

NEW YORK  
**CONSUMER GUIDE**  
TO HMOs

**2004**

State of New York  
**George E. Pataki**  
Governor

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Department of Insurance  
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Commissioner of Health



STATE OF NEW YORK

September 1, 2004

Dear New Yorker:

Consumers need reliable information to compare the quality of health insurers. The *New York Consumer Guide to HMOs* accomplishes this goal by helping you make the health insurance choice that will best serve you and your family.

The Department of Insurance and the Department of Health have once again combined forces to produce the 2004 *Consumer Guide to HMOs*. The guide offers descriptions of health insurance products available in New York State, such as the newly enhanced Healthy NY program; information on how to choose an HMO; and easy-to-read tables that will help you compare HMOs in terms of quality and service.

The guide also provides vital information on customer service, such as consumer complaints, grievances, and appeals. Telephone numbers for HMOs operating in your area are also included. New York State is committed to promoting a fair and competitive health insurance market and educating consumers so they make smart choices.

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

The information in this guide will help you choose the health insurance plan that best fits your needs. Please review it carefully.

Very truly yours,

George E. Pataki  
Governor

[www.state.ny.us](http://www.state.ny.us)



STATE OF NEW YORK

September 1, 2004

Dear New Yorker:

Over the past decade, Governor Pataki has introduced a series of meaningful health insurance reform measures. Landmark laws — such as the Women’s Health & Wellness Act of 2002, the Health Care Reform Act of 2000, the External Review Law of 1998, and the Women’s Health and Cancer Rights Act of 1997 — have helped improve health care and access to health care services for millions of New Yorkers. During this time, the New York State Insurance Department and the New York State Health Department have been responsible for implementing these important initiatives.

Governor Pataki and the Legislature have also worked hard to reduce New York State’s uninsured population through special programs such as Child Health Plus, Family Health Plus, and Healthy NY. Thanks to Healthy NY, quality health insurance is now within reach of tens of thousands of small business owners and uninsured workers. Last year, Governor Pataki announced enhancements to the Healthy NY program, making the coverage more affordable and providing additional choices for prescription drug coverage.

The *New York Consumer Guide to HMOs* is designed to help you make sense of your health coverage options. The newly revised guide contains a ranking of all major HMOs in New York State by complaints closed in the consumer’s favor. The guide also contains important information from the Department of Health to help you assess the quality of care offered by New York HMOs. In addition, the guide includes information on external review cases closed by each HMO in the past year as well as the percentage of those cases decided in the consumer’s favor.

You should be aware that the guide is also available on the Insurance Department’s Web site ([www.ins.state.ny.us](http://www.ins.state.ny.us)) as an *interactive* application, where you can quickly find information about HMOs operating in your area. Detailed information on health plan quality performance is also available in interactive format through the Department of Health Web site ([www.health.state.ny.us](http://www.health.state.ny.us)).

Since 1999, the Insurance Department and Health Department have offered this type information to New Yorkers, updated annually. Our goal is simple: providing every New York resident with timely information to make informed HMO comparisons. Let us once again help you make these important choices.

Very truly yours,

Gregory V. Serio  
Superintendent of Insurance  
[www.ins.state.ny.us](http://www.ins.state.ny.us)

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# HOW TO CHOOSE A NY HMO

## A Step-by-Step Guide

### Step 1

#### Identify your options.

You should narrow your focus and compare HMOs that:

- Offer care and service in the area where you live and work
- Your doctor(s) participate in
- Your employer offers as a benefit
- Have premiums, deductibles and copayments that you can afford

### Step 2

#### Determine which issues are most important to you in an HMO.

This Guide provides answers to questions you may have when choosing an HMO:

- How do HMOs rank based on member complaints to the New York State Insurance Department?
- How often are HMO decisions to deny care or service changed?
- Do HMO members have access to the care and service they need?
- How well do HMOs help members maintain good health and avoid illness?
- How is the quality of HMO providers determined?

### Step 3

#### Evaluate and compare the performance of HMOs.

This Guide tells you how well New York HMOs performed in five areas:

- Complaints
- Independent External Reviews
- Access to Care and Service
- Staying Healthy and Living With Illness
- Quality of Providers

You will learn what each performance area measures, how New York HMOs rate and what the results mean. Tables compare each HMO's performance to the average performance of all New York HMOs.

