Indiana HMO Report Cards

Welcome to the Indiana's Consumer HMO Report Card. This is a way that the State shares information about the performance of Indiana Health Maintenance Organizations (HMOs).

Selecting a health care plan is an important decision. However, measuring the potential quality of a plan can be confusing. Often, consumers don't realize a plan doesn't measure up to the competition until they have a medical emergency or file a health claim. The information in this "report card" is designed to help you weigh those important decisions. We want to help you make informed health care plan choices.

You will find sections explaining how you can use the data, how HMO plans work, explanations of the advantages and disadvantages, and a list of questions to ask yourself when selecting a health care plan, and information on the financial stability of the plans. Learn as much as you can about your options and rights as an insurance consumer in Indiana. Use this report card as a starting point in finding the answers to your questions.

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HOW HMOS WORK

A Health Maintenance Organization (HMO) is a health plan that provides health care services to enrollees through a network of providers. The plan contracts with providers and pays them for the services they provide. You choose a Primary Care Physician (PCP) from the network and receive your care through that PCP. The PCP refers you to specialists and other providers when needed. If you receive non-emergency services from providers that are not part of the HMO network, the HMO may not pay. The HMO is responsible for the availability, accessibility and quality of health services provided. These elements are subject to regular internal and external reviews by an organization of doctors and nurses – ensuring that appropriate standards of care are being met.

HOW THE DATA IS COLLECTED

Measuring the quality of healthcare plan is important. Obviously, there are many variations from one plan to another. Fortunately, surveys and reports have been created to assist consumers in their process of comparing. The State of Indiana, through the Indiana Department of Insurance, monitors the quality of care and services provided by HMOs. The Department investigates consumer complaints and conducts in-depth reviews of each plan. Many Indiana plans also belong to national review organizations that perform quality audits of the plans. Indiana HMOs are asked to provide information through one of these national review organizations, using a standardized data collection program.

The National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) developed performance standards in 1992 to compare plans. The Health Plan Employer Data and Information Set (HEDIS®) has evolved as the primary measuring tool for health plans to collect data. Health plans collect HEDIS® in a consistent manner. This allows the data to be compared fairly. The performance measures address the quality of service provided for health issues such as: cancer, doctor visits, and how many patients receive certain preventive tests. Comparing this data between healthcare plans can help tell you how well health plans are providing service to their current members.

QUALITY MATTERS

What do you know about the quality of Indiana 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 care 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 that is provided by your health plan might influence your health and your family's health.
- If you are an employer, the quality of care that is provided by your health plan might 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

HOW TO USE THIS REPORT CARD

It is true. Some health organizations do a better job than others do when it comes to keeping members healthy and caring for them when they are sick. Our report card helps your compare health benefits in several areas. At a glance you are able to measure how a company stacks up against its competitors. In additions, the guide includes information on filing complaints and appeals.

This is just the beginning…

The data contained in this report card should be a starting point – not the sole foundation for selecting a health plan. Our hope is that this guide will help you make informed decisions when selecting a health plan. In addition to the report card, be sure to read the detailed information outlined in the benefits and marketing materials provided by the plan. The topics mentioned in this report card are intended to help you recognize specific questions to ask. Making yourself informed will help ease some of the intimidation that can be experienced when evaluating your health care options.

WHO IS INCLUDED…

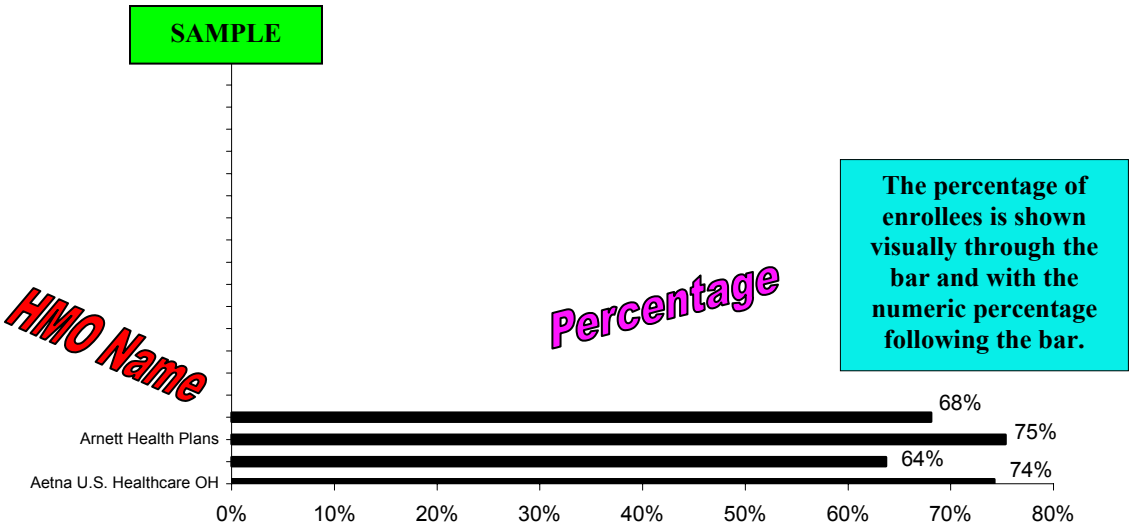
Eighteen (18) HMOs are included in our report card. The following table lists the number of members enrolled in the plan in 2003 and the percentage of Primary Care Physicians that are Board Certified (Board Certification requires additional training).

