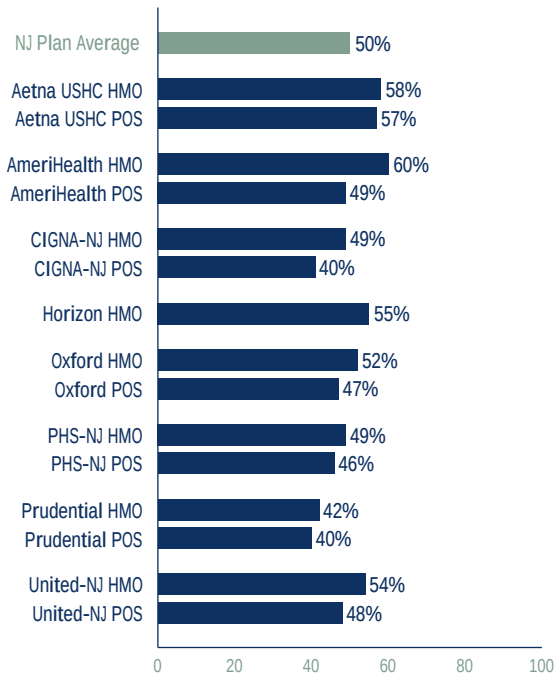
Getting care quickly

Percent of members who responded "always" when asked about obtaining: advice • timely appointments and • responded "never" to waiting over 15 minutes past appointment time.



Customer service

Percent of members who responded "not a problem" when asked about: finding or understanding written information • getting needed help from customer service • completing paperwork.



Doctors and Medical Care

Are health plan members satisfied with their physicians and other providers?

Circles compare each health plan's score to the average for New Jersey health plans. Higher than average scores mean better performance. Bar graphs on the next page show scores for each plan on these topics.

Performance Compared to the Average

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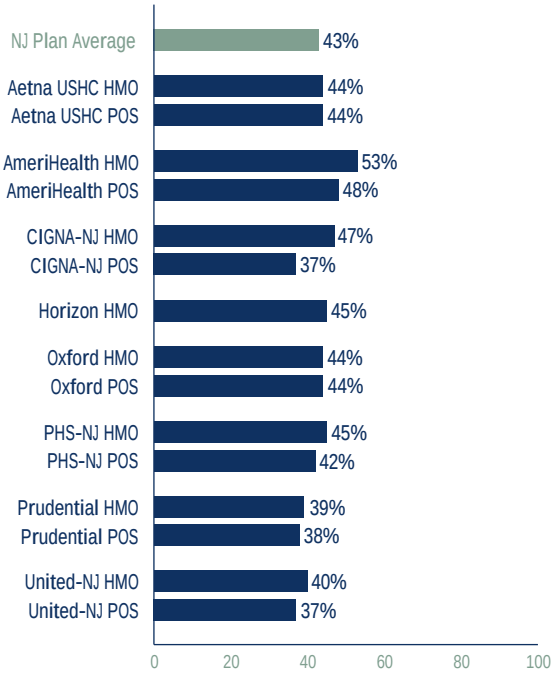
- ○ **Lower.** Score for plan is *below the average* score for New Jersey health plans.

Health Plan	Rating of health care	Rating of personal doctor	Rating of specialist seen most often	How well doctors communicate
Aetna USHC HMO	◓	◓	◓	◓
Aetna USHC POS	◓	◓	◓	◓
AmeriHealth HMO	●	●	◓	●
AmeriHealth POS	●	◓	◓	●
CIGNA-NJ HMO	◓	◓	◓	◓
CIGNA-NJ POS	○	◓	◓	○
Horizon HMO	◓	◓	◓	◓
Oxford HMO	◓	◓	◓	◓
Oxford POS	◓	◓	◓	◓
PHS-NJ HMO	◓	◓	◓	◓
PHS-NJ POS	◓	◓	◓	◓
Prudential HMO	◓	◓	◓	◓
Prudential POS	○	◓	◓	◓
United-NJ HMO	◓	◓	◓	◓
United-NJ POS	○	○	◓	○

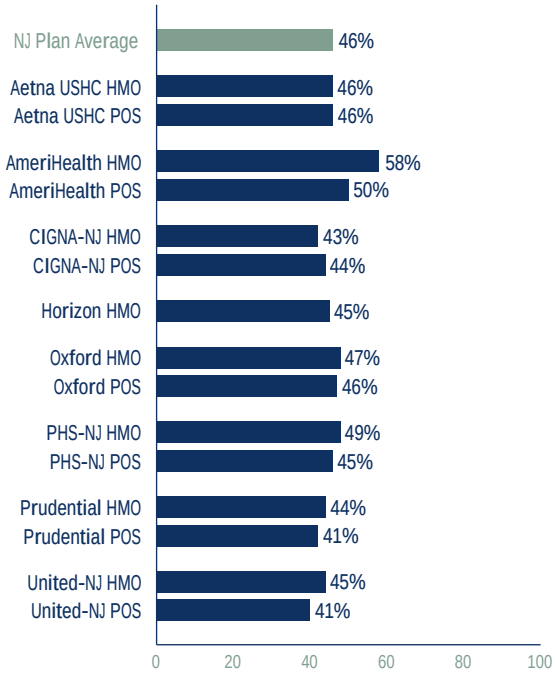
Rating of health care

Percent of members who rated quality of care a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



