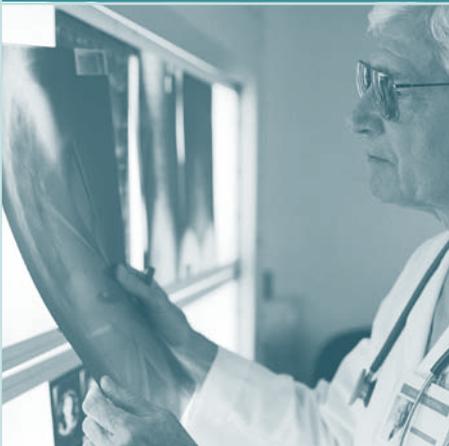




2005 NEW YORK CONSUMER GUIDE to

Health Insurers



State of New York
George E. Pataki
Governor

**State of New York
Department of Insurance**
Howard Mills
Superintendent of Insurance

**State of New York
Department of Health**
Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner of Health



STATE OF NEW YORK

September 1, 2005

Dear New Yorker:

New York State is committed to promoting a fair and competitive insurance marketplace and educating consumers about health insurance. 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.

Health insurance consumers need reliable information to compare the quality of companies offering coverage in New York State. This guide explains consumer complaints, the internal grievance procedure and how external appeals are handled. Telephone numbers of insurers are also provided.

Uninsured New Yorkers should pay particular attention to the recent enhancements to Healthy NY. These enhancements have broadened eligibility standards, eliminated co-payments for routine examinations of children and other well-child visits, and helped stabilize Healthy NY premiums for eligible New Yorkers.

I am confident this guide will help you select the health insurance plan that best fits your needs, and I invite you to review it carefully.

Very truly yours,

George E. Pataki
Governor

www.state.ny.us



STATE OF NEW YORK

September 1, 2005

Dear New Yorker:

As important as health insurance is to you and your family, so is choosing the right health insurance company or plan. In trying to assure that all New Yorkers get the best quality health insurance, the Pataki Administration has worked to enact meaningful health insurance reform for all New Yorkers. The Women's Health & Wellness Act of 2002, the Health Care Reform Act of 2000 and the External Review Law of 1998 are just a few examples of the major health insurance initiatives signed into law by Governor Pataki.

Governor Pataki and the New York State Legislature have also exhibited leadership in addressing New York State's uninsured population through the creation of Child Health Plus, Family Health Plus and the Healthy NY programs. Child Health Plus provides comprehensive health insurance to children who do not have health insurance. Family Health Plus provides comprehensive health insurance to lower income adults who are not eligible for Medicaid but do not have health insurance through their employers. Launched in 2001, Healthy NY is a state-sponsored health insurance program offering affordable health insurance benefits to New York's small business owners, sole proprietors and working uninsured individuals and their families. Changes to Healthy NY were made over the past couple of years to make coverage even more affordable for uninsured New Yorkers.

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

The guide also includes important information from the Department of Health on other measures of consumer satisfaction as well as clinical indicators of a health plan's quality of care. In addition, the guide includes information on New York State's external review experience of insurers and HMOs.

New Yorkers should have the opportunity to compare health plans on major quality of care and consumer services factors to help them to make the right health care coverage decisions. That's the primary objective of this guide. We're confident you will find this guide a valuable resource when choosing your health care insurer.

Very truly yours,

Howard Mills
Superintendent of Insurance
www.ins.state.ny.us

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner of Health
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About This Guide

The purpose of this Guide is to:

- Inform you about the health insurance products offered in New York State and how they work.
- Help you choose a health insurer based on information about the insurers' quality of care and service.

Data Sources

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

- **New York State Insurance Department (NYSID)** is responsible for supervising and regulating insurance business in New York State.
 - NYSID provided the:
 - Complaint and appeals information that appears in Chapter 2.
 - Grievance information that appears in Chapter 3.
 - NYSID collects data as part of its regulatory responsibilities.
 - NYSID data are from calendar year 2004.
- **New York State Department of Health (DOH)** works to protect and promote the health of New Yorkers through prevention, science and the assurance of quality health care delivery.
 - The New York State DOH provided information on HMO performance that appears in Chapter 3.
 - DOH collects the data through the New York State Department of Health's Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Health Plans (CAHPS®).
 - DOH data are from calendar year 2003.

Related Resources

2004 New York Managed Care Plan Performance

Report: This report is published by the NYDOH and contains the most recent information from member satisfaction surveys, standardized quality measures and the providers in the plans' networks. To obtain a copy, please call 518-486-6074 or download the report at www.health.state.ny.us/nysdoh/mancare/qarrfull/qarr_2004/qarintro.htm

Insurance Help For the Seriously Ill (and their Caregivers):

The following website provides detailed insurance information. It also includes information on health insurance rights and how to exercise these rights to ensure proper access to health insurance coverage. Visit: www.insurancehelpny.com

New York Consumer Guide to HMOs: This guide includes information and data comparing HMO performance and premiums, historical complaint data and tips on how to choose an HMO. Visit: www.nyshmoguide.org

Have Questions about 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.*

GENERAL INFORMATION

CHAPTER ONE

2005 NEW YORK CONSUMER GUIDE to

Health Insurers



Understanding Health Insurance

Different Ways to Get Health Insurance

1. Buy individual health insurance directly from an HMO

New York requires all health maintenance organizations (HMO) to offer standardized HMO and point of service (POS) plans to people who buy health insurance on their own. Chapter 4 (page 47) has information about covered benefits for these plans. Premium information is on pages 59-61.

2. Qualify for reduced cost health insurance through New York State programs

Individuals may also qualify to obtain insurance through various New York State programs such as Healthy NY, Child Health Plus and Family Health Plus. Details of these programs appear in Chapter 4 on pages 48-50.

3. 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 below.

- **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. (See page 6 for a summary of New York's consumer protection laws.)
- **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 (summarized on page 6) do not apply. If you are uncertain, ask your employer's benefit manager if the health coverage provided is self-insured.

- **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.

How to Choose a Health Insurer

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

Use the Comparison of Different Types of Health Insurance Coverage table on the next page to familiarize yourself with the different types of plans.

Step 2: Compare the costs

Compare the amount of 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 insurer offers 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 specialists, 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 insurer performed best in this Guide

The Guide provides information about the quality of care and services provided by New York insurers. Compare the results among the insurers you are interested in based on Steps 1-4. Consider all the results that contribute to the insurer's performance. Small differences in results 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.

To learn about commonly used health insurance terms, refer to the **Glossary of Health Insurance Terms on pages 53-54.**

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.

	Health Maintenance Organizations		Non-profit Indemnity Insurers and Commercial Insurers	
	HMO A health insurer that directly contracts with or employs a network of doctors, hospitals and other types of providers.	HMO/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.	Fee-for-Service You and the insurer each pay for part of the costs for health care services that you receive. There is no specific network of providers.	PPO Most similar to traditional fee-for-service coverage except has a network of providers. 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 get care from in-network or out-of-network providers. When you go out-of-network, you will usually pay more and fewer services are covered.	You have an unlimited choice of doctors and hospitals.	You may get care from in-network or out-of-network providers. When you go out-of-network, you will usually pay more.
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 need a referral to a specialist.	You do not usually need a referral to go to a specialist; however, certain services may require pre-authorization from your health insurer.
How do you pay for services in-network?	There is no deductible. You pay a copayment (typically between \$10 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.	In fee-for-service there are no "in-network" or "out-of-network" options. Your doctor or hospital charges 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.	You pay a small copayment. Network providers agree not to charge more than the insurer's allowable charge. May require members to satisfy an annual deductible.
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.