HEALTH MAINTENANCE ORGANIZATION	TOTAL ENROLLEES IN 2003	TOTAL PRIMARY CARE PHYSICIANS	NUMBER AND % OF PCPS BOARD CERTIFIED
ADVANTAGE Health Solutions, Inc.	52159	1085	886 81.7%
Aetna U.S. Healthcare – IL	79240	2955	2584 87.4%
Aetna U.S. Healthcare – OH	205503	5194	4339 83.5%
Anthem Ins. Dba Anthem Blue Cross Blue Shield	77790	2365	1640 69.3%
Arnett Health Plans	44024	121	105 86.8%
CIGNA HealthCare of IL	182523	3347	2762 82.5%
CIGNA HealthCare of IN	117731	2011	1445 71.9%
Humana Health Plan – KY	100268	818	636 77.8%
Humana Health Plan – OH	289455	2888	2561 88.7%
IU Health Plan, Inc.	9015	114	103 90.4%
M- Plan, Inc.	174410	1408	1242 88.2%
One Health Plan of Indiana, Inc.	2791	1328	1146 86.3%
Physicians Health Plan of Northern IN	63307	454	373 82.2%
Southeastern Indiana Health Organization (SIHO)	Not Reported	Not Reported	Not Reported
UNICARE Health Plans of the Midwest	164716	Not Reported	Not Reported
United HealthCare of IL	Not Reported	Not Reported	Not Reported
United HealthCare of KY	Not Reported	Not Reported	Not Reported
Welborn Clinic dba Welborn Health Plans and Health Care Solutions	34112	Not Reported	Not Reported

Reading the Information…

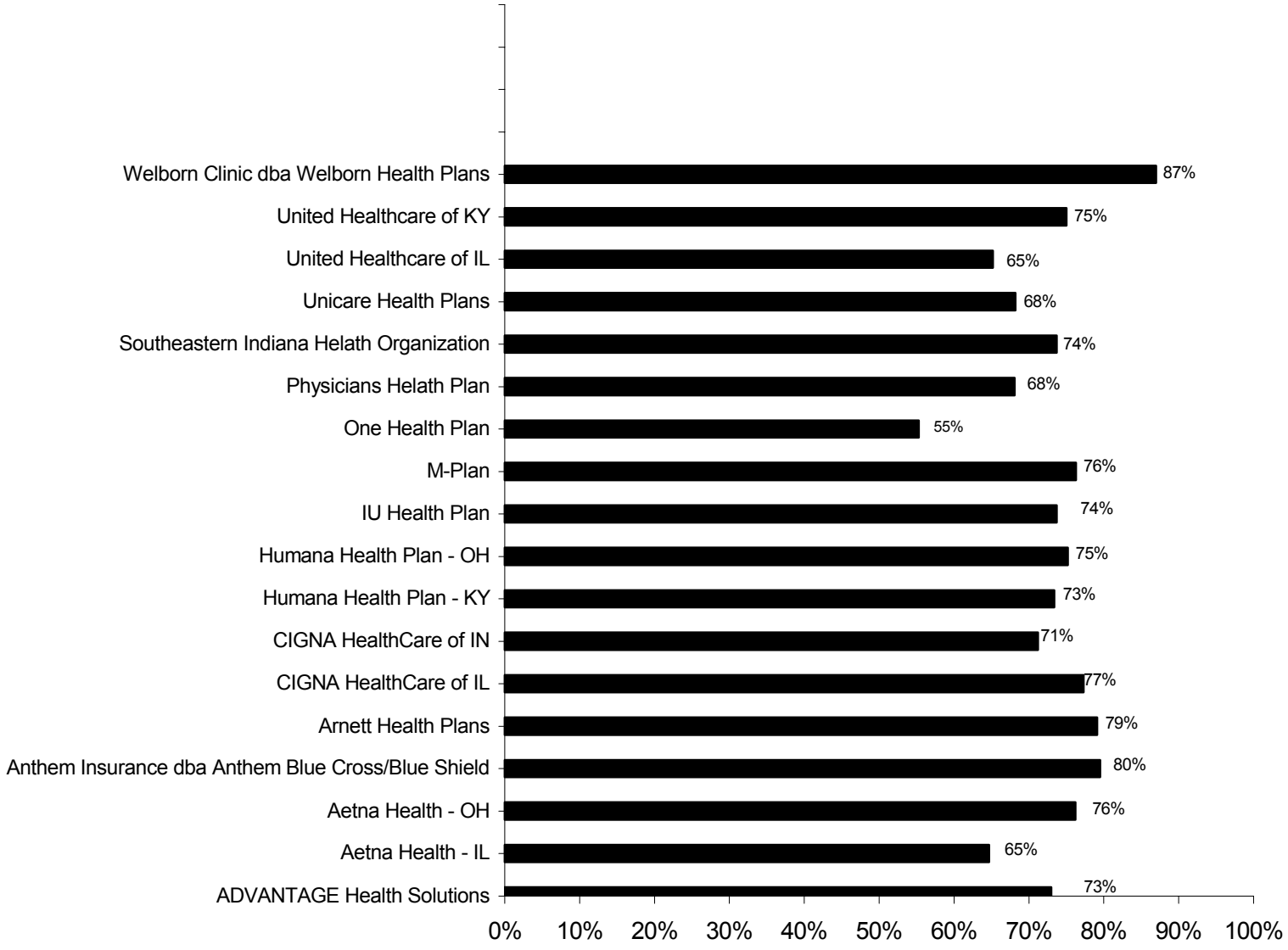
On each chart, you will notice the various health plans are labeled making it easy to compare services and quality. In some instances you may notice that a plan did not report (N/R) data. Information not being reported can happen for several reasons and does not necessarily mean there is a problem.

