

2014

New Jersey

HMO and PPO

Performance

Report

Compare Your Choices



Chris Christie, Governor
Kim Guadagno, Lt. Governor



New Jersey
Department
of
Banking and
Insurance

Kenneth E. Kobylowski, Commissioner



May 2015

Dear Consumers:

We are pleased to present a combined Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) report for 2014. This year's report is expanded to include PPO data. The report contains information on the performance of New Jersey's HMOs and PPOs 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.

Kenneth E. Kobylowski
Commissioner
Department of Banking and Insurance

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 at DOBI.

In 2014 DOBI is expanding this report on health plan performance by including data for PPOs. DOBI has compiled a single performance report to show side-by-side results of 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 2012 and 2013. For HMOs the information combines plan performance for the HMO and Point of Service (POS)* products. For PPOs, the information combines plan performance for all PPO products offered.

This report contains information on the following HMO and PPO products:

- ▶ **Aetna-HMO/POS & PPO** (Aetna Health Inc. – a New Jersey corporation; Aetna Life Ins. Co.)
- ▶ **AmeriHealth-HMO/POS & PPO** (AmeriHealth HMO; AmeriHealth Ins. Co. of NJ)
- ▶ **Cigna-HMO/POS & PPO** (Cigna HealthCare of NJ, Inc.; Cigna Health and Life Ins.)
- ▶ **Horizon-HMO & PPO** (Horizon Healthcare of NJ; Horizon BCBS of NJ)
- ▶ **United/Oxford-HMO/POS & PPO** (Oxford Health Plans of NJ; Oxford Health Ins., United Healthcare Ins. Co.)

This report does not include performance for New Jersey Department of Human Services programs (NJ FamilyCare). *See page 35 for ways you can obtain information on these programs.*

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 32 for more details).

***For information on contacting these and other
New Jersey plans, see page 33.***

This report is also available on the Department's web site:

<http://www.state.nj.us/dobi/lifehealthactuarial/hmo2014/>

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

* 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.

New Jersey HMO & PPO Performance Report

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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 cost.

This report provides information about how well HMO & 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 or health care provider is available in the HMO's or PPOs 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:

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

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

HMO/POS & PPO	Testing for breast cancer %	Testing for cervical cancer %	Testing for colorectal cancer %	Immunizations for children %
HMO				
Aetna - HMO/POS	69	78	64	77
AmeriHealth - HMO/POS	67	76	50	71
Cigna - HMO/POS	71	81	61	79
Horizon - HMO	66	67	62	74
Oxford - HMO/POS	67	77	53	70
PPO				
Aetna - PPO	67	79	57	75
AmeriHealth - PPO	72	80	58	70
Cigna - PPO	65	79	53	80
Horizon - PPO	62	66	55	70
Oxford - PPO	68	76	53	67
United - PPO	65	78	58	68

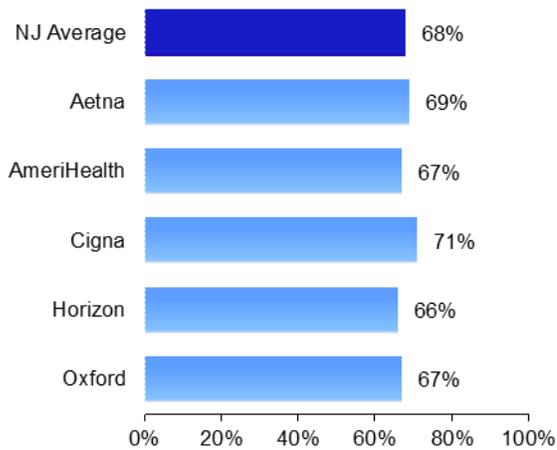
See the next page for each HMO's & PPO's score →

Testing for breast cancer

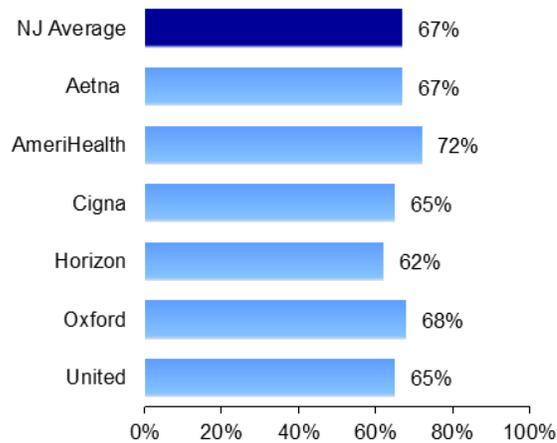
Mammograms are recommended for detection of breast cancer. Percentage of women aged 42–69 who received a mammogram within the past two years.

A higher percentage rate is better for the Breast Cancer Screening measure. It shows that more women did get a mammogram within the measurement year.

HMO



PPO

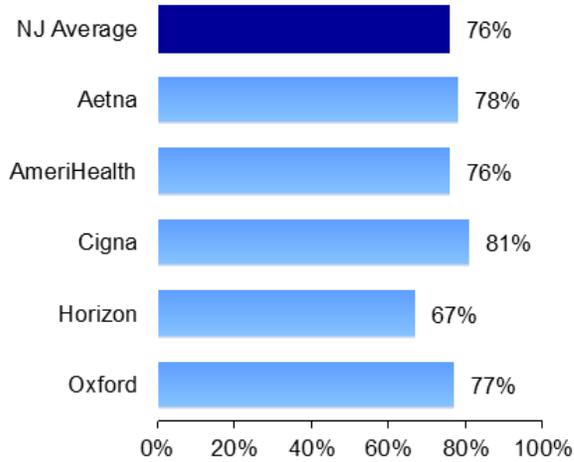


Testing for cervical cancer

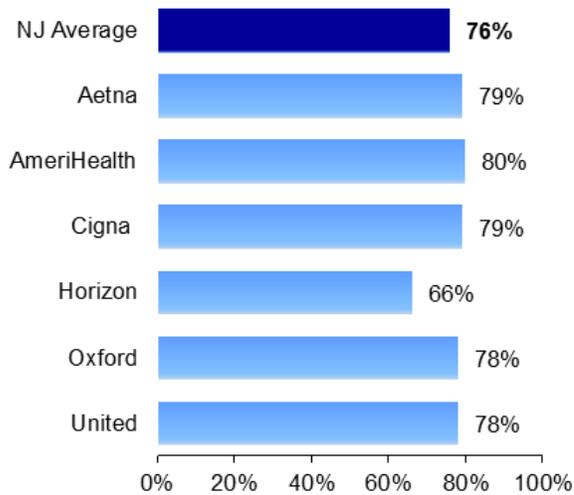
Pap smears are recommended for detection of cervical cancer. Percentage of women aged 21–64 who received a Pap test within the past three years.

A higher percentage rate is better for the cervical cancer screening measure. It shows that more women did get a Pap test within a given timeframe.

