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2004

NEW YORK CONSUMER GUIDE TO
HEALTH INSURERS



STATE OF NEW YORK

September 1, 2004

Dear New Yorker:

Health insurance consumers need reliable information to compare the quality of companies offering coverage in New York State. The New York Consumer Guide to Health Insurers provides quality information to help you make the best choices for you and your family.

This year, the Department of Insurance and the Department of Health have once again combined forces to provide this comprehensive guide to health insurers. The guide describes health insurance products available in New York State such as the Healthy NY program; provides information on how to choose a health plan; and offers easy-to-read tables with quality and service comparisons.

The guide also explains consumer complaints, the internal grievance procedure and how external appeals are handled. Telephone numbers of insurers are also provided. New York State is committed to promoting a fair and competitive insurance marketplace and educating consumers about health insurance.

Uninsured New Yorkers should pay particular attention to the enhancements to Healthy NY that took effect last year. These enhancements have broadened eligibility standards, eliminated co-payments for routine examinations of children and other well-child visits, and reduced Healthy NY premiums by an average of 17% for eligible New Yorkers.

I am confident this guide will help you select the health insurance plan that best fits your needs.

Very truly yours,

George E. Pataki
Governor

www.state.ny.us



STATE OF NEW YORK

September 1, 2004

Dear New Yorker:

One of the most important decisions you'll ever make is choosing the right health insurer or HMO for your family. Recognizing that, the Pataki Administration has worked to enact meaningful health insurance reform for all New Yorkers. Landmark legislation such as the Women's Health & Wellness Act of 2002, the Health Care Reform Act of 2000, the External Review Law of 1998 are all examples of major health insurance initiatives signed into law by Governor Pataki.

Governor Pataki and the Legislature have also exhibited leadership in addressing New York State's uninsured population through the Child Health Plus, Family Health Plus, and the Healthy NY programs. Healthy NY is a state-sponsored health insurance program to help ensure affordable health insurance benefits are accessible to New York State's small business owners, sole proprietors and working uninsured individuals. In March 2003, Governor Pataki announced changes to Healthy NY designed to make coverage more affordable to uninsured New Yorkers and to provide more choices for prescription drug coverage.

The year 2004 marks the publication of the Health Department and Insurance Department's sixth annual New York Consumer Guide to Health Insurers. This guide contains a ranking of all major health insurers and HMOs in New York State by complaints closed in the consumer's favor, and also includes valuable information on grievance procedure determinations and utilization review appeals.

This guide also contains important information from the Department of Health on certain rates of treatment, enrollee primary care visit rates and other indicators of a health plan's quality of care. In addition, the guide includes information on New York State's external review experience of HMOs and other insurers.

The goal behind the empowerment of health insurance consumers with this information is simple: every New Yorker should have the opportunity to compare health plans on major quality of care and consumer service factors. We are convinced you will find this guide a valuable resource.

Very truly yours,

Gregory V. Serio
Superintendent of Insurance
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Data Sources & Contact Information

New York State Insurance Department (NYSID)

The Insurance Department is responsible for supervising and regulating insurance business in New York State. The Department’s mission is to:

- Ensure the continued sound and prudent conduct of insurers’ financial operations;
- Provide fair, timely and equitable fulfillment of insurer obligations;
- Protect policyholders from financially impaired or insolvent insurers;
- Eliminate fraud, other criminal abuse and unethical conduct in the industry; and
- Foster growth of the insurance industry in the State.

New York State Department of Health (DOH)

The New York State DOH works to protect and promote the health of New Yorkers through prevention, science and the assurance of quality health care delivery.

Data Sources

Performance information found in this Guide is from two primary sources:

- **The New York State Insurance Department (NYSID)** provided the complaint and appeals information. Data are from calendar year 2003.
- **The New York State Department of Health (DOH)**, through its Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Health Plans (CAHPS,), provided additional information on HMO performance. See page 35 for more information. Data are from calendar year 2002.

Related publication: *2003 New York State Managed Care Performance* published by the New York State Department of Health. To obtain a copy, please call 518-486-6074 or visit the Department of Health’s Web site at www.health.state.ny.us.

For more contact information, see the inside back cover of this publication.

Contact Information

If you have questions about how to use this Guide, please contact:

New York State Insurance Department
 Consumer Services Bureau
 One Commerce Plaza
 Albany, New York 12257
 1-800-342-3736

For additional copies, call 518-474-4557 or visit the Web site at www.ins.state.ny.us.

Note: *The information in this Guide is derived from health policies sold by insurance companies and HMOs. Some of these health insurers also participate in the Medicare and Medicaid programs; however, data derived from these programs are not included in this Guide. Medicare and Medicaid beneficiaries might still find information in this Guide helpful. For specific information on Medicare, call the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees this program, at 1-800-MEDICARE (1-800-633-4227) or visit Medicare’s Web site at www.medicare.gov. For information on New York’s Medicaid program, please contact your local county Department of Social Services or consult with DOH’s 2003 New York Managed Care Performance guide which does include information on Medicaid managed care.*



**GENERAL
INFORMATION**
CHAPTER ONE

General Information

Understanding Health Insurance

Purpose

This Guide contains information on health insurance coverage that is either offered by your employer or that you can purchase on your own, directly from an insurance company or HMO.

The purpose of this Guide is to help you:

- Make an informed decision about a health insurer by comparing the performance of several insurers.
- Make better use of your health coverage by learning more about your insurer's performance.

Different Ways to Get Health Insurance

1. Buy individual health insurance (an individual plan)

New York requires all health maintenance organizations (HMO) to offer a standardized HMO or point of service (POS) plan to people who buy health insurance on their own. Appendix 2, on pages 59-61, has information about covered benefits for these plans. Premium information is on pages 62-64.

Individuals may also be eligible for or qualify to purchase insurance through various New York programs, such as Healthy NY, Child Health Plus and Family Health Plus. Details of these programs appear on pages 51-54.

2. Get health insurance coverage through an employer or association

Many employers and associations offer health insurance coverage to their employees, members and eligible dependents. There are different types of plans that an employer or association can offer, as well as different cost sharing options. These different plans are described to the right.

■ **Insured Plan:** In this type of plan, an employer contracts with a licensed health insurer or HMO to provide coverage for its employees. Such coverage is subject to all state insurance laws, protections and required covered benefits.

■ **Self-Insured Plan:** In this type of plan, an employer pays for employees' health care costs out of a fund that the company has set aside for medical expenses. Employers may contract with an outside party to administer health benefits, which is often an insurance company. Under a federal statute known as ERISA, the U.S. Department of Labor has authority over self-insured employer health plans. Therefore, New York's consumer protection and insurance laws do not apply. If you are uncertain, ask your employer's benefit manager if the health coverage provided is self-insured. (See note on page 8 for more information.)

■ **Professional Association:** In this type of plan, an association offers its members group rates on insurance plans that are generally less expensive and easier to apply for than individual plans. These plans are typically offered through a licensed insurance company.

Comparison of Different Types of Health Insurance Coverage

The table presents general rules that may not apply to your insurer. Be sure to check with your insurer or employer to verify how your health care coverage works.

Description	Managed Care In general, managed care plans make arrangements with particular doctors, hospitals and other providers to deliver services. These providers make up a plan's "network."			Fee-for-Service You and the insurer each pay for part of the costs for health care services that you receive.
	HMO A health insurer that directly contracts with or employs a network of doctors, hospitals and other types of providers.	POS Combines an HMO with the flexibility of an out-of-network option. You can use providers in the plan's network or go outside of the network.	PPO Most similar to traditional fee-for-service coverage except has a network. When you use a provider in the network, your costs are lower and more services are covered.	
What is your choice of doctors and hospitals?	You must get care from providers in the network.	You may use in-network or out-of-network providers. When you go out-of-network, you will usually pay more and fewer services are covered.	You may use in-network or out-of-network providers. When you go out-of-network, you will usually pay more.	You have an unlimited choice of doctors and hospitals.
How do you get specialty care?	You need a referral to go to a specialist who is also in the network.	You need a referral to a network specialist to receive in-network coverage. You can go to a specialist who is out-of-network without a referral.	You do not usually need a referral to go to a specialist; however, certain services may require pre-authorization from your health insurer.	You do not need a referral.
How do you pay for services in-network?	There is no deductible. You pay a copayment (usually between \$5 and \$25) for a doctor's office visit and most services.	If you use a provider in the network, there is no deductible, but you pay a copayment.	You pay a portion of the cost, typically 20-30%, known as coinsurance. Network providers agree not to charge more than the insurer's allowable charge. Some PPOs require you to pay a copayment instead of coinsurance. Some PPOs may require members to satisfy an annual deductible before they cover services.	Your doctor or hospital sends a bill for services provided. After you pay your deductible, you are responsible for a portion of the costs, typically 20-30%, known as coinsurance. Most insurers set an allowable reimbursement for a service. For example, if your doctor charges \$125 for a visit and your insurance only allows \$100, you may be responsible for the \$25 difference in addition to your deductible and coinsurance.
How do you pay for services out-of-network?	Out-of-network services are typically not covered.	If you use an out-of-network provider, then you are reimbursed for services as you would be with fee-for-service insurance.	If you use an out-of-network provider, then you are reimbursed for services as you would be with fee-for-service insurance.	

How to Choose a Health Insurer

To learn about commonly used health insurance terms, refer to the **Glossary of Health Insurance Terms on page 6.**

Step 1: Determine the type of health coverage that best fits your needs and budget

Use the Comparison of Different Types of Health Insurance Coverage table on the previous page to familiarize yourself with the different types of plans available including health maintenance organizations (HMOs), point of service (POS) plans, preferred provider organizations (PPOs) and fee-for-service.

Step 2: Compare the costs

Compare the monthly premium as well as the out-of-pocket expenses such as deductibles, coinsurance and copayments of different insurance plans.

Step 3: Decide which health insurers offer the benefits you want

Think about your family's health care needs and choose an insurer that best covers the services you need most. Try to estimate your needs for prescription drugs, well-child care and mental health services.

Step 4: If you want a managed care plan, determine whether your preferred doctors and hospitals (also known as "providers") are in the plan's network

In a managed care plan, you typically receive care from a network of providers. To confirm the availability of your preferred doctor and hospital, check the health plan's provider directory, or call your provider's office. Check to see if there are any restrictions to whom and where your primary care physician (PCP) can make referrals if you anticipate needing a specialist. If you choose a doctor in a medical group as your PCP, you may be limited to specialists and hospitals affiliated with that medical group.

Step 5: See which insurers performed best in this Guide

Using the information you gathered based on the steps above, choose the health insurers that best fit your family's needs. Compare their performance in this Guide. Consider all the results that contribute to the insurer's performance. Small differences in performance measures may not be significant.

Step 6: Integrate the information you have learned from this Guide

Eliminate the insurers that do not meet your basic requirements. Then, choose the insurer that performs best on the features most important to you.

Glossary of Health Insurance Terms

Commonly used health insurance terms in this Guide

Allowable Fee, or Usual and Customary Reimbursement (UCR): The maximum amount a health insurer will pay for a service or procedure.

Balance Billing: A billing practice in which you are billed for the difference between what your insurer pays and the fee that the provider normally charges. Balance billing is prohibited under most HMO contracts in New York, but may arise when you use services of out-of-network providers under a PPO or POS arrangement.

Coinsurance: Some insurance coverage requires you to pay a percentage of the cost of covered medical services, usually 20-30 percent. For example, you pay 20 percent of the cost, and your insurance pays 80 percent of the cost. Your portion of the cost is the coinsurance.

Commercial Insurers: Health insurance can also be written by life insurers, property/casualty insurers and other types of insurers. These insurers offer products similar to those provided by non-profit indemnity insurers. (See non-profit indemnity insurers.) Policyholders are subject to deductibles and significant out-of-pocket costs unless they use a preferred provider network.

Complaint: A complaint occurs whenever a consumer or provider complains to the State of New York about a health insurer or HMO.

Copayment: A flat fee for specified medical services required by some insurers. For example, you pay a \$10 copayment for a doctor visit or a \$50 copayment for a hospital stay.

Deductible: The amount you must pay each year for your medical expenses before your insurance policy starts paying. Deductibles are common in fee-for-service coverage and PPOs.

External Review: You may request an independent external review when you are denied health care services on the basis that those services are experimental, investigational, or not medically necessary. The review is conducted by an external review organization that is not affiliated with your insurer, your doctor, or your family.

Fee-for-Service (FFS): Also known as indemnity insurance, FFS is a type of health coverage that typically allows you to go to any doctor or provider. Your insurance company will reimburse your provider for each covered service provided. Deductibles and coinsurance usually apply in FFS coverage.

First-level Internal Appeal Process: Once you have received a decision on your utilization review appeal, you have completed the first-level internal appeal process. If the decision is not in your favor, you are entitled to request an external review. If you and your insurer waive the first-level review, you are then permitted to proceed directly to an external review. *(See utilization review appeal and external review.)*

Grievance: A grievance is a complaint to an HMO by a member or provider about an action or decision. Decisions regarding the medical necessity of a service are not considered grievances. They are handled as utilization review appeals. *(See utilization review appeal.)*

Health Maintenance Organization (HMO): The HMO arranges for, or contracts with, a variety of health care providers to deliver a range of services to consumers who make up its membership. All HMOs employ managed care strategies that emphasize prevention, detection and treatment of illness. HMOs use primary care physicians as the coordinator of patient care needs. An HMO may offer consumers an HMO plan or POS plan. *(See health maintenance organization plan and point of service plan.)*

Health Maintenance Organization (HMO) Plan:

A type of coverage that provides comprehensive health services to members in return for a monthly premium and copayment. In an HMO plan, members are assigned to a primary care physician (PCP) who coordinates each assigned member's care. The PCP refers patients to specialists and provider services as needed. Although many HMOs require their members go to the doctors and other providers in the HMO provider network, some HMO plans offer the option to go out-of-network (for example in a POS plan). HMO plans often require members receive a referral from their PCP before seeing a specialist. *(See primary care physician and point of service plan.)*

Non-profit Indemnity Insurers: Non-profit indemnity insurers employ managed care strategies but offer a more traditional approach to coverage than HMOs. Non-profit indemnity insurers reimburse policyholders, physicians and hospitals. Non-profit policyholders are subject to deductibles and out-of-pocket costs that are considerably higher than those required by HMOs unless they use a preferred provider network.