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 the next page.
- 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 HMO 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)

Your Right to Appeal an Insurer's Decision

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 must 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 as stated above.

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.

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.

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

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 a Workers Compensation claim or for a claim under no-fault auto coverage.

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. 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.

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 because the service is considered experimental, investigational or not medically necessary, review the prior section about appealing an insurer's decision or contact:

www.ins.state.ny.us/extappqa.htm

1-800-400-8882 (independent 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)

COMPLAINT AND
APPEAL INFORMATION FOR
ALL TYPES OF INSURERS
CHAPTER TWO

2005 NEW YORK CONSUMER GUIDE to

Health Insurers



Overview

This chapter contains information about the volume of complaints and appeals for each New York insurer.

The State of New York groups insurers into three categories:

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

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 5.

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.

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 annual premium. Premium 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 2004. 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 2004. Premiums are used in calculating the complaint ratio so that different sized insurers can be compared fairly.

Membership:* Membership in each plan as of 12/31/04, including spouses and children.

* Premium and Membership data exclude Medicare and Medicaid.

Complaints – HMOs, 2004

Data sources: NYSID

HMOs are listed alphabetically. HMOs with a lower ratio receive a better rank (1=best, 16=worst).

HMO ^a	Rank ^b	Total Complaints to NYSID	Upheld Complaints to NYSID	Total Complaints to DOH ^c	Upheld Complaints to DOH ^c	Premium (Millions \$)	Membership (as of 12/31/04)	Complaint Ratio
Aetna Health	13	766	303	10	1	1,053.6	288,854	0.288
CDPHP	3	74	7	0	0	698.9	241,245	0.010
CIGNA	14	214	67	4	0	145.7	36,977	0.460
Community Blue (HealthNow)	7	363	81	1	1	866.8	304,517	0.093
Empire HealthChoice	6	704	52	12	1	1,279.0	452,152	0.041
Excellus ^d	5	140	36	6	3	1,355.0	523,049	0.027
GHI-HMO Select	12	124	28	16	7	104.6	44,494	0.268
Health Net of NY	11	475	122	42	14	653.1	201,113	0.187
HIP ^e	10	836	275	32	13	1,821.1	579,763	0.151
IHA	2	62	3	0	0	590.4	236,429	0.005
MDNY	16	308	249	23	8	135.2	40,140	1.842
MVP Health Plan	4	128	14	0	0	975.2	327,452	0.014
Oxford ^f	9	1,353	347	30	14	2,435.3	661,520	0.142
Rochester Area HMO (Preferred Care)	1	78	1	5	3	236.5	95,866	0.004
UnitedHealthcare of NY ^f	15	165	52	16	4	68.4	52,830	0.760
Vytra	8	235	28	21	4	261.2	84,735	0.107
TOTAL		6,025	1,665	218	73	12,679.9	4,171,136	Avg.=0.131

NOTE: The complaint ratio does not include Department of Health (DOH) complaints.

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

^b The table ranks insurers by complaint ratio.

^c These complaints were received and closed in 2004 by the NY State Department of Health (DOH). They are not included in the complaint ratios.

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

^e Complaint ratios, Insurance Department complaints, and premiums include data from Health Insurance Plan's (HIP's) HMO and non-HMO business. In 2004, roughly 2% of HIP's business was attributable to its non-HMO operation.

^f The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

Complaints – Non-profit Indemnity Insurers, 2004

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 ^b	Total Complaints	Upheld Complaints	Premium (Millions \$)	Complaint Ratio
Excellus Health Plan, Inc.	3	302	67	2,218.2	0.030
Group Health, Inc. (GHI)	4	1,093	277	2,302.2	0.120
HealthNow NY, Inc.	2	131	19	797.3	0.024
Vytra Health Services	1	65	1	57.2	0.017
TOTAL		1,591	364	5,374.9	Avg.=0.068

^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 2004, 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.

^b The table ranks insurers by complaint ratio.

Complaints – Commercial Insurers, 2004

Data source: NYSID

Insurers are listed alphabetically. Insurers with a lower ratio receive a better rank (1=best, 27=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	12	10	1	74.7	0.013
Aetna Group	16	79	15	490.0	0.031
AIG Group	18	27	5	128.0	0.039
American Family Life	11	7	1	90.0	0.011
CIGNA Health Group	20	251	83	1,767.2	0.047
Citigroup	3	4	0	99.5	0.000
CNA Insurance Group	10	20	1	110.7	0.009
Combined Life	24	33	9	122.1	0.074
Empire HealthChoice Assurance	14	754	74	3,421.8	0.022
First Rehabilitation Life Ins. Co. of Am.	5	1	0	73.9	0.000
Fortis Group	15	4	2	68.8	0.029
GE Global Group	1	7	0	175.2	0.000
Guardian Life Group	21	189	32	505.0	0.063
Hartford F&C Group	2	5	0	149.1	0.000
Health Net Ins. of NY	27	293	117	220.5	0.531
Horizon Healthcare Ins. Co. of NY	26	162	66	172.5	0.383
John Hancock Life Insurance Co.	19	13	5	125.8	0.040
Metropolitan Group	17	81	12	379.7	0.032
Mutual of Omaha Group	13	10	1	68.6	0.015
MVP Health Ins. Corp.	22	15	6	93.6	0.064
New York Life Ins. Co.	7	2	0	59.7	0.000
Northwestern Mutual Group	8	0	0	59.4	0.000
Oxford Health Insurance ^c	23	545	126	1,871.0	0.067
Prudential Ins. Co. of America	6	5	0	65.8	0.000
UnitedHealthCare Ins. Co. of NY ^c	25	1,018	367	2,787.2	0.132
UnumProvident Corp. Group	9	6	2	457.6	0.004
Zurich Insurance Group	4	0	0	74.9	0.000
TOTAL		3,541	925	13,712.3	Avg.=0.067

^a Excludes commercial insurers with less than \$50 million in premium. Many of the commercial companies listed 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. If the ratios are the same, the insurer with the higher annual premium amount is ranked higher.

^c The holding companies for Oxford Health Insurance and UnitedHealthCare Ins. Co. of NY merged in 2004, however the two individual companies remain independent and report data separately.

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.

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 2004. 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 2004.
- **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 2004. 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 12/31/04, including spouses and children.

* Premium and Membership data exclude Medicare and Medicaid.

Prompt Pay Complaints – HMOs, 2004

Data source: NYSID

HMOs are listed alphabetically. HMOs with a lower ratio receive a better rank (1=best, 16=worst).

