

2005 NEW YORK CONSUMER GUIDE to



State of New York
George E. Pataki
Governor

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

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





STATE OF NEW YORK

September 1, 2005

Dear New Yorker:

New York State is committed to promoting a fair and competitive health insurance market and educating consumers so they can make smart choices. The *New York Consumer Guide to HMOs* accomplishes these goals by providing the information to help 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 2005 *New York Consumer Guide to HMOs*. The guide offers descriptions of health insurance products available in New York State, such as the 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.

Consumers need reliable information to compare the quality of health insurers, and New York State is committed to providing quality information. This guide provides vital information about customer service, such as consumer complaints, grievances, and appeals. Telephone numbers for HMOs operating in your area are included as well.

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

The information in this guide will help you choose the health insurance plan that best fits the needs of you and your family. I invite you to review it carefully.

Very truly yours,

George E. Pataki
Governor

www.state.ny.us



STATE OF NEW YORK

September 1, 2005

Dear New Yorker:

Governor Pataki has been a leading force in introducing meaningful health insurance reform measures. Landmark legislation – such as the Women's Health & Wellness Act of 2002, the Health Care Reform Act of 2000, the External Review Law of 1998, and the Women's Health and Cancer Rights Act of 1997 – were all signed into law under Governor Pataki. Each initiative has helped improve health care and access to health care services for all New Yorkers.

Governor Pataki and the New York State Legislature have also demonstrated leadership in addressing the uninsured population. Child Health Plus, Family Health Plus and the Healthy NY program are all great examples of programs created to help reduce the uninsured population. Child Health Plus provides comprehensive health insurance to children who do not have health insurance. Family Health Plus provides comprehensive health insurance to lower income adults who are not eligible for Medicaid but do not have health insurance through their employers. Launched in 2001, Healthy NY is a state-sponsored program designed to ensure that affordable health benefits are accessible to New York's small businesses, sole proprietors and working uninsured individuals. Since enhancements were made to the Healthy NY program in March 2003, it has become even more affordable, while offering a wider array of choices for prescription drug coverage.

The *New York Consumer Guide to HMOs* is aimed at giving consumers a greater awareness of their health care options and contains a ranking of all major health maintenance organizations (HMOs) in New York State based on the number of complaints state regulators closed in the consumer's favor. This guide also contains important information from the Department of Health on other measures of consumer satisfaction as well as clinical indicators of an HMO's quality of care. Additionally, 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. External reviews, most of which focus on determinations of medical necessity, are filed with the Insurance Department and adjudicated by independent external review agents.

Moreover, the *New York Consumer Guide to HMOs* is available on the Insurance Department's Web site (www.ins.state.ny.us) where you can find information quickly. 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).

Please review the information in this guide carefully to help choose the health insurance plan that best fits your needs.

Sincerely,

Howard Mills
Superintendent of Insurance
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Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner of Health
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HOW TO CHOOSE AN HMO

A Step-by-Step Guide

Step 1

Identify your options.

You should narrow your focus and compare HMOs that:

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

Step 2

Determine which features are most important to you in an HMO, and evaluate and compare the HMO performance in these areas.

How do HMOs rank based on member complaints to the New York State Insurance Department?	See Complaints on page 6.
How often are HMO decisions to deny care or service changed?	See Independent External Reviews on page 8.
Do HMO members have access to the care and service they need?	See Access to Care and Service on page 10.
How well do HMOs help members maintain good health and avoid illness?	See Staying Healthy and Living with Illness on page 12.
How is the quality of HMO providers determined?	See Quality of Providers on page 14.

Step 3

Select an HMO.

After completing steps 1-2, 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.

To learn about commonly used health insurance terms, refer to the **Terms You Should Know** on page 24.

How do HMO and HMO/POS plans work?

Health maintenance organizations (HMOs) deliver health care to members using provider **networks**, which are 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 HMO/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/POS option at any time during the year. They cannot be denied coverage if they have health problems. However, they may be subject to a waiting period of up to one year for certain pre-existing conditions.

A Word About Premiums

To compare prices of HMOs in your area, view their current premiums on the Web at www.nyshmoguide.org.

