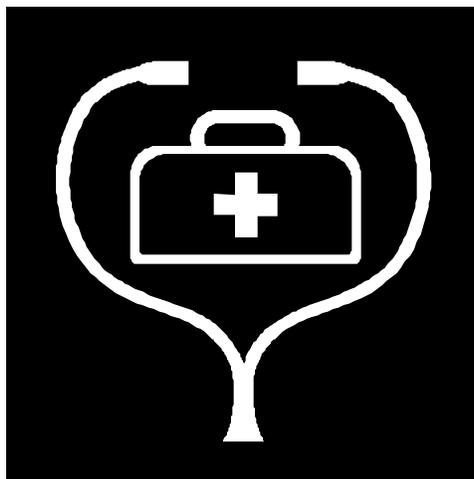


Buying a Health Plan?

Managed Care and HMOs



A booklet for small- to medium-size employers, health benefit plan administrators, and union officials who are trying to decide on a managed care option as a way of providing health care benefits to their plan participants

The Pennsylvania Health Care Cost Containment Council promotes competition in the health care marketplace by providing purchasers, providers, and policy-makers with useful information about health care providers. The Pennsylvania Health Care Cost Containment Council is an independent state agency that collects information about the cost and quality of health care services in Pennsylvania. Please contact our agency to receive any of the following free reports:

- *Focus on Heart Attack in Pennsylvania*
- *A Consumer Guide to Coronary Artery Bypass Graft Surgery*
- *Cesarean Section Deliveries in Pennsylvania*
- *Hospital Effectiveness Report*
- *Hospital Financial Report*
- *Utilization Study of Major Organ Transplants*

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Section 1 – Introduction

The Pennsylvania Health Care Cost Containment Council

The Pennsylvania Health Care Cost Containment Council was created by the Pennsylvania legislature in 1986 to stimulate competition in the health care marketplace by providing useful information about the cost and quality of health care. Previous Council reports have focused on hospital-specific data and, to a limited degree, physician-specific data. The health care industry, however, is experiencing enormous change involving a shift in traditional roles, especially as it relates to the management of health care.

As payors exert more influence over providers, and purchasers seek to choose from multiple “managed care options,” it is fair to recognize that providers are no longer solely responsible for the delivery of quality care. Payors are evolving from the traditional approach of financing the delivery of health care to one of influencing the organization of the delivery system. While it is important to remember that patients are not treated by payors, it is increasingly the case that in today’s market, payors directly or indirectly influence the delivery of care.

As these newly emerging and evolving health systems work to achieve positive outcomes for their health plan members in the most cost-efficient manner, it is important to monitor and report on these results. In late 1995, the Pennsylvania Health Care Cost Containment Council, through a series of strategic planning sessions, identified as its primary future role to develop information about the impact and influence of managed care on health care cost and quality issues.

What Is the Purpose of This Booklet?

Those who make decisions about purchasing health care benefits for their employees or members are confronted with a new array of choices calling themselves managed care. This booklet addresses the most common concerns of purchasers about cost, service, access, and quality. It provides small- and medium-size employers, health benefits plan administrators, and union officials a framework to begin a constructive dialogue with those plan representatives. This booklet is intended to be a starting point of questions to ask and issues to raise before making any choices.

Section 2 – Managed Care and HMOs

Traditionally, most Pennsylvanians received their health care benefits as an employee benefit or from a government sponsored health program, such as Medicare or Medicaid. These health plans made arrangements that paid independent physicians and hospitals a fee for each service provided to the plan participants. These fee-for-service arrangements were among the contributing factors to duplication of services, unnecessary services, and to escalating health care costs. One response to this problem was the formation of health maintenance organizations (HMOs).

What is an HMO?

An HMO (health maintenance organization) is an organized system which combines the delivery and financing of health care and which offers basic health services to voluntarily enrolled members. An HMO can be viewed as a system which combines some of the features of a health insurer and a health care delivery system. Unlike traditional insurers, HMOs are actively involved in the care their members receive. HMO enrollees are required to select a primary care physician who has the responsibility to coordinate preventive and primary care services and refer patients to specialty care when necessary. The HMO manages the delivery of health care services and shares financial responsibility with providers to deliver care for a fixed price.

