2005 New Jersey

HMO PERFORMANCE REPORT

Richard J. Codey
Acting Governor

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

Fred M. Jacobs, M.D., J.D.
Commissioner

DEPARTMENT OF BANKING AND INSURANCE

Donald Bryan
Acting Commissioner

September 2005

Dear Consumers:

We are pleased to present the ninth annual *New Jersey HMO Performance Report.* This report contains information on the performance of New Jersey's managed health care plans, how well these plans deliver important health care services, and how members rate the services they receive.

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

New Jersey 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.

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Fred M. Jacobs, M.D., J.D.
Commissioner
Department of Health and Senior Services

Donald Bryan
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Department of Banking and Insurance

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

This report includes information on New Jersey commercial health plans' health maintenance organization (HMO) and point-of-service (POS) products. The report includes all such health plans currently marketed in New Jersey that had at least 2,000 members in both 2003 and 2004. For most plans the information combines plan performance for the HMO and POS products. *See page 20 for more information about the distinction between HMO and POS products.*

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

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

This report contains information on the following health plans:

- **Aetna–HMO/POS** (Aetna Health, Inc.–New Jersey)
- **AmeriHealth–HMO/POS** (AmeriHealth HMO)
- **CIGNA–HMO/POS** (CIGNA HealthCare of New Jersey)
- **Health Net–HMO/POS** (Health Net of New Jersey, Inc.)
- **Horizon–HMO** (Horizon Healthcare of New Jersey)
- **Oxford–HMO/POS** (Oxford Health Plans–New Jersey)
- **United–HMO/POS** (UnitedHealthcare of New Jersey, Inc.)
- **WellChoice–HMO** (WellChoice HMO of New Jersey)*

*WellChoice is also known as Empire HealthChoice.

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

For additional copies of this report, please contact the Office of Health Care Quality Assessment, Division of Health Care Quality & Oversight, New Jersey Department of Health and Senior Services, P.O. Box 360, Trenton, New Jersey 08625-0360; telephone (800) 418-1397; fax (609) 530-7478. There is a charge for multiple copies.

This report is also available on the Department's web site:
www.state.nj.us/health/hmo2005
or can be requested by e-mail:
hmo@doh.state.nj.us

Data analysis was provided by the Center for State Health Policy, Rutgers, the State University of New Jersey.

New Jersey HMO Performance Report

Contents

Quality Matters

Important Questions About Quality You Should Consider

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

This report provides information about:

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

Why is the quality of health care important?

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

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

What should you consider when choosing your health plan?

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

When choosing a health plan, consider:

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

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

Performance Summary

How New Jersey Health Plans Perform Overall

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

Higher than average scores mean better performance.

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

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

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

Service and Access

Are members satisfied with their health plan's services?

A comparison of each health plan's performance to the New Jersey plan average shows how effective the plans are in providing services to their members (pages 4 and 5).

Higher than average scores mean better performance.

HEALTH PLAN	Rating of health plan	Getting needed care	Claims processing	Customer service
Aetna–HMO/POS	●	●	●	●
AmeriHealth–HMO/POS	◒	◒	◒	◒
CIGNA–HMO/POS	◒	◒	◒	◒
Health Net–HMO/POS	◒	◒	◒	◒
Horizon–HMO	◒	◒	◒	◒
Oxford–HMO/POS	◒	◒	◒	◒
United–HMO/POS	◒	◒	◒	◒
WellChoice–HMO	◒	○	◒	◒

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

Performance Compared to the Average

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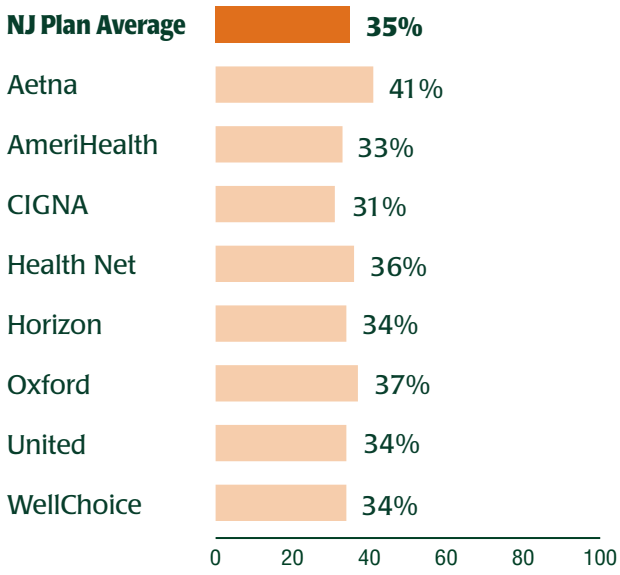
- ○ **Lower** than the New Jersey health plan average

