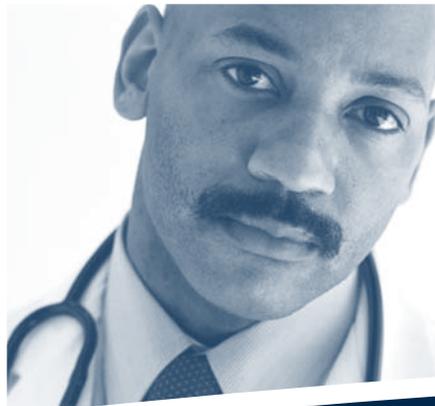


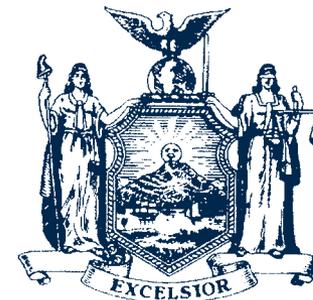
2006 NEW YORK CONSUMER GUIDE TO HMOs



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, 2006

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 quality information to guide you making the health insurance choice that will best serve you and your family.

The Department of Insurance and the Department of Health have once again worked together to produce the 2006 *Consumer Guide to HMOs*. The guide offers descriptions of health insurance products available in New York State, such as the newly enhanced HealthyNY 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.

Uninsured New Yorkers should note the recent changes to the HealthyNY program, the state's reduced-cost health insurance program for the working uninsured and small businesses. These enhancements have broadened eligibility standards, eliminated co-payments for routine examinations of children and other well-child visits, and led to an overall boost in HealthyNY's enrollment figures

Consumers need reliable information to compare the quality of health insurers. 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.

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



STATE OF NEW YORK

September 1, 2006

Dear New Yorker:

The *New York Consumer Guide to HMOs* provides New Yorkers with important information that will help increase their awareness of the health care options available to them and contains a ranking of all major health maintenance organizations (HMOs) in New York State. The guide summarizes data on HMO complaints investigated by state regulators and sustained in favor of consumers.

The guide also contains important information from the State Department of Health on measures associated with consumer satisfaction as well as clinical indicators of an HMO's quality of care. Additionally, the guide includes information on external review cases for 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 reviewed by independent experts.

Governor George E. 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 by 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 HealthyNY program are all great examples of programs created and/or expanded to help reduce the uninsured population statewide.

Child Health Plus provides comprehensive health insurance to children who do not have coverage. Family Health Plus provides comprehensive health insurance to lower income adults who are not eligible for Medicaid. Launched in 2001, HealthyNY 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 HealthyNY program in March 2003, it has become even more affordable, while offering a wider array of choices for prescription drug coverage.

The 2006 edition of the New York Consumer Guide to HMOs is now available on the Insurance Department's web site at: www.ins.state.ny.us. Detailed information on health plan quality performance is also available in interactive format through the Department of Health web site at: www.nyhealth.gov. We trust that you will find this new guide helpful in your efforts to choose a health care plan that best meets your needs.

Sincerely,

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

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner of Health
www.health.state.ny.us

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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 services 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's performance in these areas.

How do HMOs rank based on 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 and 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.nyshmguide.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 \$20 and \$40) 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 Cesarean section).
- Stay in the hospital after a mastectomy for as long as the doctor determines necessary.
- 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 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 switch to a new HMO and have a life-threatening, degenerative or disabling condition or disease. Their provider must agree 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.

INDEPENDENT EXTERNAL REVIEWS

If your HMO 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**. Reviews are conducted by external review organizations certified by the State of New York.

Here are the steps to appeal an HMO's decision:

1. Follow your HMO's internal appeal process for denied services. Call the Member Services Department's phone number on your insurance card for information on the appeal process.
 2. If you are not satisfied with the decision you received from your HMO's internal appeal process, you may request an external review by submitting a completed application to the New York State Insurance Department within 45 days of receiving your HMO's decision. To request an independent external review application, contact the New York Insurance Department at 800-400-8882, or visit the Web site at www.ins.state.ny.us. With your application, you must submit a written notice from your HMO stating that:
 - a denial of health care services was upheld by the HMO's first-level internal appeal process, or
 - you and your HMO agreed to waive the internal appeal process.
- Your cost for an external review could be up to \$50. However, the fee is refunded if the decision is in your favor.
3. After you submit a request for an external review, the Insurance Department will notify you and your HMO whether your case qualifies. Your HMO must then send your medical and treatment records to the external review organization. You and your doctor can submit additional information as soon as you are notified that an external appeal organization has been assigned to review your case.
 4. There are two types of reviews: standard and expedited.
 - For a **standard review**, the external review organization must make a decision within 30 days of receiving your request for an external review from the State.