HMO ^a	Rank ^b	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Membership (as of 12/31/04)	Prompt Pay Complaint Ratio
Aetna Health	13	766	428	211	1,053.6	288,854	0.200
CDPHP	1	74	9	1	698.9	241,245	0.001
CIGNA	15	214	162	55	145.7	36,977	0.377
Community Blue (HealthNow)	7	363	227	44	866.8	304,517	0.051
Empire HealthChoice	6	704	275	28	1,279.0	452,152	0.022
Excellus ^c	5	140	30	15	1,355.0	523,049	0.011
GHI-HMO Select	12	124	49	16	104.6	44,494	0.153
Health Net of NY	11	475	265	82	653.1	201,113	0.126
HIP ^d	10	836	572	204	1,821.1	579,763	0.112
IHA	2	62	23	1	590.4	236,429	0.002
MDNY	16	308	259	228	135.2	40,140	1.686
MVP Health Plan	4	128	41	6	975.2	327,452	0.006
Oxford ^e	8	1,353	445	141	2,435.3	661,520	0.058
Rochester Area HMO (Preferred Care)	3	78	69	1	236.5	95,866	0.004
UnitedHealthcare of NY ^e	14	165	84	22	68.4	52,830	0.322
Vytra	9	235	147	22	261.2	84,735	0.084
TOTAL		6,025	3,085	1,077	12,679.9	4,171,136	Avg.=0.085

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

^b The table ranks insurers by complaint ratio.

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

^d Complaint ratios, Insurance Department complaints, and premium include data from Health Insurance Plan's (HIP's) HMO and nonprofit 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 nonprofit operation.

^e The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

**Prompt Pay Complaints –
Non-profit Indemnity Insurers, 2004**

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 ^b	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Excellus Health Plan, Inc.	2	302	98	32	2,218.2	0.014
Group Health, Inc. (GHI)	4	1,093	444	141	2,302.2	0.061
HealthNow NY, Inc.	3	131	35	12	797.3	0.015
Vytra Health Services	1	65	44	0	57.2	0.000
TOTAL		1,591	621	185	5,374.9	0.034

^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.

^b The table ranks insurers by complaint ratio.

COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

**Prompt Pay Complaints –
Commercial Insurers, 2004**

Data source: NYSID

Insurers are listed alphabetically. Insurers with a lower ratio receive a better rank (1=best, 27=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	9	10	2	0	74.7	0.000
Aetna Group	16	79	29	3	490.0	0.006
American Family Life	17	7	1	1	90.0	0.011
AIG Group	19	27	7	1	128.0	0.008
CIGNA Health Group	22	251	129	50	1,767.2	0.028
Citigroup	6	4	0	0	99.5	0.000
CNA Insurance Group	5	20	3	0	110.7	0.000
Combined Life	24	33	10	4	122.1	0.033
Empire HealthChoice Assurance	20	754	356	56	3,421.8	0.016
First Rehabilitation Life Ins. Co. of Am.	10	1	1	0	73.9	0.000
Fortis Group	11	4	1	1	68.8	0.000
GE Global Group	2	7	1	0	175.2	0.000
Guardian Life Group	21	189	86	13	505.0	0.026
Hartford F&C Group	3	5	1	0	149.1	0.000
Health Net Ins. of NY	27	293	139	57	220.5	0.258
Horizon Healthcare Ins. Co. of NY	26	162	86	41	172.5	0.238
John Hancock Life Insurance Co.	4	13	1	1	125.8	0.000
Metropolitan Group	18	81	47	4	379.7	0.011
Mutual of Omaha Group	12	10	3	0	68.6	0.000
MVP Health Ins. Corp.	7	15	11	5	93.6	0.000
New York Life Ins. Co.	14	2	2	0	59.7	0.000
Northwestern Mutual Group	15	0	0	0	59.4	0.000
Oxford Health Insurance ^c	23	545	139	53	1,871.0	0.028
Prudential Ins. Co. of America	13	5	2	0	65.8	0.000
UnitedHealthCare Ins. Co. of NY ^c	25	1,018	461	237	2,787.0	0.085
Unumprovident Corp. Group	1	6	1	0	457.6	0.000
Zurich Insurance Group	8	0	0	0	74.9	0.000
TOTAL		3,541	1,519	527	13,712.1	0.038

^a Excludes commercial insurers with less than \$50 million in premium. Many of the commercial companies listed 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. If the ratios are the same, the insurer with the higher annual premium amount is ranked higher.

^c The holding companies for Oxford Health Insurance and UnitedHealthCare Ins. Co. of NY merged in 2004, however the two individual companies remain independent and report data separately.

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.

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 2004.
- **Closed Appeals:** Number of UR appeals that the health insurer was able to reach a decision on by the close of 2004.
- **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, an unusually low reversal rate may indicate 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, an unusually high reversal rate may indicate 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, 2004

Data source: NYSID

HMOs are listed alphabetically.

HMO ^a	Filed Appeals	Closed Appeals ^b	Reversed Appeals	Reversal Rate
Aetna Health ^c	692	679	342	50%
CDPHP	464	467	140	30%
CIGNA	253	250	121	48%
Community Blue (HealthNow)	824	811	301	37%
Empire HealthChoice	215	218	75	34%
Excellus ^d	579	578	154	27%
GHI-HMO Select	115	114	74	65%
Health Net of NY	893	908	378	42%
HIP ^e	130	135	86	64%
IHA	155	146	50	34%
MDNY	365	362	194	54%
MVP Health Plan	776	765	152	20%
Oxford ^f	4,263	4,316	1,714	40%
Rochester Area HMO (Preferred Care)	149	148	48	32%
UnitedHealthcare of NY ^f	61	64	17	27%
Vytra	145	145	69	48%
TOTAL	10,079	10,106	3,915	Avg.=39%

^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 2004 because closed UR appeals also include UR appeals filed prior to 2004.

^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 nonprofit business. In 2004, roughly 2% of HIP's business was attributable to its nonprofit operation.

^f The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

**Utilization Review Appeals –
Non-profit Indemnity Insurers, 2004**

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.	582	572	195	34%
Group Health, Inc. (GHI)	5,969	6,029	3,679	61%
HealthNow NY, Inc.	304	321	127	40%
Vytra Health Services	66	66	38	58%
TOTAL	6,921	6,988	4,039	Avg.=58%

^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 2004 because closed UR appeals also include UR appeals filed prior to 2004.

COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

Utilization Review Appeals – Commercial Insurers, 2004

Data source: NYSID

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 Insurance of Connecticut	0	0	0	0%
Aetna Life Ins. Co.	282	288	95	33%
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.	1,516	1,396	666	48%
Empire HealthChoice Assurance	550	543	201	37%
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.	15	14	13	93%
Guardian Life Ins. Co. of America	1,399	1,418	971	68%
Hartford Life Ins. Co.	0	0	0	0%
Health Net Insurance of NY	184	178	69	39%
Horizon Healthcare Insurance	154	154	51	33%
John Hancock Life Ins. Co.	0	0	0	0%
Metropolitan Life Ins. Co.	2,990	2,990	2,511	84%
Mutual of Omaha Insurance	35	33	21	64%
MVP Health Ins. Co.	20	22	6	27%
New York Life Ins. Co.	0	0	0	0%
Northwestern Mutual Life Ins. Co.	0	0	0	0%
Oxford Health Insurance ^d	2,203	2,274	695	31%
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 ^d	1,900	1,922	159	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	11,248	11,232	5,458	Avg.=49%

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 2004 because closed UR appeals also include UR appeals filed prior to 2004.

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

^d The holding companies for Oxford Health Insurance and UnitedHealthCare Ins. Co. of NY merged in 2004, however the two individual companies remain independent and report data separately.

Independent External Reviews

When your insurer denies health care services because it contends the 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 must agree jointly to waive the internal appeal process. (See page 7 for more information about how to request an external review.)

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.

