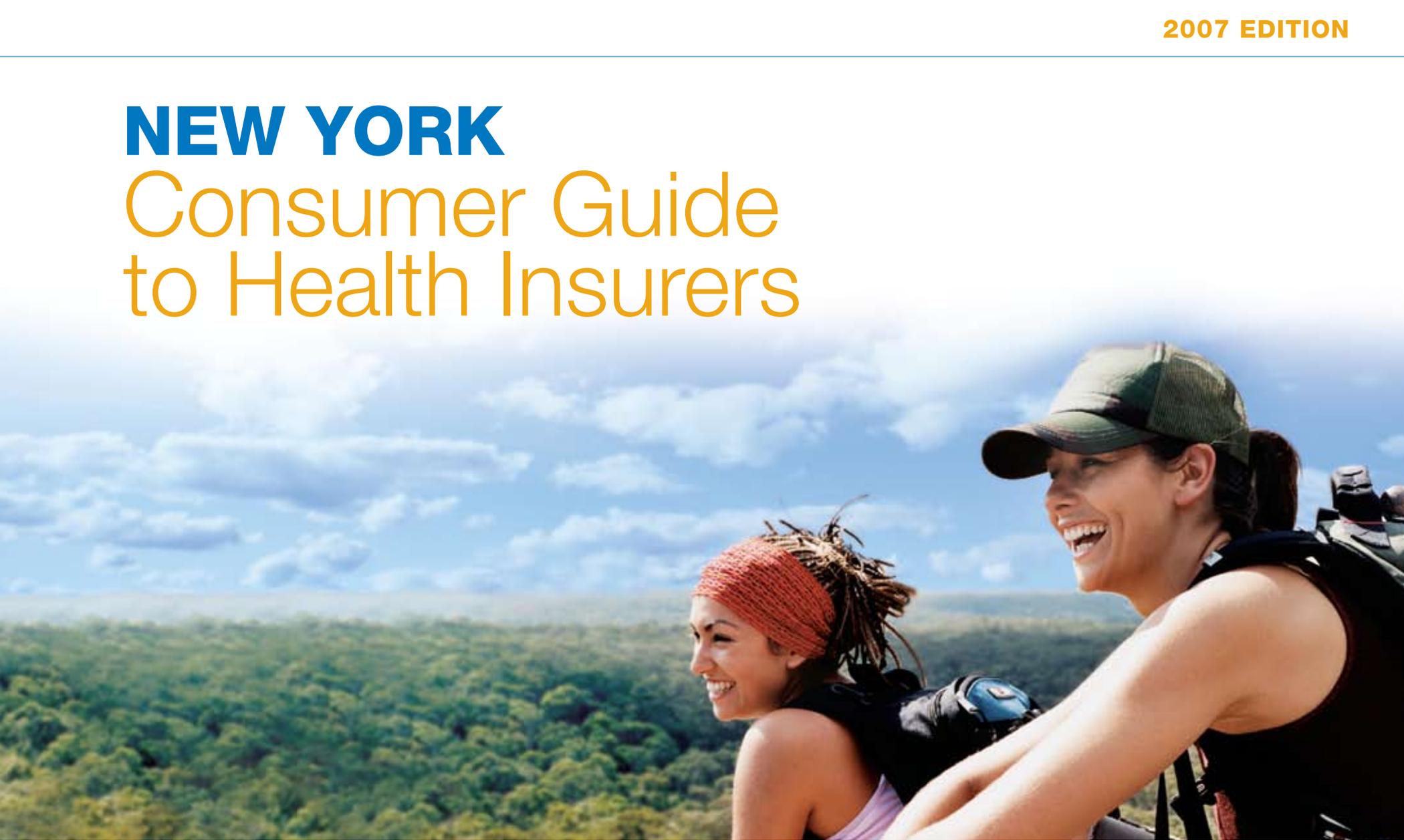


NEW YORK

Consumer Guide to Health Insurers



New York State
Eliot Spitzer, Governor

New York State Department of Insurance
Eric R. Dinallo, Superintendent of Insurance

New York State Department of Health
Richard F. Daines, M.D., Commissioner of Health



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“New York State is committed to promoting a fair and competitive health insurance market and educating consumers so they can make smart, informed choices for themselves and their families.”

“Consumers need reliable information to compare and select quality health insurers. This guide is designed to help you learn more about your health insurance choices and what to do if you have a complaint.”

“Our goal is affordable health insurance coverage for all New Yorkers. This guide helps people make informed choices about coverage and costs.”

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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 quality of care and service.

Refer to the **Glossary of Health Insurance Terms** on pages 53–54 for commonly used terms in this Guide. The first time the term is used it will appear in **bold**.

Data Sources

Information about the performance of health insurers in this Guide comes from two New York agencies.

1. **New York State Insurance Department (NYSID)** is responsible for protecting the public interest by supervising and regulating insurance business in New York State.
 - NYSID compiles complaint and appeal information that appears in Section 2 and grievance information that appears in Section 3.
 - NYSID data are from calendar year 2006.

2. **New York State Department of Health (DOH)** works to protect and promote the health of New Yorkers through prevention, science and ensuring delivery of quality health care.
 - DOH compiles information on HMO performance that appears in Section 3.
 - DOH collects data through the New York State Department of Health's Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).¹
 - DOH data are from calendar year 2005, except where noted.

Details About the Data

- The Guide does not include HMOs with less than \$25 million in premiums or fewer than 5,000 members.
- The Guide does not include commercial and non-profit companies with less than \$50 million in premiums.
- Data derived from Medicare or Medicaid programs are not included.²
- Health insurers are listed alphabetically in the data tables, except for the Overall Complaint Ranking table on pages 51-52.
- UnitedHealthcare does not issue individual coverage.
- QARR data is not available for Atlantis Health Plan.

Questions About This Guide?

Contact:

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

For additional copies, call
518-474-4557 or visit
www.ins.state.ny.us/hgintro/htm

¹CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

²For information about Medicare or Medicare Part D coverage, call the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees this program, at 800-MEDICARE (800-633-4227), or visit the Web site at www.medicare.gov. You can also contact the New York State Office for the Aging Health Insurance Information Counseling & Assistance Program (HIICAP) by calling 800-701-0501 or visit the Web site at www.hiicap.state.ny.us. For information on New York's Medicaid program, contact your local county Department of Social Services.

Crosswalk of Select Health Insurer Names

NYSID data in this Guide are reported by parent company name. DOH data are reported by **health maintenance organization** (HMO) product name, with the exception of DOH complaints data. When you look at the *HMO Quality of Care and Service* section, use this table to cross-reference the HMO product to its parent company name, for comparison. For all other health insurers, the parent company name is also the HMO product name.

Parent Company Name	HMO Product Name
NYSID Name	DOH Name
Community Blue (HealthNow)	Blue Shield of Northeastern New York (BSNENY) (Albany area) Community Blue (Buffalo area)
Excellus Health Plan, Inc. (HMO)	Blue Choice is also known as Finger Lakes or Rochester Area, depending on who is reporting the data. Univera Healthcare Upstate HMO
Rochester Area HMO	Preferred Care
NYSID data for HIP HMO also includes: Health Insurance Plan of Greater New York HIP Insurance Company of New York PerfectHealth Insurance Company Vytra Health Services, Inc. Vytra Healthcare of Long Island, Inc.	HIP HMO – Data reflect HIP HMO data only

A photograph of a person running on a trail. The person is wearing a red long-sleeved shirt and black shorts. The background shows a hilly, outdoor environment with dry grass and a clear blue sky. The image is partially overlaid by a yellow graphic element on the right side.

UNDERSTANDING HEALTH INSURANCE
SECTION ONE

Understanding Your Health Insurance Options

New Yorkers generally have three options from which to choose a health insurance plan. Pages 6 and 45 describe each of these options in greater detail.

Option 1 Purchase health insurance directly from an HMO (an individual plan).

People who select this option purchase insurance directly from an HMO or HMO/point-of-service (POS) plan. The State of New York requires all HMOs and HMO/POS plans to offer standardized coverage to people who buy health insurance on their own.

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

The State of New York offers a number of health care programs available for eligible individuals.

Option 3 Get health insurance coverage through an employer or association.

Many employers and associations make health insurance available for their employees, members and families. These plans may be provided by a licensed health insurer or HMO, or they might be self-insured plans.

How to Get Health Insurance

	Directly purchase health insurance (individual plan)	Qualify for reduced-cost health insurance through New York State programs	Get health insurance coverage through an employer or association
Insurance Options	<p>HMO: A health insurer that directly contracts with or employs a network of doctors, hospitals and other types of providers.</p> <p>HMO/POS: A health insurer that combines an HMO with the flexibility of being able to see out-of-network doctors.</p>	<p>Healthy NY is a program that offers health insurance to small employers, sole proprietors and uninsured working individuals.</p> <p>Child Health Plus is a health insurance plan for children who are under 19 years of age.</p> <p>Family Health Plus is a health insurance program for adults between 19 and 64 years of age who are uninsured and have incomes too high to qualify for Medicaid.</p>	<p>Insured Plan: An employer contracts with a licensed health insurer or HMO to provide coverage for its employees.</p> <p>Self-Insured Plan: An employer creates a fund to cover medical expenses and typically contracts with an outside party to administer the health benefits.</p> <p>Professional Association: An association may offer its members group rates on insurance plans that are generally less expensive than individual plans.</p>
Special Considerations	<p>For a pre-existing medical condition, a member may have to wait up to a year for coverage of the condition if treatment was recommended or received within the 6 months prior to the date of enrollment. The waiting period may be reduced if the individual was previously covered and applied within 63 days of expiration of coverage. It is important that insurance coverage does not lapse beyond this point. Contact NYSID or the individual health insurer for details about the pre-existing condition waiting period.</p>	<p>Individuals must meet eligibility criteria, which are different for each program. Eligibility for these reduced-cost health plans is based on a person's income. See page 45 for information about cost and enrollment.</p>	<p>Employers and associations can offer different types of plans and different cost-sharing options.</p> <p>New York consumer protections and insurance laws (summarized on page 8) do not apply to self-insured plans. These plans are regulated by the U.S. Department of Labor under a federal statute known as ERISA. Ask your employer's benefit manager if the health coverage provided is self insured.</p>

How to Choose a Health Insurer

Step 1: Determine the type of health coverage that best fits your needs. Use the Comparison of Health Insurance Coverage table on page 6 to become familiar with different types of health insurers.

Step 2: Determine which health insurer provides coverage in your area. If you are considering an HMO, see the table on page 32 for service areas. For other types of insurance, contact the individual health insurer to find out if there are participating providers in your area.

Step 3: Decide which health insurer offers the benefits and doctors you need. Think about your family's health care needs and choose a health 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.

In an HMO, you typically receive care from a network of providers. To determine if your doctors and hospital participate, check the HMO's provider directory or call your provider's office. If you think you will need a specialist, check whether your **primary care physician** (PCP) is restricted from referring you to certain specialists.

Step 4: Compare cost. Compare the monthly premium of different plans, as well as your out-of-pocket expenses, such as deductibles, co-insurance and copayments. To see HMO rates, visit www.ins.state.ny.us/ihmoindx.htm.

Step 5: Use this Guide to see which health insurers performed best. This Guide has information about the quality of care and services provided by New York HMOs (see Section 3), as well as complaint and appeal data for New York health insurers (see Section 2). Compare results among health insurers you are interested in, based on Steps 1-4.

Step 6: Integrate the information you have learned from this Guide. Use the personal worksheet on page 5 to gather information important to you. Eliminate the health insurers that do not meet your basic requirements or which are not in your service area, then choose the health insurer that performs best on the features most important to you.



Worksheet to Choose a Health Insurer

This worksheet can help you organize and evaluate information about the health insurers available to you. You can use information in this Guide and in other materials you may have obtained from your employer and the health insurer to complete the worksheet. In the first column, fill in the names of the health plans you are considering and meet the criteria for access. Then put a check mark for the other criteria that the health insurer meets.

For All Types of Health Insurers								For HMOs Only			
Access: Which health insurers are available where you live or work? For HMOs see page 32; for other health insurers, review the information from your employer or the health insurer.	Benefits: Which health insurers offer the benefits you want? Review benefit information from your employer or the health insurer.	Health Care Provider: Which health insurers include your preferred doctor or health care provider? Review the health insurers' physician directories and call their Customer Service Departments.	Cost: Which health insurers fall within your price range? Review cost information from your employer or health insurers. Be sure to consider the amount of copays, co-insurance or deductibles.	Complaints: How does the insurer rank, compared with other insurers? See page 12.	Prompt Pay Complaints: How does the insurer rank, compared with other insurers? See page 16.	Internal Appeals: Which health insurers have low reversal rates? See page 22.	External Appeals: Which health insurers have low reversal rates? See page 26.	Access & Service: Look at the measures important to you. How do the HMOs you have chosen perform? See page 34.	Staying Healthy & Living with Illness: Look at the measures important to you. How do the HMOs you have chosen perform? See page 36.	Quality of Providers: Look at the measures important to you. How do the HMOs you have chosen perform? See page 38.	Grievances: Which HMOs have low reversal rates? See page 40.

