



# Guide to Managed Care in Massachusetts

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## About this Guide

The Commonwealth of Massachusetts collects information and analyzes data on the performance of health insurers' managed care plans (Health Plans) in Massachusetts to promote quality of care and improve the value of health care services for Massachusetts residents. This Guide provides information that compares the performance of Massachusetts health plans on measures important for ensuring quality care and services. In addition, this guide should help consumers and employers to:

- choose a health plan or assess their current health plan by using the information on measures relevant to them
- base their health care purchasing decisions on quality and the best value for their money

**Note:** The information presented here pertains to the commercial plans licensed to do business in Massachusetts. These plans afford consumers and employers the ability to choose. Health plans offered by Medicare, Medicaid/MassHealth, and self-funded/ERISA plans are not covered here. To find information about those plans, please see the “Additional Resources” section for contact information. Commonwealth Care, a government-subsidized health insurance program, is not included in the comparison.

Before enrolling in a health plan, you should consult the plan brochure and read the policy to understand specific information about the benefits, the costs and the way the plan may work for you.

At the end of this guide, there is a glossary of health insurance terms.



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## Data Sources

The quality of care you receive is determined by your doctors and your health plan. Purchasers of care therefore hold the payers such as the health plans accountable for the quality and cost of the care plan members receive. This guide offers readers information that can help them assess the relative value of their health plan choices, including disease prevention, screening and early detection, and acute and chronic care measures.

Information from the Division of Health Care Finance and Policy, the Division of Insurance's Bureau of Managed Care and the National Committee for Quality Assurance's (NCQA) 2009 Quality Compass® database was used to develop this guide.

### Health Plan Records

NCQA is managed care's major accrediting and standards-setting body, which analyzes quality data on hundreds of health plans from the Health Plan Employer Data and Information Set (HEDIS®). The measures included here demonstrate how well plans hold providers accountable in preventing and treating illness and providing consumer services to members. This Guide does not present a complete list of available quality indicators; only indicators on consumer services and preventing and managing illness are included. For more information from NCQA, please visit their website at <http://www.ncqa.org>

### Member Survey

NCQA's data also include member satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, which contains data from respondents sampled from enrollees in health plans. CAHPS measures provide information on what consumers say about their experiences with their health plans and medical care.

For information on hospitals and physician groups please visit the MyHealthCareOptions website at <http://hcqcc.hcf.state.ma.us/>. This site compares quality and costs of health care.



# Types of Plans

## Managed Care Plan Programs

Today, there is emphasis on the role of consumers in managing their own health care and health care finances. As a result, many people who have health insurance are enrolled in managed care plans which usually cover a wide range of health services and offer patients lower costs when they use the doctors and other providers who participate in the plan (network providers). The main difference between managed care plans (network-based coverage) and indemnity (non-network-based coverage) has to do with the choice of doctors and other providers, out-of-pocket costs, and how bills are paid. Please see the glossary for more information on indemnity insurance.

The three main managed health plan programs include Health Maintenance Organizations (HMO), Point-of-Service plans (POS), and Preferred Provider Organizations (PPO). An overview of each of these types of plans is presented below:

### Health Maintenance Organization (HMO)

HMOs operate as both insurers and providers because they not only spread the cost of health care across the people enrolled in them, but they also arrange for and coordinate the necessary health care services for their enrollees. HMOs have a network of physicians, hospitals, and other medical providers, and require members to choose a primary care physician (PCP). A PCP is the member's primary care provider with regards to all health-related issues and must refer the member to other physicians, including a specialist, if necessary.



## Types of Plans

### **Managed Care Plan Programs (continued)**

#### Point-of-Service Plans (POS)

POS plans combine features from both HMOs and indemnity (fee-for service) plans. As HMO products, POS plans permit plan members to receive care outside of the HMO network, usually with higher cost sharing. POS plans have primary care physicians who coordinate patient care. Point of Service plans have no deductibles and very limited co-payments for in-network coverage. If you prefer to go out of network, you may have to meet a deductible before your plan pays towards any services you receive.

#### Preferred Provider Organizations (PPO)

PPOs are similar to HMOs in that they enter into contractual arrangements with hospitals, physicians and other health care providers, who together form a provider network that provides services at discounted rates to their members. In a PPO you have more flexibility in choosing physicians and other providers than in an HMO. You may see both participating and non-participating providers, but your out-of-pocket costs will be higher and the member's coverage is limited.



# Consumer Directed Coverage

## Tax-Exempt Health Coverage

These types of arrangements are intended to provide individuals and families greater control over their health care coverage and costs. Included in this category are: Health Savings Accounts (HSA) combined with High Deductible Health Plans (HDHP), Health Reimbursement Accounts (HRA) and Flexible Spending Accounts.

### Flexible Spending Accounts (FSA)

These are arrangements set up by employers to allow employees to set aside pre-tax money to pay for qualified medical expenses during the year. Only employers may set up an account and may or may not contribute to it. There may be a limit to the amount you can contribute to the account. FSAs have a “use it or lose it” provision—any unused money in the account at the end of the plan year will be forfeited.

### Health Savings Accounts (HSAs)

These are tax-exempt accounts that can be used to pay for current or future qualified medical expenses. In other words, members can use the fund to pay qualified medical expenses or roll over unused funds at year end for future use. People can purchase HSAs from most financial institutions like banks, credit unions, and insurance companies. If an employer makes it available for employees and contributes to it, the contributions are excluded from the employee gross income. In order to open a HSA, an individual must have health coverage under a HSA-qualified high deductible health plan (HDHP). If you have an Archer MSA, you may roll it into a HSA. New Archer MSAs may not be established after December 31, 2007 per Internal Revenue Code (IRC) Section 220 as amended.



# Consumer Directed Coverage

## Tax-Exempt Health Plan Programs (continued)

### Health Reimbursement Accounts (HRAs)

Like Health Savings Accounts, HRAs are tax-exempt accounts that can be used to pay for current or future qualified medical expenses. HRAs are employer-established benefit plans that are funded solely by employer contributions which are excluded from employee gross income, with no limits on the amount an employer can contribute. Though it is not a requirement, HRAs are often paired with HDHPs.

### High Deductible Health Plan (HDHP)

HDHPs are insurance policies that can be provided by the employer or purchased from any company that sells health insurance. They are also known as catastrophic health insurance and are often paired with health saving accounts (HSAs). Like HSAs, they are tax-exempt and earnings or savings roll over from year to year as long as they are used to pay for qualified medical expenses. HDHPs are policies that charge lower monthly premiums than traditional plans because the consumer pays the first \$1,200 to \$5,000 or more in medical bills before the insurance pays anything. To qualify, an insurance plan must have high deductibles of at least \$2,400 for families and \$1,200 for individuals. In addition to the high deductibles, consumers need to note that the insurance company may weave many cost-reducing limitations on the plan to lower the premium. The limitations or loopholes may include:

- A cap on lifetime coverage

- A cap on doctor visits

- A cap on hospitalization costs

- Other high out-of-pocket costs in addition to deductible



## Other Health Plan Programs

### Patient Protection and Affordable Care Act

In March 2010, Congress passed and the President signed into law the Patient Protection and Affordable Care Act also known as Affordable Care Act, which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. For more information, please visit [www.HealthCare.gov](http://www.HealthCare.gov)

### The Commonwealth Health Connector

The Health Connector is an independent state agency that was created by the 2006 Massachusetts Health Reform Law in order to connect individuals, families and businesses to a choice of affordable, high quality health insurance plans through the following two programs:

Commonwealth Care – a government-subsidized health insurance program for qualified uninsured adults, whose family income is 0%-300% of the Federal Poverty Limit (FPL). Annually, 300% FPL is \$32,496 for a single person and \$66,156 for a family of four. Commonwealth Care plans are offered by Boston Medical Center (BMC) HealthNet Plan, CeliCare Health Plan of Massachusetts, Fallon Community Health Plan, Neighborhood Health Plan, and Network Health.

Commonwealth Choice – a non-subsidized insurance program for small employers and individuals. Commonwealth Choice plans are offered by Blue Cross Blue Shield of Massachusetts, CeliCare Health Plan of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Associated HMO.

For more information on these programs, please visit the Health Connector's website at [www.MAhealthconnector.org](http://www.MAhealthconnector.org)



## Other Health Plan Programs

### The Commonwealth Care Bridge Program

The Commonwealth Care Bridge program is a special state-subsidized health insurance program for uninsured legal immigrants known as Aliens with Special Status (AWSS) whose family income is 0%-300% of the Federal Poverty Limit (FPL). The Health Connector, the Massachusetts' Executive Office of Health and Human Services, and the Executive Office of Administration and Finance oversee the program. Coverage through the Commonwealth Care Bridge program is offered by CeliCare Health Plan of Massachusetts. For more information on this program, please visit the CeliCare website at [www.celticarehealthplan.com/current-members/commonwealth-care-bridge/](http://www.celticarehealthplan.com/current-members/commonwealth-care-bridge/)

### Unlicensed Health Plans

Prior to purchasing any insurance coverage, consider contacting the Massachusetts Division of Insurance at (617) 521-7794 or visit their website at [www.mass.gov/doi](http://www.mass.gov/doi) for consumer guides and up-to-date information on approved health insurance coverage products. Not all health plans are licensed to operate in Massachusetts. For instance, Discount Plans, which provide consumers with discounts for medical, dental, vision, and other health care products or services from certain providers in exchange for a fee, are not insurance products and are therefore not regulated by the Division of Insurance. The Office of Attorney General recently disseminated regulations to protect consumers from misleading marketing by promoters of these plans.

For more information on how to protect yourself please visit [http://www.mass.gov/Cago/docs/healthcare/health\\_advisory.pdf](http://www.mass.gov/Cago/docs/healthcare/health_advisory.pdf)

**Note:** Residents of Massachusetts age 18 or older are required to have health insurance coverage or face a penalty (unless you are exempt or qualify for a waiver).



**Table 1: Plan Profiles (1 of 2)**

Plan Name	Plan Address	Telephone/TTY Website	# of HMO/POS Members 12/31/09	MA Counties Served	NCQA Accreditat ion Status	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness
<b>Aetna Health, Inc.</b>	401-1 Totten Pond Rd, Waltham, MA 02451	(781) 902 3800 (800) 842 9710 www.AETNA.com	10,857	All but Duke and Nantucket	Excellent	***	****	****	****	****
<b>Blue Cross Blue Shield of Massachusetts</b>	401 Park Drive, Boston MA 02215	(800) 522 1254 (800) 247 2583 www.bluecrossma. com	1,208,826	All	Excellent	****	****	****	****	****
<b>CIGNA HealthCare of Massachusetts, Inc.</b>	P.O. Box 5200, Scranton, PA 18505-5200	(800) 244 6224 (800) 654 5988 www.cigna.com	26,026	All but Duke and Nantucket	Excellent	****	****	****	****	****
<b>ConnectiCare of Massachusetts, Inc.</b>	175 Scott Swamp Road P.O. Box 4050, Farmington, CT 06034-4050	(800) 251 7722 (800) 833 8134 www.ConnectiCare .com	5,750	Berkshire, Franklin, Hampden, Hampshire and Worcester	Excellent	****	****	****	****	****
<b>Fallon Community Health Plan, Inc.</b>	10 Chestnut St. Worcester, MA 01608	(800) 868 5200 (877) 608 7677 www.fchp.org	138,370	All but Duke and Nantucket	Excellent	****	****	****	****	****

**Notes:** Information on number of Counties Served was retrieved from the Managed Care Bureau of the Massachusetts Division of Insurance and represents HMO members only.  
Plans were given one to four stars rating for the quality measures, where four stars \*\*\*\* is the highest rating.



**Table 1: Plan Profiles (2 of 2)**

Plan Name	Plan Address	Telephone/TTY Website	# of HMO/POS Members 12/31/09	MA Counties Served	NCQA Accreditat ion Status	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness
<b>Harvard Pilgrim Health Care, Inc.</b>	93 Worcester St. Wellesley, MA 02481	(888) 888 4742 (800) 637 8257 www.harvardpilgrim. org	516,835	All	Excellent	****	****	****	****	****
<b>Health New England</b>	1 Monarch Place, Suite 1500, Springfield, MA 01144-4004	(800) 842 4464 www.hne.com	1,208,826	Berkshire, Franklin, Hampden, Hampshire and Worcester	Excellent	****	****	****	****	****
<b>Neighborhood Health Plan, Inc.</b>	263 Summer St. Boston, MA 02210	(800) 462 5449 (800) 655 1761 www.nhp.org	66,715	All but Berkshire, Franklin and Hampshire	Excellent	****	***	****	****	****
<b>Tufts Associated HMO, Inc.</b>	700 Mount Auburn St. Watertown, MA 02472-1508	(800) 462 0224 (800) 868 5850 www.tuftshealthplan. com	28,059	All	Excellent	****	****	****	****	****
<b>UnitedHealth- care of New England, Inc.</b>	475 Kilvert St Warwick, RI 02886	(888) 735 5842 www.uhc.com	365,985	All but Berkshire, Duke, Franklin, Hampden, Hampshire and Nantucket	Excellent	***	****	***	***	****

**Notes:** Information on number of Counties Served was retrieved from the Managed Care Bureau of the Massachusetts Division of Insurance and represents HMO members only.  
Plans were given one to four stars rating for the quality measures, where four stars \*\*\*\* is the highest rating.



## Choosing a Health Plan

Choosing a health plan for yourself and/or your family is your responsibility. The best plan for someone else may not be the best for you. You will need to examine the types of plans, the benefits offered by the organization you are considering, and if the plan meets the required minimum creditable coverage (MCC). Some important things to consider when selecting a health plan include:

- Employer offerings: many employers only offer one plan

- The quality of care and service you will receive

- Whether you will be able to see the doctor you want

- Whether your special health care needs are covered

- The overall cost of the plan for you and your family

In addition, you may wish to ask how a plan handles:

- Physical therapy and other rehabilitative services

- Home health, nursing home and hospice care

- On-going care for chronic diseases, conditions or disabilities

- Obstetrics-gynecological care and family planning

- Care and counseling for mental health

- Services for drug and alcohol abuse

- Experimental treatments

- Chiropractic or alternative health care, such as acupuncture

- Wellness



## Choosing a Health Plan

When choosing a health plan, you may wish to consider the following questions:

### ***Does the plan meet the Minimum Creditable Coverage?***

Minimum Creditable Coverage (MCC) is the essential benefits you need to be considered insured and avoid tax penalties. Insurers licensed in Massachusetts must let consumers know if their plans meet these standards. For more information, please visit <https://www.mahealthconnector.org>

### ***What plan benefits are offered?***

Most plans offer the basic medical coverage. When considering a plan, check how it handles the following:

- Physical examinations and health screenings
- Care by specialists
- Prescription medications
- Hospitalizations and emergency care
- Dental services
- Vision care

### ***Will I be allowed to select my caregivers?***

The three main types of health plan (HMO, POS, and PPO) differ according to how flexible you are in your choice of caregivers. For instance, if you or a family member has a chronic condition like high blood pressure or diabetes, you should choose a point-of service (POS) plan or preferred provider organization (PPO), which offers unrestricted access to specialists. In that situation, an HMO, which restricts members to providers in a defined network, may not be suitable. However, the choice and protection provided by an HMO might be enough for someone young and healthy.

### ***Can I keep my current physicians?***

You will need to check the provider network of an organization before you make your choice. If the physicians you use are not in the plan of your choice, switching to others may not be easy. Your health may be affected if you chose your current caregivers because of their specific expertise.



## Choosing a Health Plan

### ***Can I get a premium discount from a plan?***

Many plans offer discounts if you take a health risk assessment, stop smoking, or keep a chronic disease like diabetes in control. So, check out wellness management incentives.

### ***Should I consider a catastrophic health insurance?***

Catastrophic health insurance coverage provides for major hospital and medical expenses. If you will like to pay a lower monthly premium than traditional plans, you will need catastrophic insurance. In this instance, you should consider pairing the catastrophic plan with a tax-deductible account such as health savings account (HSA), which you set up yourself or a health reimbursement account (HRA), which your employer sets up and funds. This way, you can cover the high-deductibles with the HSA or HRA. Please see the section on Health Plan Programs for more information.

### ***How do I know if there are caps on my coverage?***

Check your chosen plan's brochure for caps because most plans impose annual limits on coverage or medications. If your monthly premium is very low, chances are you have caps on your coverage or doctor's visits. Please see the section on Health Plan Programs for more information.

### ***Will my medications be covered?***

Always review the plan's list of medications or formulary to see your co-pay. A brand-name drug for a chronic condition can be costly and may not be on your plan's list. You may wish to consider getting your medications by mail because it often includes lower co-pays. Many plans offer this option.



**Table 2: Comparison of Health Plan Types**

HMO	POS	PPO	FFS
Who can I see for care?			
Your plan's network of doctors, hospitals, specialists, and other health care professionals.	In-network or out-of-network providers. However, if you go out of network, you will have to pay more for your care.	In-network or out-of-network providers. However, if you go out of network, you will have to pay more for your care.	Any health care provider that accepts your plan.
Do I need to designate a primary care provider (PCP)?			
Yes. Your PCP helps manage and coordinate all your health care needs.	Yes.	No.	No.
How do I pay for services?			
You pay a copayment for most or all health care services. There is usually no need to fill out a claim form.	For in-network providers, you may pay a copayment or coinsurance for any service you use and you may have a deductible. There is usually no need to fill out a claim form. For out-of-network providers, you may pay a higher copayment or coinsurance and may have a higher deductible than for in-network services. Members may also have to fill out a claim form.	For in-network providers, you may pay a copayment or coinsurance for any service you use and you may have a deductible. There is usually no need to fill out a claim form. For out-of-network providers, you may pay a higher copayment or coinsurance and may have a higher deductible than for in-network services. Members may also have to fill out a claim form.	You may pay a deductible and coinsurance. Members may have to fill out a claim form.
Do I need a referral from my PCP to see a specialist?			
Yes, usually for most visits to specialists.	Yes, usually for most in-network specialists.	No.	Referrals are usually not needed to see any provider.
Who pays if I see a provider outside of my network?			
Usually, you pay for care outside the network out of your own pocket. Plan may pay for emergency care provided by out-of-network providers.	You pay more for care than you would had you used an in-network provider unless you received emergency care.	You pay more for care than you would had you used an in-network provider unless you received emergency care.	Networks are not relevant.



## Health Plan Costs

### *How do I estimate the costs?*

To determine the cost of your chosen health plan, you need to consider the monthly contribution in addition to other payments you may face when you use health services. Here are some of the costs you may incur:

**Premium:** In every plan you have monthly premium contributions which is the amount you pay to belong to a health plan. You may pay all or part of the monthly premium depending on whether your employer contributes to some of the premium costs.

**Deductible:** This is the amount of money the policyholder pays for medical bills before insurance starts to pay its part. Most workers enrolled in PPOs have annual deductibles for single coverage that must be met before the plan pays anything. In contrast, only half of workers in POS and 20% of those in HMOs have annual deductibles for single coverage.<sup>[1]</sup> However, a majority of workers enrolled in PPOs do not have to meet the deductible before preventive care and prescription drugs are covered by their plans.

**Co-payment:** The dollar amount the policyholder pays at each visit for a medical service is called co-payment. A majority of enrollees in HMO, PPO, and POS plans have co-payments for physician office visits, while those covered in HDHP have co-insurance requirements.

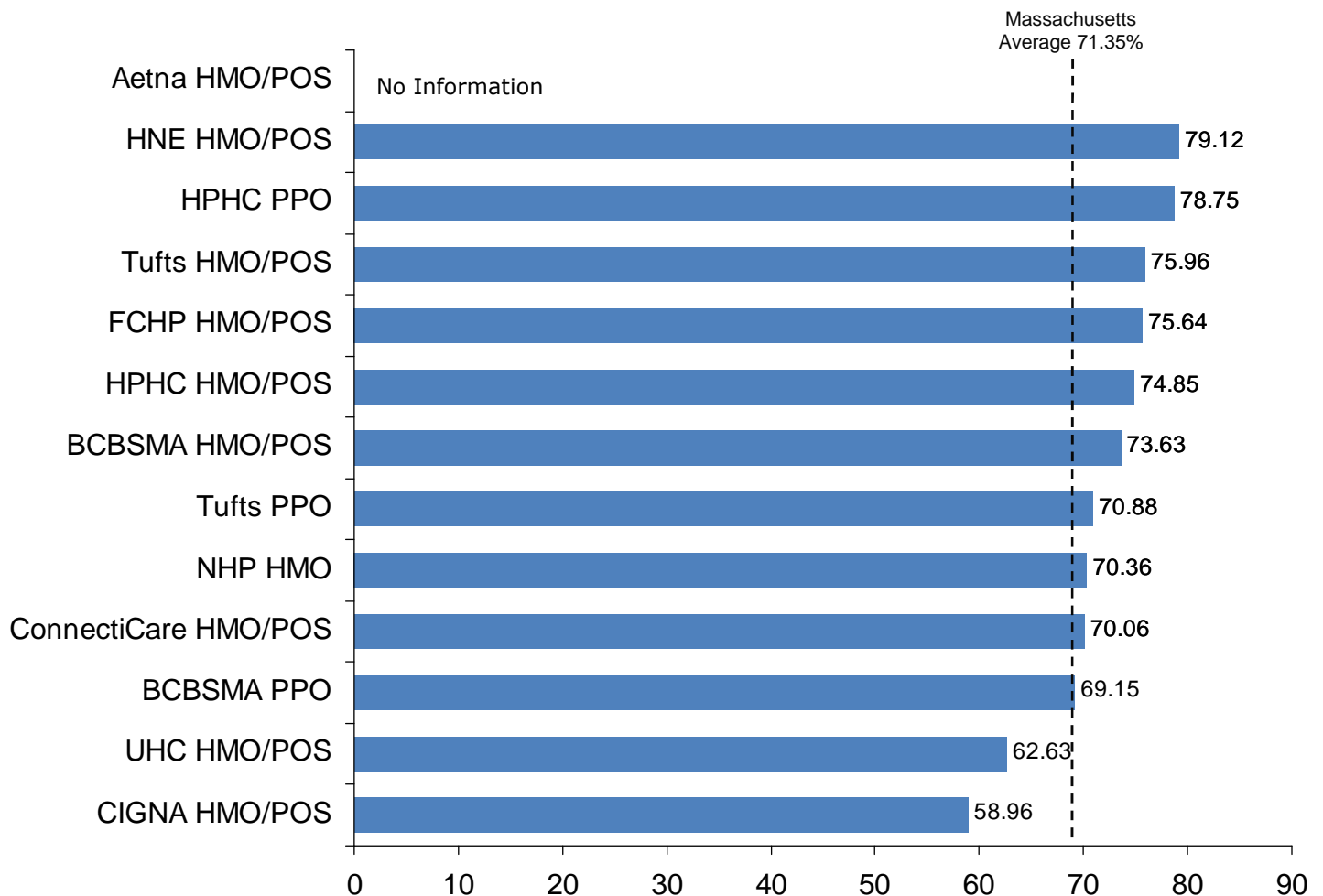
Most covered people also pay a portion of the cost of their prescription drugs. A majority of employees are enrolled in health plans that have three or more levels or tiers of co-payments that are based on the type or cost of the medication. The average co-payment for the first tier drugs or generics is \$10.

**Cost-sharing:** This is an amount you must pay for medical care after you have met your deductible. In addition to the annual deductible amount, covered people are often faced with cost sharing during hospitalization or when having outpatient surgery. The cost sharing may include a separate annual hospital deductible.

[1] The Kaiser Family Foundation and Health Research & Educational Trust. Employer Benefits: 2008 Annual Survey



## Health Plan Costs: Plan Information on Cost



The percentage of members who said the plan easily informed them about the cost of treatment.

A higher score for this measure is desirable because it indicates that the plan provides the information their members need to make a fully informed decision.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Quality of Care and Service

There are various services and protections available to help you choose a health plan that offers the level of care you and your family need. In addition to the resources described in the “Measuring Quality” section, you can check if your health plan is licensed to operate in Massachusetts and accredited by a reputable organization.

### ***Accreditation by the Massachusetts Bureau of Managed Care***

The Bureau of Managed Care within the Division of Insurance (DOI) sets minimum standards for managed care organizations (MCO) and investigates complaints against a carrier for noncompliance with accreditation requirements. Massachusetts law requires all MCOs to be accredited by the Bureau and let the Bureau know what systems are in place to manage care, and detect problems and correct them.

However, not all plans are subject to Massachusetts law. For instance, self-funded/ERISA plans, Medicare and Medicaid/MassHealth plans, the Group Insurance Commission self-funded plans, and the Federal Employees Plan are exempt from state insurance laws.

### ***Accreditation by Private Accrediting Organizations***

Another way to determine the quality of a health plan is to find out whether or not it is accredited by a private accrediting organization. The value of accreditation varies by what is required to become accredited and how dependable the system is. The NCQA and the Utilization Review Accreditation Commission (URAC) are two organizations that accredit health plans.

Table 1 on pages 13 and 14 shows the National Committee for Quality Assurance (NCQA) accreditation status for the health plans that sought NCQA accreditation.



## Quality of Care and Service

There is no one plan that will meet everyone's needs. Some plans will be better than others for you and your family's health care needs. For instance, if your family includes a toddler, you will need to know how well a plan works to keep immunizations current. If your family includes someone that has a heart disease, you should consider a plan's success in treating heart disease. However, you'll also have to consider if a plan serves people in your geographic area. This information is presented in Table 1: Plan Profiles.

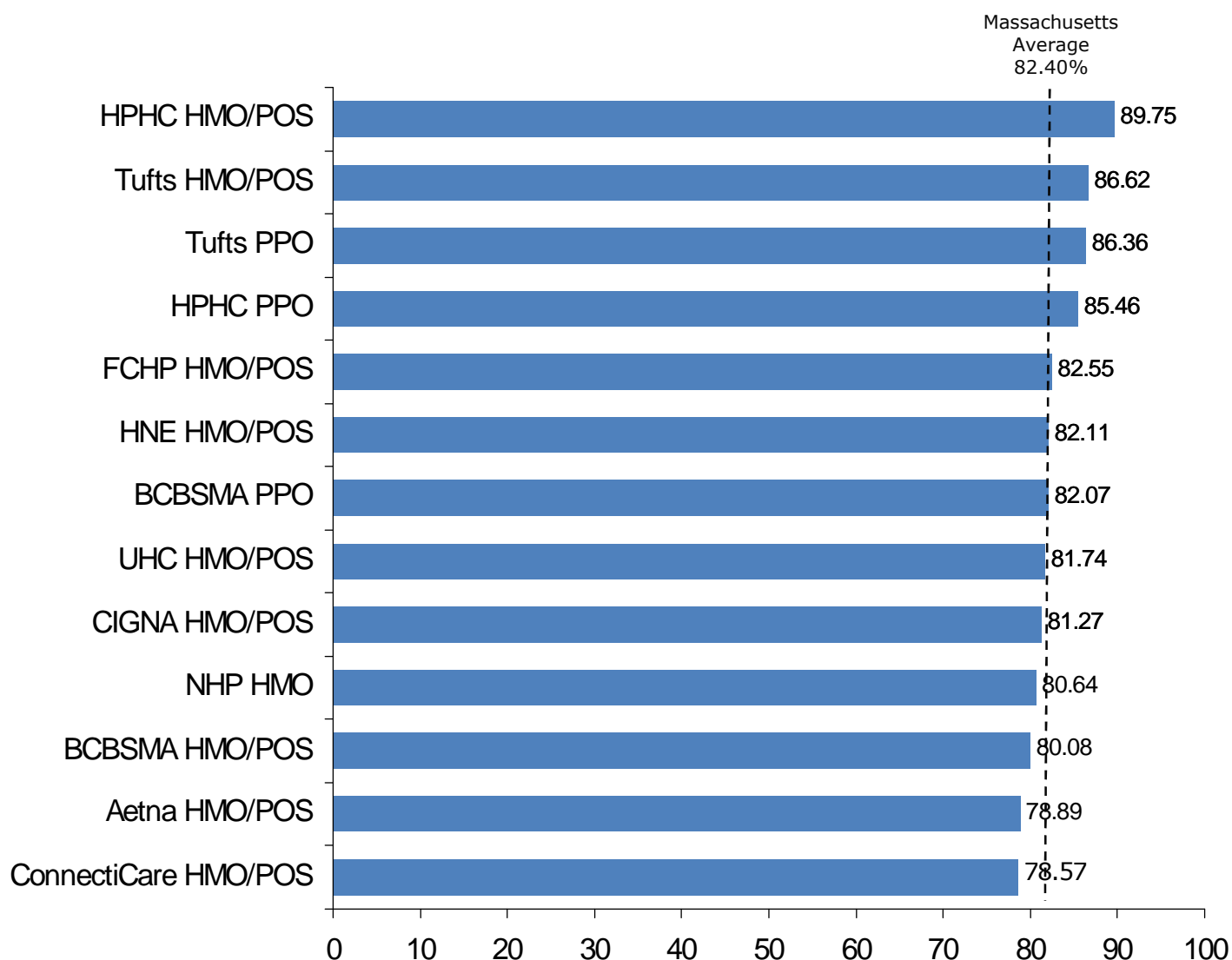
You may also wish to know if a plan you are considering has a program in place for managing chronic disease like asthma or diabetes. However, to make a good choice, you need to ask if a diabetic who is at risk for blindness can receive needed eye examinations.

The following charts present results of data analyzed by the NCQA about how well health plans and their providers fared in preventing and treating illness and providing consumer services to their members. These charts allow you to consider quality measures in your choice of a health plan.

Please note that the charts include only health plans for which there are data on the selected quality measures. These measures were selected because they indicate the plans and their providers performance on consumer services and preventing and managing illness.