### Step 4

#### Select an HMO.

After completing steps 1-3, you should be ready to select an HMO. Focus on large rather than small differences when you compare plans. Basing a decision on a small difference may not change your family's health care experience.



## How do HMO and POS plans work?

Health maintenance organizations (HMO) deliver health care to members using provider **networks**, which are the groups of doctors, hospitals and other health care providers that have agreed to serve members of a particular HMO. Health benefits are covered if the member uses providers that are **in-network**.

All New York HMOs also offer a **point of service** (POS) option that allows members to seek care from providers that are **out-of-network**. Services provided by out-of-network providers generally cost the member more in out-of-pocket expenses.

The table to the right highlights some of the important similarities and differences between HMO and POS options.

### Choices Available for Individual Coverage

Under New York State Insurance Law, New Yorkers purchasing health insurance on their own can choose either an HMO plan or an HMO's POS option at any time during the year. They cannot be denied coverage if they have health problems. However, they may be subject to certain pre-existing condition limitations before coverage begins.

### A Word About Premiums

To compare prices of HMOs in your area, view their current premiums on the Web at [www.nyshmoguide.org](http://www.nyshmoguide.org).

### Facts About HMO and POS Options

	HMO	POS Option
Can I get services from providers who are out-of-network?	No. The HMO pays for all covered services as long as you use in-network providers. If you go out-of-network, you pay the entire cost.	Yes. You pay more for out-of-network providers, and fewer health services may be covered.
How do I pay for services?	There is no deductible. You are charged a copayment (usually between \$5 and \$25) for a physician office visit.  You usually do not need to fill out claim forms.	If you use an in-network provider, there is no deductible and you are charged a copayment. You do not need to fill out a claim form.  If you use an out-of-network provider, you may pay a deductible and a greater portion of the medical expenses. You may need to fill out a claim form.
Do I need to choose a primary care physician (PCP)?	Yes. You are usually required to choose a PCP from a list of in-network doctors. Your PCP takes care of most of your medical needs.	Yes. You usually need to choose a PCP from the list of in-network doctors.  You have the option of using the PCP or going to an out-of-network doctor.
Do I need a referral from my PCP to see a specialist?	Yes. Before you go to a specialist, you usually need a referral from your PCP.	Sometimes. You usually need a referral from your PCP to see an in-network specialist, and to be covered for the maximum benefit with minimum cost to you.  You do not need a referral to see an out-of-network specialist, but you will probably pay more in copayments and deductibles.

# COMPLAINTS

## How do HMOs rank based on member complaints to the New York State Insurance Department?



### To find the answer...

Look at the table to the right. You will find information about **complaints** against HMOs that were reviewed and closed by the New York State Insurance Department in the year 2003.

The Insurance Department reviews each complaint, and then decides if the HMO is at fault and needs to remedy the problem. An **upheld complaint** occurs when the Insurance Department agrees with the member or provider. An HMO's **complaint ratio** is determined by comparing the number of upheld complaints to the HMO's size, which is indicated by its **total premium**.

New York law requires that all HMOs pay providers and members within 45 days of receipt of an undisputed claim for health care services. The Insurance Department reviews each **prompt pay complaint** and decides if the HMO is at fault and needs to remedy the problem. An **upheld prompt pay complaint** occurs when the Department agrees with the member or provider that a payment was late (or that the HMO made a late decision not to pay the claim).

The table ranks HMOs by their complaint ratio from best (lowest complaint ratio) to worst (highest complaint ratio). A better ranking means that the HMO had fewer upheld complaints relative to its size. Keep in mind, HMOs with a larger premium typically have more members and therefore, more complaints than smaller HMOs. For each HMO, the table tells you:

- **Rank** based on complaint ratio
- **Total complaints** closed in 2003
- Number of **upheld complaints** (including prompt pay complaints) in 2003
- Number of **upheld prompt pay complaints** in 2003
- **Total premium** in 2003
- **Membership** in each plan, including spouses and children
- **Complaint ratio**



### To make a decision...

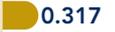
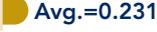
Evaluate the importance of this performance measure to you and your family. For example, are you concerned that a particular plan has had a lot of complaints filed against it?