Comparison of Health Insurance Coverage

The general rules presented in this table might not apply to every health insurer. Be sure to check with the health insurer or your employer to verify how the 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. All care is provided by or coordinated through your PCP.	HMO/POS Combines an HMO with the flexibility of an out-of-network option. You may use providers in the health insurer's network or go outside of the network.	Fee-for-Service (FFS) You and the health insurer each pay for part of the cost for health care services you receive. There is no specific network of providers.	PPO Most similar to traditional FFS coverage, except that there is a network of providers. When you use an in-network provider, your cost is lower and more services are covered.
Which doctors and hospitals can you choose?	You must choose providers in the network.	You may get care from in-network or out-of-network providers. When you go out of the network, you will usually pay more.	You have an unlimited choice of doctors and hospitals.	You may get care from in-network or out-of-network providers. When you use an out-of-network provider, you usually pay more.
How do you get specialty care?	You need a referral from your PCP to see a specialist and you must choose a specialist in the network.	You need a referral from your PCP to see an in-network specialist. You may go to an out-of-network specialist without a referral.	You do not need a referral to see a specialist.	You do not usually need a referral to see a specialist, but certain services may require preauthorization from your health insurer.
How do you pay for in-network services?	There is no deductible. You pay a copayment (typically between \$20 and \$40) for a doctor's office visit and for most services.	You pay a copayment if you see an in-network provider, and there is no deductible.	There are no in-network or out-of-network options. Your doctor or hospital charges you for services. After you pay your deductible, you are responsible for a portion of the costs, typically 20%–30% of the allowable reimbursement, known as " co-insurance ".	You pay a small copayment. Network providers agree not to charge more than the health insurer's allowable charge.
How do you pay for out-of-network services?	Out-of-network services are usually not covered.	You are reimbursed for services if you use an out-of-network provider, as you would be with FFS insurance.	Most health 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 co-insurance.	You are reimbursed for services if you use an out-of-network provider, as you would be with FFS insurance.



New York Consumer Protections

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

Consumers have the right to the following.

- An external review for any service denied because the health insurer considers it to be experimental, investigational or not medically necessary. These denials must be made by a physician or, under certain circumstances, a health care professional who would normally treat the condition. See page 9 for more details.
- A second medical opinion by an appropriate specialist for the treatment of cancer.
- To remain in the hospital after a mastectomy, until you and your doctor decide that you are ready to go home.
- Reconstructive surgery after a mastectomy.
- Medically necessary chiropractic visits, subject to limitations.

- Emergency ambulance services, subject to a copay only.
- Covered emergency room treatments based on the “prudent layperson” standard, which considers the presenting symptoms and the length of time symptoms have been present, not the ultimate diagnosis.
- Men are entitled to prostate cancer screening.
- Women are entitled to:
 - Direct access to primary and preventive OB/GYN services at least twice a year.
 - Coverage for bone mineral density measurements and testing.
 - Coverage for contraception under most group health insurance contracts.
 - Remain in the hospital for 48 hours after a natural delivery of a child and at least 96 hours after a Cesarean section delivery.
- In addition to these rights, HMO members are guaranteed the following rights.
 - Access to needed specialists.
 - To a full, honest and confidential discussion with their physician about their medical needs.
 - To file a grievance with their HMO for any denials based on limitations or exclusions in their contract.

For more information on HMO member rights, see the Managed Care Bill of Rights on the New York Department of Health Web site: http://www.health.state.ny.us/health_care/managed_care/billofrights/bill.htm

Note: *Many large employers that offer health coverage to their employees self-insure their health benefits. Such plans are not subject to New York laws. See page 2 for more information.*

Your Right to Appeal a Health Insurer's Decision

If you are dissatisfied with a health insurer's decision to deny or limit a medical service because it determined that the service is experimental, investigational or not medically necessary, you have the right to appeal the decision. You can use the insurer's **internal appeal** process to request that the insurer reconsider its decision. If you disagree with the result, you can request an **external appeal** conducted by a third party not affiliated with the health insurer. See the box to the right for more information about whether you are eligible for the external appeal process.

The External Appeal Process

Whom to contact: New York State Insurance Department.

Who can appeal: You or your authorized representative, including your provider.

What you can appeal: Denials of coverage for services that your health insurer determines are not medically necessary, or are experimental or investigational.

When you can appeal: You must request an external appeal within 45 days from receipt of your health insurer's first-level internal appeal decision, or within 45 days of receipt of a letter from your health insurer agreeing to waive the internal appeal process.

What to send: A completed application (a physician's statement is required for experimental/ investigational and expedited appeals) and a copy of the health insurer's first-level appeal decision or a letter from the health insurer waiving the appeal. Send the information to:

New York Insurance Department
External Appeal
P.O. Box 7209
Albany NY 12224-0209

What you must pay: \$50 (the fee is waived under certain conditions). The fee is returned to the patient if the health insurer denial is overturned in full or in part.

External Appeal Data

See pages 26–29 for external appeal data for health insurers.

What Will Happen?

The Insurance Department will:

1. Review the appeal request within 5 business days.
2. Assign the request to an external appeal agent if the request is eligible and complete.

The external appeal agent will:

1. Have a medical expert (or experts) review the appeal.
2. Determine the outcome.

When you will get a decision:

30 days (plus 5 business days, if additional information is requested).

In urgent situations:

An expedited appeal will be reviewed by the Insurance Department within 24 hours and the outcome will be determined by the external review agent within 3 days.

How to Get More Information:

NYSID Hotline 800-400-8882 or visit www.ins.state.ny.us/extapp/extappqa.htm

Eligibility

You *are not* eligible to appeal your health insurer's coverage decision through the external appeal process if:

- The service or treatment you are seeking is not covered by your health insurer.
- Medicare is your only source of health insurance coverage.
- Your health insurer is a self-insured (ERISA) plan that is not subject to state regulation.
- The review is for workers' compensation claims or for claims under no-fault auto coverage.
- Your health insurance was issued outside of New York.



COMPLAINT AND APPEAL INFORMATION
FOR ALL TYPES OF HEALTH INSURERS

SECTION TWO

2

Overview

This guide contains information about the number of complaints and appeals filed against New York health insurers. The information is presented by the following types of health insurers, which are discussed on page 6:

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

The table summarizes the types of complaints and appeals reported in this Guide.

Type of data	Complaints	Prompt Pay Complaints	Internal Appeals	External Appeals	Grievances
Definition	Complaints to the State of New York about health insurers, including prompt pay complaints.	Complaints about the timely processing of a claim.	A request to a health insurer to reconsider its decision to deny coverage of a medical service that it considers experimental, investigational or not medically necessary.	An independent, third-party review of a health insurer's denial of a service considered experimental, investigational or not medically necessary.	A complaint to an HMO about denial of coverage based on limitations or exclusions in the contract.
Filed by	Consumers, their designee or providers.	Consumers, their designee or providers.	Consumers or their authorized representative, which may be the provider. The provider can file on its behalf for services already provided.	Consumers or their authorized representative, which may be the provider. The provider can file on its behalf for services already provided.	Consumers, their designee or providers.
Reviewed by	NYSID or DOH	NYSID	The health insurer's medical director	State-certified, independent external review organization	Internal HMO committee
More information	Pages 12-15	Pages 16-19	Pages 22-25	Pages 26-29	Pages 40-41

Complaints

Each year, NYSID and DOH receive complaints from consumers and health care providers about health insurers. After reviewing each complaint, the state decides if the health insurer acted appropriately. If the state decides that the insurer did not, the health insurer must remedy the problem.

Understanding the Charts

- **Rank:** A better rank means that the health insurer had fewer upheld complaints, relative to its size.
- **Total Complaints to NYSID:** Total number of complaints closed by the Insurance Department in 2006. Complaints to the Insurance Department typically involve issues concerning prompt payment, reimbursement, coverage, benefits, rates and premiums.
- **Upheld Complaints by NYSID:** Number of closed complaints where the Insurance Department determined that the health insurer did not comply with statutory or contractual obligations. Complaints upheld by the Insurance Department are used to calculate the complaint ratio and rank.
- **Premium*:** Dollar amount of premiums generated by a health insurer in New York during 2006. Premiums are used to calculate the complaint ratio so that health insurers of different sizes can be compared fairly.

**Premium data exclude Medicare and Medicaid.*

- **Complaint Ratio:** Number of upheld complaints by NYSID, divided by the health insurer's **total annual premium**. Total annual premium, a measure of a health insurer's size, is used to calculate the complaint ratio so that health insurers of different sizes can be compared fairly. Large health insurers may receive more complaints because they serve more people than smaller health insurers.
- **Total Complaints to DOH:** Total number of complaints against HMOs closed by DOH. Complaints to DOH involve concerns about the quality of care received by HMO members.
- **Upheld Complaints to DOH:** Number of complaints closed by DOH that were decided in favor of the consumer or provider.

Complaints—HMOs 2006

Data source: NYSID and DOH

HMOs with a lower complaint ratio receive a better rank.

HMO	Data Compiled by NYSID					Data Compiled by DOH ¹	
	Rank 1 = Best, 15 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premiums (Millions\$)	Complaint Ratio	Total Complaints to DOH	Upheld Complaints by DOH
Aetna Health	11	485	173	779.8	 0.2218	3	0
Atlantis Health Plan ²	—	—	—	—		1	0
CDPHP	5	82	9	651.1	 0.0138	3	0
CIGNA	12	80	34	117.2	 0.2900	2	0
Community Blue (Health Now)	4	86	14	1,037.5	 0.0135	13	0
Empire HealthChoice	7	689	75	1,819.3	 0.0412	8	0
Excellus	3	134	20	1,893.3	 0.0106	14	2
GHI-HMO Select	10	133	29	132.5	 0.2188	21	2
Health Net of NY	13	766	300	437.8	 0.6852	8	3
HIP	9	1,536	728	4,127.6	 0.1763	50	0
Independent Health Association (IHA)	1	27	4	586.9	 0.0068	11	2
MDNY	15	271	236	93.8	 2.5152	8	0
MVP Health Plan	2	111	8	944.3	 0.0085	1	0
Oxford	8	1,195	279	1,928.8	 0.1446	22	0
Rochester Area HMO (Preferred Care)	6	18	5	321.6	 0.0155	1	0
UnitedHealthcare of New York	14	59	25	28.5	 0.8752	5	0
TOTAL	—	5,672	1,939	14,900.7	 Avg. = 0.3491	171	9

¹ DOH complaint data is from 2006.

 Denotes length of bar graph shortened due to spatial constraints.

² Atlantis Health Plan has the minimum premium required to report data, but did not report the data by the deadline, so the data are not reported in this Guide.

Complaints—Non-profit Indemnity Insurers 2006

Data source: NYSID

Health insurers with a lower complaint ratio receive a better rank.

Non-profit Indemnity Insurer ¹	Rank 1= Best, 3 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio
Excellus Health Plan, Inc.	1	279	90	2,921.5	0.03
Group Health, Inc. (GHI)	3	1,343	379	2,391.4	0.16
HealthNow NY, Inc.	2	94	37	1,078.2	0.03
TOTAL		1,716	506	6,391.2	Avg = 0.08

¹Delta Dental and Dentcare Delivery Systems are not included because they do not write a comprehensive health insurance product.



Complaints—Commercial Insurers 2006

Data source: NYSID

Health insurers with a lower complaint ratio receive a better rank.