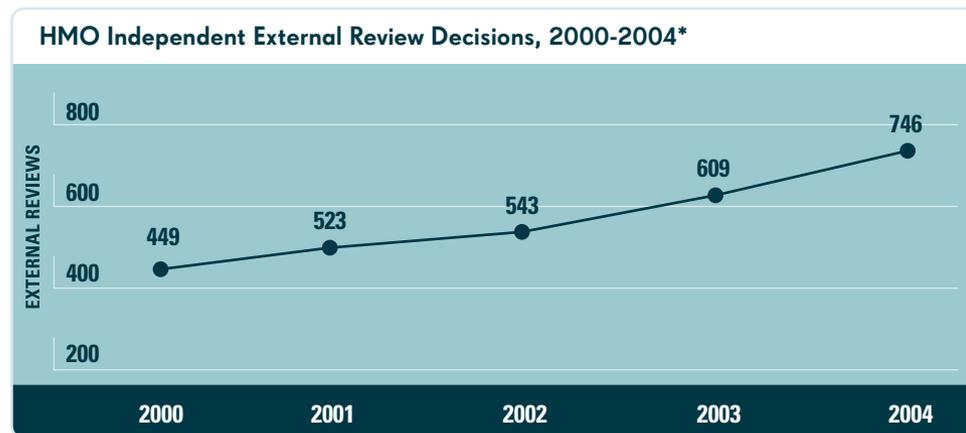
The **reversal rate** is the percentage of cases in which the external review agent decides that the insurer's decision to deny coverage should be changed. In other words, the reversal rate is the percentage of reviews decided in favor of the consumer. Please note that **reversed in part** decisions *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 2004.
- **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.

New Yorkers are requesting more independent external reviews. Since 2000, the number of HMO external review decisions has increased 66%.



*External review requests to HMOs with less than \$25 million in annual premium (*i.e.*, HMOs not listed in the New York Insurance Department's Annual Consumer Guide to Health Insurers) are excluded from totals.

Independent External Reviews - HMOs, 2004

Data source: NYSID

HMOs are listed alphabetically.

HMO ^a	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ^b
Aetna Health	30	12	2	16	47%
CDPHP	13	4	0	9	31%
CIGNA	16	12	0	4	75%
Empire HealthChoice	112	49	5	58	48%
Excellus ^c	59	21	4	34	42%
GHI-HMO Select	2	1	1	0	100%
Health Net of NY	61	22	1	38	38%
HealthNow New York, Inc. (Community Blue HMO)	87	21	1	65	25%
HIP ^d	34	13	4	17	50%
IHA	5	2	0	3	40%
MDNY	5	1	2	2	60%
MVP Health Plan	18	8	2	8	56%
Oxford ^e	290	96	29	165	43%
Rochester Area HMO (Preferred Care)	7	4	1	2	71%
UnitedHealthcare of NY ^e	0	0	0	0	0%
Vytra	7	3	0	4	43%
TOTAL	746	269	52	425	Avg.=43%

^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 nonprofit business. In 2004, roughly 2% of HIP's business was attributable to its nonprofit operation.

^e The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

**Independent External Reviews –
Non-profit Indemnity Insurers, 2004**

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	75	33	4	38	49%
Group Health, Inc. (GHI)	93	26	13	54	42%
HealthNow NY, Inc.	27	7	0	20	26%
Vytra Health Service	0	0	0	0	0%
TOTAL	195	66	17	112	Avg.=43%

^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.

COMPLAINT AND APPEAL INFORMATION FOR ALL TYPES OF INSURERS

Independent External Reviews – Commercial Insurers, 2004

Data source: NYSID

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	7	2	1	4	43%
American Family Life	0	0	0	0	0%
AIG Group	0	0	0	0	0%
CIGNA Health Group	5	0	1	4	20%
Citigroup	0	0	0	0	0%
CNA Insurance Group	1	1	0	0	100%
Combined Life	0	0	0	0	0%
Empire HealthChoice Assurance	182	78	18	86	53%
First Rehabilitation Life Ins. Co. of Am.	0	0	0	0	0%
Fortis Group	0	0	0	0	0%
GE Global Group	1	0	0	1	0%
Guardian Life Group	8	3	1	4	50%
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	19	5	4	10	47%
John Hancock Life Insurance Co.	0	0	0	0	0%
Metropolitan Group	13	7	0	6	54%
Mutual of Omaha Group	0	0	0	0	0%
MVP Health Ins. Corp.	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 ^c	47	22	3	22	53%
Prudential Ins. Co. of America	0	0	0	0	0%
UnitedHealthCare Ins. Co. of NY ^c	72	35	2	35	51%
Unumprovident Corp. Group	0	0	0	0	0%
Zurich Insurance Group	0	0	0	0	0%
TOTAL	355	153	30	172	Avg.=52%

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.

^c The holding companies for Oxford Health Insurance and UnitedHealthCare Ins. Co. of NY merged in 2004, however the two individual companies remain independent and report data separately.

QUALITY OF CARE
AND SERVICE FOR HMOS
CHAPTER THREE

2005 NEW YORK CONSUMER GUIDE to

Health Insurers



Overview

On the following pages, you will find information about:

- 1. HMO Service Areas** (pages 32-33) - 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 34-35): 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 36-37): Shows how well HMOs ensured that children received well-child and preventive care visits, women received chlamydia screening, diabetics received an eye exam, members who had an acute cardiovascular event had their cholesterol level tested and had a good result, and members who were hospitalized for mental illness received appropriate treatment and follow-up.

- Quality of Providers (pages 38-39): 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 their HMO in the last year.

3. Grievances (pages 40-41) - Shows how often HMO members or providers complained directly to the HMO about an action or decision.

4. NCQA Accreditation (pages 42-43) - Lists the accreditation status of New York’s HMOs as determined by NCQA, an independent non-profit organization that assesses managed care organizations. For more information on NCQA, visit www.ncqa.org.

5. How HMOs Pay Primary Care Physicians (page 44) - 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 QARR and CAHPS® data reported were collected from calendar year 2003.*

* Grievance data are based on information from the New York State Insurance Department. 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
 Current as of June 2005

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			•	•	•				•
Empire HealthChoice	•		•	•	•				•
Excellus ^b	•	•	•			•	•	•	
GHI-HMO Select	•	•	•	•	•		•	•	•
Health Net of NY			•	•	•				•
HealthNow	•	•	•			•	•	•	
HIP			•	•	•				•
IHA		•							
Managed Health				•	•				
MDNY				•					

table continued on next page

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

^a Service areas are current as of 6/1/05. Also includes HMOs with less than \$25 million in premium or fewer than 5,000 members.

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

HMO Service Areas^a

Current as of June 2005

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)		•				•			
United Healthcare of NY			•	•	•		•	•	•
Vytra				•	•				

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

^a Service areas are current as of 6/1/05. Also includes HMOs with less than \$25 million in premium or fewer than 5,000 members.

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.

For “Members Rating Their HMO...”
66% gave their HMO an 8, 9 or 10 rating.

Problems Getting Needed Care

Members responded that they had experienced a problem getting:

- a personal doctor they were happy with
- a referral to see a specialist
- care they and their doctor believed was necessary
- timely approvals for care

The New York HMO average is 23% in “Problems Getting Needed Care.” A lower score in this performance area represents better performance.

Getting Care Quickly

Members responded that they “usually” or “always”:

- get needed help or advice from their doctor’s office
- get appointments for regular or routine care as soon as they want
- get care right away for an illness or injury
- wait no more than 15 minutes past an appointment time to see a provider

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 provider visit.