Participating Provider: A health care provider (e.g., doctor, psychologist, hospital) who agrees to accept the terms, conditions and allowable payments of an insurer.

Point of Service (POS) Plan: A type of managed care coverage that allows members to choose to receive services either from participating HMO providers or from providers outside the HMO's network. Members pay less for in-network care. For out-of-network care, members usually pay a deductible and coinsurance.

Preferred Provider Organization (PPO): A type of managed care coverage based on a network of doctors and hospitals that provides care to an enrolled population at a prearranged discounted rate. PPO members usually pay more when they receive care outside the PPO network.

Primary Care Physician (PCP): An internist, pediatrician, family physician, general practitioner, or in some instances an obstetrician/gynecologist. If you are enrolled in an HMO, you usually must choose a PCP from a list of participating providers. The PCP coordinates your care and makes referrals to specialists as needed.

Prompt Pay Complaint: A complaint from a consumer or provider to the New York State Insurance Department about the late payment of claims.

Referral: Authorization from your primary care physician or health insurer to see a specialist or receive a special test or procedure. HMOs often require that you obtain a referral for most specialty care. It is important to know what your health insurer's rules and procedures are for referrals.

Self-Insured Health Plan: In this type of plan, an employer will pay for employees' health care costs out of a fund that the company has set aside for medical expenses. Employers may contract with an outside organization, often an insurance company, to administer the plan. Under a federal statute known as ERISA, the U.S. Department of Labor has authority over self-insured employer health plans. Therefore, New York's consumer protection and insurance laws do not apply.

Specialist: A doctor who has been specially trained in and practices a specific type of medicine other than primary care (e.g., cardiologists, dermatologists, gastroenterologists). If you are enrolled in an HMO, you usually will need a referral from your primary care physician to see a specialist.

Utilization Review (UR) Appeal: A UR Appeal occurs when a consumer asks an insurer to reconsider its refusal to pay for a medical service the insurer considers experimental, investigational, or not medically necessary. *(See first-level internal appeal process.)*

New York Consumer Protections

The State of New York is committed to making available quality health care to all of its residents. Below is a summary of the laws protecting health insurance consumers in New York:

- Consumers have the right to have any denial of services by their health insurer reviewed by an external party if the reason for denial includes that the service is considered experimental, investigational, or not medically necessary. The independent external review process in New York is described on pages 10-11 of this Guide.
- A woman having a mastectomy has the right to remain in the hospital until she and her doctor decide that she is ready to go home. Health insurance companies must pay for a second surgical opinion and the cost of reconstructive surgery.
- New mothers have the right to remain in the hospital for 48 hours after a delivery and at least 96 hours after a Cesarean section delivery. If the mother chooses to leave the hospital earlier, the law entitles her to one visit by a home health care professional. This law also requires hospitals to provide educational programs for new mothers.
- Members of managed care plans are guaranteed the following rights:
 - Access to needed specialists.
 - Health care professionals must make decisions about medical necessity.
 - Emergency room treatments are covered based on a “prudent lay person” standard. An example is someone having chest pain who believes he/she may be having a heart attack. Even if it turns out to be indigestion, the insurance company should pay for the emergency room treatment because most reasonable individuals would have responded in the same manner.
 - A full, frank and confidential discussion with your physician about your medical needs.
- The Women's Wellness and Preventative Service Act provides women with direct access to primary and preventative OB/GYN services at least two times per year. This act also provides coverage for bone mineral density measurements and testing. To qualify for the bone density testing coverage, the covered person must meet either the eligibility criteria under the Medicare program or those set by the National Institute of Health (NIH) for the detection of osteoporosis. In addition, the act covers contraceptive drugs and devices under the prescription drug coverage portion of a health insurance contract. Religious employers may request a contract without the contraceptive coverage.

- Members have the right to medically necessary chiropractic visits, subject to limitations.
- Health insurers must pay undisputed claims within 45 days of receipt or face fines up to \$500 per day for each unpaid claim and must pay interest. The Insurance Department established a prompt pay hotline at 1-800-358-9260 for complaints.

Note: *Many large employers that offer health coverage to their employees self-insure their health benefits. Under federal law, if you receive health coverage through a self-insured plan (sometimes referred to as an ERISA plan), state protections such as the ones listed above do not apply. If you have a complaint regarding a self-insured plan, please contact:*

*United States Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
202-693-8300*

1-866-4-USA-DOL (1-866-487-2365)

For the Seriously Ill (and their Caregivers): In 2004, the New York Insurance Department established a Web site to assist those with serious illnesses and their caregivers:
www.ins.state.ny.us/website1/inshelp/c_start.htm

Who to Contact When You Have a Problem

If you have a problem with your health insurer, you should first contact your insurer's Member Services Department to try to resolve it. If you cannot resolve the problem to your satisfaction, call the appropriate State agency listed to the right for assistance.

For issues concerning **payment, reimbursement, coverage, benefits, rates** and **premiums** contact:

New York State Insurance Department

Consumer Services Bureau

One Commerce Plaza

Albany, NY 12257

www.ins.state.ny.us

1-800-358-9260 (prompt pay complaints)

1-800-342-3736 (coverage, benefits, rates and premiums)

If you have been denied coverage of health care services based on medical necessity, review your rights to an independent external review described in the next section or call:

1-800-400-8882 (external reviews for denied coverage)

For issues concerning **HMO Quality of Care**, contact:

New York State Department of Health

Office of Managed Care

Bureau of Managed Care Certification and

Surveillance-Complaint Unit

Corning Tower, Rm. 1911

Albany, NY 12237

www.health.state.ny.us

1-800-206-8125 (quality of care)

Your Right to an Independent External Review

When your insurer denies health care services that it considers experimental, investigational, or not medically necessary, you can request that an outside medical professional review your case and issue a determination. This is called an independent external review. Before requesting an external review, you must complete the first-level internal appeal process with your health insurer, or you and your insurer may jointly agree to waive the internal appeal process.

About External Reviews

- An **external review** is an independent review of a denial of services by your health insurer.
- Reviews are conducted by external review organizations certified by the State of New York.
- To request an external review, you must complete an application and submit it to the New York State Insurance Department within 45 days of receiving an adverse decision (see next page for details).
- Your cost for an external review could be up to \$50. However, the fee is refunded if the decision is in your favor.

Eligibility for an External Review

To be eligible for an external review, you must:

1. Follow your insurer's internal appeal process for denied services. (Call the Member Services Department phone number on your insurance card for information on the appeal process.)
2. Have received a written notice from your insurer that:
 - a denial of health care services has been upheld by the insurer's first-level internal appeal process; **or**
 - you and your insurer have agreed to waive the internal appeal process.
3. Submit a request for an external review to the State within 45 days of:
 - receiving either the first adverse decision from your insurer's internal appeal; **or**
 - a written confirmation from your insurer that the internal appeal process was waived.
4. Request an external review for a service that is a covered benefit under your plan.

You are **not** eligible for an external review if:

1. The service or treatment you are seeking is not a covered benefit under your plan.
2. Medicare is your only source of health services.
3. Your health plan is a self-insured plan (sometimes known as an ERISA plan), which is not subject to state regulation.
4. The review is for Workers' Compensation claims or for claims under no-fault auto coverage.

To request an independent external review application, contact the New York Insurance Department at 1-800-400-8882 or visit the Web site at www.ins.state.ny.us.

The External Review Process

For a standard review, the external review organization must make a determination within 30 days of receiving your request for an external review from the State. An expedited review can be requested if your doctor determines that a delay in providing the treatment or service poses an immediate or serious threat to your health.

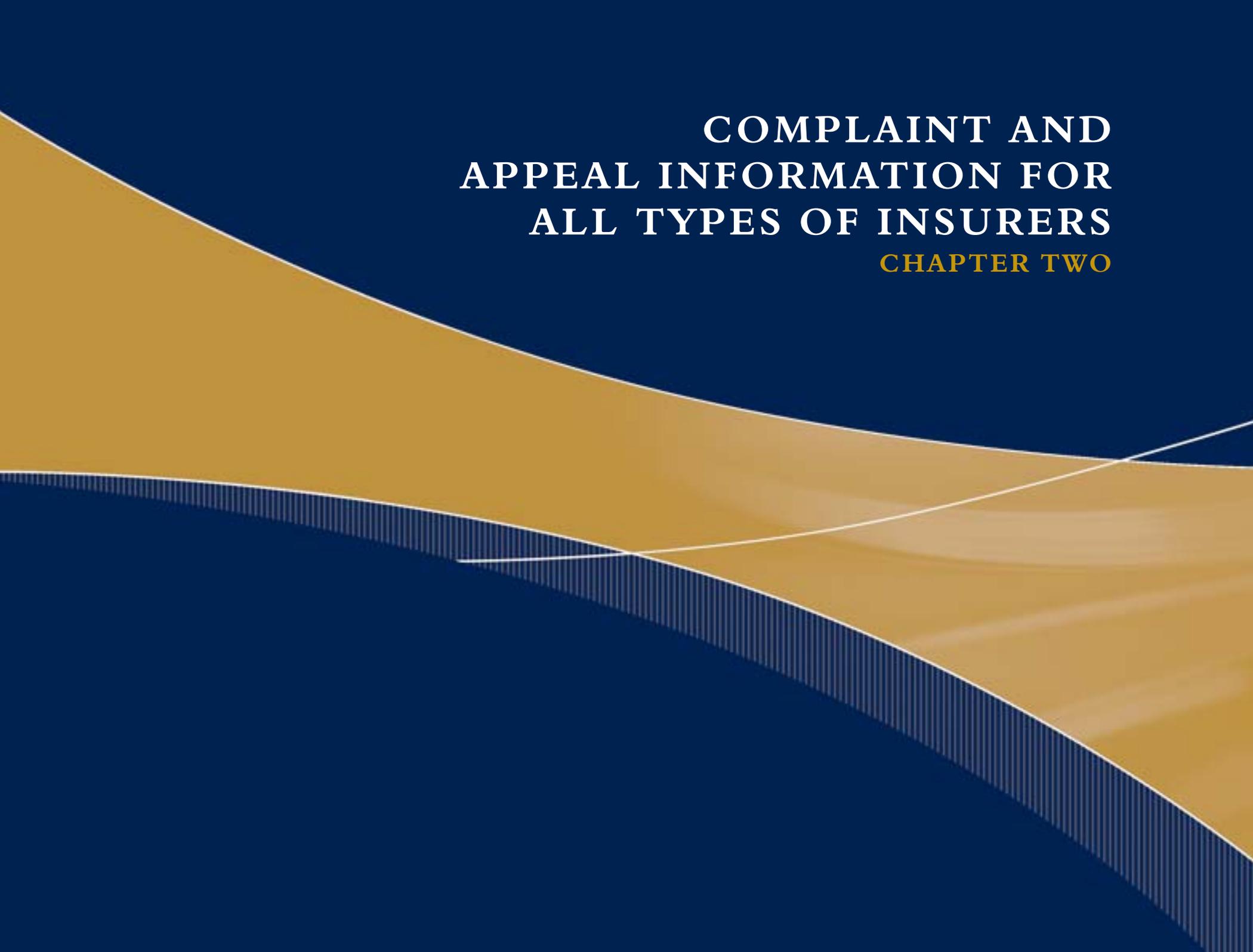
Your doctor must send written testimony about your need for immediate care to the Insurance Department. If granted, an expedited review must produce a determination within three days of an external review organization receiving your request.

1. After an External Review is Requested

- a) You and your health insurer will be notified if your case qualifies.
- b) Your health insurer must then send your medical and treatment records to the external review organization. You and your doctor can submit additional information even when the external review organization has not requested it. If your first-level appeal has been upheld (or if you and your insurer agreed to waive the internal appeal process), you and your doctor should submit this additional information as soon as you are notified an external appeal agent has been assigned to review your case.

2. After a Decision Has Been Made

- a) If your review was **not expedited**, you and your health insurer will be notified in writing of the decision within two business days of the external review organization's decision.
- b) If your review was **expedited**, you and your health plan will be notified of the external review organization's decision by telephone or fax. Written notification will follow.
- c) The decision of the external review organization is final and binding for you and your health plan, meaning that the decision cannot be changed or altered by either party.



COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

CHAPTER TWO

Complaint and Appeal Information for All Types of Insurers

Overview

This chapter contains information about complaints, prompt pay complaints, utilization review (UR) appeals and independent external reviews for companies that provide health insurance to New Yorkers.

For regulatory purposes the state of New York groups insurers into three categories:

1. HMOs
2. Non-profit indemnity insurers
3. Commercial insurers

For consistency, this chapter organizes insurers in these same categories. Non-profit indemnity insurers and commercial insurers typically offer coverage through preferred provider organizations and fee-for-service plans, while HMOs typically use a network of providers. For more information, refer to the table on page 4.

On the following pages, you will find information about:

Complaints: Consumer and provider complaints about health insurers to the State of New York. These complaints include prompt pay complaints.

Prompt Pay Complaints: Complaints about the late payment of an undisputed claim.

Utilization Review Appeals: A request from consumers that a health insurer reconsiders its decision to deny coverage of a medical service the insurer considers experimental, investigational, or not medically necessary.

Independent External Reviews: Reviews by a State-certified independent external review organization of a health insurer's denial of service.