Commercial Insurer	Rank ¹ 1 = Best, 29 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio
Aetna Group	24	162	63	964.7	0.0653
American Family Life Asr. Co. of NY	12	12	2	132.1	0.0151
American International Group	22	27	7	144.0	0.0486
American Progressive L&H Ins. Co. of NY	17	19	4	162.9	0.0246
CIGNA Health Group	26	93	33	434.1	0.0760
Citigroup	2	5	0	99.4	0.0000
CNA Insurance Group	21	16	3	63.2	0.0475
Combined Life Ins. Co. of New York	16	21	3	122.8	0.0244
Fortis Group	13	6	1	57.9	0.0173
GE Global Group	1	10	0	204.0	0.0000
Guardian Life Group	23	151	32	505.1	0.0634
Hartford F & C Group	7	12	1	137.9	0.0072
HealthNet Ins. of NY Inc.	27	83	26	271.2	0.0959
Highmark Inc.	4	8	0	66.4	0.0000
Horizon Healthcare Ins. Co. of NY	28	102	28	168.2	0.1665
John Hancock Life Ins. Co.	10	8	2	144.6	0.0138
Liberty National	20	12	2	53.4	0.0374
Massachusetts Mutual Life Ins. Co.	15	4	1	52.8	0.0189
Metropolitan Group	5	49	1	469.6	0.0021
Mutual of Omaha Group	19	19	2	62.9	0.0318
New York Life Ins. Co.	11	7	1	70.1	0.0143
Northwestern Mutual	3	1	0	67.8	0.0000
Oxford Health Ins. Inc.	25	386	106	1,454.8	0.0729
Protective Life Ins. Group	18	23	2	67.0	0.0299
Prudential Ins. Co. of America	9	7	1	77.3	0.0129
UnitedHealth Group	29	1,064	326	991.5	0.3288
UnumProvident Corp. Group	6	41	3	432.4	0.0069
Wellpoint Inc.	14	609	94	5,397.6	0.0174
Zurich Ins. Group	8	2	1	77.9	0.0128
TOTAL		2,959	745	12,953.7	Avg = 0.0432

¹If the ratios are the same among insurers, the insurer with the higher annual premium amount receives a better rank.

Prompt Pay Complaints

Consumers and providers can file complaints with the Insurance Department when they believe a health insurer is not processing claims in a timely manner. These complaints are called **prompt pay complaints**.

New York requires all health insurers to:

- Pay undisputed claims within 45 days of receipt, *or*
- Request all additional information from the consumer or the provider, if necessary, within 30 days of receipt of the claim, *or*
- Deny the claim within 30 days of receipt.

Providers may be less willing to participate with health insurers that do not process claims on a timely basis. A severe claims payment problem may indicate that the health insurer has financial problems.

NYSID has established a dedicated hotline for consumers and providers to file prompt pay complaints at **800-358-9260**.

Understanding the Charts

- **Rank:** A better rank means that the health insurer had fewer upheld prompt pay complaints, relative to its size.
- **Total Complaints:** Total number of complaints closed by the Insurance Department in 2006. Complaints to the Insurance Department typically involve issues about prompt payment, reimbursement, coverage, benefits, rates and premiums.
- **Total Prompt Pay Complaints:** Total number of prompt pay complaints closed by the Insurance Department in 2006.

- **Upheld Prompt Pay Complaints:** Number of closed prompt pay complaints where the Insurance Department determined the health insurer was not processing claims in a timely manner.
- **Premium*:** Dollar amount of premiums generated by a health insurer in New York in 2006. Premiums are used to calculate the prompt pay complaint ratio so that health insurers of different sizes can be compared.
- **Prompt Pay Complaint Ratio:** Number of upheld prompt pay complaints divided by a health insurer's total annual premium. Large health insurers might receive more complaints because they serve more people and pay more claims than smaller health insurers. Total annual premium, a measure of a health insurer's size, is used to calculate the prompt pay complaint ratio so health insurers of different sizes can be compared fairly.

**Premium data exclude Medicare and Medicaid.*

Prompt Pay Complaints—HMOs 2006

Data source: NYSID

HMOs with a lower prompt pay complaint ratio receive a better rank.

HMO	Prompt Pay Ranking 1 = Best, 15 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aetna Health	11	485	282	113	779.8	0.1449
Atlantis Health Plan ¹	—	—	—	—	—	0.0000
CDPHP	3	82	24	2	651.1	0.0031
CIGNA	12	80	40	24	117.2	0.2047
Community Blue (HealthNow)	6	86	17	8	1,037.5	0.0077
Empire HealthChoice	7	689	302	42	1,819.3	0.0231
Excellus	5	134	28	10	1,893.3	0.0053
GHI-HMO Select	10	133	53	17	132.5	0.1282
Health Net of NY	14	766	604	266	437.8	0.6076
HIP	9	1,536	946	445	4,127.6	0.1069
Independent Health Association (IHA)	1	27	4	0	586.9	0.0000
MDNY	15	271	249	230	93.8	2.4512
MVP Health Plan	4	111	28	3	944.3	0.0032
Oxford	8	1,195	476	132	1,928.8	0.0684
Rochester Area HMO (Preferred Care)	2	18	0	0	321.6	0.0000
UnitedHealthcare of New York	13	59	17	13	28.6	0.4551
TOTAL	—	5,672	3,070	1,305	14,900.7	Avg. = 0.2806

¹Atlantis Health Plan has the minimum premium required to report data, but did not report the data by the deadline, so the data are not reported in this Guide.

 Denotes length of bar graph shortened due to spatial constraints.

**Prompt Pay Complaints—
Non-profit Indemnity Insurers 2006**

Data source: NYSID

Health insurers with a lower prompt pay ratio receive a better rank.

Non-profit Indemnity Insurer ¹	Rank 1 = Best, 3 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Excellus Health Plan, Inc.	1	279	94	47	2,921.5	0.02
Group Health, Inc. (GHI)	3	1,343	615	104	2,391.4	0.04
HealthNow NY, Inc.	2	94	37	30	1,078.2	0.03
TOTAL		1,716	746	181	6,391.2	Avg. = 0.03

¹Delta Dental and Dencare Delivery Systems are not included because they do not write a comprehensive health insurance product.



Prompt Pay Complaints—Commercial Insurers 2006

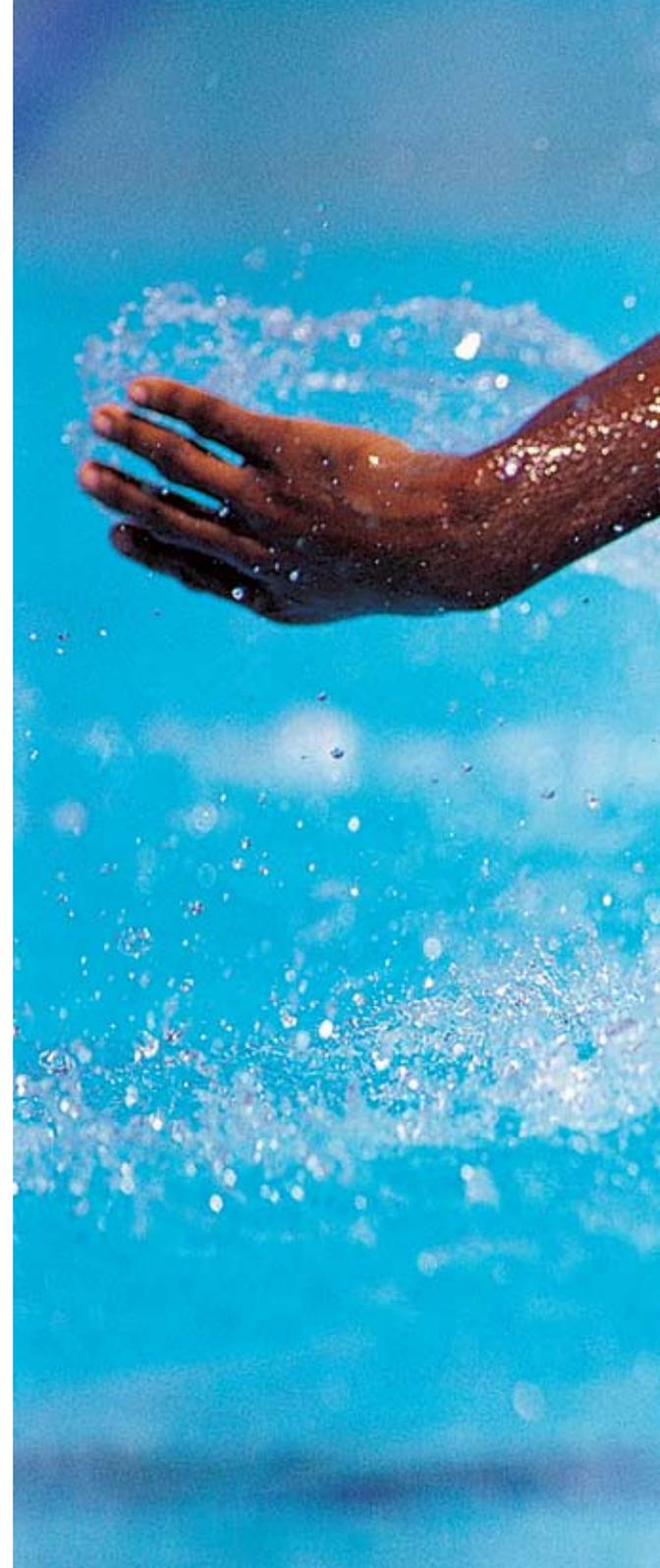
Data source: NYSID

Health insurers with a lower prompt pay ratio receive a better rank.

Commercial Insurer	Rank ¹ 1 = Best, 29 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aetna Group	25	162	67	35	964.7	0.0363
American Family Life Assurance Co. of NY	4	12	2	0	132.1	0.0000
American International Group	24	27	11	5	144.0	0.0347
American Progressive L&H Ins. Co. of NY	17	19	10	1	162.9	0.0061
CIGNA Health Group	26	93	45	23	434.1	0.0530
Citigroup	5	5	0	0	99.4	0.0000
CNA Insurance Group	11	16	1	0	63.2	0.0000
Combined Life Ins. Co. of New York	21	21	9	2	122.8	0.0163
Fortis Group	12	6	1	0	57.9	0.0000
GE Global Group	1	10	1	0	204.0	0.0000
Guardian Life Group	22	151	39	10	505.1	0.0198
Hartford F&C Group	3	12	4	0	137.9	0.0000
Health Net Ins. of New York Inc.	27	83	27	16	271.2	0.0590
Highmark Inc.	10	8	2	0	66.4	0.0000
Horizon Healthcare Insurance Co. of NY	28	102	61	15	168.2	0.0892
John Hancock Life Ins. Co.	2	8	1	0	144.6	0.0000
Liberty National	13	12	1	0	53.4	0.0000
Massachusetts Mutual Life Ins. Co.	14	4	0	0	52.8	0.0000
Metropolitan Group	15	49	9	1	469.6	0.0021
Mutual of Omaha Group	20	19	1	1	62.9	0.0159
New York Life Ins. Co.	19	7	2	1	70.1	0.0143
Northwestern Mutual	8	1	0	0	67.8	0.0000
Oxford Group	23	386	104	42	1,454.8	0.0289
Protective Life Ins. Group	9	23	4	0	67.0	0.0000
Prudential Ins. Co. of America	7	7	1	0	77.3	0.0000
UnitedHealth Group	29	1,064	515	198	991.5	0.1977
UnumProvident Corp. Group	16	41	12	1	432.4	0.0023
Wellpoint Inc.	18	609	261	42	5,397.6	0.0078
Zurich Ins. Group	6	2	0	0	77.9	0.0000
TOTAL		2,959	1,191	393	12,953.7	Avg. = 0.0303

¹If ratios are the same among health insurers, the health insurer with the higher annual premium amount receives a better rank.

**“To ensure good health: eat lightly,
breathe deeply, live moderately,
cultivate cheerfulness...”**





...and maintain an interest in life.”

William Londen

Internal Appeals

An internal appeal or **utilization review (UR)** occurs when a consumer asks a health insurer to reconsider its refusal to pay for a medical service that the health insurer considers experimental, investigational or not medically necessary. Health insurers are required to have appeals reviewed by medical professionals. Common internal appeals involve the medical necessity of hospital admissions, length of hospital stays and use of certain medical procedures.

Understanding the Charts

- **Filed Appeals:** Number of internal appeals submitted to the health insurer by consumers and providers in 2006.
- **Closed Appeals:** Number of internal appeals that the health insurer was able to reach a decision on by the end of 2006.
- **Reversed Appeals:** Number of closed internal appeals that the health insurer decided in favor of the consumer. If an internal appeal decision is reversed on appeal, the health insurer agrees to pay for the service or procedure.
- **Reversal Rate:** Percentage of reversed appeals divided by closed appeals.

Keep in Mind:

- Pay specific attention to a health insurer that has a very high or very low reversal rate, while
- Keeping the following in mind.
 - There is no “ideal” reversal rate.
 - A low reversal rate may indicate that the health insurer makes its initial decisions correctly, so fewer decisions require reversal, but an unusually low reversal rate may indicate that the health insurer does not give appropriate reconsideration to initial decisions.
 - A high reversal rate may indicate that a health insurer’s appeal process is responsive to consumers, but an unusually high reversal rate may indicate that the health insurer’s process for making initial medical necessity decisions is flawed.
 - The number of internal appeals filed may be higher for health insurers that actively promote the appeal process and encourage members to appeal denied services.