- An **expedited review** can be requested if your doctor determines that a delay in providing the treatment or service poses an immediate or serious threat to your health. Your doctor must send written testimony about your need for immediate care to the Insurance Department. The external review organization must make a decision within 3 days.

5. The external review organization will notify you of its decision as follows:
 - a) If your review was **standard**, you and your HMO will be notified in writing within two business days of the external review organization decision.
 - b) If your review was **expedited**, you and your HMO will be notified of the decision by telephone or fax within three days of receiving your request. Written notification will follow.

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

You are not eligible to appeal your HMO's coverage decision through the external review process 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 (sometimes 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.
- Your health coverage was issued outside of New York.

Independent External Reviews – You can find data on **page 9** regarding the total number of external reviews, number of reversed reviews, number of reversed in part reviews and upheld reviews for HMOs.

COMPLAINTS

How do HMOs rank based on 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 2005. 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 acted appropriately. If not, the HMO must remedy the problem. An **upheld complaint** occurs when the Insurance Department has determined the health plan has not complied with their statutory or contractual obligations. 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 determines if the payment or denial was late. An **upheld prompt pay complaint** occurs when the Department determines the claim was not processed in the appropriate time frame.

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.

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, 2005

Data source: NYSID

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

HMO ¹	Rank ²	Total Complaints	Upheld Complaints to NYSID	Upheld Prompt Pay Complaints	Premium (Millions \$)	Membership (as of 12/31/05)	Prompt Pay Complaint Ratio
Aetna Health	13	764	398	333	878.7	217,923	 0.3790
CDPHP	2	86	6	0	598.2	206,914	0.0000
CIGNA	10	89	38	19	131.3	34,901	 0.1447
Community Blue (HealthNow) ³	6	161	55	39	1,217.5	252,451	0.0320
Empire HealthChoice	7	948	111	69	1,599.9	499,167	 0.0431
Excellus ⁴	5	98	16	7	1,898.8	490,283	0.0037
GHI-HMO Select	11	251	49	28	131.4	45,753	 0.2131
Health Net of NY	15	1,501	874	805	458.6	181,792	 1.7553
HIP ⁵	9	716	378	309	3,453.9	580,201	 0.0895
Independent Health Association (IHA)	4	36	2	2	556.2	210,976	0.0036
MDNY	14	229	187	176	116.2	32,455	 1.5146
MVP Health Plan	3	119	8	2	1,013.8	275,618	0.0020
Oxford ⁶	8	1,883	338	169	2,087.2	530,794	 0.0810
Rochester Area HMO (Preferred Care)	1	12	1	0	270.2	112,761	0.0000
UnitedHealthcare of NY ⁶	12	74	33	13	49.3	18,861	 0.2632
Vytra ⁷	16	1007	694	492	236.2	68,117	 2.0830
TOTAL		7,974	3,188	2,463	14,697.4	3,758,967	 Avg. = 0.4130

¹ Excludes HMOs with less than \$25 million in premium or fewer than 5,000 members.

² The table ranks insurers by complaint ratio.

³ Community Blue includes Blue Cross Blue Shield of Western NY and Blue Shield of Northeastern NY.

⁴ Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

⁵ Complaint ratios, Insurance Department complaints and premiums include data from Health Insurance Plan's (HIP) HMO and non-profit business. Complaints and premiums for HIP's A&H commercial company are not included in this ranking. In 2005, roughly 5% of HIP's business was attributable to its non-profit operation.

⁶ The holding companies for Oxford Health Plans of NY and UnitedHealthCare of NY merged in 2004; however, the two individual companies remain independent and report data separately.

⁷ Vytra merged with HIP effective March 29, 2006, however their data are reported separately in this Guide.

 Denotes length of bar graph was shortened due to spatial constraints.