Access and Service
Data source: DOH

Performance Compared to the New York HMO Average

- ★ Significantly *better* than the NY HMO average
- *Not significantly different* than the NY HMO average
- 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.	66%	23%	80%	93%	94%
Aetna	●	●	○	○	○
Blue Choice	★	★	★	○	★
BSNENY-HMO ^a	●	●	★	★	★
CDPHP	★	★	★	★	★
CIGNA	○	○	○	○	○
Community Blue	●	●	●	★	★
Empire	●	●	★	○	●
GHI-HMO Select	○	○	●	●	●
Health Net of NY	●	●	●	★	●
HIP	●	○	○	○	○
Independent Health	★	★	★	★	★
MDNY	○	●	○	★	★
MVP Health Plan	★	★	●	★	★
Oxford ^b	●	●	○	★	★
Preferred Care	★	★	★	★	★
UnitedHealthcare of NY ^b	●	●	●	○	●
Univera HealthCare	●	●	★	●	●
Upstate HMO	○	●	●	○	○
Vytra	●	●	○	★	★

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

^a Albany Division of Community Blue.

^b The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

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.

Well-Child & Preventive Visits in 3rd, 4th, 5th, or 6th Year of Life

It is important for children to receive well-child and preventive visits to receive proper immunizations and ensure good overall health. Plans were rated on the percentage of children (ages 3-6) who had a well-child visit or preventive health visit in the past year.

For “Well-Child & Preventive Visits in 3rd, 4th, 5th, 6th Years of Life,” 80% of children 3-6 years of age received a well-child visit or preventive health visit in the past year.

Chlamydia Screening (Ages 16-20)

Early detection of chlamydia is crucial to a women’s primary and preventive health care. Early detection and treatment of chlamydia prevents permanent reproductive damage. Plans were rated on the percentage of women (ages 16-20) who had at least one test for chlamydia within the past year.

Comprehensive Diabetes Care (Eye Exam)

It is important for diabetics to have regular eye exams to ensure that damage to the eye is not occurring as a result of high blood glucose levels. Plans were rated on the percentage of diabetic members who received an eye screening exam within the past two years.

Cholesterol Management After Acute Cardiac Events (LDL-C <100mg/dL)

Reducing bad cholesterol levels is important for reducing the risk of a recurring heart attack or stroke. Plans were rated on the percentage of members who had an acute cardiovascular event and who had a cholesterol test done with a good result (bad cholesterol LDL-C or cholesterol level <100mg/dL) within the year of the event.

Follow-Up After Hospitalization for Mental Illness (7 days)

Appropriate treatment and follow-up of mental illness can reduce the duration of disability from mental illness and the likelihood of recurrence. Plans were rated on the percentage of members (ages 6 and older) who were hospitalized for treatment for selected mental health disorders and were seen by a mental health provider within 7 days of discharge.

Staying Healthy and Living with Illness

Data source: DOH

Performance Compared to the New York HMO Average

- ★ Significantly *better* than the NY HMO average
- *Not significantly different* than the NY HMO average
- Significantly *worse* than the NY HMO average

HMO	Well-Child & Preventive Visits in 3rd, 4th, 5th, 6th Years of Life	Chlamydia Screening (Ages 16-20)	Comprehensive Diabetes Care (Eye Exam)	Cholesterol Management After Acute Cardiac Events (LDL-C <100 mg/dL)	Follow-Up After Hospitalization for Mental Illness (7 Days)
NY HMO Avg.	80%	37%	53%	54%	63%
Aetna	○	○	○	●	●
Blue Choice	★	★	★	●	★
BSNENY-HMO ^a	●	●	●	●	●
CDPHP	★	○	●	●	○
CIGNA	○	○	○	●	○
Community Blue	★	○	●	●	○
Empire	○	○	●	★	●
GHI-HMO Select	★	○	●	●	○
Health Net of NY	●	○	●	●	○
HIP	○	★	●	●	●
Independent Health	★	★	●	○	★
MDNY	★	○	○	●	●
MVP Health Plan	★	○	●	●	●
Oxford ^b	●	○	●	●	○
Preferred Care	★	★	★	●	★
UnitedHealthcare of NY ^b	○	○	○	●	●
Univera HealthCare	●	●	●	●	●
Upstate HMO	○	●	★	●	★
Vytra	★	○	○	●	●

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

^a Albany Division of Community Blue.

^b The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

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

For “How Well Doctors Communicate,” 92% of HMO 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 2003. 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

- ★ Significantly *better* than the NY HMO average
- *Not significantly different* than the NY HMO average
- 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)
			Primary Care	OB/GYN	Pediatric	
NY HMO Avg.	77%	92%	86%	79%	78%	5.0%
Aetna	●	●	○	★	○	2.8
Blue Choice	●	●	●	●	●	3.0
BSNENY-HMO ^a	●	●	★	●	●	3.7
CDPHP	●	★	○	●	●	6.7
CIGNA	●	○	○	○	●	4.1
Community Blue	○	●	●	★	○	4.8
Empire	●	●	★	★	●	3.5
GHI-HMO Select	●	★	●	●	●	3.4
Health Net of NY	●	○	○	●	★	8.2
HIP	○	○	○	○	○	10.0
Independent Health	●	★	○	●	●	5.7
MDNY	○	●	●	★	●	4.9
MVP Health Plan	●	●	★	●	●	5.1
Oxford ^b	●	○	★	●	★	2.7
Preferred Care	★	★	★	★	★	3.5
UnitedHealthcare of NY ^b	●	●	★	●	●	3.4
Univera HealthCare	●	●	○	○	○	5.8
Upstate HMO	★	●	★	●	●	6.7
Vytra	●	●	★	★	○	5.2

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

^a Albany Division of Community Blue.

^b The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

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 20 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.

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.

If you want more detail, 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, an unusually low reversal rate may 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, an unusually high reversal rate may indicate 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 – 2004

Data source: NYSID

HMOs are listed alphabetically.

HMO ^a	Filed Grievances	Closed Grievances ^b	Upheld Grievances	Reversed Grievances	Reversal Rate
Aetna Health	1,827	1,787	717	1,070	60%
CDPHP	2,419	2,427	903	1,524	63%
CIGNA	321	320	131	189	59%
Community Blue (HealthNow)	2,399	2,464	923	1,541	63%
Empire HealthChoice	480	476	387	89	19%
Excellus ^c	1,136	1,151	907	244	21%
GHI-HMO Select	411	402	162	240	60%
Health Net of NY	1,748	3,217	1,633	1,584	49%
HIP ^d	1,152	1,114	467	647	58%
IHA	1,082	1,052	663	389	37%
MDNY	342	338	143	195	58%
MVP Health Plan	287	284	170	114	40%
Oxford ^e	8,587	8,220	4,475	3,745	46%
Rochester Area HMO (Preferred Care)	345	307	201	106	35%
United Healthcare of NY ^e	220	233	139	94	40%
Vytra	269	269	223	46	17%
TOTAL	23,025	24,061	12,244	11,817	Avg.=49%

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

^b Closed grievances can exceed filed grievances in 2004 because closed UR appeals also include UR appeals filed prior to 2004.

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

^d Includes Health Insurance Plan's (HIP's) HMO and nonprofit business. In 2004, roughly 2% of HIP's business was attributable to its nonprofit operation.