Internal Appeals—HMOs 2006

Data source: NYSID

HMO	Filed Appeals	Closed Appeals ¹	Reversed Appeals	Reversal Rate
Aetna Health	673	658	286	43%
Atlantis Health Plan ²	—	—	—	0%
CDPHP	420	418	166	40%
CIGNA	367	375	188	50%
Community Blue (HealthNow)	682	667	289	43%
Empire HealthChoice	198	198	61	31%
Excellus	970	954	326	34%
GHI-HMO Select	199	205	121	59%
Health Net of NY	2,232	2,256	778	34%
HIP	112	65	33	51%
Independent Health Association (IHA) ³	50	49	35	71%
MDNY	305	323	138	43%
MVP Health Plan	236	241	41	17%
Oxford	4,684	4,675	2,133	46%
Rochester Area HMO (Preferred Care)	139	151	47	31%
UnitedHealthcare of New York	13	13	7	54%
TOTAL	11,280	11,248	4,649	Avg. = 43%

¹Closed internal appeals can exceed filed UR appeals in 2006 because closed internal appeals also include UR appeals filed prior to 2006.

²Atlantis Health Plan has the minimum premium required to report data, but did not report the data by the deadline, so the data are not reported in this Guide.

³Includes appeals for the Art. 43 managed care contracts.

**Internal Appeals—
Non-profit Indemnity Insurers 2006**

Data source: NYSID

Non-profit Indemnity Insurer ¹	Filed Appeals	Closed Appeals ²	Reversed Appeals	Reversal Rate
Excellus Health Plan, Inc.	1,756	1,649	548	33%
Group Health, Inc. (GHI)	5,910	5,962	3,754	63%
HealthNow NY, Inc.	334	324	129	40%
TOTAL	8,000	7,935	4,431	45%

¹Delta Dental and Dentcare Delivery Systems are not included because they do not write a comprehensive health insurance product.

²Closed internal appeals can exceed filed internal appeals in 2006 because closed internal appeals also include internal appeals filed prior to 2006.



Internal Appeals—Commercial Insurers 2006

Data source: NYSID

Commercial Insurer ¹	Filed Appeals	Closed Appeals ²	Reversed Appeals	Reversal Rate
Aetna Group	421	421	113	27%
American Family Corp.	0	0	0	0%
American International Group	0	0	0	0%
American Progressive	0	0	0	0%
CIGNA Health Group	832	852	340	40%
Citigroup	0	0	0	0%
CNA	0	0	0	0%
Combined Life Ins. Co. of New York	0	0	0	0%
Fortis Group	0	0	0	0%
GE Global Group	20	20	12	60%
Guardian Life	2,267	2,256	1,683	75%
Hartford Group	0	0	0	0%
Health Net Ins. Co. of NY	482	475	154	32%
Highmark Inc.	0	0	0	0%
Horizon Healthcare Ins. Co. of NY	427	434	182	42%
John Hancock Life Ins. Co.	0	0	0	0%
Liberty National	0	0	0	0%
Massachusetts Mutual Life Ins. Co.	0	0	0	0%
Metropolitan Group	6,031	6,031	5,224	87%
Mutual of Omaha	15	15	5	33%
New York Life Ins. Co.	0	0	0	0%
Northwestern Mutual	0	0	0	0%
Oxford Health Ins. Inc.	1,398	1,432	480	34%
Protective Life Ins.	0	0	0	0%
Prudential Ins. Co. of America	0	0	0	0%
UnitedHealth Group	177	185	62	34%
UNUM Provident	0	0	0	0%
Wellpoint Inc.	524	521	197	38%
Zurich Ins. Group	0	0	0	0%
TOTAL	12,594	12,642	8,452	Avg. = 17%

¹Many of the commercial companies do not write traditional comprehensive health insurance products and therefore they have no internal appeals.

²Closed internal appeals can exceed filed internal appeals in 2006 because closed internal appeals also include internal appeals filed prior to 2006.

External Appeals

If your health insurer denies health care services because it claims the services are experimental, investigational or not medically necessary, you can request an external appeal. Before requesting an external appeal, you must complete the health insurer's first-level internal appeal process, or you and your health insurer may agree jointly to waive the internal appeal process. (See page 9 for more information about the external appeal process.)

Understanding the Charts

- **Total Appeals:** Total number of cases submitted to an external appeal organization in 2006.
- **Reversed Appeals:** Number of cases where an external appeal organization decided in favor of the consumer.
- **Reversed in Part:** Number of cases where an external appeal organization decided partially in favor of the consumer. For example, an HMO refused payment of a 5-day hospital stay, claiming it was not medically necessary. The external review organization decided that only 3 of the 5 days were medically necessary.

- **Upheld Appeals:** Number of cases where an external appeal organization agreed with the health insurer's decision not to cover a service or procedure.
- **Reversal Rate:** Percentage of cases in which the external appeal organization decided to change the health insurer's decision to deny coverage. 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.

Note: *A high reversal rate may indicate that a health insurer does not make appropriate coverage decisions.*

External Appeals—HMOs 2006

Data source: NYSID

HMO	Total Appeals	Reversed Appeals	Reversed in Part	Upheld Appeals	Reversal Rate ¹
Aetna Health	42	21	1	20	52.4%
Atlantis Health Plan	9	3	3	3	66.7%
CDPHP	9	5	0	4	55.6%
CIGNA	13	9	2	2	84.6%
Empire HealthChoice	140	56	17	67	52.1%
Excellus	110	58	2	50	54.5%
GHI-HMO Select	5	2	2	1	80.0%
Health Net of NY	130	51	10	69	46.9%
HealthNow New York, Inc. (Community Blue HMO)	34	9	1	24	29.4%
HIP	29	12	6	11	62.1%
IHA	11	4	0	7	36.4%
MDNY	3	1	0	2	33.3%
MVP Health Plan	19	6	0	13	31.6%
Oxford	244	92	16	136	44.3%
Rochester Area HMO (Preferred Care)	11	9	0	2	81.8%
UnitedHealthcare of New York	3	1	0	2	33.3%
TOTAL	812	339	60	413	Avg. = 49.1%

¹Rate includes "reversed-in-part" decisions.

**External Appeals—
Non-profit Indemnity Insurers 2006**

Data source: NYSID

Non-profit Indemnity Insurer ¹	Total Appeals	Reversed Appeals	Reversed in Part	Upheld Appeals	Reversal Rate ²
Excellus Health Plan, Inc	158	83	2	73	 53.8%
Group Health, Inc. (GHI)	119	43	7	69	 42.0%
HealthNow NY, Inc.	47	16	4	27	 42.6%
TOTAL	324	142	13	169	 Avg. = 47.8%

¹Delta Dental and Dentcare Delivery Systems are not included because they do not write a comprehensive health insurance product.

²Rate includes “reversed-in-part” decisions.

External Appeals—Commercial Insurers 2006

Data source: NYSID

Commercial Insurers ¹	Total Appeals	Reversed Appeals	Reversed in Part	Upheld Appeals	Reversal Rate ²
Aetna Group	28	7	2	19	32.1%
American Family Corp.	0	0	0	0	0.0%
American International Group	0	0	0	0	0.0%
American Progressive	0	0	0	0	0.0%
Cigna Health Group	24	8	1	15	37.5%
Citigroup	0	0	0	0	0.0%
CNA Insurance Group	0	0	0	0	0.0%
Combined Life	0	0	0	0	0.0%
Fortis Group	0	0	0	0	0.0%
GE Global Group	2	2	0	0	100%
Guardian Life Group	19	6	3	10	47.4%
Hartford F & C Group	0	0	0	0	0.0%
Health Net Ins. Of NY	18	5	2	11	38.9%
Highmark Inc.	0	0	0	0	0.0%
Horizon Healthcare Ins. Co.	16	11	1	4	75.0%
John Hancock GROUP	0	0	0	0	0.0%
Liberty National	0	0	0	0	0.0%
Massachusetts Mutual Life Ins. Co.	0	0	0	0	0.0%
Metropolitan Group	21	7	2	12	42.9%
Mutual of Omaha Group	1	1	0	0	100%
New York Life Ins. Co.	0	0	0	0	0.0%
Northwestern Mutual	0	0	0	0	0.0%
Oxford Group	4	2	0	2	50.0%
Protective Life Ins. Group	0	0	0	0	0.0%
Prudential Life Ins. Co.	0	0	0	0	0.0%
UnitedHealth Group	118	47	3	68	42.4%
UnumProvident Corp. Group	0	0	0	0	0.0%
Wellpoint Inc.	229	108	18	103	55.0%
Zurich Ins. Group	0	0	0	0	0.0%
TOTAL	480	204	32	244	Avg. = 49.2%

¹Many of these commercial companies do not write traditional comprehensive health insurance products and thus have no external appeals.

²Rate includes "reversed-in-part" decisions.

A low-angle, upward-looking photograph of a basketball player in a red jersey. The player is in mid-air, reaching up with their right arm to shoot a basketball into a hoop. The basketball is suspended in the air, just above the hoop. The background is a clear, bright blue sky. The basketball hoop and backboard are visible in the upper right corner. The overall composition is dynamic and energetic.

QUALITY OF CARE AND
SERVICE FOR HMOS
SECTION THREE

3

Overview

This section contains information that applies to HMOs only and not to all types of health insurers. On the following pages, you will find information about these topics.

1. **HMO Service Areas** (page 32)—Find HMOs that offer services near where you live or work.
2. **HMO Performance**—How well the HMO you selected performed in specific areas.
 - **Access and Service** (pages 34–35): How members rated their HMO; their ability to get needed care and to get care quickly; and what percentage of HMO members saw a provider within the past 3 years.
 - **Staying Healthy and Living With Illness** (pages 36–37): Shows how well HMOs ensured that: 2-year-olds were fully immunized; women ages 21-25 received chlamydia screening; adults who smoke received advice from their doctor about quitting; adults who had a heart attack received beta-blocker treatment for 6 months; and members who were hospitalized for treatment of select mental disorders were seen within 30 days of discharge.

- **Quality of Providers** (pages 38–39): How HMO members rated their personal doctor or nurse. This section also shows the percentage of physicians certified by a medical board (**board certified**) and the percentage of physicians who left the HMO in the last year.

3. **Grievances** (pages 40–41): How often HMO members or providers complained directly to the HMO about denials based on limitations or exclusions in the contract.

4. **NCQA Accreditation** (page 42): Lists the accreditation status of New York's HMOs, as determined by NCQA, an independent, non-profit organization that evaluates HMOs. For more information on NCQA, visit www.ncqa.org

5. **How HMOs Pay Primary Care Physicians** (page 43): Explains the different ways HMOs compensate PCPs for providing care to members.



HMO Service Areas¹

Use the following table to find the HMOs that operate in your area.
 Certain plans may not be available for all counties in each 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
	Includes Albany, Clinton, Essex, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.	Includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.	Includes Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan and Ulster Counties.	Includes Nassau and Suffolk Counties.	Includes Bronx, Kings, New York, Queens and Richmond Counties.	Includes Livingston, Monroe, Ontario, Seneca, Wayne and Yates Counties.	Includes Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins Counties.	Includes Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego and St. Lawrence Counties.	Includes Westchester and Rockland Counties.
Aetna Health			•	•	•		•	•	•
Connecticare (formerly Amerihealth)			•						•
Atlantis					•				
CDPHP	•		•		•		•	•	
CIGNA			•	•	•				•
Empire HealthChoice	•		•	•	•				•
Excellus	•	•	•			•	•	•	
GHI-HMO Select	•		•	•	•		•	•	•
Health Net of NY			•	•	•				•
HealthNow (Community Blue)	•	•	•			•	•	•	
HIP			•	•	•				•
Independent Health Association (IHA)		•							
Managed Health				•	•				
MDNY				•					
MVP Health Plan	•		•				•	•	•
Oxford			•	•	•				•
Rochester Area HMO (Preferred Care)		•				•			

¹Service areas are current as of June 1, 2007.