See the next page for each health plan's scores

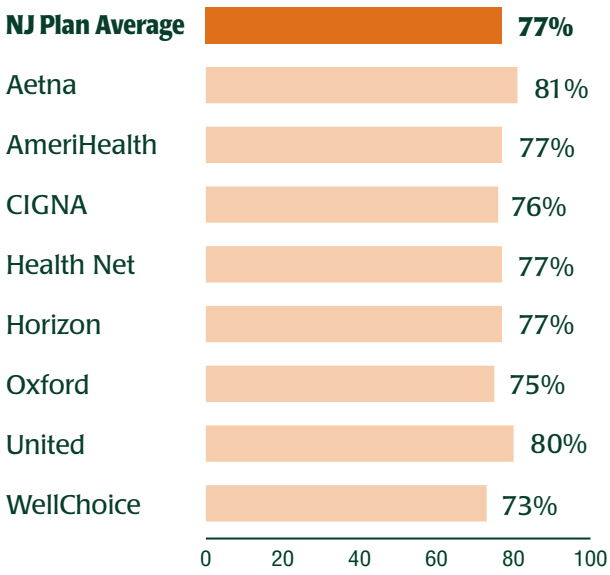
Rating of health plan

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



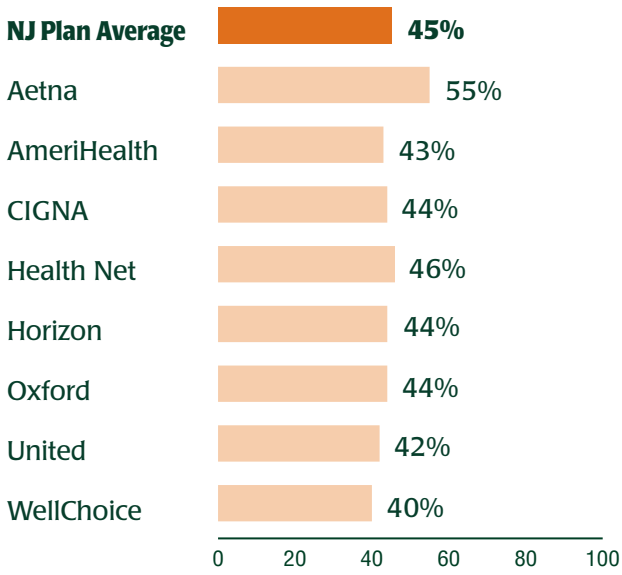
Getting needed care

Percent of members who reported *no problem* getting • a personal doctor they like • to see a specialist • necessary tests or treatment • timely approvals for care:



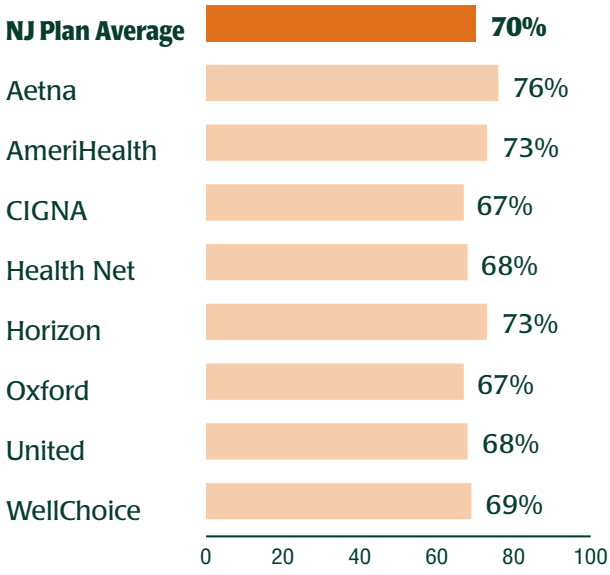
Claims processing

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



Customer service

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



Doctors and Medical Care

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

A comparison of each health plan's performance to the New Jersey plan average shows how effective the plans are in providing high quality medical care to their members (pages 6 and 7).

Higher than average scores mean better performance.

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

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

Performance Compared to the Average

- ● **Higher** than the New Jersey health plan average
- ◓ **About the Same** as the New Jersey health plan average
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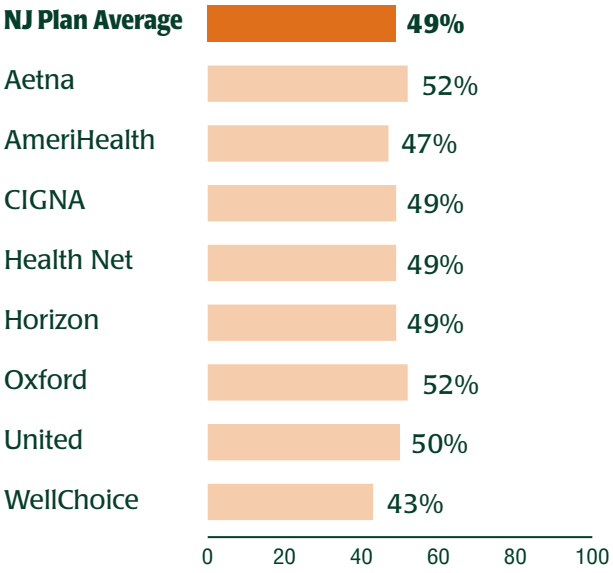
See the next page for each health plan's scores