Some of the principles behind an HMO are:

- To have members choose a primary care physician from a panel of providers to manage the total care of patients and to refer them to specialty care when necessary;
- To provide comprehensive health care benefits including preventive and medical education benefits intended to keep people healthy and out of hospitals;
- To ensure delivery of quality health care; and
- To establish reimbursement arrangements that encourage the delivery of cost-effective care.

Types of Managed Care Plans

The success of HMOs in managing and slowing health care cost increases has led traditional insurers and other organizations to incorporate some of the cost and quality management features of HMOs without some of the restrictive features. Many of these “hybrids” are described as managed care. The terms “managed care” and “HMO” are sometimes used interchangeably. Managed care, however, is a broader concept.

Some types of managed care plans include:

- **Managed indemnity plans:** Most traditional insurance plans today have some structures to manage utilization such as prior authorization of surgical services, utilization review, or case management.
- **Preferred Provider Organization (PPO):** A PPO contracts with a network of providers who have agreed to provide services at a reduced rate. Normally there is an increased cost to plan members when they use services out of the network. In a PPO, a member is not normally required to select a primary care physician. PPOs are reviewed and approved by the Departments of Health and Insurance.

Some PPOs, referred to as gatekeeper PPOs, require members to select a primary care physician. Gatekeeper PPOs are regulated by the Departments of Health and Insurance and are required to meet many of the same requirements as HMOs.

- **Point of Service (POS):** A POS option, usually offered by an HMO or PPO, allows an individual more liberal, but still reduced, out-of-network benefits than an HMO but retains the primary care physician features of an HMO. A POS plan is considered a gatekeeper PPO by the Departments of Health and Insurance and is reviewed and approved by them.
- **Medical Service Organization (MSO):** MSO is one name for an integrated health care delivery network that contracts with payors to provide a comprehensive array of benefits. Some forms of MSOs that accept financial risk to provide services to a group of members may be referred to as a Physician Hospital Organization (PHO) or a Physician Organization (PO). They may contract with an HMO or directly with those employers governed by the provisions of ERISA. MSOs are considered by the Insurance Department and the Department of Health under the broader designation of “integrated delivery systems.”

This booklet focuses on HMOs. However, the issues discussed can also apply to other managed care organizations.

Why Consider an HMO or a Managed Care Organization?

Health maintenance organizations (HMOs) and other managed care organizations (MCOs) have demonstrated an ability to deliver quality health care services while at the same time managing the cost to employers. In concept, they are able to do this by:

- Providing a full range of preventive benefits with lower out-of-pocket expenses to members. Preventive care reduces hospitalizations and saves money.
- Incorporating internal quality review and management standards to ensure access to appropriate quality services.
- Coordinating and controlling access to specialty and hospital care. Referrals to specialty and most hospital care must be approved by the primary care physician, often referred to as a gatekeeper.
- Negotiating with physician and hospital providers to deliver care to a group of patients for a predetermined rate.

Why Regulate HMOs?

Research into the traditional health care delivery system with its fee-for-service features has documented significant amounts of unnecessary or inappropriate use of medical services. There are wide variations across the country, even in neighboring communities, in the way physicians practice medicine. Many HMOs have used medical practice protocols and utilization review guidelines to improve quality and efficiency in the delivery of health care and to reduce the utilization of inappropriate health care services.

Concerns that HMOs might, in some cases, limit access to necessary services has led most states to impose some regulations on HMOs. In Pennsylvania, HMOs and gatekeeper PPOs are jointly regulated by the Departments of Health and Insurance. These regulations are designed to ensure that consumers are adequately protected. Government, both federal and state, as well as private agencies each have different roles in the regulation and oversight of managed care organizations.

Who Regulates HMOs and Managed Care Organizations?

FEDERAL GOVERNMENT

The **Federal Government** helped to encourage the growth of HMOs with the passage of the HMO act in 1973. The Act established standards and incentives for “federal qualification” of HMOs that marked a first step toward uniform standards for the industry. The role of the Federal Government today is focused more on monitoring the quality and cost effectiveness of Medicare HMOs through the Health Care Financing Administration (HCFA) and KePRO, an organization in Pennsylvania that contracts with HCFA to monitor quality of care.