Access and Service

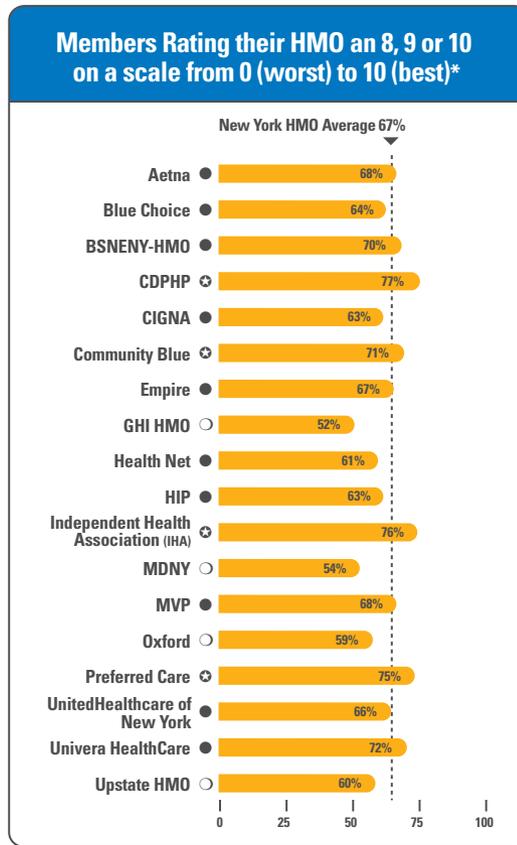
Data source: DOH

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

Understanding These Charts

The circles in the charts show how each HMO compares to the average for all New York HMOs. Look for HMOs with a “⊕” in the chart; these HMOs performed better than the New York HMO average. In other words, they had a greater percentage of satisfied members and were more likely to be seen by a provider.

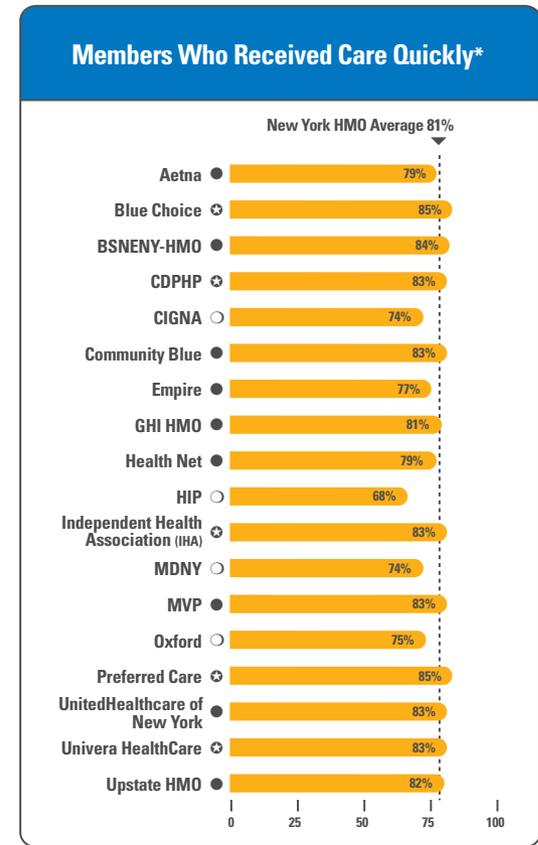
The 67% New York HMO Average for “Members Rating Their HMO...” means that on a scale of 0 (worst) to 10 (best), 67% of all HMO members gave their HMO an 8, 9 or 10 rating.



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.

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

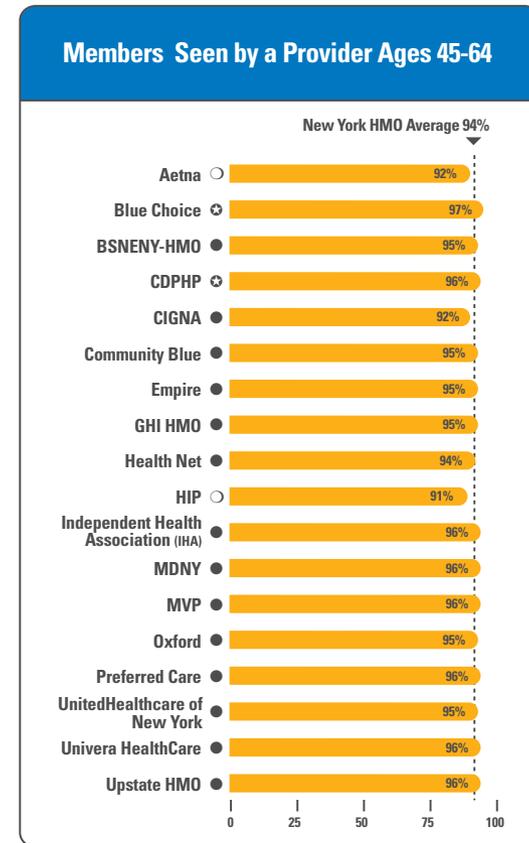
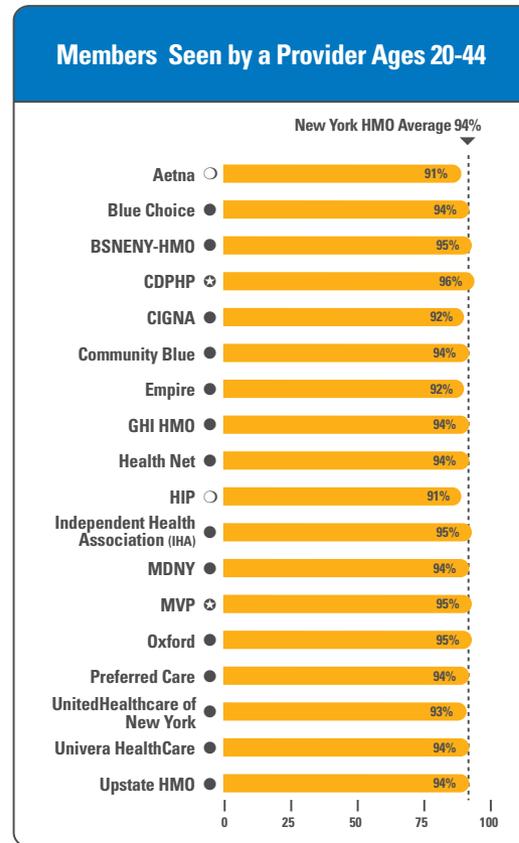
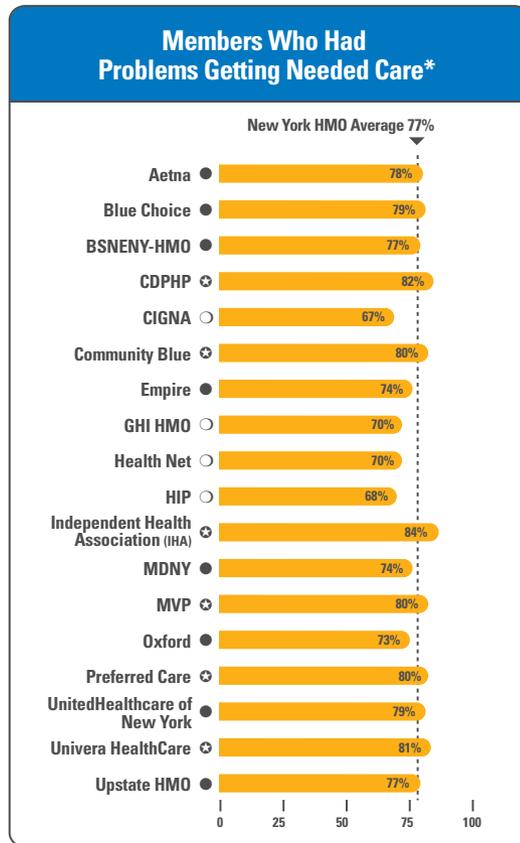


Members responded that they “usually” or “always”:

- 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 the appointment time to see a provider.

Notes: Symbols show statistically significant differences between each HMO's score and the New York average. "Statistically significant" means scores varied by more than could be accounted for by chance. Plans showing the same percentage can have different circles, and thus, be performing at different levels, either because the actual rates are rounded for display purposes or because there are plan eligible population size differences (i.e., denominators) used to calculate the rates.

*Data are from 2006.



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 approval for care.

Even healthy members need to see a provider to ensure that 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 3 years, as reported by the HMO. A higher score means that more people in the HMO had a provider visit.

Staying Healthy and Living With Illness

Data source: DOH

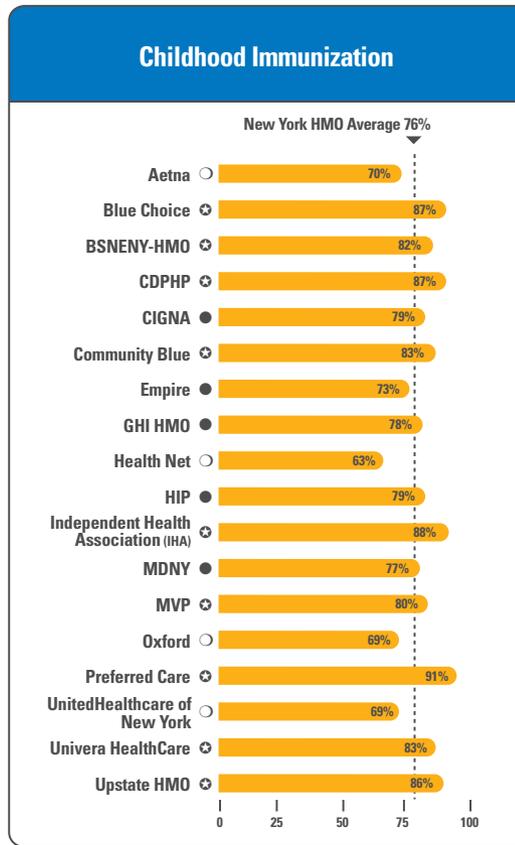
New York HMOs were rated on how well they help people maintain good health and recover from illness.

Understanding These Charts

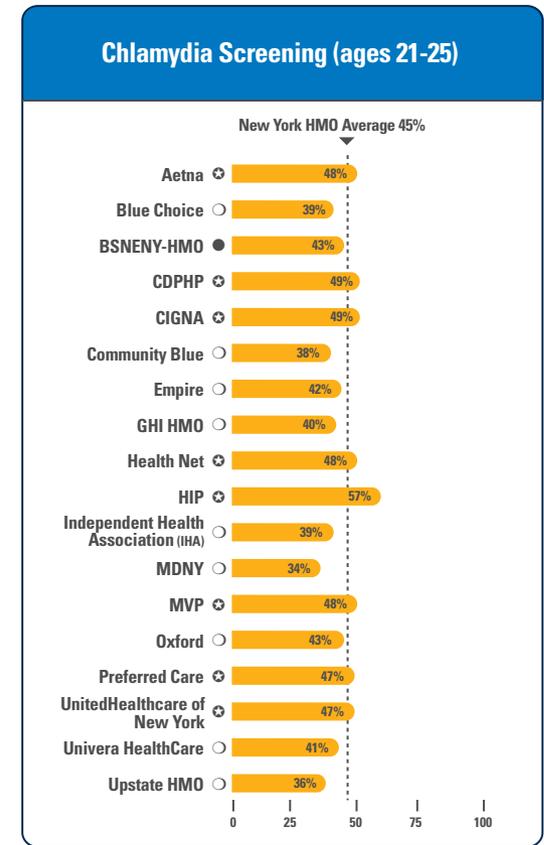
The circles in the charts show how each HMO compares to the average for all New York HMOs. Look for HMOs with a “⊕” in the chart; these HMOs performed better than the New York HMO average. In other words, they had a greater percentage of members who received these services.