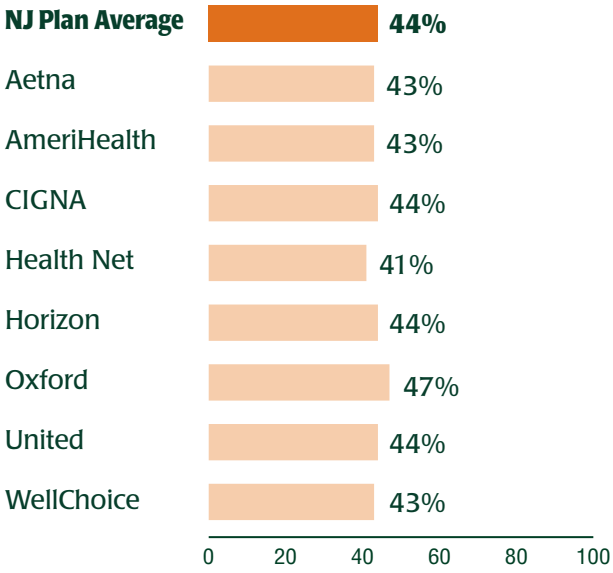
Rating of health care

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



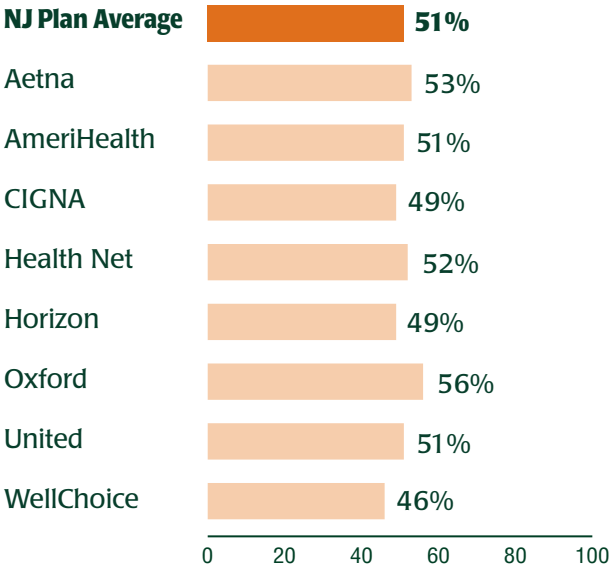
Getting care quickly

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



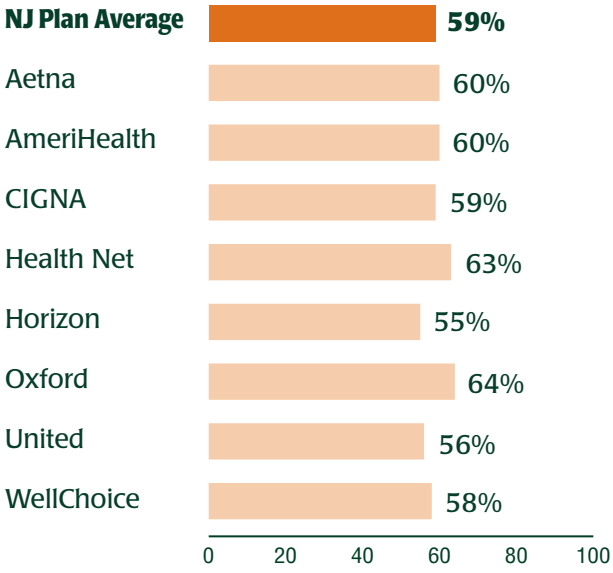
Rating of personal doctor

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



How well doctors communicate

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



Staying Healthy

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

A comparison of each health plan's performance to the New Jersey plan average shows how effective the plans are in working with doctors to provide important preventive services that help members stay healthy (pages 8 and 9).

Higher than average scores mean better performance.

HEALTH PLAN	Testing for breast cancer	Testing for cervical cancer	Check-ups for new mothers	Immunizations for children
Aetna–HMO/POS	◓	◓	◓	◓
AmeriHealth–HMO/POS	◓	◓	◓	◓
CIGNA–HMO/POS	◓	◓	●	◓
Health Net–HMO/POS	◓	◓	◓	◓
Horizon–HMO	◓	◓	●	●
Oxford–HMO/POS	◓	◓	◓	○
United–HMO/POS	◓	◓	○	○
WellChoice–HMO	○	◓	◓	◓

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

Performance Compared to the Average

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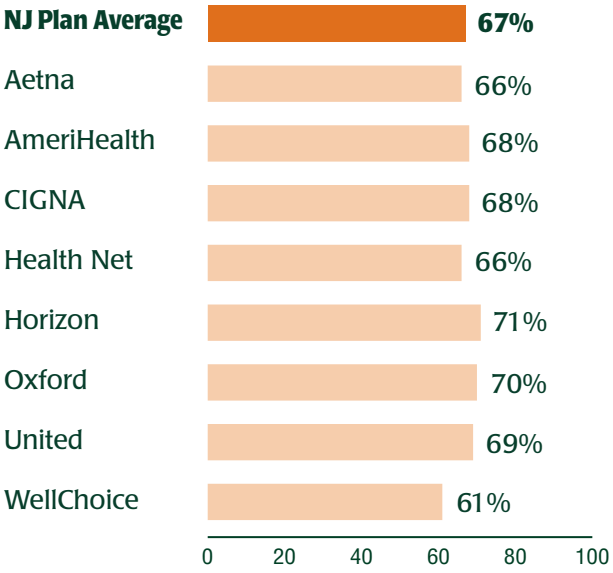
See the next page for each health plan's scores

