2000

New Jersey
HMO Performance Report

Compare Your Choices

Christine Todd Whitman
Governor

Christine Grant
Commissioner
Department of Health and Senior Services

October 2000

Dear Consumers:

We are pleased to present the fourth annual *New Jersey HMO Performance Report*. This report card looks at the performance of New Jersey's managed health care plans, how well these plans deliver important health care services and what members think about the services they receive. This year we added the following new measures: claims processing, cholesterol management, management of medicine for depression and blood sugar testing for people with diabetes.

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

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

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

Christine Todd Whitman, Governor

Christine Grant, Commissioner
Department of Health and Senior Services

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

This report includes health maintenance organizations (HMOs) and point of service (POS) plans in New Jersey that enrolled at least 2,000 commercial members in 1998 and 1999. These health plans cover 99 percent of the State's commercial enrollment. For most plans, the information combines a plan's performance for their HMO and POS products. However, for AtlantiCare Health Plans and Horizon Healthcare of New Jersey, Inc., the POS products are not included. This report does not cover the performance of health plans that serve Medicare or Medicaid beneficiaries. See page 17 for ways to get information on Medicare and Medicaid plans. See page 20 for the distinctions between HMOs and POS plans.

This report is based on a measurement system, HEDIS®, which includes both measures collected by the plans and a consumer survey. All measures were verified by independent auditors.

This report contains information on the following health plans:

- **Aetna U.S. Healthcare–New Jersey** (Aetna USHC–HMO/POS)
- **AmeriHealth, Inc.** (AmeriHealth–HMO/POS)
- **AtlantiCare Health Plans** (AtlantiCare–HMO)
- **CIGNA HealthCare of New Jersey, Inc.** (CIGNA–HMO/POS)
- **Horizon Healthcare of New Jersey, Inc.** (Horizon–HMO)
- **Oxford Health Plans–New Jersey, Inc.** (Oxford–HMO/POS)
- **Physicians Health Services of New Jersey, Inc.** (PHS–HMO/POS)
- **Prudential HealthCare–New Jersey** (Prudential–HMO/POS)*
- **UnitedHealthcare of New Jersey, Inc.** (United–HMO/POS)
- **University Health Plans, Inc.** (University–HMO/POS)

* Aetna U.S. Healthcare purchased Prudential HealthCare in 1999.

For 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. This 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.

New Jersey HMO Performance Report

Table of Contents

Important Questions About Quality You Should Consider

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

This report provides information about:

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

Why is the quality of health care important?

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

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

What should you consider when choosing your health plan?

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

When choosing a health plan, consider:

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

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

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. These health plans cover 99 percent of the State's commercial enrollment.

Higher than average scores mean better performance.

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

	Overall Performance See the following pages for more detail			
HEALTH PLAN	**Service and Access** See pages 4 & 5	**Doctors and Medical Care** See pages 6 & 7	**Staying Healthy** See pages 8 & 9	**Getting Better/Living with Illness** See pages 10–13
Aetna USHC—HMO/POS	●	●	◓	●
AmeriHealth—HMO/POS	●	●	●	●
AtlantiCare—HMO	●	◓	◓	◓
CIGNA—HMO/POS	○	○	◓	◓
Horizon—HMO	◓	◓	●	◓
Oxford—HMO/POS	◓	◓	●	●
PHS—HMO/POS	◓	◓	◓	◓
Prudential—HMO/POS	◓	◓	○	◓
United—HMO/POS	◓	○	◓	◓
University—HMO/POS	○	◓	○	○

Service and Access

Are members satisfied with their health plan's services?

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

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Performance Compared to the Average

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

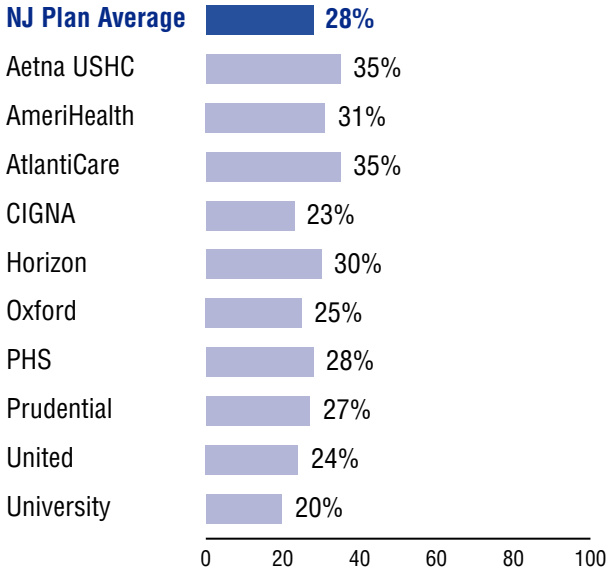
HEALTH PLAN	Rating of health plan	Getting needed care	Claims processing	Customer service
Aetna USHC—HMO/POS	●	●	●	●
AmeriHealth—HMO/POS	◒	◒	●	◒
AtlantiCare—HMO	●	◒	◒	●
CIGNA—HMO/POS	○	○	○	◒
Horizon—HMO	◒	◒	◒	◒
Oxford—HMO/POS	◒	◒	◒	◒
PHS—HMO/POS	◒	◒	◒	●
Prudential—HMO/POS	◒	◒	◒	○
United—HMO/POS	○	◒	◒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