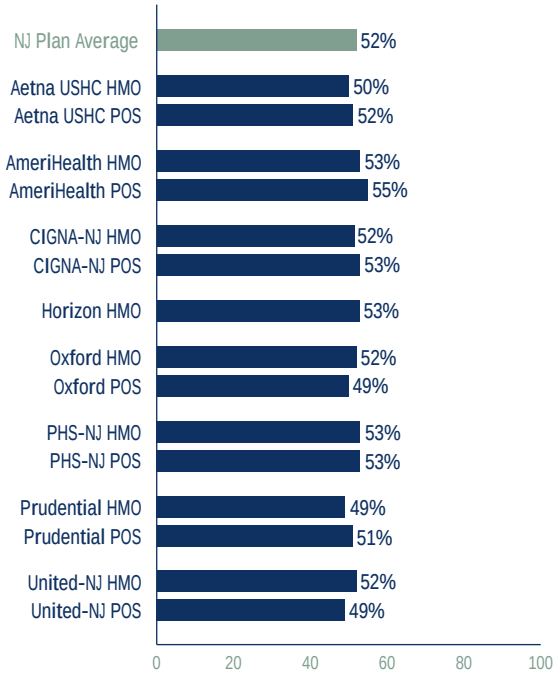
Rating of personal doctor

Percent of members who rated their personal doctor a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



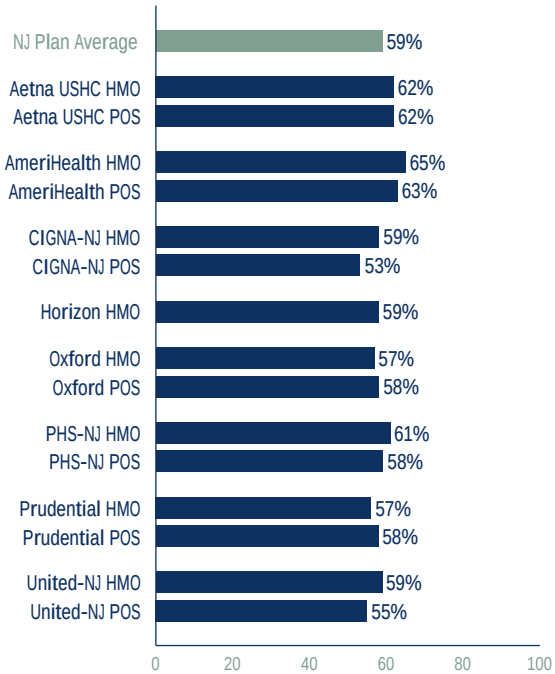
Rating of specialist seen most often

Percent of members who rated the specialist they saw most often a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



How well doctors communicate

Percent of members who responded “always” when asked about their doctor: listening carefully • explaining things clearly • showing respect • spending enough time with them.



Staying Healthy

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

Circles compare each health plan's score to the average for New Jersey health plans. Higher than average scores mean better performance. Bar graphs on the next page show scores for each plan on these topics.

Performance Compared to the Average

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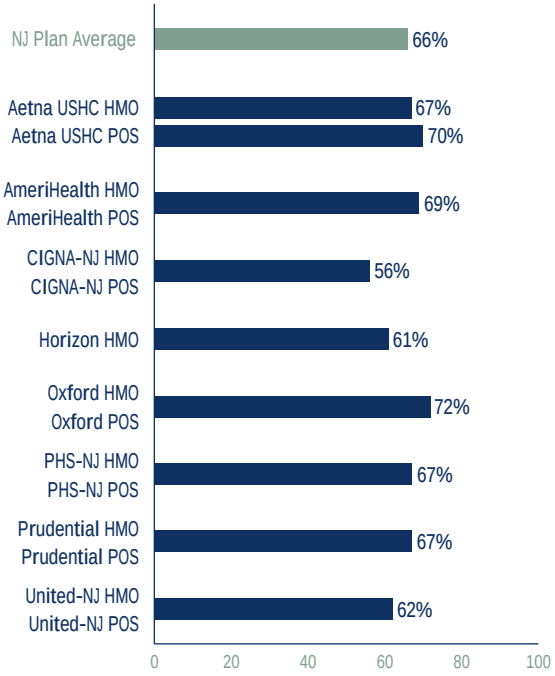
- ○ **Lower.** Score for plan is *below the average* score for New Jersey health plans.

Health Plan	Testing for breast cancer *	Testing for cervical cancer *	Prenatal care for pregnant women *	Check-ups for new mothers *
Aetna USHC HMO	◓	●	◓	◓
Aetna USHC POS	●	●	●	●
AmeriHealth HMO	◓	◓	○	○
AmeriHealth POS				
CIGNA-NJ HMO	○	○	○	○
CIGNA-NJ POS				
Horizon HMO	○	○	◓	●
Oxford HMO	●	◓	●	◓
Oxford POS				
PHS-NJ HMO	◓	○	●	◓
PHS-NJ POS				
Prudential HMO	◓	◓	◓	◓
Prudential POS				
United-NJ HMO	○	○	◓	◓
United-NJ POS				

* Some plans chose to report their HMO and POS information separately.

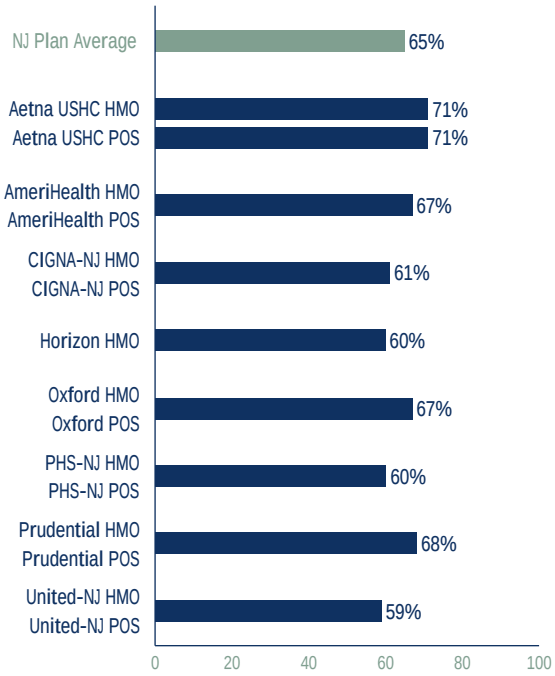
Testing for breast cancer

Women are less likely to die if breast cancer is discovered early through a mammogram. Percent of women ages 52–69 who received a mammogram within the past two years.