^e The holding companies for Oxford HMO and UnitedHealthcare of NY merged in 2004, however the two individual companies remain independent and report data separately.

NCQA Accreditation

What Is NCQA?

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving the quality of health care. 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 2005

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) ^b	Excellent
CDPHP	Excellent
CIGNA	Commendable
Empire Health Choice	Excellent
Excellus BlueCross BlueShield, Rochester	Excellent
Excellus (Univera Healthcare HMO)	Excellent
Excellus (Upstate HMO)	Excellent
GHI-HMO Select	Excellent
Health Net of NY	Not NCQA Accredited ^c
HIP	Commendable
IHA	Excellent
MDNY	Not NCQA Accredited ^c
MVP Health Plan	Excellent
Oxford	Excellent
Rochester Area HMO (Preferred Care)	Excellent
UnitedHealthcare of NY	Excellent
Vytra	Excellent

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

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

^b Albany Division of Community Blue.

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

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

Per-service fee: 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.*

HEALTH INSURANCE OPTIONS
FOR UNINSURED NEW YORKERS
CHAPTER FOUR

2005 NEW YORK CONSUMER GUIDE to

Health Insurers



Available Insurance Options

Uninsured New Yorkers seeking health insurance can either:

- purchase coverage directly from an HMO (referred to as individual coverage), **or**
- apply for reduced-cost health insurance through New York State (eligibility requirements exist).

Choices available for individual coverage

New Yorkers purchasing health insurance on their own can choose from either an HMO or HMO/POS plan. For a description of the differences between HMO and HMO/POS plans, see the table on page 5.

You can purchase either of these benefit packages from HMOs operating in your area. See pages 32-33 to determine which HMOs operate in your area.

Enrollment and coverage of pre-existing conditions

Individuals may enroll in either an HMO or HMO/POS plan at any time and may not be denied coverage for health reasons. For a pre-existing medical condition, an individual 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 of the application for coverage. The waiting period may be reduced if the individual was previously covered and applied within 63 days of the expiration of that coverage. It is important for individuals to not let their insurance coverage lapse beyond this period of time. Contact individual health insurers for details about the pre-existing condition waiting period.

Standardized benefits and costs

A table outlining the benefits and out-of-pocket costs of the two standardized plans appears in Appendix 3 on pages 57-58. The price of coverage (premiums) 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. Tables showing the high and low premium rates for the standard individual health plans begin on page 59.

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

Choices available from New York State

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 increasing the availability of comprehensive health insurance coverage for New York’s uninsured workers and their families.

New York State offers three programs designed especially for eligible uninsured New Yorkers and their families.

- **Healthy NY** (page 48) is a program that offers health insurance to small employers, sole proprietors and uninsured working individuals.
- **Child Health Plus** (page 49) is a health insurance plan for children who are under the age of 19.
- **Family Health Plus** (page 50) 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.

Healthy NY

The Healthy NY program offers affordable insurance coverage to assist:

- small business owners in providing health insurance to their employees and their families
- working individuals whose employers do not provide health insurance

Eligibility for Enrollment

Small business owners may participate if:

- your business has not provided comprehensive health insurance during the past 12 months or not contributed more than \$50 per month per employee for coverage (or \$75 per month per employee for businesses located in the following counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, and Putnam).
- you have 50 or fewer employees.
- thirty percent of your employees earn \$34,000 or less annually.
- your business is willing to contribute 50% to the Healthy New York premium for full-time employees.

Individuals may participate 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 in the third column.

Summary of Benefits

Under the Healthy NY program, all New York HMOs offer a comprehensive health insurance benefits package. The services covered under the benefits package are listed below. The prescription drug benefit is optional and available at an additional charge.* 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

* This optional coverage provides up to \$3,000 in drug coverage per person, per year. Refer to Appendix 4 for Healthy NY cost comparison information.

Healthy NY Income Individual Eligibility Guidelines Effective January 2005 and subject to revision.

Family Size	Household Income Limits
1	Up to \$23,800
2	Up to \$31,950
3	Up to \$40,100
4	Up to \$48,250
5	Up to \$56,400
Each extra person	Add \$8,150

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

Cost

Obtaining insurance coverage through Healthy NY is specifically designed to be more affordable than other insurance options. Keep in mind that even though Healthy NY benefits are the same for each HMO, the monthly premiums you have to pay will vary. For more information about premiums, see pages 59-61.

Enrolling

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

Child Health Plus is New York State's health insurance plan for children under age 19. This plan is available from dozens of insurers throughout the State.

Eligibility for Enrollment

Your children may be eligible for Child Health Plus if:

- the children are under age 19
- the children are not eligible for Medicaid and have limited or no health insurance
- a parent or a family member is not 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.

Even if your family income is relatively high, your children may still qualify for Child Health Plus.

Summary of Benefits

These are the services covered under Child Health Plus:

- 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

Cost

Depending on your gross family income, you may have to pay a monthly contribution to enroll in Child Health Plus (see table below). Families that insure a child through the Child Health Plus program do not have to pay copayments to receive services.

Enrolling

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

Child Health Plus B* Premiums

Effective January 2005 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	\$1,269	\$1,270-1,762	\$1,763-1,984	\$1,984
2	\$1,703	\$1,704-2,365	\$2,366-2,663	\$2,663
3	\$2,138	\$2,139-2,968	\$2,969-3,342	\$3,342
4	\$2,573	\$2,574-3,571	\$3,572-4,021	\$4,021
5	\$3,007	\$3,008-4,174	\$4,175-4,700	\$4,700
For each extra person add	\$435	\$604	\$680	--

* 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

Family Health Plus offers health insurance coverage to lower-income adults whose income disqualifies them for other public programs such as Medicaid, and who do not have health insurance through their employers. Family Health Plus helps assure that adult family members and their children can receive quality health care.

Eligibility for Enrollment

You may be eligible for Family Health Plus health care benefits if:

- you are an adult between the ages of 19 and 64
- you do not have health coverage
- you are not eligible for Medicaid, or eligible only because of high medical costs (Unlike Medicaid, there are no asset or resource tests.)
- your total household income is within the annual limits listed at the top of the next column

Family Health Plus Eligibility

Effective January 2005 and subject to revision.

Family Size	Maximum Gross Annual Income	
	Single or Married Adult (not living with children under age 21)	Parent(s) (living with at least one child under age 21)
1	\$9,570	--
2	\$12,830	\$19,245
3	--	\$24,135
4	--	\$29,025
5	--	\$33,915
6	--	\$38,805
7	--	\$43,695
For each extra person add		\$4,890

Summary of Benefits

Family Health Plus offers a comprehensive package of benefits. 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)

Cost

There is no cost to apply for or participate in Family Health Plus. There are no application fees, co-payments, or deductibles once you are enrolled. There are no sliding scale fees or any other cost-sharing for Family Health Plus.

Enrolling

Contact your local Social Services district office about Family Health Plus and an enrollment facilitator will answer questions and assist you with the enrollment process. More information is also available on the New York State Department of Health's Web site at www.health.state.ny.us.

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Glossary of Health Insurance Terms

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.

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): In an HMO plan, members are assigned to a primary care physician (PCP) who coordinates a member's care. HMOs may require members to receive a referral from their PCP before seeing a specialist. (See **primary care physician** and **point of service plan**.) Although many HMOs require their members go to doctors and other providers in the HMO network, some HMO plans offer the option to go out-of-network (for example in a POS plan).