Again, use this information as your first step to learning more about your health plan options. If you have additional questions, contact the Indiana Department of Insurance.



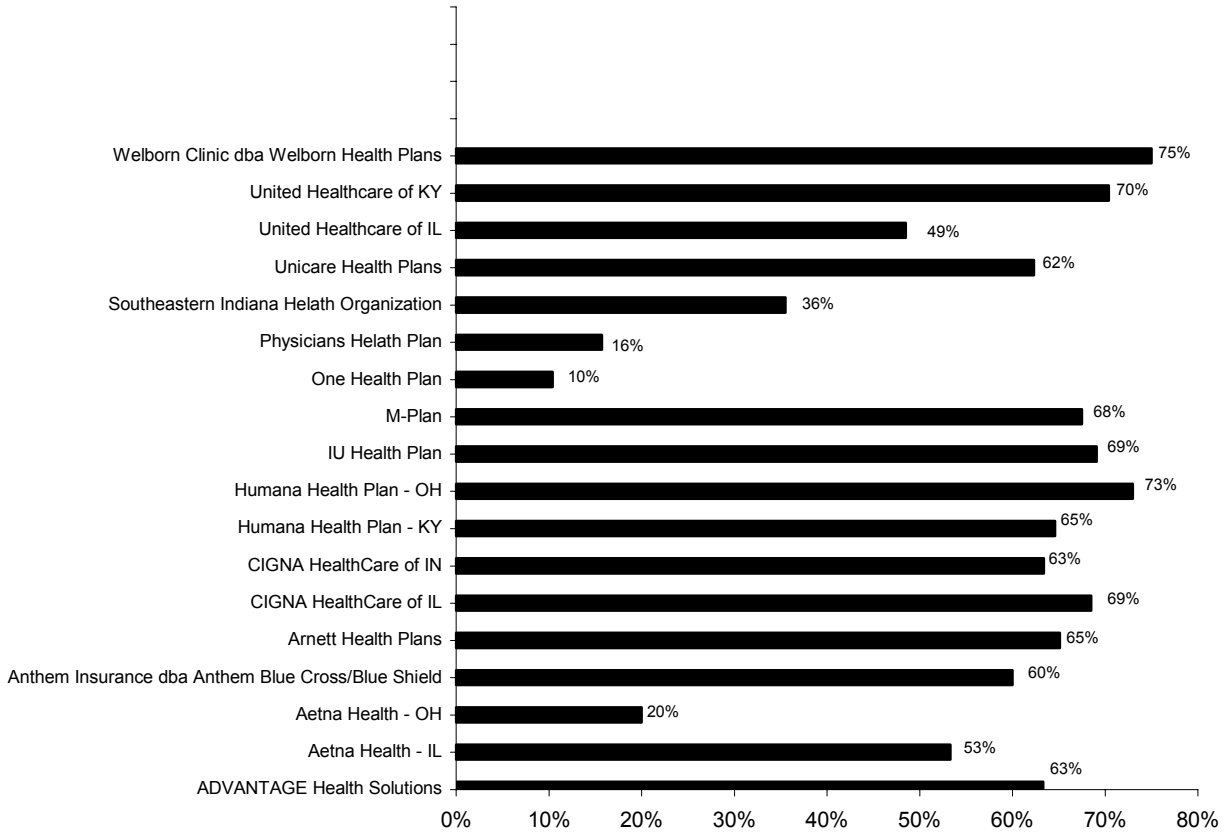
TESTING FOR BREAST CANCER