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

See the next page for each health plan's scores

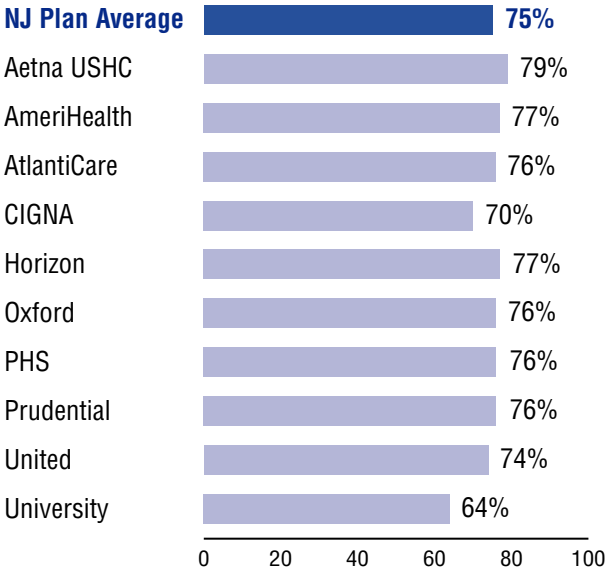
Rating of health plan

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



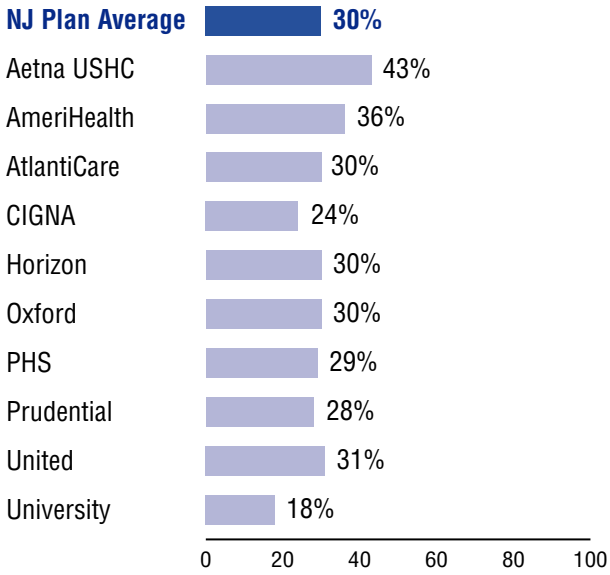
Getting needed care

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



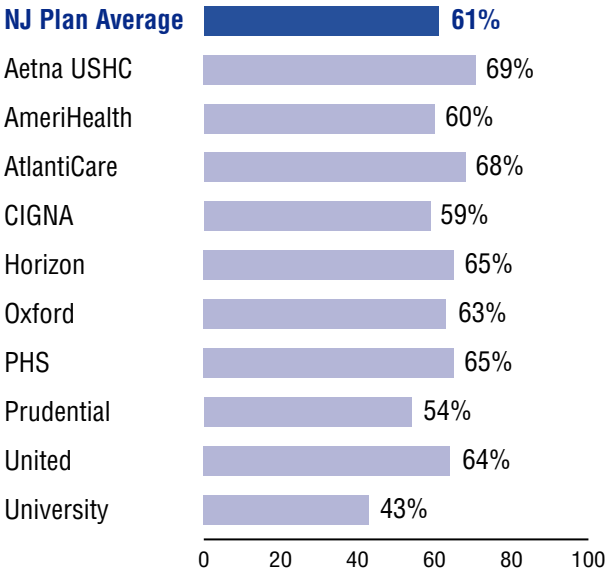
Claims processing

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



Customer service

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



Doctors and Medical Care

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

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

Higher than average scores mean better performance.