Independent 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.

Managed Care Organization: This type of insurer arranges for, or contracts with, a variety of health care providers to deliver a range of services to consumers who make up its membership. Managed care strategies emphasize prevention, detection and treatment of illness. Primary care physicians serve as the coordinator of patient care needs. Types of managed care organizations include HMOs and POS plans. (See **health maintenance organization** plan 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.

Point of Service (POS) Plan: A type of HMO coverage that allows members to choose to receive services either from a physician in the network or outside the 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 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**.)

Overall Complaint Ranking^a 2004

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
GE Global Group ^c	1	7	0	175.2	0.000	^H HMO ^c Commercial Insurer ^N Non-profit Indemnity Insurer ^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.
Hartford F&C Group ^c	2	5	0	149.1	0.000	
Citigroup ^c	3	4	0	99.5	0.000	
Zurich Insurance Group ^c	4	0	0	74.9	0.000	
First Rehabilitation Life Ins. Co. of Am. ^c	5	1	0	73.9	0.000	
Prudential Ins. Co. of America ^c	6	5	0	65.8	0.000	
New York Life Ins. Co. ^c	7	2	0	59.7	0.000	
Northwestern Mutual Group ^c	8	0	0	59.4	0.000	
Rochester Area HMO (Preferred Care) ^H	9	78	1	236.5	0.004	
Unumprovident Corp. Group ^c	10	6	2	457.6	0.004	
IHA ^H	11	62	3	590.4	0.005	
CNA Insurance Group ^c	12	20	1	110.7	0.009	
CDPHP ^H	13	74	7	698.9	0.010	
American Family Life ^c	14	7	1	90.0	0.011	
Aegon Group ^c	15	10	1	74.7	0.013	
MVP Health Plan ^H	16	128	14	975.2	0.014	
Mutual of Omaha Group ^c	17	10	1	68.6	0.015	
Vytra Health Services ^N	18	65	1	57.2	0.017	
Empire HealthChoice Assurance ^c	19	754	74	3,421.8	0.022	
HealthNow NY, Inc. ^N	20	131	19	797.3	0.024	
Excellus ^H	21	140	36	1,355.0	0.027	
Fortis Group ^c	22	4	2	68.8	0.029	
Excellus Health Plan, Inc. ^N	23	302	67	2,218.2	0.030	
Aetna Group ^c	24	79	15	490.0	0.031	
Metropolitan Group ^c	25	81	12	379.7	0.032	
AIG Group ^c	26	27	5	128.0	0.039	

Table continued on next page

Overall Complaint Ranking^a 2004 (continued)

Name	Rank ^b	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio	Insurer Categories
John Hancock Life Insurance Co. ^c	27	13	5	125.8	0.040	^H HMO
Empire HealthChoice ^H	28	704	52	1,279.0	0.041	^c Commercial Insurer
CIGNA Health Group ^c	29	251	83	1,767.2	0.047	^N Non-profit Indemnity Insurer
Guardian Life Group ^c	30	189	32	505.0	0.063	
MVP Health Ins. Corp. ^c	31	15	6	93.6	0.064	
Oxford Health Insurance ^c	32	545	126	1,871.0	0.067	
Combined Life ^c	33	33	9	122.1	0.074	
Community Blue (HealthNow) ^H	34	363	81	866.8	0.093	
Vytra ^H	35	235	28	261.2	0.107	
Group Health, Inc. (GHI) ^N	36	1,093	277	2,302.2	0.120	
UnitedHealthCare Ins. Co. of NY ^c	37	1,018	367	2,787.0	0.132	
Oxford ^H	38	1353	347	2,435.3	0.142	
HIP ^H	39	836	275	1,821.1	0.151	
Health Net of NY ^H	40	475	122	653.1	0.187	
GHI-HMO Select ^H	41	124	28	104.6	0.268	
Aetna Health ^H	42	766	303	1,053.6	0.288	
Horizon Healthcare Ins. Co. of NY ^c	43	162	66	172.5	0.383	
CIGNA ^H	44	214	67	145.7	0.460	
Health Net Ins. of NY ^c	45	293	117	220.5	0.531	
UnitedHealthcare of NY ^H	46	165	52	68.4	0.760	
MDNY ^H	47	308	249	135.2	1.842	
TOTAL		11,157	2,954	31,766.9	Avg.=0.093	

^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.

Standardized Benefits and Out-of-Pocket Costs for Individuals Buying Health Insurance on Their Own

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 HMO/POS plan on their own and not through an employer.

	What You Pay		
	HMO	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%

^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.

Table continued on next page

Standardized Benefits and Out-of-Pocket Costs *(continued)*

	What You Pay		
	HMO	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.

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 HMO/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 2005. 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 32 and 33 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 page 62.

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$851.39	\$411.03	\$972.39	\$684.66	\$197.27	\$160.20	\$174.02	\$130.73
Husband/Wife	\$1,857.23 ^a	\$822.06	\$2,236.36 ^a	\$1,432.02	\$404.40	\$349.60	\$356.74	\$268.00
Parent/Child(ren)	\$1,887.29 ^b	\$739.85	\$2,236.36 ^a	\$1,288.82	\$374.82	\$304.39	\$330.64	\$261.46
Family	\$2,279.58	\$1,233.09	\$2,603.54	\$1,745.89	\$572.09	\$466.64	\$504.66	\$371.27

^a Premium rate for a family under a two-tier rate structure, single & family.

^b Premium rate for a family under a three-tier rate structure, single, two-person, & family.

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$630.38	\$386.09	\$787.99	\$605.58	\$165.88	\$132.19	\$138.15	\$101.89
Husband/Wife	\$1,652.71 ^a	\$884.55	\$2,179.71 ^a	\$978.53	\$349.22	\$271.26	\$307.32	\$208.87
Parent/Child(ren)	\$1,685.08 ^b	\$884.55 ^c	\$2,179.71 ^a	\$978.53 ^d	\$318.14	\$237.59	\$262.50	\$195.64
Family	\$1,810.49	\$1,070.48	\$2,179.71	\$1,406.66	\$474.31	\$349.85	\$417.38	\$307.87

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$897.89	\$408.90	\$1,025.50	\$673.78	\$259.97	\$160.20	\$227.45	\$130.73
Husband/Wife	\$1,924.81 ^a	\$817.80	\$2,314.60 ^a	\$1,347.70	\$556.68	\$349.60	\$487.05	\$268.00
Parent/Child(ren)	\$1,924.81 ^a	\$599.10 ^e	\$2,314.60 ^a	\$1,192.61	\$477.21	\$304.39	\$419.94	\$261.46
Family	\$2,404.07	\$1,008.00 ^f	\$2,773.78	\$1,745.89	\$790.53	\$466.64	\$691.64	\$371.27

Long Island Area —Includes Nassau and Suffolk Counties.