Make a decision based on the priorities you have for your family's health care. *The Complaints category is only one of five performance areas presented in this Guide.*

## Complaints – HMOs, 2003

Data source: NYSID

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

HMO <sup>a</sup>	Rank	Total Complaints	Upheld Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Membership (as of 12/31/03)	Complaint Ratio
Aetna Health	12	1,201	369	298	1,167.4	348,033	 0.316
CDPHP	2	112	12	7	664.2	264,752	0.018
CIGNA	15	251	92	67	202.5	61,294	 0.454
Community Blue (HealthNow)	7	151	30	17	818.1	350,324	0.037
Empire HealthChoice	3	855	23	10	1,023.2	390,419	0.022
Excelsus <sup>b</sup>	4	164	32	13	1,405.2	561,394	0.023
GHI-HMO Select	10	98	21	17	85.7	35,646	 0.245
Health Net of NY	14	1,198	201	155	588.5	212,318	 0.342
HIP <sup>c</sup>	16	1,695	963	898	1,581.5	586,303	 0.609
IHA	6	76	20	15	601.2	270,964	0.033
MDNY	17	303	199	181	153.3	47,023	 1.298
MVP Health Plan	5	244	23	9	936.1	345,731	0.025
Oxford	13	2,830	870	658	2,744.2	831,891	 0.317
Rochester Area HMO (Preferred Care)	1	8	3	0	213.8	96,740	0.014
UnitedHealthcare of NY	11	180	33	21	106.4	63,032	 0.310
Vytra	8	174	17	8	267.7	93,653	0.064
WellCare <sup>d</sup>	9	11	3	3	30.7	15,957	0.098
<b>TOTAL</b>		<b>9,551</b>	<b>2,911</b>	<b>2,377</b>	<b>12,589.8</b>	<b>4,575,474</b>	 Avg.=0.231

<sup>a</sup> Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.

<sup>b</sup> Excelsus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

<sup>c</sup> Complaint ratio, Insurance Department complaints, and premium include data from Health Insurance Plan's (HIP's) HMO and non-profit business. In 2003, roughly 2% of HIP's business was attributable to its non-profit operation.

<sup>d</sup> WellCare writes only government-sponsored business; the \$30.7 premium is derived in large part from the Child Health Plus and Family Health Plus programs.

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

# INDEPENDENT EXTERNAL REVIEWS

## How often are HMO decisions to deny care or service changed?



### To find the answer...

Look at the table to the right. You will find information about external reviews requested by members and closed by an independent external review organization in the year 2003. When an HMO denies care 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 **external review**.

An independent external review organization evaluates the HMO's decision to deny care, then decides if the HMO should change its decision. A **reversed review** occurs when the independent external review organization decides in favor of the member and reverses the HMO's decision to deny care. For more information on eligibility and the external review process, please see page 19.

An HMO's **reversal rate** is the percentage of cases in which the decision to deny coverage is changed. A lower reversal rate means that the HMO had fewer reversed reviews. Please note, there is no "ideal" reversal rate. For each HMO, the table tells you:

- **Total number of external reviews**
- **Number of reversed reviews**
- **Reversal rate**



### To make a decision...

Only a small percentage of an insurer's coverage decisions were subject to an independent external review and there is no ideal reversal rate. Evaluate the importance of this performance measure to you and your family.

Make a decision based on the priorities you have for your family's health care. *The Independent External Reviews category is only one of five performance areas presented in this Guide.*

#### You are eligible for an independent external review if:

- Your HMO considers the treatment experimental, investigational, or not medically necessary.
- You have appealed the denial of care or service to your HMO through its formal appeal process, and your HMO did not change its decision.

For information on how to request an independent external review, please see page 19 of this Guide. For more detailed information, please see the *2004 New York Consumer Guide to Health Insurers* also available on the Web at [www.ins.state.ny.us](http://www.ins.state.ny.us). You can also call the external review hotline at **1-800-400-8882**.

## Independent External Reviews - HMOs, 2003

Data source: NYSID

HMOs are listed alphabetically.

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



**Remember,**  
you have the right to an external review of any final adverse decision denying coverage because the procedure, service or treatment is considered not medically necessary.

<sup>a</sup> Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members. Excludes Medicaid external reviews.

<sup>b</sup> Rate includes "Reversed in Part" decisions.

<sup>c</sup> Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

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

<sup>e</sup> WellCare writes only government-sponsored business; its premium is derived in large part from the Child Health Plus and Family Health Plus programs.