## Rating of Personal Doctor



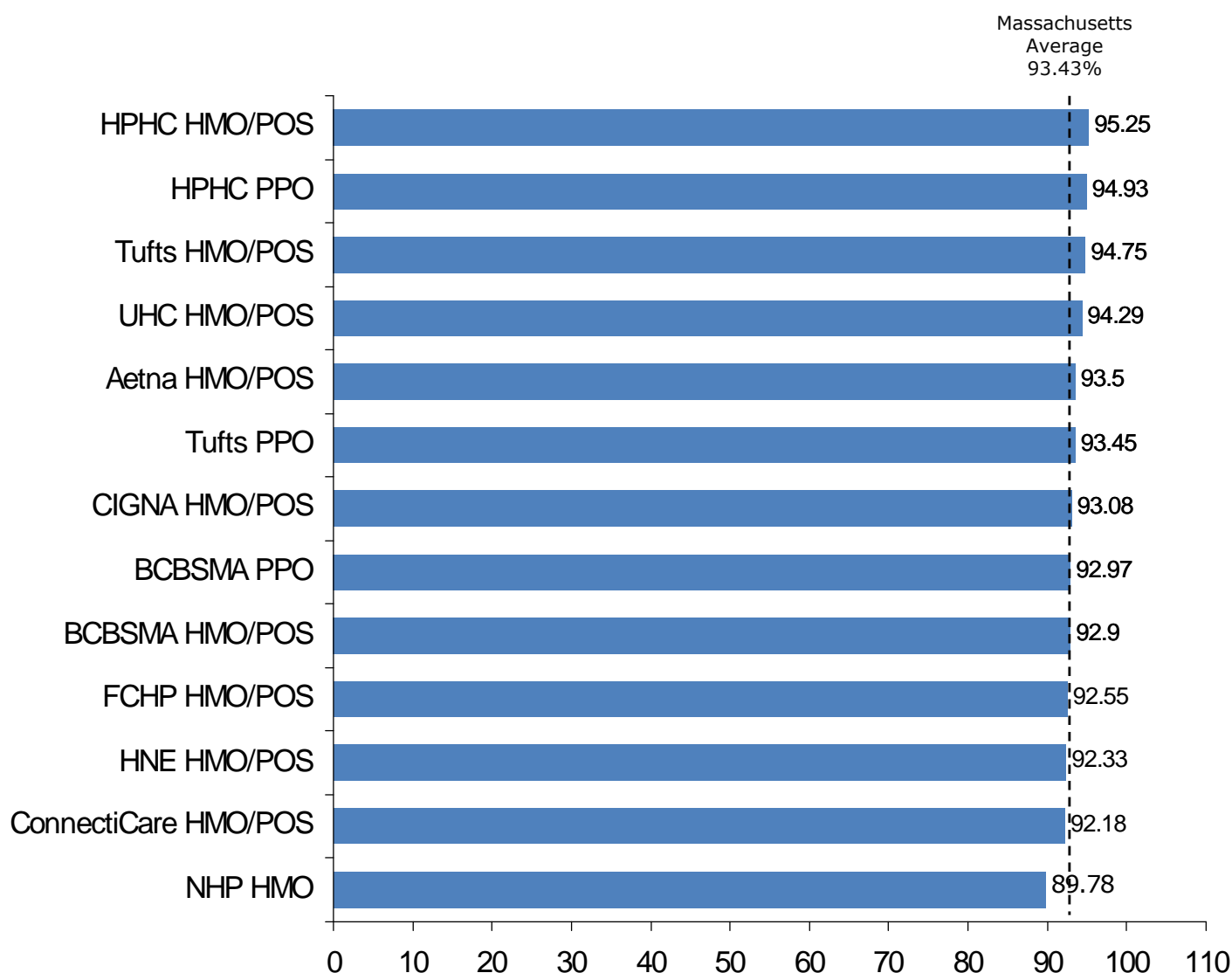
The percentage of members who rated their personal doctors 8, 9 or 10, where 0 is the worst personal doctor possible and 10 is the best.

A high rate indicates that more members rate their personal doctors positively.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# How Well Doctors Communicate



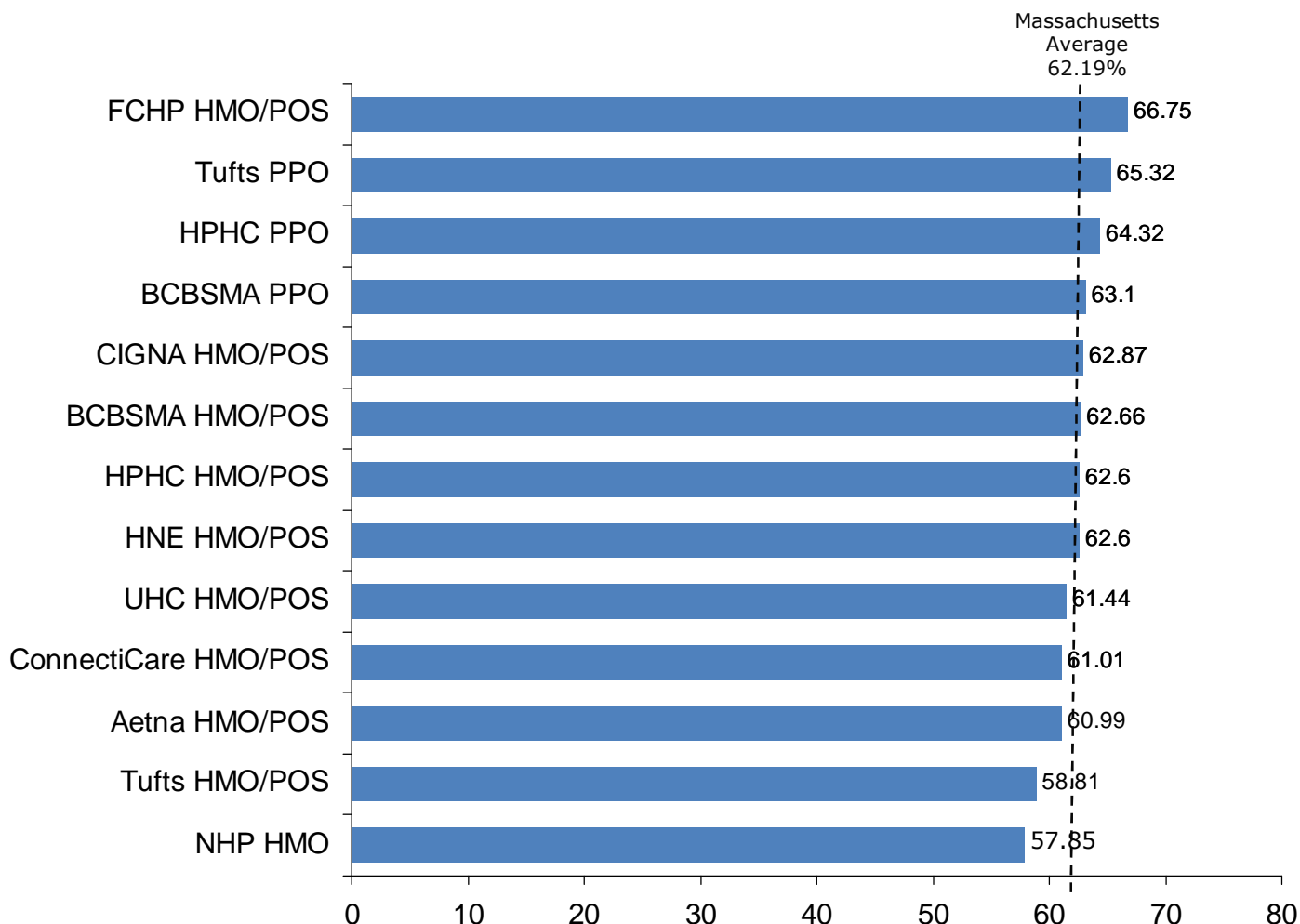
The overall percentage of members who said their personal doctors always or usually spent enough time with them, listened carefully to them, and often explained things in a way that was easy to understand.

A high score for this measure is favorable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Shared Decision Making



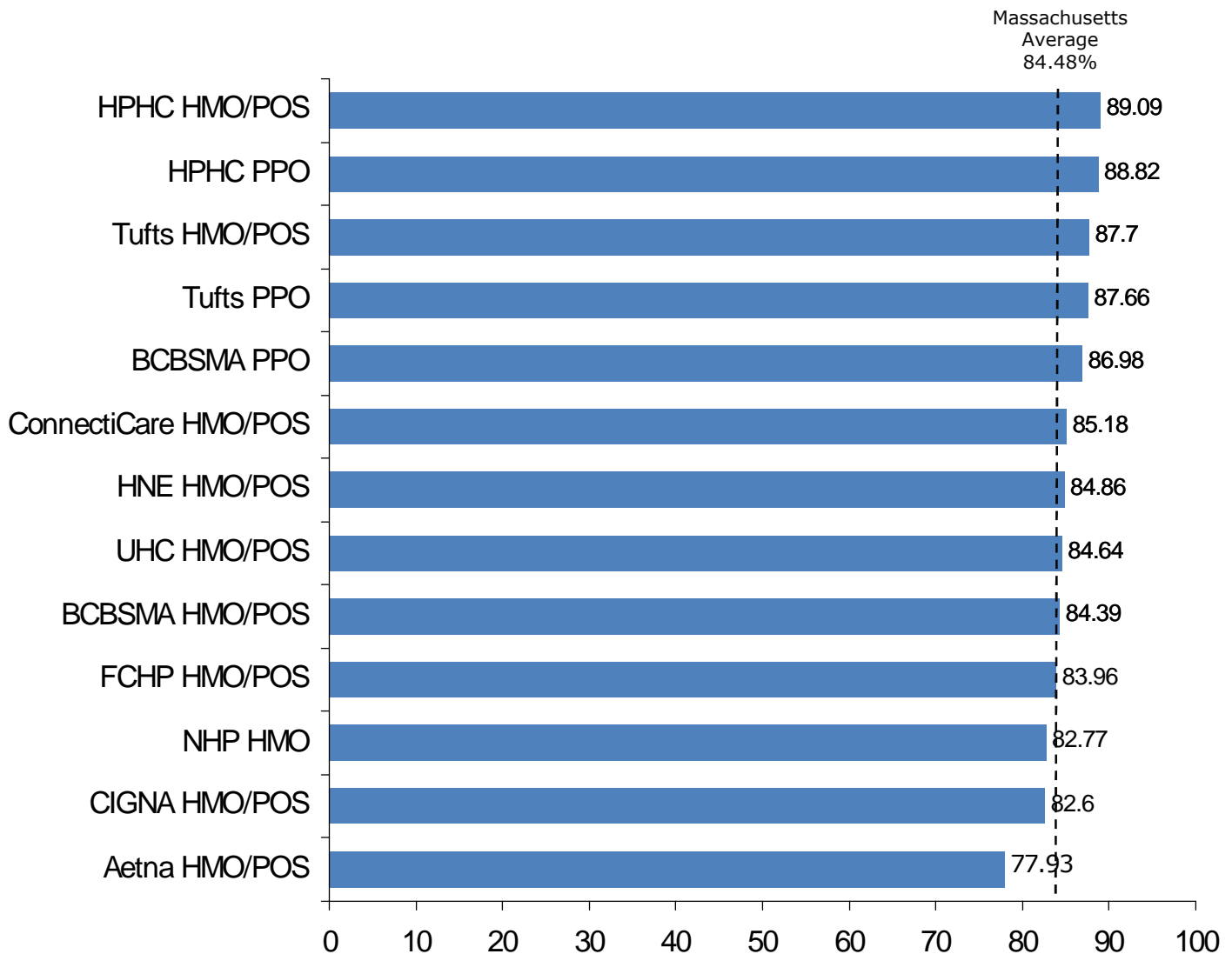
The percentage of members who said their doctor or other health care provider offered choices of treatment to them, discussed the pros and cons of each choice and asked which choice was best for them.

A higher score for this measure is desirable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Getting Needed Care



The overall percentage of members who said it was always or usually easy for them to get appointments with specialists, and to get tests or treatments they thought they needed through their health plan.

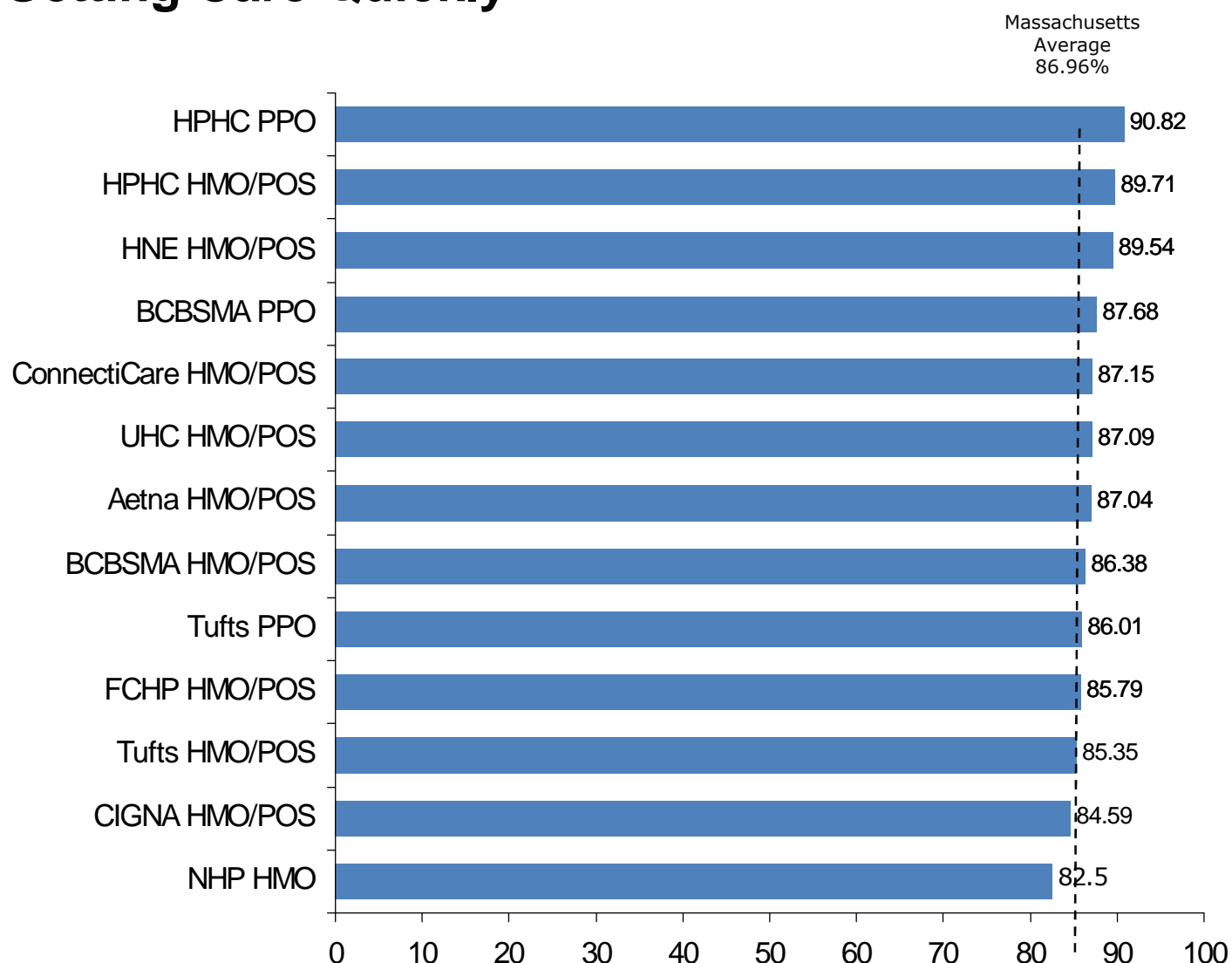
One concern about managed care is that it may limit access to necessary care.

A high score on this measure is favorable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Getting Care Quickly



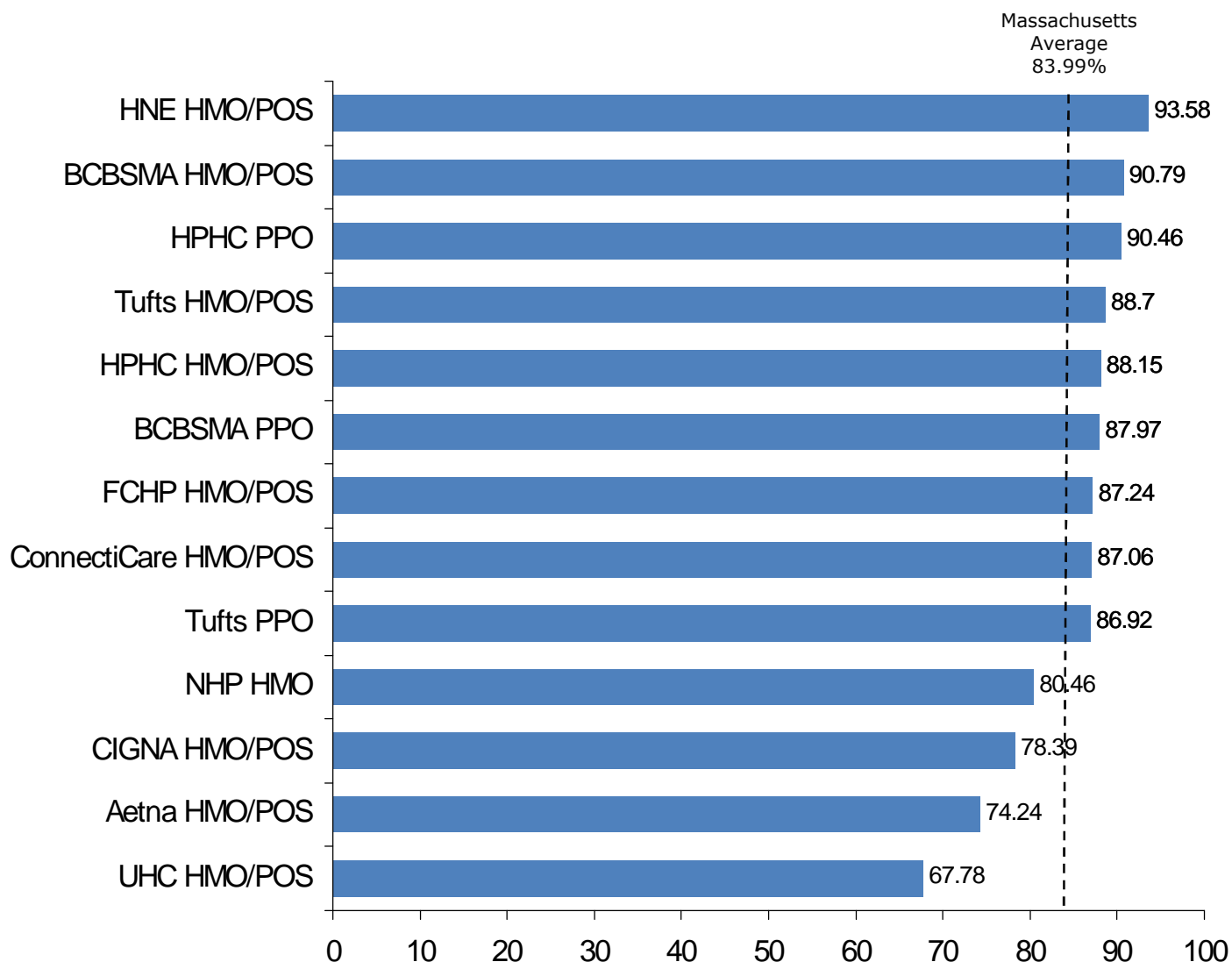
The overall percentage of members who said it was always or usually easy for them to get appointments for health care at a doctor's office or clinic and access care as soon as they thought they needed.

A higher score for this measure is desirable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Health Plan Customer Service



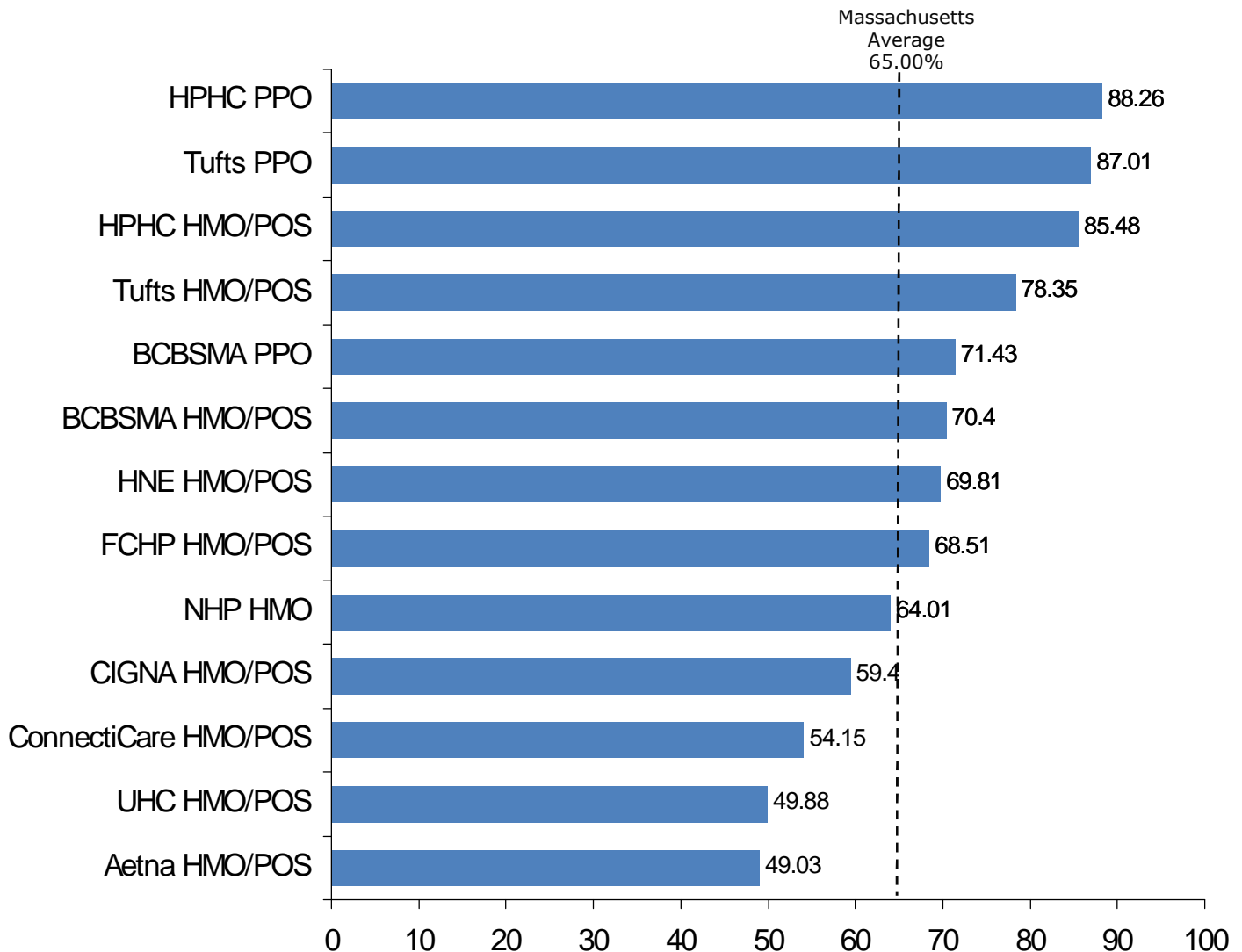
The overall percentage of members who said their health plan's customer service department always or usually gave them the information or help they needed and treated them with courtesy and respect.

A higher score on this measure is desirable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Rating of Health Plan



The percentage of members who rated their health plan 8, 9, or 10, where 0 is the worst health plan possible and 10 is the best.

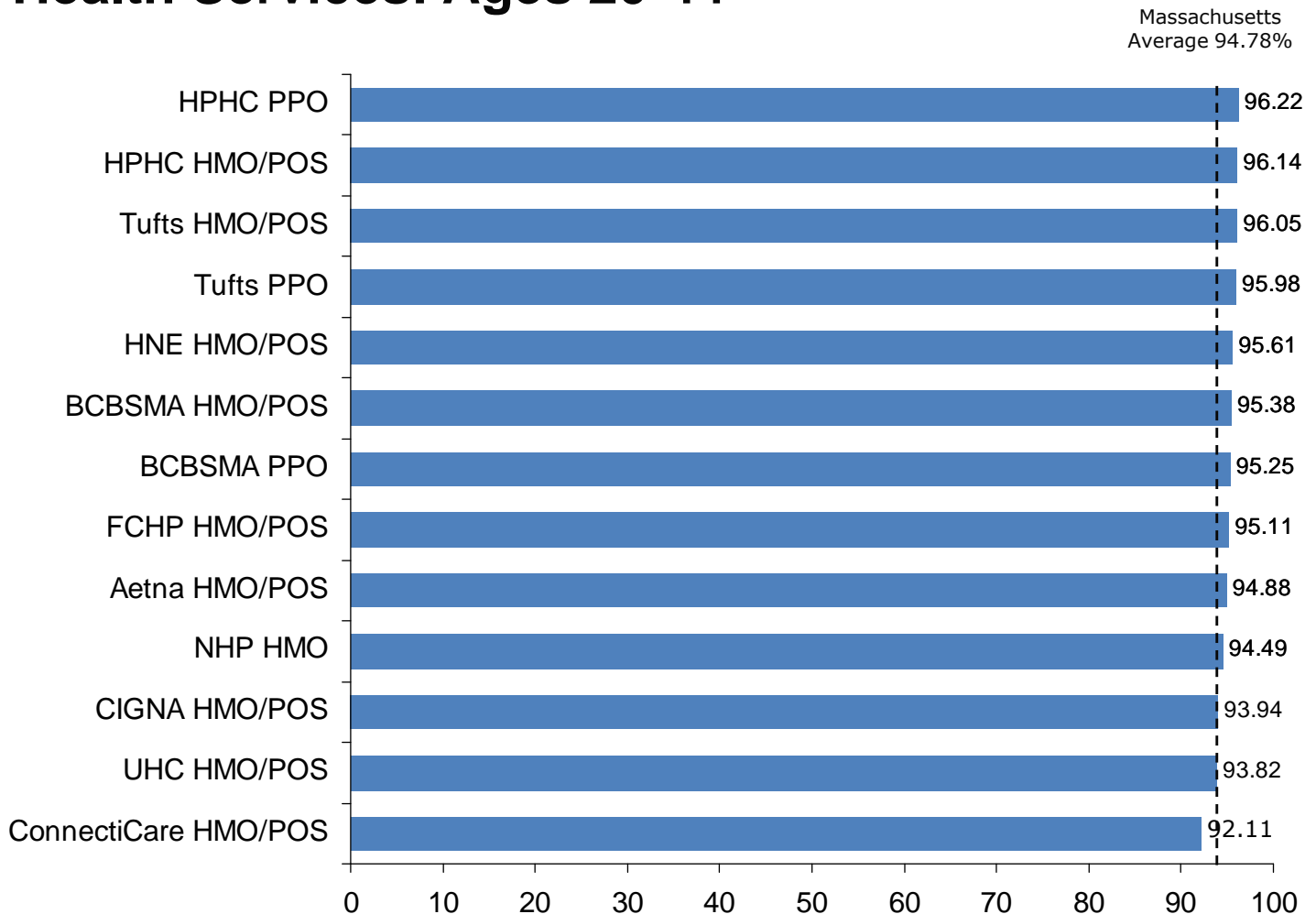
This measure gauges the overall member satisfaction with their health plan.

A higher score on this measure is desirable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Adult Access to Preventive Health Services: Ages 20-44



The percentage of adults ages 20-44 who have had a preventive care visit during the specified measurement period.

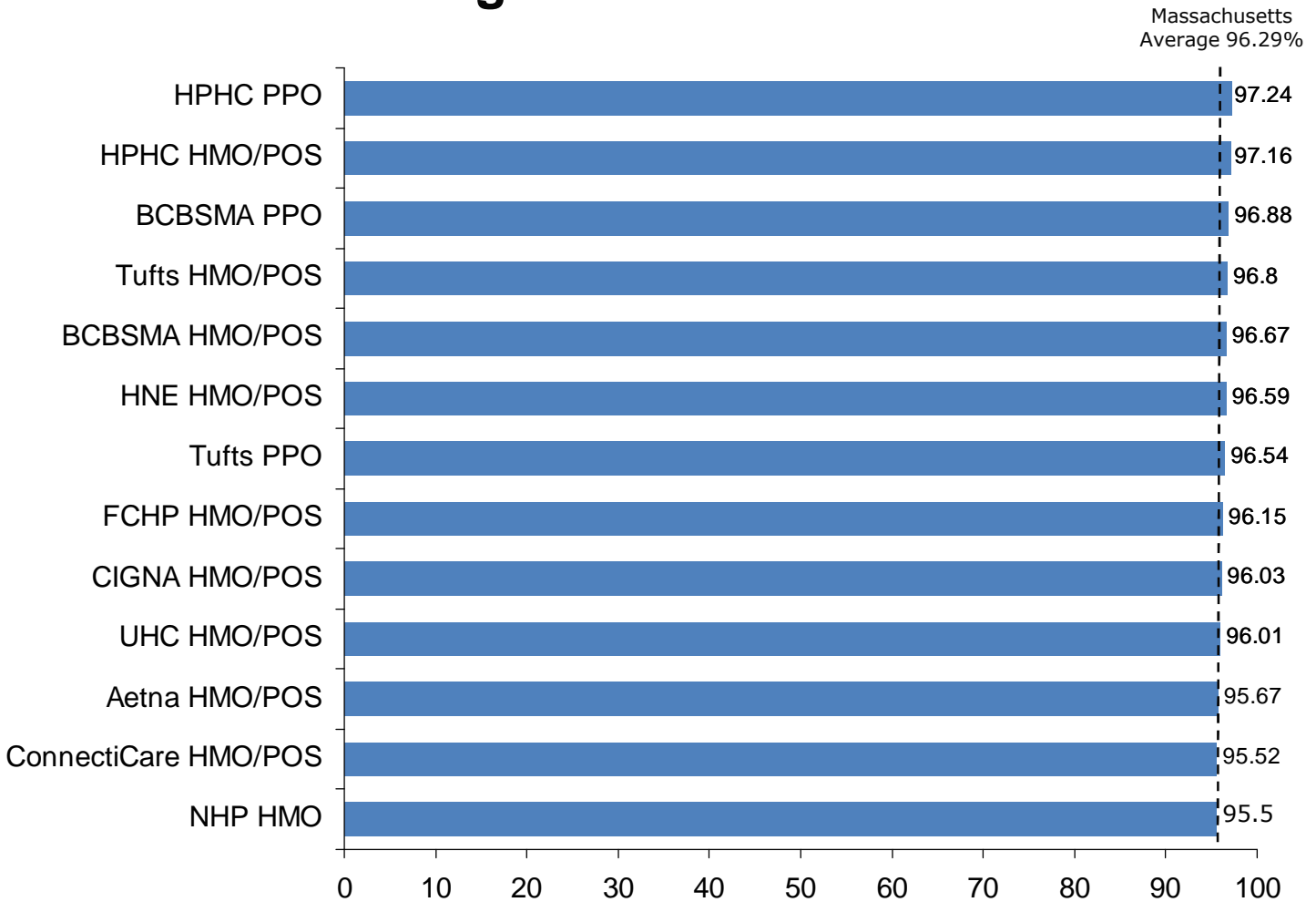
A high rate means that members in that plan are seen at least once every three years for preventive care.