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

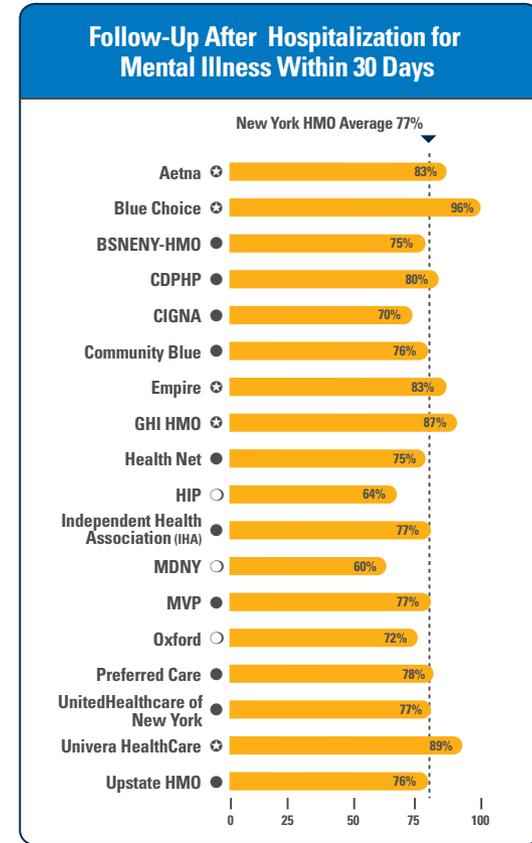
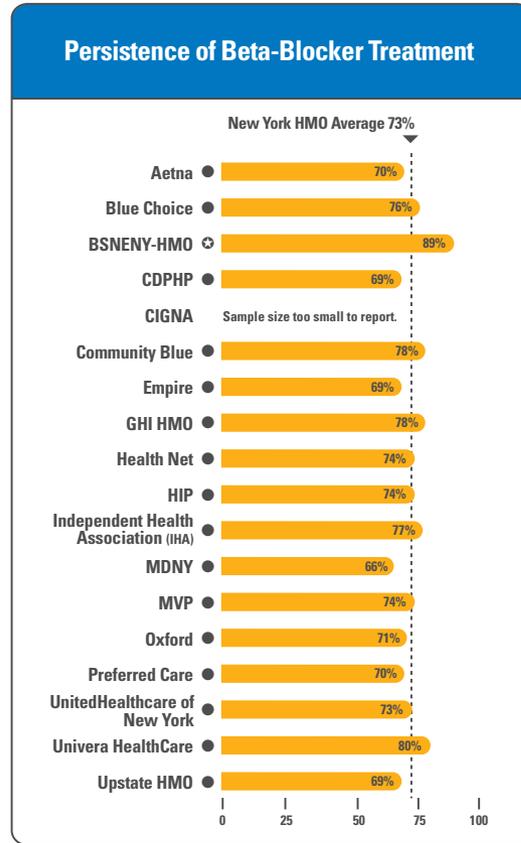
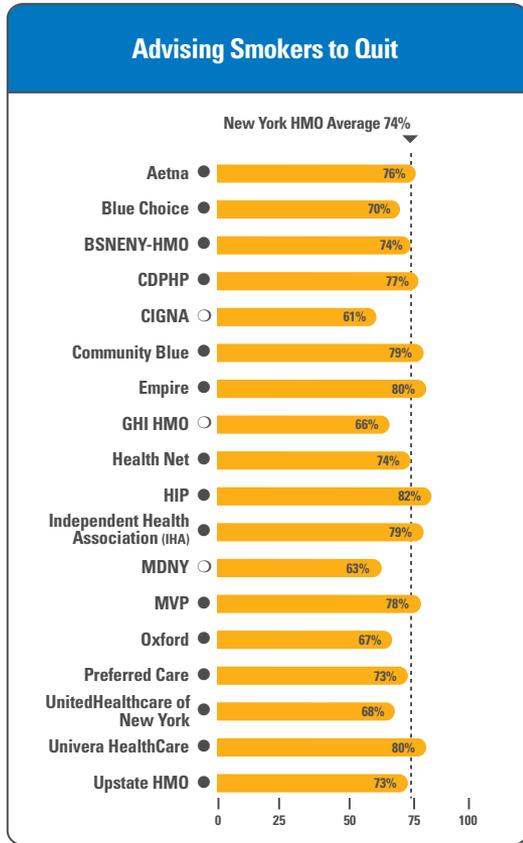


Childhood immunizations prevent the resurgence of many serious infectious diseases. HMOs were rated on the percentage of 2-year-olds who were fully immunized with the following vaccines: 4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B, and 1 Varicella.



Chlamydia is the leading cause of preventable infertility and can lead to pelvic inflammatory disease. Women with chlamydial infections often do not have symptoms, so routine screening and treatment is essential. HMOs were rated on the percentage of sexually active young women who had at least one test for chlamydia.

Notes: Symbols show statistically significant differences between each HMO's score and the New York average. "Statistically significant" means scores varied by more than could be accounted for by chance. Plans showing the same percentage can have different circles, and thus, be performing at different levels, either because the actual rates are rounded for display purposes or because there are plan eligible population size differences (i.e., denominators) used to calculate the rates.



Clinician advice to stop smoking improves the chances a smoker will quit. Smokers who quit have immediate and long-term benefits, reducing risks for many diseases and improving health in general. HMOs were rated on the percentage of members, 18 years and older, who are either current smokers or who recently quit, who received advice within the last 2 years from a health care provider to quit smoking.

Use of beta-blockers reduces the likelihood of dying after a heart attack. It also reduces the risk and severity of another heart attack and preserves heart function. HMOs were rated on the percentage of members, 35 years and older, who were hospitalized after a heart attack and who received beta-blocker medication for 6 months.

Adequate and timely follow-up care for patients discharged from an inpatient mental health facility helps to provide transitional care to an outpatient setting. Follow-up can prevent readmission or identify patients who would benefit from readmission. HMOs were rated on the percentage of members who were hospitalized for treatment for selected mental health disorders (such as depression or bipolar disorder) and were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge.

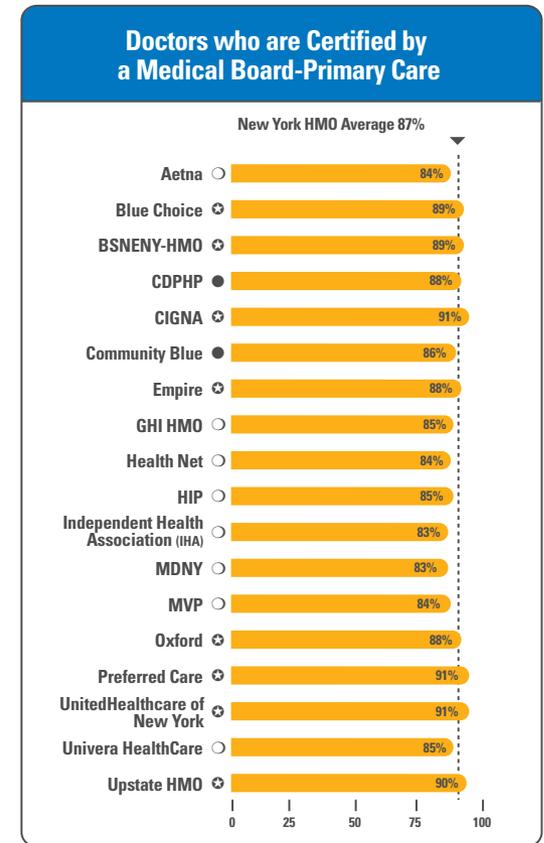
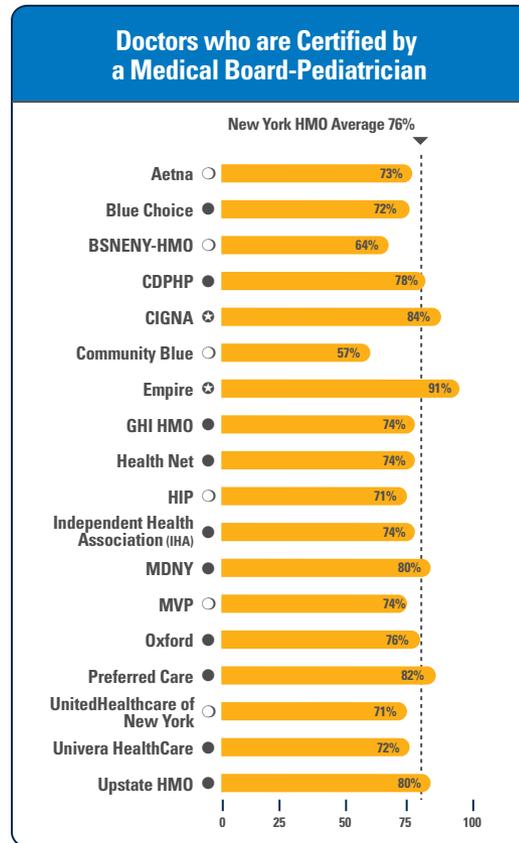
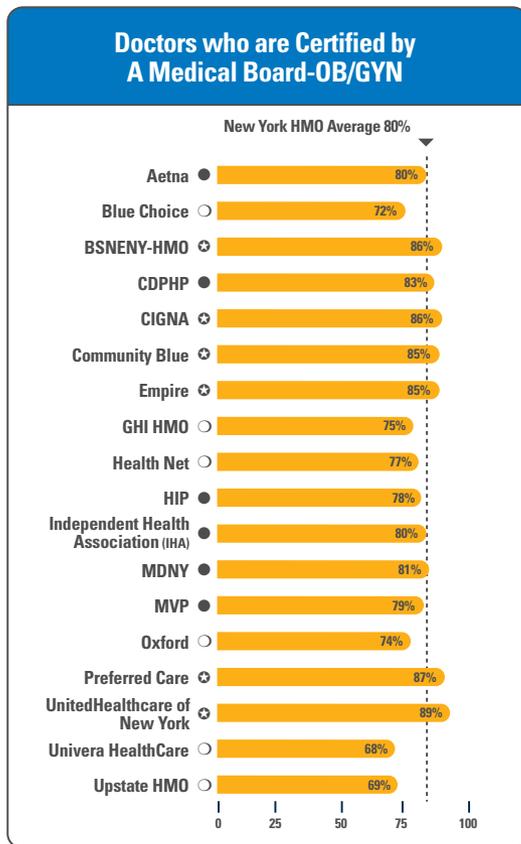
Quality of Providers

Data source: DOH

The quality, stability and availability of physicians in an HMO provider network can impact the overall quality of care delivered to HMO members.

Understanding These Charts

Look for the HMOs that have “⊕” in the chart; these HMOs performed better than the new York HMO average.



Performance Compared to the New York HMO Average

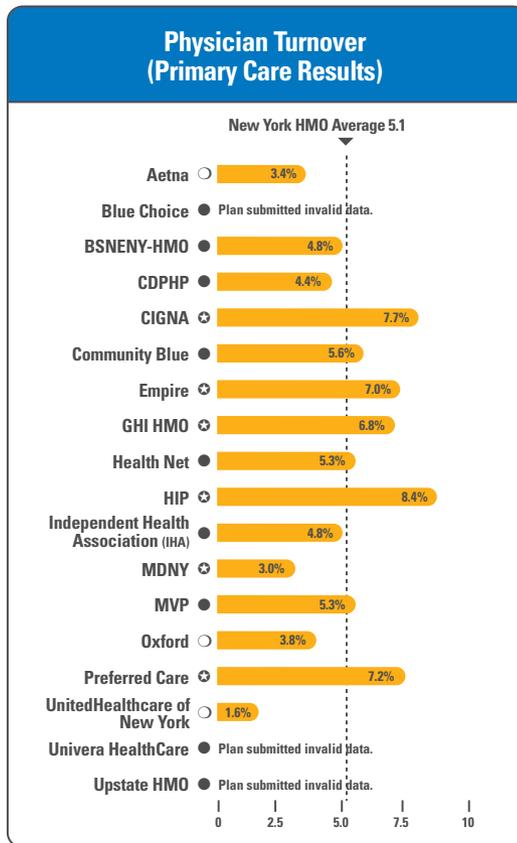
- ⊕ Significantly **better** than the NY HMO average
- **Not significantly different** than the NY HMO average
- Significantly **worse** than the NY HMO average

To be board certified, a doctor must receive additional training and pass an exam in his or her specialty. While board certification is not a guarantee of quality, it shows that the physician has knowledge that the specialty board considers necessary. The chart shows the percentage of PCPs, 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.

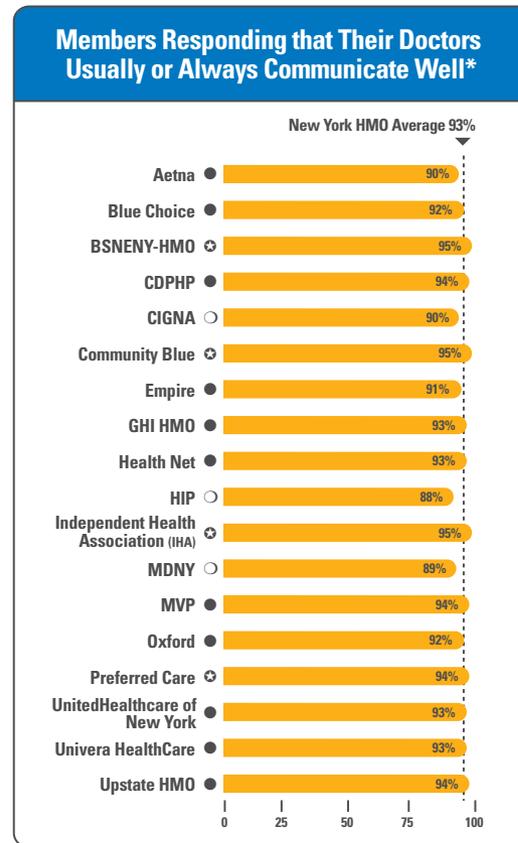
Note: There are times when it is appropriate for HMOs to contract with physicians who are not board certified, as in the case of older physicians trained before board certification was available. In addition, an HMO covering a rural area may have a lower percentage of board-certified physicians, since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

Notes: Symbols show statistically significant differences between each HMO's score and the New York average. "Statistically significant" means scores varied by more than could be accounted for by chance. Plans showing the same percentage can have different circles, and thus, be performing at different levels, either because the actual rates are rounded for display purposes or because there are plan eligible population size differences (i.e., denominators) used to calculate the rates.