# ACCESS TO CARE & SERVICE

## Do HMO members have access to the care and service they need?



### To find the answer...

Look at the table to the right. You will find information about how members rated their HMO in terms of **access to care and service**. They answered several questions about their experience and satisfaction with their HMO. Members were asked:

- How they would **rate their HMO** overall
- If they had **problems getting needed care**
- If they had **received care quickly**

The results of all the performance measures in this area are presented in the table. Notice that each HMO is rated as performing significantly better than the average, not significantly different than the average or significantly worse than the average of all New York HMOs.

In addition, HMO health records showed how many members **visited a health care provider** in the last three years.



### To make a decision...

These measures indicate how well an HMO provides needed access for its members. Evaluate the importance of each performance measure to you and your family. One particular performance measure in this area may be more important to you than others.

Make your decision based on the priorities you have for your family's health care. *The Access to Care and Service category is only one of five performance areas presented in this Guide.*



**Remember**, if you have a medical emergency, you have the right to receive care at any emergency room without obtaining prior approval from your HMO.

**Access and Service**  
Data source: DOH

**Performance Compared to the New York HMO Average**

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

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

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

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

# STAYING HEALTHY

## How well do HMOs help members maintain good health and avoid illness?



### To find the answer...

Look at the table to the right. You will find information about how well each HMO helped people stay healthy and avoid illness. It shows the percentage of:

- children with persistent **asthma** who received appropriate medications to control their condition
- women who had a **cervical cancer** screening within the past three years
- members with **depression** who were given appropriate medication and had at least three follow-up visits during a 12-week treatment period
- adults with persistent **asthma** who received appropriate medications to control their condition
- members with hypertension who controlled their **blood pressure** (at or below 140/90)

The results of all the performance measures in this area are presented in the table. Notice that each HMO is rated as performing significantly better than the average, not significantly different than the average or significantly worse than the average of all New York HMOs.



### To make a decision...

These measures indicate how well an HMO delivers preventive care to help members stay healthy. Evaluate the importance of each performance measure to you and your family. One particular performance measure in this area may be more important to you than others.

Make your decision based on the priorities you have for your family's health care. *The Staying Healthy category is only one of five performance areas in this Guide.*



**Remember**, you have the right to a second medical opinion if you are diagnosed with cancer.

**Staying Healthy**

Data source: DOH

**Performance Compared to the New York HMO Average**

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

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

NV – Plan submitted invalid data.

SS – Rate not suitable for comparison because of a small sample size.

\* Albany Division of Community Blue.

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

# QUALITY OF PROVIDERS

## How is the quality of HMO providers determined?



### To find the answer...

Look at the table to the right. You will find information about how members rated their HMO's quality of providers. They answered several questions about the quality of their providers, including overall service and communication. Members were asked if their doctors "usually" or "always":

- **Listen carefully** to them
- **Explain** things in a way they understand
- Show **respect** for what they have to say
- Spend enough **time** with them during visits

The results of all the performance measures in this area are presented in the table. Notice that each HMO is rated as performing significantly better than the average, not significantly different from the average or significantly worse than the average of all New York HMOs.

In addition, the table shows the percentage of their doctors who are certified by a Medical Board. A doctor must receive additional training and pass an exam in his/her specialty to be **Board Certified**.

The last column in the table shows the percentage of primary care physicians who left the HMO's network in 2002. A lower percentage means the HMO's provider network is more **stable**.



### To make a decision...

These measures indicate how satisfied members are with their health care providers and how many providers have undergone specialized training. Evaluate the importance of each performance measure to you and your family. One particular performance measure in this area may be more important to you than others.

Make your decision based on the priorities you have for your family's health care. *The Quality of Providers category is only one of five performance areas in this Guide.*



**Remember**, if your HMO does not have an appropriate in-network provider for your condition, you have the right to see an out-of-network provider without additional cost.

## Quality of Providers

Data source: DOH

### Performance Compared to the New York HMO Average

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

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

SS – Rate not suitable for comparison because of a small sample size.

\* Albany Division of Community Blue.

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

# OPTIONS FOR UNINSURED NEW YORKERS

## Special New York Programs



### Review of Available Options

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

Remember, HMOs are required by law to offer HMO/POS coverage to individuals at all times during the year.