Federal law (ERISA) also permits private sector employers to offer self-insured benefit plans that are exempt from state government regulations and mandates. These self-insured benefit plans may include features of HMOs but without the government oversight.

STATE GOVERNMENT

The HMO Act of Pennsylvania divides regulatory responsibility between the Departments of Health and Insurance. A certificate of authority, jointly issued by the two Departments, is required for operation of an HMO in Pennsylvania.

The **Department of Health** reviews quality and access standards and monitors grievances and grievance procedures for HMO patients. It sets guidelines for benefits, provider networks, reporting, and quality assurance. The Department of Health also requires HMOs in Pennsylvania to undergo an external quality review. Questions about the Department of Health's role in the licensure process can be directed to the Bureau of Health Care Financing at the Department of Health at (717) 787-5193.

The **Insurance Department** monitors the financial strength of HMOs to ensure that the organization has sufficient resources to deliver promised health care services. It also approves rates, rating structures, marketing practices, and some contractual agreements. Questions about the Insurance Department's role in licensure can be directed to the Department at (717) 787-5173.

Who Accredits Managed Care Organizations?

Accreditation is a voluntary process which HMOs and other organizations seek as a way of demonstrating their commitment to quality improvement. In Pennsylvania, the Department of Health requires HMOs to submit to an external quality review process to ensure progress in quality assurance and to identify quality improvement opportunities. Accreditation is one way of satisfying this requirement, therefore, most HMOs in Pennsylvania seek accreditation.

The **National Committee for Quality Assurance (NCQA)** has two primary functions in the oversight of managed care organizations.

1. **Accreditation.** NCQA reviewers evaluate how well a plan manages its quality improvement process as well as other aspects of service delivery. HMOs as well as other managed care organizations can seek accreditation. There are four levels of accreditation, including full, one year, provisional, and denial. Information about accreditation status is available from the HMO or from NCQA at (202) 955-3500. (*See page 8 for further discussion of Accreditation.*)

2. **“Report Card.”** NCQA has developed a report card called Healthplan Employer Data and Information Set (HEDIS), which measures and profiles the performance of the organizations in specific areas. *(See page 9 for further discussion of Report Cards.)*

The **Accreditation Association for Ambulatory Health Care** accredits ambulatory health care organizations, such as outpatient surgical centers and clinics, as well as HMOs. It is one of the organizations approved by the Pennsylvania Department of Health for external quality review of HMOs.

The **Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)** reviews and accredits hospitals and other health care organizations. They accredit managed care organizations, as part of their network accreditation program.

The **Utilization Review Accreditation Committee (URAC)** accredits utilization review firms. HMOs normally have an internal process to review service utilization. Other managed care organizations may subcontract this function to utilization review firms. These firms may request accreditation from URAC in order to demonstrate conformance to recognized standards.

Section 3—Access and Service

Purchasers continue to be concerned that their members have access to adequate and appropriate health care when they need it and that the HMO is sensitive to the needs of their members. Because HMOs contract selectively with physicians, hospitals and other providers, it is important to ask careful questions to assure that service providers are accessible. Listed below are some questions that many consider important to ask your health plan representative before offering that plan to your employees. They should be able to give you answers about their plan as well as an industry norm as a point of comparison. This is not intended as a complete list, but a starting point for dialogue with the health plans.

Access to the Delivery System

- **How do members access primary and specialty care?**

HMOs require that members choose a primary care physician from among a panel of providers. The primary care physician is responsible for coordinating preventive services and referring patients to specialty care when necessary. Many HMOs permit direct access to OB/GYNs, behavioral care specialists, and other specialties.

- **Can members choose a physician who is not part of the health plan’s network of providers?**

A physician can refer a member for medically necessary care to another physician who is not part of the network. Plans differ in their coverage of services for self-referrals to non-network providers.

- **How do members access care when they travel outside the health plan’s primary location?**

All HMOs in Pennsylvania provide coverage for valid emergencies when traveling outside the primary service area of the plan. However, coverage and method of treating urgent care outside the area vary widely.

- **How large is the HMO and the HMO network of providers?**

The scope and availability of providers is as important as the total number of providers. Make sure that the right type of providers are available to serve the needs of your group.