*Data are from 2006.

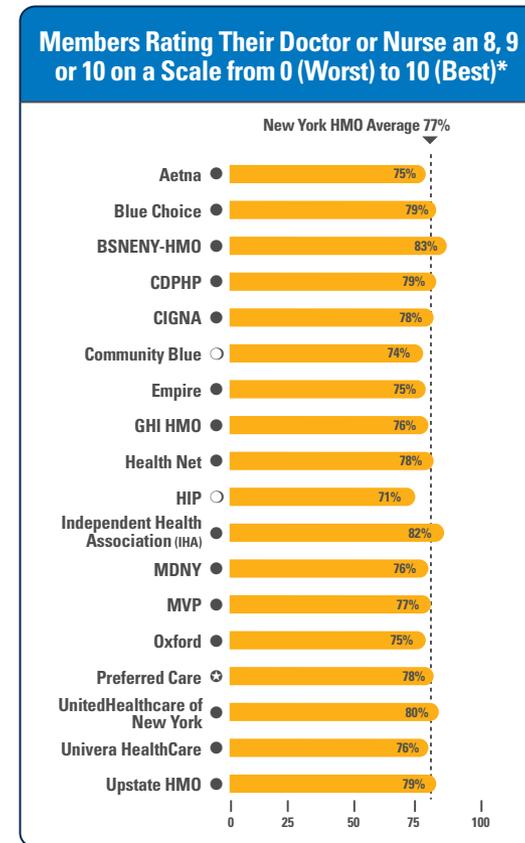


Going to the same doctor over time makes it easier to receive better and more coordinated care. If most doctors remain in an HMO physician network, members are less likely to need to change doctors. The chart shows the percentage of PCPs who left the HMO's network in 2005. A lower percentage means the HMO's provider network is more stable.



Members responded that their doctors or health-care 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.



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.

Grievances

A **grievance** is when a member or provider complains to a health insurer about denials based on limitations or exclusions in the contract. Medical necessity issues are internal appeals, not grievances. (See page 22 for information on internal appeals.) Common grievances include trouble getting referrals to specialists and disagreements over benefit coverage.

According to New York State law, HMOs must have a system in place for responding to members' concerns. A committee within the HMO reviews grievances and decides whether to reverse them or uphold the denials.

Example: A 30% reversal rate indicates that in 3 out of 10 grievances, the HMO changed its initial decision and decided in favor of the consumer or provider.

Understanding the Chart

- **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.
- **Reversal Rate:** Percentage of grievances that the HMO decided in favor of the consumer or provider.

Keep in Mind:

Pay specific attention to a 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 makes correct decisions, so fewer of its decisions require reversal, but an unusually low reversal rate may mean that the HMO does not give appropriate reconsideration to its initial decisions.
- A high reversal rate may indicate that the HMO's grievance process is responsive to members, but an unusually high reversal rate may indicate that its 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 2006

Data source: NYSID

HMO	Filed Grievances	Closed Grievances ¹	Upheld Grievances	Reversed Grievances	Reversal Rate
Aetna Health Inc.	772	741	496	245	33%
Atlantis Health Plan ²	—	—	—	—	
Capital District Phys. Health Plan	1,705	1,696	518	1,178	69%
CIGNA Healthcare of New York	363	353	138	215	61%
Community Blue	917	932	433	499	54%
Empire Health Choice	673	681	543	138	20%
Excellus Health Plan	1,344	1,300	979	321	25%
GHI HMO Select	354	361	122	239	66%
Health Net of New York	1,701	1,532	678	884	58%
HIP	1,205	1,144	420	724	63%
Independent Health Association (IHA)	174	171	67	104	61%
MDNY Healthcare	369	386	207	179	46%
MVP Health Plan	374	341	267	74	22%
Oxford Health Plans of New York	5,704	5,624	2,969	2,655	47%
Rochester Area HMO (Preferred Care)	273	284	161	123	43%
UnitedHealthcare of New York	38	38	20	18	53%
TOTAL	15,966	15,584	8,018	7,596	Avg. = 48%

¹Closed grievances can exceed filed grievances in 2006 because closed grievances also include grievances filed prior to 2006.

²Atlantis Health Plan has the minimum premium required to report data, but did not report the data by the deadline, so the data are not reported in this Guide.

NCQA Accreditation

The National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving health care by assessing and reporting on the quality of health plans.

What Is NCQA Accreditation?

NCQA Accreditation evaluates aspects of HMOs that are important but are generally difficult for people to determine on their own.

NCQA has a team of doctors and health care experts who conduct a comprehensive review of a health plan’s systems and structure against more than 60 different standards. Plans also have to submit clinical performance measures (known as HEDIS^{®1}) as part of the accreditation process. HEDIS data are precisely defined, which makes it possible to compare the performance of HMOs on an “apples-to-apples” basis.

NCQA assigns 1 of 5 possible accreditation outcomes based on the plan’s performance.

******Excellent:** The health plan demonstrates 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 must also achieve HEDIS results that are in the highest range of national or regional performance.

*****Commendable:** The health plan demonstrates levels of service and clinical quality that meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement.

****Accredited:** The health plan meets most of NCQA’s basic requirements for consumer protection and quality improvement.

***Provisional:** The health plan’s service and clinical quality meet some of NCQA’s basic requirements for consumer protection and quality improvement.

Denied: The health plan does not meet NCQA’s basic requirements for consumer protection and quality improvement.

Because participation in NCQA Accreditation is voluntary, not all New York HMOs have an accreditation status.

HMO NCQA Accreditation Status as of July 2007

Note: HMO names in this table may differ from HMO names listed in other sections of this Guide. See the table on page iii.

HMO	NCQA Accreditation Status ²
Aetna Health	****
Atlantis Health Plan	—
Blue Choice	****
BSNENY-HMO (Albany)	****
CDPHP	****
CIGNA	****
Community Blue (Buffalo)	****
Empire HealthChoice	****
GHI-HMO Select	****
Health Net of NY	****
HIP	****
IHA	****
MDNY	—
MVP Health Plan	****
Oxford	****
Rochester Area HMO (Preferred Care)	****
Univera HealthCare	****
Upstate HMO	****

¹HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

²Accreditation status does not include Medicare or Medicaid.

NCQA's Online Health Plan Report Card

To learn more about NCQA Accreditation and to get detailed information about plan performance 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 PCPs in a variety of ways; a typical HMO uses more than one method. No method is the best or right way. Ask your doctor if you have questions or concerns about how your HMO pays PCPs.

Payment Methods

- **Fee for Service:** The HMO pays PCPs for each office visit, procedure and test. Payment is usually based on allowable fee or usual and customary reimbursement.

Allowable Fee or Usual and Customary Reimbursement (UCR):

The maximum amount a health insurer will pay for a service or procedure. Out-of-network services are normally paid based on this amount.

- **Capitation:** The HMO pays PCPs the same amount every month for every member under their primary care, regardless of the services a member receives. Supporters of capitation believe it gives physicians the incentive to keep people healthy through preventive care in order to avoid costly illnesses; others believe it 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 a portion of the PCP's payment to cover unexpected services such as specialty care, laboratory services or hospitalization. If patients do not use these services, the HMO returns the withheld amount to the physician. Some believe that this method helps reduce unnecessary expenses; others believe it discourages providers from offering necessary services.

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.

HEALTH INSURANCE OPTIONS FOR UNINSURED NEW YORKERS

SECTION FOUR



Insurance Options for Uninsured New Yorkers

New Yorkers that do not have health insurance can either:

- Apply for reduced-cost health insurance through New York State (eligibility requirements exist), *or*
- Purchase coverage directly from an HMO (individual coverage).

Program	Programs Offered by New York State			Purchase Insurance Coverage
	Healthy NY	Child Health Plus	Family Health Plus	HMO Plan or HMO/POS Plan
Who Qualifies?	Small employers, sole proprietors and working uninsured individuals who meet income limits.	Children who are under 19 years of age and do not have other health insurance. Governor Spitzer signed a law in 2007 that expanded the eligibility criteria, making this program available to more children.	Adults between 19 and 64 years of age who are uninsured and whose income is too high to qualify for Medicaid.	Uninsured adults and families who are not eligible for other programs.
Cost	Healthy NY benefits are the same for each HMO, but monthly premiums you have to pay will vary.	Depending on your family's gross income, you may have to pay a monthly contribution to enroll in Child Health Plus. Families that insure a child through this program do not have to pay copayments to receive services.	There is no cost to participate in Family Health Plus. There are no premiums or deductibles. Modest copayments apply to some services.	You can purchase either of these benefit packages from HMOs operating in your area. See page 32 to determine which HMOs operate in your area. Rates can be found at www.ins.state.ny.us/ihmoindx.htm
Enrollment	Call this toll-free number: 866-HEALTHY-NY (866-432-5849), or visit the Web site at www.HealthyNY.com	Call this toll-free number: 800-698-4KIDS (800-698-4543) or visit the Web site at http://www.health.state.ny.us/nysdoh/chplus/index.htm	Contact your local Social Services district office about Family Health Plus or visit the Web site at http://www.health.state.ny.us/nysdoh/fhplus/index.htm	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, see page 2.

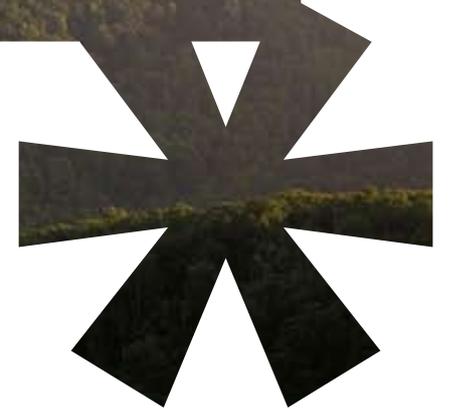
HMO Participation in NY Health Insurance Programs

This table shows HMO participation in New York State programs for uninsured New Yorkers.

HMO	Healthy NY	Child Health Plus	Family Health Plus
Aetna Health	✓		
Atlantis Health Plan	✓		
BlueCross BlueShield of Western New York (Community Blue)	✓		
BlueShield of Northeastern New York (BSNENY)	✓	✓	✓
CDPHP	✓	✓	✓
CIGNA	✓		
Connecticare of New York	✓		
Empire HealthChoice	✓	✓	
Excellus BlueCross BlueShield, Rochester	✓	✓	✓
Excellus Health Plan (Upstate HMO)	✓		
GHI-HMO Select	✓	✓	✓
Health Net of NY	✓		
HIP	✓	✓	✓
IHA	✓		
MDNY	✓		
Managed Health (Healthfirst)	✓		
MVP Health Plan	✓	✓	✓
Oxford	✓		
Rochester Area HMO (Preferred Care)	✓		
Univera Healthcare	✓		
UnitedHealthcare of New York			✓



GLOSSARY OF HEALTH INSURANCE TERMS
OVERALL COMPLAINT RANKING
APPENDICES



Glossary of Health Insurance Terms

Commonly used health insurance terms in this Guide

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

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

Complaint: When a consumer or provider complains to the State of New York about a health insurer.

Copayment: A flat fee for specified medical services required by some health insurers. For example, you pay a \$20 copayment for a doctor visit or a \$50 copayment for a hospital stay.

Deductible: The amount members must pay each year for medical expenses before their insurance policy starts paying. Deductibles are common in FFS plans and PPOs.

Experimental/Investigational: Services that your health insurer or HMO have determined are either unproven for the diagnosis or treatment of your condition or not generally recognized by the medical community as effective or appropriate for the diagnosis or treatment of your condition.

External Appeal: A review of a denial of health care services the health insurer considers to be experimental, investigational or not medically necessary. The review is conducted by an external review organization not affiliated with the health insurer or the member's doctor or family.

Fee-for-Service (FFS): Also known as *indemnity insurance*, FFS is a type of health coverage in which members may go to any doctor or provider. The health insurer reimburses for each covered service provided. Deductibles and co-insurance usually apply in FFS coverage.

First-Level Internal Appeal Process: The process of appealing medical necessity, experimental and investigational denials through your health insurer. If the appeal is not decided in your favor, you are entitled to request an external review. (See *External Appeal*.)

Grievance: When a member or provider complains to a health insurer about denials based on limitations or exclusions in the contract.

Health Maintenance Organization (HMO)

Plan: A type of managed care coverage in which members receive comprehensive health services in return for a monthly premium and copayment. Members are assigned to a PCP who coordinates their care and refers patients to specialists and provider services, as needed. Although many HMOs require members to see doctors and other providers in the HMO provider network, some offer members the option to go out of network (POS plans, for example). HMO plans often require members to get a PCP referral before seeing a specialist. (See *Primary Care Physician and Point of Service Plan*.)