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

- **Healthy NY** (page 15) is a unique program designed to offer health insurance to small employers, sole proprietors and uninsured working individuals. The program offers two standardized health insurance benefit packages (one with and one without a prescription drug benefit) that are made more affordable through State sponsorship.
- **Child Health Plus** (page 16) is a health insurance plan for children who are under the age of 19. The monthly premium varies depending on family income and family size.
- **Family Health Plus** (page 17) is a health insurance program for adults between the ages of 19 and 64 who are uninsured but have incomes too high to qualify for Medicaid. The Medicaid program provides funding, with cost shared between Federal, State and local governments.

# HEALTHY NY

## Coverage for small businesses and the working uninsured

### Healthy NY

Healthy NY brings affordable, comprehensive health insurance to the working uninsured. Healthy NY is for small businesses, sole proprietors and working people without health insurance. Each program has its own set of eligibility rules.

#### Summary of Benefits

Under the Healthy NY program, all New York HMOs offer two standard, yet comprehensive health insurance benefit packages to qualifying small businesses, sole proprietors and individuals. One package provides no prescription drug benefit; the other offers a \$3,000 per person, per year prescription drug benefit. Healthy NY benefit packages are specifically designed to be more affordable than other coverages. You must pay a monthly premium for Healthy NY. Even though Healthy NY benefits are the same at each HMO, premiums vary.

Coverage for important services such as hospital care, regular medical checkups and prescription drugs are available. Doctors and health care providers who are part of the HMO's network provide all services.

For more information about enrolling in Healthy NY, or if you are a small business or sole proprietor, call this toll-free number: **1-866-HEALTHY-NY** (1-866-432-5849) or visit the Web site at [www.HealthyNY.com](http://www.HealthyNY.com).

#### Eligibility and Enrollment

To be eligible for Healthy NY coverage through the individual program, your total household income must not exceed the limits listed below. The amount of the household income limit depends upon the number of household members you have.

#### Healthy NY Income Individual Eligibility Guidelines

*Effective January 2004 and subject to revision.*

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

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

# CHILD HEALTH PLUS

## Coverage for children



### Child Health Plus

Child Health Plus provides comprehensive health insurance to New York children who do not have health care coverage. All services are provided on an **in-network** basis, which means that enrolled children must use doctors and health care providers who are part of the HMO's network of providers. Not all HMOs participate in Child Health Plus. See page 23 to find which HMOs participate.

#### Summary of Benefits

Families who insure a child through the Child Health Plus program must pay a monthly contribution to enroll. However, you are not charged a co-payment for services received. Important services such as well-child care, immunizations, hospital care, prescription drugs and outpatient care are available to children at little or no cost through Child Health Plus.

To find more information about enrolling your child in Child Health Plus, call this toll-free number: **1-800-698-4KIDS** (1-800-698-4543) or visit the New York State Department of Health's Web site at **www.health.state.ny.us**.

#### Eligibility and Enrollment

Children under age 19 who are not eligible for Medicaid and who have limited or no health insurance may be eligible for Child Health Plus. Even if your family income is relatively high, your children may still qualify for Child Health Plus. To be eligible for Child Health Plus, your total household income must not exceed the amounts shown in the table below.

#### Child Health Plus B\* Income Eligibility Levels

*Effective January 2004 and subject to revision.*

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

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

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

<sup>d</sup> 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

## Coverage for adults and families

### Family Health Plus

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. All services are provided on an **in-network** basis, which means that enrolled members must use doctors and health care providers that are part of the HMO's network of providers. Not all HMOs participate in Family Health Plus; see page 23 to find out which do.

#### Summary of Benefits

Coverage for important services such as hospital care, regular medical checkups, prescription drugs and outpatient care are available to enrollees and their families free of charge. The Medicaid program provides funding, with cost shared between Federal, State and local governments.

To find more information about enrolling you or your family in Family Health Plus, call this toll-free number: **1-877-934-7587** or visit the New York State Department of Health's Web site at **[www.health.state.ny.us](http://www.health.state.ny.us)**.

#### Eligibility and Enrollment

Family Health Plus provides health care benefits for adults, ages 19–64, who do not have health coverage. Household income must be below the maximum limits shown below and the family must not be eligible for Medicaid. Enrollment facilitators are located throughout New York to help ease the enrollment process and to answer questions. Local social services district offices also accept applications.