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 2005. When an HMO denies care that it considers experimental, investigational or not medically necessary, you can request that 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 not to cover a service or procedure. For more information on eligibility and the external review process, please see page 5.

An HMO's **reversal rate** is the percentage of cases in which the external review organization decided to change the HMO's decision to deny coverage. 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 **reversed reviews**
- Total number of cases **reversed in part**
- Total **upheld reviews**
- **Reversal Rate**

Keep in mind...

Only a small percentage of an HMO's coverage decisions were subject to an independent external review. 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, 2005

Data source: NYSID

HMOs are listed alphabetically.

HMO ¹	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ²
Aetna Health	24	13	3	8	67%
CDPHP	7	4	0	3	57%
CIGNA	15	7	0	8	47%
Community Blue (Healthnow) ³	45	10	1	34	24%
Empire HealthChoice	155	63	14	78	50%
Excellus ⁴	87	42	1	44	49%
GHI-HMO Select	8	4	0	4	50%
Health Net of NY	90	43	4	43	52%
HIP ⁵	26	7	4	15	42%
IHA	9	4	0	5	44%
MDNY	10	4	0	6	40%
MVP Health Plan	11	4	0	7	36%
Oxford ⁶	212	74	19	119	44%
Rochester Area HMO (Preferred Care)	5	1	0	4	20%
UnitedHealthCare of NY ⁶	4	2	0	2	50%
Vytra ⁷	9	3	0	6	33%
TOTAL	717	285	46	386	Avg = 44%

¹ 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.

² Rate includes "Reversed in Part" decisions.

³ Community Blue includes Blue Cross Blue Shield of Western NY and Blue Shield of Northeastern NY.

⁴ Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

⁵ Includes Health Insurance Plan's (HIP's) HMO and nonprofit business. In 2005, roughly 5% of HIP's business was attributable to its nonprofit operation.

⁶ The holding companies for Oxford Health Plans of NY and UnitedHealthcare of NY merged in 2005, however, the two individual companies remain independent and report data separately.

⁷ Vytra merged with HIP effective March 29, 2006, however their data are reported separately in this Guide.

ACCESS TO CARE AND 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 last 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 HMO members responded "usually or always" for having received care 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.	68%	24%	80%	93%	94%
Aetna	●	●	●	○	●
Blue Choice ¹	●	★	★	●	★
BSNENY-HMO ²	●	★	★	★	●
CDPHP	★	★	★	●	●
CIGNA	○	○	○	●	○
Community Blue ³	●	●	★	●	●
Empire	★	○	○	●	●
GHI HMO	○	○	●	●	●
Health Net	●	●	●	●	●
HIP	●	○	○	○	○
Independent Health Association (IHA)	★	★	★	●	★
MDNY	○	○	○	●	●
MVP	●	★	★	●	●
Oxford ⁴	●	●	○	●	●
Preferred Care	★	★	★	●	●
UnitedHealthCare of New York ⁴	●	●	○	●	●
Univera HealthCare ¹	★	●	★	●	●
Upstate HMO ¹	●	●	●	●	●
Vytra ⁵	●	●	○	★	●

NOTE: Symbols show statistically significant differences between each HMO's score and the New York average. Statistically significant means scores varied by more than could be accounted for by chance.

¹ These are Excellus Companies

² Albany Division of Community Blue.

³ Blue Cross Blue Shield of Western NY (Buffalo Division) only.

⁴ The holding companies for Oxford Health Plan NY and UnitedHealthCare of NY merged in 2004; however, the two individual companies remain independent and report their data separately.

⁵ Vytra merged with HIP effective March 29, 2006, however their data are reported separately in this Guide.

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 in the following areas.

- **Breast Cancer Screening** Early detection of breast cancer increases a woman's chance of survival. Plans were rated on the percentage of women between the ages 50–69 years who had a mammogram within the last two years.
- **Colorectal Cancer Screening** Screening for colorectal cancer allows for the early detection of cancer when it is highly curable, as well as the detection of growths, or polyps that could become pre-cancerous. Plans were rated on the percentage of adults, ages 50–80 years, who had appropriate screening for colorectal cancer.
- **Follow-up with a Practitioner after Receiving Anti-depressant Medications** Follow-up after receiving anti-depressant medications helps to ensure that the medication is adequately alleviating symptoms and that side effects are minimal. By continuing treatment with their provider, patients with depressive disorders may prevent a relapse of symptoms and/or prevent future recurrences of depression. Plans were rated on the percentage of members 18 years and older, who were diagnosed with depression and treated with an antidepressant medication, and who had at least three follow-up contacts with a primary care or mental health provider during the 12-week acute treatment phase.