Facts About HMO and HMO/POS Options

	HMO	HMO/POS
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 (typically between \$10 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.	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 coinsurance and deductibles.

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 those 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 for any final adverse determination denying coverage because a procedure, service or treatment is considered experimental, investigational or not medically necessary.

YOUR RIGHT TO APPEAL AN INSURER'S DECISION

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 decision. This is called an **independent external review**.

To be eligible for an external review, you must:

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

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

- 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: www.ins.state.ny.us.

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 2004. 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.

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).

For each HMO, the table tells you:

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

Keep in mind...

HMOs with a larger premium typically have more members and therefore, more complaints than smaller HMOs. Thus **complaint ratios** are a better measure of HMO performance.

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, 2004

Data source: NYSID

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

HMO ^a	Rank ^b	Total Complaints	Upheld Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Membership (as of 12/31/04)	Complaint Ratio
Aetna Health	13	766	303	211	1,053.6	288,854	0.288
CDPHP	3	74	7	1	698.9	241,245	0.010
CIGNA	14	214	67	55	145.7	36,977	0.460
Community Blue (HealthNow)	7	363	81	44	866.8	304,517	0.093
Empire HealthChoice	6	704	52	28	1,279.0	452,152	0.041
Excellus ^c	5	140	36	15	1,355.0	523,049	0.027
GHI-HMO Select	12	124	28	16	104.6	44,494	0.268
Health Net of NY	11	475	122	82	653.1	201,113	0.187
HIP ^d	10	836	275	204	1,821.1	579,763	0.151
IHA	2	62	3	1	590.4	236,429	0.005
MDNY	16	308	249	228	135.2	40,140	1.842
MVP Health Plan	4	128	14	6	975.2	327,452	0.014
Oxford ^e	9	1,353	347	141	2,435.3	661,520	0.142
Rochester Area HMO (Preferred Care)	1	78	1	1	236.5	95,866	0.004
UnitedHealthcare of NY ^e	15	165	52	22	68.4	52,830	0.760
Vytra	8	235	28	22	261.2	84,735	0.107
TOTAL		6,025	1,665	1,077	12,679.9	4,171,136	Avg.=0.131

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

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

^b The table ranks insurers by complaint ratio.

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

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

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

INDEPENDENT EXTERNAL REVIEWS

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

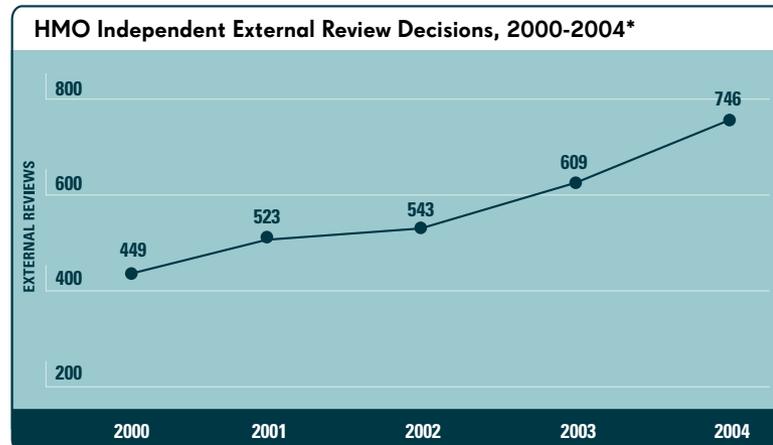


To find the answer...

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 2004. When an HMO denies care that it considers experimental, investigational or not medically necessary, you can request an independent organization review your case and issue a decision. This is called an **independent 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 5.

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



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

An HMO's **reversal rate** is the percentage of cases in which the decision to deny coverage is changed. In other words, the reversal rate is the percentage of the reviews decided in favor of the consumer. **Reversed in part** is the number of cases that an external review organization decided partially in favor of the consumer. Please note that reversed in part decisions *are* included in the reversal rate.

For each HMO, the table tells you:

- Total number of **external reviews**
- Number of cases **reversed in part**
- Number of **reversed reviews**
- **Reversal rate**

Keep in mind...

Only a small percentage of an insurer's coverage decisions are subject to an independent external review and there is no ideal reversal rate.