HMO



PPO

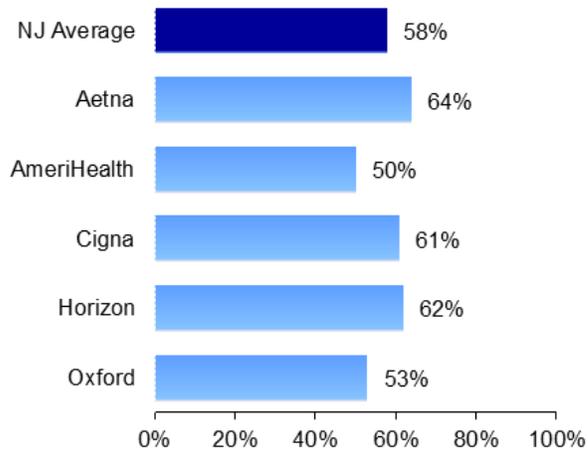


Colorectal Cancer Screening

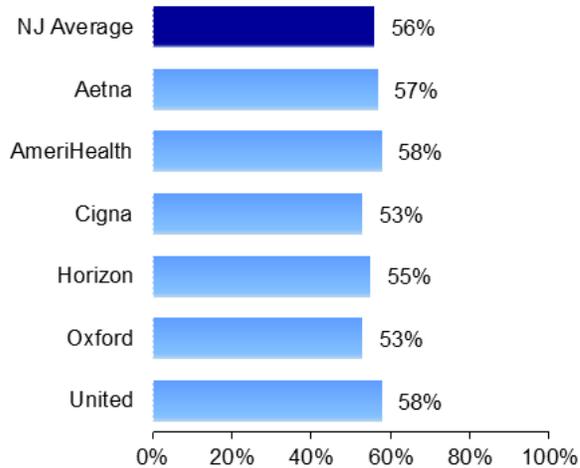
Colonoscopy is used to look for early signs of colorectal cancer. Percentage of members 50-75 who had appropriate screening for colorectal cancer.

A higher percentage rate is better for the colorectal cancer screening measure. It shows that more adults of 50-75 age groups did get screened for colorectal cancer.

HMO



PPO

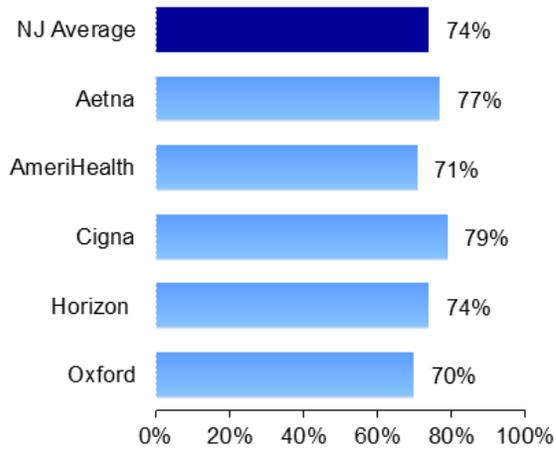


Immunizations for children

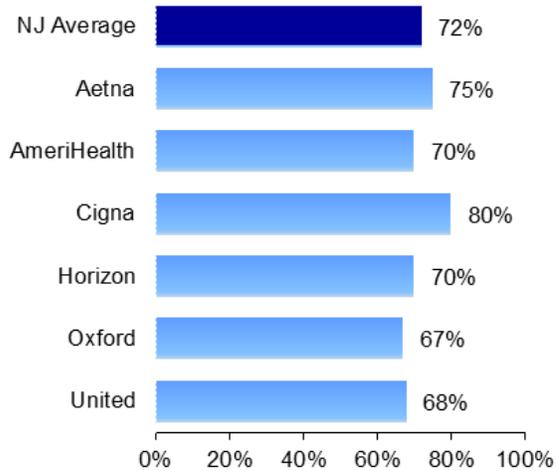
Immunizations prevent childhood diseases such as polio, measles, mumps, rubella and whooping cough. Percentage of children who received recommended immunizations by age two.

A higher percentage rate is better for the childhood immunization status. A higher percentage shows that more children did get all their required immunizations.

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.

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

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

HMO/POS & PPO	Testing children with pharyngitis for strep %	Treatment for children with upper respiratory infection %	Avoidance of antibiotic treatment in adults w/ acute bronchitis %	Use of spirometry testing in diagnosis of COPD %
HMO				
Aetna - HMO/POS	82	86	19	45
AmeriHealth - HMO/POS	84	86	23	35
Cigna - HMO/POS	78	88	18	46
Horizon - HMO	83	83	24	47
Oxford - HMO/POS	86	84	30	49
PPO				
Aetna - PPO	84	86	20	48
AmeriHealth - PPO	83	89	20	45
Cigna - PPO	82	87	20	49
Horizon - PPO	79	86	31	44
Oxford - PPO	82	89	40	47
United - PPO	83	86	20	47

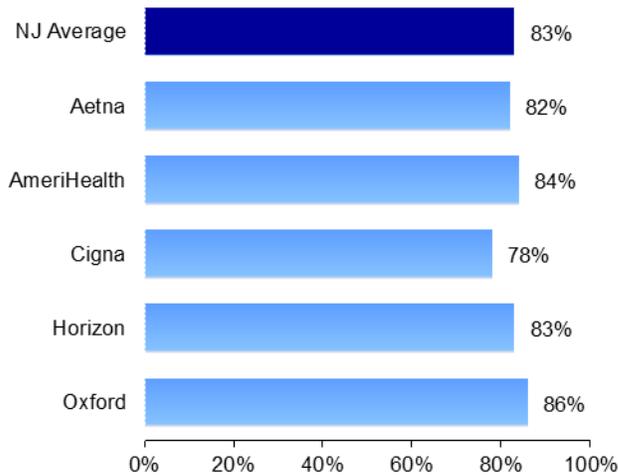
See the next page for each HMO's & PPO's score →

Testing children with pharyngitis for strep

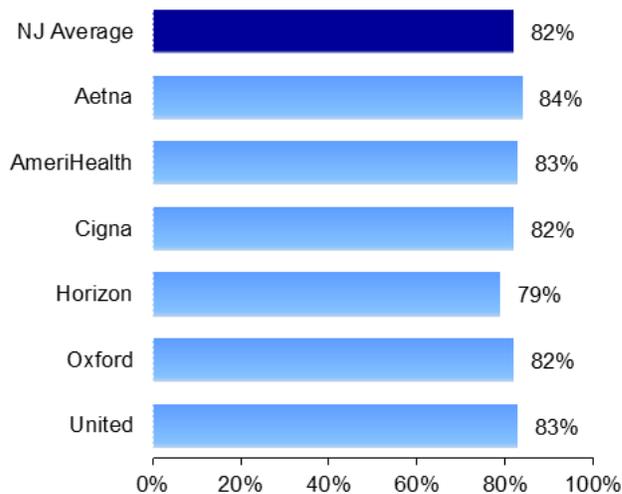
Strep testing is recommended for detection of pharyngitis. The percentage of children 2-18 years of age diagnosed with pharyngitis and dispensed an antibiotic who also received a strep test for the episode.