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



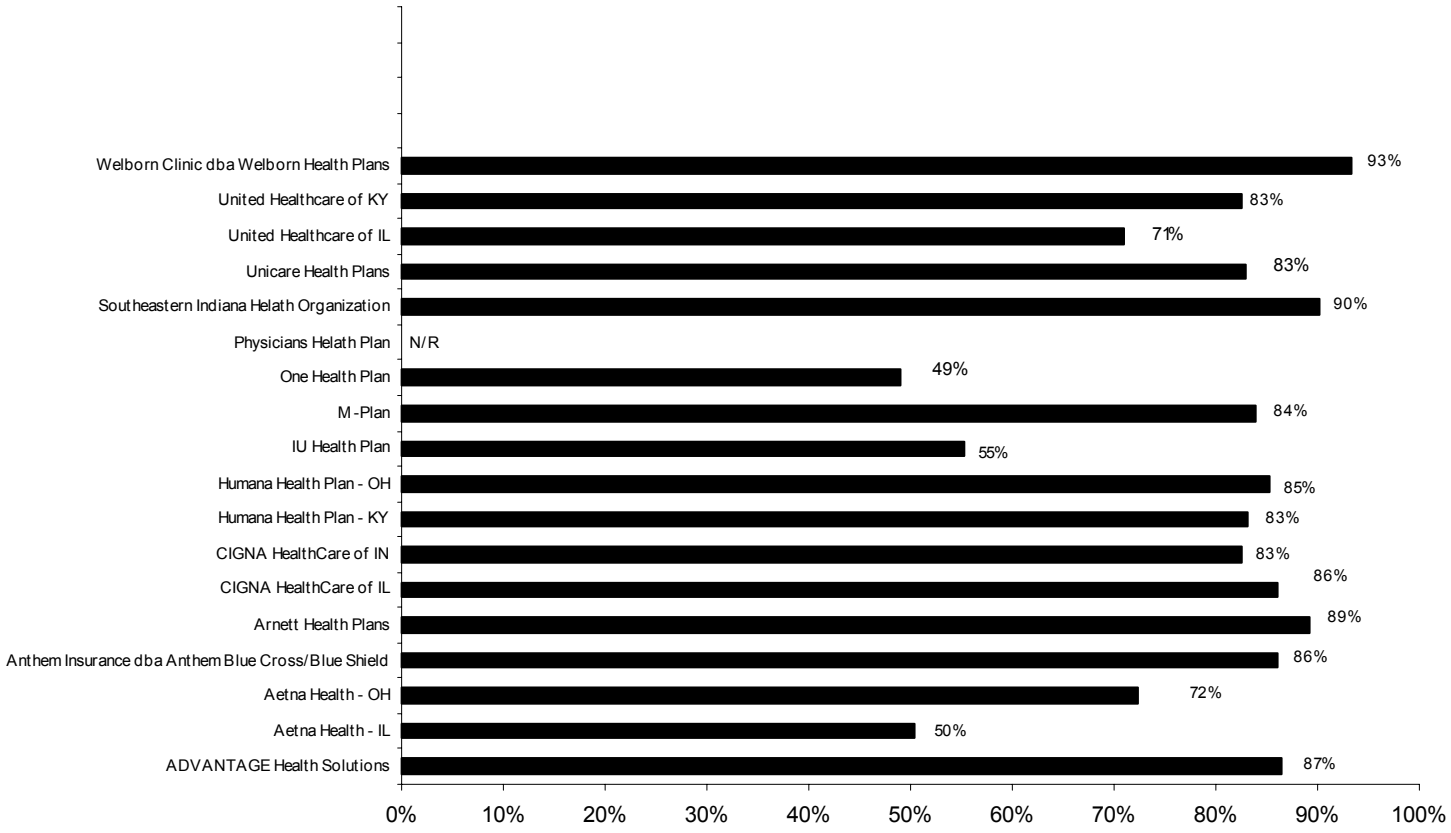
IMMUNIZATIONS FOR CHILDREN

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



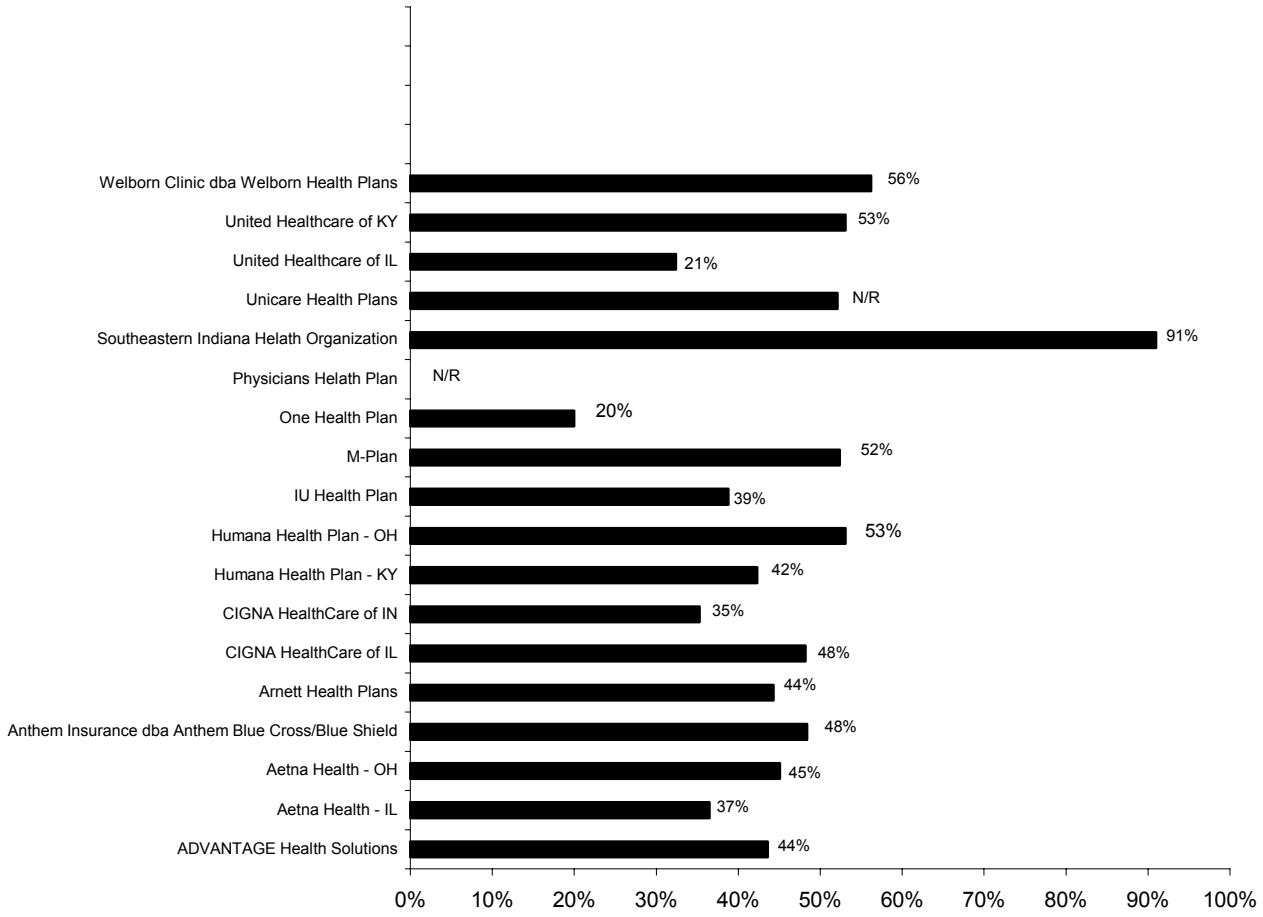
BLOOD SUGAR TESTING FOR PEOPLE WITH DIABETES