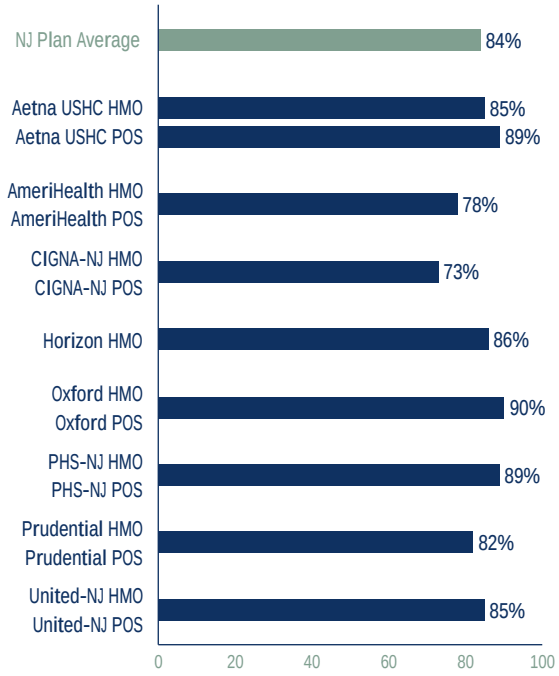
Testing for cervical cancer

Deaths from cervical cancer are significantly reduced by early detection through a Pap test (a test to find cervical cancer). Percent of adult women who received a Pap test within the past three years.



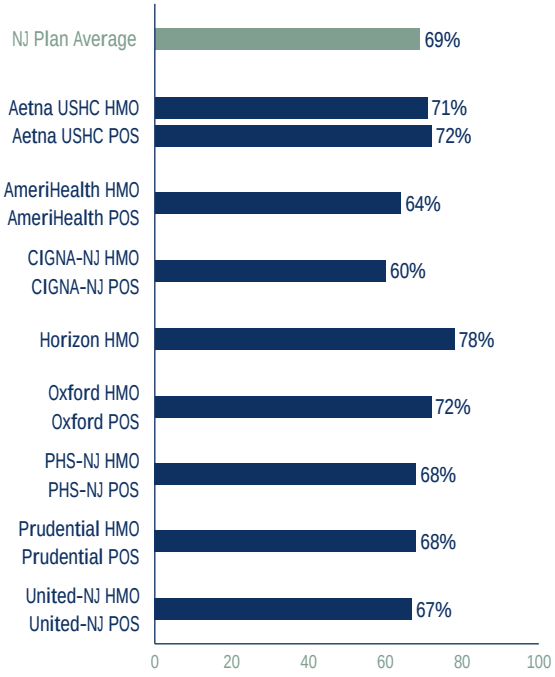
Prenatal care for pregnant women

Early prenatal care contributes to having a healthy baby. Percent of pregnant women who received their first prenatal care visit during the first three months of pregnancy.



Check-ups for new mothers

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



Care for Kids

How well does the health plan care for children?

Circles compare each health plan's score to the average for New Jersey health plans. Higher than average scores mean better performance. Bar graphs on the next page show scores for each plan on these topics.

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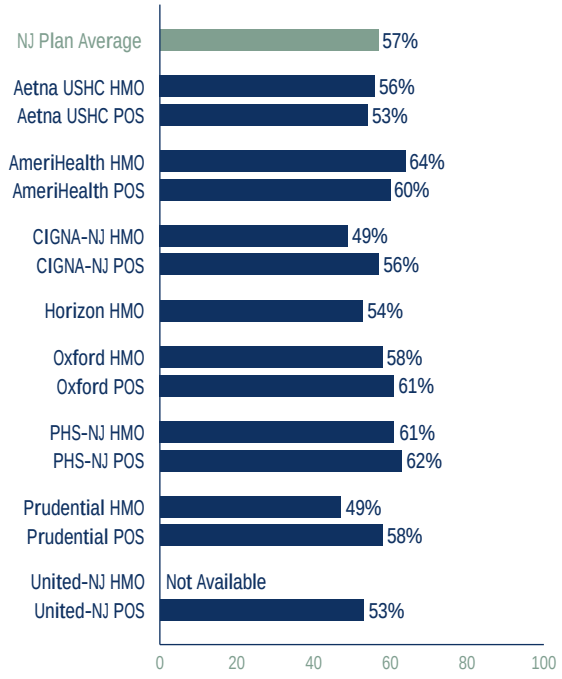
Health Plan	Rating of child's health care	Rating of child's personal doctor	Immunizations for children *	Immunizations for adolescents *
Aetna USHC HMO	◓	◓	◓	●
Aetna USHC POS	◓	◓	◓	●
AmeriHealth HMO	●	●	●	●
AmeriHealth POS	◓	◓		
CIGNA-NJ HMO	○	◓	◓	●
CIGNA-NJ POS	◓	◓		
Horizon HMO	◓	◓	◓	◓
Oxford HMO	◓	◓	●	●
Oxford POS	◓	◓		
PHS-NJ HMO	◓	◓	○	◓
PHS-NJ POS	●	●		
Prudential HMO	○	○	○	○
Prudential POS	◓	◓		
United-NJ HMO	Not Available	Not Available	◓	○
United-NJ POS	◓	◓		

* Some plans chose to report their HMO and POS information separately.

Not Available—Health plan could not report the information due to small enrollment.