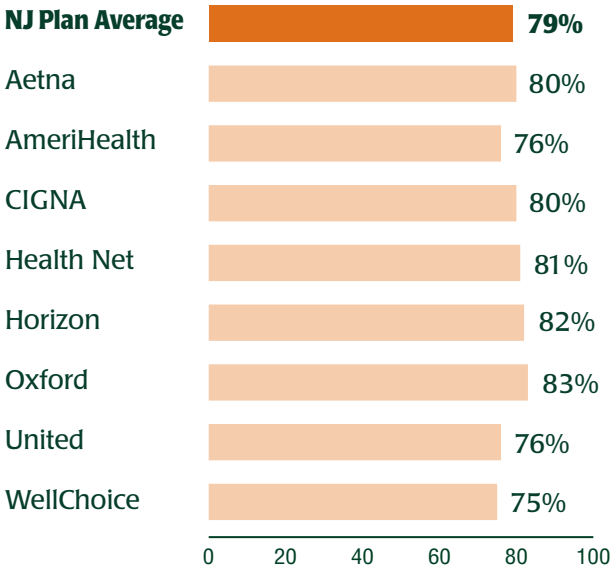
Testing for breast cancer

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



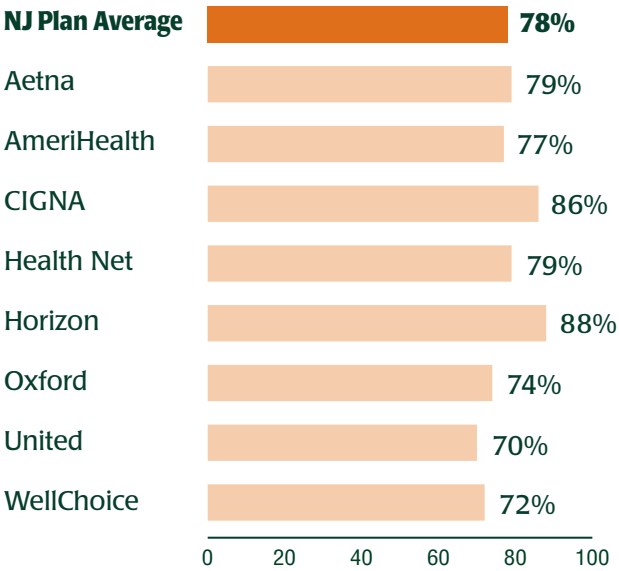
Testing for cervical cancer

Women are more likely to survive if cervical cancer is found early through a Pap test. Percent of women aged 18–64 who received a Pap test within the past three years:



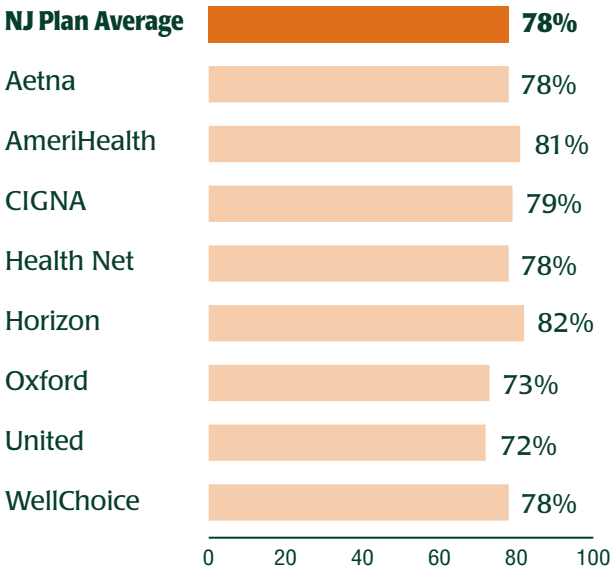
Check-ups for new mothers

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



Immunizations for children

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



Getting Better / Living with Illness

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

A comparison of each health plan's performance to the New Jersey plan average shows how effective the plans are in working with doctors to care for members who are sick or living with chronic illness (pages 10–13).

Higher than average scores mean better performance.