- **What is the ratio of members to primary care physicians in your service area?**

It is important to know how many members on average are served by each primary care physician. That number should reflect your service area — not the entire service area of the plan. Plans should provide a current list that also indicates how many, by specialty, of the primary care physicians (PCPs) are accepting new patients.

- **What are the health plan's standards for geographic proximity to providers and hours of operation?**

A group may require, for example, that 90 percent of its members live within 10 miles of a primary care provider. However, there are no hard and fast standards for physician-to-population ratios, nor are there rules for distance to travel. Factors such as terrain and public transportation will influence the standards for your group.

- **What percentage of claims for visits to a hospital Emergency Room (ER) were denied by the plan during the reporting year? And how does that compare with industry averages?**

Health plans want to discourage inappropriate use of services such as the use of the emergency room for non-urgent care. Not only is it more expensive, but treating non-urgent care in the ER may delay treatment for a genuine emergency. Plans may extend primary care office hours or provide educational outreach to encourage more appropriate utilization of the ER. A high denial rate for ER visit claims may be an indicator that a plan needs to do a more effective job to encourage appropriate alternatives.

- **Where do you refer patients for specialty care? How are they selected?**

A plan should be able to provide outcome statistics to support a decision to include a specialty provider in its network.

- **How are physicians selected, recredentialed and compensated?**

Health plans use various criteria to recruit physician and hospital providers. For example, board certification is often used as one requirement for physician credentialing. You should ask about the plan's criteria for selecting physicians and hospitals and also how often the plan checks to see that the provider credentials are maintained.

Plans differ in the way physicians are compensated. Some plans may provide incentives to reduce the use of services. Some plans have developed programs to improve physician performance. Member satisfaction surveys are sometimes used in the formula to determine compensation for a primary care physician. You should ask if your plan uses these or other programs.

Member Services

- **How are complaints or grievances handled?**

The Department of Health approves complaints or grievance procedures for HMOs as a condition for receiving a Certificate of Authority to operate in Pennsylvania. Ask to see those procedures and ask how quickly grievances are handled by the health plan.

- How many grievances per 1,000 members were filed and how many were appealed to the Department of Health? How many were resolved in favor of the member?**

Grievances are one way to assess member satisfaction with service and service providers. Not only is the number of grievances useful information, but the average length of time in answering a grievance may be an indicator of the sensitivity of the plan to consumer complaints.
- What are the results of patient and consumer satisfaction surveys?**

Some health plans survey their members about how satisfied they have been with services. Many of the questions are targeted at specific service areas. There is usually at least one question about overall satisfaction. The plan should be able to report the results of the surveys and indicate how the plan uses the patient satisfaction survey results as part of its quality improvement efforts.
- What is the voluntary disenrollment rate? How does that compare with state or national benchmarks?**

Surveys indicate that most people who change health plans do so because they change jobs or their employer changes health plans. However, plans closely monitor their voluntary disenrollment rate. When the disenrollment rate is not related to price competition, it may be an indicator of member dissatisfaction with the managed care organization (MCO). Price competition can occur as a result of the MCO's premium or the efforts of employers to steer employees by subsidizing the contribution rates.

Section 4—Costs and Other Financial Considerations

A major consideration is the premium cost of a health plan, as well as the out-of-pocket expenses to the members. The size and financial strength of the plan are also important.

- What are the premium costs? What is the plan's history of rate increases over the past five years? What financing arrangements are possible (community rates, risk sharing, self-insurance, other)?**

Premiums for HMOs are usually set at monthly rates for single and family coverage. With community rated premiums, all groups pay the same. Experience rated groups pay based on the health and utilization of services of their group.
- What benefits are covered?**

HMO benefits usually include a full range of preventive and medical-surgical benefits. Differences between plans emerge in areas such as mental health benefits, pharmaceutical benefits, chiropractic benefits, dental, and vision care services.
- What co-pays, if any, are required?**

Many plans require patients to pay a small payment when they use services such as physician office visits or prescriptions.