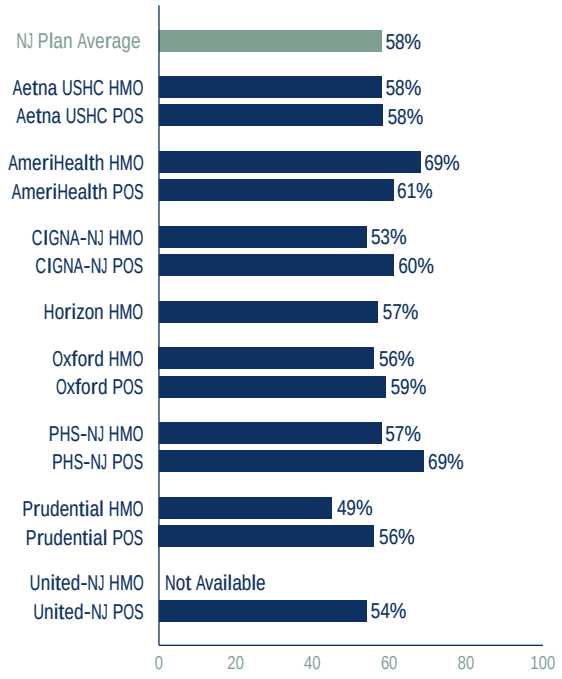
Rating of child's health care

Percent of members who rated their child's quality of care a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



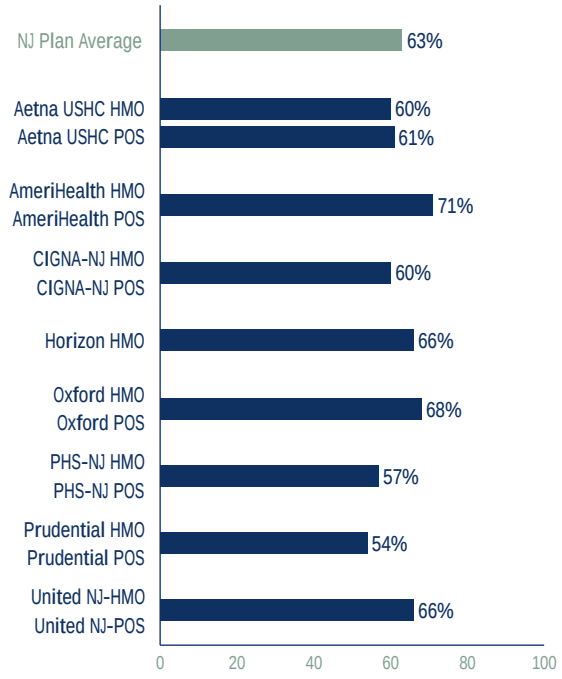
Rating of child's personal doctor

Percent of members who rated child's personal doctor a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



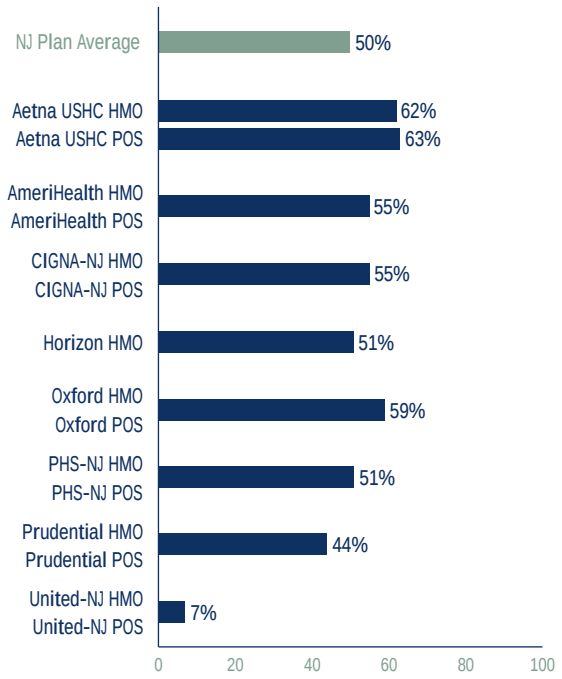
Immunizations for children

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



Immunizations for adolescents

Immunizations begin at birth and should be continued through adolescence. Percent of adolescents who received a second immunization for measles, mumps and rubella by age 13.



Getting Better / Living with Illness

How well does the health plan care for people when they become sick?

Circles compare each health plan's score to the average for New Jersey health plans. Higher than average scores mean better performance. Bar graphs on the next page show scores for each plan on these topics.

Performance Compared to the Average

- ● **Higher.** Score for plan is *above the average* score for New Jersey health plans.
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- ○ **Lower.** Score for plan is *below the average* score for New Jersey health plans.

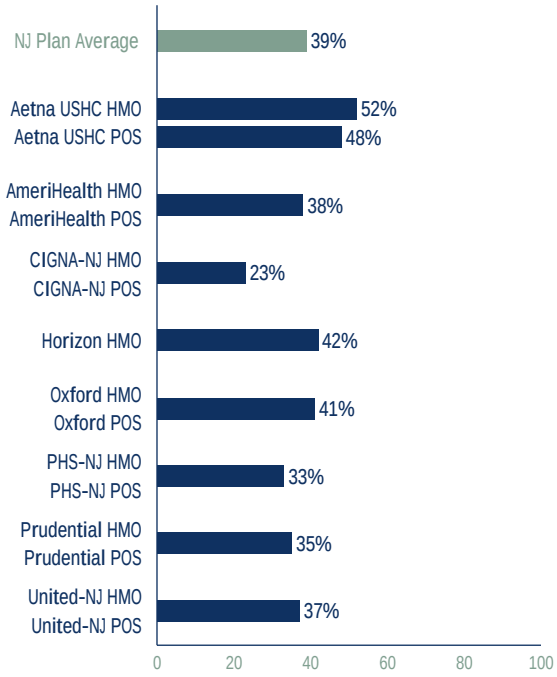
Health Plan	Eye exams for people with diabetes *	Care after hospitalization for mental illness *	Beta blocker medication after a heart attack *	Cholesterol screening for heart patients *
Aetna USHC HMO	●	◒	●	●
Aetna USHC POS	●	○	●	●
AmeriHealth HMO	◒	◒	●	●
AmeriHealth POS				
CIGNA-NJ HMO	○	●	○	○
CIGNA-NJ POS				
Horizon HMO	◒	●	●	●
Oxford HMO	◒	○	◒	●
Oxford POS				
PHS-NJ HMO	○	○	○	○
PHS-NJ POS				
Prudential HMO	◒	●	◒	Not Reported
Prudential POS				
United-NJ HMO	◒	Not Reported	◒	○
United-NJ POS				

* Some plans chose to report their HMO and POS information separately.