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



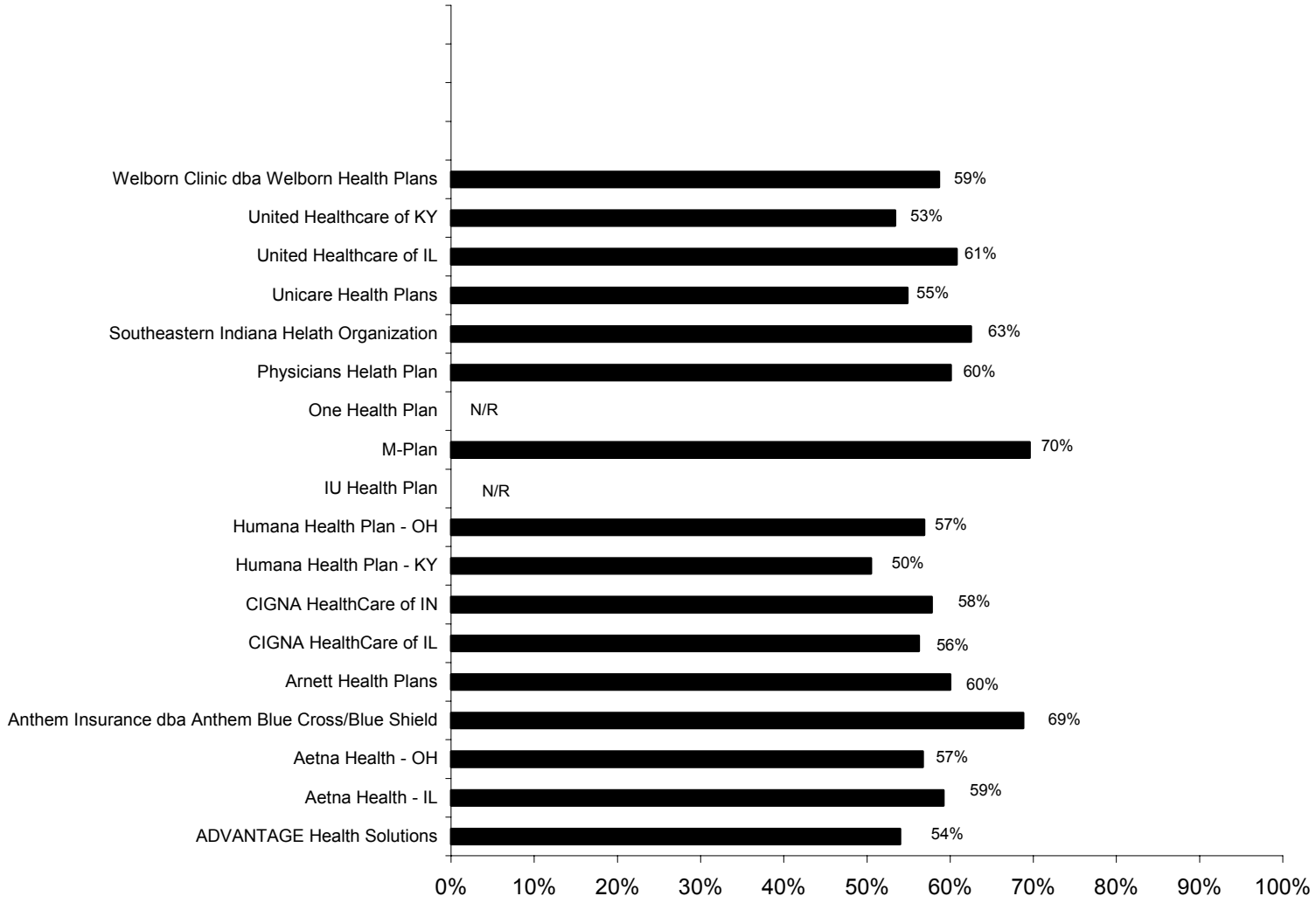
EYE EXAMS FOR PEOPLE WITH DIABETES

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



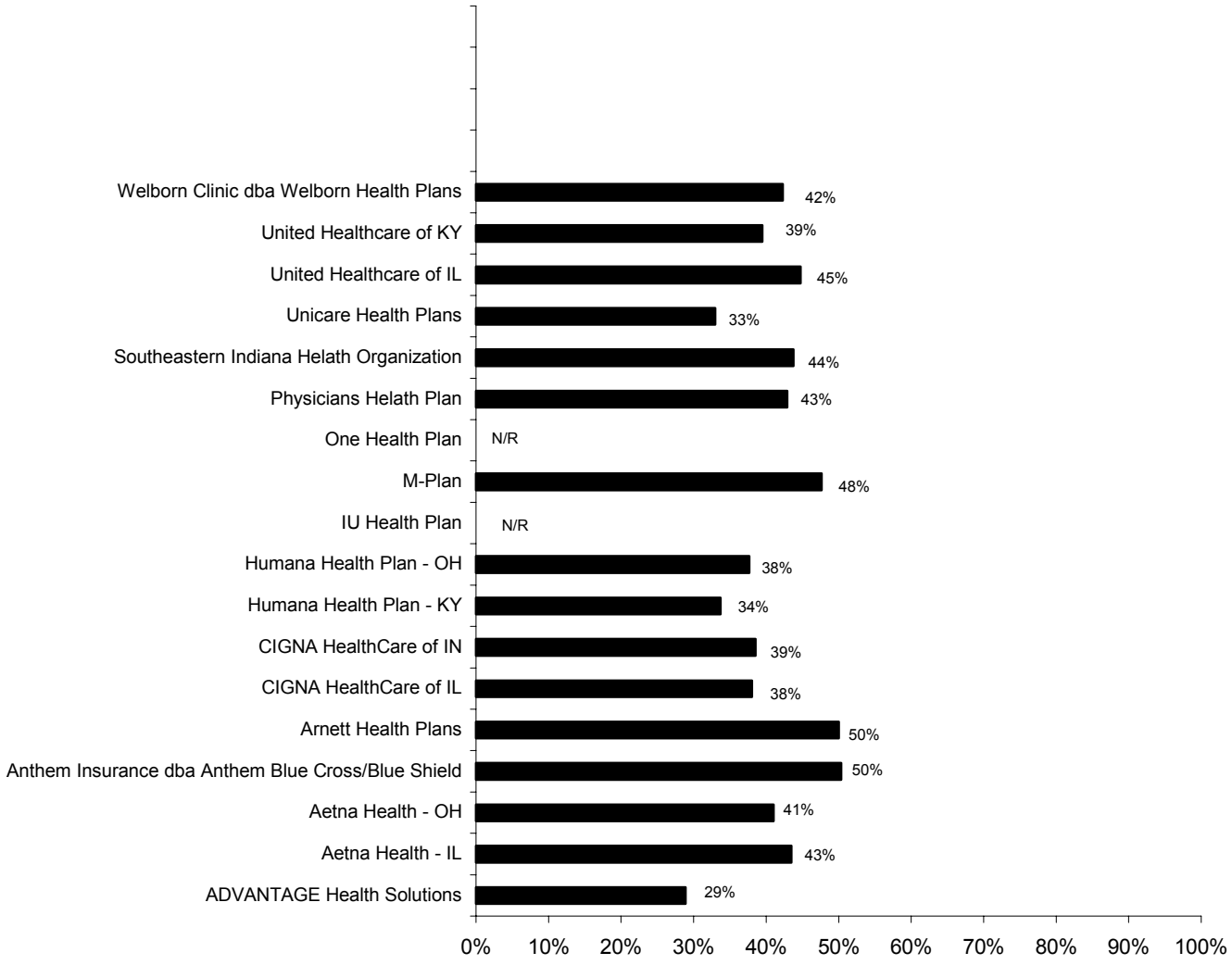
