

NEW YORK Consumer Guide to HMOs



New York State
Eliot Spitzer, Governor

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

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



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

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

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

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ABOUT THIS GUIDE

The purpose of this guide is to:

- Inform you about the health insurance products offered in New York State and how they work.
- Help you choose an HMO based on quality of care and service.

Refer to the **Terms You Should Know** on page 25 for commonly used terms in this Guide. The first time the term is used, it will appear in **bold**.

Data Sources

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

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

2. **New York State Department of Health (DOH)** works to protect and promote the health of New Yorkers through prevention, science and ensuring delivery of quality health care.

- DOH compiles information on HMO performance that appears in Section 2.
- DOH collects data through the New York State DOH Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).¹
- DOH data are from calendar year 2005, except where noted.

Details About the Data

- The Guide does not include HMOs with less than \$25 million in premiums or fewer than 5,000 members.
- Data derived from Medicare or Medicaid programs are not included.
- HMOs are listed alphabetically in the data tables.
- UnitedHealthcare does not issue individual coverage.
- QARR data are not available for Atlantis Health Plan.

Questions About This Guide?

Contact:

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

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

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

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

CROSSWALK OF SELECT HEALTH INSURER NAMES

NYSID data in this Guide are reported by parent company name. DOH data are reported by **health maintenance organization (HMO)** product name, with the exception of DOH complaint data. When you look at the *Six HMO Performance Areas* section, use this table to cross-reference the HMO product to its parent company name, for comparison.

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

HOW TO CHOOSE A NEW YORK 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 doctors participate in
- Offer care and services in the area where you live and work
- Have premiums, deductibles and copayments that you can afford

*Many employers offer coverage through self-insured plans. These plans are regulated by the U.S. Department of Labor under a federal statute known as ERISA. Ask your employer's benefit manager if the health coverage provided is self-insured. New York insurance laws and member rights summarized on page 8 do not apply to self-insured plans.

Step 2

Use the *Worksheet to Help You Choose an HMO* on page 5 to gather information important to you.

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 10.

How do HMOs rank based on grievances to an HMO?

See **Grievances** on page 12.

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

See **External Appeals** on page 14.

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

See **Access to Care and Service** on page 16.

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

See **Staying Healthy and Living with Illness** on page 18.

How is the quality of HMO providers determined?

See **Quality of Providers** on page 20.

Step 3

Select an HMO.

After completing steps 1 and 2, you should be ready to select an HMO. Focus on large differences when you compare plans. Basing your decision on a small difference may not change your family's health care experience.

WORKSHEET TO HELP YOU CHOOSE AN HMO

This worksheet can help you organize and evaluate information about the HMOs available to you.

You can use information in this Guide and in other materials you may have obtained from your employer and the HMO to complete the worksheet. In the first column, fill in the names of the HMOs you are considering and which meet the criteria for access. Then put a check mark for the other criteria that the HMOs meet.

Access: Which HMOs are available where you live or work? See page 7 for the HMO services areas.	Benefits: Which HMOs offer the benefits you want? Review benefit information from your employer or HMO.	Health Care Provider: Which HMOs include your preferred doctor or health care provider? Review the HMO's physician directories and call its Customer Service Department.	Cost: Which HMOs fall within your price range? Review cost information from your employer or HMO. Be sure to consider the amount of copays, co-insurance or deductibles.	Complaints: How does the HMO rank, compared with other insurers? See page 10.	External Appeals: Which HMOs have low reversal rates? See page 14.	Access & Service: Look at the measures important to you. How do the HMOs you have chosen perform? See page 16.	Staying Healthy & Living with Illness: Look at the measures important to you. How do the HMOs you have chosen perform? See page 18.	Quality of Providers: Look at the measures important to you. How do the HMOs you have chosen perform? See page 20.	Grievances: Which HMOs have low reversal rates? See page 12.



HOW DO HMO AND HMO/POS PLANS WORK?

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 members more in out-of-pocket expenses.

A Word About Premiums

To compare prices of HMOs in your area, view their current premiums on the Web at www.ins.state.ny.us/ihmoindx.htm

Choices Available for Individual Coverage

Under New York State Insurance Law, New Yorkers purchasing health insurance on their own can choose either an HMO or an HMO/POS plan option at any time during the year. You cannot be denied coverage if you have health problems, but you may be subject to a waiting period of up to one year for certain **pre-existing conditions**. See page 22 for more information.