Plans are responsible for providing care to all members. Members who do not access preventive health care are more likely to develop advanced or preventable disease.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Adult Access to Preventive Health Services: Ages 45-64



The percentage of adults ages 45-64 who have had a preventive care visit during the specified measurement period.

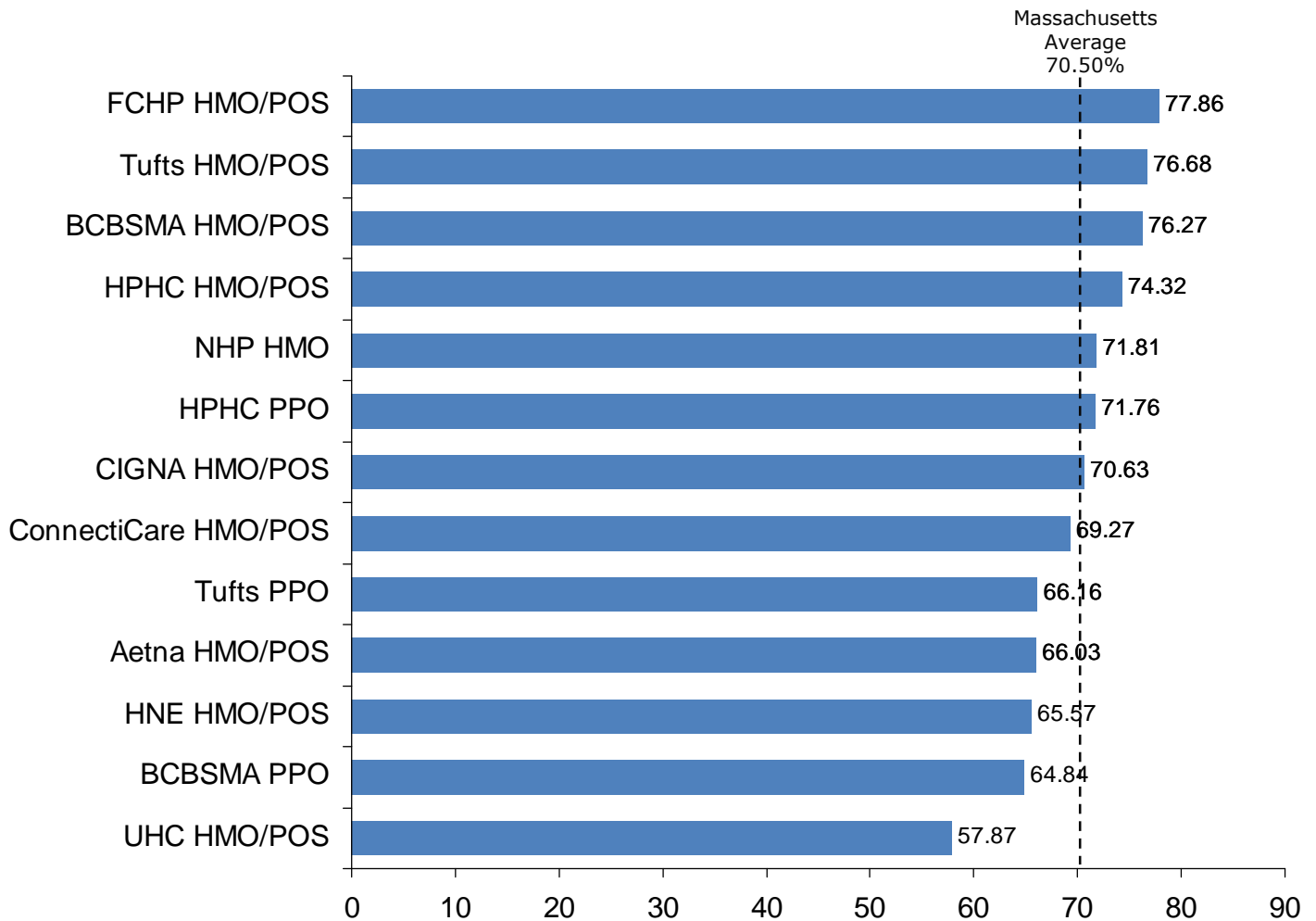
A high rate means that members in that plan are seen at least once every three years for preventive care.

Plans are responsible for ensuring that all members receive care. Members who do not access preventive health care are more likely to develop advanced or preventable disease.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Colorectal Cancer Screening



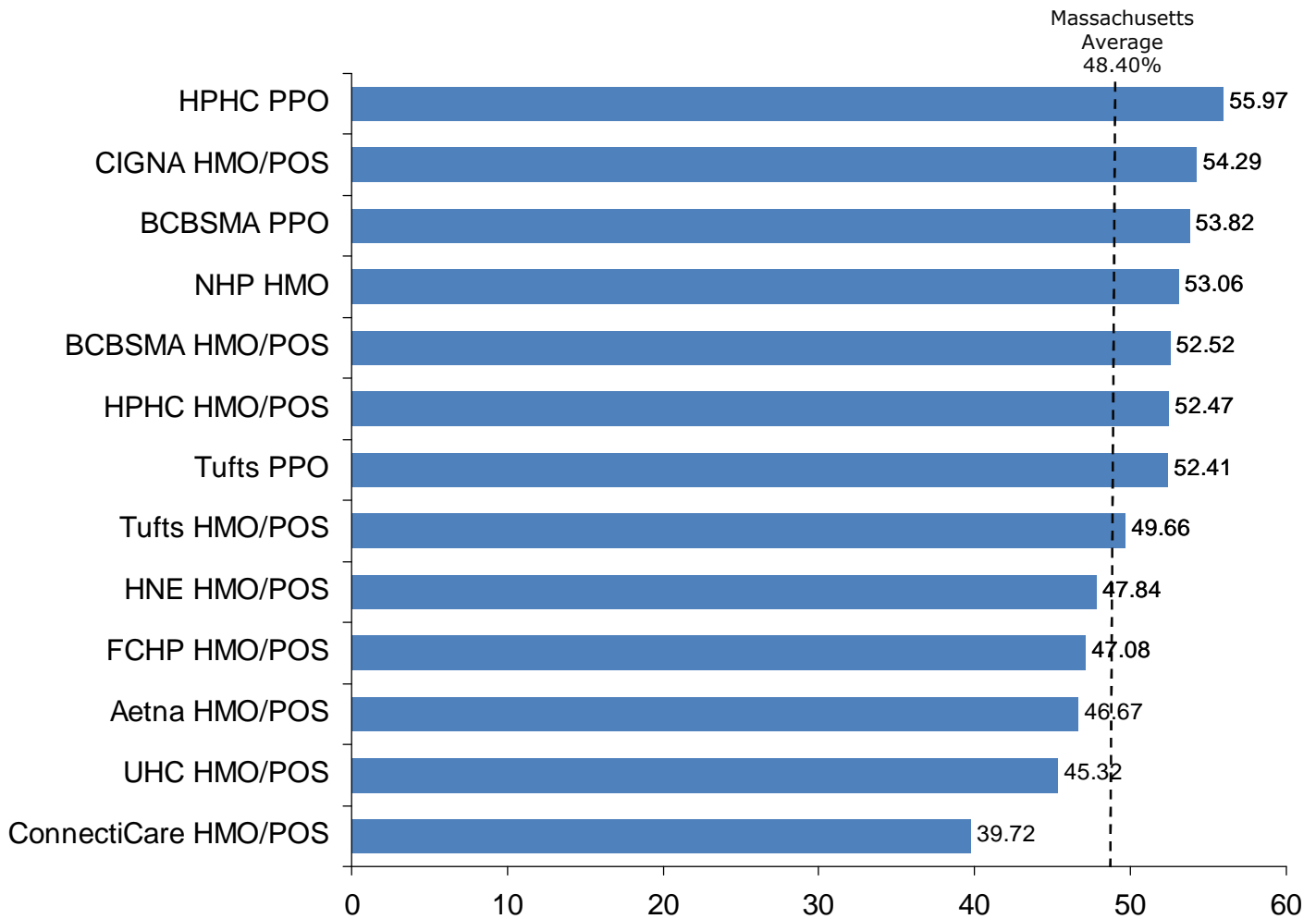
The percentage of adults ages 50 to 80 who had appropriate screening for colorectal cancer. A higher score in this measure indicates better overall plan performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



## Flu Shots for Adults



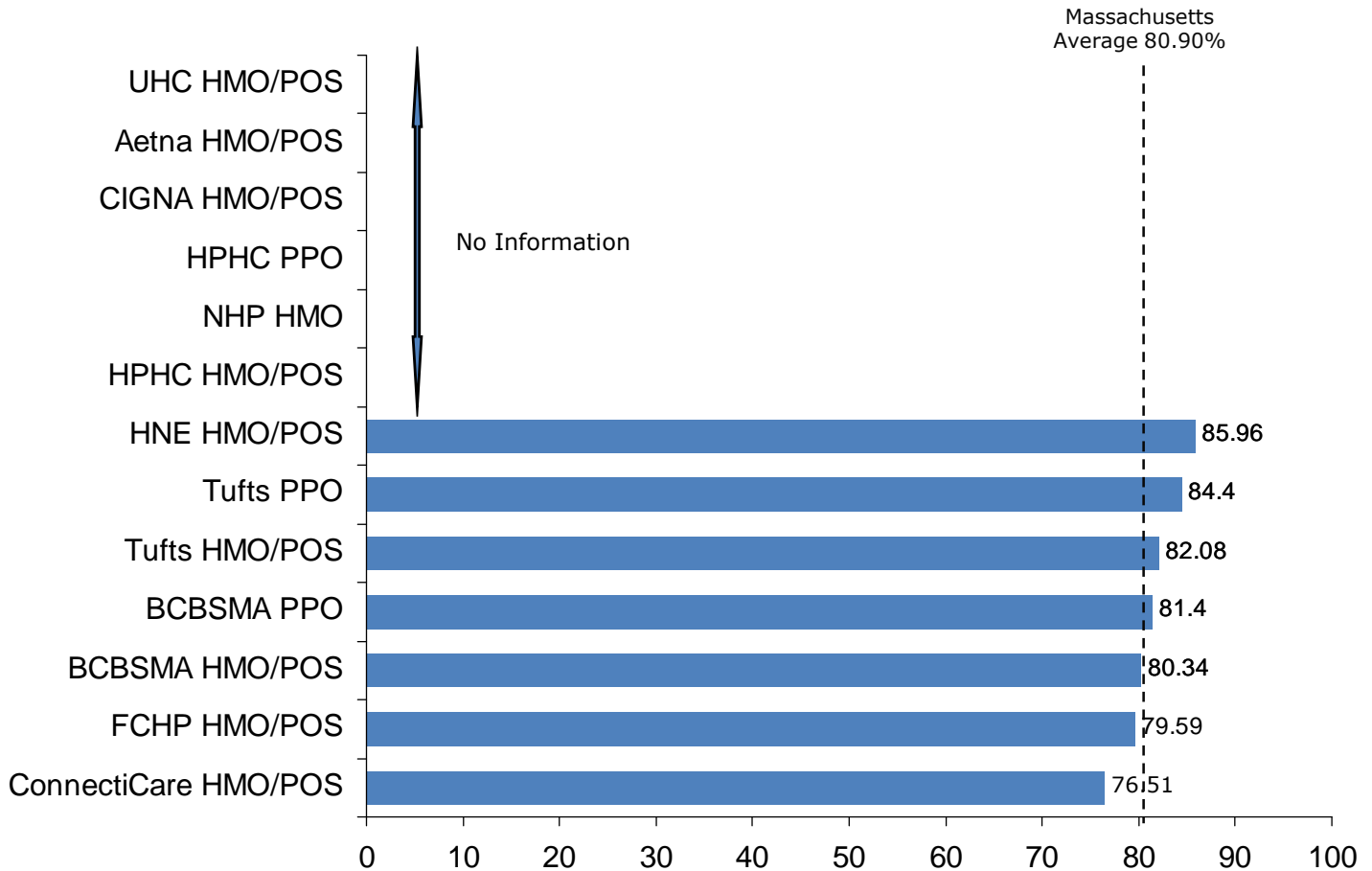
The percentage of members ages 50 to 64 who received an influenza vaccination.

A higher rate on this measure indicates better performance.

**Note:** The Massachusetts Average is the average for HMO and POS plans.



## Smoking Cessation: Advising Smokers to Quit



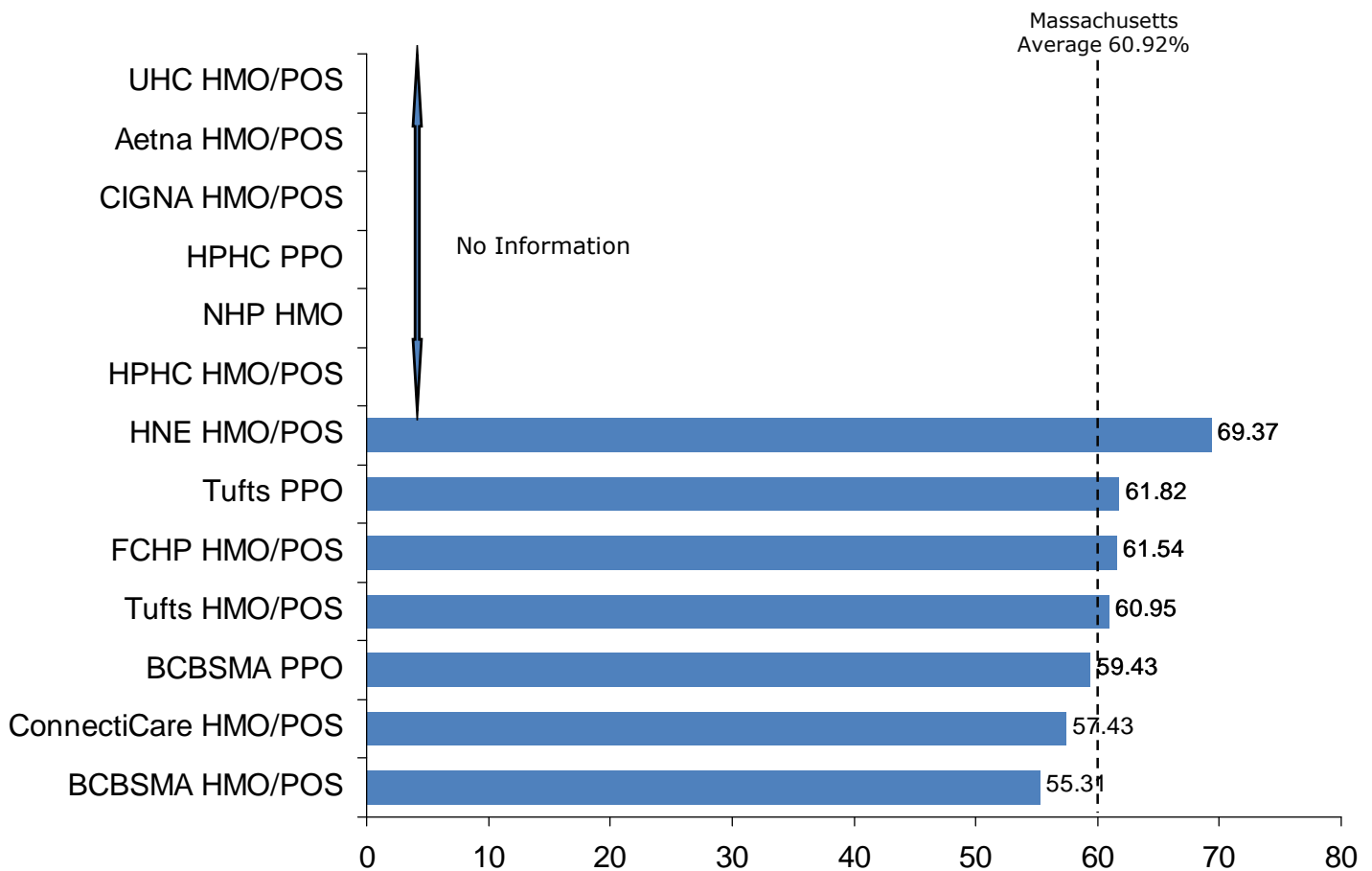
The percentage of members ages 18 and older who were current smokers, who were seen by a practitioner and received advice to quit smoking.

A higher rate on this measure indicates better performance. Smoking is the leading preventable cause of death in the United States.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Smoking Cessation: Discussing Medications



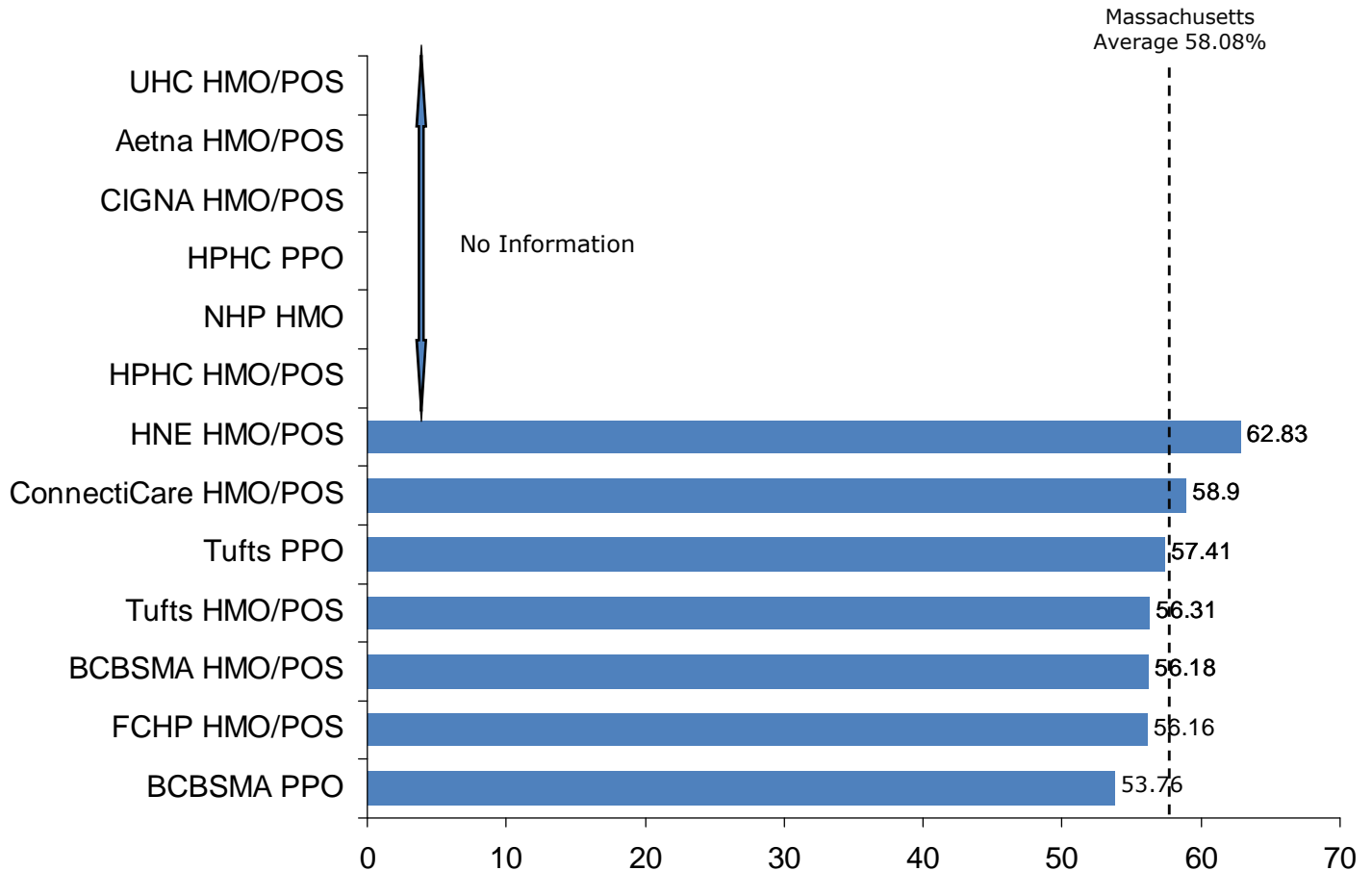
The percentage of members ages 18 and older who were current smokers and whose practitioner recommended or discussed smoking cessation medications.

A higher rate on this measure indicates better performance. Smoking is the leading preventable cause of death in the United States.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Smoking Cessation: Discussing Strategies



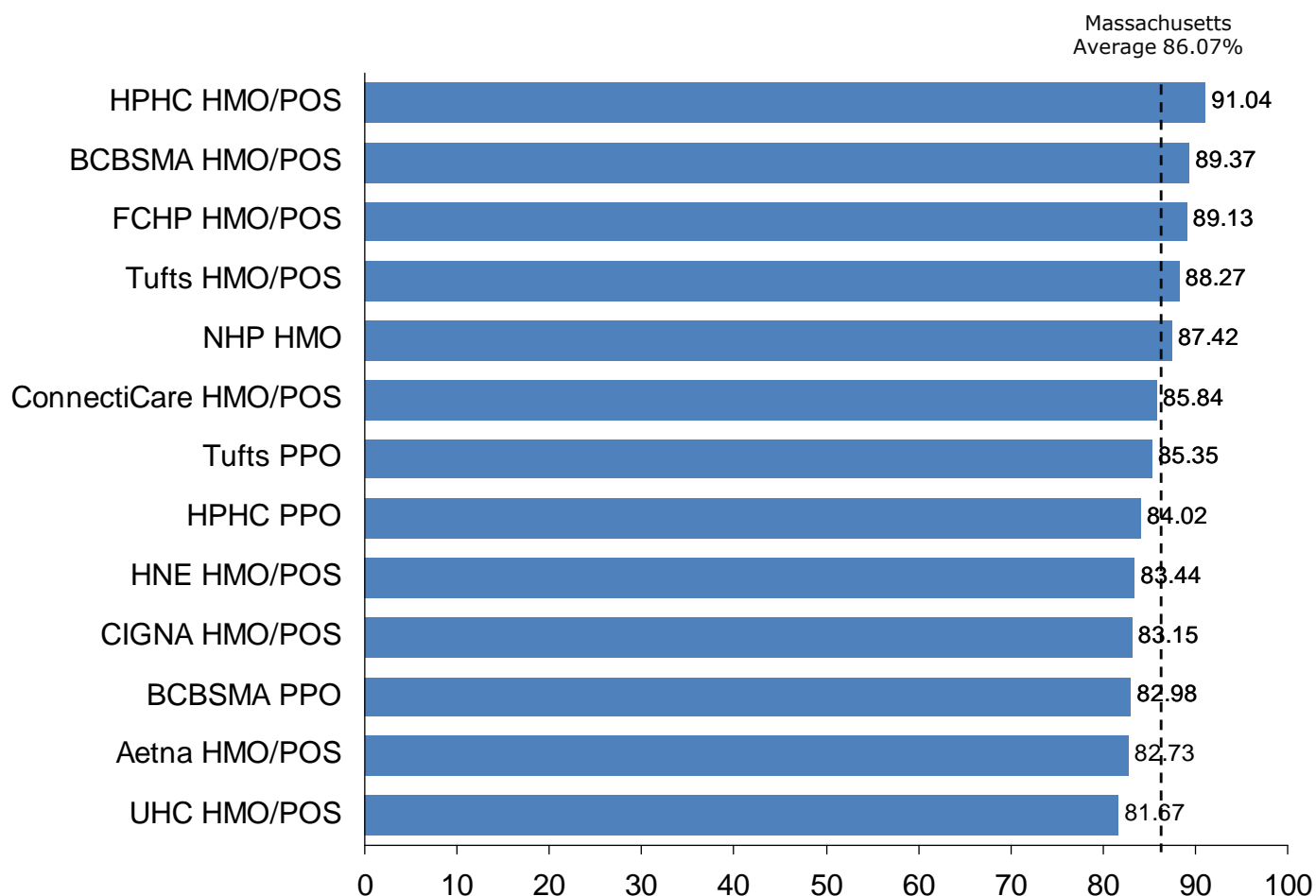
The percentage of members ages 18 and older who were current smokers and whose practitioner recommended or discussed smoking cessation methods or strategies.

A higher rate on this measure indicates better performance. Smoking is the leading preventable cause of death in the United States.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Cervical Cancer Screening



The percentage of women ages 21-64 who received one or more Pap tests to screen for cervical cancer within the last three years.

Death from cervical cancer is far less likely if it is detected early. Fortunately, the Pap test is very effective in detecting cervical cancer early.

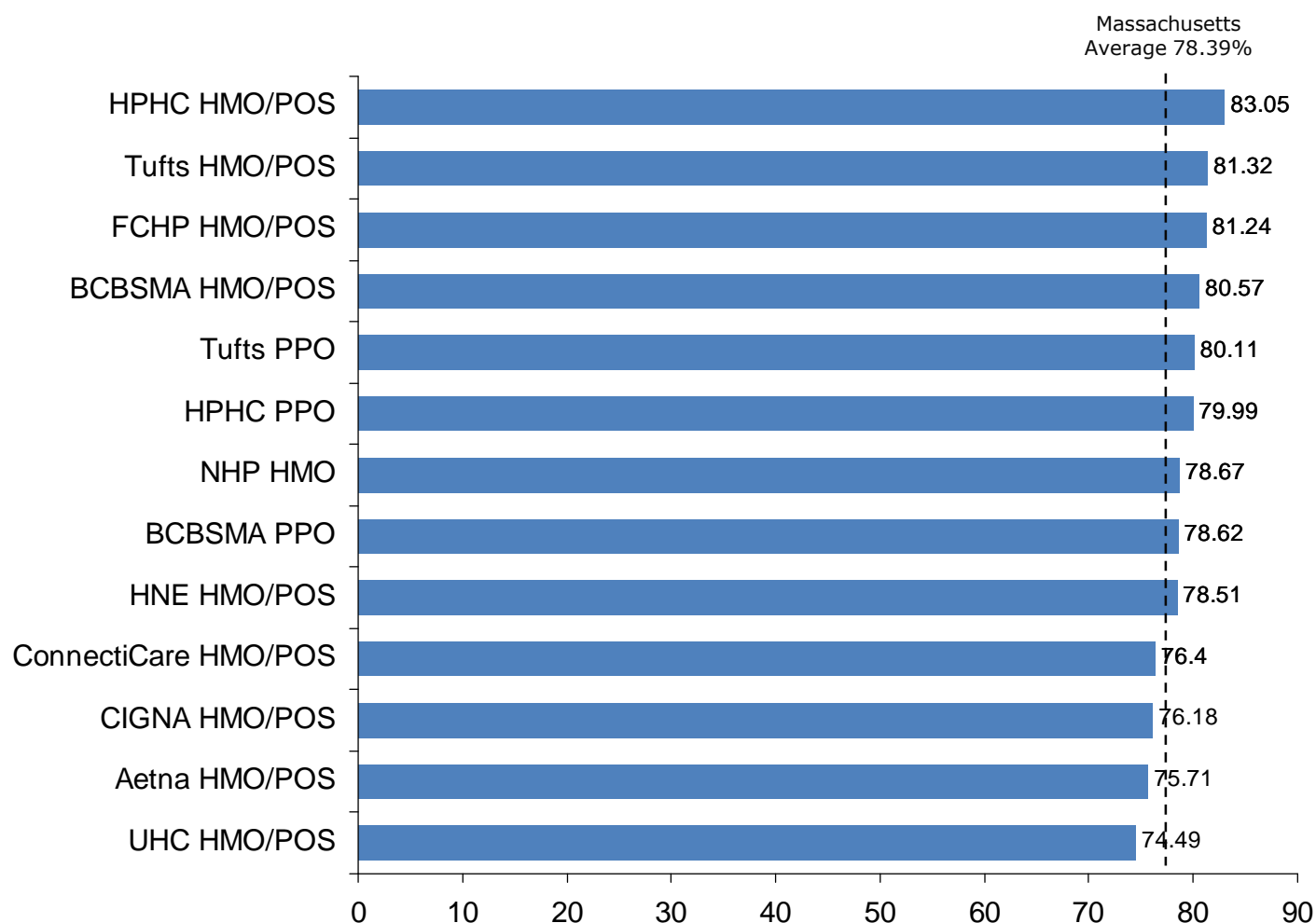
Higher rates on this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Breast Cancer Screening



The percentage of women ages 40-69 who had a mammogram within the last two years.

Early detection of breast cancer can lead to more successful treatment.

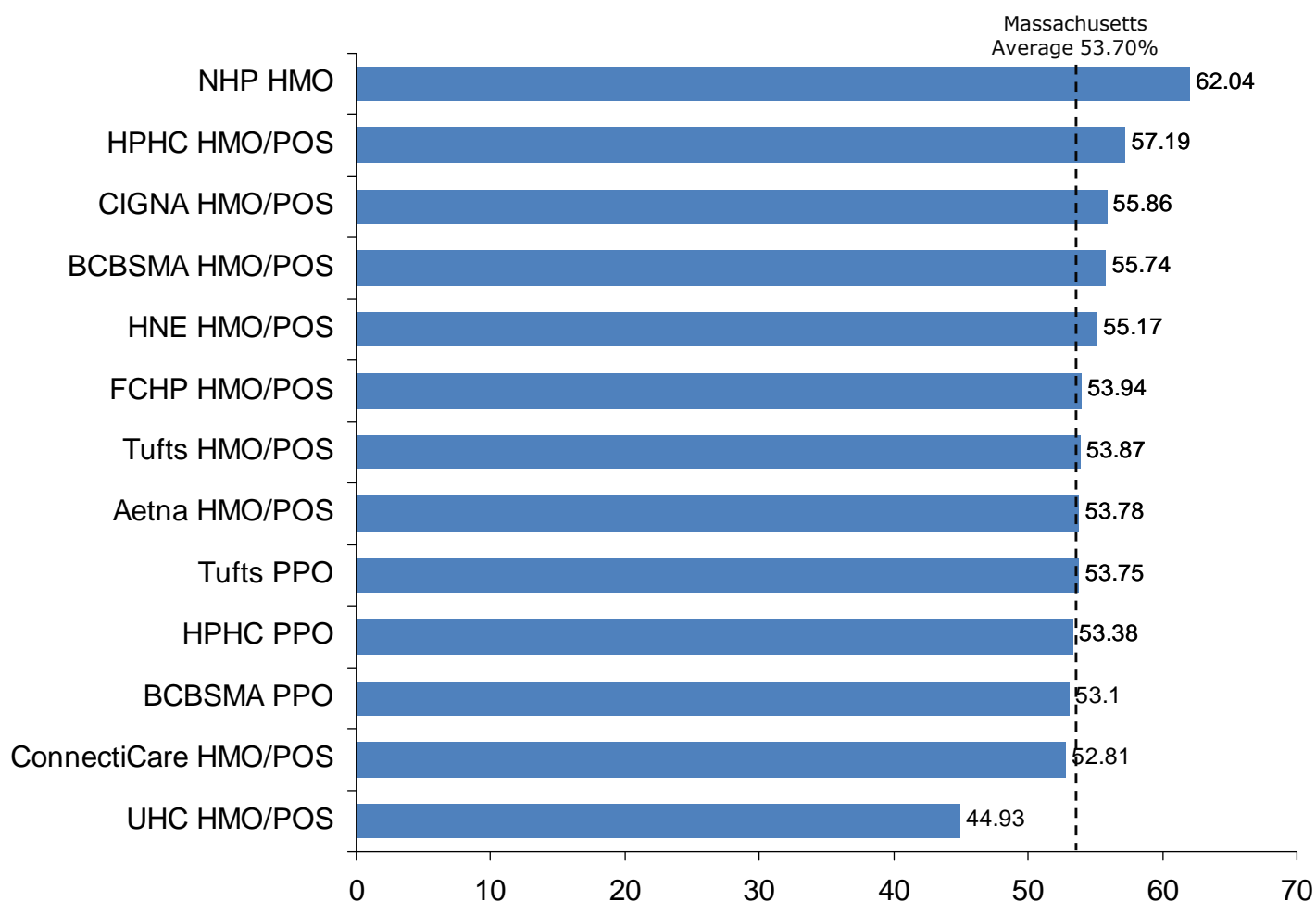
Mammogram is the most effective way to detect breast cancer.