- **How much of the premium dollar is spent to deliver health care services?**

Health plans track how much of the premium dollar is spent on health care. The medical loss ratio is the percentage of the total premium dollar that is spent on medical services delivered to HMO members. In Pennsylvania in 1994, the median medical loss ratio for HMOs with at least 5,000 members was .82. That means that 82 cents of every premium dollar for that plan was spent on medical services. The high value in 1994 was .92 and the low value was .45.

- **How financially stable is the plan?**

The health care industry is changing very rapidly with consolidations and new companies emerging frequently. While it is not always easy to determine the financial stability of any organization, you should inquire about how long it has been in business and whether the plan has sufficient reserves to cover anticipated expenses. An acceptable rating from a financial rating service, such as AM Best or Standard & Poors, helps to assess the plan's financial strength.

Section 5 – Quality

Quality is difficult to define and even harder to measure. Yet organizations, including health care organizations, strive continuously to measure and improve the quality of their products and services. The Institute of Medicine defines health care quality as care to individuals and populations which increases the likelihood of a desired outcome and is consistent with the current state of professional knowledge. Experts tend to describe three dimensions of quality: structure, process, and outcome. No single dimension alone is sufficient to describe quality.

1. Structure

Structure comprises properties of personnel and facilities and are used as indicators of the expected quality of care. It can include such items as safety, organizational structure and staffing of health care providers.

2. Process

Process describes what is done for patients and by patients and includes the content of care and the skill with which care was executed. The process of care is critical to the delivery of quality care. An example of a process indicator is the frequency of cholesterol screening for the at-risk population.

3. Outcome

Outcome is the end result of care. Is cholesterol reduced? Is the patient restored to health and full functional status? Is the patient satisfied with the health care services? Some outcomes like functional status are difficult to measure. Others, which may be easier to measure, such as mortality, are sometimes difficult to link to a specific process of care.

Accreditation

Accreditation agencies like the National Committee for Quality Assurance (NCQA) focus primarily on structure and process. Accreditation by the NCQA is strictly voluntary. How to define and measure health plan performance is still a new concept, and there is no clear consensus on the best way to approach the issue. As a purchaser, it is important that you understand basic concepts and not be reluctant to ask questions about quality.

The Pennsylvania Department of Health requires HMOs in Pennsylvania to undergo an independent quality review to ensure progress in quality assurance and to identify quality improvement opportunities. Accreditation is one way of satisfying this requirement. Accreditation by NCQA is not limited to HMOs. Other types of managed care organizations can receive accreditation. Accreditation involves an intensive on-site review of the following plan activities:

- **Quality Management and Improvement;**
- **Members' Rights and Responsibilities;**
- **Preventive Health Services;**
- **Utilization Management; and**
- **Medical Records.**

The status of accreditation is available from the Pennsylvania Department of Health, Bureau of Health Care Financing at (717) 787-5193 or the NCQA at (202) 955-3500.

What Is a Managed Care "Report Card"?

Efforts to define, measure, and report on managed care organizations including health maintenance organizations are continually evolving. Currently, the leading effort is the Healthplan Employer Data and Information Set (HEDIS). HEDIS is a voluntary effort to measure and report on the performance of health plans. It has developed measures in the following categories:

- **Quality of Care;**
- **Member Access and Satisfaction;**
- **Membership and Utilization;**
- **Finances; and**
- **Health Plan Management.**

How Does HEDIS Measure Quality?

HEDIS (currently V 2.5) reports the rates of utilization for a number of preventive services as its quality indicators. Many of these measures are an indirect measure of outreach to at-risk populations. A newer version of HEDIS is expected in early 1997 and may include a number of additional measures. Some of the quality indicators in the current version of HEDIS are:

- **Childhood immunization rate** measures the percentage of children who have received a complete set of immunizations.
- **Cervical cancer screening rate** measures the percentages of women between ages 21 and 64 who have been screened for cervical cancer.
- **Percentage of low and very low birthweight babies** measures the number of live births weighing less than 2500 or 1500 grams (5.5 and 3.3 lbs.) to mothers who were continuously enrolled in the plan for 12 months prior to delivery.
- **Asthma inpatient admission rate** measures admission rates for asthma. Low admission rates are regarded as an indicator of the plan's ability to manage this chronic disease.

Is HEDIS alone an Adequate Measure of Quality?