Performance Compared to the Average

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

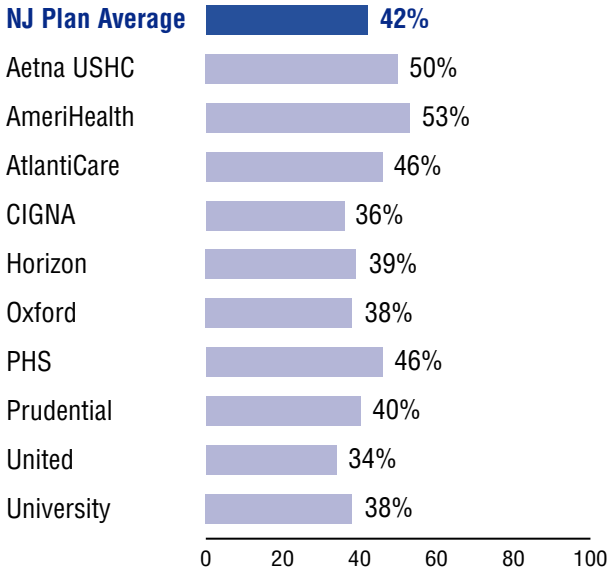
HEALTH PLAN	Rating of health care	Getting care quickly	Rating of personal doctor	How well doctors communicate
Aetna USHC—HMO/POS	●	●	◒	●
AmeriHealth—HMO/POS	●	●	●	●
AtlantiCare—HMO	◒	●	◒	◒
CIGNA—HMO/POS	○	○	○	○
Horizon—HMO	◒	◒	◒	◒
Oxford—HMO/POS	◒	◒	◒	◒
PHS—HMO/POS	◒	◒	◒	◒
Prudential—HMO/POS	◒	◒	◒	◒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

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

See the next page for each health plan's scores

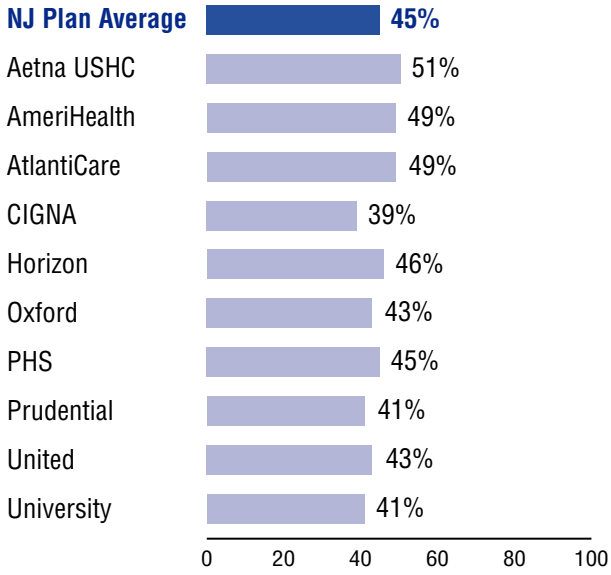
Rating of health care

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



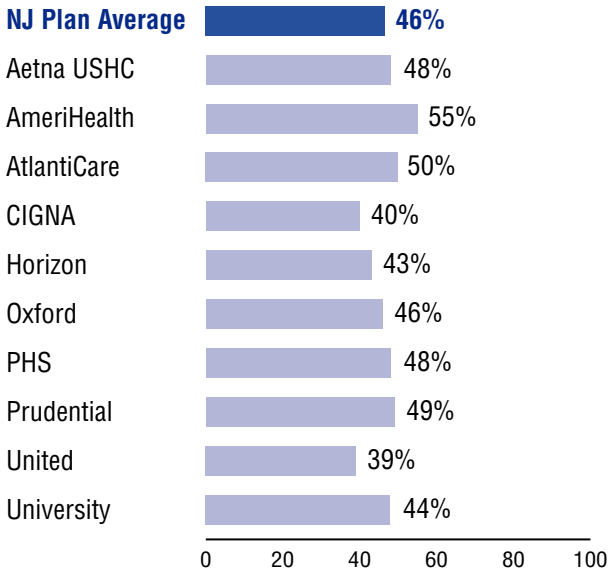
Getting care quickly

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



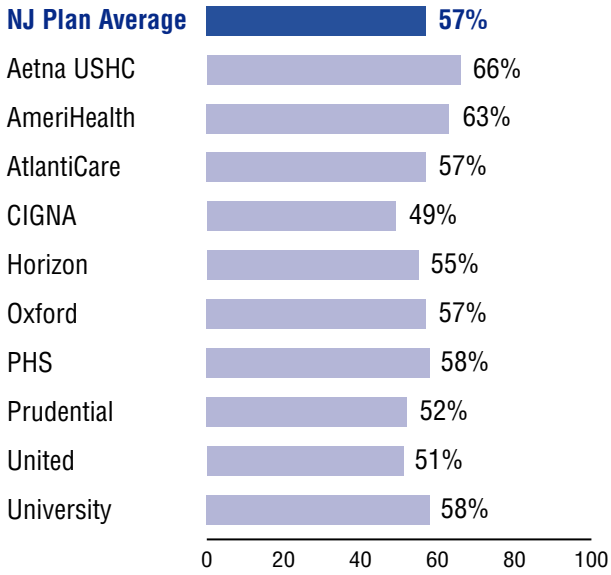
Rating of personal doctor

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



How well doctors communicate

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



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

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

Higher than average scores mean better performance.