ANTIDEPRESSANT MEDICATION - ACUTE PHASE

Medication can be an effective tool for treatment of depression. Following is the rate of effective acute phase depression treatment.

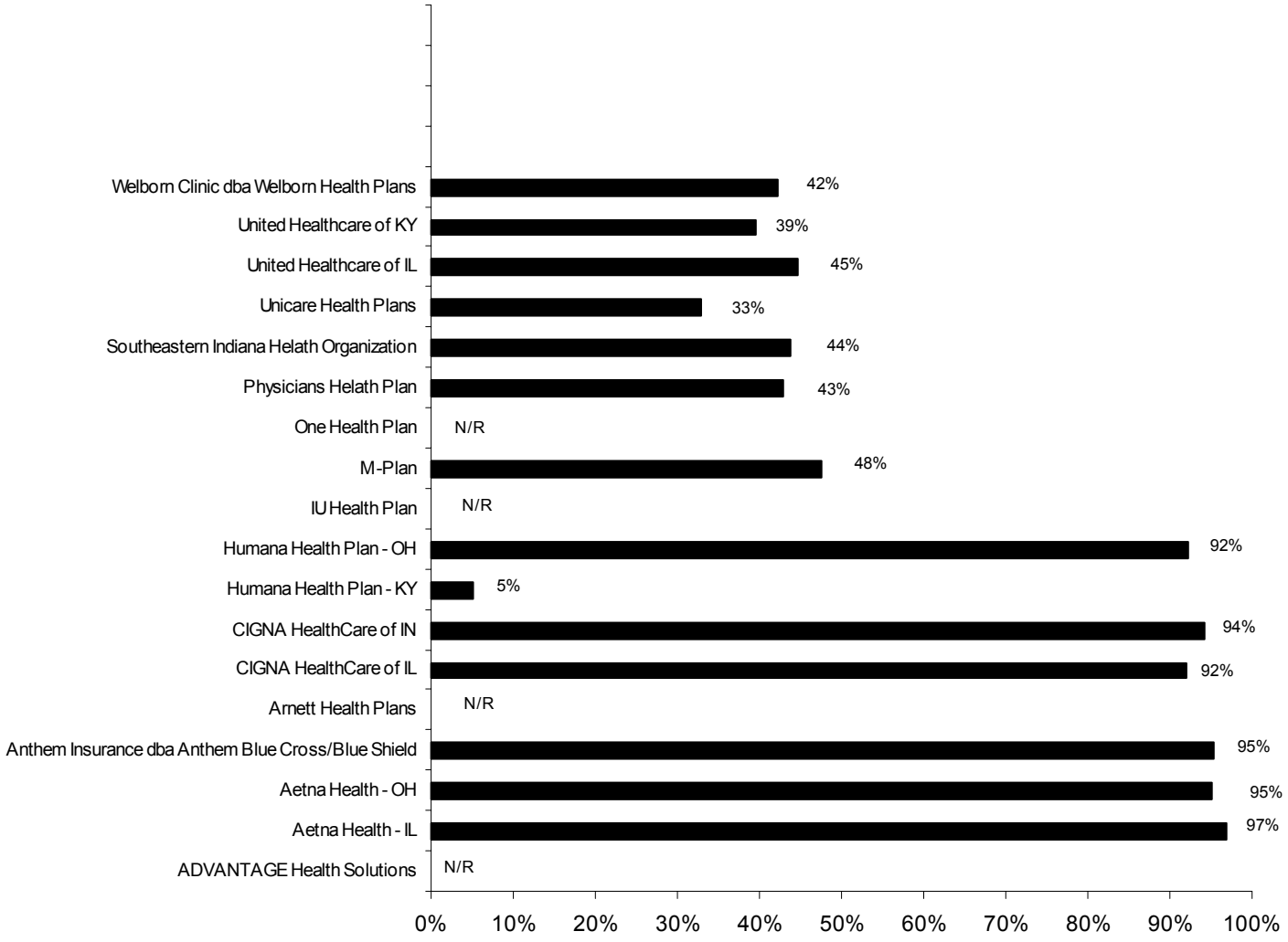


ANTIDEPRESSANT MEDICATION - CONTINUATION PHASE

Medication can be an effective tool for treatment of depression. Following is the rate of effective depression treatment following an acute depression phase.