Note: *Because of their small size, HMOs with less than \$25 million in direct premium (or fewer than 5,000 members), and non-profit indemnity insurers and commercial insurers with less than \$50 million in direct premium are excluded from the tables in this chapter.*

Complaints

Each year, New York State receives complaints about health insurers from consumers and health care providers. After reviewing each complaint, the State decides if the health insurer is at fault and needs to remedy the problem.

Understanding This Chart

How to quickly review these charts

An upheld complaint occurs when the State agrees with the consumer or provider that the insurer made an inappropriate decision. Pay attention to an insurer's **rank** and **complaint ratio**. The charts rank insurers by their complaint ratio from best (lowest ratio) to worst (highest ratio). A better ranking means that the insurer had fewer upheld complaints relative to its size.

A **complaint ratio** is the number of upheld complaints divided by a health insurer's total annual premium. Total annual premium, a measure of an insurer's size, is used to calculate the complaint ratio so insurers of different sizes can be compared fairly. Large insurers may receive more complaints because they serve more people than smaller insurers.

Example: A 1.0 ratio indicates one **upheld complaint** for every \$1 million in premium. A 0.5 ratio indicates one upheld complaint for every \$2 million in premium.

The chart shows the following additional information for each insurer:

- **Total Complaints:** Total number of complaints, including prompt pay complaints, closed by the Insurance Department in 2003. Complaints to the Insurance Department typically involve issues concerning payment, reimbursement, coverage, benefits, rates and premium.
- **Upheld Complaints:** Number of closed complaints where the Insurance Department agrees with the consumer or provider. Remember that only complaints upheld by the Insurance Department are used to calculate the complaint ratio and ranking.
- **Total Complaints to DOH:** Total number of complaints about HMOs closed by the Department of Health (DOH). Complaints to the DOH involve concerns about the quality of care received by HMO members.
- **Upheld Complaints to DOH:** Number of complaints closed by the DOH that are decided in favor of the consumer or provider. The number in this column is not used to calculate an insurer's complaint ratio and ranking.
- **Premium:*** Dollar amount of premiums generated by a health insurer in New York during 2003. Premiums are used in calculating the complaint ratio so that different sized insurers can be compared fairly.
- **Membership:*** Membership in each plan as of 12/31/03, including spouses and children.

* Premium and Membership data exclude Medicare and Medicaid.

COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

Complaints – HMOs, 2003

Data sources: NYSID, DOH

HMOs are listed alphabetically. HMOs with a lower ratio receive a better rank (1=best, 17=worst).

HMO ^a	Rank ^b	Total Complaints	Upheld Complaints	Total Complaints to DOH ^c	Upheld Complaints to DOH	Premium (Millions \$)	Membership (as of 12/31/03)	Complaint Ratio
Aetna Health	12	1,201	369	24	3	1,167.4	348,033	0.316
CDPHP	2	112	12	0	0	664.2	264,752	0.018
CIGNA	15	251	92	10	5	202.5	61,294	0.454
Community Blue (HealthNow)	7	151	30	0	0	818.1	350,324	0.037
Empire HealthChoice	3	855	23	15	3	1,023.2	390,419	0.022
Excellus ^d	4	164	32	12	4	1,405.2	561,394	0.023
GHI-HMO Select	10	98	21	17	4	85.7	35,646	0.245
Health Net of NY	14	1,198	201	75	26	588.5	212,318	0.342
HIP ^e	16	1,695	963	31	15	1,581.5	586,303	0.609
IHA	6	76	20	0	0	601.2	270,964	0.033
MDNY	17	303	199	21	10	153.3	47,023	1.298
MVP Health Plan	5	244	23	0	0	936.1	345,731	0.025
Oxford	13	2,830	870	41	19	2,744.2	831,891	0.317
Rochester Area HMO (Preferred Care)	1	8	3	4	0	213.8	96,740	0.014
UnitedHealthcare of NY	11	180	33	15	4	106.4	63,032	0.310
Vytra	8	174	17	16	1	267.7	93,653	0.064
WellCare ^f	9	11	3	0	0	30.7	15,957	0.098
TOTAL		9,551	2,911	281	94	12,589.7	4,575,474	Avg.=0.231

^a Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.^b The table ranks HMOs by complaint ratio.^c DOH complaints do not include complaints from the Family Health Plus program.^d Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.^e Complaint ratio, Insurance Department complaints, and premium include data from Health Insurance Plan's (HIP's) HMO and non-profit business. In 2003, roughly 2% of HIP's business was attributable to its non-profit operation.^f WellCare does not write nongovernment-sponsored business; it's \$30.7 premium is derived in large part from the Child Health Plus and Family Health Plus programs.

NOTE: Complaint ratios do not include Department of Health (DOH) complaints.

Complaints – Non-profit Indemnity Insurers, 2003

Data source: NYSID

Insurers are listed alphabetically. Insurers with a lower ratio receive a better rank (1=best, 4=worst). If you are considering only HMOs, this chart is not relevant.

Non-profit Indemnity Insurer ^a	Rank	Total Complaints	Upheld Complaints	Premium (Millions \$)	Complaint Ratio
Excellus Health Plan, Inc.	2	258	64	1,971.2	0.032
Group Health, Inc. (GHI)	4	1,597	514	2,172.5	0.237
HealthNow NY, Inc.	3	137	25	642.1	0.039
Vytra Health Services	1	12	1	60.3	0.017
TOTAL		2,004	604	4,846.1	Avg.=0.125

^a Excludes non-profit indemnity insurers with less than \$50 million in premium. Also excludes Dentcare Delivery Systems because, unlike the four ranked non-profit insurers, Dentcare does not write a comprehensive health insurance product. In 2003, Dentcare Delivery Systems wrote \$60.4 million in premium, while posting one upheld complaint. Health Insurance Plan (HIP) non-profit data are included in the HMO Complaint chart.

Complaints – Commercial Insurers, 2003

Data source: NYSID

Insurers are listed alphabetically. Insurers with a lower ratio receive a better rank (1=best, 28=worst). If you are considering only HMOs, this chart is not relevant.

Commercial Insurer ^a	Rank ^b	Total Complaints	Upheld Complaints	Premium (Millions \$)	Complaint Ratio
Aegon Group	17	8	2	77.6	0.026
Aetna Group	19	67	11	353	0.031
American Family Life	4	2	0	69.7	0.000
AIG Group	20	37	5	131.6	0.038
CIGNA Health Group	23	183	89	1,495.6	0.060
Citigroup	12	7	1	105.9	0.009
CNA Insurance Group	21	21	6	153.3	0.039
Combined Life	14	26	2	124.8	0.016
Empire HealthChoice Assurance	10	1,109	26	3,379.5	0.008
First Rehabilitation Life Ins. Co. of Am.	5	4	0	65.8	0.000
Fortis Group	2	3	0	82.6	0.000
GE Global Group	9	17	1	170.3	0.006
Guardian Life Group	16	119	12	507.8	0.024
Hartford F & C Group	1	3	0	132.1	0.000
Health Net Ins. of NY	27	194	51	211.6	0.241
Horizon Healthcare Ins. Co. of NY	28	103	49	150.2	0.326
John Hancock Life Insurance Co.	11	6	1	118.4	0.008
Metropolitan Group	18	63	11	355.2	0.031
Mutual of Omaha Group	24	20	6	72.5	0.083
MVP Health Ins. Corp.	13	5	1	63.8	0.016
New York Life Ins. Co.	6	2	0	58.8	0.000
Northwestern Mutual Group	7	0	0	55.2	0.000
Oxford Health Insurance	25	451	125	1,283.9	0.097
Prudential Ins. Co. of America	15	5	1	61.2	0.016
Union Labor Life Ins. Co.	22	11	3	62.7	0.048
UnitedHealthCare Ins. Co. of NY	26	876	245	2,346.3	0.104
UnumProvident Corp. Group	8	4	2	443.6	0.005
Zurich Insurance Group	3	0	0	74.2	0.000
TOTAL		3,346	650	12,207.2	0.053

^a Excludes commercial insurers with less than \$50 million in premium. Many of the commercial companies listed above do not write traditional comprehensive health insurance products. Some of these commercial companies write POS coverage for HMOs (i.e., they are responsible for paying claims when HMO members use out-of-network doctors).

^b The table ranks insurers by complaint ratio. For 0.000 ratios, the insurer with the higher annual premium amount is ranked higher.

Prompt Pay Complaints

New York's Prompt Payment Law requires that all insurers pay providers and consumers within 45 days of receipt of an undisputed claim for health care services. Providers may be less willing to participate with insurers that do not pay claims on a timely basis. A severe claims payment problem may indicate that the insurer has financial problems. Both consumers and providers can file complaints with the Insurance Department when they believe that an insurer is not paying claims on time.

The New York State Insurance Department has established a dedicated hotline for consumers and providers to file prompt pay complaints at 1-800-358-9260.

Understanding This Chart

How to quickly review these charts

An upheld prompt pay complaint is when the State agrees with the consumer or provider that a payment (or decision not to pay) was late. Pay attention to an insurer's **rank** and **prompt pay complaint ratio**. The charts rank insurers by their prompt pay complaint ratio from best (lowest ratio) to worst (highest ratio). A better ranking means that the insurer had fewer upheld prompt pay complaints relative to its size.

A **prompt pay complaint ratio** is the number of upheld prompt pay complaints divided by a health insurer's total annual premium. Large insurers may receive more complaints because they serve more people and pay more claims than smaller insurers. Total annual premium, a measure of an insurer's size, is used to calculate the prompt pay complaint ratio so insurers of different sizes can be compared fairly.

Example: A 1.0 ratio indicates one **upheld prompt pay complaint** for every \$1 million in premium. A 0.5 ratio indicates one upheld prompt pay complaint for every \$2 million in premium.

The chart shows the following additional information for each insurer:

Total Complaints: Total number of complaints, including prompt pay complaints, closed by the Insurance Department in 2003. Complaints to the Insurance Department typically involve issues concerning payment, reimbursement, coverage, benefits, rates and premium.

Total Prompt Pay Complaints: Total number of prompt pay complaints closed by the Insurance Department in 2003.

Upheld Prompt Pay Complaints: Number of closed prompt pay complaints where the Insurance Department agrees with the consumer or provider.

Premium:* Dollar amount of premiums generated by a health insurer in New York during 2003. Premiums are used in calculating the prompt pay complaint ratio so that different sized insurers can be compared fairly.

Membership:* Membership in each plan as of 12/31/03, including spouses and children.

* Premium and Membership data exclude Medicare and Medicaid.

Prompt Pay Complaints – HMOs, 2003

Data source: NYSID

HMOs are listed alphabetically. HMOs with a lower ratio receive a better rank (1=best, 17=worst).

HMO ^a	Rank ^b	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Membership (as of 12/31/03)	Prompt Pay Complaint Ratio
Aetna Health	13	1,201	898	298	1,167.4	348,033	0.255
CDPHP	5	112	46	7	664.2	264,752	0.011
CIGNA	15	251	172	67	202.5	61,294	0.331
Community Blue (HealthNow)	6	151	41	17	818.1	350,324	0.021
Empire HealthChoice	4	855	373	10	1,023.2	390,419	0.010
Excellus ^c	2	164	44	13	1,405.2	561,394	0.009
GHI-HMO Select	11	98	66	17	85.7	35,646	0.198
Health Net of NY	14	1,198	956	155	588.5	212,318	0.263
HIP ^d	16	1,695	1,434	898	1,581.5	586,303	0.568
IHA	7	76	24	15	601.2	270,964	0.025
MDNY	17	303	247	181	153.3	47,023	1.181
MVP Health Plan	3	244	85	9	936.1	345,731	0.010
Oxford	12	2,830	2,061	658	2,744.2	831,891	0.240
Rochester Area HMO (Preferred Care)	1	8	1	0	213.8	96,740	0.000
UnitedHealthcare of NY	10	180	100	21	106.4	63,032	0.197
Vytra	8	174	100	8	267.7	93,653	0.030
WellCare ^e	9	11	8	3	30.7	15,957	0.098
TOTAL		9,551	6,656	2,377	12,589.8	4,575,474	Avg.=0.189

^a Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.

^b The table ranks HMOs by complaint ratio.

^c Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

^d Complaint ratio, Insurance Department complaints, and premium include data from Health Insurance Plan's (HIP's) HMO and non-profit business. Complaints and premium for HIP's A&H commercial company are not included in this ranking. In 2003, roughly 2% of HIP's business was attributable to its non-profit operation.

^e WellCare does not write nongovernment-sponsored business, the \$30.7 million in premium is derived in large part from the Child Health Plus and Family Health Plus programs.

**Prompt Pay Complaints –
Non-profit Indemnity Insurers, 2003**

Data source: NYSID

Insurers are listed alphabetically. Insurers with a lower ratio receive a better rank (1=best, 4=worst). If you are considering only HMOs, this chart is not relevant.

Non-profit Indemnity Insurer ^a	Rank	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Excellus Health Plan, Inc.	2	258	79	32	1,971.2	0.016
Group Health, Inc. (GHI)	4	1,597	1,004	382	2,172.5	0.176
HealthNow NY, Inc.	3	137	34	15	642.1	0.023
Vytra Health Services	1	12	3	0	60.3	0.000
TOTAL		2,004	1,120	429	4,846.1	Avg.=0.089

^a Excludes non-profit indemnity insurers with less than \$50 million in premium. Also excludes Dentcare Delivery Systems. Health Insurance Plan (HIP) non-profit data are included in the HMO Prompt Pay chart.

Prompt Pay Complaints – Commercial Insurers, 2003
Data source: NYSID

Insurers are listed alphabetically. Insurers with a lower ratio receive a better rank (1=best, 28=worst). If you are considering only HMOs, this chart is not relevant.