Performance Compared to the Average

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

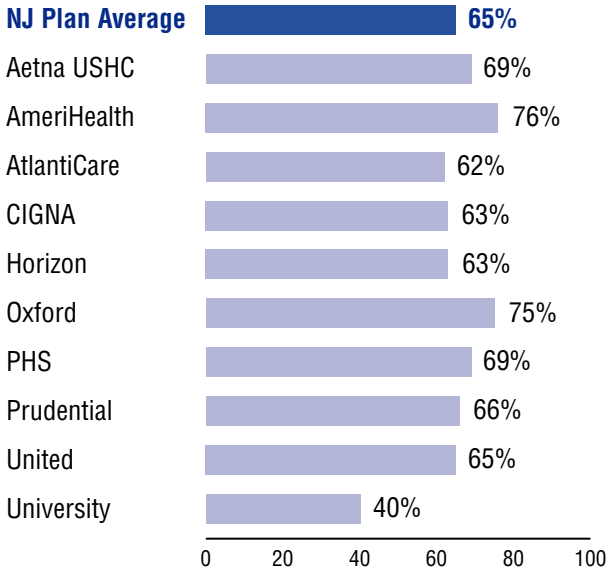
HEALTH PLAN	Testing for breast cancer	Testing for cervical cancer	Check-ups for new mothers	Immunizations for children
Aetna USHC—HMO/POS	●	◒	●	◒
AmeriHealth—HMO/POS	●	◒	○	●
AtlantiCare—HMO	◒	○	●	○
CIGNA—HMO/POS	◒	◒	○	●
Horizon—HMO	◒	◒	●	●
Oxford—HMO/POS	●	●	◒	◒
PHS—HMO/POS	●	○	◒	◒
Prudential—HMO/POS	◒	◒	○	○
United—HMO/POS	◒	◒	◒	Not Reported
University—HMO/POS	○	Not Reported	◒	Not Applicable

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.
Not Reported—Health plan did not meet audit requirements or did not report the measure.
Not Applicable—Health plan was unable to report the measure due to small enrollment.