HEALTH PLAN	Management of medicine for depression	Care after hospitalization for mental illness	Appropriate medications for asthma (children)	Controlling high blood pressure
Aetna–HMO/POS	○	●	◒	◒
AmeriHealth–HMO/POS	○	◒	◒	◒
CIGNA–HMO/POS	●	◒	◒	◒
Health Net–HMO/POS	●	◒	●	◒
Horizon–HMO	◒	●	◒	●
Oxford–HMO/POS	◒	○	◒	●
United–HMO/POS	◒	◒	◒	○
WellChoice–HMO	Not Applicable	Not Applicable	Not Applicable	◒

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

Performance Compared to the Average

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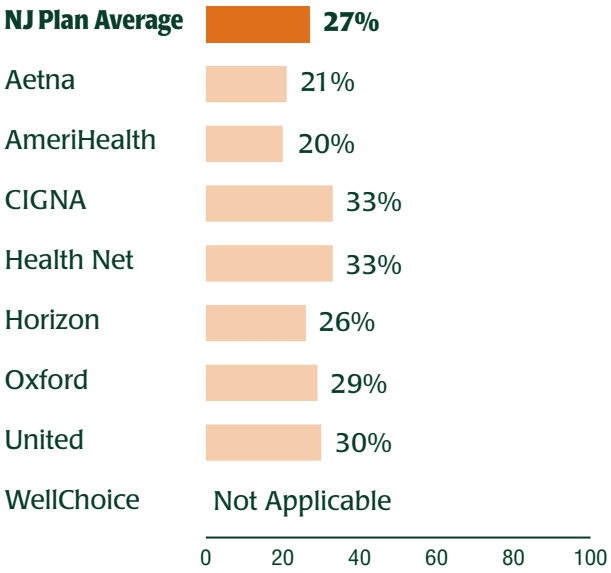
See the next page for each health plan's scores

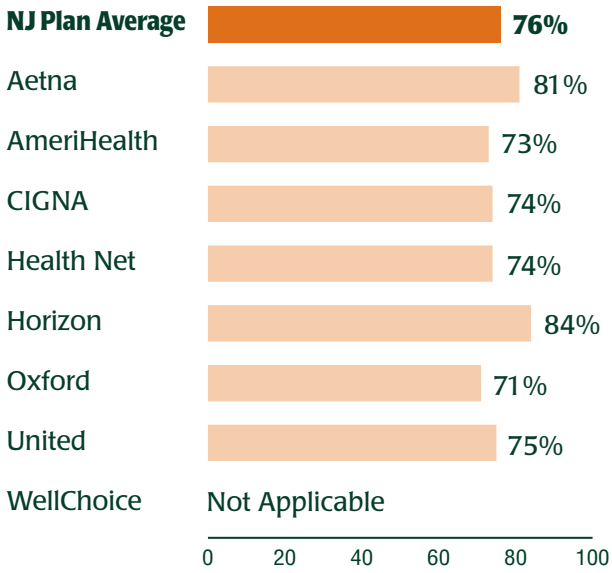
Management of medicine for depression

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



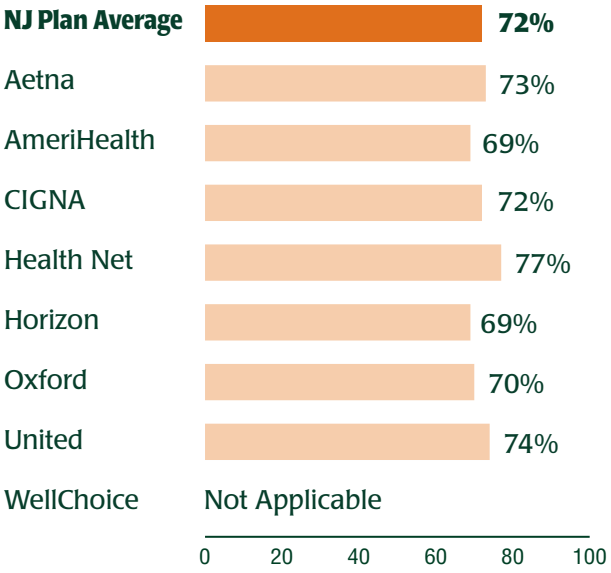
Care after hospitalization for mental illness

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



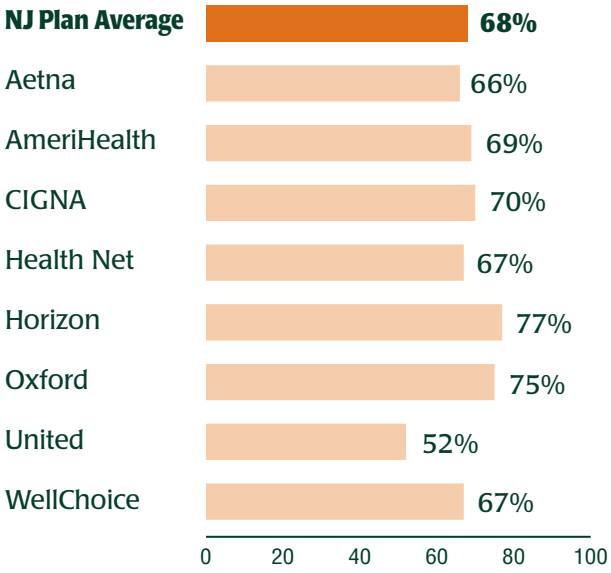
Appropriate medications for asthma (children)

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 5–17 with persistent asthma who received an appropriate therapy in the past year:



Controlling high blood pressure

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



Getting Better / Living with Illness (continued)

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

A comparison of each health plan's performance to the New Jersey plan average shows how effective the plans are in working with doctors to care for members who are sick or living with chronic illness (pages 10–13).