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

HMO



PPO

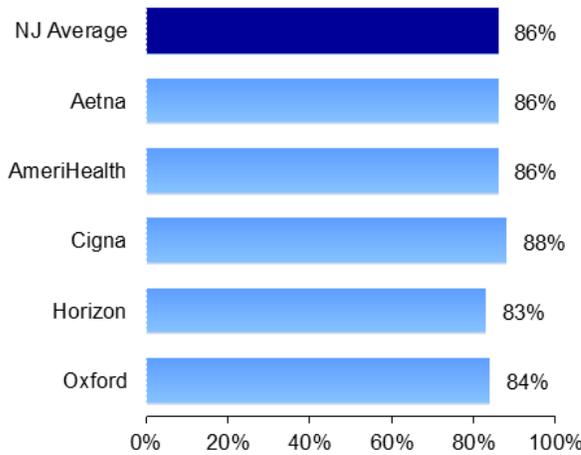


Avoidance of antibiotic treatment* for children with upper respiratory infection (URI)

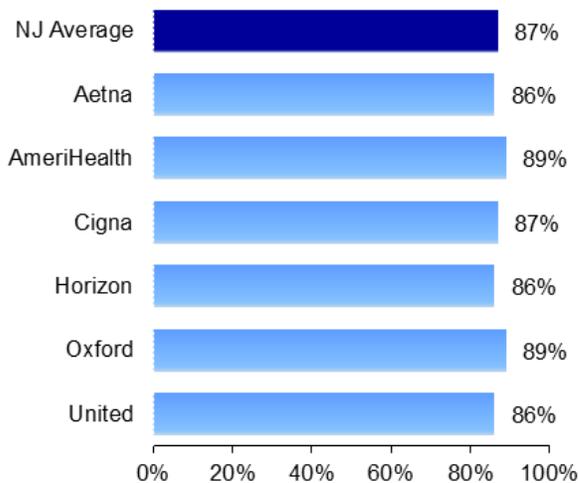
An upper respiratory infection (URI), is one of the most common illnesses, leading to more doctor visits. The percentage of children 3 months to 18 years of age with a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic.

A higher percentage rate is better for this health measure. That means more infants, children and adolescents did not get an inappropriate and unnecessary antibiotic prescription.

HMO



PPO



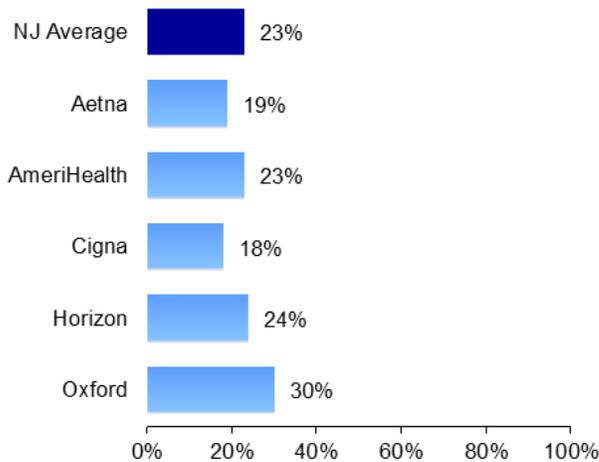
* Inappropriate use of antibiotics has been shown to promote resistant bacteria that are more difficult to treat. The federal Center for Disease Control and Prevention (CDC) and other organizations urge physicians to avoid prescribing antibiotics when not medically indicated.

Avoidance of antibiotic treatment* in adults with acute bronchitis

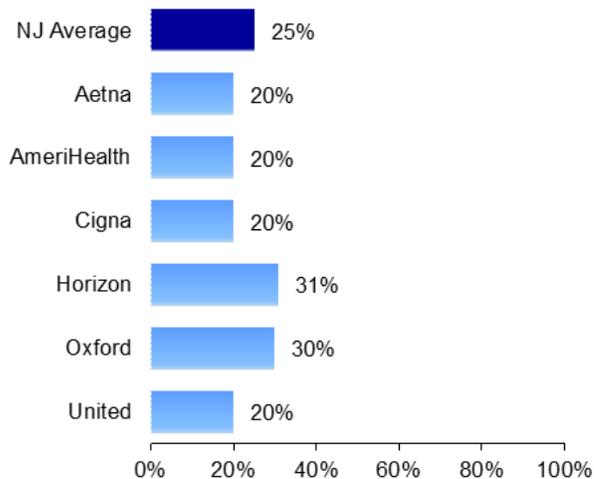
Use of antibiotics usually is not an appropriate treatment for acute bronchitis. The percentage of adults ages 18-64 years with a diagnosis of acute bronchitis and were not dispensed an antibiotic prescription.

A higher percentage rate is better for this health measure. A higher percentage rate indicates more adults with acute bronchitis were appropriately treated, but not given unnecessary antibiotic medication as part of their treatment.

HMO



PPO



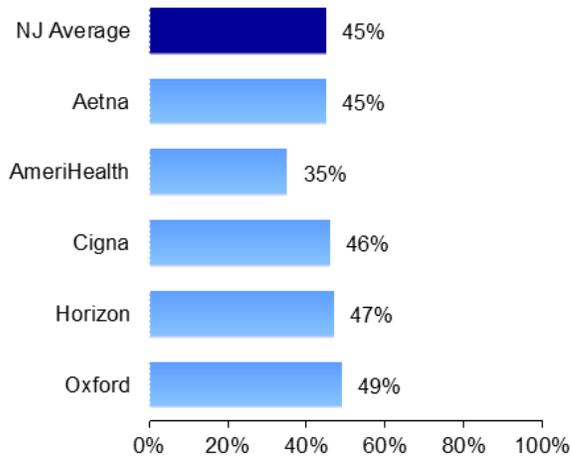
* Inappropriate use of antibiotics has been shown to promote resistant bacteria that are more difficult to treat. The federal Center for Disease Control and Prevention (CDC) and other organizations urge physicians to avoid prescribing antibiotics when not medically indicated.

Use of spirometry testing in the assessment and diagnosis of COPD

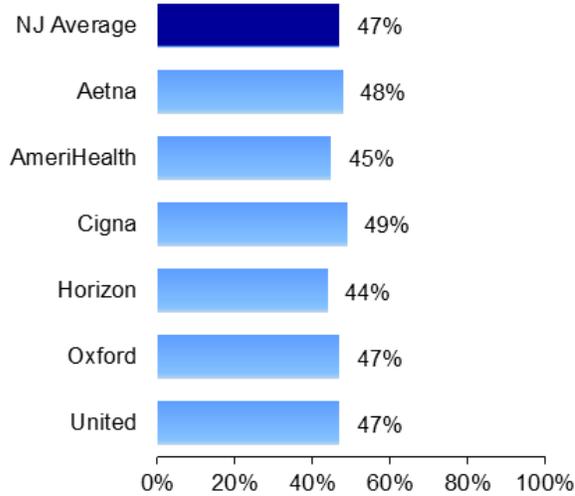
Spirometry testing measures air flow through the lungs and can confirm a COPD diagnosis. Members, 40 years of age and older, with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

A higher percentage rate is better for this measure. It means that more adults who are 40 and above this age got the best diagnostic test for COPD (a lung function test called spirometry).