Commercial Insurer ^a	Rank ^b	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aegon Group	6	8	0	0	77.6	0.000
Aetna Group	20	67	18	4	353	0.011
American Family Life	8	2	0	0	69.7	0.000
AIG Group	17	37	8	1	131.6	0.008
CIGNA Health Group	24	183	103	65	1,495.6	0.043
Citigroup	4	7	0	0	105.9	0.000
CNA Insurance Group	16	21	2	1	153.3	0.007
Combined Life	21	26	7	2	124.8	0.016
Empire HealthChoice Assurance	15	1,109	756	10	3,379.5	0.003
First Rehabilitation Life Ins. Co. of Am.	9	4	1	0	65.8	0.000
Fortis Group	5	3	1	0	82.6	0.000
GE Global Group	1	17	2	0	170.3	0.000
Guardian Life Group	18	119	50	4	507.8	0.008
Hartford F & C Group	2	3	2	0	132.1	0.000
Health Net Ins. of NY	27	194	71	26	211.6	0.123
Horizon Healthcare Ins. Co. of NY	28	103	51	32	150.2	0.213
John Hancock Life Insurance Co.	3	6	0	0	118.4	0.000
Metropolitan Group	19	63	24	3	355.2	0.008
Mutual of Omaha Group	23	20	6	3	72.5	0.041
MVP Health Ins. Corp.	10	5	2	0	63.8	0.000
New York Life Ins. Co.	12	2	1	0	58.8	0.000
Northwestern Mutual Group	13	0	0	0	55.2	0.000
Oxford Health Insurance	25	451	118	60	1,283.9	0.047
Prudential Ins. Co. of America	11	5	1	0	61.2	0.000
Union Labor Life Ins. Co.	22	11	4	2	62.7	0.032
UnitedHealthCare Ins. Co. of NY	26	876	417	172	2,346.3	0.073
UnumProvident Corp. Group	14	4	2	1	443.6	0.002
Zurich Insurance Group	7	0	0	0	74.2	0.000
TOTAL		3,346	1,647	386	12,207.2	Avg.=0.032

^a Excludes commercial insurers with less than \$50 million in premium. Many of the commercial companies listed above do not write traditional comprehensive health insurance products. Some of these commercial companies write POS coverage for HMOs (i.e., they are responsible for paying claims when HMO members use out-of-network doctors).

^b The table ranks insurers by prompt pay complaint ratio. For 0.000 ratios, the insurer with the higher annual premium amount is ranked higher.

Utilization Review Appeals

A utilization review (UR) appeal occurs when a consumer asks an insurer to reconsider its refusal to pay for a medical service the insurer considers experimental, investigational, or not medically necessary. Insurers are required to have medical professionals review appeals. Common UR appeals involve the medical necessity of hospital admissions, the length of hospital stays and the use of certain medical procedures.

Understanding This Chart

How to quickly review these charts

A reversed appeal occurs when the health insurer reverses its initial decision not to cover a service or procedure. Pay attention to an insurer's reversal rate. The reversal rate is the percentage of appeals decided in favor of the consumer (i.e., the insurer agrees to pay for the service).

The chart shows the following additional information for each insurer:

- **Filed Appeals:** Number of UR appeals submitted to the health insurer by consumers in 2003.
- **Closed Appeals:** Number of UR appeals that the health insurer was able to reach a decision on by the close of 2003.
- **Reversed Appeals:** Number of closed UR appeals that the health insurer decided in favor of the consumer. If a UR decision is reversed on appeal, the insurer agrees to pay for the service or procedure.

Keep in Mind:

- You should pay specific attention to a health insurer that has a very high or very low reversal rate. Please note the following:
 - There is no ideal reversal rate.
 - A low reversal rate may indicate that the health insurer is making its initial decisions correctly, so fewer of these decisions require reversal. However, a low reversal rate could mean that the insurer is not giving appropriate reconsideration to its initial decisions.
 - A high reversal rate may indicate that an insurer's appeals process is responsive to consumers. However, a high reversal rate could mean that the insurer's process for making initial medical necessity decisions is flawed.
- The number of UR appeals filed may be higher for health insurers that actively promote the appeals process and encourage members to appeal denied services.

Utilization Review Appeals – HMOs, 2003

Data source: NYSID

HMOs are listed alphabetically.

HMO ^a	Filed Appeals	Closed Appeals ^b	Reversed Appeals	Reversal Rate
Aetna Health ^c	740	1,204	403	33%
CDPHP	439	433	210	48%
CIGNA	188	190	100	53%
Community Blue (HealthNow)	756	751	226	30%
Empire HealthCoice	169	168	63	38%
Excellus ^d	596	616	246	40%
GHI-HMO Select	128	131	88	67%
Health Net of NY	1,268	1,223	376	31%
HIP ^e	139	132	79	60%
IHA	85	85	29	34%
MDNY	451	446	234	52%
MVP Health Plan	788	795	142	18%
Oxford	5,954	6,000	3,123	52%
Rochester Area HMO (Preferred Care)	45	48	8	17%
UnitedHealthcare of NY	43	43	8	19%
Vytra	51	51	23	45%
WellCare ^f	43	42	22	52%
TOTAL	11,883	12,358	5,380	Avg.=44%

^a Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.

^b Closed UR appeals can exceed filed UR appeals in 2003 because closed UR appeals also include UR appeals filed prior to 2003.

^c Utilization Review Appeals for Aetna's commercial company, Aetna Health Insurance Co. of NY, are included under Aetna Health HMO.

^d Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

^e Includes Health Insurance Plan's (HIP's) HMO and non-profit business. In 2003, roughly 2% of HIP's business was attributable to its non-profit operation.

^f WellCare does not write nongovernment-sponsored business; its premium is derived in large part from the Child Health Plus and Family Health Plus programs.

**Utilization Review Appeals –
Non-profit Indemnity Insurers, 2003**

Data source: NYSID

Non-profit indemnity insurers are listed alphabetically. If you are considering only HMOs, this chart is not relevant.

Non-profit Indemnity Insurer ^a	Filed Appeals	Closed Appeals ^b	Reversed Appeals	Reversal Rate
Excellus Health Plan, Inc.	447	444	141	 32%
Group Health, Inc. (GHI)	5,230	5,169	3,288	 64%
HealthNow NY, Inc.	204	181	61	 34%
Vytra Health Services	10	10	6	 60%
TOTAL	5,891	5,804	3,496	 Avg.=60%

^a Excludes non-profit indemnity insurers with less than \$50 million in premium. Also excludes Dentcare Delivery Systems. Health Insurance Plan (HIP) non-profit data included in the HMO UR appeals chart.

^b Closed UR appeals can exceed filed UR appeals in 2003 because closed UR appeals also include UR appeals filed prior to 2003.

Utilization Review Appeals – Commercial Insurers, 2003

Data source: NYSID

COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

Commercial insurers are listed alphabetically. If you are considering only HMOs, this chart is not relevant.

Commercial Insurer ^a	Filed Appeals	Closed Appeals ^b	Reversed Appeals	Reversal Rate
Aetna Health Insurance Co. of New York ^c	-	-	-	-
Aetna Life Ins. Co.	330	460	136	30%
American Family Life	0	0	0	0%
CIGNA Life Ins. Co. of NY	0	0	0	0%
Combined Life Ins. Co. of NY	0	0	0	0%
Connecticut General Life Ins. Co.	717	731	339	46%
Empire HealthChoice Assurance	607	628	237	38%
First Fortis Life Ins. Co.	0	0	0	0%
First Rehabilitation Life Ins Co of America	0	0	0	0%
First Unum Life Ins. Co.	0	0	0	0%
GE Capital Life Assur. Co. of NY	0	0	0	0%
GE Group Life Assurance Co.	4	4	0	0%
Guardian Life Ins. Co. of America	619	606	392	65%
Hartford Life Ins. Co.	0	0	0	0%
Health Net Insurance of NY	272	314	148	47%
Horizon Healthcare Insurance	63	60	22	37%
John Hancock Life Ins. Co.	0	0	0	0%
Metropolitan Life Ins. Co.	2,795	2,795	2,280	82%
Mutual of Omaha Insurance	16	16	6	38%
MVP Health Ins. Co.	98	97	14	14%
New York Life Ins. Co.	0	0	0	0%
Northwestern Mutual Life Ins. Co.	0	0	0	0%
Oxford Health Insurance	2,018	1,955	673	34%
Paul Revere Life Ins. Co.	0	0	0	0%
Provident Life & Casualty Ins. Co.	0	0	0	0%
Prudential Ins. Co. of America	0	0	0	0%
Transamerica Financial Life Ins. Co.	0	0	0	0%
Travelers Ins. Co.	0	0	0	0%
United HealthCare Ins. Co. of NY	1,120	1,084	85	8%
Union Labor Life Ins. Co.	0	0	0	0%
United States Life Ins. Co. in the City of NY	0	0	0	0%
TOTAL	8,659	8,750	4,332	Avg.=50%

NOTE: Plan names in this table may differ from health plan names listed in prior sections of this Guide.

^a Excludes commercial insurers with less than \$50 million in premium. Many of the commercial companies do not write traditional comprehensive health insurance products, thus have no UR appeals.

^b Closed UR appeals can exceed filed UR appeals in 2003 because closed UR appeals also include UR appeals filed prior to 2003.

^c Utilization Review Appeals for Aetna Health Insurance Co. of NY are included under Aetna Health HMO.

Independent External Reviews

When your insurer denies health care services because it claims services are experimental, investigational, or not medically necessary, you can request an external review. Before requesting an external review, you must complete the insurer's first level internal utilization review appeal process, or you and your insurer may agree jointly to waive the internal appeal process. (See pages 10-11 for more information about how to request an external review.)

Understanding This Chart

How to quickly review these charts

A **reversed review** occurs when the independent external review organization decides in favor of the consumer and reverses the insurer's decision not to cover a service or procedure. Pay attention to an insurer's reversal rate.

The **reversal rate** is the percentage of cases in which the external review agent decides that the insurer's decision to deny coverage should be changed. In other words, the reversal rate is the percentage of reviews decided in favor of the consumer. Please note that **reversed in part** decisions **are** included in the reversal rate.

A high reversal rate may indicate that an insurer is not making appropriate coverage decisions.

The chart shows the following additional information for each insurer:

- **Total Reviews:** Total number of cases submitted to external review organizations in 2003.
- **Reversed Reviews:** Number of cases that external review organizations decided in favor of the consumer.
- **Reversed In Part:** Number of cases that an external review organization decided partially in favor of the consumer. For example, an HMO may refuse payment of a five-day hospital stay claiming it was not medically necessary. The external review organization may then decide that only three of the five days were medically necessary.
- **Upheld Reviews:** Number of cases where external review organizations agreed with the insurer's decision not to cover a service or procedure.

Independent External Reviews - HMOs, 2003

Data source: NYSID

HMOs are listed alphabetically.

HMO ^a	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ^b
Aetna Health	36	15	1	20	44%
CDPHP	6	3	0	3	50%
CIGNA	4	2	0	2	50%
Community Blue (HealthNow)	73	31	7	35	52%
Empire HealthChoice	75	28	4	43	43%
Excellus ^c	50	14	3	33	34%
GHI-HMO Select	2	2	0	0	100%
Health Net of NY	58	24	3	31	47%
HIP ^d	29	9	1	19	34%
IHA	3	0	0	3	0%
MDNY	5	2	0	3	40%
MVP Health Plan	17	8	0	9	47%
Oxford	238	65	23	150	37%
Rochester Area HMO (Preferred Care)	4	3	0	1	75%
UnitedHealthcare of NY	5	2	0	3	40%
Vytra	4	2	1	1	75%
WellCare ^e	0	0	0	0	0%
TOTAL	609	210	43	356	Avg.=42%

^a Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members. Excludes Medicaid external reviews. Medicare denial of claims are not subject to external review.

^b Rate includes "Reversed in Part" decisions.

^c Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

^d Includes Health Insurance Plan's (HIP's) HMO and non-profit business. In 2003, roughly 2% of HIP's business was attributable to its non-profit operation.

^e WellCare does not write nongovernment-sponsored business; its premium is derived in large part from the Child Health Plus and Family Health Plus programs.

**Independent External Reviews –
Non-profit Indemnity Insurers, 2003**

Data source: NYSID

*Non-profit indemnity insurers are listed alphabetically.
If you are considering only HMOs, this chart is not relevant.*

Non-profit Indemnity Insurer ^a	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ^b
Excellus Health Plan, Inc.	47	19	2	26	45%
Group Health, Inc. (GHI)	55	11	9	35	36%
HealthNow NY, Inc.	27	6	2	19	30%
Vytra Health Services	0	0	0	0	0%
TOTAL	129	36	13	80	Avg.=38%

^a Excludes non-profit indemnity insurers with less than \$50 million in premium. Also excludes Dentcare Delivery Systems. Health Insurance Plan (HIP) non-profit data are included in the HMO External Review chart.

^b Rate includes "Reversed in Part" decisions.

Independent External Reviews – Commercial Insurers, 2003

Data source: NYSID

COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

Commercial insurers are listed alphabetically. If you are considering only HMOs, this chart is not relevant.