The process of defining, measuring, and reporting the quality of health plans is an evolving discipline. Currently, HEDIS addresses issues for quality improvement and remains the measurement of choice by many plans and employers. NCQA is in the process of updating HEDIS, which may include up to 80 additional measures and several new categories by the time the new version is released in 1997. Some consulting firms have developed their own measures. Some items that have been proposed include long term survival rates for cervical cancer and functional status of asthma patients. These outcomes are difficult to measure and interpret, especially when members change plans frequently during a lifetime.

Clinical outcomes measures can be used to supplement or replace the HEDIS measures. An outcome measure is a performance measure which assesses patient health status resulting from health care treatment. An example of a clinical outcome measure is mortality. A comparison of clinical outcomes of different provider networks can be meaningful. The Pennsylvania Health Care Cost Containment Council has demonstrated an ability to compare risk-adjusted mortality rates of hospitals and physician groups in its *Consumer Guide to Coronary Artery Bypass Graft (CABG) Surgery* reports and the recently released *Focus on Heart Attack* report. The Council has also aggregated the performance of providers to analyze outcome measure by payor classification.

Some questions to ask your health plan representative about clinical outcomes include:

- **What are the referral hospitals?**
- **What is their risk adjusted mortality rate?**
- **How well does that rate compare with state and national norms?**

Section 6 – Conclusion

The decision to change health plans and implement a managed care program requires a strategic plan that takes into consideration the group's own goals, employee expectations, demographics, geographic locations and local health care market. There is no single solution that works for all groups.

Surveys of health benefit professionals have indicated the most important criteria in selecting a health plan are cost, access, service, and quality. This booklet is intended to give you some basic understanding of these issues, especially quality, and to promote a constructive dialogue between you and your health plan representative.

Section 7 – Glossary

AAAH

Accreditation Association for Ambulatory Health Care; One of the organizations approved by the Pennsylvania Department of Health for external quality review of HMOs, as well as outpatient surgical centers and clinics.

Certificate of Authority

The equivalent of a “license” for HMOs and PPOs to operate in Pennsylvania. The Pennsylvania Insurance Department and Department of Health share responsibility for ensuring compliance with the requirements for a Certificate of Authority.

DOH

Department of Health; Together with the Pennsylvania Insurance Department, issues the Certificate of Authority that allows HMOs to operate in Pennsylvania.

ERISA

Employee Retirement and Income Security Act; Broad ranging Federal legislation passed in 1973 directed primarily to employee retirement plans. Allows some large employers to operate benefit plans exempt from state government regulations.

Gatekeeper

A primary care physician within an HMO who is responsible for managing all clinical aspects of a patient's care, including all referrals to specialty and hospital care. *Also see PCP.*

Grievance

A formal complaint.

HCFA

Health Care Financing Administration; Division of the U.S. Department of Health and Human Services which monitors quality and cost effectiveness of Medicare HMOs and others.

Health Plan

Health maintenance organizations, preferred provider organizations, insured plans, self-insured plans, and other plans that cover health care services.

HEDIS

Healthplan Employer Data and Information Set; Developed by NCQA as a report card that profiles the performance of the managed care organizations.

HMO

Health Maintenance Organization; Integrates financing and delivery of health care into a single system. Manages the utilization and assumes financial responsibility to deliver care within a fixed price.

JCAHO

Joint Commission for the Accreditation of Healthcare Organizations; Reviews and accredits hospitals and other healthcare organizations.

KePRO

Keystone Peer Review Organization; A Pennsylvania health care information company that provides quality and utilization review services to the federal, state, and private sector.

Managed Indemnity Plan

A traditional insurance plan with some structures to manage utilization such as pre-surgical authorization or case management.

MCO

Managed Care Organization; A term that includes health maintenance organizations, preferred provider organizations, integrated delivery systems, and others.

Medical Loss Ratio

The ratio of premium income an HMO expends for delivery of health care services to its enrollees.

MSO

Medical Service Organization; An integrated health care delivery network that contracts with payors to provide a comprehensive array of benefits. *Also see PHO.*

NCQA

National Committee for Quality Assurance; Has two primary functions in regulation of MCOs: Accreditation and producing report cards, i.e., HEDIS.