HMO



PPO



Getting Better/Living with Illness

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:

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

The following tables show how well each HMOs and PPOs performed and the average in New Jersey.

HMO/POS & PPO	Management of medicine for depression %	Care after hospitalization for mental illness %	Follow-up care for children prescribed ADHD medications	Appropriate medications for asthma %
HMO				
Aetna - HMO/POS	71	76	38	97
AmeriHealth - HMO/POS	68	60	19	100
Cigna - HMO/POS	60	84	NA	NA
Horizon - HMO	74	76	40	93
Oxford - HMO/POS	66	70	46	96
PPO				
Aetna - PPO	76	75	42	96
AmeriHealth - PPO	72	61	37	97
Cigna - PPO	58	72	49	95
Horizon - PPO	75	68	36	95
Oxford - PPO	68	64	54	87
United - PPO	61	78	42	96

NA - not applicable due to insufficient data

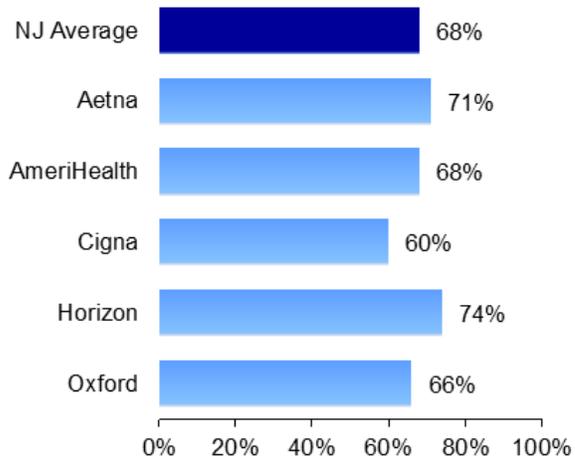
See the next page for each HMO's & PPO's score →

Management of medicine for depression

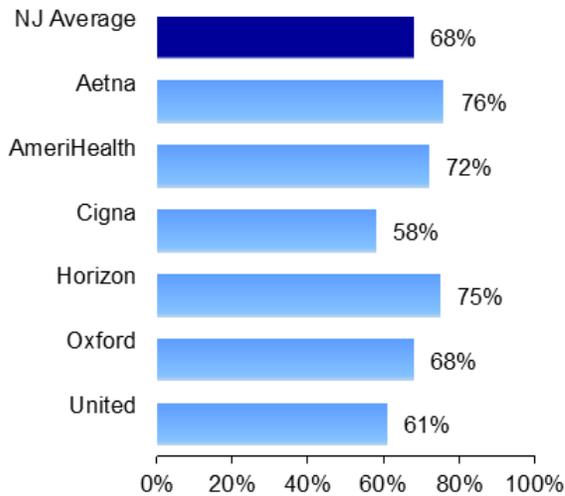
People taking medicine for depression need to be monitored. Percent of members given medicine for depression who had follow-up visits in the measurement year.

A higher percentage is better for the effective acute phase treatment. That means that more adults with depression were effectively treated with 12 weeks of antidepressant medication during the acute phase of treatment.

HMO



PPO

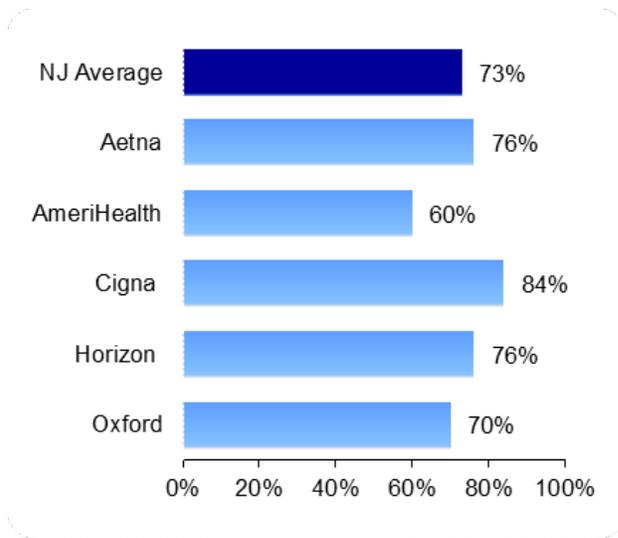


Care after hospitalization for mental illness

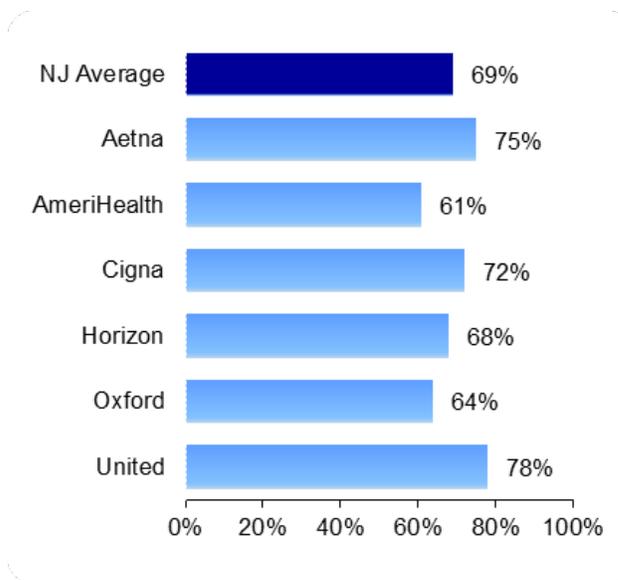
Therapy after a hospital stay for mental illness is important for recovery. Percent of members hospitalized for mental illness who received care afterwards.

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

HMO



PPO

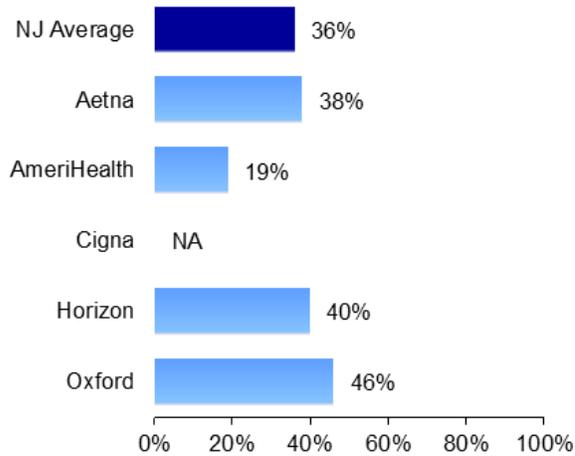


Follow-up care for children prescribed ADHD medications

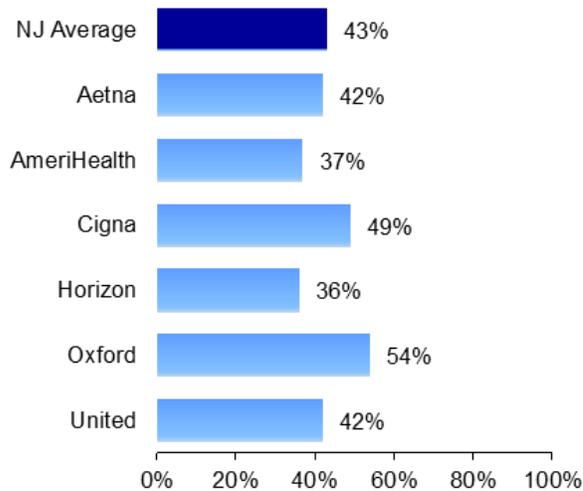
Children prescribed ADHD medications need to be monitored. Percent of members given medicine for Initiation Phase of ADHD who had follow-up visit within 30 days of Initiation-Phase.