Higher rates for this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Chlamydia Screening



The percentage of women ages 16 to 24 identified as sexually active who had at least one test for chlamydia.

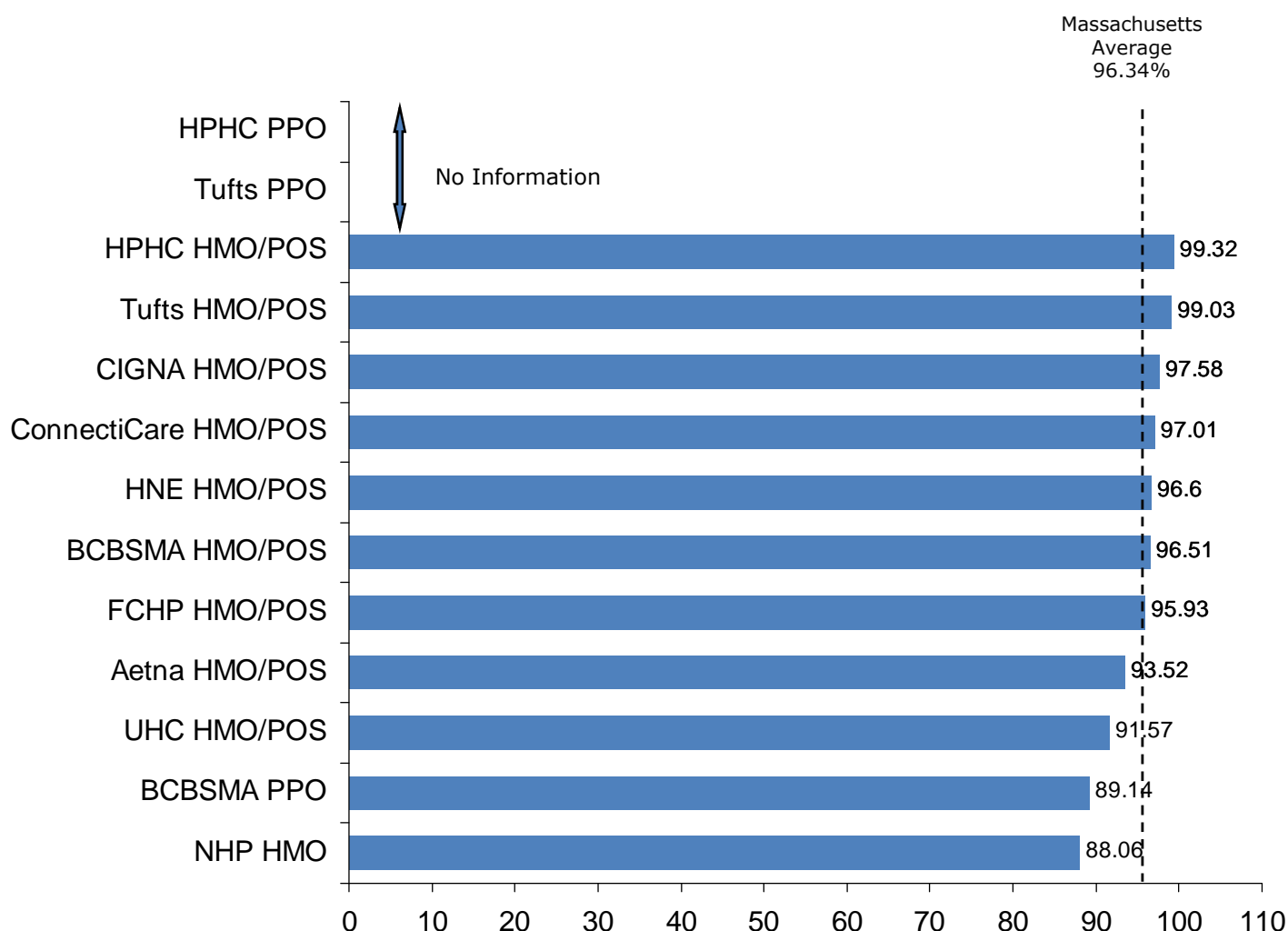
Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States. Screening for chlamydia is important because most women who have the condition do not experience any symptoms. Untreated, chlamydia can be passed on to a woman's partner, could lead to infection spreading to the uterus and ovary, infertility, and ectopic pregnancy.

Higher rates on this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Timeliness of Prenatal Care



The percentage of members who delivered live babies and who received prenatal care as a member of the health plan in the first trimester of their pregnancy or within 42 days of enrollment in the plan.

Higher rates on this measure indicate better performance.

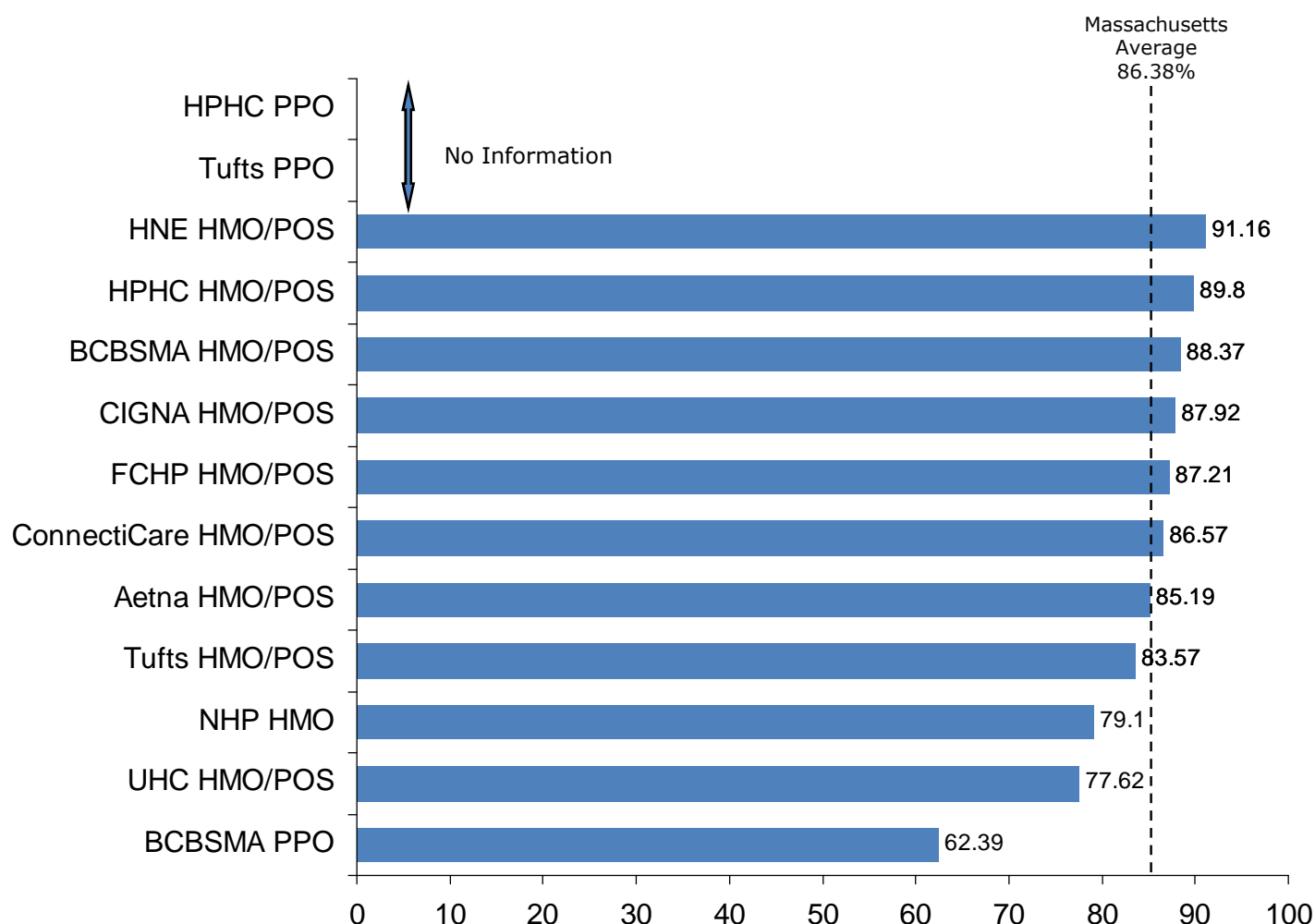
Ideally, all pregnant women should receive prenatal care within the first trimester or shortly after enrollment in a plan. Prenatal care has significant effect on the health of the baby, and on the mother's readiness to care for her newborn.

**Notes:** The Massachusetts Average is the average for HMO and POS plans..

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Postpartum Care



The percentage of members who delivered live babies and had a postpartum visit on or between 21 and 56 days after delivery.

The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once between four and six weeks after giving birth so that they can be evaluated and receive any necessary assistance.

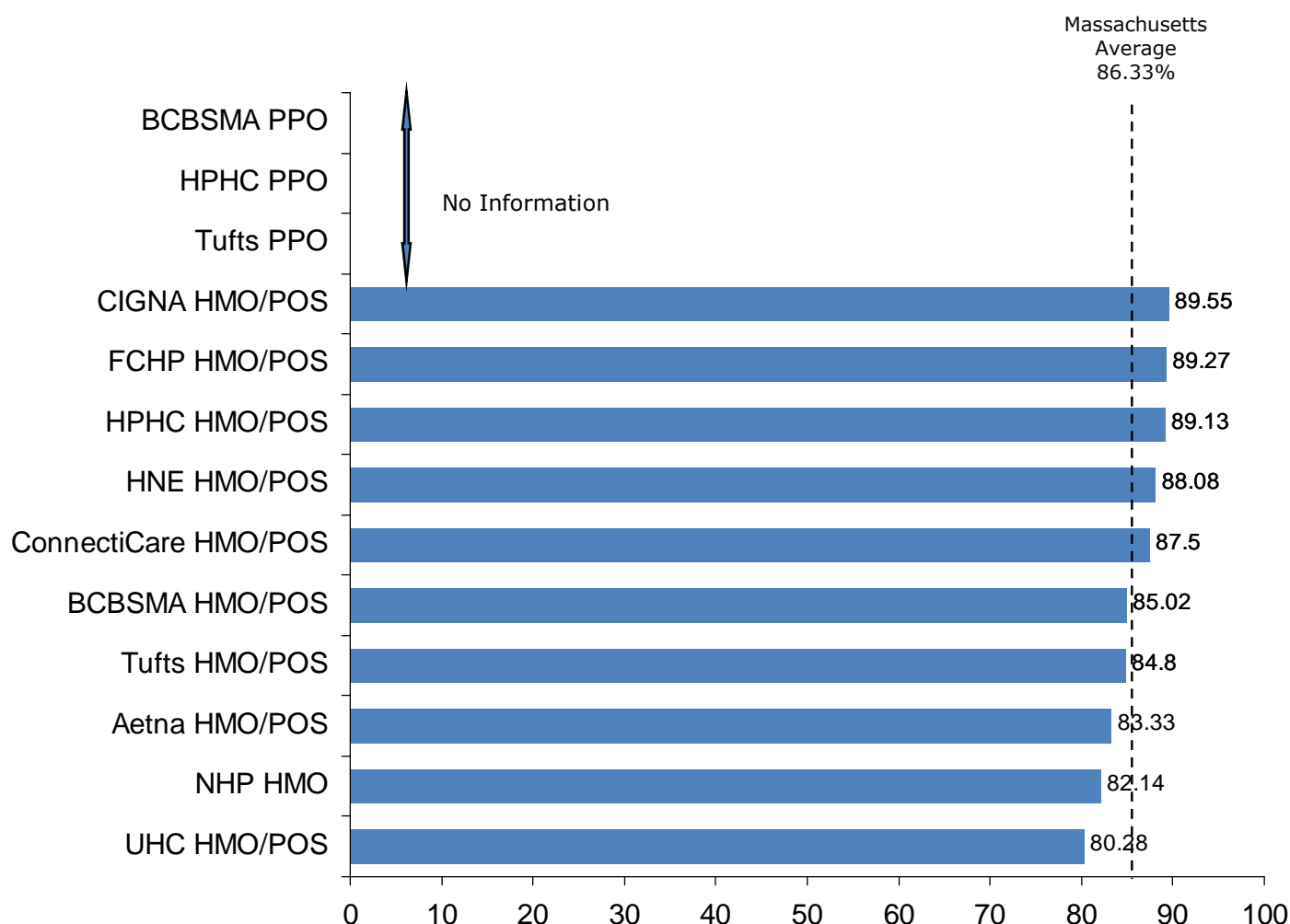
Higher rates indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Childhood Immunization



The percentage of children who by their second birthday have received:

four DTaP immunizations; three polio virus immunizations; one mumps/measles/rubella (MMR) immunization; two hemophilus influenza type B (HiB) immunizations; three hepatitis B immunizations; at least one chicken pox immunization and at least four pneumococcal conjugate immunizations.

Immunizations protect children against preventable and serious illness. At least 19 immunizations must be given for a child to be counted as fully immunized.

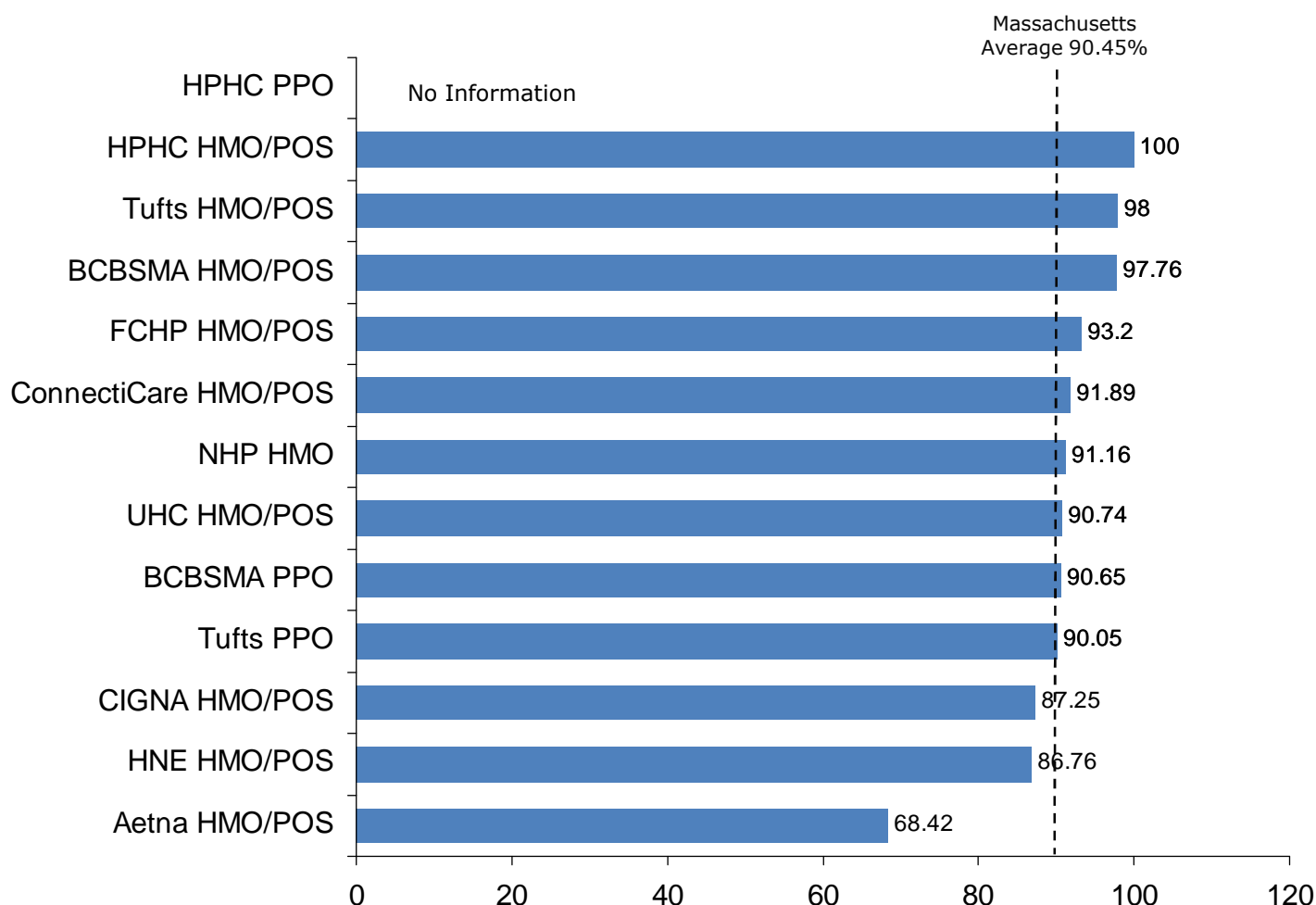
Higher rates of this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



## Well-Child Visits: First 15 Months of Life



The percentage of children who had six or more well-child visits by the time they turned 15 months of age.

Regular check-ups or well-child visits are the best ways to detect physical, developmental, behavioral and emotional problems so that appropriate treatment can be given. The American Academy of Pediatrics recommends six well-child visits in the first year of life.

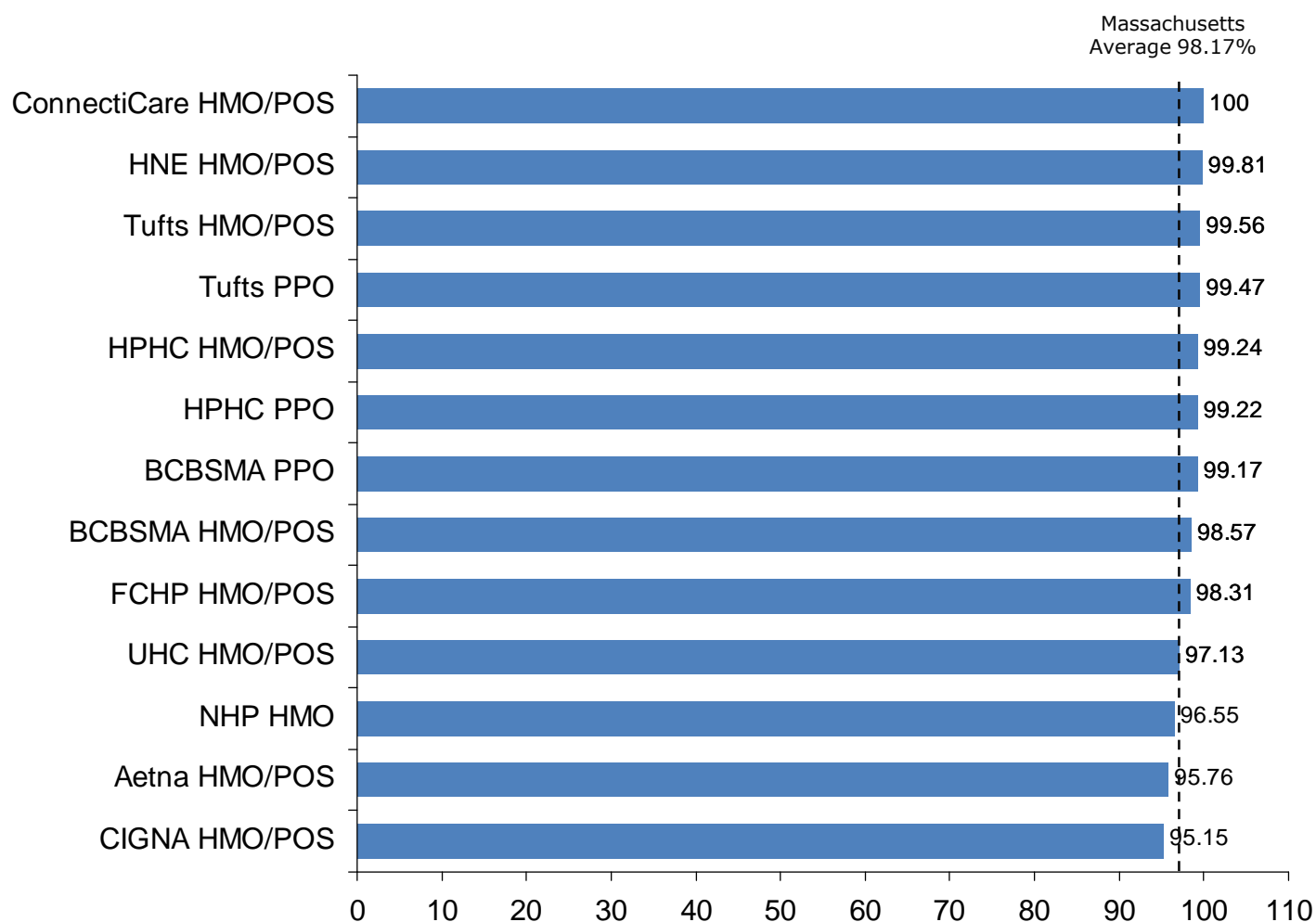
A high score for this measure is desirable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



## Well-Child Visits: 12 to 24 Months of Life



The percentage of children 12 to 24 months of age who had a visit with a primary care practitioner during the one year period.

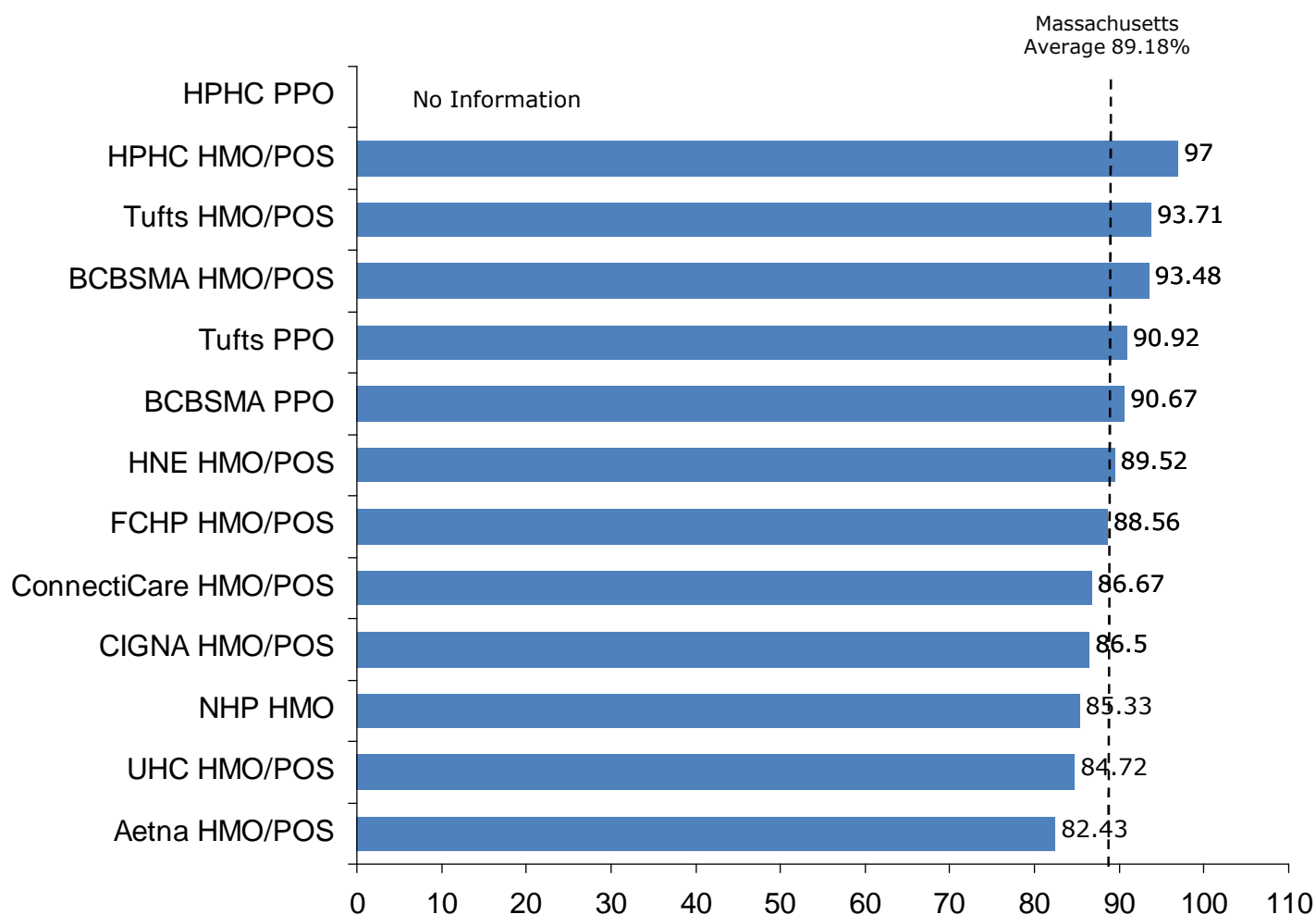
These regular check-ups provide the opportunity for physicians to offer guidance and counseling to parents.

A high rate is desirable.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



## Well-Child Visits: 3rd, 4th, 5th, and 6th Years of Life



The percentage of children ages 3-6 who received at least one well-child visit with a primary care provider (PCP) during the past year.

The American Academy of Pediatrics recommends annual well-child visits for 2 to 6 year-olds. Well child visits during the pre- and early-school years are particularly important to help children reach their full potential and become productive and successful members of society. Vision, speech and language problems can be detected early and treated.

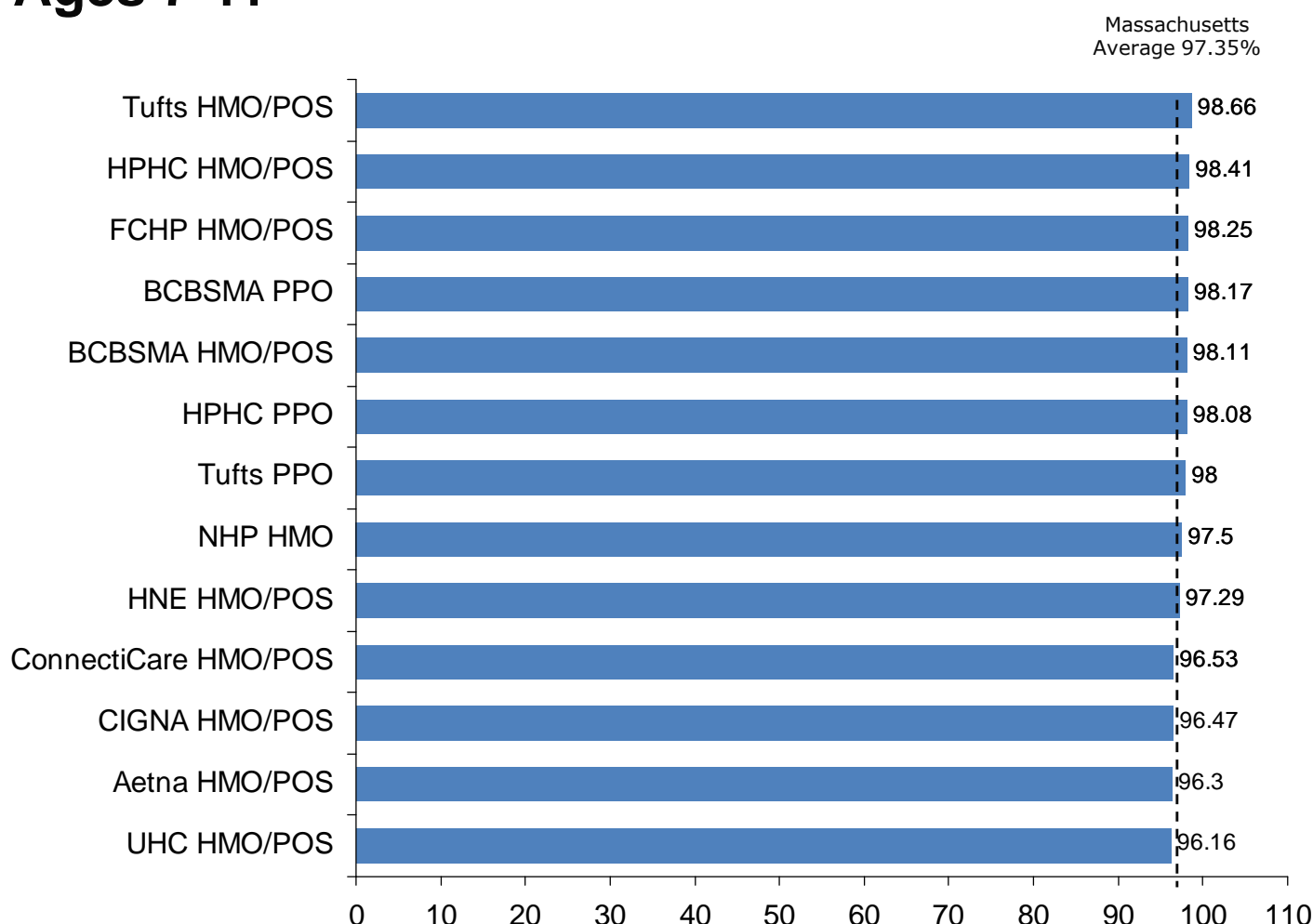
A high score on this measure indicates better performance.