- **Controlling High Blood Pressure** Controlling high blood pressure reduces risk of heart and kidney diseases, stroke and heart failure. Plans were rated on the percentage of members, ages 46–85 years, who have hypertension and have controlled blood pressure (at or below 140/90).
- **Use of Appropriate Medications for People with Asthma (Ages 5-17)** Successful management of persistent asthma can be achieved with appropriate medications. Plans were rated on the percentage of members, ages 5–17 years, with persistent asthma who received appropriate long-term control medications to control their condition.

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.*

Only 56% of health plan members ages 50-80 had colorectal cancer screening.

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	Breast Cancer Screening	Colorectal Cancer Screening	Follow-up with a Practitioner after Receiving Anti-depressant Medications	Controlling High Blood Pressure	Use of Appropriate Medications For People with Asthma (Ages 5-17)
NY HMO Avg.	74%	56%	24%	71%	74%
Aetna	○	○	★	○	○
Blue Choice ¹	★	★	○	●	★
BSNENY-HMO ²	★	○	○	●	●
CDPHP	★	★	●	●	●
CIGNA	●	○	★	●	○
Community Blue ³	●	○	○	●	●
Empire	●	○	●	●	○
GHI HMO	○	○	●	●	○
Health Net	★	★	★	●	★
HIP	○	○	★	●	○
Independent Health Association (IHA)	★	●	○	●	★
MDNY	○	○	●	○	○
MVP	●	●	●	★	★
Oxford ⁴	●	★	★	●	★
Preferred Care	★	●	○	★	●
UnitedHealthCare of New York ⁴	●	○	★	○	●
Univera HealthCare ¹	●	●	○	●	●
Upstate HMO ¹	★	●	○	●	●
Vytra ⁵	●	●	●	★	●

NOTE: Symbols show statistically significant differences between each HMO's score and the New York average. Statistically significant means scores varied by more than could be accounted for by chance.

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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. Members were asked several questions about the quality of their 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 to 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 2004. 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
- NV: Plan submitted invalid data.

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.	78%	92%	86%	79%	76%	4.5%
Aetna	●	●	○	★	○	3.1
Blue Choice¹	●	★	●	○	●	NV
BSNENY-HMO²	●	●	★	★	○	5.1
CDPHP	●	●	●	★	●	1.8
CIGNA	●	○	○	○	○	3.0
Community Blue³	●	★	●	★	○	4.0
Empire	●	●	★	★	★	6.8
GHI HMO	●	●	●	●	●	2.6
Health Net	★	●	○	●	★	4.8
HIP	●	○	●	●	●	8.4
Independent Health Association (IHA)	●	★	○	●	●	4.9
MDNY	●	○	●	★	★	4.0
MVP	●	●	○	●	●	4.4
Oxford⁴	●	●	★	●	★	4.4
Preferred Care	●	★	★	★	★	4.3
UnitedHealthCare of New York⁴	●	●	●	●	○	3.6
Univera HealthCare¹	●	●	○	○	●	NV
Upstate HMO¹	●	●	★	○	●	NV
Vytra⁵	●	●	★	★	★	3.3

NOTE: Symbols show statistically significant differences between each HMO's score and the New York average. Statistically significant means scores varied by more than could be accounted for by chance.

¹ These are Excellus companies.

² Albany Division of Community Blue.

³ Blue Shield of Western NY (Buffalo Division) only.

⁴ The holding companies for Oxford Health Plan NY and UnitedHealthCare of NY merged in 2004; however, the two individual companies remain independent and report their data separately.

⁵ Vytra merged with HIP effective March 29, 2006, however their data are reported separately in this Guide.

OPTIONS FOR UNINSURED NEW YORKERS

Review of Available Options

New York State is committed to expanding quality health care coverage to uninsured New Yorkers. Legislation has been enacted to increase 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.

- **HealthyNY** (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.