For the Initiation phase of follow-up care for children prescribed ADHD medications, a higher percentage rate is better; this means that more children got a follow-up visit during the 30-day initiation phase.

HMO



PPO

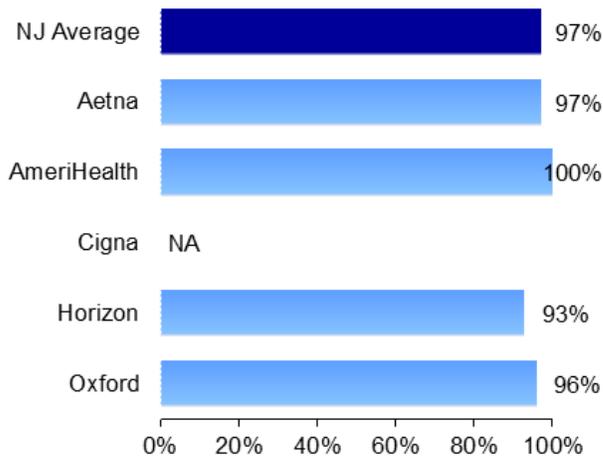


Appropriate medications for asthma (children)

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

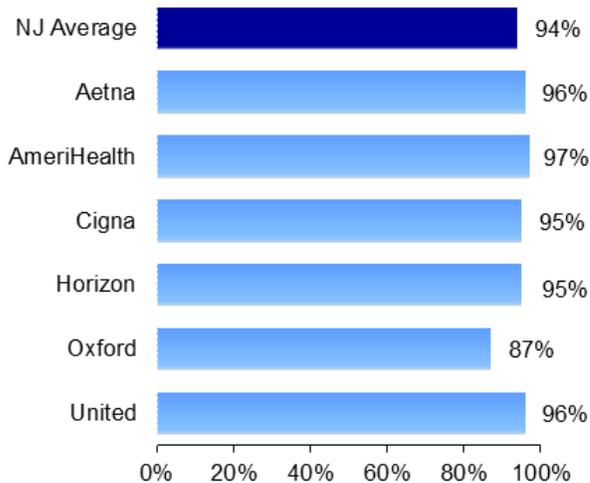
A higher percentage rate is better for this performance indicator. This means that more children ages 5-11 years with asthma were appropriately prescribed asthma medications.

HMO



NA - Not applicable as data samples are too small

PPO



Getting Better/Living with Illness (continued)

How well does the HMO or PPO care for members who 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:

- Controlling high blood pressure
- Cholesterol management of heart patients
- Blood sugar testing for people with diabetes
- Eye exams for people with diabetes

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

HMO/POS & PPO	Controlling high blood pressure %	Cholesterol management of heart patients %	Blood sugar testing for people with diabetes %	Eye exams for people with diabetes %
HMO				
Aetna - HMO/POS	59	51	86	55
AmeriHealth - HMO/POS	60	64	87	44
Cigna - HMO/POS	68	60	89	54
Horizon - HMO	66	56	86	55
Oxford - HMO/POS	44	88	86	46
PPO				
Aetna - PPO	54	53	88	52
AmeriHealth - PPO	62	63	84	47
Cigna - PPO	63	65	88	49
Horizon - PPO	67	52	88	47
Oxford - PPO	45	NR	86	42
United - PPO	47	NR	86	45

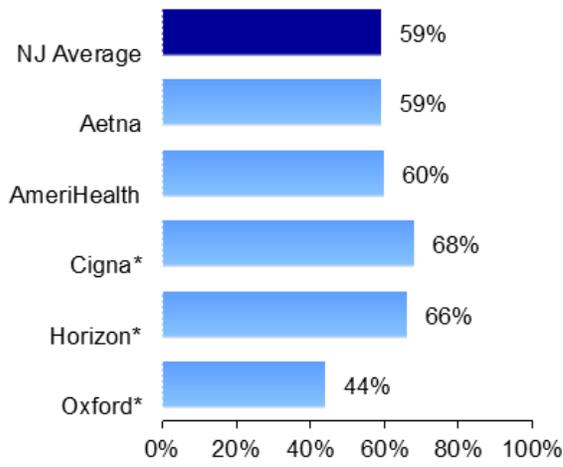
See the next page for each HMO's & PPO's score →

Controlling high blood pressure

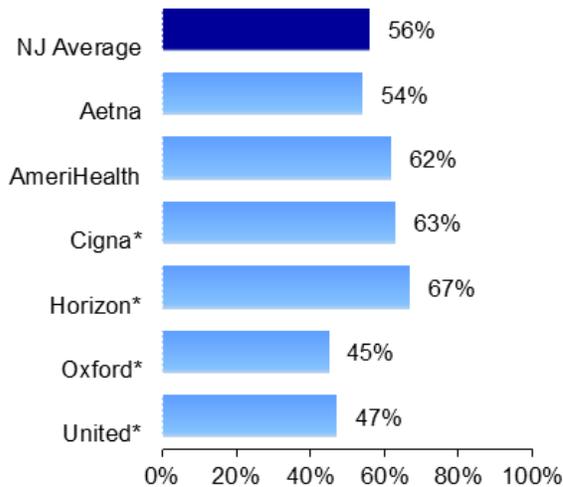
High blood pressure (hypertension) is a major risk factor for a number of diseases. Percent of members aged 18–85 with hypertension whose blood pressure was under control at their most recent medical visit.

A higher percentage rate is better for this health measure. A higher percentage shows that more adults with hypertension did get adequate control of their blood pressure.