Higher than average scores mean better performance.

HEALTH PLAN	Cholesterol management of heart patients	Beta blocker treatment after a heart attack	Blood sugar testing for people with diabetes	Eye exams for people with diabetes
Aetna–HMO/POS	◓	◓	◓	◓
AmeriHealth–HMO/POS	○	◓	◓	◓
CIGNA–HMO/POS	●	◓	◓	◓
Health Net–HMO/POS	◓	◓	◓	◓
Horizon–HMO	◓	●	◓	●
Oxford–HMO/POS	●	◓	◓	○
United–HMO/POS	○	◓	◓	○
WellChoice–HMO	Not Applicable	Not Applicable	◓	○

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

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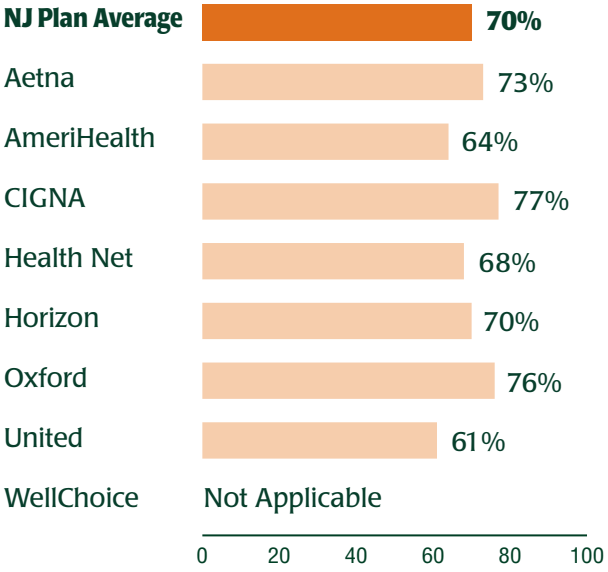
See the next page for each health plan's scores

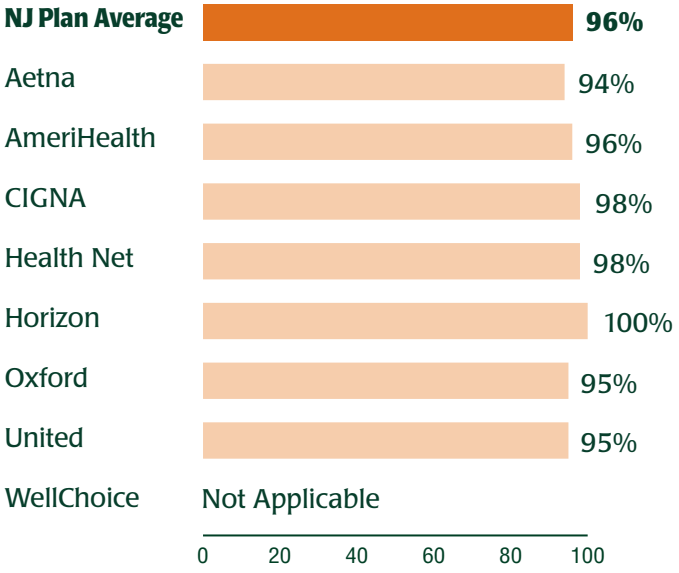
Cholesterol management of heart patients

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



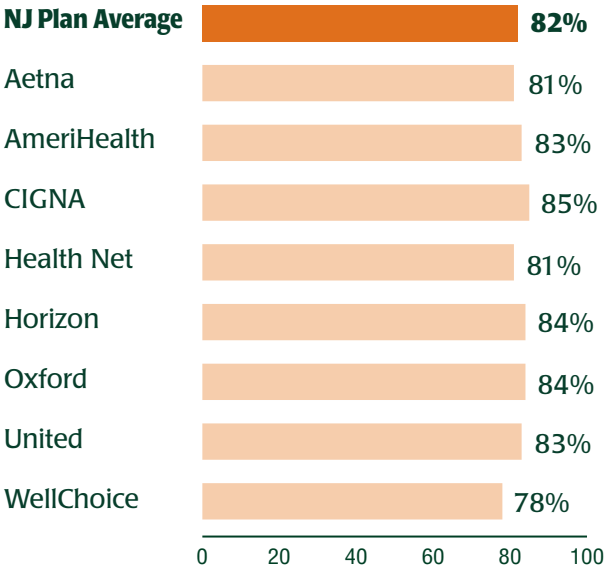
Beta blocker treatment after a heart attack