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.*

Independent External Reviews - HMOs, 2004

Data source: NYSID

HMOs are listed alphabetically.

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

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

^b Rate includes "Reversed in Part" decisions.

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

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

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

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**. Members were asked several questions about their experience and satisfaction with their HMO such as:

- How they would **rate their HMO** overall on a scale from 0 (worst possible) to 10 (best possible).
- If they had **problems getting needed care** such as getting a referral to a specialist, or care they and their doctor believed was necessary.
- If they had **received care quickly** such as getting needed help or advice from their doctor's office, or getting care right away for an illness or injury.

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

Keep in mind...

Several factors contribute to why HMO members may rate their HMO low. These include members having problems getting needed care or receiving care quickly. While all the factors are not represented here, make your decision based on 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.*

When asked, 80% of members responded as having received needed care and services quickly from their HMO.



Access and Service

Data source: DOH

Performance Compared to the New York HMO Average

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

HMO	Members Rating their HMO an 8, 9 or 10 on a scale from 0 (worst) to 10 (best)	Members Who Had Problems Getting Needed Care	Members Who Received Care Quickly	Members Seen by a Provider	
				Ages 20-44	Ages 45-64
NY HMO Avg.	66%	23%	80%	93%	94%
Aetna	●	●	○	○	○
Blue Choice	★	★	★	○	★
BSNENY-HMO ^a	●	●	★	★	★
CDPHP	★	★	★	★	★
CIGNA	○	○	○	○	○
Community Blue	●	●	●	★	★
Empire	●	●	★	○	●
GHI-HMO Select	○	○	●	●	●
Health Net of NY	●	●	●	★	●
HIP	●	○	○	○	○
IHA	★	★	★	★	★
MDNY	○	●	○	★	★
MVP Health Plan	★	★	●	★	★
Oxford ^b	●	●	○	★	★
Preferred Care	★	★	★	★	★
UnitedHealthcare of NY ^b	●	●	●	○	●
Univera HealthCare	●	●	★	●	●
Upstate HMO	○	●	●	○	○
Vytra	●	●	○	★	★

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

^a Albany Division of Community Blue.

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

STAYING HEALTHY and LIVING WITH ILLNESS

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 members stay healthy and avoid illness. It shows the percentage of:

- **Well-Child & Preventive Visits in 3rd, 4th, 5th, or 6th Year of Life** It is important for children to receive well-child and preventive visits to receive proper immunizations and to ensure good overall health. Plans were rated on the percentage of children (ages 3-6) who had a well child visit or preventive health visit in the past year.
- **Chlamydia Screening (Ages 16-20)** Early detection of chlamydia is crucial to a women's primary and preventive health care. Early detection and treatment of chlamydia prevents permanent reproductive damage. Plans were rated on the percentage of women (ages 16-20) who had at least one screening test for chlamydia in the past year.
- **Comprehensive Diabetes Care (Eye Exam)** It is important for diabetics to have regular eye exams to ensure that damage to the eye is not occurring as a result of high blood glucose levels. Plans were rated on the percentage of diabetic members who received an eye exam within the past two years.

Of those members with diabetes, 53% had an eye exam performed within the past two years.

- **Cholesterol Management After Acute Cardiac Events (LDL-C <100mg/dL)** Reducing bad cholesterol levels is important for reducing the risk of a recurring heart attack or stroke. Plans were rated on the percentage of members who an acute cardiovascular event and who had a cholesterol test done with a good result (bad cholesterol level was less than 100 mg/dL) within the year of the event.
- **Follow-Up After Hospitalization for Mental Illness (7 days)** Appropriate follow-up after hospitalization for a mental illness can reduce the likelihood of its recurrence. Plans were rated on the percentage of members (ages 6 and older) who were hospitalized for treatment for selected mental health disorders and were seen by a mental health provider within 7 days of discharge.

Keep in mind...

These measures indicate how well an HMO delivers preventive care to help members stay healthy.

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

Staying Healthy and Living with Illness

Data source: DOH

Performance Compared to the New York HMO Average

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

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

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

^a Albany Division of Community Blue.