Not Reported—Health plan did not meet audit requirements or chose not to report.

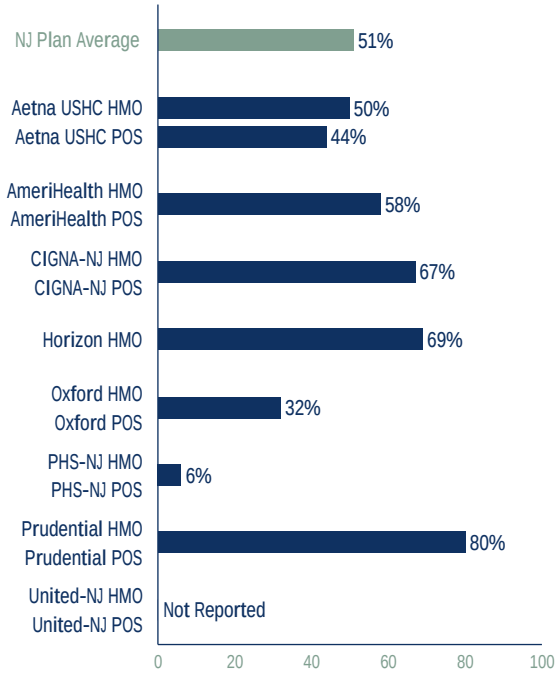
Eye exams for people with diabetes

Blindness from diabetes can be reduced with early detection through eye exams. Percent of members with diabetes who received an eye exam in the past year.



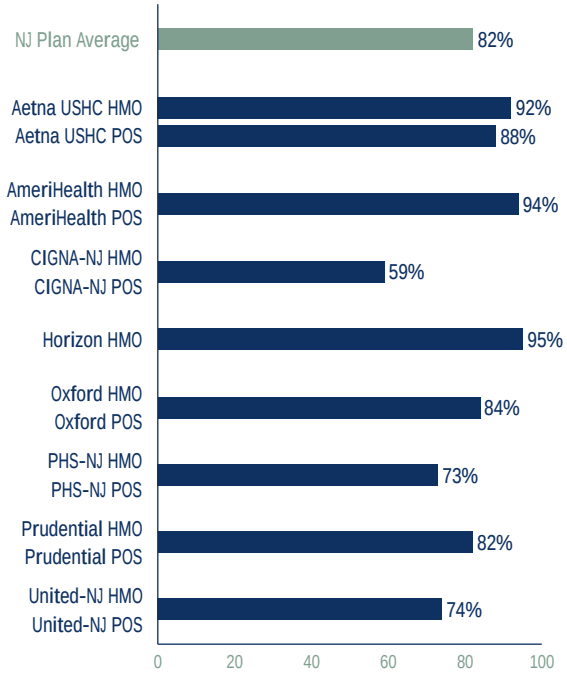
Care after hospitalization for mental illness

Follow-up therapy after a hospital stay for mental illness is important to detect problems or adjust medications. Percent of members who received care after mental health hospitalization.



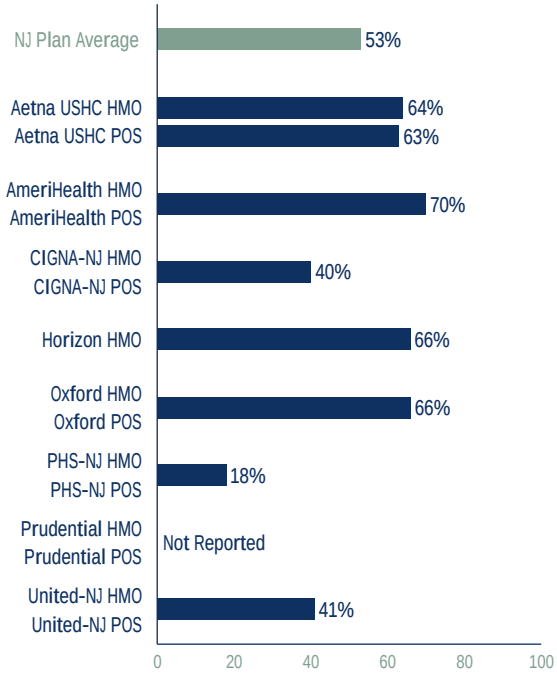
Beta blocker medication after a heart attack

Beta blocker medication following a heart attack can help prevent future heart attacks. Percent of members who had a heart attack and received a beta blocker medication.



Cholesterol screening for heart patients

Managing cholesterol can reduce heart attacks and strokes. Percent of members who had a heart attack, heart bypass surgery or angioplasty and had their cholesterol levels checked.



Getting Better / Living with Illness

How do frequent users of health services rate their health plan?

Circles compare each health plan's score to the average for New Jersey health plans. Higher than average scores mean better performance. Bar graphs on the next page show scores for each plan on these topics.