Commercial Insurers ^a	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ^b
Aegon Group	0	0	0	0	0%
Aetna Group	11	1	1	9	18%
American Family Life	0	0	0	0	0%
AIG Group	0	0	0	0	0%
CIGNA Health Group	27	12	1	14	48%
Citigroup	0	0	0	0	0%
CNA Insurance Group	1	1	0	0	100%
Combined Life	0	0	0	0	0%
Empire HealthChoice Assurance	151	61	12	78	48%
First Rehabilitation Life Ins. Co. of Am.	0	0	0	0	0%
Fortis Group	0	0	0	0	0%
GE Global Group	0	0	0	0	0%
Guardian Life Group	0	0	0	0	0%
Hartford F & C Group	0	0	0	0	0%
Health Net Ins. of NY	0	0	0	0	0%
Horizon Healthcare Ins. Co. of NY	8	5	1	2	75%
John Hancock Life Insurance Co.	0	0	0	0	0%
Metropolitan Group	4	2	0	2	50%
Mutual of Omaha Group	4	3	0	1	75%
MVP Health Ins. Co.	0	0	0	0	0%
New York Life Ins. Co.	0	0	0	0	0%
Northwestern Mutual Group	0	0	0	0	0%
Oxford Health Insurance	18	3	1	14	22%
Prudential Ins. Co. of America	0	0	0	0	0%
Union Labor Life Ins. Co.	0	0	0	0	0%
UnitedHealthCare Ins. Co. of NY	56	27	3	26	54%
UnumProvident Corp. Group	0	0	0	0	0%
Zurich Insurance Group	0	0	0	0	0%
TOTAL	280	115	19	146	Avg.=48%

NOTE: Plan names in this table may differ from health plan names listed in prior sections of this Guide.

^a Excludes commercial insurers with less than \$50 million in premium. Many of these commercial companies do not write traditional comprehensive health insurance products, thus have no external review cases.

^b Rate includes "Reversed in Part" decisions.



**ADDITIONAL INFORMATION
ABOUT HMOs**
CHAPTER THREE

Additional Information About HMOs

Overview

On the following pages, you will find information about:

- 1. HMO Service Areas** (pages 36-37) — Find plans that offer services near where you live or work.
- 2. HMO Performance** — How well the HMOs you selected performed in the following areas:
 - **Access and Service** (pages 38-39): Shows how members rated their HMO, their ability to get needed care, their ability to get care quickly and what percentage of HMO members saw a provider within the past three years.
 - **Staying Healthy and Living with Illness** (pages 40-41): Shows how well HMOs ensured that children with asthma received proper medication, women received cervical cancer screening, members who were diagnosed with depression received treatment, adult members with asthma received proper medication, and members with hypertension had their blood pressure controlled.

- **Qualified Providers** (pages 42-43): Shows how HMO members rated their personal doctor or nurse. This section also shows the percentage of physicians that are certified by a medical board (“board certified”) and the percentage of physicians who left the HMO in the last year.

- 3. Grievances** (pages 44-45) — Shows how often HMO members or providers complained directly to the HMO about an action or decision.

- 4. NCQA Accreditation** (pages 46-47) — Lists the accreditation status of New York’s HMOs as determined by NCQA, an independent non-profit organization that evaluates managed care organizations. For more information on NCQA, visit www.ncqa.org.

- 5. How HMOs Pay Primary Care Physicians** (page 48) — Explains the different ways HMOs compensate primary care physicians for providing care to members.

Note: *The HMO performance information in most of this section is from the New York State Department of Health’s Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Health Plans (CAHPS®).^{*} QARR measures are largely adopted from a standardized “measuring tool” called the Health Plan Employer Data and Information Set (HEDIS®), which is a set of performance measures that allows the public to compare the quality of HMOs. An independent organization audited the data to verify its accuracy. CAHPS® is a standardized member survey administered to HMO members. Please note that the data reported were collected for calendar year 2002.*

^{*} Grievance data are based on information from the New York State Insurance Department. NCQA Accreditation data are based on information from the National Committee for Quality Assurance (NCQA).

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HMO Service Areas^a

HMOs are located in every region of the state. Use the following table to find the HMOs that operate in your area.

HMO	Albany Area	Buffalo Area	Hudson Valley Area	Long Island Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Westchester Area
Aetna Health			•	•	•		•	•	•
Amerihealth Health Plan			•						•
Atlantis					•				
CDPHP	•		•				•	•	
CIGNA			•	•	•				•
Community Blue (HealthNow)	•	•	•			•	•	•	
Empire HealthChoice	•		•	•	•				•
Excellus ^b	•	•	•			•	•	•	
GHI-HMO Select	•		•	•	•		•	•	•
Health Net of NY			•	•	•				•
HIP			•	•	•				•
Horizon Healthcare			•	•	•				•
IHA		•							
Managed Health				•	•				
MDNY				•					

table continued on next page

HMO Service Areas^a

HMO	Albany Area	Buffalo Area	Hudson Valley Area	Long Island Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Westchester Area
MVP Health Plan	•		•				•	•	•
Oxford			•	•	•				•
Rochester Area HMO (Preferred Care)		•				•			
UnitedHealthcare of NY			•	•	•		•	•	•
Vytra				•	•				
WellCare	•		•		•				•

^a Service areas are current as of 6/1/04. Also includes HMOs with less than \$25 million in premium or fewer than 5,000 members.

^b Excellus Group includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

NOTE: Plan names in this table may differ from health plan names listed in prior sections of this Guide.

Access and Service

Consumers rated New York HMOs on how well they provide members with timely access to needed care and customer service.

Understanding This Chart

The circles in the chart show how each HMO compares to the average for all New York HMOs. Look for HMOs with a “★” in the chart. These HMOs performed significantly better than the New York HMO average. In other words, they had a greater percentage of satisfied members.

Rating of HMO

Members rated their HMO on a scale from 0 (worst possible) to 10 (best possible). The circles in the chart are based on the number of members who gave their HMO an 8, 9 or 10 rating.

The 65% NY HMO Average for “Members Rating Their HMO...” means that 65% of HMO members who responded gave their HMO an 8, 9 or 10 rating.

Problems Getting Needed Care

When asked how much of a problem, if any, they experienced getting needed care, members responded “small problem” or “big problem.” A lower score in this performance area represents better performance.

The New York HMO average is 25% in “Problems Getting Needed Care.” This means 25% of all responders indicated they had either a small or big problem getting needed care.

Getting Care Quickly

Members responded that they “usually” or “always” received health plan services quickly.

Members Seen by a Provider

Even healthy members need to see a provider to ensure medical problems are prevented or caught as early as possible. The chart shows the percentage of adult HMO members who had an outpatient or preventive care visit within the past three years as reported by the HMO. A **higher** score means more people in the HMO have had a visit with a provider.

Access and Service

Data source: DOH

Performance Compared to the New York HMO Average

- ★ Rate for the HMO is significantly **better** than the NY HMO average
- Rate for the HMO is **not significantly different** than the NY HMO average
- Rate for the HMO is significantly **worse** than the NY HMO average

HMO	Members Rating their HMO an 8, 9 or 10 on a scale from 0 (worst) to 10 (best)	Members Who Had Problems Getting Needed Care	Members Who Received Care Quickly	Members Seen by a Provider	
				Ages 20-44	Ages 45-64
NY HMO Avg.	65%	25%	79%	93%	94%
Aetna	●	○	●	90	91
Blue Choice	★	★	★	93	95
BSNENY-HMO*	●	●	★	94	95
CDPHP	★	★	★	96	96
CIGNA	○	○	○	91	91
Community Blue (HealthNow)	●	●	★	94	95
Empire	●	●	●	91	93
GHI-HMO Select	○	○	●	92	93
Health Net	●	○	○	94	94
HIP	●	○	○	90	89
Independent Health	●	★	★	94	95
Managed Health, Inc.	SS	SS	SS	92	96
MDNY	○	●	○	95	95
MVP Health Plan	★	★	★	95	95
Oxford	●	●	●	94	95
Preferred Care	★	★	★	95	96
UnitedHealthcare of New York	●	●	○	89	93
Univera HealthCare	●	●	●	93	95
Upstate HMO	●	●	★	94	96
Vytra Health Plans	●	★	●	95	95

SS – Rate not suitable for comparison because of a small sample size.
 * Albany Division of Community Blue.

NOTE: Plan names in this table may differ from health plan names listed in prior sections of this Guide.

Staying Healthy and Living with Illness

New York HMOs were rated on how well they help people maintain good health and recover from illness.

Understanding This Chart

The circles show how each HMO compares to the average for all New York HMOs. Look for HMOs with a “+” in the chart. These HMOs performed significantly better than the New York HMO average. In other words, they had a greater percentage of members who received needed services to maintain good health or recover from illness.

Use of Appropriate Medications for Children with Asthma (Ages 5-17)

It is important for children with asthma to be receiving the proper medications for long-term control of asthma. Plans were rated on the percentage of members (ages 5-17) with persistent asthma who received appropriate medications to control their condition.

Cervical Cancer Screening

Early detection of cervical cancer through a Pap test is a crucial component of women’s primary and preventive health care. When detected and treated early, cervical cancer is one of the most treatable cancers. Plans were rated on the percentage of women (ages 21-64) who had a Pap test within the last three years.

Antidepressant Medication Management

Follow-up therapy is important for patients after they have been diagnosed with depression. Treatment should include medication and contact with a primary care or mental health provider. Plans were rated on the percentage of members with depression who were given appropriate medication and had at least three follow-up visits during a 12-week treatment period.

Use of Appropriate Medications for People with Asthma (Ages 18-56)

It is important for adults with asthma to be receiving the proper medications for long-term control of asthma. Plans were rated on the percentage of members (ages 18-56) with persistent asthma who received appropriate medications to control their condition.

Controlling High Blood Pressure

Reducing high blood pressure is important for reducing the risk of heart attack and stroke. Plans were rated on the percentage of members (ages 46-85) who have hypertension and who controlled their blood pressure (at or below 140/90).

The 65% NY HMO Average for “Use of Appropriate Medications for Children with Asthma (Ages 5-17)” means that 65% of all children diagnosed with asthma received the appropriate medication.

Staying Healthy and Living with Illness

Data source: DOH

Performance Compared to the New York HMO Average

- ★ Rate for the HMO is significantly **better** than the NY HMO average
- Rate for the HMO is **not significantly different** than the NY HMO average
- Rate for the HMO is significantly **worse** than the NY HMO average

HMO	Use of Appropriate Medications for Children with Asthma (Ages 5-17)	Cervical Cancer Screening	Antidepressant Medication Management	Use of Appropriate Medications for People with Asthma (Ages 18-56)	Controlling High Blood Pressure
NY HMO Avg.	65%	81%	23%	68%	62%
Aetna	○	○	★	○	NV
Blue Choice	★	●	○	★	●
BSNENY-HMO*	★	●	○	★	●
CDPHP	★	●	●	★	●
CIGNA	○	○	★	○	○
Community Blue (HealthNow)	●	★	○	●	●
Empire	●	○	○	●	○
GHI-HMO Select	●	●	○	●	★
Health Net	●	●	★	★	○
HIP	○	○	★	○	★
Independent Health	●	★	○	●	●
Managed Health, Inc.	SS	○	SS	SS	●
MDNY	★	●	●	●	○
MVP Health Plan	★	●	●	★	★
Oxford	●	●	★	●	●
Preferred Care	●	●	○	●	★
UnitedHealthcare of New York	●	○	★	●	○
Univera HealthCare	●	●	★	★	●
Upstate HMO	●	★	○	●	●
Vytra Health Plans	●	●	★	●	●

NV – Plan submitted invalid data.
 SS – Rate not suitable for comparison because of a small sample size.
 *Albany Division of Community Blue.

NOTE: Plan names in this table may differ from health plan names listed in prior sections of this Guide.

Quality of Providers

The quality, stability and availability of the physicians in an HMO provider network can impact the overall quality of care delivered to health plan members. New York HMOs were rated on these characteristics of their providers.

Understanding This Chart

The circles show how each HMO compares to the average for all New York HMOs. Look for HMOs with a “🌟” in the chart. These HMOs performed significantly better than the New York HMO average. In other words, they had a greater percentage of satisfied members.

Rating of Doctor or Nurse

Members rated their doctor or nurse on a scale from 0 (worst possible) to 10 (best possible). The circles are based on the percentage of members who gave their HMO an 8, 9 or 10 rating.

How Well Doctors Communicate

Members responded that their doctors or health providers “usually” or “always”:

- listen carefully to them
- explain things in a way they understand
- show respect for what they have to say
- spend enough time with them during visits

The 92% NY HMO Average for “How Well Doctors Communicate” means that 92% of members who responded thought their doctor usually or always listened to them and spent enough time with them.

Board Certification

A doctor must receive additional training and pass an exam in his or her specialty to be considered board certified. While board certification is not a guarantee of quality, it shows that the physician has the knowledge that the specialty board considers necessary. The chart shows the percentage of primary care physicians, obstetricians/gynecologists (OB/GYN) and pediatricians who are board certified. A higher percentage means the HMO has more board certified physicians in the practice areas listed.

Note: *There are times when it is appropriate for HMOs to contract with physicians who are not board certified, as in the case of older physicians who were trained before board certification was available. In addition, an HMO covering a rural area may have a lower percentage of board certified physicians, since a limited number of physicians practice in these regions.*

Physician Turnover

Going to the same doctor makes it easier to receive better and more coordinated care. If most doctors stay in an HMO, you are less likely to have to change doctors. The chart shows the percentage of primary care physicians who left the HMO’s network in 2002. A lower percentage means the HMO’s provider network is more stable.

Quality of Providers

Data source: DOH

Performance Compared to the New York HMO Average

- ★ Rate for the HMO is significantly **better** than the NY HMO average
- Rate for the HMO is **not significantly different** than the NY HMO average
- Rate for the HMO is significantly **worse** than the NY HMO average

HMO	Members Rating their Doctor or Nurse an 8, 9 or 10 on a scale from 0 (worst) to 10 (best)	Members Responding that their Doctors Usually or Always Communicate Well	Doctors who are Certified by a Medical Board			Physician Turnover (Primary Care results)
			Primary Care	OB/GYN	Pediatric	
NY HMO Avg.	76%	92%	85%	77%	81%	6.4%
Aetna	●	○	84	84	72	3.8
Blue Choice	●	★	88	84	75	3.6
BSNENY-HMO*	●	★	86	82	69	4.5
CDPHP	●	★	78	83	65	7.1
CIGNA	○	○	82	72	80	3.2
Community Blue (HealthNow)	●	●	80	82	68	4.3
Empire	●	●	85	76	75	6.3
GHI-HMO Select	○	○	86	81	85	3.0
Health Net	★	●	83	77	86	14.5
HIP	●	○	79	57	75	10.0
Independent Health	●	★	77	76	75	3.9
Managed Health, Inc.	SS	SS	84	74	84	6.7
MDNY	●	●	89	86	79	5.0
MVP Health Plan	●	★	90	80	78	5.9
Oxford	●	●	90	78	80	1.0
Preferred Care	●	★	91	91	96	5.3
UnitedHealthcare of New York	●	○	91	83	79	3.4
Univera HealthCare	●	●	84	80	64	5.9
Upstate HMO	●	●	88	80	77	15.5
Vytra Health Plans	●	●	90	86	85	1.7

SS – Rate not suitable for comparison because of a small sample size.
 * Albany Division of Community Blue.