For questions about individual coverage, contact:

New York State Insurance Department
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
800-342-3736
www.ins.state.ny.us



HEALTHYNY

Coverage for Small Businesses and the Working Uninsured

The HealthyNY 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

If you are a **small employer**, you may participate if:

- your business has not provided comprehensive health insurance during the past 12 months or contributed more than \$50 per employee per month for coverage (or \$75 per month per employee for businesses located in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange and Putnam Counties),
- you have 50 or fewer employees,
- 30 percent of your employees earn \$35,500 or less annually,
- your business is willing to contribute 50 percent of the HealthyNY premium, and
- your business meets certain participation requirements.

You may participate as an **individual** 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 the sole proprietor of a business,

- you have been without health insurance for 12 months or have lost coverage for certain reasons,
- you are ineligible for Medicare or employer coverage, and
- your total household income is within the annual limits listed below.

Summary of Benefits HealthyNY Annual Income Individual Eligibility Guidelines

Effective January 2006 and subject to revision.

Family Size	Household Income Limits
1	Up to \$25,125
2	Up to \$33,375
3	Up to \$41,625
4	Up to \$49,875
5	Up to \$58,125
Each extra person	Add \$8,250

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

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

- inpatient and outpatient hospital services
- physician services, including second opinions for surgery and cancer treatment

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

Cost

Obtaining insurance coverage through HealthyNY is specifically designed to be more affordable than other insurance options. Keep in mind that even though HealthyNY benefits are the same at each HMO, the monthly premiums you have to pay will vary. For more information about premiums, visit the HealthyNY Web site: www.HealthyNY.com.

Enrolling

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

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

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, and
- a parent or a family member is not a public agency employee with access to family coverage through a State health benefits plan where the public agency pays all or part of the cost of the health benefits.

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

Summary of Benefits

These are the services covered under Child Health Plus:

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

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

Cost

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

Enrolling

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

Child Health Plus B* Premiums *Effective January 2006 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	\$1,306	\$1,307 - \$1,813	\$1,814 - \$2,042	\$2,042
2	\$1,759	\$1,760 - \$2,442	\$2,443 - \$2,750	\$2,750
3	\$2,213	\$2,214 - \$3,071	\$3,072 - \$3,459	\$3,459
4	\$2,666	\$2,667 - \$3,700	\$3,701 - \$4,167	\$4,167
5	\$3,119	\$3,120 - \$4,329	\$4,330 - \$4,875	\$4,875
For each extra person add	\$454	\$629	\$709	--

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

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

^b Maximum of \$27 per family.

^c Maximum of \$45 per family.

^d The full premium will vary, depending on the HMO selected, but 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.

There is no cost to apply for or participate in Family Health Plus. There are no application fees, premiums, or deductibles. Modest co-payments apply to some services.

Eligibility for Enrollment

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

- you are an adult age 19 to 64,
- you do not have health coverage,
- you are not eligible for Medicaid, or eligible only because of high medical costs, and
- your total household income and resources are within the limits.

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, premiums or deductibles. Modest co-payments apply to some services.

Family Health Plus Eligibility

Effective January 2006 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	\$9,800	--
2	\$13,200	\$19,800
3	--	\$24,900
4	--	\$30,000
5	--	\$35,100
6	--	\$40,200
7	--	\$45,300
For each extra person add		\$5,100

Enrolling

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

NEW YORK HMO SERVICE AREAS AND PHONE NUMBERS



A comprehensive listing of all New York HMOs appear 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 Areas¹

Current as of June 2006

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

HMO		Albany Area	Buffalo Area	Hudson Valley Area	Long Island Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Westchester Area
Aetna Health	800-435-8742			•	•	•		•	•	•
Connecticare (formerly Amerihealth)	800-846-8578			•						•
Americhoice	800-493-4647					•				
Atlantis	866-747-8422					•				
CDPHP	800-777-2273	•		•				•	•	
CIGNA	800-345-9458			•	•	•				•
Empire HealthChoice	800-261-5962	•		•	•	•				•
Excellus ²	800-462-0108	•	•	•			•	•	•	
GHI-HMO Select	877-244-4466	•	•	•	•	•		•	•	•
Health Net of NY	800-848-4747			•	•	•				•
HealthNow ³ (Community Blue)	800-544-2583	•	•	•			•	•	•	
HIP	800-447-8255			•	•	•				•
Independent Health Association (IHA)	800-453-1910		•							
Managed Health	888-260-1010				•	•				
MDNY	800-707-6369				•					
MVP Health Plan	888-687-6277	•		•				•	•	•
Oxford	800-969-7480			•	•	•				•
Rochester Area HMO (Preferred Care)	800-950-3224		•				•			
United Healthcare of NY ⁴	800-705-1691			•	•	•		•	•	•
Vytra	800-406-0806				•	•				