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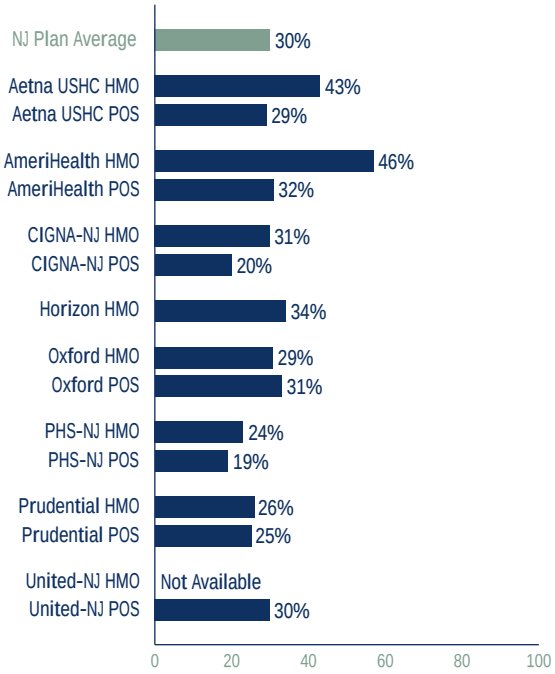
- ○ **Lower.** Score for plan is *below the average* score for New Jersey health plans.

Health Plan	Rating of health plan	Rating of health care	Getting needed care	Getting care quickly
Aetna USHC HMO	●	◓	●	◓
Aetna USHC POS	◓	◓	◓	◓
AmeriHealth HMO	●	●	●	●
AmeriHealth POS	◓	◓	◓	●
CIGNA-NJ HMO	◓	◓	◓	◓
CIGNA-NJ POS	○	○	○	○
Horizon HMO	◓	◓	◓	◓
Oxford HMO	◓	◓	◓	◓
Oxford POS	◓	◓	◓	◓
PHS-NJ HMO	◓	◓	◓	◓
PHS-NJ POS	○	●	◓	●
Prudential HMO	◓	◓	◓	◓
Prudential POS	◓	◓	◓	○
United-NJ HMO	Not Available	Not Available	Not Available	Not Available
United-NJ POS	◓	◓	○	◓

Not Available—Health plan could not report the information due to small enrollment.

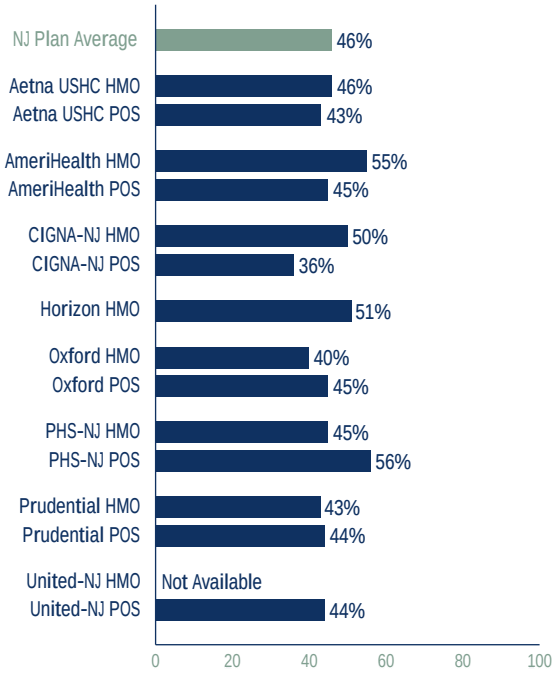
Frequent users rating of health plan

Percent of members who rated their health plan a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



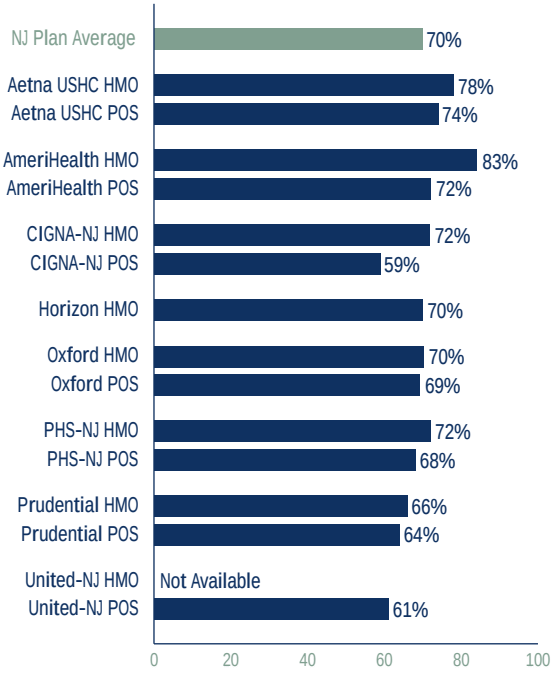
Frequent users rating of health care

Percent of members who rated quality of care a 9 or 10 on a 0 to 10-point scale, with 10 being the best.



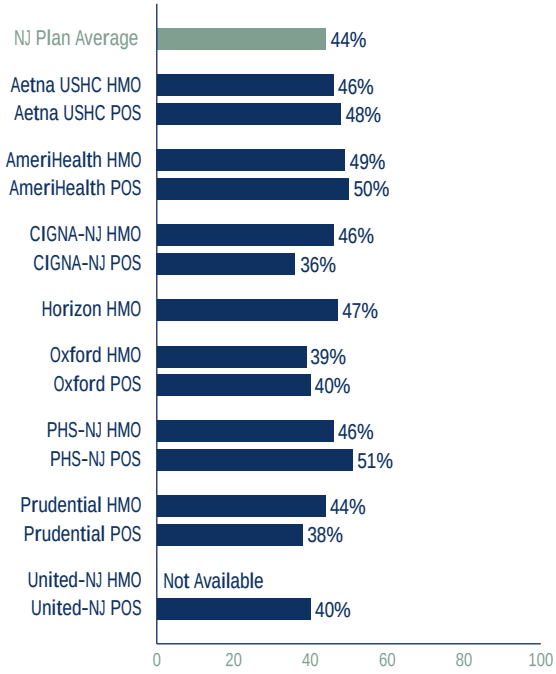
Frequent users getting needed care

Percent of members who responded “not a problem” when asked about obtaining: a personal doctor they are happy with • a referral to see a specialist • necessary care • timely approvals for care.