NOTE: Plan names in this table may differ from health plan names listed in prior sections of this Guide.

Grievances

A grievance is a complaint to an HMO by a member or provider about an action or decision. Medical necessity issues are not grievances; they are handled as utilization review (UR) appeals. (See page 24 for information on UR appeals.)

By State law, HMOs in New York are required to have a system in place for responding to their members' concerns. Common grievances include trouble getting referrals to specialists and disagreements over benefit coverage. A committee within the HMO reviews the grievance and makes a decision.

Understanding This Chart

How to quickly review these charts

The **reversal rate** given for an HMO is the percentage of grievances that an HMO decided in favor of the consumer or provider.

Example: A 30% reversal rate indicates that in three out of ten grievances, the HMO changed its initial decision and decided in favor of the consumer or provider.

The chart shows the following additional information for each insurer:

- **Filed Grievances:** Number of grievances submitted to the HMO.
- **Closed Grievances:** Number of grievances the HMO was able to make a decision on by the end of the reporting period.
- **Upheld Grievances:** Number of closed grievances where the HMO stood by its original decision and did not decide in favor of the member or provider.
- **Reversed Grievances:** Number of closed grievances where the HMO changed its initial decision and decided in favor of the member or provider.

Keep in Mind:

- You should pay specific attention to an HMO that has a very high or very low reversal rate. Please note the following:
 - There is no ideal reversal rate.
 - A low reversal rate may indicate that the HMO is making its decisions correctly, so fewer of its decisions require reversal. However, a low reversal rate could mean that the HMO is not giving appropriate reconsideration to its initial decisions.
 - A high reversal rate may indicate that an insurer's grievance process is responsive to members. However, a high reversal rate could mean that the HMO's process for making initial decisions is flawed.
- The number of grievances filed may be higher for HMOs that actively promote the grievance process to members.

Grievances, 2003

Data source: NYSID

HMO ^a	Filed Grievances	Closed Grievances ^b	Upheld Grievances	Reversed Grievances	Reversal Rate
Aetna Health	1,729	1,986	1,109	877	44%
CDPHP	2,160	2,112	721	1,391	66%
CIGNA	288	278	108	170	61%
Community Blue (HealthNow)	3,632	3,561	1,025	2,536	71%
Empire HealthChoice	612	637	525	112	18%
Excellus ^c	1,906	1,935	1,413	522	27%
GHI-HMO Select	410	424	137	287	68%
Health Net of NY	4,990	3,509	1,418	2,091	60%
HIP ^d	1,604	1,674	431	1,243	74%
IHA	907	909	608	301	33%
MDNY	342	340	141	199	59%
MVP Health Plan	214	217	132	85	39%
Oxford	5,639	5,574	2,996	2,578	46%
Rochester Area HMO (Preferred Care)	140	136	79	57	42%
UnitedHealthcare of NY	122	122	103	19	16%
Vytra	248	248	182	66	27%
WellCare ^e	287	286	284	2	1%
TOTAL	25,230	23,948	11,412	12,536	Avg.=52%

^a Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.
^b Closed grievances can exceed filed grievances in 2003 because closed grievances also include grievances filed prior to 2003.
^c Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.
^d Includes Health Insurance Plan's (HIP's) HMO and non-profit business. In 2003, roughly 2% of HIP's business was attributable to its non-profit operation.
^e WellCare does not write nongovernment-sponsored business; its premium is derived in large part from the Child Health Plus and Family Health Plus programs.

NCQA Accreditation

What Is NCQA?

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality everywhere. NCQA began accrediting managed care plans in 1991 to meet consumers' and employers' needs for information about managed care plan quality. Today, the organization reviews and reports on a wide range of health care organizations. NCQA is governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts and policy makers.

What is NCQA Accreditation?

NCQA Accreditation evaluates aspects of a managed care plan that are important to people, but that are generally difficult for people to determine on their own. NCQA Accreditation is nationally recognized as a “seal of approval” for health plans.

When NCQA accredits a managed care plan, a team of doctors and health care experts conducts a comprehensive, exhaustive review of the plan's systems and structure against more than 60 different standards. The NCQA team spends several days with the plan reviewing records and meeting with plan personnel. Plans also are required to submit HEDIS clinical performance measures as part of the accreditation process, and only those plans that consistently achieve high results can earn the top accreditation category of “Excellent.”

HEDIS measures health plans in areas such as:

- Does a plan ensure that children get all of their recommended immunizations?
- Does a plan provide important tests and screenings to detect or help manage illnesses?
- How do members rate their health plan and ability to get needed care?

After NCQA scores the results of its findings, it assigns a plan one of five possible accreditation levels:

Excellent: NCQA's highest accreditation status is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level also must achieve HEDIS results that are in the highest range of national or regional performance.

Commendable: This accreditation outcome is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

Accredited: Health plans that earn the Accredited designation must meet most of NCQA's basic requirements for consumer protection and quality improvement.

Provisional: Provisional accreditation indicates that a health plan's service and clinical quality meet some, but not all of NCQA's basic requirements for consumer protection and quality improvement.

Denied: Denied indicates that a health plan did not meet NCQA's requirements during its review.

The table on the next page shows how NCQA rates the HMOs serving New York. **Participation in NCQA Accreditation is voluntary, so not all New York HMOs will have an accreditation status.**

HMO NCQA Accreditation Status as of July 2004

HMO ^a	NCQA Accreditation Status
Aetna Health	Excellent
Blue Cross Blue Shield of Western New York (Community Blue)	Excellent
BlueShield of Northeastern New York (BSNENY)	Excellent
CDPHP	Excellent
CIGNA	Commendable
Empire Health Choice	Excellent
Excellus BlueCross BlueShield, Rochester	Excellent
Excellus Health Plan (Upstate HMO)	Excellent
GHI-HMO Select	Commendable
Health Net of NY	Not NCQA Accredited ^b
HIP	Commendable
IHA	Excellent
MDNY	Not NCQA Accredited ^b
MVP Health Plan	Excellent
Oxford	Excellent
Rochester Area HMO (Preferred Care)	Excellent
UnitedHealthcare of New York	Commendable
Univera HealthCare	Excellent
Vytra	In Progress ^c
WellCare	Not NCQA Accredited ^b

^aExcludes HMOs with less than \$25 million in premium or fewer than 5,000 members. Excludes Medicaid and Medicare.

^bParticipation in NCQA Accreditation is voluntary, thus some plans will not have an accreditation status.

^cAccreditation review began in June 2004.

NOTE: HMO names in this table may differ from HMO names listed in prior sections of this Guide.

NCQA's Online Health Plan Report Card

To learn more about NCQA Accreditation and to get more detailed information about how a plan performed on NCQA Accreditation, look at NCQA's consumer-friendly online Health Plan Report Card at www.ncqa.org.

How HMOs Pay Primary Care Physicians

New York HMOs pay primary care physicians (PCPs) in a variety of ways. A typical HMO uses more than one method. No method is the best or right way. If you have questions or concerns about how your PCP is paid by your HMO, you should ask him or her about it.

Payment Methods

Fee-For-Service: The HMO pays PCPs for each office visit, procedure and test.

Capitation: The HMO pays PCPs the same amount every month for every member that is under his/her primary care. The HMO pays the same amount regardless of the services a member receives from the physician. Supporters of capitation believe it gives physicians the incentive to keep people healthy through preventive care in order to avoid costly illnesses. Others think that capitation creates an incentive to avoid providing necessary but expensive services.

Bonus: The HMO pays PCPs additional amounts if they meet quality, customer service or cost-saving goals.

Withhold: The HMO holds back part of a PCP's payment to cover unexpected services such as specialty care, laboratory services, or hospitalization. If a physician's patients do not use such services, the HMO pays the withheld amount back to the physician. Some believe that this method helps reduce unnecessary expenses. Others believe this method may discourage providers from offering necessary services.

Note: *Many HMOs use a combination of these methods to pay their primary care physicians.*

The background features a dark blue field. A large, flowing gold shape enters from the top left and curves across the middle. Below this, a white grid of thin vertical lines is visible, partially obscured by the gold shape and the text.

HEALTH INSURANCE OPTIONS
FOR UNINSURED NEW YORKERS
CHAPTER FOUR

Health Insurance Options for Uninsured New Yorkers

Review of Available Options

New York State is committed to expanding quality health care coverage to uninsured New Yorkers. Governor George E. Pataki proposed and signed into law important legislation that has increased the availability of comprehensive health insurance coverage for New York's uninsured workers and their families.

This section of the Guide presents three programs designed especially for uninsured New Yorkers and their families.

- **Healthy NY** (page 52) is a unique program designed to offer health insurance to small employers, sole proprietors and uninsured working individuals. The program offers two standardized health insurance benefit packages (one with and one without a prescription drug benefit) that are made more affordable through State sponsorship.
- **Child Health Plus** (page 53) is a health insurance plan for children who are under the age of 19. The monthly premium varies depending on family income and family size.

- **Family Health Plus** (page 54) is a health insurance program for adults between the ages of 19 and 64 who are uninsured but have incomes too high to qualify for Medicaid. The Medicaid program provides funding, with cost shared between Federal, State and local governments.

Healthy NY

Healthy NY brings affordable, comprehensive health insurance to the working uninsured. Healthy NY is for small businesses, sole proprietors and individuals without health insurance.

The Healthy NY program is designed to assist small business owners in providing their employees and their employees' families with the health insurance they need and deserve. In addition, working individuals whose employers do not provide health insurance may also purchase comprehensive coverage directly through the Healthy NY program. Each group of participants has its own distinctive set of eligibility criteria and participation rules.

In 2003, Healthy NY premiums were reduced by an average of 17%.

Eligibility and Enrollment

Your **small business** may participate if:

- your business has not provided comprehensive health insurance during the past 12 months or contributed more than \$50 per employee per month for coverage.
- you have 50 or fewer employees.
- thirty percent of your employees earn \$33,000 or less annually.
- your business is willing to contribute 50 percent of the Healthy NY premium.
- your business meets certain participation requirements.

You may qualify for **individual** participation if:

- you have been employed at some time during the past year, or your spouse has been employed in the past year, or you are a sole proprietor.
- you have been without health insurance for 12 months or have lost coverage for certain reasons.
- you are ineligible for Medicare or employer coverage.
- your total household income is within the annual limits listed above, with respect to the number of household members you have.

Healthy NY Income Individual Eligibility Guidelines Effective January 2004 and subject to revision.

Family Size	Household Income Limits
1	Up to \$23,275
2	Up to \$31,225
3	Up to \$39,175
4	Up to \$47,125
5	Up to \$55,075
Each extra person	Add \$7,950

Note: Pregnant women count as two people for the purpose of determining family size.

Summary of Benefits

Under the Healthy NY program, all New York HMOs offer two standard, yet comprehensive health insurance benefit packages to qualifying small businesses, sole proprietors and individuals. One package provides no prescription drug benefit; the other offers a \$3,000 per person, per

year prescription drug benefit. Healthy NY benefit packages are specifically designed to be more affordable than other coverages. You must pay a monthly premium for Healthy NY services will be provided by an HMO and include:

- inpatient and outpatient hospital services
- physician services, including second opinions for surgery and cancer treatment
- outpatient surgery facility charges for covered surgical procedures
- pre-admission testing
- maternity care
- adult preventive health services
- preventive and primary health care services for dependent children
- equipment, supplies and self-management education for the treatment of diabetes
- diagnostic x-ray and laboratory services
- emergency room services
- optional prescription drugs benefit (\$3,000 maximum per person, per year)

Keep in mind that even though Healthy NY benefits are the same at each HMO, premiums vary. For more information about premiums, see pages 62-64. To find more information about enrolling in Healthy NY, call this toll-free number: 1-866-HEALTHY-NY (1-866-432-5849), or visit the Web site at www.HealthyNY.com.

Child Health Plus

New York State has a health insurance plan for children called Child Health Plus. This plan is available from dozens of insurers throughout the State.

Eligibility and Enrollment

Children under age 19 who are not eligible for Medicaid and who have limited or no health insurance may be eligible for Child Health Plus. Even if your family income is relatively high, your children may still qualify for Child Health Plus. Children who have a parent or family member who is a public agency employee with access to family coverage through a State health benefits plan where the public agency pays all or part of the cost of the health benefits coverage are not eligible to enroll.

Summary of Benefits

Families that insure a child through the Child Health Plus program do not have to pay copayments to receive services. Depending on your gross family income, however, you may have to pay a monthly contribution to enroll in Child Health Plus. Eligible children will receive these benefits:

- well-child care, immunizations and physical exams
- diagnosis and treatment of illness and injury
- x-rays and lab tests

- outpatient surgery
- inpatient hospital medical or surgical care
- emergency care
- prescription and nonprescription drugs if ordered by a physician
- short-term therapeutic outpatient services
- limited inpatient/outpatient treatment for alcoholism, substance abuse, mental health
- dental care and vision care

- speech and hearing services
- durable medical equipment
- emergency ambulance transportation to a hospital

Enrolling in Child Health Plus is easy. Call this toll-free number: 1-800-698-4KIDS (1-800-698-4543), and ask an enrollment facilitator about Child Health Plus. To find more information about Child Health Plus, check the New York State Department of Health Web site at www.health.state.ny.us.