#### Family Health Plus Eligibility

*Effective January 2004 and subject to revision.*

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

# HMO MEMBER RIGHTS

## New York HMO Members have the right to...



- Receive care for an emergency condition at an emergency room without getting prior approval from their HMO.
- A second medical opinion if they are diagnosed with cancer.
- Stay in the hospital for at least 48 hours after childbirth (96 hours following a caesarean section) and for as long as the doctor determines necessary after a mastectomy.
- Go directly to a participating provider for certain obstetrical/gynecological services without a referral from their primary care physician.
- See an out-of-network provider without additional cost if their HMO does not have an appropriate in-network provider for their condition.
- Receive a "standing referral" to a specialist; members do not need a referral each time they see the same specialist.
- Continue to see their current provider for the duration of postpartum care related to delivery if they switch to a new HMO during their second or third trimester of pregnancy. The provider must agree to the new HMO's terms.
- Continue to see their current provider for 60 days if they have a life-threatening, degenerative or disabling condition or disease and their provider agrees to the new HMO's terms.
- File a grievance if they disagree with any HMO determination other than one involving medical necessity or experimental or investigational treatment.
- Have any grievance decided within 48 hours when a delay would increase the risk to their health.
- Appeal through the HMO's own utilization review process any determination that a procedure, service or treatment is not covered because it is considered experimental, investigational or not medically necessary.
- An expedited appeal through the HMO's utilization review process if they are undergoing a course of treatment or if their doctor believes an immediate appeal is warranted.
- An external review by an independent external review organization of any final adverse determination denying coverage because a procedure, service or treatment is considered experimental, investigational or not medically necessary.

# YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

## Eligibility and the review process

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**.

### To be eligible for an external review, you must:

- Follow your insurer's internal appeal process for denied services.
- 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 that you and your insurer have agreed to waive the internal appeal process.
- 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.
- Request an external review for a service that is a covered benefit under your plan.

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

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

### The External Review Process

After an external review is requested, you and your health insurer are notified when your case qualifies. Your health insurer must then send your medical and treatment records to the external review organization. You and your doctor may submit additional information. A determination is issued within 30 days of when your request was received.

If a delay in treatment poses an immediate or serious threat to your health, an expedited review determination can be issued within three days.

The decision of the external review organization is final and binding for you and your health plan, which means that the decision cannot be changed or altered by either party.

**To request an independent external review application, contact the Insurance Department at 1-800-400-8882, or visit the Web site at [www.ins.state.ny.us](http://www.ins.state.ny.us).**

# NEW YORK HMO LISTING

## Phone numbers and service areas



A comprehensive listing of all New York HMOs follows on the next page. You will find information specific to each HMO including:

- Telephone number
- Areas in which they provide service

### This listing includes:

#### Service Areas

- **Albany** includes Albany, Clinton, Essex, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.
- **Buffalo** includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.
- **Hudson Valley** includes Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan and Ulster Counties.
- **Long Island** includes Nassau and Suffolk Counties.
- **New York City** includes Bronx, Kings, New York, Queens and Richmond Counties.

- **Rochester** includes Livingston, Monroe, Ontario, Seneca, Wayne and Yates Counties.
- **Syracuse** includes Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins Counties.
- **Utica/Watertown** includes Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego and St. Lawrence Counties.
- **Westchester** includes Westchester and Rockland Counties.

HMO Service Areas

HMO <sup>a</sup>	Phone	Service Areas								
		Albany	Buffalo	Hudson Valley	Long Island	New York City	Rochester	Syracuse	Utica/Watertown	Westchester
Aetna Health	800-872-3862			•	•	•		•	•	•
AmeriHealth Health Plan	800-877-9829			•						•
Atlantis	212-747-0877					•				
CDPHP	800-777-2273	•		•				•	•	
CIGNA	800-345-9458			•	•	•				•
Community Blue (HealthNow)	800-544-2583	•	•	•			•	•	•	
Empire HealthChoice	800-261-5962	•		•	•	•				•
Excensus <sup>b</sup>	800-462-0108	•	•	•			•	•	•	
GHI-HMO Select	877-244-4466	•		•	•	•		•	•	•
Health Net of NY	800-848-4747			•	•	•				•
HIP	800-447-8255			•	•	•				•
Horizon Healthcare	866-326-3389			•	•	•				•
IHA	877-453-1910		•							
Managed Health	888-260-1010				•	•				
MDNY	888-707-6369				•					
MVP Health Plan	888-687-6277	•		•				•	•	•
Oxford	800-666-1353			•	•	•				•
Rochester Area HMO (Preferred Care)	800-950-3224		•				•			
UnitedHealthcare of NY	800-705-1691			•	•	•		•	•	•
Vytra	800-406-0806				•	•				
WellCare	800-288-5441	•		•		•				•

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

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

<sup>b</sup> Excensus Group includes Finger Lakes HMO & Blue Choice HMO (800-462-0108), Upstate HMO (800-722-7884) and the Univera Healthcare HMO (800-337-3338).