Frequent users getting care quickly

Percent of members who responded “always” when asked about obtaining: advice • timely appointments and • responded “never” to waiting over 15 minutes past appointment time.



Your Responsibilities

How can you get the most from your health plan?

You and your health plan share responsibility for your health care. Knowing how your health plan operates can help increase your satisfaction by understanding how to get the care you need when you need it.

To get the most from your health plan you should:

- Read the member handbook or talk to your employer to understand what services the plan will pay for ("covered services") and what it doesn't pay for ("exclusions").
- If your plan has a member newsletter or magazine, read it to stay current about any new policies affecting how your plan works.
- Know how to choose or change your primary care physician.
- Ask questions if you don't understand information the plan or provider sends to you.
- Know what hours your plan's customer service department and physician's office are open.
- Understand how to schedule appointments for routine and urgent care.
- Figure out when you need a referral to see a specialist or obtain services.
- Know how to get referrals for a specialist, if your plan requires them.
- Know what your plan requires you to do if you need to use a hospital emergency room.
- Take good care of your health by getting appointments for check-ups or other preventive care.
- Ask your doctor questions, including the risks and benefits of any treatments that your doctor recommends.

Appeals and Complaints

What are your appeal rights in New Jersey?

To Appeal a Health Plan Decision

Your health plan is required to have an appeal process that gives you an opportunity to resolve disagreements about denial of a covered service. **If you are dissatisfied with the result of the health plan's appeal process, you can have your case reviewed by an independent organization selected by the New Jersey Department of Health and Senior Services.**

Here are steps to take if you believe you have been denied medical services covered by your health plan contract:

Preliminary

Review the medical services covered by your insurance contract and the explanation of the appeal process in the member handbook provided by the plan. Your health plan should inform you of your options at each stage of the process.

Stage 1

To begin the process of appeal, you should inform the health plan, either verbally or in writing, of your dissatisfaction with the health plan's decision to deny or limit services you believe are covered. You can communicate your appeal on your own or have a doctor do it for you with your permission. This is the opportunity for you or your doctor to discuss the issue with a physician from the health plan.

Stage 2

If you are not satisfied with the results of the initial communications with the health plan, you can request the health plan to have your appeal reviewed by a panel of doctors and other health care professionals not involved in your case. The panel members may either be part of the health plan's network or outside consultants in the relevant medical specialty. If the panel decides in favor of the health plan, you must receive written notification of the reasons why your appeal was denied. The health plan also must give you instructions and forms that you can use to file your appeal with the Department of Health and Senior Services.

Stage 3

You can file an appeal with the Department of Health and Senior Services within 60 days of receiving the health plan's denial in Stage 2. There is a fee of $25, which is reduced to $2 for those eligible for government assistance programs. An independent utilization review organization (IURO) will review your appeal. If the IURO determines you did not receive necessary medical services covered by the plan, it will recommend that the health plan provide the appropriate medical services. The health plan must then notify you or your doctor whether it accepts the IURO's recommendation. If it does not, it must explain the reasons for its rejection.

To File a 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. New Jersey regulations require health plans to have a system to resolve complaints about such things as quality of medical care, choice of doctors and other health care providers, difficulties with health plan services, or disputes about plan business and marketing practices. The health plan is required to respond to your complaint within 30 days. The member handbook provided by the health plan contains a description of the complaint process and the telephone number and address of the health plan staff responsible for resolving complaints.

If you are dissatisfied with the resolution reached through the health plan's complaint process, contact the appropriate State agency:

For complaints about quality of care, choice of providers or getting access to providers in a plan's network, contact:

NJ Department of Health and Senior Services
Office of Managed Care
P.O. Box 360, Trenton, NJ 08625-0360
(888) 393-1062

For complaints about a health plan's business practices such as payment of claims, member enrollment, or termination of coverage, contact:

NJ Department of Banking and Insurance
Division of Enforcement and Consumer Protection
P.O. Box 329, Trenton, NJ 08625-0329
(800) 446-7467

Note: The process for appealing a health plan decision or filing a complaint is different if you are a member of a plan that is classified as "self-funded." Check with your employer or health plan to find out which process applies to you.

HMO and POS Plan Differences

How do HMOs and POS plans work?

In managed care, including HMOs (health maintenance organizations) and POS (point-of-service) plans, you usually get care from a set group of doctors and hospitals that make up the plan's provider network. This differs from fee-for-service (indemnity) insurance, which does not have provider networks and permits you to get care from any doctor or hospital. However, fee-for-service insurance may have less predictable and higher out-of-pocket costs.

The table below highlights some of the important similarities and differences among HMOs, POS plans and fee-for-service. The table presents general rules. Be sure to check with your plan or employer to verify information.

This report only contains information on HMOs and POS plans in New Jersey.

	HMO	POS	Fee-for-Service
Can you get services from providers who are not in the network?	No. The HMO pays for covered services only if you go to providers in the network.	Yes. If you use providers who are not part of the network you will pay more.	Yes. You may receive care from any provider of your choice.
How do you pay for services?	There is no deductible. You are charged a pre-set amount or co-payment (usually between $5 and $25) for a physician office visit. You do not usually need to fill out claim forms.	If you go to a provider who is in the network, there is no deductible and you are charged a co-payment. No claim forms need to be filled out. If the provider is not in the network, you pay a deductible and a greater portion of the costs. You may need to fill out a claim form.	After you pay a deductible, you pay a percentage of the cost of the covered services and the insurer pays the remaining costs. Usually, you pay 20% of the cost and the insurer pays 80%.
Do you need to choose a primary care provider (PCP)?	Yes. You are usually required to choose a PCP from a list of network doctors. Your PCP takes care of most of your medical needs.	Yes. You usually need to select a PCP from the list of network doctors.	No. You can get care from any doctor of your choice.
Do you need a referral from your PCP to go to a specialist?	Yes. Before you go to a specialist, you usually need a referral from your PCP.	Depends. You need a referral from your PCP only if you want to go to a specialist who is in the network. You do not need a referral to go to a specialist who is not in the network.	No. You do not need a referral to go to a specialist.