PCP

Primary Care Physician; A generalist physician (family practice, general internal medicine, and general pediatrics) who provides primary care services to a group of patients. The primary care physician is the patient's first point of entry into the health care system and the continuing focal point for all needed health care services.

PHC4

Pennsylvania Health Care Cost Containment Council; An independent state agency with the legislative mandate to report on the cost and quality of health care services in Pennsylvania.

PHO

Physician Hospital Organization; A type of medical service organization that integrates hospitals and physician practice groups and provides services to a group of members by contracting either with an HMO or directly with employers.

PO

Physician Organization; A type of medical service organization that integrates physician practice groups and provides services to a group of members by contracting either with an HMO or directly with employers.

POS

Point of Service; Combines features of an HMO and a PPO. It allows members to make the decision at the time they seek health care services whether or not to use network providers. A POS retains the primary care physician gatekeeper of an HMO, but, as in a PPO, members must pay higher co-payments and deductibles for out-of-network services.

PPO

Preferred Provider Organization; A network of providers that have agreed to provide services at a reduced rate. PPOs do not require an enrollee to choose a single primary care physician.

URAC

Utilization Review Accreditation Committee; Reviews and accredits those utilization review firms which wish to demonstrate conformance to recognized standards.

Section 8—Pennsylvania HMOs (August 1996)

Advantage Health Plan

121 Seventh Street
Pittsburgh, PA 15222-3408

Aetna Health Plans of Central and Eastern PA

955 Chesterbrook Blvd., Suite 200
Wayne, PA 19087

Alliance Health Network

1700 Peach Street, Suite 244
Erie, PA 16501

Best Healthcare of Western Pennsylvania

One Chatham Place
Pittsburgh, PA 15219

Cigna Healthcare of Pennsylvania

One Beaver Valley Road
P.O. Box 15422, Suite CHP
Wilmington, DE 19803

First Priority Health/HMO NE PA

70 North Main Street
Wilkes-Barre, PA 18711

Geisinger Health Plan

100 North Academy Avenue
Danville, PA 17822-3020

Health America of Central Pennsylvania

2601 Market Place Street
Harrisburg, PA 17110-9339

Health America Pittsburgh

Five Gateway Center
Pittsburgh, PA 15222

Healthcare Management Alternatives (HMA)

5070 Parkside Avenue, Suite 6200
Philadelphia, PA 19131

Health Central

2605 Interstate Drive, Suite 140
Harrisburg, PA 17110

HealthGuard of Lancaster

280 Granite Run Drive, Suite 105
Lancaster, PA 17601-6810

Health Partners of Philadelphia

4700 Wissahickon Avenue, Suite 118
Philadelphia, PA 19144-4283

HIP Health Plan of Pennsylvania

6 Neshaminy Interplex, Suite 600
Trevose, PA 19053

Keystone Health Plan Central

300 Corporate Center Drive, Level 6
Camp Hill, PA 17011

Keystone Health Plan East

1901 Market Street
Philadelphia, PA 19103

Keystone Health Plan West

Fifth Avenue Place
120 Fifth Avenue, Suite 30803
Pittsburgh, PA 15222

Medigroup HMO

1700 Market Street, Suite 1050
Philadelphia, PA 19103

Optimum Choice Inc. of PA

1755 Oregon Pike, First Floor
Lancaster, PA 17601

Oxford Health Plan of PA

Curtis Center
601 Walnut Street, Suite 900
Independence Square West
Philadelphia, PA 19106

PhilCare Health Systems, Inc.

2005 Market Street
Commerce Square, Suite 500
Philadelphia, PA 19103

Prudential Health Care Plan

220 Gibraltar Road, Suite 200
Horsham, PA 19044

QualMed Plans for Health of Pennsylvania

500 North Gulph Road, Suite 200
King of Prussia, PA 16406

Three Rivers Health Plans

300 Oxford Drive
Monroeville, PA 15146

U.S. Healthcare/HMO of PA

980 Jolly Road
P.O. Box 1109
Blue Bell, PA 19422

U.S. Healthcare Pittsburgh

Two Marquis Plaza, Suite 300
5313 Cambells Run Road
Pittsburgh, PA 15205

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