See the next page for each health plan's scores

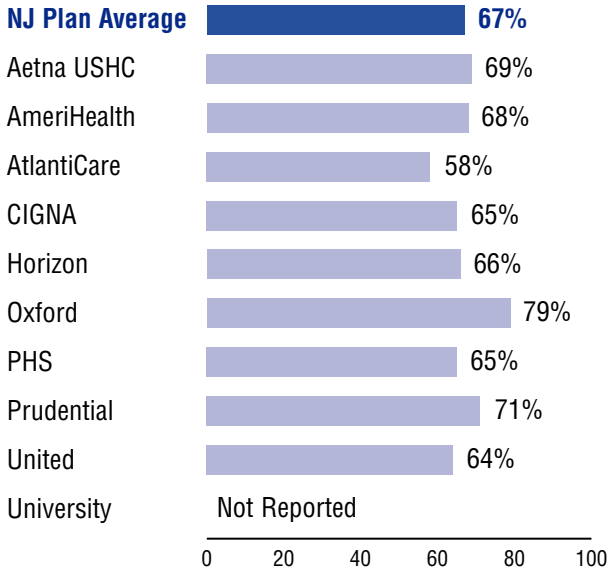
Testing for breast cancer

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



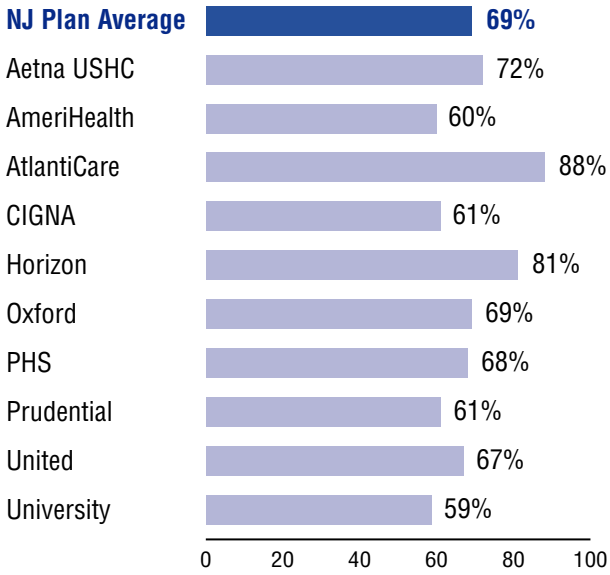
Testing for cervical cancer

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



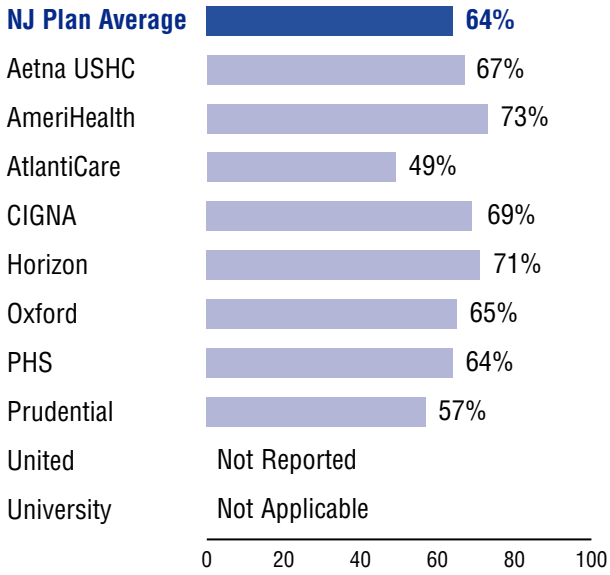
Check-ups for new mothers

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



Immunizations for children

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



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

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

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HEALTH PLAN	Beta blocker medicine after a heart attack	Cholesterol management of heart patients	Care after hospitalization for mental illness	Management of medicine for depression
Aetna USHC—HMO/POS	●	●	●	○
AmeriHealth—HMO/POS	●	◒	◒	Not Applicable
AtlantiCare—HMO	Not Applicable	Not Applicable	Not Applicable	Not Applicable
CIGNA—HMO/POS	○	●	◒	◒
Horizon—HMO	◒	●	◒	◒
Oxford—HMO/POS	●	●	◒	●
PHS—HMO/POS	○	○	○	○
Prudential—HMO/POS	◒	○	●	◒
United—HMO/POS	Not Reported	○	◒	●
University—HMO/POS	Not Reported	Not Applicable	Not Applicable	Not Reported

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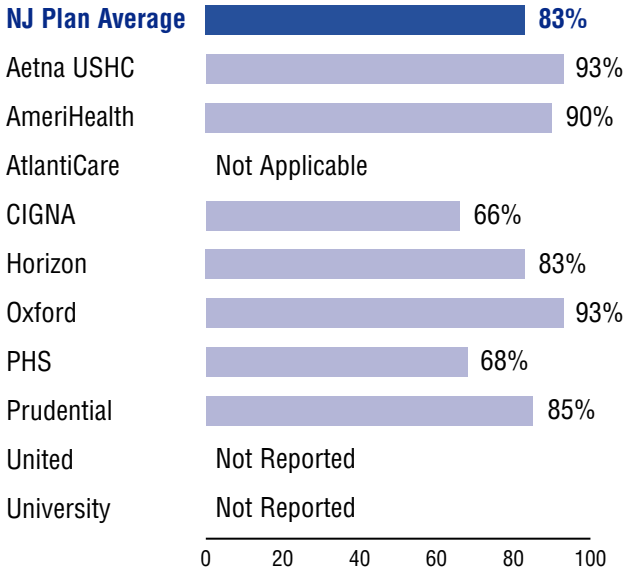
Not Applicable—Health plan was unable to report the measure due to small enrollment.

See the next page for each health plan's scores

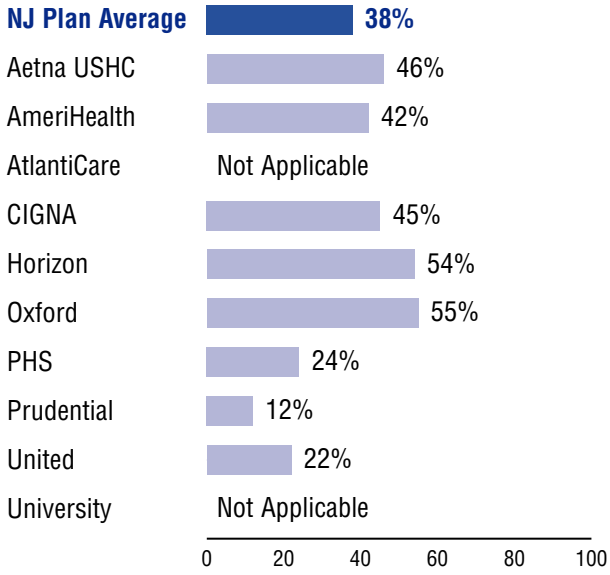
Beta blocker medicine after a heart attack