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

¹ Service areas are current as of June 1, 2006, and include HMOs with less than \$25 million in premium or fewer than 5,000 members.

² Excellus Health Plan includes Finger Lakes HMO, Upstate HMO and Univera Healthcare HMO.

³ Community Blue includes Blue Cross Blue Shield of Western NY and Blue Shield of Northeastern NY.

⁴ United Healthcare no longer offers individual coverage effective September 1, 2006.

NEW YORK HMO 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 HealthyNY, 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.

NCQA’s Online Health Plan Report Card

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

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 **HealthyNY**, **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.

HMO NCQA Accreditation Status as of July 2006 and Participation in New York Programs

HMO	NCQA Accreditation Status ¹	HealthyNY	Child Health Plus	Family Health Plus
Aetna Health	Excellent	✓		
BlueCross BlueShield of Western New York	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	Excellent	✓	✓	✓
Health Net of NY	Not NCQA Accredited	✓		
HIP	Commendable	✓	✓	✓
IHA	Excellent	✓		
MDNY	Not NCQA Accredited	✓		
MVP Health Plan	Excellent	✓	✓	✓
Oxford	Excellent	✓		
Rochester Area HMO (Preferred Care)	Excellent	✓		
UnitedHealthcare of NY	Commendable		✓	✓
Univera Healthcare	Excellent	✓	✓	✓
Vytra	Not NCQA Accredited	✓		

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

¹ Accreditation Status does not include Medicare or Medicaid.

TERMS YOU SHOULD KNOW

Health insurance terms in this Guide



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

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

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

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

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

Experimental/Investigational: Services that your insurer or HMO have determined are either: 1) unproven for the diagnosis or treatment of your condition, or 2) not generally recognized by the medical community as effective or appropriate for the diagnosis or treatment of your condition.

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.

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

Independent External Review: A review when a member is denied health care services because the insurer considers the services to be experimental, investigational or not medically necessary. The review is conducted by an external review organization that is not affiliated with the insurer or the member's doctor or family.

Point of Service (POS) Option: A type of coverage in which members receive services either from participating HMO providers or from providers outside the HMO's network. Members pay less for in-network care and usually pay a deductible and coinsurance for out-of-network care. Members usually pay more when they receive care outside of the provider network.

Pre-existing condition: A condition for which treatment was recommended or received in the 6 months preceding the enrollment date.

Pre-existing condition waiting period: The time during which the health plan does not have to provide coverage for a pre-existing condition, not to exceed 12 months. The waiting period may be reduced if the individual was previously covered and applied for new coverage within 63 days of the expiration of that coverage.

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

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.

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

Data Sources

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

- New York State Insurance Department (NYSID) is responsible for supervising and regulating insurance business in New York State.
 - NYSID provided information on Complaints and Independent External Reviews.
 - NYSID collects data as part of its regulatory responsibilities.
 - NYSID data are from calendar year 2005.
 - Data is limited in this Guide and does not include plans where the premium and/or membership falls below the \$25 million or 5,000 member threshold established for inclusion in the data tables.
- 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 provided 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 (CAHPS®).
 - DOH data are from calendar year 2004.

Related Resources

2005 New York Managed Care Plan

Performance Report This report is published by the NYDOH and contains the most recent information from member satisfaction surveys, standardized quality measures and providers in the plans' network. To obtain a copy, please call 518-486-9012 or download the report at www.health.state.ny.us/health_care/managed_care/qarrfull/qarr_2005/qarr2005.pdf.

Insurance Help for the Seriously Ill (and Their Caregivers)

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

HealthyNY Web site

This Web site includes information on HealthyNY coverage and eligibility criteria. Visit: www.HealthyNY.com

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
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.