Notes: The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Children's Well-Care Visits: Ages 7-11



The percentage of members ages 7 to 11 who had a visit with a primary care practitioner (PCP) during the measurement year.

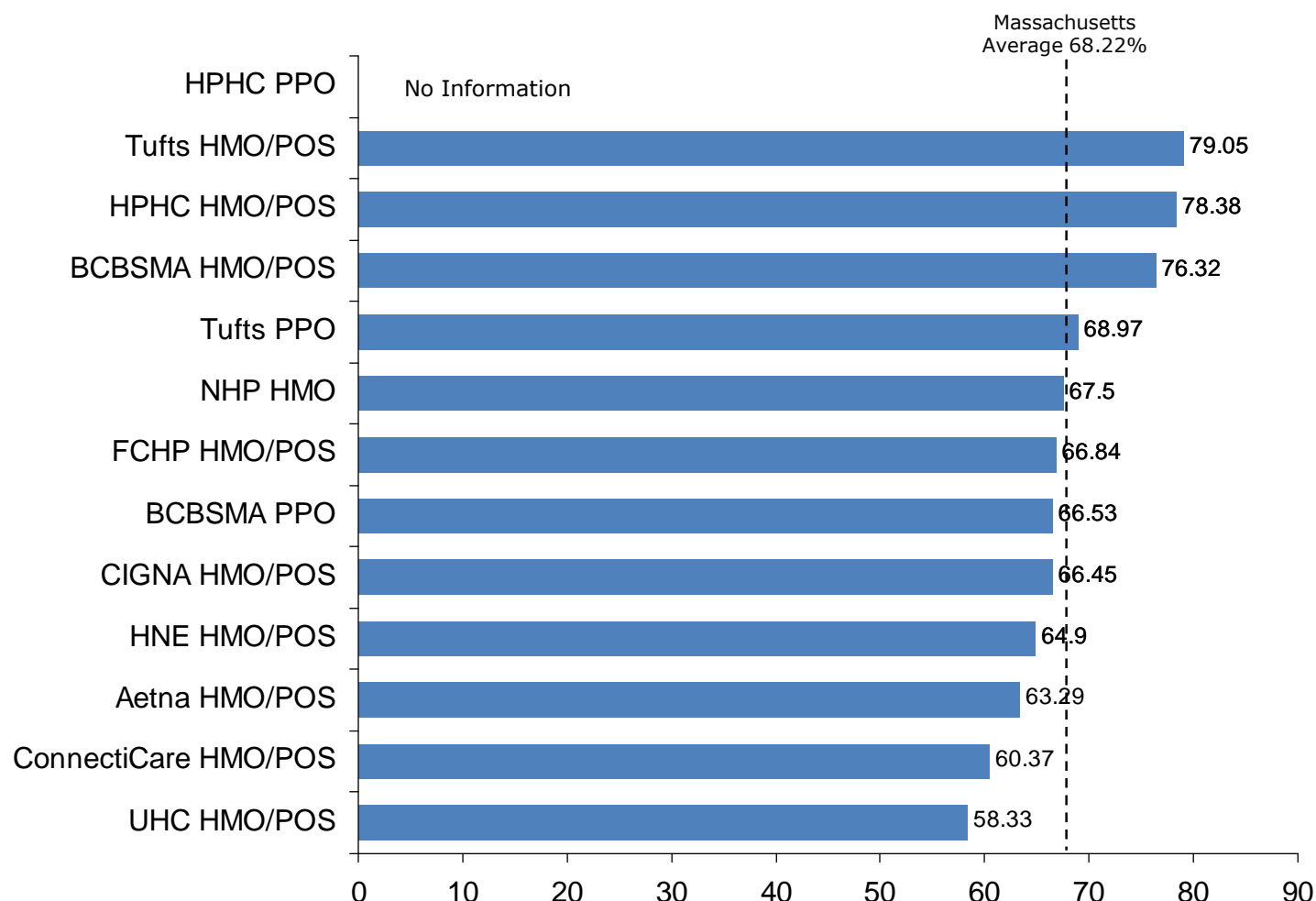
Health plans accept a premium for every member and are therefore responsible for ensuring the provision of care to all members. Children who do not access preventive care have a higher likelihood of developing advanced or preventable diseases.

A high score on this measure represents the percent of children in the plan who are seen by the plan providers at least annually.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Adolescent Well-Care Visits



The percentage of members ages 12-21, who had at least one comprehensive well-care visit with a primary care (PCP) or an OB/GYN provider during the measurement year.

Health plans accept a premium for every member and are therefore responsible for ensuring the provision of care to all members. Children who do not access preventive care have a higher likelihood of developing advanced or preventable diseases, at higher personal and financial cost.

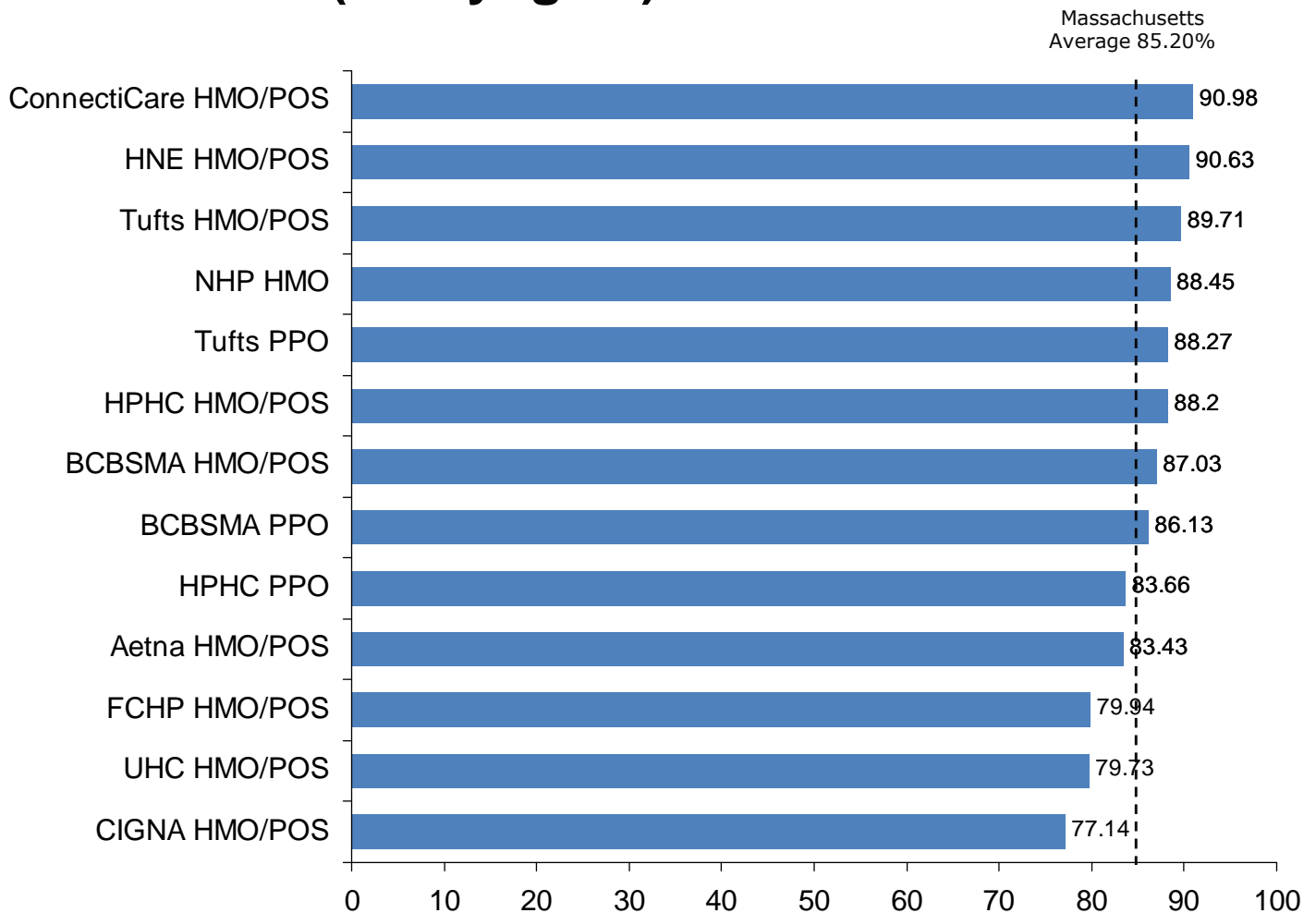
A high score on this measure indicates that a high percent of adolescents are seen at least annually.

Notes: The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Appropriate Testing for Children with Sore Throat (Pharyngitis)



The percentage of children ages 12-18 who were diagnosed with sore throat, given an antibiotic and had a confirmed streptococcus (strep) test for the episode.

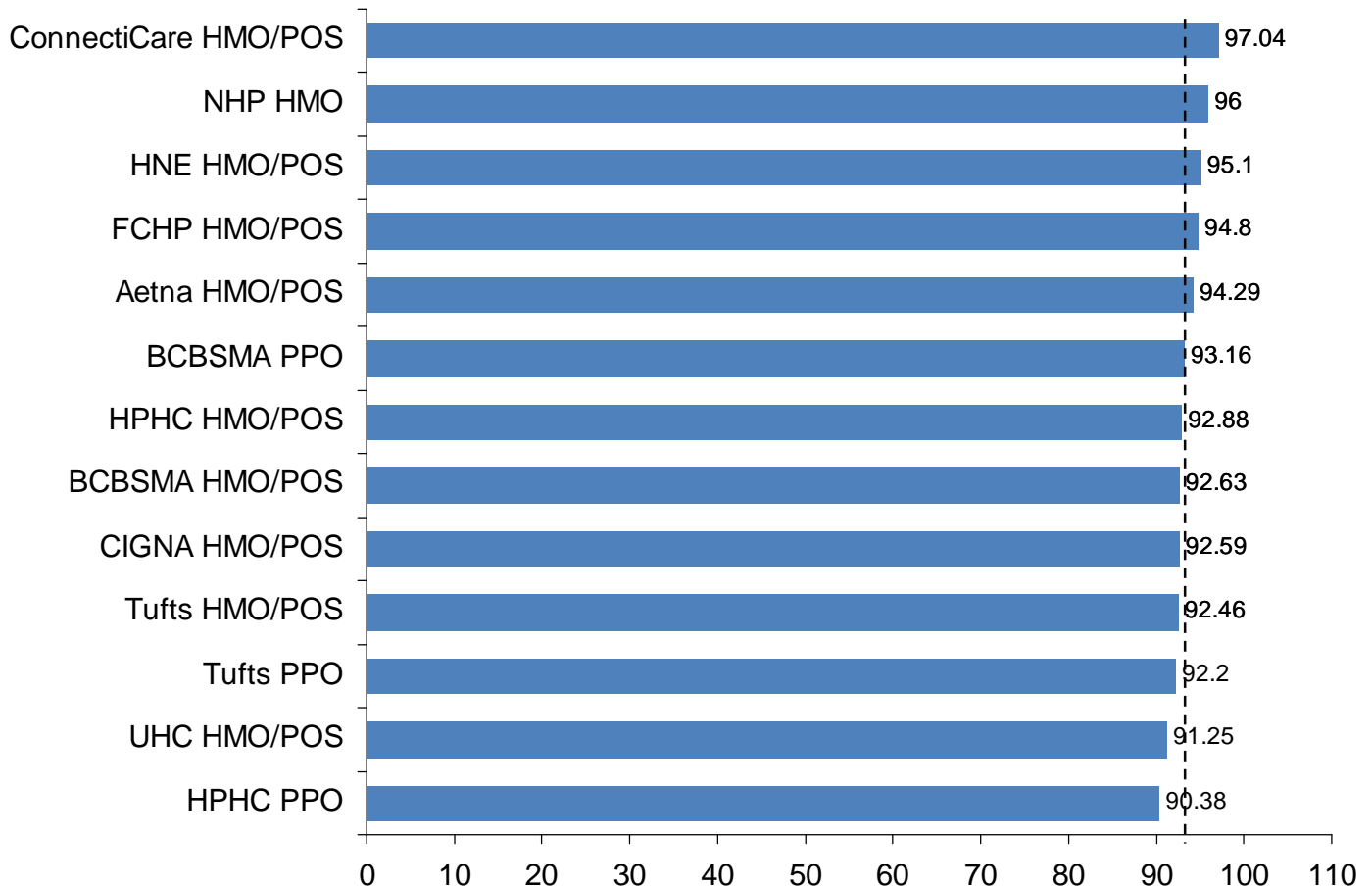
A higher rate represents better performance or appropriate testing.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Appropriate Treatment for Children with Cold (Upper Respiratory Infection)

Massachusetts  
Average 93.67%



The percentage of children ages 3 months to 18 years who were diagnosed as having a cold and were not given an antibiotic in the past year.

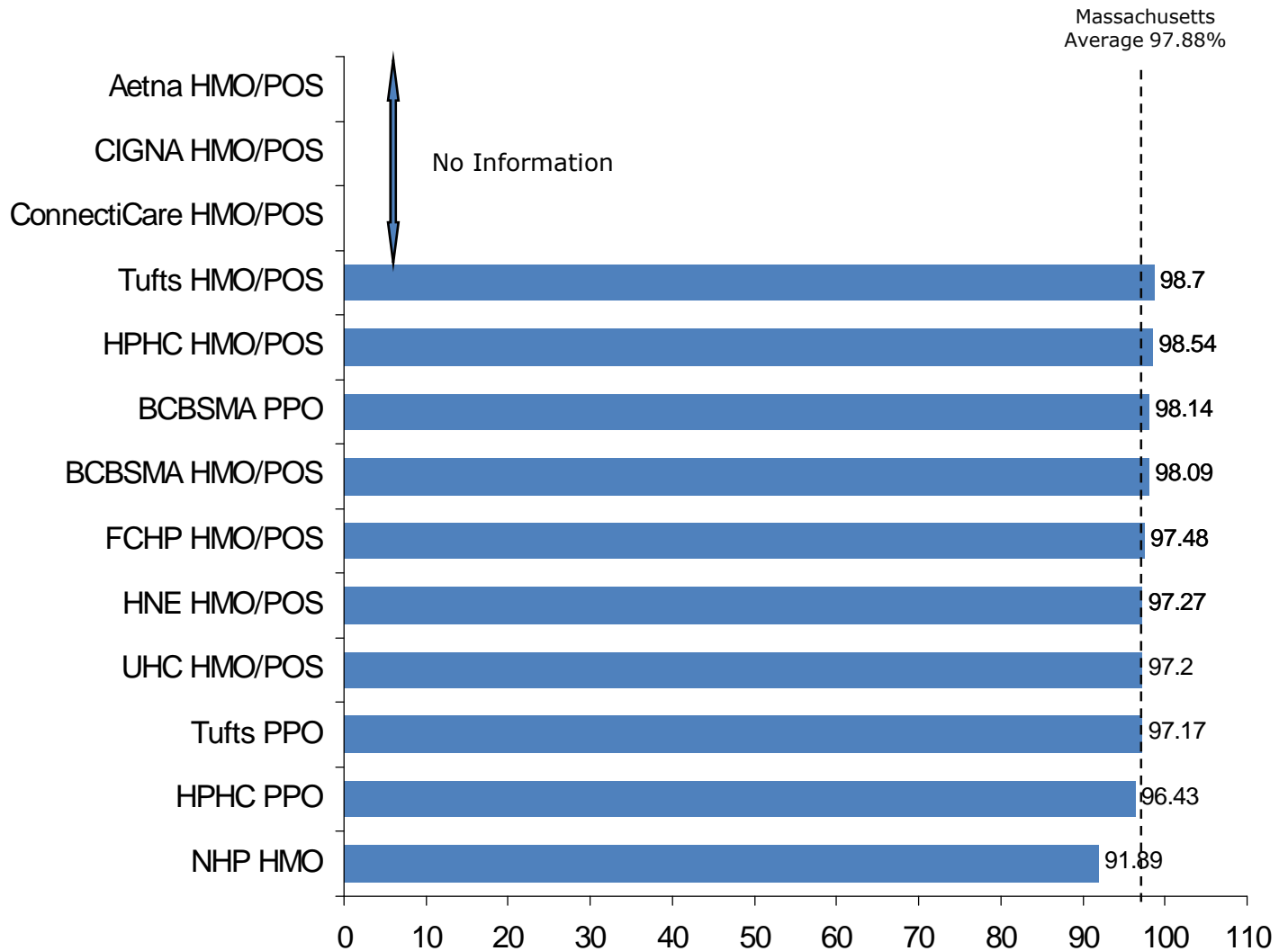
A higher score indicates appropriate treatment of children with colds (i.e., the proportion for whom antibiotics were not prescribed).

To prevent resistance to antibiotics and harmful drug interaction, it is important that children who only have a cold not be given antibiotics.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Appropriate Medication for Children Ages 5-9 with Asthma



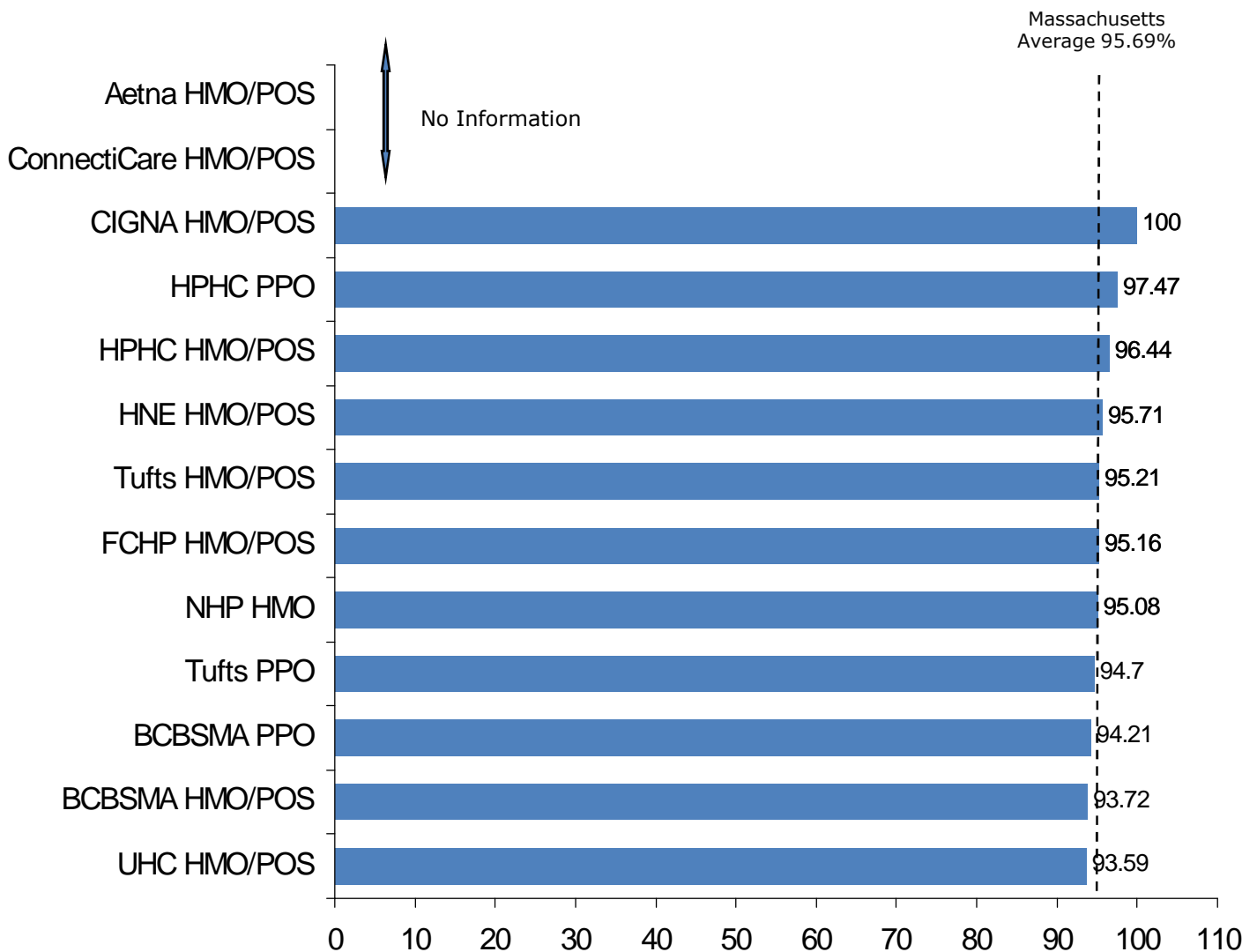
The percentage of children ages 5-9 who were identified as having persistent asthma and were prescribed appropriate medication.

A higher rate on this measure indicates that a high percentage of children with asthma receive appropriate medications to control their disease.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Appropriate Medication for Children Ages 10-17 with Asthma



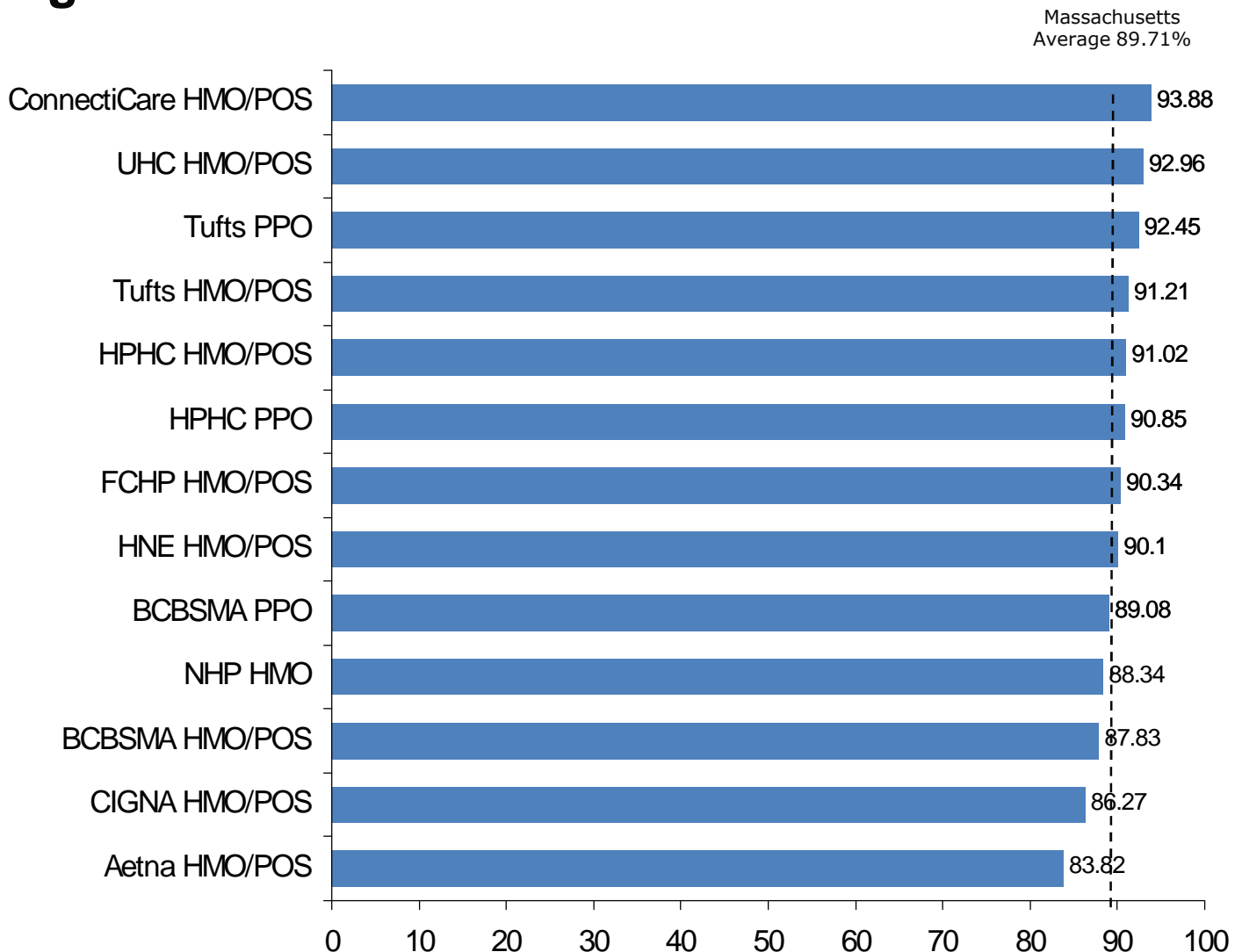
The percentage of children ages 10-17 who were identified as having persistent asthma and were prescribed appropriate medication.

A higher rate on this measure indicates that a high percentage of children with asthma receive appropriate medications to control their disease.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Appropriate Medication for People Ages 18-56 with Asthma



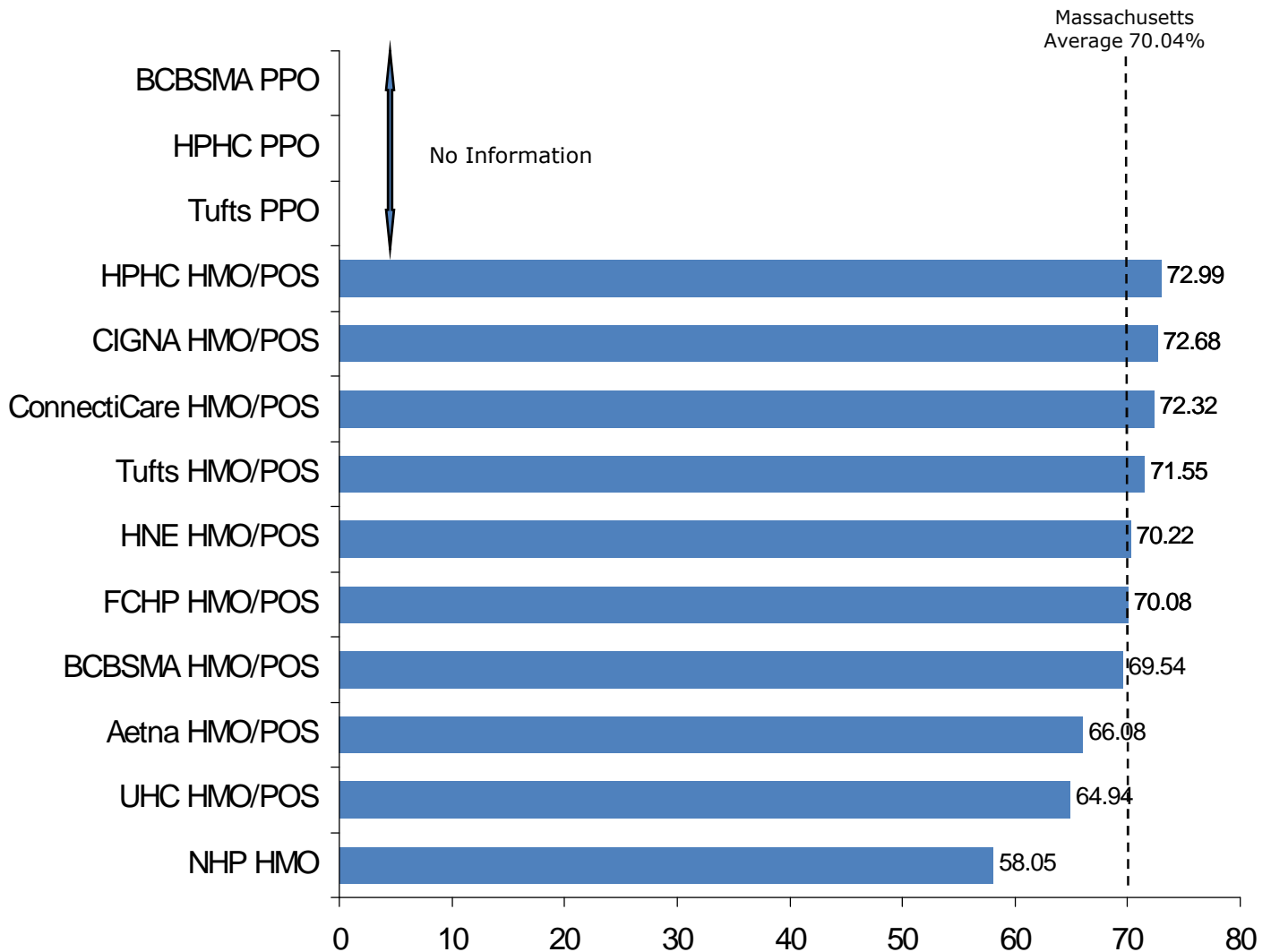
The percentage of people ages 18-56 who were identified as having persistent asthma and were prescribed appropriate medication.

A higher rate on this measure indicates that a high percent of people with asthma receive appropriate medications to control their disease.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Controlling High Blood Pressure



The percentage of members ages 18-85 who had a diagnosis of high blood pressure and whose blood pressure was adequately controlled (<140/90).