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



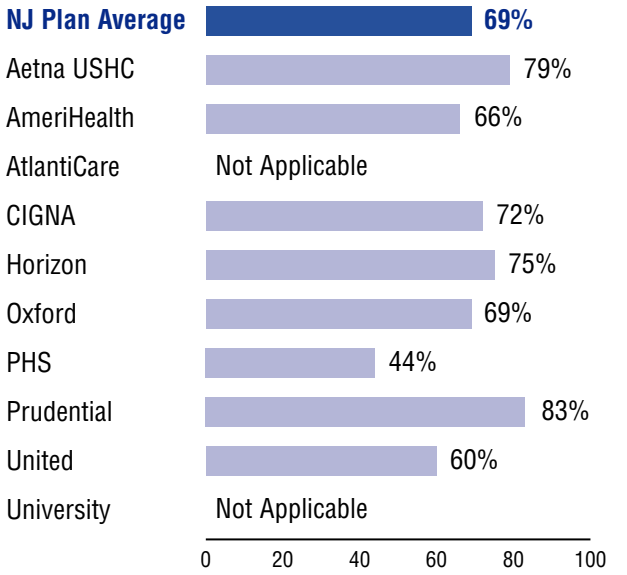
Cholesterol management of heart patients

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



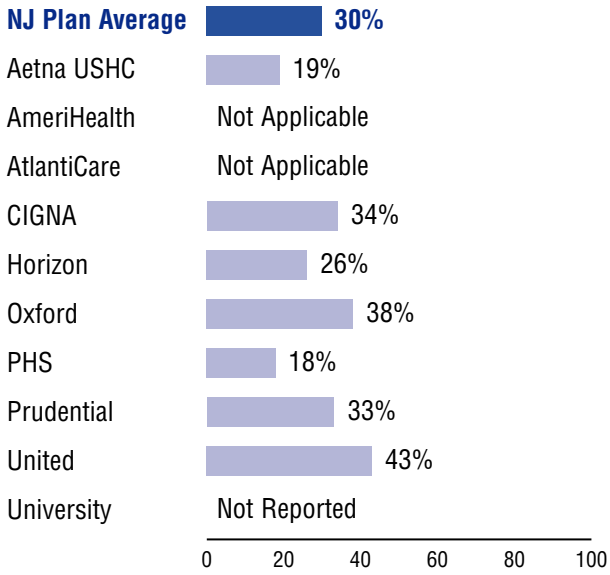
Care after hospitalization for mental illness

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



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:



continued

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

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

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

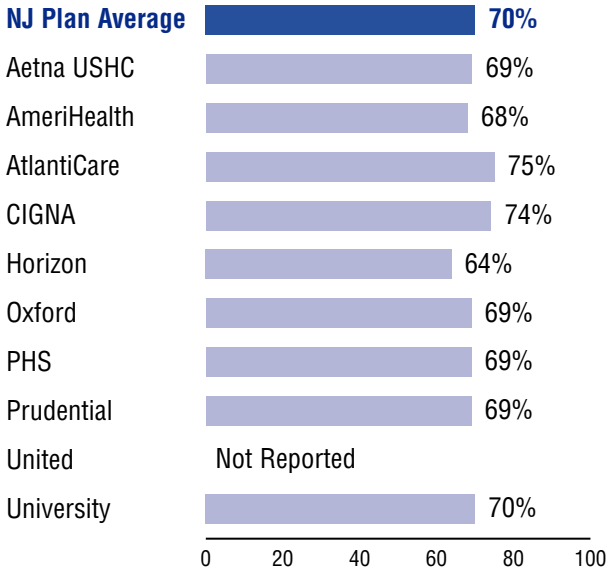
HEALTH PLAN	Blood sugar testing for people with diabetes	Eye exams for people with diabetes	Frequent users* getting needed care	Frequent users* getting care quickly
Aetna USHC—HMO/POS	◓	●	●	●
AmeriHealth—HMO/POS	◓	●	◓	◓
AtlantiCare—HMO	◓	◓	◓	◓
CIGNA—HMO/POS	◓	○	◓	◓
Horizon—HMO	○	●	◓	◓
Oxford—HMO/POS	◓	●	◓	◓
PHS—HMO/POS	◓	●	◓	◓
Prudential—HMO/POS	◓	○	◓	◓
United—HMO/POS	Not Reported	◓	◓	◓
University—HMO/POS	◓	○	○	◓

Due to differences in sample size, health plans with the same or similar scores can have different circle ratings.
Not Reported—Health plan did not meet audit requirements or did not report the measure.
* Frequent users had five or more visits to a doctor during the year.