Child Health Plus B* Income Eligibility Levels

Effective January 2004 and subject to revision.

Family Size ^a	Family Pays NO COST if Monthly Income is Less Than	Family Pays \$9 ^b PER CHILD PER MONTH if Monthly Income is Between	Family Pays \$15 ^c PER CHILD PER MONTH if Monthly Income is Between	Family Pays FULL PREMIUM ^d if Monthly Income is More Than
1	\$1,241	\$1,242–1,723	\$1,724–1,940	\$1,940
2	\$1,665	\$1,666–2,311	\$2,312–2,603	\$2,603
3	\$2,089	\$2,090–2,899	\$2,900–3,265	\$3,265
4	\$2,513	\$2,514–3,488	\$3,489–3,928	\$3,928
5	\$2,937	\$2,938–4,076	\$4,077–4,590	\$4,590
6	\$3,361	\$3,362–4,664	\$4,665–5,253	\$5,253
7	\$3,785	\$3,786–5,253	\$5,254–5,915	\$5,915
8	\$4,209	\$4,210–5,841	\$5,842–6,578	\$6,578
For each extra person add	\$424	\$589	\$663	

* You may not enroll your child in Child Health Plus B if your family's income makes you eligible for Child Health Plus A (Medicaid). Income limits for Child Health Plus A are lower for most families than Child Health Plus B limits.

^a Pregnant women count as two when determining family size. ^b Maximum of \$27 per family. ^c Maximum of \$45 per family.

^d The full premium will vary, depending on the insurer selected. It is usually much less than you would pay for comparable private insurance.

Family Health Plus

The Health Care Reform Act of 2000 marked an extraordinary achievement in New York State’s commitment to expanding quality health care coverage to nearly one million uninsured New Yorkers under a bold new initiative called **Family Health Plus**.

Family Health Plus is a new program that builds on the Child Health Plus program to offer health coverage. The program is aimed at lower-income adults whose income or resources disqualifies them for other public programs such as Medicaid, but who do not have health insurance through their employers. Family Health Plus helps assure that adult family members can receive quality health care.

Eligibility and Enrollment

Family Health Plus will offer health care benefits for adults, 19 to 64, who do not have health coverage.

Those who join must be ineligible for Medicaid, or eligible only because of high medical costs. Unlike Medicaid, there are no asset or resource tests. Coverage begins when the member has been determined eligible and has enrolled in a plan.

Just like Child Health Plus, enrollment facilitators are located throughout New York to help ease the enrollment process and to answer questions. Local Social Services district offices also accept applications. Once enrolled in the program, participants may re-certify through the mail.

Family Health Plus Eligibility

Effective January 2004 and subject to revision.

Family Size	Maximum Gross Annual Income	
	Single or Married Adult (not living with children under age 21)	Parent (living with at least one child under age 21)
1	\$9,310	--
2	\$12,490	\$18,735
3	--	\$23,505
4	--	\$28,275
5	--	\$33,045
6	--	\$37,815
7	--	\$42,585
For each extra person add		\$4,770

Summary of Benefits

Family Health Plus offers a comprehensive package of benefits similar to Child Health Plus. The Medicaid program provides funding, with cost shared between Federal, State and local governments. Services are provided by a managed care plan, and include:

- physician services
- inpatient and outpatient health care
- prescription drugs
- lab tests and x-rays
- vision, speech and hearing services
- durable medical equipment
- emergency room and emergency ambulance services
- drug, alcohol and mental health treatment
- diabetic supplies and equipment
- radiation therapy, chemotherapy and hemodialysis
- dental services (if offered by the plan)

To find more information about enrolling you or your family in Family Health Plus, contact your local Social Services district office. You can also visit the New York State Department of Health’s Web site at www.health.state.ny.us.

APPENDICES

Overall Complaint Ranking

Information for New Yorkers Buying Health Insurance on their Own

High and Low Premiums by Region

Telephone Numbers of Health Insurers

Appendix 1

Overall Complaint Ranking^a

The table shows an overall ranking of all New York insurers (HMOs, non-profit indemnity insurers and commercial insurers), based on complaints closed by the New York State Insurance Department. Since comparing different types of insurers is not an “apples to apples” type of comparison, consider an insurer’s ranking within its category along with this overall ranking.

Name	Rank ^b	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio	Insurer Categories
Hartford F & C Group ^c	1	3	0	132.1	0.000	^H HMO
Fortis Group ^c	2	3	0	82.6	0.000	^c Commercial Insurer
Zurich Insurance Group ^c	3	0	0	74.2	0.000	^N Non-profit Indemnity Insurer
American Family Life ^c	4	2	0	69.7	0.000	
First Rehabilitation Life Ins. Co. of Am. ^c	5	4	0	65.8	0.000	
New York Life Ins. Co. ^c	6	2	0	58.8	0.000	
Northwestern Mutual Group ^c	7	0	0	55.2	0.000	
UnumProvident Corp. Group ^c	8	4	2	443.6	0.005	
GE Global Group ^c	9	17	1	170.3	0.006	
Empire HealthChoice Assurance ^c	10	1,109	26	3,379.5	0.008	
John Hancock Life Insurance Co. ^c	11	6	1	118.4	0.008	
Citigroup ^c	12	7	1	105.9	0.009	
Rochester Area HMO (Preferred Care) ^H	13	8	3	213.8	0.014	
MVP Health Ins. Corp. ^c	14	5	1	63.8	0.016	
Combined Life ^c	15	26	2	124.8	0.016	
Prudential Ins. Co. of America ^c	16	5	1	61.2	0.016	
Vytra Health Services ^N	17	12	1	60.3	0.017	
CDPHP ^H	18	112	12	664.2	0.018	
Empire HealthChoice ^H	19	855	23	1,023.2	0.022	
Excellus ^H	20	164	32	1,405.2	0.023	
Guardian Life Group ^c	21	119	12	507.8	0.024	
MVP Health Plan ^H	22	244	23	936.1	0.025	
Aegon Group ^c	23	8	2	77.6	0.026	
Metropolitan Group ^c	24	63	11	355.2	0.031	
Aetna Group ^c	25	67	11	353.0	0.031	
Excellus Health Plan, Inc. ^N	26	258	64	1,971.2	0.032	

Table continued on next page

Overall Complaint Ranking ^a (continued)

Name	Rank ^b	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio	Insurer Categories
IHA ^H	27	76	20	601.2	0.033	^H HMO ^C Commercial Insurer ^N Non-profit Indemnity Insurer
Community Blue (HealthNow) ^H	28	151	30	818.1	0.037	
AIG Group ^C	29	37	5	131.6	0.038	
HealthNow NY, Inc. ^N	30	137	25	642.1	0.039	
CNA Insurance Group ^C	31	21	6	153.3	0.039	
Union Labor Life Ins. Co. ^C	32	11	3	62.7	0.048	
CIGNA Health Group ^C	33	183	89	1,495.6	0.060	
Vytra ^H	34	174	17	267.7	0.064	
Mutual of Omaha Group ^C	35	20	6	72.5	0.083	
Oxford Health Insurance ^C	36	451	125	1,283.9	0.097	
WellCare ^H	37	11	3	30.7	0.098	
UnitedHealthCare Ins. Co. of NY ^C	38	876	245	2,346.3	0.104	
Group Health, Inc. (GHI) ^H	39	1,597	514	2,172.5	0.237	
Health Net Ins. of NY ^C	40	194	51	211.6	0.241	
GHI-HMO Select ^H	41	98	21	85.7	0.245	
UnitedHealthcare of NY ^H	42	180	33	106.4	0.310	
Aetna Health ^H	43	1,201	369	1,167.4	0.316	
Oxford ^H	44	2,830	870	2,744.2	0.317	
Horizon Healthcare Ins. Co. of NY ^C	45	103	49	150.2	0.326	
Health Net of NY ^H	46	1,198	201	588.5	0.342	
CIGNA ^H	47	251	92	202.5	0.454	
HIP ^H	48	1,695	963	1,581.5	0.609	
MDNY ^H	49	303	199	153.3	1.298	

^a Small insurers and small HMOs are not included. Please consult individual complaint tables for size criteria.

^b The chart ranks insurers and HMOs by complaint ratio. For 0.000 ratios, the insurer or HMO with the higher premium amount is ranked higher.

Appendix 2

Information for New Yorkers Buying Health Insurance on their Own*

Choices available for individual coverage

New Yorkers purchasing health insurance on their own can choose from either a health maintenance organization (HMO) plan or point of service (POS) plan. You can purchase either of these benefit packages from HMOs operating in your area. See pages 36-37 to determine which HMOs operate in your area.

Similarities between HMO and POS plans

Both types of plans offer a comprehensive benefits package and emphasize prevention, detection and treatment of illness before it becomes a serious threat to an individual's health. The two plans have standardized benefit packages that offer hospital, doctor, preventive, well-child and emergency room services, as well as a prescription drug benefit.

New Yorkers should also determine whether they are eligible for reduced-cost health insurance through the Healthy NY, Child Health Plus, or Family Health Plus programs. Details of these programs appear on pages 51-54.

* Appendix 2 is geared toward New Yorkers who do not obtain health insurance coverage through their employers or other groups. They purchase and pay for such coverage on their own.

Differences between HMO and POS plans

Where the two plans differ is in a member's ability to go outside the provider network. Under the HMO option, coverage applies only to care you get from providers who are part of the HMO's network. Health care you get from providers outside the network is usually not covered.

Under the POS option, members are covered for services provided by both providers in and outside of the plan's network. Members usually pay a deductible and coinsurance. For a description of the differences between HMO and POS plans, see the table on page 4.

Enrollment and cost

Individuals may enroll in either of these plan options at any time and may not be denied coverage for health reasons. The price of coverage is based on a "community rate," which is the average cost offered to all individuals seeking the same coverage from the same HMO in a geographic region.

For questions about individual coverage, contact:

New York State Insurance Department
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
1-800-342-3736

www.ins.state.ny.us

Coverage of pre-existing conditions

For a pre-existing medical condition, a member may have to wait up to a year for coverage of the condition if it was diagnosed and treated within six months prior to the date an application for coverage was filed. In most cases, the waiting period can be reduced if the member was previously covered and applied within 63 days of the expiration of that coverage. It is important for members to not let their insurance coverage lapse beyond this period of time. Contact individual health insurers for details about how the plan credits previous coverage related to the pre-existing condition waiting period.

Standardized benefits and out-of-pocket costs

A table outlining the benefits and out-of-pocket costs of the two standardized plans begins on the next page.

Premium rates

Tables showing the high and low premium rates for the standard individual health plans begin on page 62.

Standardized Benefits and Out-of-Pocket Costs

The table shows the schedule of standardized benefits and the amount of out-of-pocket costs for covered services for individuals buying a standardized HMO or POS plan on their own and not through an employer.

	What You Pay		
	HMO	POS	
		Network	Out-of-Network (after deductible) ^a
Doctor's Services			
Allergy Testing and Treatment	\$15/visit	\$10/visit	20%
Anesthesia	\$15/visit	\$10/visit	20%
Bone Mineral Density Measurements & Tests	\$15/visit	\$10/visit	20%
Delivery of Child	20% up to \$200	\$10	20%
Diagnostic Services and Treatments	\$15/visit	\$10/visit	20%
Mammography Screening	\$15/visit	\$10/visit	20%
Obstetrical/Gynecological Services	\$15/visit	\$10/visit	20%
Office Visits	\$15/visit	\$10/visit	20%
Pre- and Post-Natal Care	No Cost	No Cost	20%
Radiation Therapy and Chemotherapy	\$15/visit	\$10/visit	20%
Second Surgical Opinions	\$15/visit	No Cost	0% ^b
Surgical Services (per occurrence)	20% up to \$200	\$10/visit	20%
Well-Child Care (including immunizations)	No Cost	No Cost	Not covered
X-ray and Laboratory Services	\$15/visit	\$10/visit	20%
Hospital Services			
Inpatient Admission	\$500	No Cost	20%
Outpatient Surgery	\$75/visit	No Cost	20%
Ambulance Service	No Cost	No Cost	20%
Emergency Room Care (no admission to hospital)	\$50/visit	\$35/visit	20%
Hospital Alternatives			
Skilled Nursing Facility	No Cost	No Cost	20%
Home Health Care (200 visit limit)	\$15/visit	\$10/visit	20% ^b
Hospice Care – Inpatient (combined benefit of 210 days)	\$500	No Cost	20%
Hospice Care – Outpatient	\$15/visit	\$10/visit	20%
Private Duty Nursing			
\$5,000 maximum per calendar year (\$10,000 lifetime max)	\$15/visit	\$10/visit	20%

	What You Pay		
	HMO	POS	
		Network	Out-of-Network (after deductible) ^a
Rehabilitative Services			
Physical Therapy – Inpatient	\$500	No Cost	20%
Physical Therapy – Outpatient (limited to 90 days per condition per calendar year)	\$15/visit	\$10/visit	20%
Prescription Drugs (including contraceptive drugs & FDA-approved devices)			
\$100 deductible per individual per calendar year. \$300 per family per calendar year maximum deductible			
Retail – 34 day supply			
Generic	\$5	\$5	Not covered
Brand Name	\$10	\$10	Not covered
Mail Order – 90 day supply (may not be included in your plan)			
Generic	\$10 ^b	\$20 ^b	Not covered
Brand Name	\$10 ^b	\$20 ^b	Not covered
Alcoholism, Substance Abuse and Mental Nervous Conditions			
Mental Health – Inpatient admission (limited to 30 days combined with inpatient detoxification benefit)	\$500	No Cost	0% ^b
Mental Health – Outpatient (limited to 30 visits for regular treatment and 3 visits for crisis intervention)	10%	10%	10%
Inpatient Detoxification (limited to 30 days combined with inpatient mental health benefit)	\$500	No Cost	0% ^b
Durable Medical Equipment	No Cost	No Cost	20%
Diabetic Equipment and Supplies	\$15/item	\$10/item	20%
Prosthetic and Orthotic Devices			
Prosthetic Limbs, Artificial Eyes and External Breast Prostheses	No Cost	No Cost	20%
Deductibles			
Individual per Calendar Year	None	None	\$1,000
Family per Calendar Year	None	None	\$2,000
Maximum Out-of-Pocket Costs			
Individual Per Calendar Year	\$1,500	None	\$3,000
Family Per Calendar Year	\$3,000	None	\$5,000
Lifetime Maximum	None	None	\$500,000 ^c

^a After the deductible is paid, the coinsurance payable is based upon the usual, customary and reasonable fee or a comparable fee schedule. After deductible and coinsurance requirements are met, your plan pays 100% of the usual, customary and reasonable fee or 100% of a comparable fee schedule for services covered under the plan. You are always responsible for fees exceeding the usual, customary and reasonable fee or comparable fee schedule.