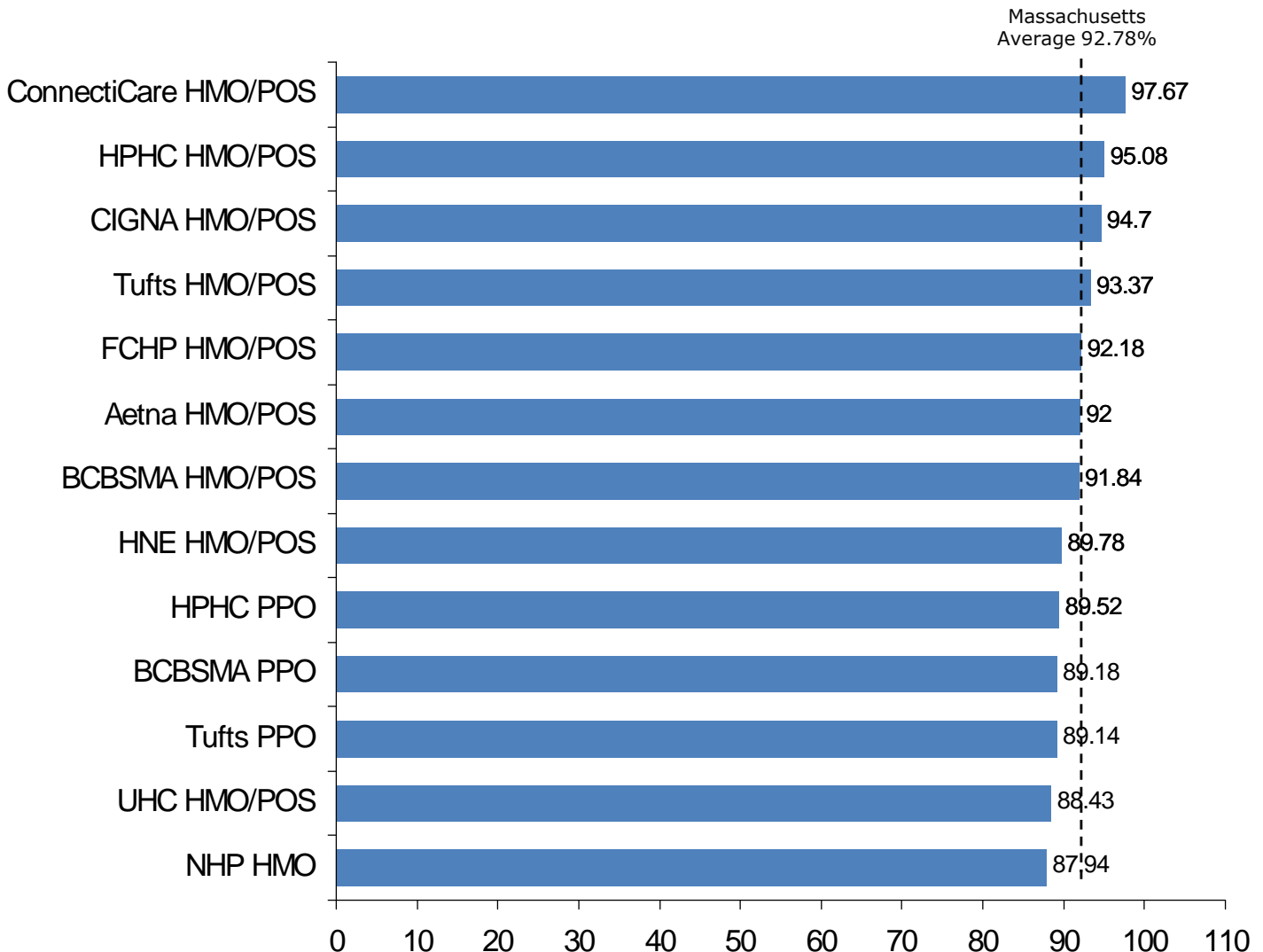
High rates on this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

Data for this measure was collected using the Hybrid method only; so no data is available for PPO plans, which report data using the administrative method of data collection.



# Cholesterol Screening for Patients with Heart Disease (Cardiovascular Conditions)



The percentage of members ages 18-75 who were discharged alive after a heart attack or had a diagnosis of heart disease a year prior to the measurement period and during the measurement year and who received an LDL-C (bad cholesterol) screening during the same time period.

When LDL-C levels are high, cholesterol can build up within the walls of the arteries and cause the build up of plaque, blocking arteries and causing heart attack and stroke. The National Cholesterol Education Program recommends close monitoring of LDL-cholesterol in patients with coronary heart disease.

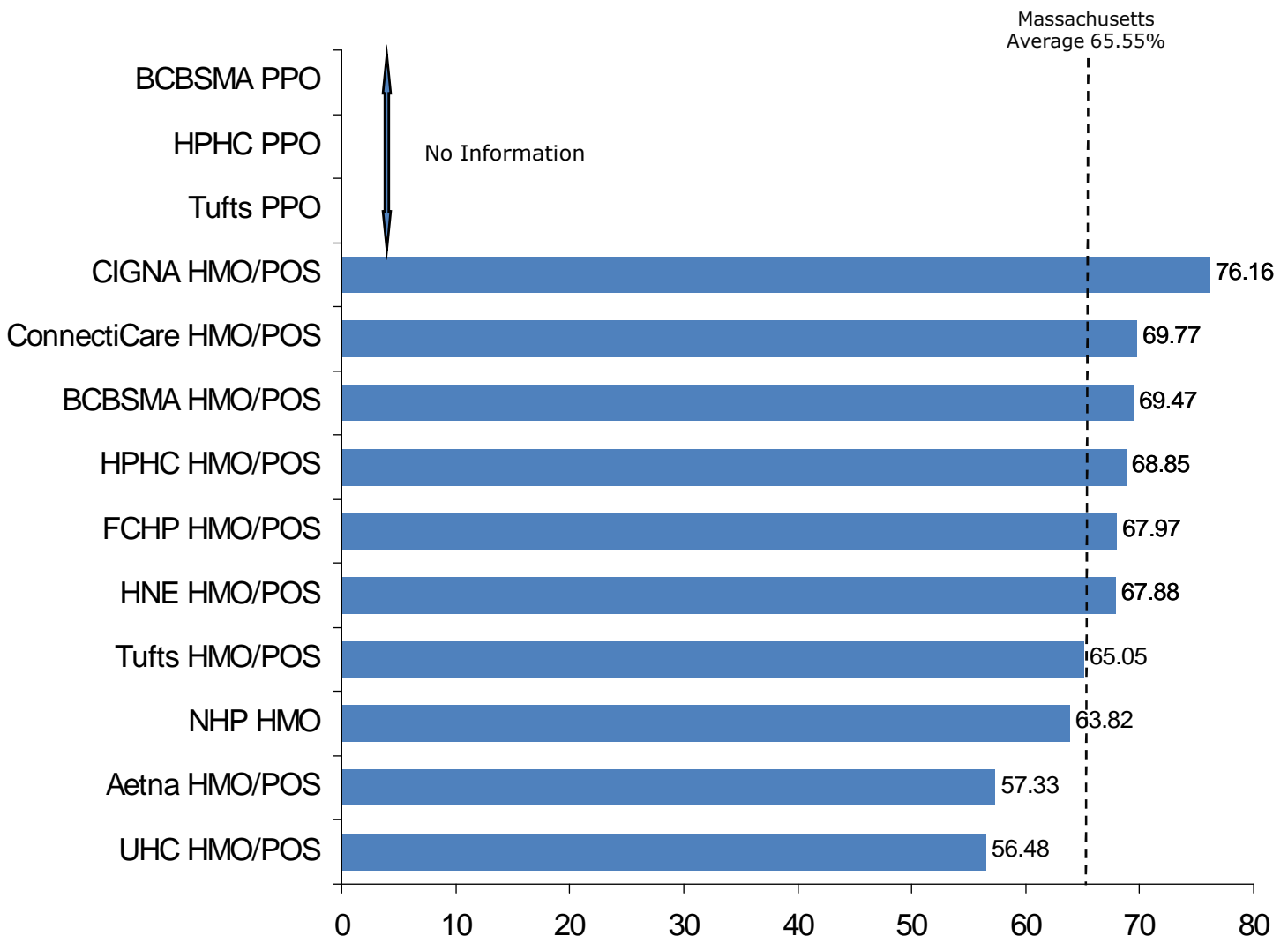
High rates on this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Cholesterol Management for Patients with Heart Disease (Cardiovascular Conditions)



The percentage of members ages 18 to 75 who were discharged alive after a heart attack or had a diagnosis of heart disease a year prior to the measurement year and during the measurement year and whose LDL-C (bad cholesterol) level was controlled ( $<100\text{mg/dL}$ ) during the same time period.

Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce repeat heart attacks and strokes and death by as much as 40 percent.

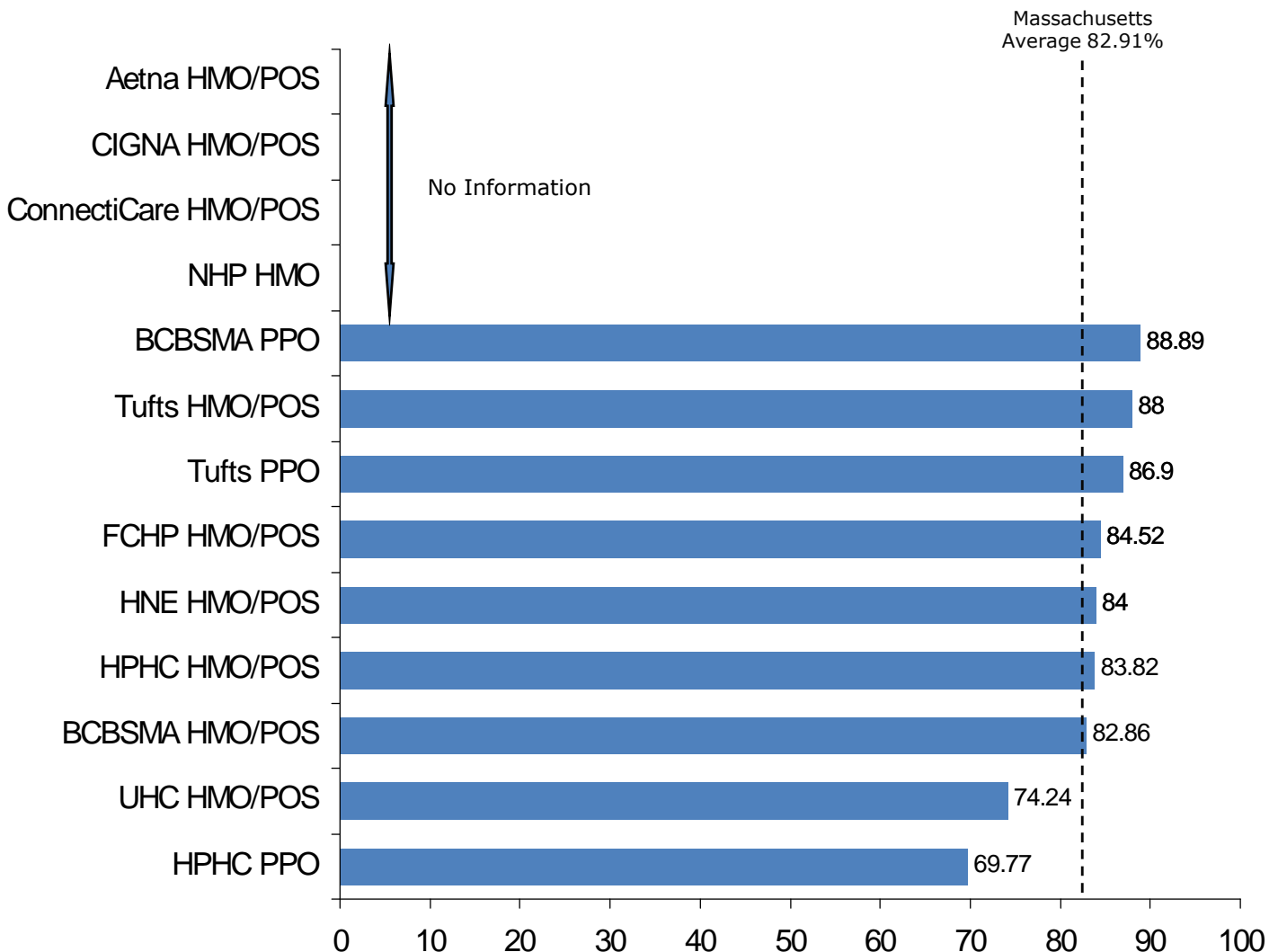
High rates of this measure indicate better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Persistence of Beta-Blocker Treatment after a Heart Attack



The percentage of members ages 18 and older who were discharged alive after a heart attack who continued to receive beta-blocker treatment (a medication that decreases stress on the heart) for six months to prevent future heart attacks.

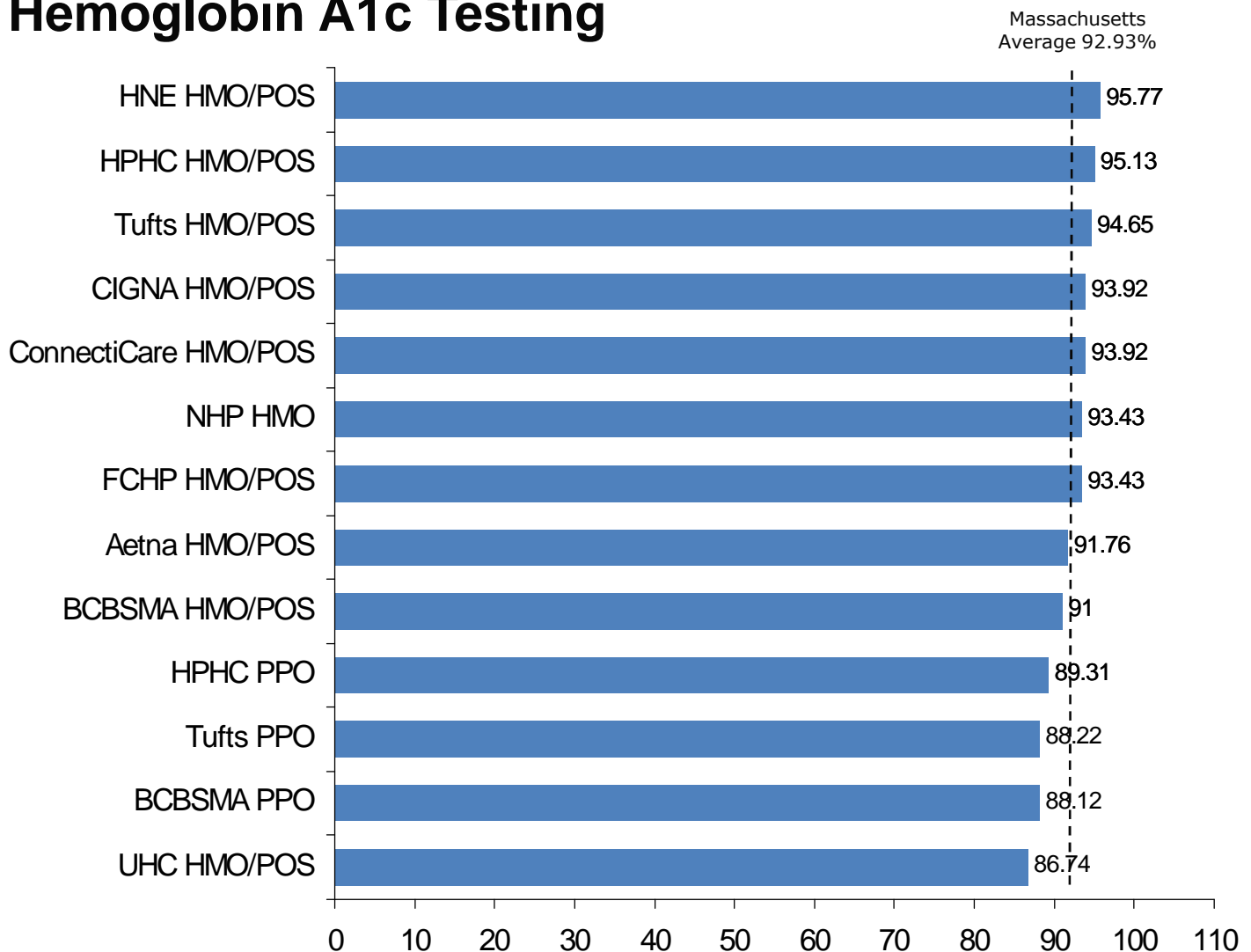
The American Heart Association and the American College of Cardiology recommend treatment using beta-blockers following a heart attack because beta blockers can reduce the probability of death. People who have had heart attack are at higher risk of having another one.

A higher rate for this measure indicates better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.



# Comprehensive Diabetes Care: Hemoglobin A1c Testing



The percentage of members ages 18-75 with diabetes (type 1 and type 2) who had received Hemoglobin A1c (HgbA1c) testing to determine adequacy of blood sugar control.

A higher rate indicates better performance

Diabetes is a complex disease that affects multiple organs, causing disabilities such as amputation, blindness, kidney failure, lower functional status and death. However, all these can be prevented if the disease is detected early and treated over a person's lifetime.

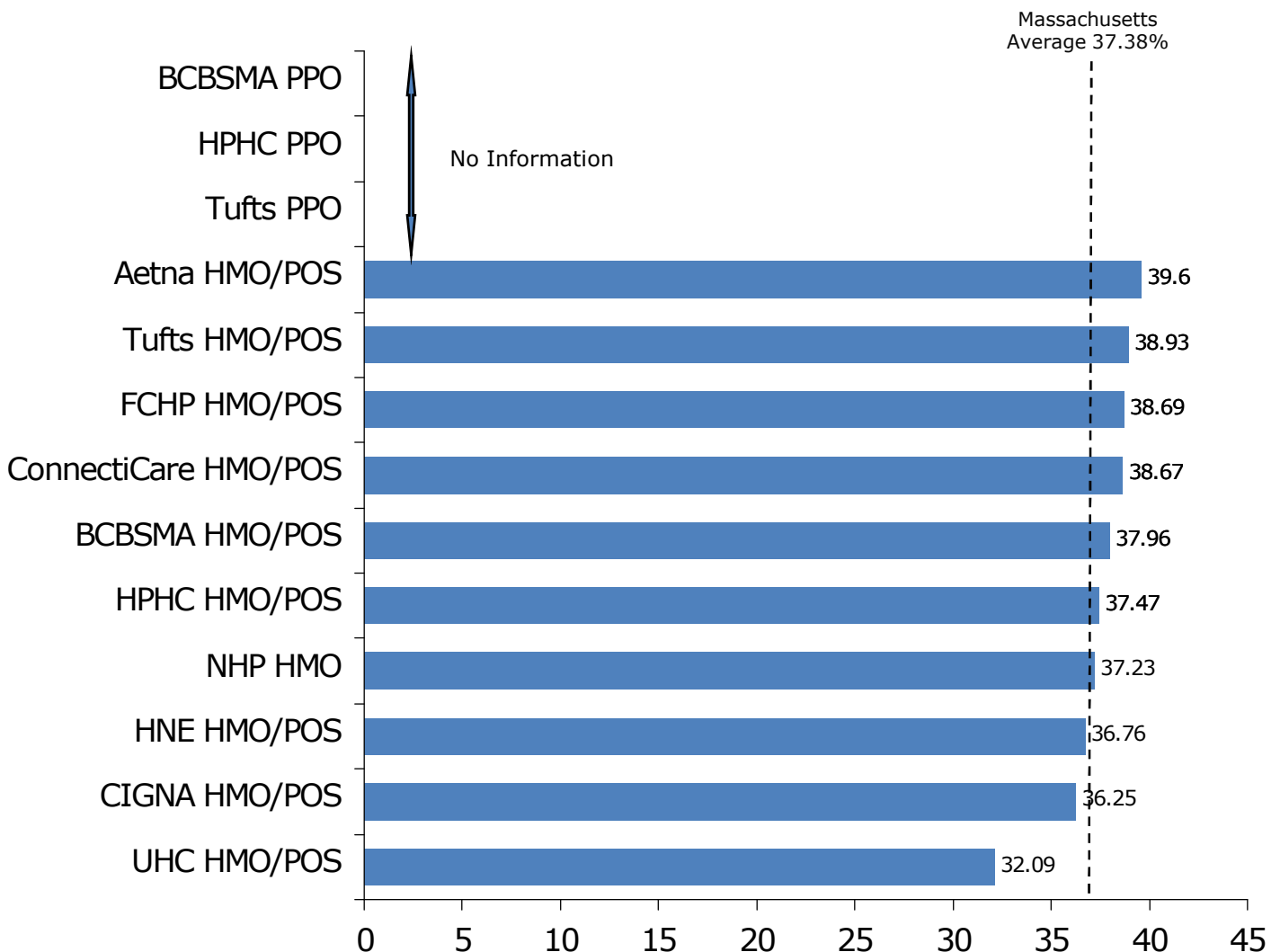
Individuals with diabetes should have a HgbA1c test at least twice a year.

**Notes:** The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



## Comprehensive Diabetes Care: Blood Pressure (<130/80)



The percentage of members ages 18-75 with diabetes (type 1 and type 2) who had a most recent blood pressure measurement <130/80.

People with diabetes who have their blood pressure controlled have less eye disease, heart attacks, and strokes.

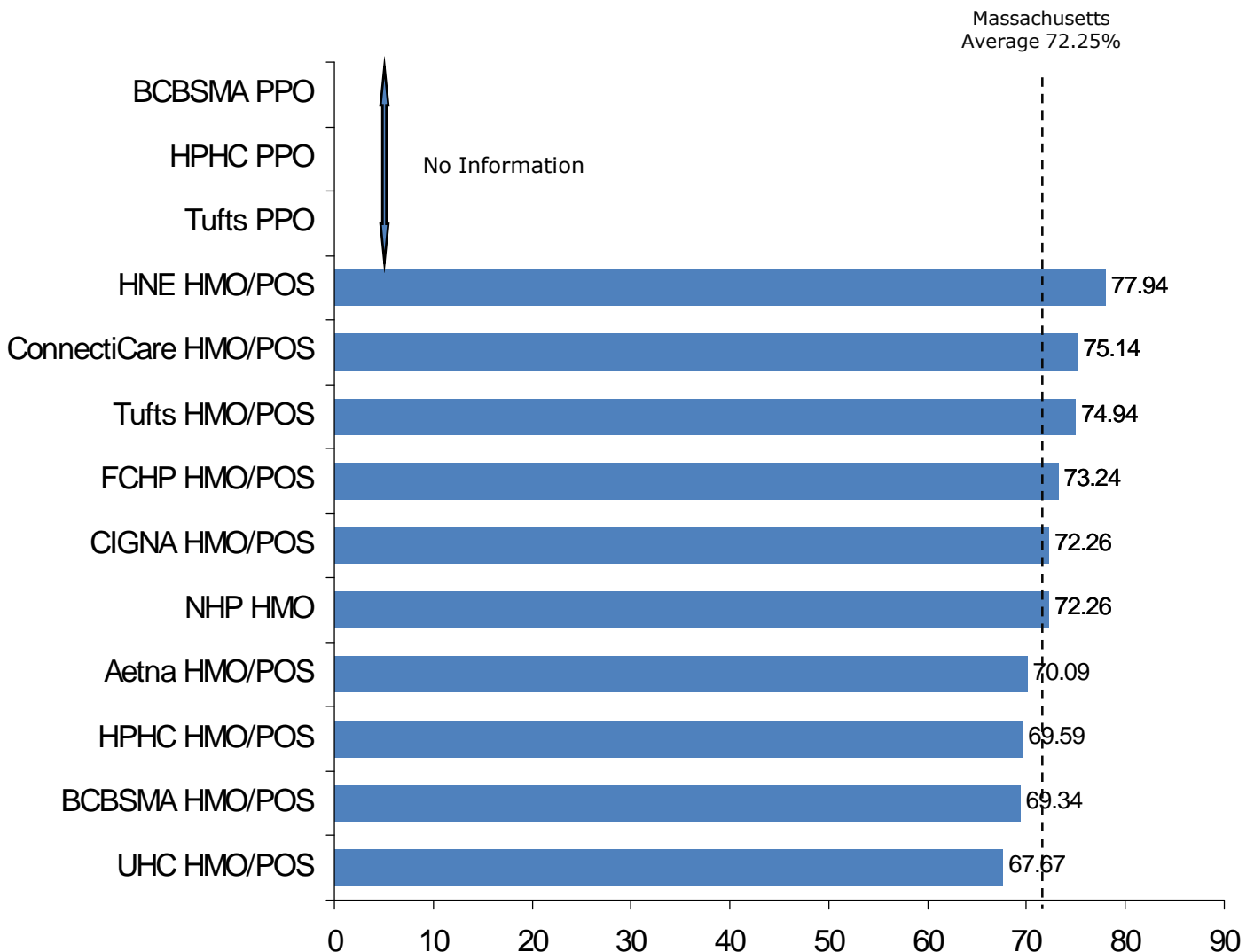
A higher rate indicates better performance.

**Notes:** The Massachusetts Average is the average for HMO and POS plans..

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Comprehensive Diabetes Care: Blood Pressure Control (<140/90)



The percentage of members ages 18-75 with diabetes (type 1 and type 2) who had a most recent blood pressure measurement <140/90.

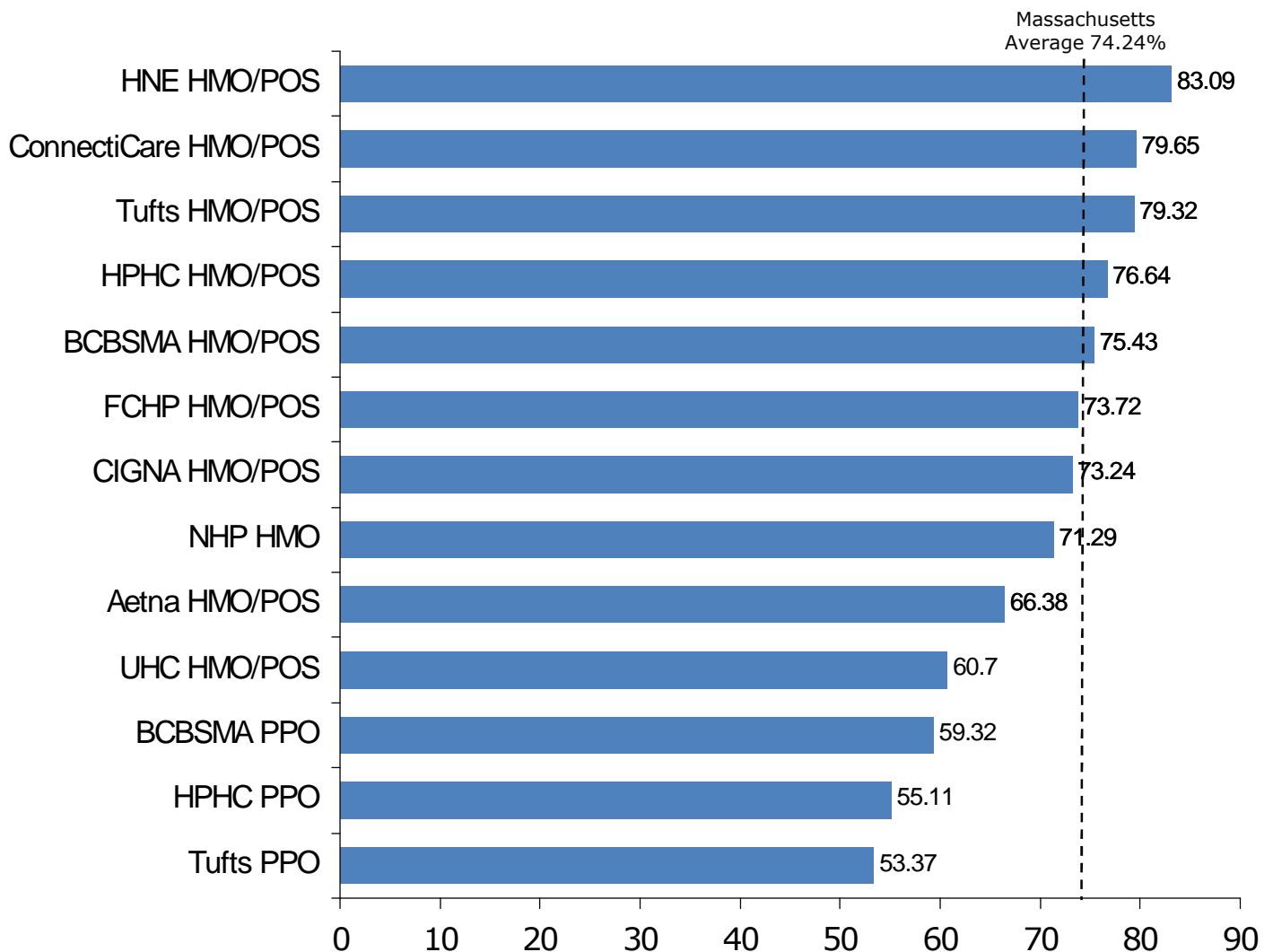
A higher rate indicates better performance (i.e., more diabetics have their blood pressure under control).

Notes: The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Comprehensive Diabetes Care: Eye Exams



The percentage of members ages 18-75 with diabetes (type 1 and type 2) who had an eye examination performed.

A higher rate indicates better performance (i.e., more diabetics have preventive eye examinations).

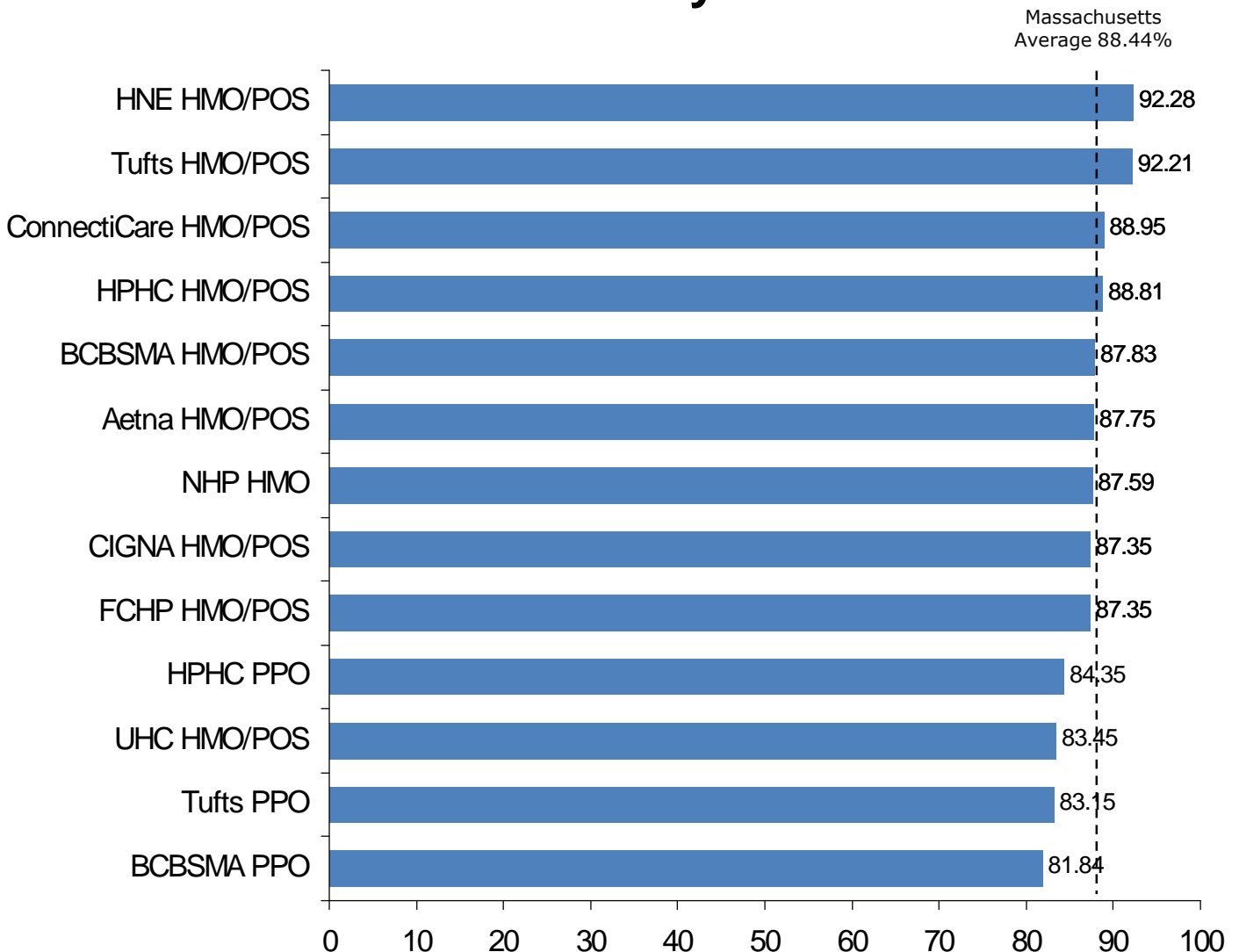
Annual diabetic eye examination are critical for preventing diabetic blindness.