See the next page for each health plan's scores

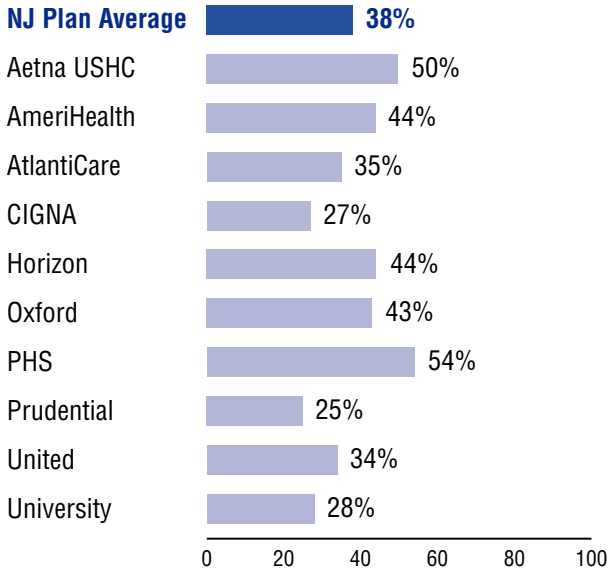
Blood sugar testing for people with diabetes

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



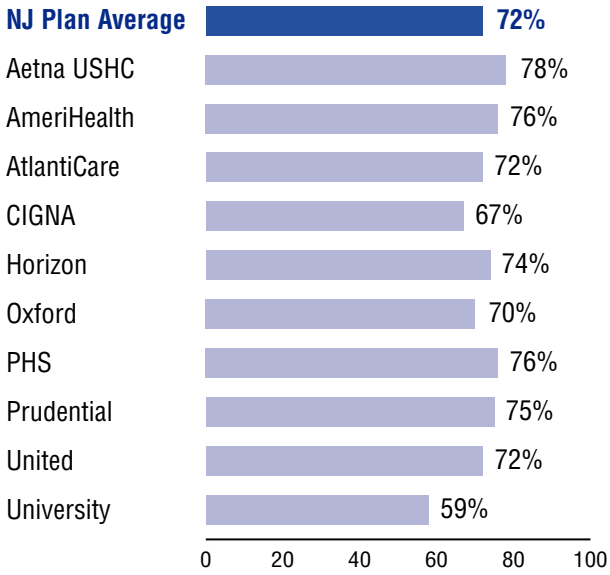
Eye exams for people with diabetes

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



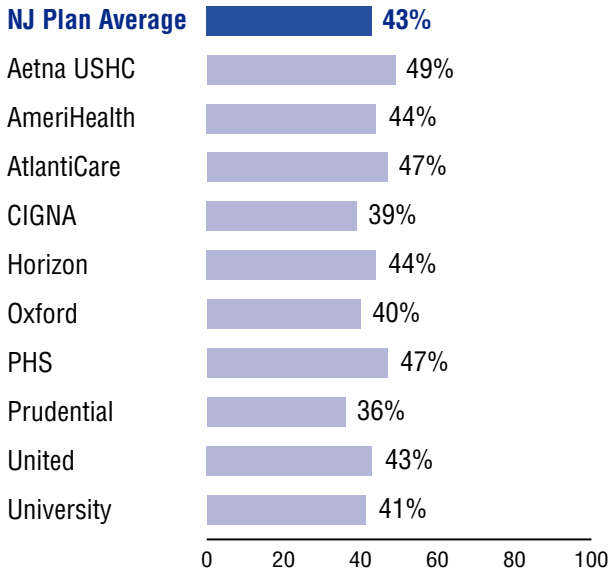
Frequent users* getting needed care

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



Frequent users* getting care quickly

Percent of frequent users who • *always* were able to obtain advice, timely appointments and care • *never* waited over 15 min. past an appointment:



Choosing Your Health Plan

Your choice of a health plan can influence your health.

Health plan quality, along with choice of providers, benefits offered and costs, can help you decide on a health plan best suited to 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.
- Focus on large differences when you compare plans.

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 can also call the plan's member services department or the provider directly.
- Decide whether the plan has enough of the kinds of doctors you are likely to need and whether they are located near your home or work.

Benefits

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

Cost

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

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

Stay Informed

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

Take Charge

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

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 any disciplinary actions issued against them.

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.

Telephone Numbers and Web Sites

The information in this report covers large commercial HMOs and POS plans in New Jersey. This table lists all HMOs and POS plans approved to provide services in New Jersey and the types of coverage that each plan offers. Use the telephone numbers and Web sites to learn more about the health plans that interest you.

Not all plans offer coverage in all counties. Talk to the health plans or your employer for details.