Getting More Information

How can you contact your health plan?

The information provided in this report covers HMOs and POS plans in New Jersey with large commercial enrollment. The table below lists all health plans approved to provide services in New Jersey. The columns to the right indicate whether the plan offers commercial coverage or participates in Medicare or Medicaid. Use the telephone numbers below to call the health plans that interest you.

Note: Not all plans offer coverage in all counties. Call the health plans or see your employer for details.

Health Plan	Telephone Number	Commercial	Medicare	Medicaid
Aetna U.S. Healthcare-New Jersey	(800) 323-9930	✔	✔	✔
AMERIGROUP New Jersey, Inc.	(800) 600-4441			✔
AmeriHealth, Inc.	(800) 877-9829	✔	✔	
AtlantiCare Health Plans	(800) 272-5995	✔		
CIGNA HealthCare of New Jersey, Inc.	(800) 345-9458	✔	✔	
Empire Health Care	(888) 476-8069	✔		
Horizon Healthcare of New Jersey, Inc.	(800) 355-2583	✔	✔	✔
Managed Healthcare Systems of New Jersey, Inc.	(800) 941-4647			✔
One Health Plan of New Jersey, Inc.	(888) 999-8036	✔		
Oxford Health Plans-New Jersey, Inc.	(800) 444-6222	✔	✔	
Physicians Health Services of New Jersey, Inc.	(800) 441-5741	✔	✔	✔
Principal Health Care of Delaware, Inc.-New Jersey	(800) 833-7423	✔		
Prudential HealthCare-New Jersey	(800) 422-7399	✔		
QualCare, Inc.	(800) 254-0130	✔		
QualMed Plans for Health, Inc.	(800) 736-2096	✔	✔	
United Healthcare of New Jersey, Inc.	(800) 705-1691	✔	✔	
University Health Plans, Inc.	(800) 564-6847	✔		✔

Buyer's Guide

The Department of Banking and Insurance publishes a Buyer's Guide 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. The Buyer's Guides and additional information about health coverage options are also available at the Department of Banking and Insurance's web site: www.naic.org/nj/njhomepg.html.

Medicare and Medicaid

For information on Medicare options, call the New Jersey Department of Health and Senior Services at (800) 792-8820 or visit Medicare's web site: www.medicare.gov. For questions about Medicaid health plan options, call the New Jersey Department of Human Services at (800) 356-1561 or visit www.state.nj.us/humanservices/.

Sources of Information

How was the information in this report collected?

This report was prepared by the Department of Health and Senior Services with the assistance of the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization that assesses and reports on the quality of care provided by managed care organizations nationally. NCQA's web site is www.ncqa.org.

There are two sources for the performance information presented in this report, consumers and health plans.

Consumers

The Eagleton Institute's Center for Public Interest Polling at Rutgers University, an independent survey company, conducted a mail and telephone survey of a representative sample of members in each HMO or POS plan. Over 12,000 health plan members were surveyed for this report. The survey included adult health plan members and parents of children enrolled in the health plan. The satisfaction surveys used—Consumer Assessment of Health Plans Study (CAHPS®)—were developed by the U.S. Department of Health and Human Services, Agency for Health Care Policy and Research (AHCPR).

Health Plans

The health plans collected data using a "measuring tool" called HEDIS® developed by NCQA. Health plans collected the data in the same way so they can be compared fairly. To verify the accuracy of the HEDIS measures, the plans had to have their data verified by an independent NCQA-Certified auditor.

Technical Notes

Health plans were allowed the option of combining or reporting HEDIS results separately for their HMO and POS products. All the health plans in this report reported combined HMO and POS results when calculating HEDIS measures with the exception of Aetna U.S. Healthcare-New Jersey. The consumer survey, however, was conducted separately for HMO and POS products for health plans in this report.

Performance ratings (circles) indicate the results of statistical tests that compare a plan's score to the average score of all New Jersey plans. Due to differences in standard error that result from different sample sizes and response rates, plans may have the same score (bars), but receive different ratings (circles). For the CAHPS® survey, a plan's score is determined to be "higher" or "lower" than the average score for New Jersey plans if: (a) the difference is statistically significant; and (b) the plan's score differs from the average by at least +/- four percentage points.

Checking on Quality

The State of New Jersey, through the Department of Health and Senior Services, monitors the quality of care and services provided by HMOs and POS plans. The Department investigates consumers' complaints and conducts in-depth reviews of each plan. Plans are also required to obtain a quality audit by an independent review organization every three years.

Take Care of Kids

If you know of a child who is not covered by health insurance, please call (800) 701-0710 for information on New Jersey KidCare. Call today to learn about the State's new affordable children's health insurance program.

This report is available on the Department's web site at www.state.nj.us/health.

New Jersey Consumer Bill of Rights

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

- The right to have a doctor—not an administrator—make the decision to deny or limit coverage
- The right to appeal a decision to deny or limit coverage, first within the managed care plan, then through an independent organization for a $25 filing fee, reduced to $2 for hardship (see page 17 for more details)
- The right to no "gag rules"—doctors are allowed to discuss all treatment options even if they are not covered services
- The right to receive up to 120 days of continued coverage—if medically necessary—from a doctor who has been terminated by a managed care health plan
- 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 obtain a current directory of doctors within the network
- The right to have a choice of specialists following a referral
- The right of consumers with chronic disabilities to be referred to specialists who are experienced treating those disabilities
- The right to access a primary care provider or a back-up 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 from your managed care plan
- The right to have a plan pay for a medical screening exam in the emergency room to determine whether an emergency medical condition exists
- The right to no retaliation against you or your doctor for filing appeals

The 1999 New Jersey HMO Performance Report
is available at our web site: www.state.nj.us/health.