BETA BLOCKER TREATMENT AFTER HEART ATTACK



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 plan best suited to your needs.

Quality of Care and Service

- Look to see how ell the plan performs in each section of this report.
- Pay special attention to the health issues that are most important to you and your famil**y.**
- 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 cover (annual or lifetime maximum).

Health Plan Stability

- How long has the plan been in business?
- How often do doctors leave the plan?
- What is their rate of disenrollment?
- Are they financially sound?

HEALTH PLAN STABILITY

There are several ways to review a plans' stability. Years in business and retention of providers can be indicators of stability. There are also independent companies that post financial ratings for health plans. You can check financial ratings at www.insure.com.

HEALTH MAINTENANCE ORGANIZATION	YEARS IN BUSINESS	PERCENT OF PROVIDER TURNOVER
ADV ANTAGE Health Solutions, Inc.	2.7	1%
Aetna Health - Illinois	10	15.2%
Aetna Health – Ohio	20	6%
Anthem Insurance dba Anthem Blue Cross/Blue Shield	20	13%
Arnett Health Plans	17	8.3%
CIGNA HealthCare of IL	16.57	6%
CIGNA HealthCare of IN	16.33	5.6%
Humana Health Plan – KY	16	4.4%
Humana Health Plan – OH	24	3.9%
IU Health Plan	6	14.3%
M-Plan	14	4.4%
One Health Plan of IN	5	13.4%
Physicians Health Plan of Northern IN	19	4.9%
Southeastern Indiana Health Organization (SIHO)	15	3%
UNICARE Health Plans of the Midwest	10	6.2%
United Healthcare of IL	N/R	N/R
United Healthcare of KY	N/R	N/R
Welborn Clinic dba Welborn Health Plans	16	9.2%

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 by 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 hear 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.

CONTACTING YOUR HEALTH PLAN

Telephone Numbers and Web Sites

The information in this report covers HMO plans in Indiana. Not all plans offer coverage in all counties. Talk to the health plans or your employer for details. For a list of all HMOs approved to do business in Indiana. Use the telephone numbers and Web sites to learn more about the health plans that interest you.

OTHER IMPORTANT RESOURCES

When making health care decisions, consider other sources of information

NCQA

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 Employer Coverage

The Indiana Department of Insurance regulates insurance sold to individuals and to employer groups that purchase insurance. The Department reviews the policies to make sure they meet Indiana insurance requirements, reviews the rates, investigates consumer complaints and enforces requirements on insurers and agents. For information about your health insurance rights and the companies that you are considering, you can contact the Department at (800) 622-4461.

Self-Insured Plans

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 (859) 578-4680 if you live in southern Indiana or (312) 353-0900 if you live in northern Indiana. You can also visit the Department of Labor website at www.dol.gov/ebsa

For Individuals that Can't Find Insurance

If you know someone who doesn't have employer group insurance and can't find individual insurance due to health conditions, have them call the Indiana Comprehensive Health Insurance Association (ICHIA). ICHIA has insurance available for people with pre-existing health conditions. Call ICHIA at (800) 552-7921 or visit their website at www.onlinehealthplan.com.

Medicare

For information on Medicare coverage options, questions or complaints, call the Indiana Department of Insurance Senior Health Insurance Information Program (SHIIP) at (800) 452-4800, see the Senior Health Insurance portion of the Department website www.in.gov/idoi/shiip.

Medicaid

For information on Medicaid health plan options, quality information and complaints, call the Family and Social Services Administration at (800) 457-4584 or visit their website at www.in.gov/fssa.

The Family and Social Services Administration administer a special health insurance program for children of low-income families. The Children's Health Insurance Program (CHIP) is designed for families that do not have other insurance. For more information, call Hoosier Healthwise at (800) 889-9949 or visit their website at www.in.gov/fssa.

PATIENT PROTECTION – KNOW YOUR RIGHTS

Members of HMOs and other health plans 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 (also called grievances) 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 an 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 an Independent Review Organization (IRO)

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 have 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 exits
- The right to a choice of participating specialists for referrals
- The right of any consumer with a chronic disability to be referred to an experienced specialist
- The right to coverage of certain preventive care, including childhood immunizations and certain cancer screenings
- The right to a minimum amount of time in the hospital after giving birth
- The right to receive continued coverage from a doctor who stops being part of the network for up to 2 months, and longer for certain medical conditions

APPEALS AND COMPLAINTS

Your plan is required to have a grievance and appeal process that gives you an opportunity to resolve disagreement about denial of a covered benefit. This process must meet various criteria, including how quickly the grievance must be resolved. The plan's process must be reviewed and approved by the Department of Insurance. Ask your plan for information on their grievance and appeal process.

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 20 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 ask the plan to arrange an external review with an Independent Review Organization.

You also have the right to file a complaint with the Indiana Department of Insurance.

Indiana Department of Insurance
311 W. Washington, Suite 300
Indianapolis, IN 46204
Fax (317) 232-5251
Phone (800) 622-4461
http://www.in.gov/idoi