HEALTH PLAN	Telephone Number	Web Site	Product Line		
			Commercial	Medicare	Medicaid
Aetna U.S. Healthcare–New Jersey	(800) 323-9930	www.aetnaushc.com	✓	✓	✓
AmeriChoice of New Jersey, Inc.	(800) 941-4647	www.americhoice.com		✓	✓
AMERIGROUP New Jersey, Inc.	(800) 600-4441	www.amerigroupcorp.com			✓
AmeriHealth, Inc.	(800) 877-9829	www.amerihealth.com	✓	✓	
AtlantiCare Health Plans	(800) 272-5995	www.atlanticare.org	✓		
CIGNA HealthCare of New Jersey, Inc.	(800) 345-9458	www.cigna.com/healthcare	✓	✓	
Coventry Health Care of Delaware, Inc.	(800) 727-9951	www.cvty.com	✓		
Empire HealthChoice, Inc.	(888) 476-8069		✓		
Horizon Healthcare of New Jersey, Inc.	(800) 355-2583	www.horizon-bcbsnj.com	✓	✓	✓
One Health Plan of New Jersey, Inc.	(800) 663-8081	www.onehealthplan.com	✓		
Oxford Health Plans–New Jersey, Inc.	(800) 444-6222	www.oxhp.com	✓	✓	
Physicians Health Services of New Jersey, Inc.	(800) 441-5741	www.phshealthplans.com	✓		✓
Prudential HealthCare–New Jersey [1]	(800) 422-7399	www.aetnaushc.com/pruhealthcare	✓		
QualCare, Inc.	(800) 254-0130	www.qualcare-usa.com	✓		
QualMed Plans for Health, Inc.	(800) 736-2096	www.qualmedpa.com	✓	✓	
UnitedHealthcare of New Jersey, Inc.	(800) 357-0942	www.uhc.com	✓		
University Health Plans, Inc.	(800) 564-6847	www.uhpnet.com	✓		✓

[1] Aetna U.S. Healthcare purchased Prudential HealthCare in 1999. Prudential HealthCare no longer offers HMO and POS products in New Jersey.

Other Important Resources

When making health care decisions, consider other sources of information.

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 consumer 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. For more information, contact the Department's Office of Managed Care at (888) 393-1062 or visit www.state.nj.us/health.

NCQA Accreditation

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

Individual and Small Employer Coverage

The New Jersey Department of Banking and Insurance 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. 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.njdobi.org.

Self-Insured Plans

Larger employers often assume financial responsibility for their health benefits instead of buying insurance. Employers may contract with outside organizations, including insurance companies, to administer their self-insured health benefits. Employees should ask if their health benefits programs are self-insured. For complaints about self-insured plans, contact the U.S. Department of Labor at (202) 219-8233.

Medicare

For information on Medicare coverage options or complaints, call the New Jersey Department of Health and Senior Services, Division of Senior Affairs at (800) 792-8820. You can also call Medicare at (800) 633-4227 or visit www.medicare.gov.

Medicaid

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

Take Care of Kids and Families

If you know someone who is not covered by health insurance, please call (800) 701-0710 or visit www.njkidcare.org for information on New Jersey KidCare and FamilyCare. Call today to learn about the State's new affordable health insurance programs for children and adults.

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/bme/docdir.htm.

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

To Appeal a Health Plan Decision

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

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

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

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

Stage 3
If you are dissatisfied with the plan's decision on your appeal, you can file an appeal with the Department of Health and Senior Services within 60 days of receiving the plan's Stage 2 decision. Your case will be reviewed by independent experts under contract to the State through the Independent Health Care Appeals Program (IHCAP).

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 resolution reached through 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 Dept. of Health and Senior Services
Office of Managed Care
PO Box 360
Trenton, NJ 08625-0360
(888) 393-1062

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

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

Note: 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 17.*

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 and Appeals

- 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 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 Appropriate Treatment

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

HMO and POS Plan Differences

How HMOs and POS Plans Work

In HMOs (health maintenance organizations) and POS (point-of-service) plans, you usually get care from doctors and hospitals that are part of the plan's provider network. This differs from fee-for-service insurance, which permits you to get care from any doctor or hospital, but may have higher out-of-pocket costs.

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

	HMO	POS	Fee-for-Service
Can you get covered services from providers who are not in the network?	No. The HMO pays for covered services only if you use network providers.	Yes, but you usually pay more.	Yes. You may get care from any provider.
How do you pay for services?	You are charged a co-payment (usually between $5 and $25) for a doctor's office visit and most other services. There is no deductible. You usually do not need to fill out claim forms.	If you use a provider who is in the network, you pay a copayment, but no deductible. No claim forms need to be filled out. If you use a provider who is not in the network, then 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 coinsurance (usually 20–30%) and the insurer pays the rest. You will need to fill out a claim form.
Do you need to choose a primary care provider (PCP)?	Yes. You usually need to choose a PCP from the network, who takes care of most of your medical needs.	Yes. You usually need to select a PCP from the network.	No. You can get care from any doctor.
Do you need a referral from your PCP to go to a specialist?	Yes, although some specialists may be available without a referral.	Depends. You need a referral only if you want to see a specialist and receive in-network benefits.	No. You do not need a referral to go to a specialist.

Other Consumer Reports

The New Jersey Department of Health and Senior Services produces other consumer reports which are available at our Web site: www.state.nj.us/health.

New Jersey Performance Report for Nursing Homes…call (609) 633-9051

Selecting a Long-Term Care Setting…call (609) 633-9051

Cardiac Services in New Jersey 1998…call (888) 393-1062

The 2000 New Jersey HMO Performance Report
is available at our Web site: www.state.nj.us/health.