Facts About HMO and HMO/POS Options

The table highlights some of the important similarities and differences between 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 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 co-insurance and deductibles.

HMO Service Areas¹

Use the following table to find the HMOs that operate in your area.
Certain plans may not be available for all counties in each area.

HMO	Albany Area	Buffalo Area	Hudson Valley Area	Long Island Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Westchester Area
	Includes Albany, Clinton, Essex, Fulton, Montgomery, Rensselaer, Saratoga, Schoharie, Warren and Washington Counties.	Includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.	Includes Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan and Ulster Counties.	Includes Nassau and Suffolk Counties.	Includes Bronx, Kings, New York, Queens and Richmond Counties.	Includes Livingston, Monroe, Ontario, Seneca, Wayne and Yates Counties.	Includes Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins Counties.	Includes Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego and St. Lawrence Counties.	Includes Westchester and Rockland Counties.
Aetna Health			•	•	•		•	•	•
Connecticare (formerly Amerihealth)			•						•
Atlantis					•				
CDPHP	•		•				•	•	
CIGNA			•	•	•				•
Empire HealthChoice	•		•	•	•				•
Excellus	•	•	•			•	•	•	
GHI-HMO Select	•		•	•	•		•	•	•
Health Net of NY			•	•	•				•
HealthNow (Community Blue)	•	•	•			•	•	•	
HIP			•	•	•				•
Independent Health Association (IHA)		•							
Managed Health				•	•				
MDNY				•					
MVP Health Plan	•		•				•	•	•
Oxford			•	•	•				•
Rochester Area HMO (Preferred Care)		•				•			

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

HMO MEMBER RIGHTS

New York HMO members have the right to...

- A full, honest and confidential discussion with their physician about their medical needs.
- Access to needed specialists.
- Receive a "standing referral" to a specialist if ongoing care is required.
- Receive care for any emergency condition at an emergency room without getting prior approval from their HMO.
- A second medical opinion for the diagnosis of cancer.
- See an out-of-network provider without additional cost if their HMO does not have an in-network provider for their condition.
- Continue to see their current provider for 60 days if they switch to a new HMO and 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 **internal appeal** 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 external review organization for any final adverse determination denying coverage because a procedure, service or treatment is considered experimental, investigational or not medically necessary.

Women are entitled to:

- Direct access to primary and preventive OB/GYN services at least twice a year.
- Coverage for bone mineral density measurements and testing.
- Coverage for contraception under most group health insurance contracts.
- Remain in the hospital for 48 hours after a natural delivery of a child and at least 96 hours after a Cesarean section delivery.
- 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.

Note: *Many large employers that offer health coverage to their employees self-insure their health benefits. Such plans are not subject to New York laws. See page 4 for more information.*

YOUR RIGHT TO APPEAL AN HMO'S DECISION

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

The External Appeal Process

Whom to contact: New York State Insurance Department.

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

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

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

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

New York Insurance Department

External Appeal
P.O. Box 7209
Albany NY 12224-0209

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

External Appeal Data

See pages 14-15 for external appeal data for HMOs.

What Will Happen?

The Insurance Department will:

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

The external appeal agent will:

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

When you will get a decision:

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

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

How to Get More Information:

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

Eligibility

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

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

COMPLAINTS

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

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

Understanding the Charts

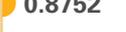
- **Rank:** A better rank means that the HMO had fewer upheld complaints, relative to its size.
- **Total Complaints to NYSID:** Total number of complaints closed by the Insurance Department in 2006. Complaints to the Insurance Department typically involve issues concerning prompt payment, reimbursement, coverage, benefits, rates and premiums.
- **Upheld Complaints by NYSID:** Number of closed complaints where the Insurance Department determined that the HMO did not comply with statutory or contractual obligations. Complaints upheld by the Insurance Department are used to calculate the complaint ratio and rank.
- **Premium*:** Dollar amount of premiums generated by an HMO in New York during 2006. Premiums are used to calculate the complaint ratio so that HMOs of different sizes can be compared fairly.
- **Complaint Ratio:** Number of upheld complaints by NYSID, divided by the HMOs **total annual premium**. Total annual premium, a measure of a HMO's size, is used to calculate the complaint ratio so that HMOs of different sizes can be compared fairly. Large HMOs may receive more complaints because they serve more people than smaller HMOs.
- **Total Complaints to DOH:** Total number of complaints against HMOs closed by DOH. Complaints to DOH involve concerns about the quality of care received by HMO members.
- **Upheld Complaints to DOH:** Number of complaints closed by DOH that were decided in favor of the consumer or provider.