HMO



PPO



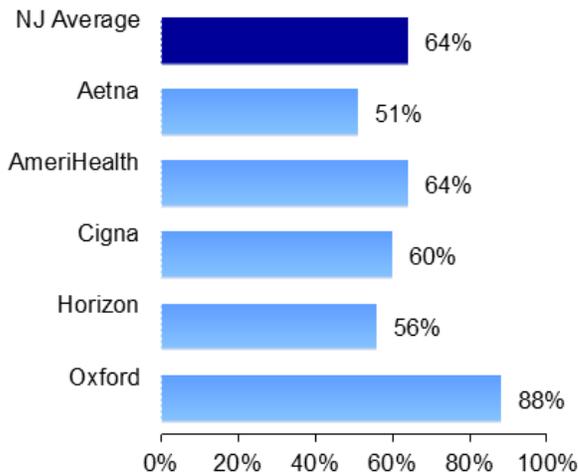
* 2012 data

Cholesterol management of heart patients

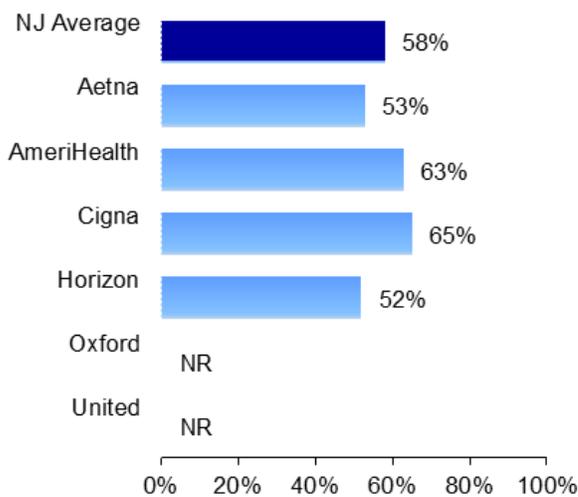
Reducing cholesterol lowers the chances of having a heart attack. Percentage of members with heart conditions who had their cholesterol level controlled.

For the cholesterol management measure, a higher percentage is better. This means that more adults ages 18-75 years, achieved good cholesterol control with LDL-C levels <100mg/dl, due to close monitoring of LDL cholesterol.

HMO



PPO



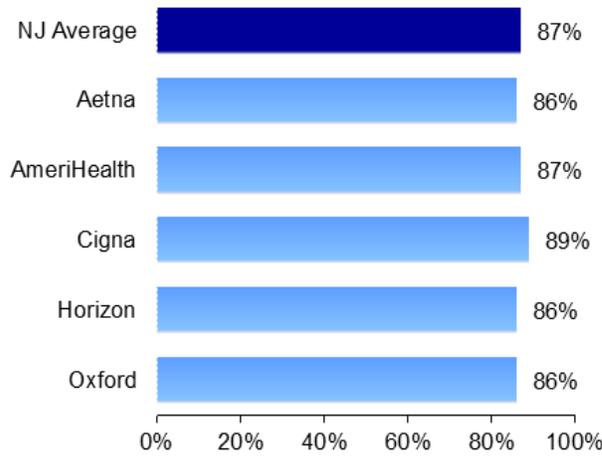
NR – Not reported

Blood sugar testing for people with diabetes

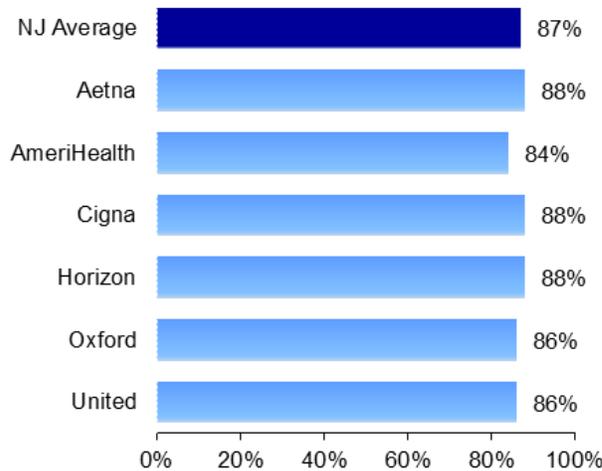
Controlling blood sugar levels can prevent complications from diabetes. Percent of members with diabetes who had a blood sugar (HbA1C) test in the measurement year.

A higher percentage rate is better for this measure. It means that more diabetic adults 18-75 years of age received appropriate HbA1c testing.

HMO



PPO

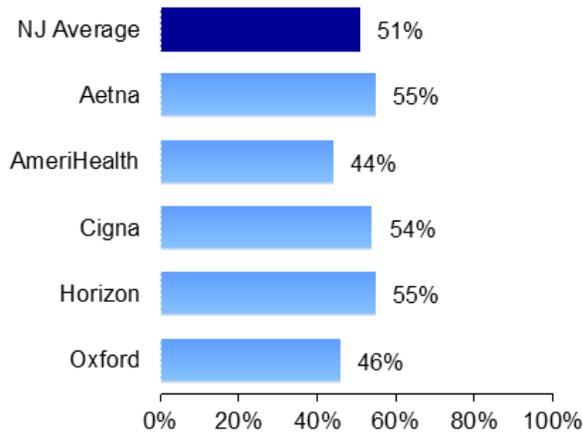


Eye exams for people with diabetes

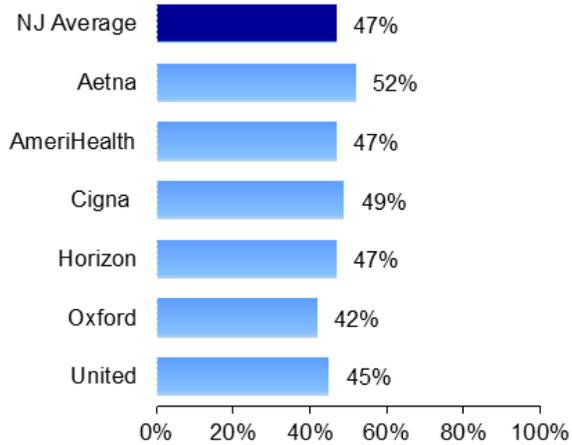
Regular eye exams can reduce the risk of blindness from diabetes. Percent of members with diabetes who received an eye exam during the measurement year.

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

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:

- HbA1c poor control (>9.0%) for people with diabetes
- Persistence of beta blocker treatment after a heart attack
- Check-ups for new mothers
- Use of imaging studies for low back pain

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

HMO/POS & PPO	HbA1c poor control (>9.0%) for people w/ diabetes %	Persistent of beta blocker treatment after heart attack %	Check-ups for new mothers %	Use of imaging studies for low back pain
HMO				
Aetna - HMO/POS	37	89	75	76
AmeriHealth - HMO/POS	33	84	81	73
Cigna - HMO/POS	26	NA	76	75
Horizon - HMO	28	84	85	74
Oxford - HMO/POS	35	82	69	70
PPO				
Aetna - PPO	32	89	72	72
AmeriHealth - PPO	37	79	78	71
Cigna - PPO	31	87	79	76
Horizon - PPO	26	81	85	72
Oxford - PPO	35	63	67	66
United - PPO	37	76	64	73

NA – Not applicable due to small sample size

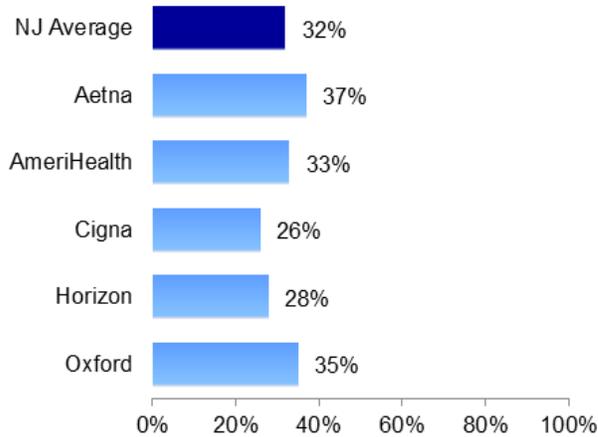
See the next page for each HMO's & PPO's score →