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

QUALITY OF PROVIDERS

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 the quality of their HMO's in-network providers or nurses (on a scale of 1-10). Members responded "usually" or "always" to questions about the quality of their HMO in-network providers, including overall service and communication such as:

- How often their doctors **listened carefully** to them
- How often their doctors **explained** things in a way they could understand
- How often their doctors showed **respect** for what they have to say
- How often their doctors spent enough **time** with them during visits

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**. There are times when it is appropriate for HMOs for contract with physicians who are not board certified, as in the case of older physicians who were trained before board certification was available.

The last column in the table, **physician turnover**, shows the percentage of primary care physicians who left the HMO's network in 2003. A lower percentage means the HMO's provider network is more stable. Going to the same doctor makes it easier to receive better and more coordinated care.

Keep in mind...

These measures indicate how satisfied members are with their health care providers and how many providers have undergone specialized training.

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.*

When asked, 92% of HMO members responded that their doctors usually or always communicated well.



Quality of Providers

Data source: DOH

Performance Compared to the New York HMO Average

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

HMO	Members Rating their Doctor or Nurse an 8, 9 or 10 on a scale from 0 (worst) to 10 (best)	Members Responding that their Doctors Usually or Always Communicate Well	Doctors who are Certified by a Medical Board			Physician Turnover (Primary Care)
			Primary Care	OB/GYN	Pediatric	
NY HMO Avg.	77%	92%	86%	79%	78%	5.0%
Aetna	●	●	○	★	○	2.8
Blue Choice	●	●	●	●	●	3.0
BSNENY-HMO ^a	●	●	★	●	●	3.7
CDPHP	●	★	○	●	●	6.7
CIGNA	●	○	○	○	●	4.1
Community Blue	○	●	●	★	○	4.8
Empire	●	●	★	★	●	3.5
GHI-HMO Select	●	★	●	●	●	3.4
Health Net of NY	●	○	○	●	★	8.2
HIP	○	○	○	○	○	10.0
IHA	●	★	○	●	●	5.7
MDNY	○	●	●	★	●	4.9
MVP Health Plan	●	●	★	●	●	5.1
Oxford ^b	●	○	★	●	★	2.7
Preferred Care	★	★	★	★	★	3.5
UnitedHealthcare of NY ^b	●	●	★	●	●	3.4
Univera HealthCare	●	●	○	○	○	5.8
Upstate HMO	★	●	★	●	●	6.7
Vytra	●	●	★	★	○	5.2

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

^a Albany Division of Community Blue.

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

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 uninsured New York 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 17) 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 18) 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 19) 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.

Coverage for small businesses and the working uninsured

The Healthy NY program offers affordable insurance coverage to assist:

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

Eligibility for Enrollment

Small business owners may participate if:

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

Individuals may participate if:

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

Summary of Benefits

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

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

* This optional coverage provides up to \$3,000 in drug coverage per person, per year.

Healthy NY Annual Income Individual Eligibility Guidelines

Effective January 2005 and subject to revision.

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

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

Cost

Obtaining insurance coverage through Healthy NY is specifically designed to be more affordable than other insurance options. Keep in mind that even though Healthy NY benefits are the same for each HMO, the monthly premiums you have to pay may vary based on the HMO you choose. For more information visit the Healthy NY Web site listed below.

Enrolling

To find more information about enrolling in Healthy NY, call this toll-free number: 1-866-HEALTHY-NY (1-866-432-5849), or visit the Web site at www.HealthyNY.com.

CHILD HEALTH PLUS Coverage for children



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

Eligibility for Enrollment

Your children may be eligible for Child Health Plus if:

- the children are under age 19
- the children are not eligible for Medicaid and have limited or no health insurance
- a parent or a family member is not a public agency employee with access to family coverage through a state health benefits plan where the public agency pays all or part of the cost of the health benefits.