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$742.55	\$408.90	\$1,222.91	\$673.78	\$256.58	\$184.63	\$225.79	\$160.21
Husband/Wife	\$1,857.31 ^a	\$817.80	\$2,445.84	\$1,347.70	\$513.12	\$369.93	\$451.55	\$325.54
Parent/Child(ren)	\$1,857.31 ^a	\$599.10 ^g	\$2,228.82 ^a	\$1,192.61	\$477.21	\$329.80	\$419.94	\$290.19
Family	\$2,153.39	\$1,008.00 ^h	\$3,546.47	\$2,002.75	\$784.86	\$544.66	\$690.68	\$472.62

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$728.36	\$309.41	\$1,040.19	\$335.19	\$256.58	\$160.59	\$225.79	\$141.32
Husband/Wife	\$1,857.31 ^a	\$693.06	\$2,228.82 ^a	\$750.82	\$516.31	\$321.18	\$454.35	\$282.64
Parent/Child(ren)	\$1,857.31 ^a	\$567.24	\$2,228.82 ^a	\$614.51	\$477.21	\$314.76	\$419.94	\$276.99
Family	\$2,079.35	\$903.45	\$3,120.56	\$978.74	\$784.86	\$481.78	\$690.68	\$423.96

a Premium rate for a family under a two-tier rate structure, single & family.

b Premium rate for a family under a three-tier rate structure, single, two-person, & family.

c Premium rate for two persons. The lowest rate for a parent with 2 or more children is \$1,016.82.

d Premium rate for two persons. The lowest rate for a parent with 2 or more children is \$1,187.76.

e Premium rate for a parent with a child. The lowest rate for a parent with 2 children is \$789.30. The lowest rate for a parent with 3 or more children is \$887.83.

f Premium rate for a couple with a child. The lowest rate for a couple with 2 children is \$1,198.20. The lowest rate for a couple with 3 children is \$1,388.40. The lowest rate for a couple with 4 or more children is \$1,454.93.

g Premium rate for a parent with a child. The lowest rate for a parent with 2 children is \$789.30. The lowest rate for a parent with 3 children is \$979.50. The lowest rates for a parent with 4 or more children is \$986.47.

h Premium rate for a couple with a child. The lowest rate for a couple with 2 children is \$1,198.20. The lowest rate for a couple with 3 children is \$1,388.40. The lowest rate for a couple with 4 or more children is \$1,578.60.

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$687.92	\$552.84	\$770.80	\$611.60	\$165.88	\$143.85	\$138.79	\$112.62
Husband/Wife	\$1,692.33 ^a	\$884.55	\$1,896.17 ^a	\$978.53	\$388.86	\$330.86	\$342.19	\$248.03
Parent/Child(ren)	\$1,827.60 ^b	\$884.55 ^c	\$1,970.44 ^b	\$978.53 ^c	\$318.14	\$309.28	\$278.98	\$227.62
Family	\$1,827.60	\$1,271.54	\$1,970.44	\$1,406.66	\$440.17	\$394.15	\$367.31	\$308.58

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$774.54	\$502.99	\$884.60	\$606.38	\$205.47	\$148.18	\$180.82	\$115.99
Husband/Wife	\$1,857.23 ^a	\$1,005.98	\$2,236.36 ^a	\$1,212.91	\$464.36	\$303.77	\$408.64	\$237.78
Parent/Child(ren)	\$1,857.23 ^a	\$890.21	\$2,236.36 ^a	\$1,073.38	\$374.82	\$296.36	\$330.64	\$231.98
Family	\$2,073.82	\$1,454.93	\$2,368.50	\$1,618.95	\$572.09	\$420.83	\$504.66	\$329.41

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

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$851.39	\$502.99	\$972.39	\$606.38	\$197.27	\$148.18	\$174.02	\$115.99
Husband/Wife	\$1,857.23 ^a	\$1,005.98	\$2,236.36 ^a	\$1,212.91	\$422.59	\$303.77	\$371.88	\$237.78
Parent/Child(ren)	\$1,887.29 ^b	\$890.21	\$2,236.36 ^a	\$1,073.38	\$374.82	\$283.93	\$330.64	\$193.89
Family	\$2,279.58	\$1,454.93	\$2,603.54	\$1,618.95	\$572.09	\$420.83	\$504.66	\$329.41

^a Premium rate for a family under a two-tier rate structure, single & family.

^b Premium rate for a family under a three-tier rate structure, single, two-person, & family.

^c Premium rate for two persons.

^d Premium rate for a parent with a child. The lowest rate for a parent with 2 children is \$789.30. The lowest rate for a parent with 3 children is \$979.50. The lowest rate for a parent with 4 or more children is \$989.14.

^e Premium rate for a couple with a child. The lowest rate for a couple with 2 children is \$1,198.20. The lowest rate for a couple with 3 children is \$1,388.40. The lowest rate for a couple with 4 or more children is \$1,578.60.

Westchester Area — Includes Westchester and Rockland Counties.

Coverage	HMO		HMO/POS		Healthy NY w/drug coverage		Healthy NY	
	High	Low	High	Low	High	Low	High	Low
Individual	\$897.89	\$408.90	\$1,040.19	\$673.78	\$259.97	\$175.69	\$227.45	\$154.60
Husband/Wife	\$1,857.31 ^a	\$817.80	\$2,228.82 ^a	\$1,347.70	\$566.69	\$369.93	\$498.69	\$325.54
Parent/Child(ren)	\$1,857.31 ^a	\$599.10 ^d	\$2,228.82 ^a	\$1,192.61	\$477.21	\$329.80	\$419.94	\$290.19
Family	\$2,404.07	\$1,008.00 ^e	\$3,120.56	\$1,950.20	\$790.53	\$511.74	\$691.64	\$450.34

Telephone Numbers of Health Insurers

HMOs ^a	
Aetna Health	800-872-3862
AmeriHealth Health Plan	800-877-9829
Atlantis	866-747-8422
CDPHP	800-777-2273
CIGNA	800-345-9458
Community Blue (HealthNow)	800-544-2583
Empire HealthChoice	800-261-5962
Excellus	
Finger Lakes HMO	800-462-0108
Upstate	800-544-0328
Univera	800-337-3338
GHI-HMO Select	877-244-4466
Health Net of NY	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

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

Non-profit Indemnity Insurers ^b	
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

^b Also includes non-profit indemnity insurers with less than \$50 million in premium.

Commercial Insurers ^c	
Aegon Group	
Stonebridge Life Insurance Company	800-527-3398
Transamerica Financial Insurance Company	888-617-6781
Aetna Group	860-273-0123
AIG Group	877-638-4244
American Family Life	800-366-3436
CIGNA Health Group	800-345-9458
Citigroup	800-221-4584
CNA Insurance Group (Encompass Insurance)	800-262-9262
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.	800-223-1969
Fortis Group	800-745-7100
GE Global Group	800-844-6543
Guardian Life Insurance	888-482-7342
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
John Hancock Mutual Life Ins. Company	800-732-5543
Metropolitan Group	800-638-5433
Mutual of Omaha Group	800-775-6000
MVP Health Ins. Co.	888-687-6277
New York Life Insurance Company	800-695-9873
Northwestern Mutual Group	800-388-8123
Oxford Health Insurance Company	800-666-1353
PerfectHealth Insurance	718-370-5380
Provident Life Group	800-858-6843
Prudential Insurance Company of America	800-828-0153
Union Labor Group	
Individual	877-820-7448
Group	888-294-5787
UnitedHealthCare Ins. Co. of NY	800-705-1691
UnumProvident Life Group	800-858-6843
Zurich-American Insurance Companies	800-382-2150

^c 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)
www.health.state.ny.us/nysdoh/chplus/index.htm
- **Family Health Plus:**
1-877-934-7587
www.health.state.ny.us/nysdoh/fhplus/index.htm
- **To Apply for an Independent External Review:**
1-800-400-8882
www.ins.state.ny.us/extappqa.htm