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

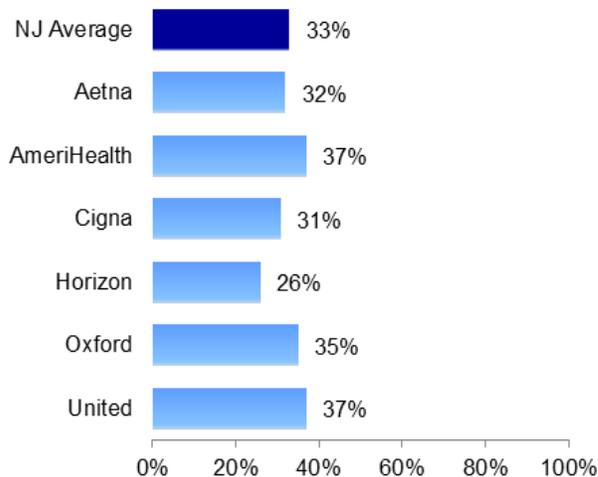
The percentage of members ages 18 to 75 years with type 1 and type 2 diabetes who had HbA1c testing during measurement year 2013 and who displayed poor HbA1c control (> 9.0%).

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

HMO



PPO

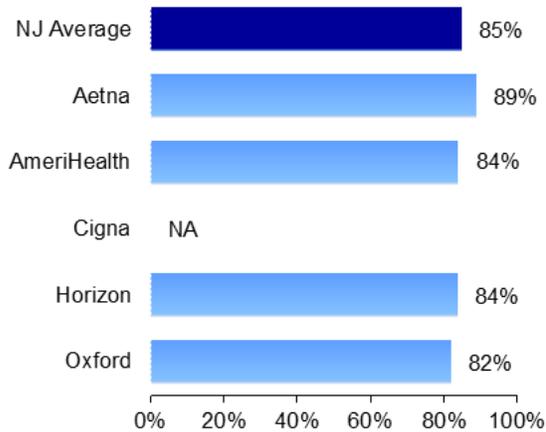


Persistence of beta blocker treatment after a heart attack

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

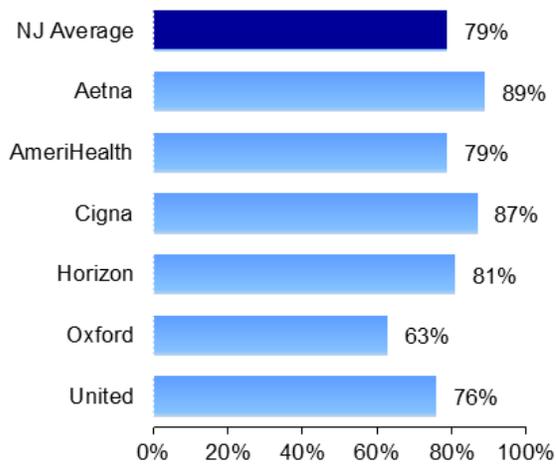
A higher percentage is better for this measure. It means that more adults with a history of having a heart attack received at least six months of beta-blocker treatment.

HMO



NA - Not applicable due to small sample size

PPO

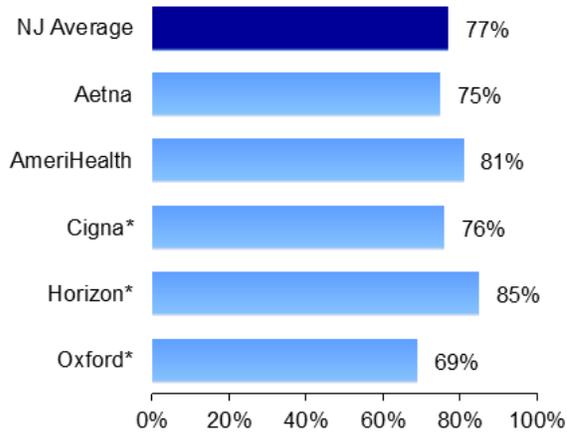


Check-ups for new mothers

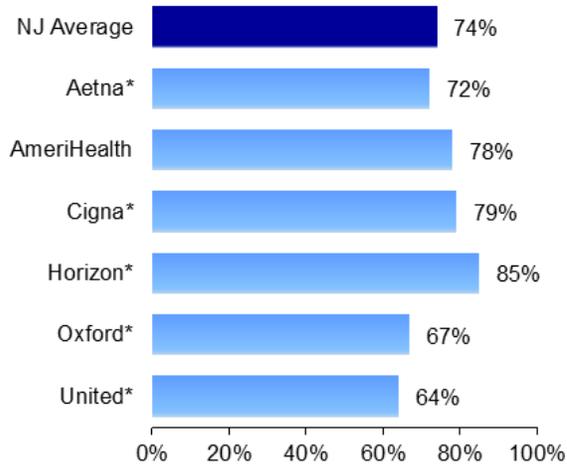
During a visit, providers can check a new mother's recovery from childbirth and answer questions. Percent of new mothers who received a check-up within eight weeks after delivery.

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

HMO



PPO



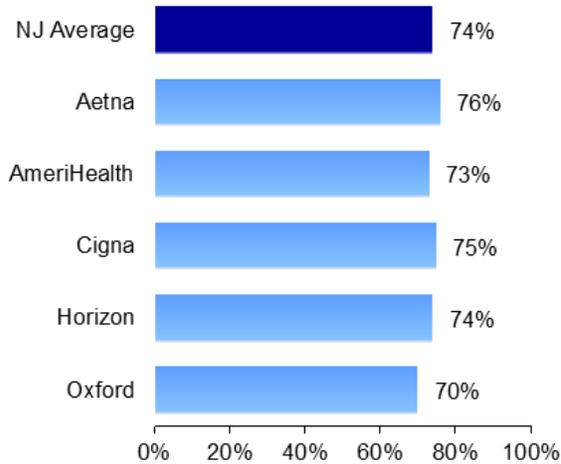
* 2012 data

Imaging Studies for Low Back Pain

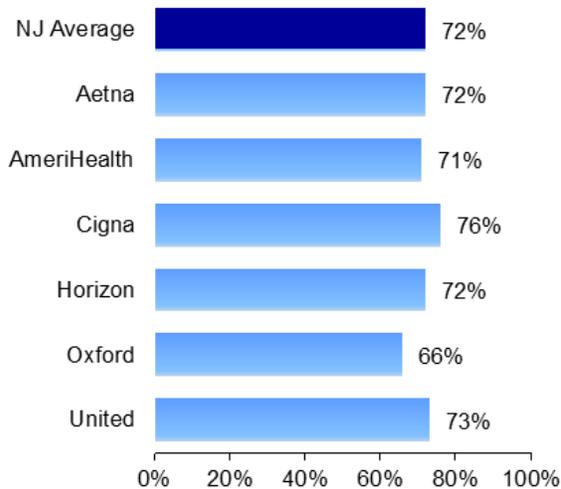
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis. A higher rate indicates appropriate treatment of low back pain.