Notes: The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Comprehensive Diabetes Care: Medical Attention For Kidney Disease



The percentage of members ages 18-75 with diabetes (type 1 and type 2) who received at least one test for kidney disease.

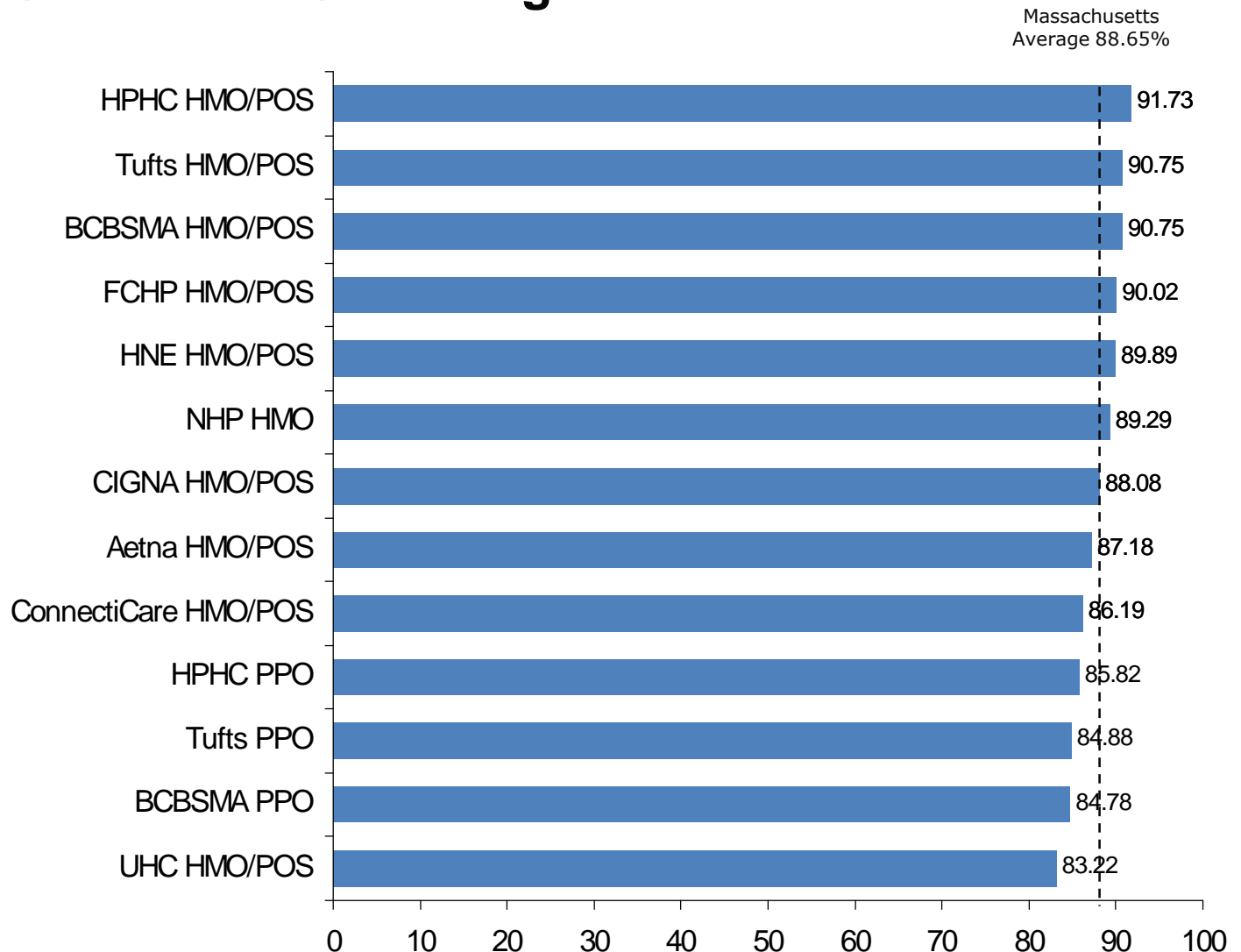
A higher rate indicates better performance (i.e., more diabetics have preventive screening for kidney disease).

Notes: The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Comprehensive Diabetes Care: Cholesterol Screening



The percentage of members ages 18-75 with diabetes (type 1 and type 2) who received lipid level (LDL-C) testing.

A higher rate for this measure is desirable.

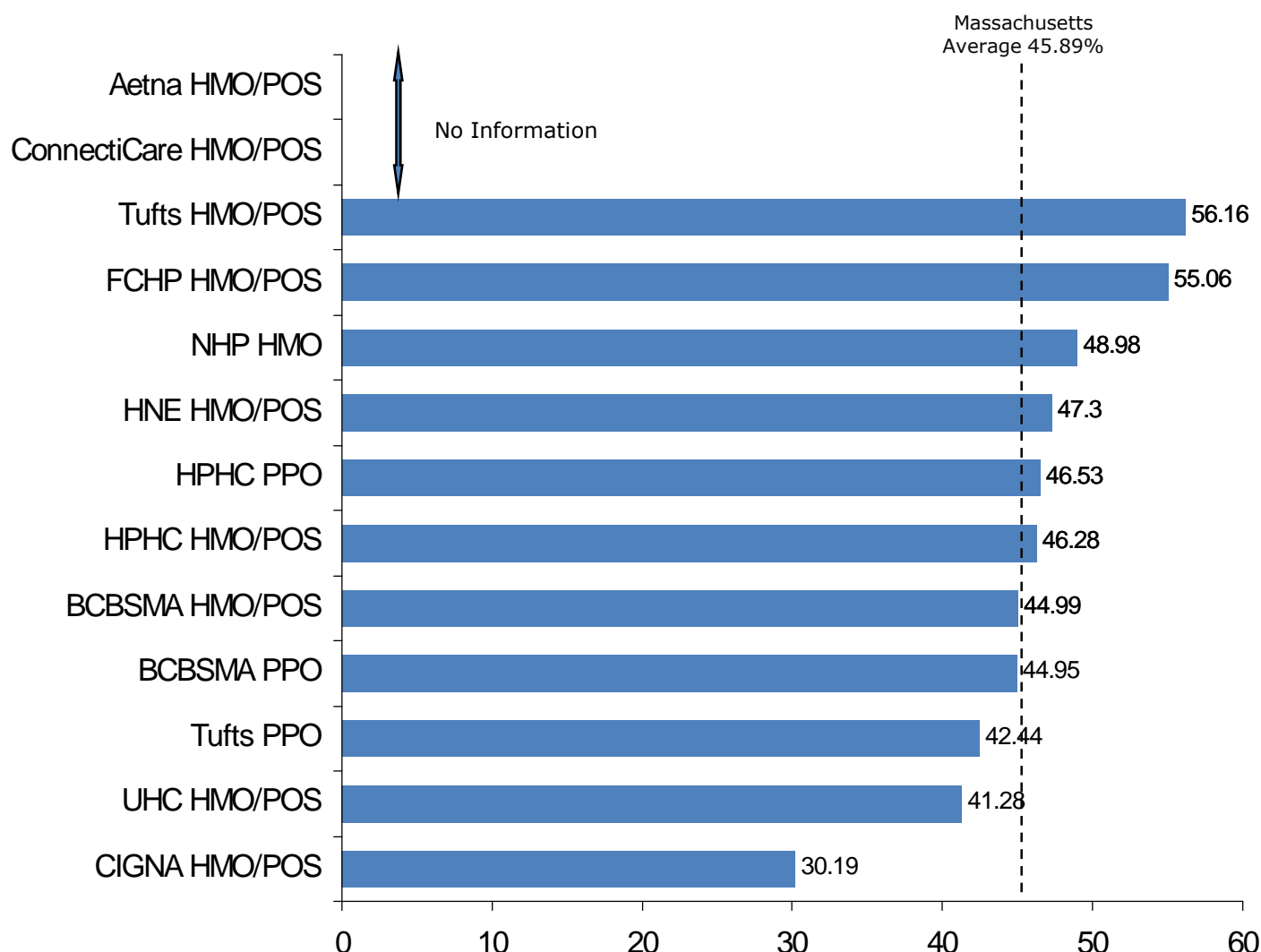
It is necessary to screen members for bad cholesterol (LDL-C) because low LDL-C means lower risk of diabetes related heart attack, stroke and other vascular disease.

Notes: The Massachusetts Average is the average for HMO and POS plans.

PPO data for this measure was based on administrative data collection method only, while HMO/POS had the option to submit data using the hybrid or administrative data collection methods.



# Follow-Up Care for Children Prescribed ADHD Medication: Initiation



The percentage of members ages 6 to 12 as of index prescription episode start date [earliest diagnosis of Attention Deficit/ Hyperactivity Disorder (ADHD)], with an outpatient prescription who had one follow-up visit with the practitioner during the 30-day initiation phase.

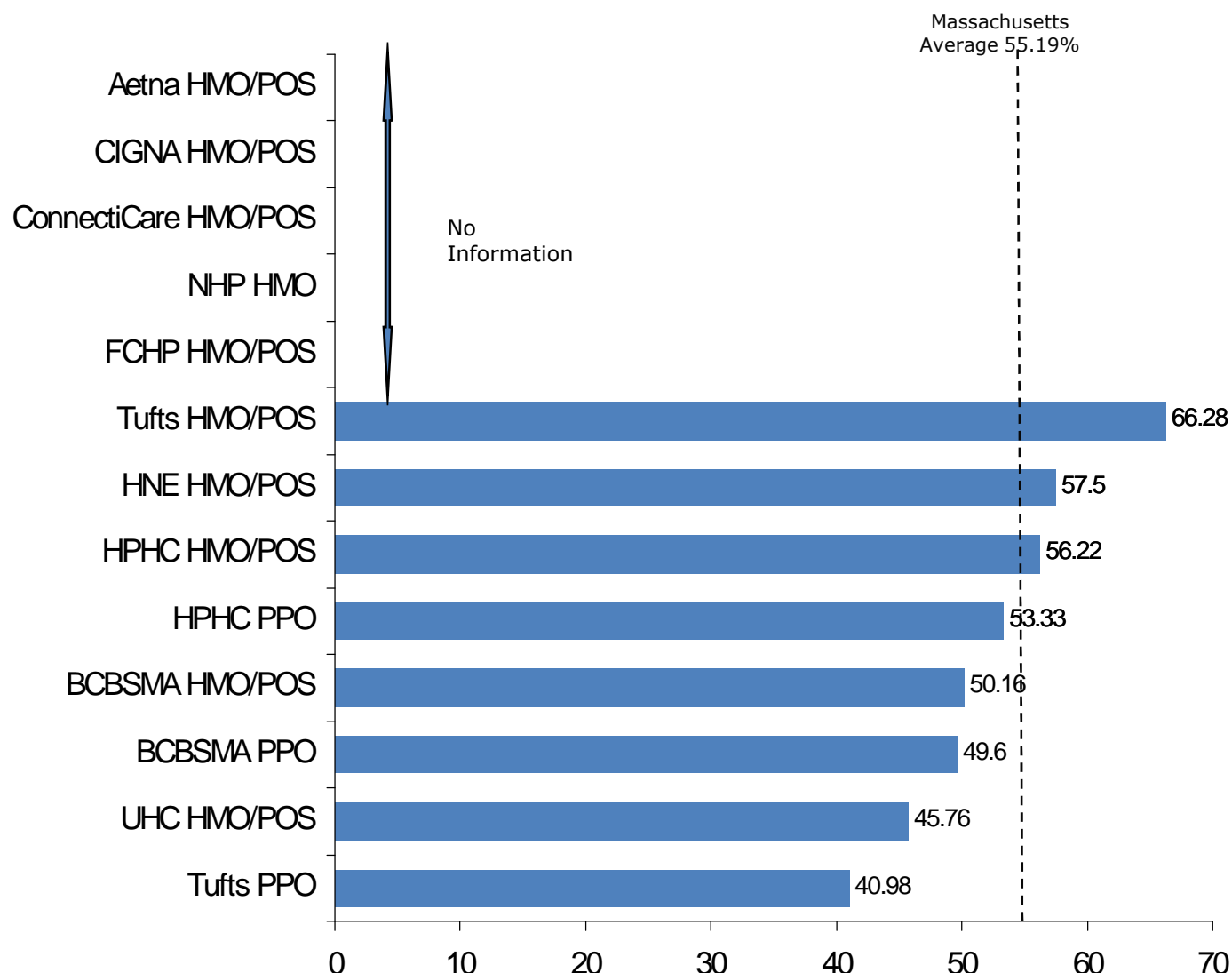
Higher rates on this measure indicate better performance.

ADHD is the most commonly treated childhood neurobehavioral disorder. Children with this condition may experience significant problems such as school difficulties, academic underachievement, and troublesome relationships with family and peers.

Notes: The Massachusetts Average is the average for HMO and POS plans.



## Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase



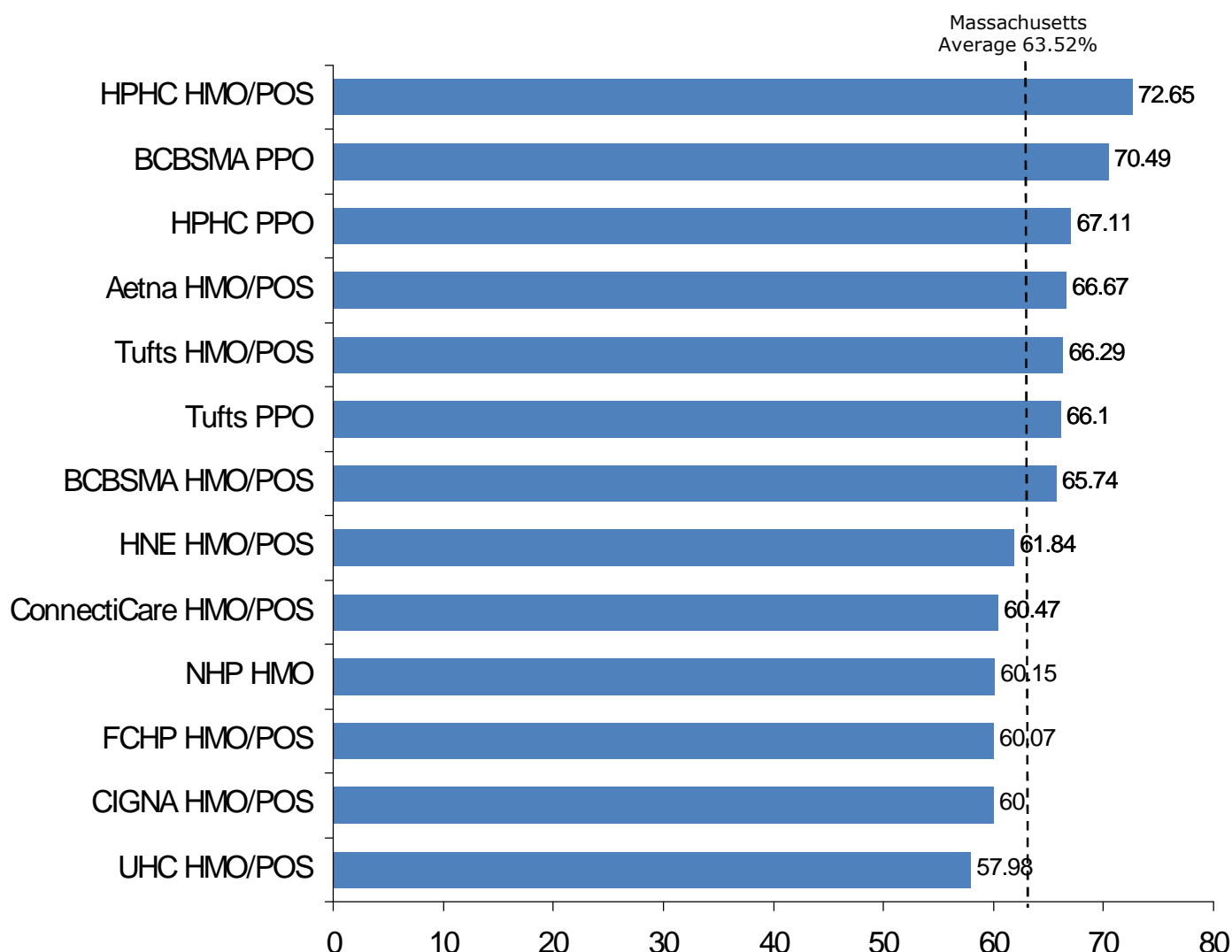
The percentage of members ages 6-12 newly prescribed Attention Deficit/Hyperactivity Disorder (ADHD) medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner during 270 days (9 months) after the Initiation Phase ended.

Higher rates on this measure indicate better performance.

Notes: The Massachusetts Average is the average for HMO and POS plans.



# Antidepressant Medication Management: Effective Acute Phase Treatment



The percentage of members ages 18 and older with new episodes of major depression who were treated with antidepressant medication and remained on the medication for the 12-week Acute Treatment Phase.

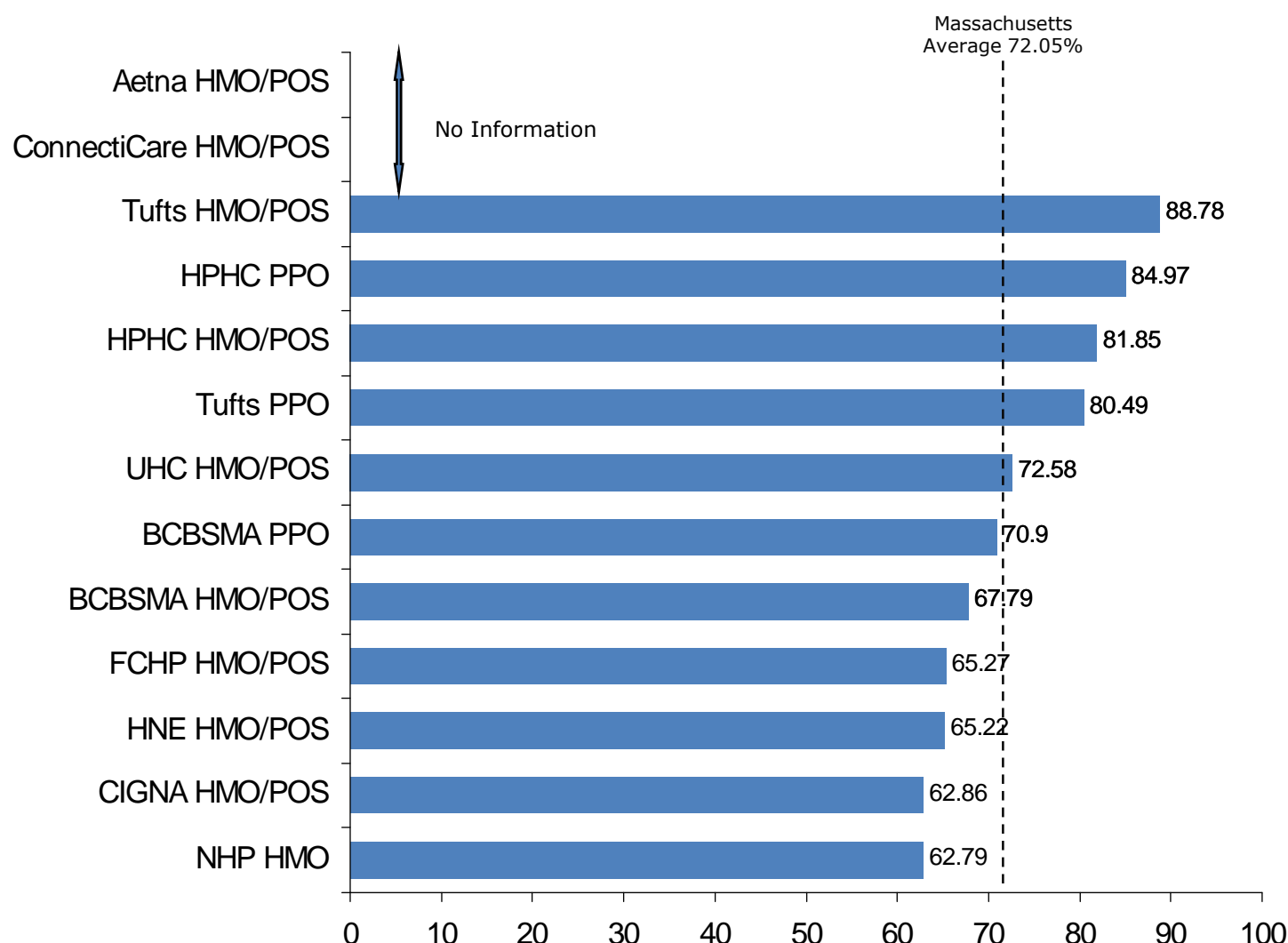
A higher rate indicates better plan performance.

Appropriate dosing and therapy throughout the acute and continuation phases decrease recurrence of depression. Thus, evaluation of length of treatment is an important indicator of a plan's success in promoting patient compliance in maintaining an effective medication regimen.

Notes: The Massachusetts Average is the average for HMO and POS plans.



# Follow-Up after Hospitalization for Mental Illness: 7 days



The percentage of plan members ages 6 and older who were hospitalized for treatment of mental health disorders and who had an outpatient visit or partial hospitalization with a mental health practitioner within 7 days of discharge.

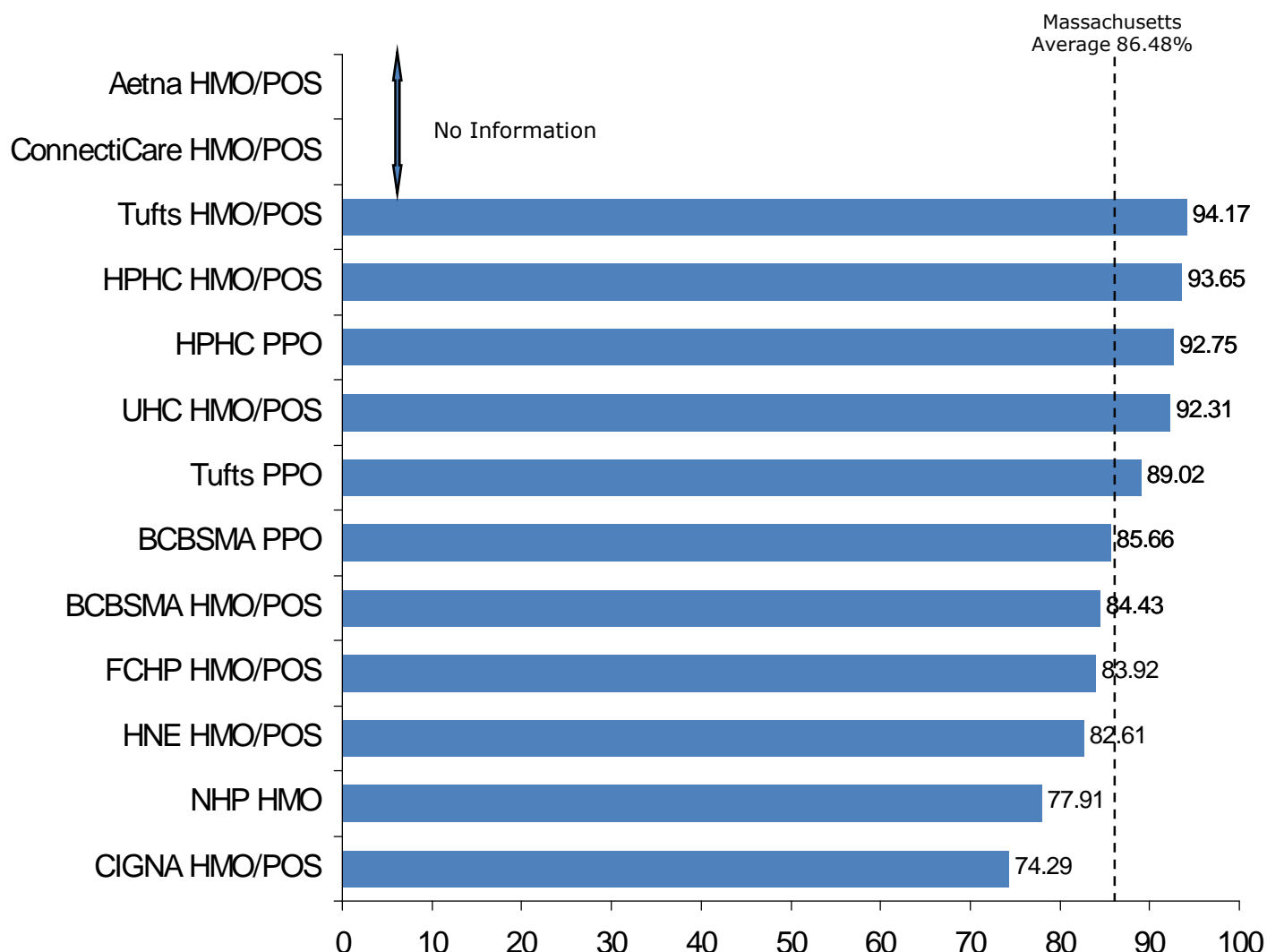
It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness because during the outpatient visit, the practitioner can ensure that the patient's transition to the normal home and work environment is supported and that gains made during hospitalization are not lost. Providers can also detect post-hospitalization reactions or medication problems.

Higher rates on this measure indicate better performance.

Notes: The Massachusetts Average is the average for HMO and POS plans.



## Follow-Up after Hospitalization for Mental Illness: 30 days



The percentage of plan members ages 6 and older who were hospitalized for treatment of mental health disorders and who had an outpatient visit or partial hospitalization with a mental health practitioner within 30 days of discharge.

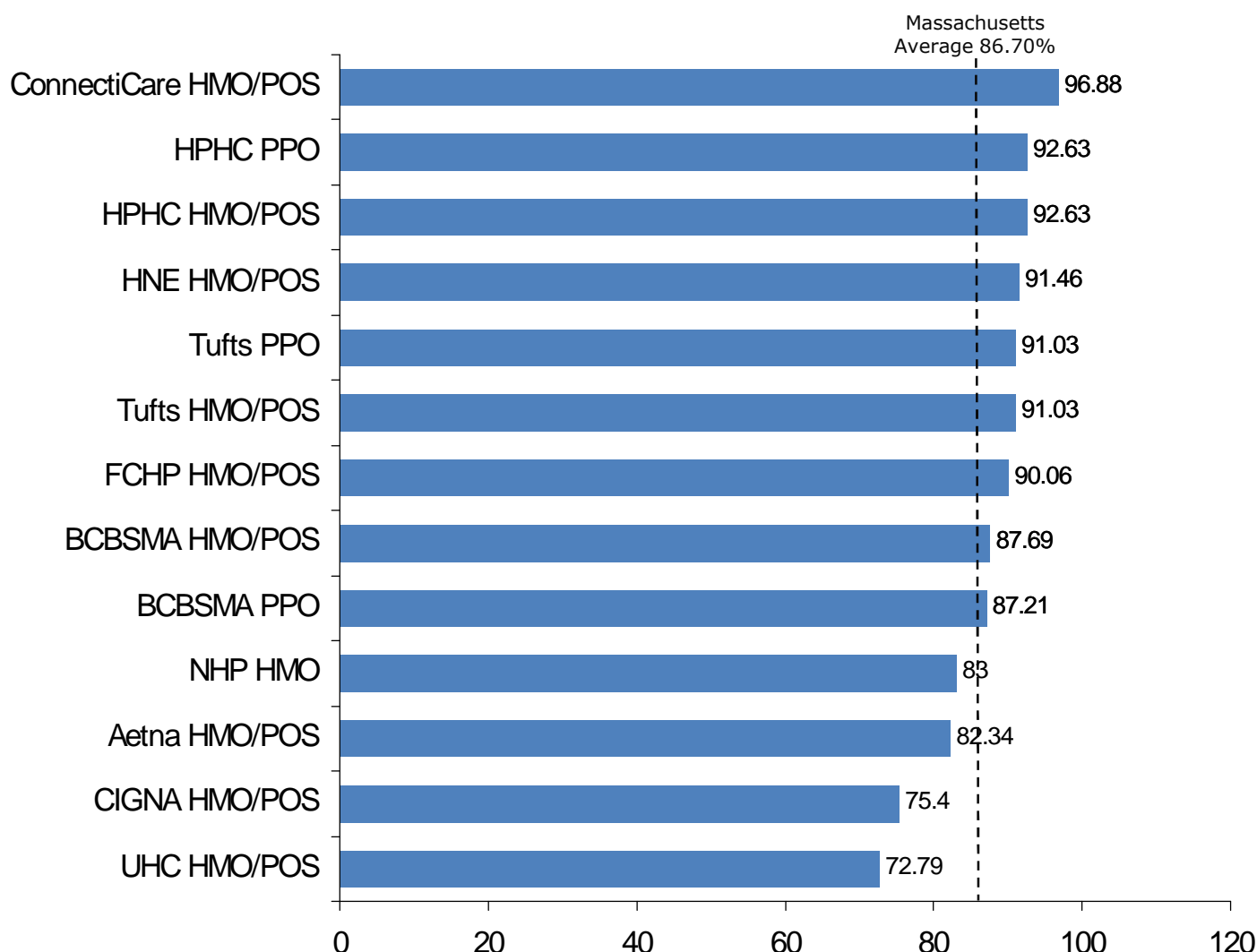
It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness because during the outpatient visit, the practitioner can ensure that the patient's transition to the normal home and work environment is supported and that gains made during hospitalization are not lost. Providers can also detect post-hospitalization reactions or medication problems, and demonstrate continuing care.