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



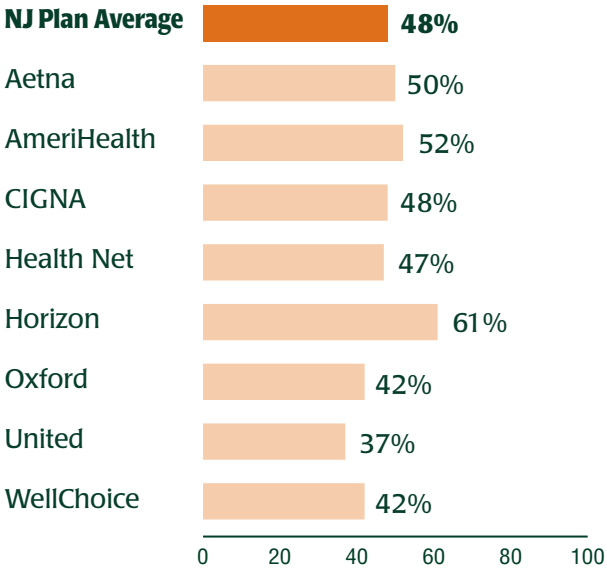
Blood sugar testing for people with diabetes

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



Eye exams for people with diabetes

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



Choosing Your Health Plan

Your choice of a health plan can influence your health.

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

Quality of Care and Service

- Look to see how well the plan performs in each section of this report.
- Pay special attention to the health issues that are most important to you and your family.
- Do not focus on small differences in a single measure that may not be meaningful. When comparing plans, look at all the factors that contribute to a health plan's performance and at large differences in the measures.

Choice of Providers

- Make sure that your preferred doctor, hospital and other providers participate in the plan by looking in the plan's directory. You should also call the plan's member services department or the provider directly. *See page 16 for ways to contact the plan.*
- Decide whether the plan has enough of the kinds of doctors you are likely to need and whether they are located near your home or work.
- Once you have selected a provider, make sure the doctor has office hours and a location convenient for you and your family.

Benefits

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

Cost

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

Accreditation

NCQA, also known as 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 health plans. To find out if your health plan is NCQA accredited, call toll-free (888) 275-7585 or visit the web site: www.ncqa.org.

URAC, also known as 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, also known as 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 plans, hospitals, home health care organizations and others. For more information on JCAHO's accreditation services, visit the web site: www.jcaho.org.

Taking Responsibility for Your Health Care

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

Know the Rules

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

Stay Informed

- **Learn** about any new policies affecting how the plan works by reading member newsletters and checking the plan's web site.
- **Know** the telephone numbers and hours of your physician's office and of the plan's member services department. Carry them in your wallet or purse in case of emergency.

Keep Records

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

Take Charge

- **Take** good care of your health by making appointments for check-ups and preventive care.
- **Talk** with your doctor about when you need regular health screenings.
- **Call** member services if you don't understand information that the plan or provider sends you.
- **Ask** for a better explanation if you don't understand the answers to your questions.

Choose a Doctor Carefully

- **Ask** for recommendations from medical societies, health care providers, referral services, hospitals, family members and friends.
- **Get** information about the doctor's training and experience from the plan or the doctor.
- **Ask** if the doctor is board certified in his or her specialty area.
- **Check** whether prospective doctors have had any disciplinary actions issued against them.
For information on New Jersey physicians see page 19.

Contacting Your Health Plan

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

Telephone Numbers, Web Sites

HEALTH PLAN	TELEPHONE	WEB SITE
Aetna Health, Inc.—New Jersey	(800) 323-9930	www.aetna.com
AmeriChoice of New Jersey	(800) 941-4647	www.americhoice.com
AMERIGROUP New Jersey	(800) 600-4441	www.amerigroupcorp.com
AmeriHealth HMO	(866) 681-7368	www.amerihealth.com
CIGNA HealthCare of New Jersey	(800) 345-9458	www.cigna.com/health
Health Net of New Jersey, Inc.	(800) 441-5741	www.healthnet.com
Horizon Healthcare of New Jersey	(800) 355-2583	www.horizonblue.com
Oxford Health Plans—New Jersey	(800) 444-6222	www.oxhp.com
UnitedHealthcare of New Jersey, Inc.	(866) 223-5802	www.uhc.com
University Health Plans, Inc.	(800) 564-6847	www.uhpnet.com
WellChoice HMO of New Jersey	(888) 476-6986	www.wellchoicenj.com

PRODUCT LINE AND SERVICE AREA INFORMATION AS OF JULY 1, 2005

NOTES:

1. Aetna Medicare is available in Bergen, Essex, Hudson, Morris, Passaic, Sussex and Union (North); Mercer (Center); and Burlington, Camden and Gloucester (South).
2. AmeriChoice Medicare is available only in Essex, Hudson, Passaic and Union (North).
3. AMERIGROUP Medicaid is available in all counties except Salem (South).
4. AmeriHealth Medicare is available only in Salem (South).
5. Health Net Medicaid is available in Essex, Hudson, Passaic and Union (North); Mercer, Middlesex and Somerset (Center); and Burlington, Camden, Cumberland, Gloucester, Ocean and Salem (South).
6. Oxford Medicare is available in Bergen, Essex, Hudson, Passaic and Union (North); Mercer, Middlesex and Monmouth (Center); and Ocean (South).
7. University Health Plans Medicaid is available in all counties except Cape May (South).