A higher percentage rate is better for this measure. This means that more adults with low back pain appropriately did not get an imaging study done. Imaging studies are mostly overused.

HMO



PPO



Frequencies of selected Procedures - HMO

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

Procedure	Age	Sex	2013 Number of Procedures	2014 Number of Procedures	2013 Procedures / 1,000 Member Years	2014 Procedures / 1,000 Member Years
Aetna						
Tonsillectomy	0-9	Male & Female	322	215	7.55	6.54
	10-19		203	146	3.17	2.86
Cardiac Catheterization	45-64	Male	656	496	9.26	8.57
		Female	407	338	5.33	5.40
	65+	Male	140	116	20.1	19.99
		Female	86	63	13.86	11.99
AmeriHealth						
Tonsillectomy	0-9	Male & Female	51	40	8.89	6.26
	10-19		18	20	2.58	2.52
Cardiac Catheterization	45-64	Male	78	96	8.57	8.77
		Female	40	40	4.73	3.93
	65+	Male	15	9	29.81	15.70
		Female	7	5	17.08	10.57
Cigna						
Tonsillectomy	0-9	Male & Female	37	17	6	5.06
	10-19		22	10	2.81	2.59
Cardiac Catheterization	45-64	Male	62	32	8.61	8.89
		Female	43	20	5.57	5.32
	65+	Male	32	10	23.68	29.38
		Female	32	6	25.33	23.12
Horizon						
Tonsillectomy	0-9	Male & Female	853	834	6.33	6.09
	10-19		477	464	2.76	2.66
Cardiac Catheterization	45-64	Male	1864	1820	10.13	10.33
		Female	1181	1108	5.64	5.5
	65+	Male	491	634	21.86	26.86
		Female	262	253	13.83	12.56
Oxford						
Tonsillectomy	0-9	Male & Female	93	90	4.91	5.08
	10-19		42	47	1.88	2.17
Cardiac Catheterization	45-64	Male	166	142	7.12	6.25
		Female	85	69	3.61	3.01
	65+	Male	18	18	13.98	14.05
		Female	6	7	6.24	7.43

Frequencies of selected Procedures - PPO

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

Procedure	Age	Sex	2014 Number of Procedures	2014 Procedures / 1,000 Member Years
Aetna				
Tonsillectomy	0-9	Male & Female	456	5.14
	10-19		216	2.10
Cardiac Catheterization	45-64	Male	688	6.50
		Female	528	4.66
	65+	Male	217	19.64
		Female	122	12.30
AmeriHealth				
Tonsillectomy	0-9	Male & Female	50	6.21
	10-19		32	3.08
Cardiac Catheterization	45-64	Male	119	9.17
		Female	55	3.92
	65+	Male	35	26.57
		Female	8	7.85
Cigna				
Tonsillectomy	0-9	Male & Female	222	4.65
	10-19		129	2.30
Cardiac Catheterization	45-64	Male	456	7.69
		Female	240	3.99
	65+	Male	160	21.65
		Female	83	11.90
Horizon				
Tonsillectomy	0-9	Male & Female	284	4.88
	10-19		165	2.33
Cardiac Catheterization	45-64	Male	723	9.10
		Female	402	4.43
	65+	Male	292	26.82
		Female	130	13.22
Oxford				
Tonsillectomy	0-9	Male & Female	40	5.47
	10-19		28	2.97
Cardiac Catheterization	45-64	Male	89	8.12
		Female	39	3.08
	65+	Male	18	15.68
		Female	15	15.67
United				
Tonsillectomy	0-9	Male & Female	306	4.27
	10-19		148	1.97
Cardiac Catheterization	45-64	Male	502	6.66
		Female	279	3.52
	65+	Male	183	16.20
		Female	133	12.35

Choosing Your HMO & PPO

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

Looking at HMO & PPO quality, along with 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 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: www.ncqa.org or <http://reportcard.ncqa.org/plan/external/plansearch.aspx>

Choice of Providers

- ▶ Make sure that your preferred doctor, hospital and other providers participate in the HMO's 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 32 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 your evidence of coverage or member handbook or calling the member services department.

- ▶ Consider your special needs and circumstances such as chronic health conditions, elder care, frequent travel, language, retirement 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 And 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 dollar, day or visit limits for specific services.

Accreditation

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

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

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

Contacting Your HMO & 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/POS & PPO		
Health Plans	Telephone	Web site
Aetna Health, Inc. - New Jersey Corp. Aetna Life Insurance Company	(800) 872-3862	www.aetna.com
AmeriChoice of New Jersey	(800) 941-4647	www.uhccommunityplan.com
AMERIGROUP New Jersey	(800) 600-4441	www.amerigroupcorp.com
AmeriHealth HMO AmeriHealth Insurance Company of New Jersey	(888) 968-7241	www.amerihealth.com
Bravo Health Pennsylvania, Inc.	(800)-235-9188	www.bravohealth.com
Cigna HealthCare of New Jersey Cigna Health and Life Insurance Co. of New Jersey	(800) 345-9458	www.cigna.com
Geisinger Health Plan	(800) 631-1656	www.thehealthplan.com
Horizon Healthcare of New Jersey Horizon BCBS of New Jersey	(800) 355-2583	www.horizonblue.com
Humana Wisconsin Health Organization Ins. Corp.	(800) 486-2620	www.humana.com
UnitedHealthCare Insurance Co. Oxford Health Plans - New Jersey Oxford Health Insurance Co.	(800) 444-6222	www.uhc.com
WellCare Health Plan of New Jersey	(866) 687-8570	www.wellcare.com

CARRIERS AS OF JULY 1, 2014

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 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 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.

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
<http://www.state.nj.us/dobi/managed.htm>

Health Care Carrier Accountability Act

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

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 35

Other Important Resources

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

Department of Banking and Insurance

Buyers Guides and other information are available for individual and small employer coverage. This information is on the New Jersey Department of Banking and Insurance's (DOBI) web site at

http://www.state.nj.us/dobi/division_insurance/ihcseh/index.html. You may also request information by calling (609) 633-1882 and pressing option "3". DOBI monitors the compliance of HMOs 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 www.state.nj.us/dobi/managed.htm or call the Office of Managed Care toll-free at (888) 393-1062.

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

Medicare

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

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: www.njfamilycare.org or www.state.nj.us/humanservices.

Physicians

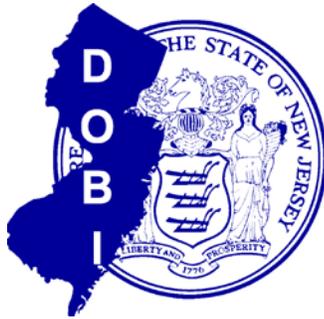
For information on New Jersey physicians, including disciplinary actions, call the New Jersey State Board of Medical Examiners at (609) 826-7100 or visit <http://www.state.nj.us/lps/ca/bme/index.html>

Additional Health Care Information

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

Self-Funded Plans

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



New Jersey
Department
of
Banking and
Insurance

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

<http://www.state.nj.us/dobi/lifehealthactuarial/hmo2014/>