# NEW YORK HMO LISTING

## Accreditation and participation status

The listing of all New York HMOs on the next page contains the following information:

- NCQA Accreditation status of each HMO
- Whether the HMO offers coverage through Healthy NY, Child Health Plus or Family Health Plus

### NCQA Accreditation Status

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving the quality of health care everywhere. NCQA Accreditation is nationally recognized as a "seal of approval" for health plans. Health plans can receive one of five NCQA accreditations:

- Excellent
- Commendable
- Accredited
- Provisional
- Denied

You will find that not all health plans are accredited by NCQA. Accreditation is a voluntary process, thus some plans will not have an accreditation status.

### Participation Status

The last three columns show HMO participation in New York State programs for uninsured New Yorkers. Review pages 14-17 to learn more about the **Healthy NY**, **Child Health Plus** and **Family Health Plus** programs.

A number of Prepaid Health Service Plans (PHSP) are similar to HMOs and offer Family Health Plus and Child Health Plus coverage. Find out more about PHSPs by visiting the New York State Department of Health's Web site at [www.health.state.ny.us](http://www.health.state.ny.us).

New York HMO Accreditation and Participation Status as of July 2004

HMO <sup>a</sup>	NCQA Accreditation Status	Healthy NY	Child Health Plus	Family Health Plus
Aetna Health	Excellent	✓		
BlueCross BlueShield of Western New York (Community Blue)	Excellent	✓	✓	✓
BlueShield of Northeastern New York (BSNENY)	Excellent	✓	✓	✓
CDPHP	Excellent	✓	✓	✓
CIGNA	Commendable	✓		
Empire HealthChoice	Excellent	✓	✓	
Excellus BlueCross BlueShield, Rochester	Excellent	✓	✓	✓
Excellus Health Plan (Upstate HMO)	Excellent	✓	✓	
GHI-HMO Select	Commendable	✓	✓	✓
Health Net of New York	Not NCQA Accredited <sup>b</sup>	✓		
HIP	Commendable	✓	✓	✓
IHA	Excellent	✓		
MDNY	Not NCQA Accredited <sup>b</sup>	✓		
MVP Health Plan	Excellent	✓	✓	✓
Oxford	Excellent	✓		
Rochester Area HMO (Preferred Care)	Excellent	✓		
UnitedHealthcare of New York	Commendable	✓	✓	✓
Univera HealthCare	Excellent	✓	✓	
Vytra	In Progress <sup>c</sup>	✓		
WellCare	Not NCQA Accredited <sup>b</sup>		✓	✓



**Remember,**  
HMOs are required by law to offer HMO/POS coverage to individuals at all times during the year.

<sup>a</sup> Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.

<sup>b</sup> Participation in NCQA Accreditation is voluntary, thus some plans will not have an accreditation status. Excludes Medicaid and Medicare.

<sup>c</sup> Accreditation review began in June 2004.

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

# TERMS YOU SHOULD KNOW

## Health insurance terms in this Guide



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

**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 POS plans.

**External Review:** You may request an independent external review if you are denied health care services because your HMO claims that those services are experimental, investigational or not medically necessary. The review is conducted by an external review organization not affiliated with your HMO.

**Health Maintenance Organization (HMO):** The HMO arranges for or contracts with a variety of health care providers to deliver a range of services to HMO members. All HMOs use managed care strategies that emphasize prevention, detection and treatment of illness. HMOs use PCPs as coordinators of patient care needs.

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

**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.

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

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

# Agency Descriptions, Data Sources, Contact Information

## New York State Insurance Department (NYSID)

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

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

## New York State Department of Health (DOH)

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

## Data Sources

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

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

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

## Contact Information

If you have questions about how to use this Guide, 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](http://www.ins.state.ny.us).

To view the interactive version of this Guide, visit [www.nyshmoguide.org](http://www.nyshmoguide.org).