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

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

Product Lines and Service Areas

PRODUCT LINES			SERVICE AREAS		
COMMERCIAL	MEDICARE	MEDICAID	NORTH	CENTER	SOUTH
✔	✔[1]		✔	✔	✔
	✔[2]	✔	✔	✔	✔
		✔[3]	✔	✔	✔
✔	✔[4]		✔	✔	✔
✔			✔	✔	✔
✔		✔[5]	✔	✔	✔
✔	✔	✔	✔	✔	✔
✔	✔[6]		✔	✔	✔
✔			✔	✔	✔
		✔[7]	✔	✔	✔
✔			✔	✔	Burlington, Camden, Ocean

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 a Health Plan Decision

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

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

Stage 1
Inform the plan, either verbally or in writing, that you disagree with the plan's decision to deny or limit services you believe are covered. Typically, a different doctor at the plan will consider your request for services. You will receive notice of whether the plan is revising or upholding the initial decision.

Stage 2
If you are dissatisfied with the results of the Stage 1 appeal, you can request, either verbally or in writing, that the plan have your appeal reviewed by a panel of doctors and other health care professionals.

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

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

To File a Health Plan Complaint

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

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

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

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

NJ Department of Banking and Insurance
Division of Enforcement and Consumer Protection
P.O. Box 329, Trenton, NJ 08625-0329
(800) 446-7467
www.state.nj.us/dobi/enfcon.htm.

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

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

Health Care Carrier Accountability Act

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

Other Important Resources

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

Department of Health and Senior Services

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

Department of Banking and Insurance

The New Jersey Department of Banking and Insurance (DOBI) publishes Buyer's Guides for individual and small employer coverage. You may obtain a copy of the Buyer's Guide for individuals at (800) 838-0935 and for small employers at (800) 263-5912. These are also available at DOBI's web site: www.njdobi.org. DOBI also posts information on enrollment by county and line of business, premiums, net worth and profitability for all New Jersey HMOs, as well as summary information on other managed care companies. This information is available on the DOBI managed care web site: www.state.nj.us/dobi/managed.htm.

Medicare

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

Medicaid

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

Physicians

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

Self-Insured 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-insured health benefits plans. These plans are not bound by our state's statutory or regulatory requirements, but rather by federal rules. Roughly half of all New Jerseyans getting health benefits through their employers are in self-insured plans. Questions or complaints about these self-insured 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.

HMO and POS Differences

How HMO and POS Products Work

In traditional HMO products, you are required to obtain care from doctors and hospitals that are part of the HMO's network, or your services will not be covered by the HMO. In POS (Point-Of-Service) products, you can use both in- and out-of-network doctors and hospitals, but the plan pays less, and you pay more, if you use out-of-network providers. In traditional fee-for-service products, there is no network and you typically can go to any doctor or hospital, but your benefits are generally lower than what you would receive under most HMO or POS products.

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

Traditional HMO	POS	Fee-for-Service
Can you get covered services from providers who are not in the network?		
No. The HMO pays for covered services only if you use network providers. In a medical emergency, the HMO will also pay for covered services from a non-network provider.	Yes, but you usually pay more than if you go to a network provider.	Yes. You may get care from any provider.
How do you pay for services?		
You are usually charged a copayment (usually between $5 and $50) for a doctor's office visit and most other services. You may or may not have to satisfy a deductible. HMOs may impose a coinsurance for some services. You usually do not need to fill out claim forms.	If you use a provider who is in the network, you typically pay a copayment, but no deductible. You do not have to fill out claim forms. If you use a provider who is not in the network: after you pay a deductible, you pay the coinsurance specified in your policy (which may range from 10–50%) and the insurer pays the rest *up to the insurer's allowed amount.* If your provider bills more than the allowed amount, you also must pay the difference between the billed and allowed charges (balance billing). You may need to fill out a claim form.	After you pay a deductible, you pay the coinsurance specified in your policy (which may range from 10–50%) and the insurer pays the rest *up to the insurer's allowed amount.* If your provider bills more than the allowed amount, you also must pay the difference between the billed and allowed charges (balance billing). You will need to fill out a claim form.
Do you need to choose a Primary Care Provider (PCP)?		
You usually need to choose a PCP from the network, who takes care of most of your medical needs.	You usually need to choose a PCP from the network.	You do not need to choose a PCP.
Do you need a referral from your PCP to go to a specialist?		
You usually need a referral, although in many HMOs some types of specialists may be available without a referral. Some HMO products allow visits to most specialists in the network without a referral.	Depends. You usually need a referral only if you want to see a specialist and receive in-network benefits. Some POS products allow visits to in-network specialists and provide in-network benefits without a referral. If you use a provider who is not in the network, you usually do not need a referral, but you will pay more than if you go to in-network providers.	You do not need a referral to go to a specialist.

Consumer Bill of Rights

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

The Right to Information about Your Plan and How it Works

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

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

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

The Right to Appropriate Treatment

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

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