^b Not subject to deductible.

^c An HMO is not required to pay more than \$500,000 in out-of-network lifetime benefits per policy.

Appendix 3

High and Low Premiums by Region

The information in the tables that follow reflects the highest and lowest monthly premiums for people buying insurance on their own in various regions of New York State. The tables also include highest and lowest monthly premiums for the Healthy NY program. The charts show big differences in costs between HMOs and POS plans. Healthy NY premiums generally will be lower than the more comprehensive coverage offered through HMO/POS plans.

For the premium rates for HMO standard individual health plans, by county, contact the New York Department of Insurance at 1-800-342-3736 or visit their Web site at www.ins.state.ny.us. Healthy NY premiums can be found at www.healthyny.com.

IMPORTANT: The premium information is current as of June 2004. Since premiums vary from plan to plan and are subject to change, please contact an HMO that you are interested in for the most current premium information.

Not all HMOs provide services in every area of the State. Refer to the service area information shown on pages 36 and 37 of the Guide and verify this with the HMO.

Since State law requires HMOs to offer only individual and family health coverage options, not every HMO offers Husband/Wife or Parent/Child(ren) coverage options. Please contact the HMO you are interested in for more information. Phone numbers for all insurers in this Guide are listed on pages 65-66.

Albany Area — Includes Albany, Clinton, Essex, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$706.55	\$346.86	\$806.96	\$565.19	\$175.24	\$125.50	\$154.21	\$110.44
Husband/Wife	\$1,503.92 ^a	\$693.72	\$1,724.24 ^a	\$1,188.40	\$350.48	\$257.28	\$308.42	\$226.41
Parent/Child(ren)	\$1,572.74 ^b	\$624.35	\$1,807.82 ^b	\$1,069.56	\$338.29	\$219.73	\$297.70	\$193.36
Family	\$1,891.56	\$1,040.58	\$2,160.41	\$1,469.56 ^a	\$525.72	\$342.51	\$462.63	\$301.41

^a Premium for a family. Insurer offers individual and family coverage.

^b Premium for a family. Insurer offers individual, husband/wife and family coverage only.

Buffalo Area — Includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$525.32	\$335.73	\$591.47	\$368.70	\$135.12	\$106.98	\$118.90	\$94.14
Husband/Wife	\$1,077.56 ^a	\$680.42	\$1,421.16 ^a	\$752.72	\$325.93	\$219.30	\$286.82	\$192.98
Parent/Child(ren)	\$1,404.23 ^b	\$680.42 ^c	\$1,542.55 ^b	\$752.72 ^d	\$265.72	\$202.10	\$233.84	\$176.49
Family	\$1,508.75	\$930.87	\$1,762.37	\$1,022.27	\$431.19	\$337.41	\$379.44	\$296.92

Hudson Valley Area — Includes Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan and Ulster Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$745.14	\$346.86	\$851.04	\$561.48	\$209.72	\$125.50	\$184.55	\$110.44
Husband/Wife	\$1,514.32 ^a	\$693.72	\$1,734.85 ^a	\$1,123.08	\$461.38	\$257.28	\$406.01	\$226.41
Parent/Child(ren)	\$1,572.74 ^b	\$539.25 ^e	\$1,807.82 ^b	\$993.84	\$387.98	\$219.73	\$341.42	\$193.36
Family	\$1,994.92	\$907.30 ^f	\$2,352.24	\$1,469.56 ^a	\$629.15	\$342.51	\$553.66	\$301.41

Long Island Area — Includes Nassau and Suffolk Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$647.73	\$368.05	\$834.51	\$561.48	\$204.55	\$164.19	\$180.00	\$144.49
Husband/Wife	\$1,651.71 ^a	\$736.10	\$1,982.09 ^a	\$1,123.08	\$426.58	\$340.20	\$375.39	\$299.38
Parent/Child(ren)	\$1,651.71 ^a	\$539.25 ^g	\$1,982.09 ^a	\$993.84	\$380.45	\$300.25	\$334.79	\$264.22
Family	\$1,774.75	\$907.30 ^h	\$2,503.53	\$1,668.96	\$625.71	\$484.79	\$550.61	\$426.62

^a Premium for a family. Insurer offers individual and family coverage only.

^b Premium for a family. Insurer offers individual, husband/wife and family coverage only.

^c Premium for two persons. The lowest rate for a parent with two or more children is \$847.35.

^d Premium for two persons. The lowest rate for a parent with two or more children is \$989.79.

^e Premium for a parent with a child. The lowest rate for a parent with two or more children is \$624.35.

^f Premium for a couple with a child. The lowest rate for a couple with two or more children is \$1,040.58.

^g Premium for a parent with a child. The lowest rate for a parent with two children is \$710.45. The lowest rate for a parent with three or more children is \$760.12.

^h Premium for a couple with a child. The lowest rate for a couple with two children is \$1,078.50. The lowest rate for a couple with three children is \$1,249.70. The lowest rate for a couple with four or more children is \$1,296.68.

ⁱ Premium for a parent with a child. The lowest rate for a parent with two or more children is \$567.24.

New York City Area — Includes Bronx, Kings, New York, Queens and Richmond Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$647.73	\$309.41	\$834.51	\$335.19	\$207.69	\$160.59	\$182.76	\$141.32
Husband/Wife	\$1,651.71 ^a	\$693.06	\$1,982.09 ^a	\$750.82	\$456.91	\$321.18	\$402.08	\$282.64
Parent/Child(ren)	\$1,651.71 ^a	\$539.25 ⁱ	\$1,982.09 ^a	\$614.51	\$384.22	\$300.25	\$338.11	\$264.22
Family	\$1,774.75	\$903.45	\$2,503.53	\$978.74	\$625.71	\$481.78	\$550.61	\$423.96

Rochester Area — Includes Livingston, Monroe, Ontario, Seneca, Wayne and Yates Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$507.68	\$425.26	\$547.34	\$470.46	\$143.37	\$124.35	\$118.68	\$98.79
Husband/Wife	\$1,051.54 ^a	\$680.42	\$1,178.20 ^a	\$752.72	\$353.51	\$281.85	\$251.69	\$243.57
Parent/Child(ren)	\$1,051.54 ^a	\$680.42 ^b	\$1,178.20 ^a	\$752.72 ^b	\$288.20	\$258.66	\$235.27	\$198.57
Family	\$1,523.00	\$978.10	\$1,642.03	\$1,082.05	\$379.45	\$340.72	\$314.93	\$261.45

Syracuse Area — Includes Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$642.77	\$419.61	\$734.11	\$490.67	\$192.00	\$128.09	\$168.96	\$112.71
Husband/Wife	\$1,503.92 ^a	\$838.32	\$1,724.24 ^a	\$1,010.76	\$422.59	\$262.58	\$371.88	\$231.07
Parent/Child(ren)	\$1,503.92 ^a	\$741.84	\$1,724.24 ^a	\$894.48	\$336.00	\$243.91	\$295.68	\$176.26
Family	\$1,720.81	\$1,126.63	\$1,965.37	\$1,262.51	\$548.34	\$363.76	\$485.42	\$310.77

Utica/Watertown Area — Includes Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego and St. Lawrence Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$706.55	\$419.16	\$806.96	\$490.67	\$192.00	\$128.09	\$168.96	\$112.71
Husband/Wife	\$1,503.92 ^a	\$838.32	\$1,724.24 ^a	\$1,010.76	\$422.59	\$262.58	\$371.88	\$231.07
Parent/Child(ren)	\$1,572.74 ^a	\$741.84	\$1,807.82 ^c	\$894.48	\$338.29	\$243.91	\$297.70	\$214.64
Family	\$1,891.56	\$1,138.52	\$2,160.41	\$1,275.73	\$551.60	\$363.76	\$485.42	\$317.22

Westchester Area — Includes Westchester and Rockland Counties.

Coverage	HMO		POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$745.14	\$368.05	\$851.04	\$561.48	\$227.95	\$156.86	\$200.60	\$138.04
Husband/Wife	\$1,651.71 ^a	\$736.10	\$1,982.09 ^a	\$1,123.08	\$501.50	\$320.10	\$441.32	\$281.69
Parent/Child(ren)	\$1,651.71 ^a	\$539.25 ^d	\$1,982.09 ^a	\$993.84	\$421.71	\$298.04	\$371.11	\$262.28
Family	\$1,994.92	\$907.30 ^e	\$2,503.53	\$1,668.96	\$683.86	\$456.92	\$601.80	\$402.09

^a Premium for a family. Insurer offers individual and family coverage only.

^b Premium for two persons.

^c Premium for a family. Insurer offers individual, husband/wife and family coverage.

^d Premium for a parent with a child. The lowest rate for a parent with two children is \$710.45. The lowest rate for a parent with three or more children is \$824.28.

^e Premium for a couple with a child. The lowest rate for a couple with two children is \$1,078.50. The lowest rate for a couple with three children is \$1,249.70. The lowest rate for a couple with four or more children is \$1,377.31.

Appendix 4

Telephone Numbers of Health Insurers

HMOs ^a	
Aetna Health	800-872-3862
AmeriHealth Health Plan	800-877-9829
Atlantis	212-747-0877
CDPHP	800-777-2273
CIGNA	800-345-9458
Community Blue (HealthNow)	800-544-2583
Empire HealthChoice	800-261-5962
Excellus	
Finger Lakes HMO & Blue Choice	800-462-0108
Upstate HMO	800-722-7884
Univera	800-337-3338
GHI-HMO Select	877-244-4466
Health Net of New York	800-848-4747
HIP of Greater New York	800-447-8255
Horizon Healthcare	866-326-3389
IHA	800-453-1910
MagnaHealth	800-352-6465
Managed Health (also Health First)	888-260-1010
MDNY	800-707-6369
MVP Health Plan	888-687-6277
Oxford	800-666-1353
Rochester Area HMO (Preferred Care)	800-950-3224
UnitedHealthcare of NY	800-705-1691
Vytra	800-406-0806
WellCare	800-288-5441

Non-profit Indemnity Insurers	
CDPHP Universal Benefits	800-777-2273
Excellus Health Plan, Inc.	800-847-1200
Group Health, Inc. (GHI)	800-444-2333
HealthNow New York, Inc.	800-888-0757
Independent Health Benefits Corporation	800-453-1910
Vytra Health Services	800-406-0806

^a Also includes HMOs with less than \$25 million in premium or fewer than 5,000 members.

Commercial Insurers ^b	
Aegon Group	
Stonebridge Life Insurance Company	800-527-3398
Transamerica Financial Insurance Company	888-617-6781
Aetna Group	860-273-0123
American Family Life	800-366-3436
Anthem Health & Life Ins. Co. of New York	718-370-5380
CIGNA Health Group	800-345-9458
Citigroup	800-221-4584
CNA Insurance Group	312-822-5000
Combined Life Ins. Co. of New York	800-951-6206
Empire HealthChoice Assurance, Inc.	800-261-5962
First Rehabilitation Life Ins. Co. of America	800-365-4999
First UNUM Life Insurance Co.	800-858-6843
Fortis Group	800-745-7100
GE Global Group	800-844-6543
Guardian Life Insurance	212-598-8000
Hartford F & C Group	860-547-5000
Health Net Insurance of New York	800-848-4747
Horizon Healthcare Ins. Co. of New York	877-237-1840

Commercial Insurers ^b (continued)	
John Hancock Mutual Life Ins. Company	800-732-5543
Metropolitan Group	800-MetLife
Mutual of Omaha Group	800-775-6000
MVP Health Ins. Co.	
New York Life Insurance Company	800-695-9873
Oxford Health Insurance Company	800-666-1353
Provident Life Group	212-953-1130
Prudential Insurance Company of America	800-THE-ROCK
Long Term Care	800-732-0416
Union Labor Group	
Individual	800-218-1044
Group	888-294-5787
UnitedHealthcare Insurance Group	800-705-1691
UnumProvident Life Group	212-953-1130
Zurich-American Insurance Companies	800-382-2150

^b Commercial insurers generally do not offer health insurance coverage to individuals.

Key Contacts

- **New York State Department of Insurance:**
1-800-342-3736
www.ins.state.ny.us
- **New York State Department of Health:**
1-800-206-8125
www.health.state.ny.us
- **Healthy NY:**
1-866-HEALTHY NY
(1-866-432-5849)
www.HealthyNY.com
- **Child Health Plus:**
1-800-698-4KIDS (1-800-698-4543)
- **Family Health Plus:**
1-877-934-7587
- **To Apply for an Independent External Review:**
1-800-400-8882
www.ins.state.ny.us/acrobat/extappl.pdf