Internal Appeal or Utilization Review (UR):

When a consumer asks a health insurer to reconsider its refusal to pay for a medical service it considers experimental, investigational or not medically necessary. (See *First-Level Internal Appeal Process*.)

Managed Care Organization (MCO): A type of health plan in which members receive services from a variety of participating health care providers contracted by the insurer. Managed care strategies emphasize prevention, detection and treatment of illness. PCPs coordinate patient care needs. Types of MCOs include HMOs and POS plans. (See *Health Maintenance Organization Plan and Point of Service Plan.*)

Non-profit Indemnity Insurer: An insurer that employs managed care strategies but offers a more traditional approach to coverage than HMOs. Non-profit policyholders' deductibles and out-of-pocket costs are considerably higher than those required by HMOs, unless they use a preferred provider network.

Point of Service (POS) Plan: A type of coverage in which members receive services either from participating HMO providers or from providers outside the HMO's network. Members pay less for in-network care and usually pay a higher fee, deductible and co-insurance for out-of-network care.

Pre-Existing Condition: A condition for which treatment was recommended or received in the 6 months before the enrollment date.

Pre-Existing Condition Waiting Period: The time during which the health insurer is not required to provide coverage for a pre-existing condition, not to exceed 12 months. The waiting period may be reduced if the individual was previously covered and applied for new coverage within 63 days of the expiration of coverage.

Preferred Provider Organization (PPO): A type of coverage in which members receive care from a network of doctors and hospitals at a prearranged, discounted rate. Members usually pay more when they receive care outside the PPO network.

Primary Care Physician (PCP): The PCP coordinates care and makes referrals to specialists, as needed. Generally, HMO members must choose a PCP from a list of participating providers. An internist, pediatrician, family physician, general practitioner or, in some instances, an OB/GYN may be a PCP.

Prompt Pay Complaint: A complaint from a consumer or provider to the New York State Insurance Department about untimely processing of a claim.

Referral: Authorization from a PCP or health insurer to see a specialist or receive a special test or procedure. HMOs often require members to obtain a referral for most specialty care. It is important to know a health insurer's rules and procedures for referrals.

Self-Insured Health 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 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 is trained in and practices a specific type of medicine other than primary care (e.g., cardiologist, dermatologist, gastroenterologist). HMO members usually need a referral from their PCP to see a specialist.

Total Annual Premium: Total amount of premiums received by a health insurer from all policies during a calendar year, excluding Medicaid and Medicare.



Overall Complaint Ranking

The table shows the overall rankings 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 health insurers is not an “apples to apples” type of comparison, consider a health insurer’s rank within its category along with this overall rank.

Name	Rank ¹	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio
GE Global Group ^c	1	10	0	203.9	0.0000
Citigroup ^c	2	5	0	99.3	0.0000
Northwestern Mutual ^c	3	1	0	67.7	0.0000
Highmark Inc. ^c	4	8	0	66.3	0.0000
Metropolitan Group ^c	5	49	1	469.6	0.0021
Independent Health Association, Inc. ^h	6	27	4	586.9	0.0068
Unumprovident Corp. Group ^c	7	41	3	432.4	0.0069
Hartford F & C Group ^c	8	12	1	137.9	0.0072
MVP Health Plan, Inc. ^h	9	111	8	944.3	0.0085
Excellus Health Plan, Inc. (HMO) ^h	10	134	20	1,893.3	0.0106
Zurich Ins Group ^c	11	2	1	77.9	0.0128
Prudential Ins. Co. of America ^c	12	7	1	77.3	0.0129
Community Blue ^h	13	86	14	1,037.5	0.0135
Capital District Physicians Health Plan ^h	14	82	9	651.1	0.0138
John Hancock Life Ins. Co. ^c	15	8	2	144.5	0.0138
New York Life Ins. Co. ^c	16	7	1	70.1	0.0143
American Family Life Asr. Co. of NY ^c	17	12	2	132.1	0.0151
Rochester Area HMO ^h	18	18	5	321.6	0.0155
Fortis Group ^c	19	6	1	57.9	0.0173
Wellpoint Inc. ^c	20	609	94	5,397.6	0.0174
Massachusetts Mutual Life Ins. Co. ^c	21	4	1	52.7	0.0189
Combined Life Ins. Co. of NY ^c	22	21	3	122.8	0.0244
American Progressive L&H Ins. Co. of NY ^c	23	19	4	162.8	0.0246
Protective Life Ins. Group ^c	24	23	2	66.9	0.0299
Excellus Health Plan, Inc. ⁿ	25	279	90	2,921.5	0.0300
Healthnow New York, Inc. ⁿ	26	94	37	1,078.2	0.0300
Mutual of Omaha Group ^c	27	19	2	62.8	0.0318

Insurer Categories
^h HMO
^c Commercial Insurer
ⁿ Non-profit Indemnity Insurer

¹The chart ranks health insurers and HMOs by complaint ratio. If the ratios are the same, the health insurer with the higher premium amount ranks higher.

Note: Small insurers and small HMOs are not included. Please consult *Details About the Data* on page ii.

Table continued on next page

Overall Complaint Ranking
(continued)

Name	Rank ¹	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio
Liberty National ^c	28	12	2	53.4	0.0374
Empire Health Choice HMO, Inc. ^h	29	689	75	1,819.3	0.0412
CNA Insurance Group ^c	30	16	3	63.2	0.0475
American Intl Group ^c	31	27	7	144.0	0.0486
Guardian Life Group ^c	32	151	32	505.0	0.0634
Aetna Group ^c	33	162	63	964.6	0.0653
Oxford Health Ins. Inc. ^c	34	386	106	1,454.8	0.0729
CIGNA Health Group ^c	35	93	33	434.1	0.0760
Health Net Ins. Co. of NY ^c	36	83	26	271.2	0.0959
Oxford Health Plans of New York Inc. ^h	37	1,195	279	1,928.8	0.1446
Group Health Inc. (GHI) ⁿ	38	1,343	379	2,391.4	0.1600
Horizon Healthcare Ins. Co. of NY ^c	39	102	28	168.1	0.1665
HIP Health Maintenance Organization ^h	40	1,536	728	4,127.6	0.1763
GHI HMO Select, Inc. ^h	41	133	29	132.5	0.2188
Aetna Health Inc. ^h	42	485	173	779.8	0.2218
Cigna Healthcare of New York, Inc. ^h	43	80	34	117.2	0.2900
UnitedHealth Group ^c	44	1,064	326	991.5	0.3288
Health Net of New York, Inc. ^h	45	766	300	437.8	0.6852
UnitedHealthcare of New York ^h	46	59	25	28.5	0.8752
MDNY Healthcare, Inc. ^h	47	271	236	93.8	2.5152
Atlantis Health Plan ^{h1}	—	—	—	—	—

Insurer Categories

- ^h HMO
- ^c Commercial Insurer
- ⁿ Non-profit Indemnity Insurer

¹Atlantis Health Plan has the minimum premium required to report data, but did not report the data by the deadline, so the data are not reported in this guide.

 Denotes length of bar graph shortened due to spatial constraints.

Contacts and Resources

Questions About This Guide?

Contact:

NYSID Consumer Service Bureau

One Commerce Plaza
Albany, NY 12257
800-342-3736

For additional copies, call 518-474-4557 or visit www.ins.state.ny.us/hgintro/htm

Problem with Your Health Insurer?

First contact your health insurer's Member Services Department to try to resolve the issue. If you cannot resolve the problem to your satisfaction, call the appropriate state agency for assistance.

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

NYSID Consumer Services Bureau

One Commerce Plaza
Albany, NY 12257
www.ins.state.ny.us
800-342-3736 (*coverage, benefits, rates and premiums*)
800-358-9260 (*prompt pay complaints*)

If you were denied coverage of health care services because your health insurer considers them experimental, investigational or not medically necessary, contact:

NYSID External Appeals

PO Box 7209
Albany, NY 12224-0209
www.ins.state.ny.us/extapp/extappaqa.htm
800-400-8882

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

Under federal law, if you receive health coverage through a self-insured plan (ERISA plan), New York consumer protections and insurance laws do not apply to self-insured plans (see page 2). If you have a complaint regarding a self-insured plan, contact:

United States Department of Labor

200 Constitution Avenue, NW
Washington, DC 20210
202-693-8300
866-4-USA-DOL (866-487-2365)

For issues concerning insurance fraud, contact:

NYSID Insurance Frauds Bureau

25 Beaver Street
New York NY 10004
888-FRAUDNY (888-372-8369)

Questions About Programs for the Uninsured?

- **Healthy NY:** Health insurance program for small employers, sole proprietors and uninsured working individuals.
866-HEALTHYNY (866-432-5849)
www.HealthyNY.com
- **Child Health Plus:** Health insurance program for children who are under 19 years of age.
800-698-4KIDS (800-698-4543)
<http://www.health.state.ny.us/nysdoh/chplus/index.htm>
- **Family Health Plus:** Health insurance program for adults between 19 and 64 years of age who are uninsured but have incomes too high to qualify for Medicaid.
877-934-7587
<http://www.health.state.ny.us/nysdoh/fhplus/index.htm>

Questions About Medicare and Medicaid?

For information about Medicare, Medicare Advantage, or Medicare Part D coverage, contact:

Centers for Medicare & Medicaid Services
www.medicare.gov
800-MEDICARE (800-633-4227)

New York State Office for the Aging Health Insurance Information Counseling & Assistance Program (HIICAP)
www.hiicap.state.ny.us
800-701-0501

For information about New York's Medicaid program, please contact your local county Department of Social Services.

Related Resources



Consumer Guide to HMOs

This printed guide includes information and data comparing HMO performance and

premiums, complaint data and tips on how to choose an HMO. Visit www.nyshmoguide.org for an interactive version of the guide and to look at historical complaint data.

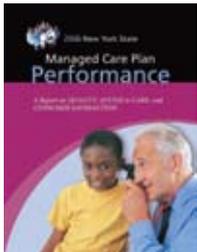
HealthyNY Web Site



This site includes information on HealthyNY coverage, eligibility criteria and information for uninsured New Yorkers. Visit www.HealthyNY.com

Looking for HMO Rates?

To view the rates charged by HMOs, visit www.ins.state.ny.us/ihmoindx.htm



2006 New York Managed Care Plan Performance Report

This report is published by DOH and contains the most recent information from member satisfaction surveys, standardized quality measures and providers in the plans' networks. To obtain a copy, call 518-486-9012 or download the report from: http://www.health.state.ny.us/health_care/managed_care/qarrfull/qarr_2005/qarrintro.htm

Insurance help for the seriously ill (and their caregivers):



This Web site provides detailed insurance information and includes information on health insurance rights and how to exercise these rights to ensure proper access to health insurance coverage. Visit www.insurancehelpny.com



Health Insurer Telephone Numbers

HMOs	
Aetna Health	800-435-8742
Atlantis	866-747-8422
CDPHP	800-777-2273
CIGNA	800-345-9458
Community Blue (HealthNow)	800-544-2583
Connecticare	800-846-8578
Empire HealthChoice	800-261-5962
Excellus	
Finger Lakes HMO	800-462-0108
Upstate HMO	800-462-0108
Univera	800-337-3338
GHI-HMO Select	877-244-4466
Health Net of New York	800-848-4747
HIP	800-447-8255
IHA	800-453-1910
Managed Health (also Health First)	888-260-1010
MDNY	800-707-6369
MVP Health Plan	888-687-6277
Oxford	800-969-7480
Rochester Area HMO (Preferred Care)	800-950-3224
UnitedHealthcare of New York	800-705-1691
Vytra	800-406-0806

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

Commercial Insurers ^a	
Aegon Group	
Stonebridge Life Insurance Company	800-527-9027
Transamerica Financial Insurance Company	888-617-6781
Aetna Group	860-273-0123
American Family Life	800-366-3436
Assurant Group	800-223-1969
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.	800-233-1969
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-MetLife
Mutual of Omaha Group	800-775-6000
MVP Health Ins. Co.	888-687-6277
New York Life Insurance Company	800-695-9873
Oxford Health Insurance Company	800-969-7480
PerfectHealth Insurance	718-370-5380
Provident Life Group	800-858-6843
Prudential Insurance Company of America	800-828-0153
Long Term Care Coverage	800-732-0416
Union Labor	
Group	888-294-5787
Individual	877-820-7448
UnitedHealth Group	800-705-1691
UnumProvident Life Group	800-858-6843
Zurich-American Insurance Companies	800-382-2150

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