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

Summary of Benefits

These are the services covered under Child Health Plus:

- well-child care, immunizations and physical exams
- diagnosis and treatment of illness and injury
- x-rays and lab tests
- outpatient surgery
- inpatient hospital medical or surgical care
- emergency care

- prescription and nonprescription drugs if ordered by a physician
- short-term therapeutic outpatient services
- limited inpatient/outpatient treatment for alcoholism, substance abuse, mental health
- dental care and vision care
- speech and hearing services
- durable medical equipment
- emergency ambulance transportation to a hospital

Enrolling

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

Cost

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

Child Health Plus B* Premiums *Effective January 2005 and subject to revision.*

Family Size ^a	Family Pays NO COST if Monthly Income is Less Than	Family Pays \$9 ^b PER CHILD PER MONTH if Monthly Income is Between	Family Pays \$15 ^c PER CHILD PER MONTH if Monthly Income is Between	Family Pays FULL PREMIUM ^d if Monthly Income is More Than
1	\$1,269	\$1,270-1,762	\$1,763-1,984	\$1,984
2	\$1,703	\$1,704-2,365	\$2,366-2,663	\$2,663
3	\$2,138	\$2,139-2,968	\$2,969-3,342	\$3,342
4	\$2,573	\$2,574-3,571	\$3,572-4,021	\$4,021
5	\$3,007	\$3,008-4,174	\$4,175-4,700	\$4,700
For each extra person add	\$435	\$604	\$680	--

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

^a Pregnant women count as two when determining family size.

^b Maximum of \$27 per family.

^c Maximum of \$45 per family.

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

Eligibility for Enrollment

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

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

Summary of Benefits

Family Health Plus offers a comprehensive package of benefits. Services are provided by a managed care plan, and include:

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

Cost

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

Family Health Plus Eligibility

Effective January 2005 and subject to revision.

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

Enrolling

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

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 the following 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

Current as of June 2005

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

HMO ^a	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	866-747-8422					•				
CDPHP	800-777-2273	•		•				•	•	
CIGNA	800-345-9458			•	•	•				•
Community Blue (HealthNow)	800-544-2583	•	•	•			•	•	•	
Empire HealthChoice	800-261-5962	•		•	•	•				•
Excellus ^b	800-462-0108	•	•	•			•	•	•	
GHI-HMO Select	877-244-4466	•	•	•	•	•		•	•	•
Health Net of NY	800-848-4747			•	•	•				•
HIP	800-447-8255			•	•	•				•
IHA	800-453-1910		•							
Managed Health	888-260-1010				•	•				
MDNY	800-707-6369				•					
MVP Health Plan	888-687-6277	•		•				•	•	•
Oxford ^c	800-666-1353			•	•	•				•
Rochester Area HMO (Preferred Care)	800-950-3224		•				•			
UnitedHealthcare of NY ^c	800-705-1691			•	•	•		•	•	•
Vytra	800-406-0806				•	•				

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

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

^b Excellus Group includes Finger Lakes HMO & Blue Choice HMO (800-462-0108), Upstate HMO (800-544-0328) and the Univera Healthcare HMO (800-337-3338).

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

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 16-19 to learn more about the **Healthy NY**, **Child Health Plus** and **Family Health Plus** programs.

A number of Prepaid Health Service Plans (PHSPs) 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.

New York HMO Accreditation and Participation Status as of July 2005

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



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

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

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

^b Albany Division of Community Blue.

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

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

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.

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.

Independent 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.

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

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 typically 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.

Data Sources, Contact Information

Data Sources

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

- New York State Insurance Department (NYSID) is responsible for supervising and regulating insurance business in New York State.
 - NYSID provides information on Complaints and Independent External Reviews.
 - NYSID collects data as part of its regulatory responsibilities.
 - NYSID data are from calendar year 2004.
- The New York State Department of Health (DOH), works to protect and promote the health of New Yorkers through prevention, science and the assurance of quality health care delivery.
 - DOH provides information on Access to Care and Service, Staying Healthy and Living with Illness and Quality of Providers.
 - DOH collects the data through the New York State Department of Health's Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Health Plans (CAHIPS®).
 - DOH data are from calendar year 2003.

Related Resources

2004 New York Managed Care Plan Performance Report This report is published by the DOH and contains the most recent information from member satisfaction surveys, standardized quality measures and the providers in the plans' networks. To obtain a copy, please call 518-486-6074 or visit: www.health.state.ny.us

New York Consumer Guide to Health Insurers This guide includes information and data comparing commercial and non-profit indemnity insurers and HMOs, including tips on how to choose a health insurer. Visit: www.ins.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.

To view the interactive version of this Guide, visit www.nyshmoguide.org.