Higher rates on this measure indicate better performance.

Notes: The Massachusetts Average is the average for HMO and POS plans.



# Board Certification Status of Family Medicine Physicians



The percentage of active family medicine physicians in the health plan network who are board certified.

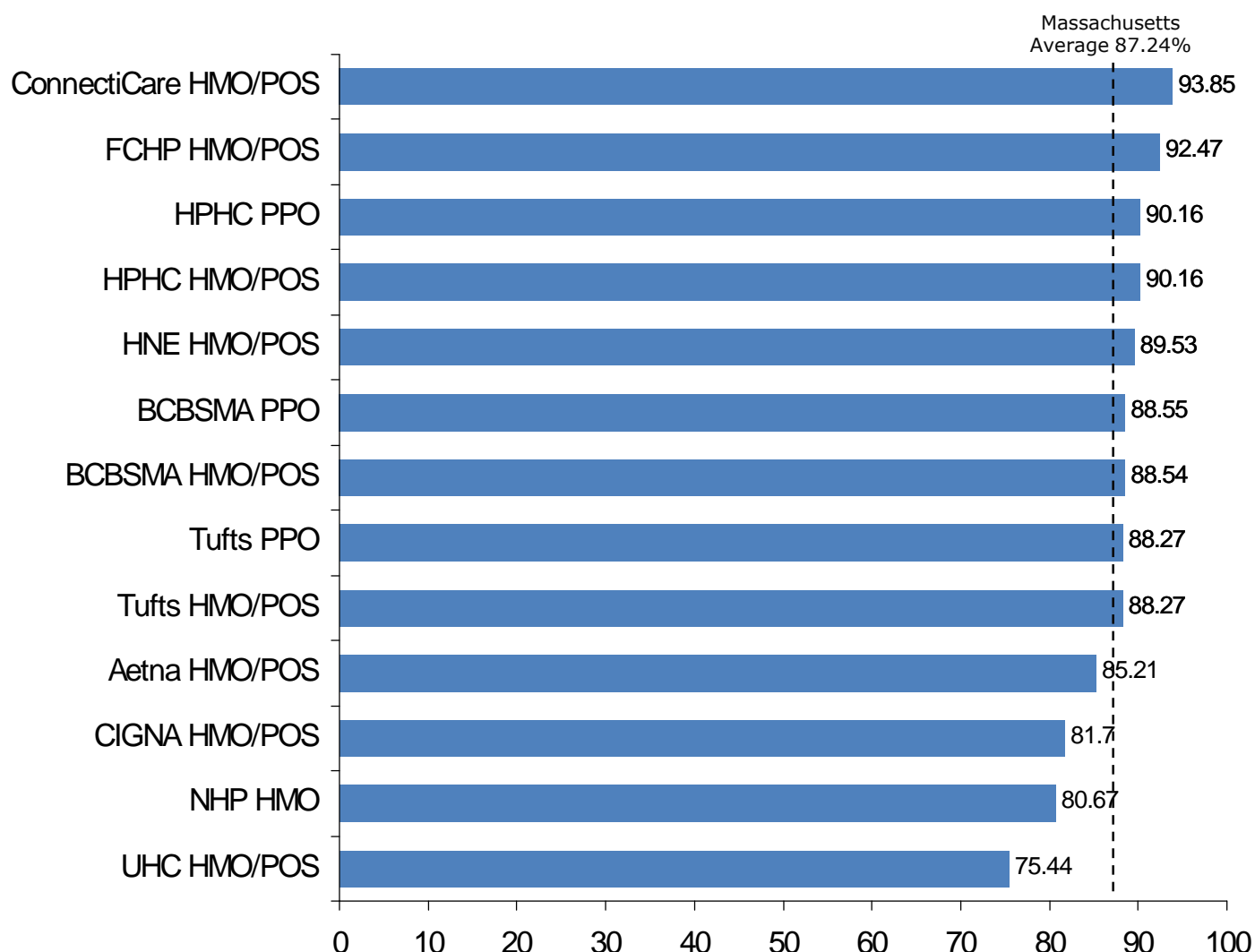
Board certification indicates successful completion of all training requirements in that specialty, practice experience and demonstration of clinical competence in a testing environment.

A higher rate for this measure is desirable.

Notes: The Massachusetts Average is the average for HMO and POS plans.



# Board Certification Status of Internal Medicine Physicians



The percentage of active internal medicine physicians in the health plan network who are board certified.

Board certification indicates successful completion of all training requirements in that specialty and practice experience.

A higher rate for this measure can indicate a health plan's commitment to recruit high quality medical staff.

Notes: The Massachusetts Average is the average for HMO and POS plans.



## Living Healthy and Staying Healthy

When choosing a plan, using the quality measures to determine your choice of a health plan based on the performance of their providers in preventing and treating illness are only a few of the steps you need to take to keep healthy. You also need to take advantage of the coverage by enrolling and participating in the plans' wellness programs. Most health plans offer wellness programs which employers provide to their employees. The wellness programs offered often include:

- Weight loss programs
- Gym membership discounts or on-site exercise facilities
- Smoking cessation
- Personal health coaching
- Classes on nutrition or healthy living
- Web-based resources for healthy living
- Wellness newsletters

Some employers offer their employees the option of completing a health risk assessment to help the employee identify potential health risks. These assessments often come with financial incentives. You may wish to take part in this. Please check each health plan's brochure to determine what they cover and what your employer provides as you make your choice.



## Health Plan Initiatives to Reduce Disparities in Health Care

Disparities in health care delivery result in lower quality of care. Researchers have found that the quality of care and access to care can vary according to the patient's background and location. The state of Massachusetts is committed to promoting equity in health care delivery across diverse patient populations. Please check each health plan's brochure to determine their programs to reduce disparities in health care. The following information on some health plans' efforts to reduce disparities were retrieved from the plans' websites, published materials, or the health plans.

### Aetna

Aetna improves health care quality among racial and ethnic minorities through various prevention and educational initiatives. One such effort is the voluntary provision of self-identified race, ethnicity and language preference data by Aetna's members. It also implemented culturally-appropriate disease management methods. In response to the prevalence of hypertension in the African-American population, Aetna evaluated the effectiveness of their Culturally Competent Disease Management Program (CCDMP) among their African-American HMO members, who were hypertensive. The aim of the initiative was to better understand the problem and improve the care. Aetna has developed recommendations for the expansion and development of Hypertension Disease Management Program for African-Americans. Targeting members with diabetes, Aetna's blood glucose monitoring program uses Spanish language services and materials to better serve and empower Spanish-speaking members with diabetes. As part of Aetna's Beginning Right<sup>SM</sup> maternity program, it offers services that help prevent preterm labor for African-American women through education and case management. Aetna created and implemented training programs to educate employees on the topic of cultural competency. In addition, Aetna celebrates diversity through publications. Their 2009 calendar, Healthy Communities, Health and Wellness Across America, focused on 12 programs designed by national and local organizations to help empower African Americans take control of their health. The publications are distributed to schools, businesses and non-profit organizations. Aetna also enhanced its outreach to the Latino community through its bilingual Hispanic calendar, Recetas de mi Abuela, My Grandmother's Recipes. It also participates in community building through funding for community organizations and an array of community initiatives.



### **Blue Cross Blue Shield of Massachusetts (BCBS)**

BCBS works closely with other organizations in the community to address the needs of diverse populations. Through the Blue Cross Blue Shield of Massachusetts Foundation, partnerships are forged to address health care disparities, improve access and reduce the barriers to quality health for diverse populations. The Foundation's Connecting Consumers to Care program provides support to community-based organizations, community health centers, and select hospital-based programs that provide a continuum of services aimed at ensuring that consumers understand, enroll, and maintain coverage under MassHealth, Commonwealth Care, and other health access programs, and utilize that coverage to access health care services to which they are entitled. Non-profit organizations which seek to improve access and reduce barriers to quality health care and support services for groups experiencing specific health disparities are supported by the Foundation through its Closing the Gap on Health Care Disparities' program. In addition, Blue Cross Blue Shield builds a diverse pool of vendors and expands opportunities for minority and women-owned businesses through its Supplier Diversity Program.



### **CIGNA**

CIGNA's diversity approach is to focus its outreach, communication, and development efforts on the community, customers, employees, and suppliers. CIGNA reaches out to charitable and community organizations with a common interest—health care- and sponsors their initiatives through their Partner of Choice program. They also assist communities with health literacy, education, and career development to help improve quality of life. For the individual customer, CIGNA's Partner of Choice for Customers program strives to understand the demographics, health culture, and lifestyle culture of the diverse customer base and target their products and services to the population's needs. As an Employer of Choice, CIGNA recruits, develops, motivates, and retains a diverse workforce that reflects their customers and the communities in which they operate. For the suppliers, CIGNA's Partner of Choice for Suppliers program partners with a range of diverse suppliers to reflect the many cultures and backgrounds of their customers.

### **ConnectiCare**

ConnectiCare encourages all practitioners to be aware of the needs of diverse populations and provide care that addresses each individual's unique circumstances. In an effort to better serve its diverse population, ConnectiCare collects data on the racial, ethnic, and cultural makeup of its membership.

### **Fallon Community Health Plan (FCHP)**

FCHP addresses cultural diversity through the provision of Spanish-language customer services, translation services for non-English speaking members, and the training of key Customer Service personnel on translation and interpretation.

### **Harvard Pilgrim Health Care**

Harvard Pilgrim Health Care Foundation aims to improve the quality of health care for people of various ethnic and linguistic backgrounds through a program called Culture Insight. The program provides training for providers in culturally competent care and for medical interpreters. Culture Insight also consults with health care organizations and institutions to design professional development and other programs to meet their specific needs. The foundation provides a limited number of grants to organizations working to improve cultural competency in medical and/or health care settings. It is also involved in the community by supporting community events.

### **Health New England**

In recognition of the importance of communicating with all their members in a culturally relevant manner, Health New England partners with community based marketing organizations to tailor their message to their members.

### **Neighborhood Health Plan (NHP)**

78% of NHP's enrollees are minorities and many of their doctors are bilingual. In addition, their multi-lingual customer care center helps members with issues and concerns in various languages, including Spanish, Portuguese, Haitian-Creole, and Cape Verdean Creole. NHP works in conjunction with the Massachusetts League of Community Health Centers (MLCHC) and Harvard Pilgrim Health Care Foundation to develop and provide training to providers in Massachusetts Community Health Centers on diversity and cultural sensitivity awareness. In addition, NHP has implemented multiple processes to collect race and ethnicity data from its membership.



### **Tufts Associated HMO**

Tufts funds programs which aim at reducing chronic diseases among minorities, such as diabetes at the Disparities Solutions Center. Tufts Health Plan's Community Partnerships program supports improvement at the community level through prevention and health promotion activities within target populations of the underserved and those at risk. In support of the Massachusetts Health Care Quality and Cost Council's goal of eliminating disparity in Healthcare delivery, Tufts' Racial Disparity Programs include language access, cultural competence, community driven programs/community partnerships, culturally and linguistically appropriate patient education, participation in cultural competence training, continuing medical education programs addressing racial disparity, and culturally tailored disease management.

### **United Healthcare**

Through its Generations of Wellness program, United Healthcare offers services tailored to the needs of black-owned businesses and their employees and addresses critical health issues and illness that disproportionately affect African-American communities. The program focuses on promoting awareness, education and new attitudes toward healthy living in order to bring a greater level of quality to health care and health insurance. For its Spanish-speaking members, United Healthcare created an Enhanced Bilingual Service and Member Access Initiative, which provides an in-language customer service. The program enhances the interaction between the Spanish-speaking members and the health plan, making assistance on enrollment, benefit information, and the choice of a doctor very easy. A similar initiative, In-language Member and Public Outreach program was created for the Asian community. This program was designed to help Chinese-speaking and Korean-speaking Americans understand and utilize social and health care resources. In addition, the UnitedHealth Foundation works with scholarship organizations to identify and support outstanding young people who aspire to higher education through its Scholars Program. Through this program, young people of diverse backgrounds are encouraged to pursue health careers to improve the quality and cultural competency of the health care system and close the gap in health disparities.

# Appeals and Complaints

There may be times when you are unhappy with your health plan and the decisions it makes about your care. In Massachusetts there are various government agencies that will help you appeal a health plan decision or file a complaint against your plan. It is important to note that the help available to you depends on your health insurance plan.

## **If Your Health Plan Is Self-funded...**

In a self-funded plan, the plan sponsor (usually an employer or union) takes responsibility for paying all of the claims incurred by the employees or union members. These plans are not subject to state insurance requirements but are covered by a federal law-the Employee Retirement Income Security Act (ERISA).

Rather than paying premiums to an insurance carrier, the plan sponsor may pay the claim or hire a third party administrator (TPA) to process claims, establish a provider network and provide customer service. The ID card issued to the employee/member may carry the TPA's name because the TPA may be part of an insurer or an HMO. This makes it difficult for members of these plans to know that their plans are self-insured.

An ERISA-covered plan must give participants and beneficiaries a summary plan description (SPD) that clearly describes their rights, benefits, and responsibilities. The SPD also must list the names of the fiduciaries. Fiduciaries are the people who have control over the assets of a plan, including its operations, which include claims payments. Your plan may have several named fiduciaries. One fiduciary may be responsible for paying claims while another is responsible for reviewing appeals of claims denials.

If you are a member of a self-funded plan and want to file an appeal, you have a specified amount of time to do so and the plan must respond within specific time frames, which are defined by the U.S. Department of Labor (DOL). You should also know who the fiduciary is in the event that you leave your job and have concerns about continuing coverage. Most beneficiaries are entitled to continue coverage if employment is terminated. Plans are required to offer beneficiaries, at their own expense, the right to maintain comparable health care coverage at a comparable cost.

If you have further questions about your rights as a member of a self-funded plan, please call (866) 444-3272 or visit the U.S. DOL website at: [www.dol.gov/ebsa](http://www.dol.gov/ebsa). The local mailing address is Employee Benefits Security Administration, J.F.K. Building Room 575, Boston, MA 02203.



### **If Your Health Plan Is Fully Insured...**

The Office of Patient Protection (OPP) within the Massachusetts Department of Public Health was established to assist consumers who are enrolled in managed care plans licensed in Massachusetts and who have questions or problems obtaining covered services. The OPP staff assists consumers in the following two ways:

- Help you navigate the managed care requirements of your health insurer; and
- Help you appeal if your insurer has denied a claim or access to services.

Please read the “Frequently Asked Questions” on the OPP website for information about the Massachusetts laws that your health insurer must follow.

If you have gone through the internal appeal process with your insurer and the answer is still “no,” OPP administers an external appeal process for an independent medical review of your case. If you are an insurer, health plan administrator, or consumer and have questions, please contact the OPP at (800) 436-7757 or visit its website at: [www.mass.gov/dph/opp](http://www.mass.gov/dph/opp)



### **How Do I File an Internal Grievance?**

Every Massachusetts-licensed health plan must have a formal internal grievance process to respond to members' concerns and issues. The grievance process must be included in the health plan's evidence of coverage. If you disagree with a decision made by your health insurance carrier, you may appeal to the carrier for review.

For example, if your health plan refuses to pay for treatment that you believe you need, or if it notifies you that it will stop providing or paying for treatment, you can request that the decision be reviewed.

If you choose to appeal a decision, do not delay completing the paperwork or contacting your health plan. When you begin the process of appealing a decision, you should keep written records of everything you do and everyone with whom you speak.

Under Massachusetts law, a licensed health plan must respond to your appeal in writing within 30 business days of receiving your appeal. There is also a process for expediting an appeal when the request involves an inpatient or a terminally ill member, or if the service is urgently needed to preserve the health of the member.



If you have appealed your plan's denial of services based on medical necessity through an internal grievance process and that decision is upheld, you may request an external review through the OPP within 45 days of receiving notice from the health plan of its final decision ("final adverse determination"). The health plan must send you a form and information on how to file an external appeal. There is also a process for filing an expedited review and for requesting that coverage continue while the external appeal is pending.

You may also get an external review form from the OPP at [www.mass.gov/dph/opp](http://www.mass.gov/dph/opp) or by calling (800) 436-7757. The completed form should be sent to the OPP with a check for \$25.00 and your consent to release your medical information. If you cannot afford the \$25.00 fee, you can request that the fee be waived. If you are unsure if your appeal is eligible for external review, you may contact the OPP for additional assistance.

The external review agency will issue a decision on standard appeals within 60 business days. Expedited appeals will be decided within five business days.

Please remember that the decision by the external review panel is final and binding. Please visit the OPP website ([www.mass.gov/dph/opp](http://www.mass.gov/dph/opp)) for answers to frequently asked questions about the external review process.



### **If Your Plan Is a MassHealth (Medicaid) Plan...**

Please direct your questions and concerns with MassHealth/Medicaid to the MassHealth Customer Service Center at (800) 841-2900. Appeals and complaints for MassHealth plans are heard by the Board of Hearings, which can be reached at (800) 655-0338.

Additional information for MassHealth can be found on its website at:

[www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### **If You Have Coverage through Medicare...**

Please direct your Medicare questions and concerns to the Medicare Customer Service line at 1-800-MEDICARE. Information on Medicare appeals can be found on the Medicare website at: [www.medicare.gov/basics/appeals.asp](http://www.medicare.gov/basics/appeals.asp).



## For Accreditation and Reports

**The Board of Registration in Medicine** offers a comprehensive look at over 27,000 physicians licensed to practice medicine in Massachusetts. Call (800) 377-0550 or visit [www.massmedboard.org](http://www.massmedboard.org).

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**

Evaluates and accredits health care organizations and programs, including hospitals, long-term care facilities, and other health care facilities, as well as health plans, managed care entities, and other insurers. Go to the JCAHO Web site at [www.jointcommission.org](http://www.jointcommission.org). Call them at 630-792-5000, or write to JCAHO, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

**The Massachusetts Department of Public Health, Division of Health Care Quality**

is the licensing authority for hospitals in Massachusetts. Call (617) 753-8000 or visit [www.mass.gov/dph/dhcq](http://www.mass.gov/dph/dhcq).

**The Division of Health Care Finance and Policy** has information on both quality and cost of care at hospitals. Visit [www.mass.gov/healthcareqc](http://www.mass.gov/healthcareqc).

**The Massachusetts Health Quality Partners (MHQP)** is a coalition of health care providers, plans and purchasers working together to improve health care quality in Massachusetts. Call (617) 972-9079 or visit [www.mhqp.org](http://www.mhqp.org).



## Other Benchmarks and Comparisons

### **National Committee for Quality Assurance**

A group that develops quality standards, performance measures, and recognition programs for organizations and individuals, including health plans, medical groups, physician networks, and individual physicians. Visit their Web site at [www.ncqa.org](http://www.ncqa.org) or call 202-955-3500.

### **Agency for Healthcare Research and Quality (AHRQ)**

An agency of the Federal government. Visit its website at <http://www.ahrq.gov> to find more information and tools to help you evaluate health plans, as well as many consumer publications on various health topics. Most of the consumer materials are available in English and Spanish. Call the AHRQ Clearinghouse at 1-800-358-9295 to order free copies of publications.

For health plan information from the National CAHPS Benchmarking Database (NCBD), please visit [www.cahps.ahrq.gov](http://www.cahps.ahrq.gov)

### **Utilization Review Accreditation Commission**

A group that accredits PPOs and other managed care networks. Visit its website at [www.urac.org](http://www.urac.org), call 202-216-9010, or write to URAC, 1220 L Street, N.W., Washington, DC 20005.



### **Information About Other Types of Health Plans**

For most Commonwealth of Massachusetts employees, please contact the Group Insurance Commission. Call (617) 727-2310 or visit [www.mass.gov/gic](http://www.mass.gov/gic).

For users of self-funded/ERISA-covered plans, please call the Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

For most federal government employees, contact your human resource office.

For Information about Medicare, Medicare-HMOs (Managed Care), and Medicare Part D (The New Pharmacy Benefit) from the federal government, visit [www.medicare.gov](http://www.medicare.gov) or call (800) MEDICARE.

For MassHealth, additional information can be found on its website at: [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

For the Connector programs, please visit the Health Connector's website at [www.MAhealthconnector.org](http://www.MAhealthconnector.org).

For health insurance counseling services for the elderly, please contact SHINE (Serving the Health Information Needs of Elderly) within the Massachusetts Executive Office of Elder Affairs.

Call 800-AGE-INFO (800-243-4636) or visit [www.800ageinfo.com](http://www.800ageinfo.com).

### **Information on Tax-Favored Health Accounts**

For general information on health savings accounts, flexible spending arrangements, and health reimbursement arrangements, please call (800) 876-1715 or visit [www.irs.gov](http://www.irs.gov).



## **AARP**

An advocacy organization comprising 35 million members. AARP focuses on issues affecting men and women aged 50 and older. Go to [www.aarp.org](http://www.aarp.org) to find many publications and other resources on health topics, including Medicare and other health insurance. Contact AARP by phone at 1-888-687-2277, or write to AARP, 601 E Street, N.W., Washington, DC 20049.

## **America's Health Insurance Plans (AHIP)**

A national association that represents health insurance plans providing medical, long-term care, disability income, dental, supplemental, stop-loss, and reinsurance to more than 200 million Americans. Go to <http://www.ahip.org> and select "Consumer Information," where you can access many consumer guides on health insurance and link directly to companies that provide health insurance coverage. Or, contact AHIP by phone at 1-202-778-3200, or write to AHIP, 601 Pennsylvania Avenue, N.W., Washington, DC 20004.



## Other Important State Resources

### **Bureau of Managed Care**

The Bureau of Managed Care within the Massachusetts Division of Insurance accredits managed care health plans in Massachusetts to make sure that they are in compliance with Massachusetts laws. The Bureau sets minimum standards for utilization review, quality management and improvement, credentialing, preventive health services, provider contacts, and consumer disclosures. The Bureau also investigates complaints against carriers for noncompliance with accreditation requirements.

If you believe a carrier has not complied with statutory requirements, please contact the Bureau at (617) 521-7372. You can find more information about the Bureau at [www.mass.gov/doi/Managed\\_Care/managed\\_care\\_home.html](http://www.mass.gov/doi/Managed_Care/managed_care_home.html)

### **Massachusetts Division of Insurance**

Prior to purchasing any insurance coverage, consider contacting the Massachusetts Division of Insurance at (617) 521-7794 or visit its website at [www.mass.gov/doi](http://www.mass.gov/doi) for consumer guides and up-to-date information on approved health insurance coverage products.



## Health Insurance Terms

**Affordable Care Act:** In March 2010, Congress passed and the President signed into law the Affordable Care Act, which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. For more information visit [www.HealthCare.gov](http://www.HealthCare.gov)

**Archer Medical Savings Accounts:** Individual accounts that may be set up by self-employed individuals and those who work for small companies. Funds in the accounts are used to pay medical expenses.

**Benefits:** The medical services included in a health insurance policy to which the insured person or persons are entitled.

**Calendar Year:** The time period from January 1 to December 31 in a single year.

**Catastrophic Health Insurance:** Insurance, with a very high deductible, covering an injury or illness with medical expenses that are above the normal parameters of basic health insurance.

**Claim:** A health-related bill submitted for payment to a health insurance company by the policy holder or health care provider.

**COBRA:** “Consolidated Omnibus Budget Reconciliation Act” of 1985 is a regulation that affects most U.S. employers of over 20 employees, whereby they must offer departing employees a continuation of their health insurance.

**Coinsurance:** The amount you must pay for medical care after you have met your deductible. Typically, your plan will pay 80 percent of an approved amount, and your coinsurance will be 20 percent, but this may vary from plan to plan.

**Co-payment:** The dollar amount the policyholder pays at each visit for a medical service; it varies according to each insurance policy. Your plan pays the rest.



# Health Insurance Terms

**Coverage:** A health service which qualifies as a benefit under the terms of an insurance contract.

**Deductible:** The amount of money the policyholder pays for medical bills before insurance starts to pay its part. This is a yearly amount and may be anywhere from several hundred dollars to several thousand per year, depending on the insurance policy.

**Disability Insurance:** Pays benefits if you are injured or become seriously ill and are no longer able to work.

**Discount Plans:** Large buying organizations formed to provide discounts on health services to its members. It is not a form of health insurance.

**Exclusions:** Services that are not covered by a plan. Sometimes called limitations, these exclusions and limitations must be clearly spelled out in plan literature.

**Family Health Insurance:** Health coverage taking into account the unique needs in each family. It can be either a group or an individual type of insurance.

**Fee-for-service Insurance:** Traditional (indemnity) health insurance where you and your plan each pay a portion of your health expenses, usually after you meet a yearly deductible. In most cases, you can choose any physician, hospital, or other provider (non-network based coverage).

**Federal Poverty Levels (FPL):** These are poverty guidelines that are loosely referred to as FPL. They are federal poverty measures that are issued each year by the United States Department of Health and Human Services for use for administrative purposes, such as determining financial eligibility for certain federal programs.



## Health Insurance Terms

**Flexible Spending Arrangements:** Employees use pre-tax dollars to set up these accounts and draw down on them to pay qualified medical expenses during the year. Unused amounts are forfeited at the end of the year.

**Formulary:** An insurance company's list of covered drugs.

**Group Health Insurance:** Health plans offered to a group of individuals by an employer, association, union, or other entity. The cost is spread out among the members of the group. Under federal guidelines, a "large employer" is one with 51 or more employees and a "small employer" averages two to 50 employees in a calendar year.

**HIPAA:** "Health Insurance Portability and Accountability Act" gives patients a means to the documents which pertain to their medical care; provides that a person with a pre-existing condition, who has had continuous health coverage for over 12 months, can leave a job and not be turned down for health insurance at a new job.

**HMO:** "Health Maintenance Organization" is a type of group health plan in which an organization is formed to provide medical care to its members. The physicians and medical personnel work for the HMO and provide medical care to the members of the HMO, with limited referrals to outside specialists. There is often an emphasis on prevention of disease and participation in programs for better health. Recently, members of HMOs may see health care professionals outside of their system, with higher fees. Members usually obtain all of their medical needs from their HMO clinics through managed medical care.

**Health Reimbursement Arrangement:** An account established by an employer to pay an employee's medical expenses. Only the employer can contribute to a health reimbursement account.



## Health Insurance Terms

**HSA:** “Health Savings Account” is a personal savings account set up by an employer or an individual to be exclusively used for medical expenses on a tax-free basis and is paired with a high deductible health insurance policy. Any balance remaining at the end of the year rolls over to the next year.

**High Deductible Health Plan:** A plan that provides comprehensive coverage for high-cost medical events. It features a high deductible and a limit on annual out-of-pocket expenses. This type of plan is usually coupled with a health savings account or a health reimbursement arrangement.

**High-Risk Pool:** A state-operated program that offers coverage for individuals who cannot get health insurance from another source due to serious illness.

**Indemnity Insurance:** A fee-for-service (FFS) health insurance that does not limit where a covered individual can get care. FFS allows you the freedom to choose any doctor, hospital, and your health care services and as long as your services are eligible, you will be charged a fee depending on how your policy rules are written. Indemnity insurance sometimes costs more than managed health plans, such as HMOs and PPOs but it affords greater freedom of choice. If you choose an indemnity plan, you may have a deductible in addition to a co-payment. You will have the freedom to choose a physician, a specialist, or hospital, with few, if any limitations. However, your options for a hospital or physician or specialist may be limited by geographic restrictions. Some indemnity plans may not cover preventative services, which include annual check-ups and routine office visits. These services may not count towards your deductible.

**Individual Health Insurance:** Health coverage on an individual basis, not part of a group. The premium is usually higher for individual health insurance than for a group policy.

**Long-Term Care Insurance:** Coverage that pays for all or part of the cost of home health care services or care in a nursing home or assisted living facility.



## Health Insurance Terms

**Managed Care:** An organized way of getting health care services and paying for care. Managed care plans feature a network of physicians, hospitals, and other providers who participate in the plan. In some plans, covered individuals must see an in-network provider; in other plans, covered individuals may go outside of the network, but they will pay a larger share of the cost.

**Maximum Limits:** The highest dollar amounts a health insurance plan will pay: 1) for a single claim; 2) over the lifetime of an insured person.

**Medicaid:** A Federal program administered by the states to provide health care for certain poor and low-income individuals and families. Eligibility and other features vary from state to state.

**Medicare:** A Federal insurance program that provides health care coverage to individuals aged 65 and older and certain disabled people, such as those with end-stage renal disease

**Network:** The doctors or other medical providers and facilities that either work for or contract with a group health care organization, such as a managed care plan.

**Open enrollment:** A set time of year when you can enroll in health insurance or change from one plan to another without benefit of a qualifying event (e.g., marriage, divorce, birth of a child/adoption, or death of a spouse). Open enrollment usually occurs late in the calendar year, although this may differ from one plan to another.

**Out-of-Network:** Doctors or other medical providers and facilities which either do not work for or which do not contract with a group health care organization.

**Policy:** The legal agreement between an insurance company and insured person, whereby the company agrees to pay for the covered medical services included in the agreement and the insured agrees to pay the premium price.

**POS:** “Point of Service” is a type of managed care with a combination of HMO and PPO characteristics. The policyholders must use a primary care physician, but they can use other network health providers when needed or go to out-of-network providers at higher cost.



## Health Insurance Terms

**PPO:** “Preferred Provider Organization” is a type of managed care in which you have more flexibility in choosing physicians and other providers than in an HMO. You can see both participating and nonparticipating providers, but your out-of-pocket expenses will be lower if you see only plan providers.

**Pre-existing Condition:** A physical or mental condition which existed before applying for a policy, for which medical care was already recommended or received, and which may not be covered by insurance, or only after a time lapse.

**Premium:** The amount you pay to belong to a health plan. If you have employer-sponsored health insurance, your share of premiums usually are deducted from your pay.

**Primary Care Physician:** Usually a family practice doctor, internist, obstetrician-gynecologist, or pediatrician. He or she is your first point of contact with the health care system, particularly if you are in a managed care plan.

**Prescription Plans:** An organized plan whereby prescription needs are provided to group members at a lower cost, usually through a vendor with a pharmacy network that covers the whole country and negotiates for lower drug costs.

**Provider:** A physician, hospital, medical care facility, or other type of medical personnel who provides health care.

**Reasonable and Customary Charge:** The prevailing cost of a medical service in a given geographic area

**Referral:** The method whereby a physician directs a patient to the services of another physician.

**SDHP:** “Self-Directed Health Plan” utilizes a money account with a declining balance used for medical expenses.





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