**Premium data exclude Medicare and Medicaid.*

Complaints—HMOs 2006

Data source: NYSID and DOH

HMOs with a lower complaint ratio receive a better rank.

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

¹ DOH complaint data is from 2006.

 Denotes length of bar graph shortened due to spatial constraints.

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

GRIEVANCES

How HMOs rank based on member grievances



A **grievance** is when a member or provider complains to an HMO about denials based on limitations or exclusions in the contract. Medical necessity issues are internal appeals, not grievances. Common grievances include trouble getting referrals to specialists and disagreements over benefit coverage.

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

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

Understanding the Chart

- **Filed Grievances:** Number of grievances submitted to the HMO.
- **Closed Grievances:** Number of grievances the HMO was able to make a decision on by the end of the reporting period.
- **Upheld Grievances:** Number of closed grievances where the HMO stood by its original decision and did not decide in favor of the member or provider.
- **Reversed Grievances:** Number of closed grievances where the HMO changed its initial decision and decided in favor of the member or provider.
- **Reversal Rate:** Percentage of grievances where the HMO decided in favor of the consumer or provider.

Keep in Mind:

Pay specific attention to an HMO that has a very high or very low reversal rate. Please note the following.

- There is no "ideal" reversal rate.
- A low reversal rate may indicate that the HMO makes correct decisions, so fewer of its decisions require reversal, but an unusually low reversal rate may mean that the HMO does not give appropriate reconsideration to its initial decisions.
- A high reversal rate may indicate that the HMO's grievance process is responsive to members, but an unusually high reversal rate may indicate that its process for making initial decisions is flawed.
- The number of grievances filed may be higher for HMOs that actively promote the grievance process to members.

Grievances 2006

Data source: NYSID

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

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

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

EXTERNAL APPEALS

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

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

Understanding the Charts

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

- **Reversal Rate:** Percentage of cases in which the external appeal organization decided to change the HMO's decision to deny coverage. In other words, the reversal rate is the percentage of reviews decided in favor of the consumer. Please note that **reversed-in-part** decisions are included in the reversal rate.

Note: A high reversal rate may indicate that an HMO does not make appropriate coverage decisions.



External Appeals—HMOs 2006

Data source: NYSID

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

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

ACCESS TO CARE AND SERVICE

Whether HMO members have access to the care and service they need

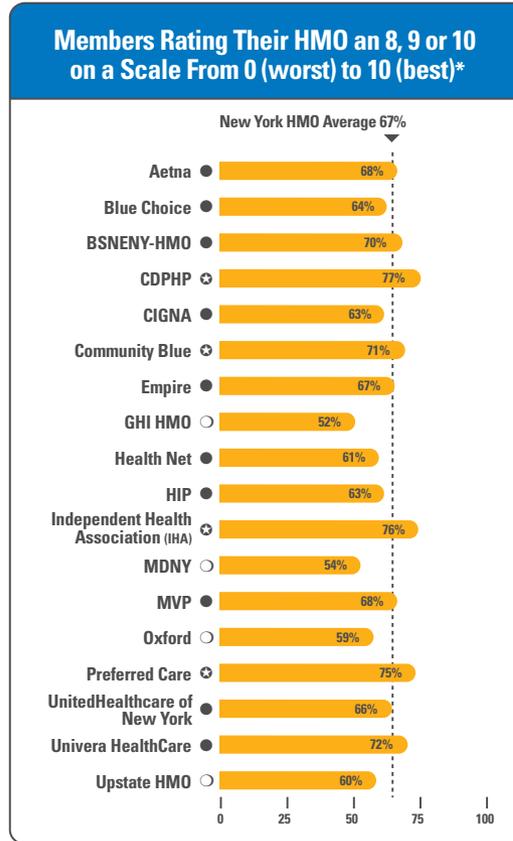
Data source: DOH

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

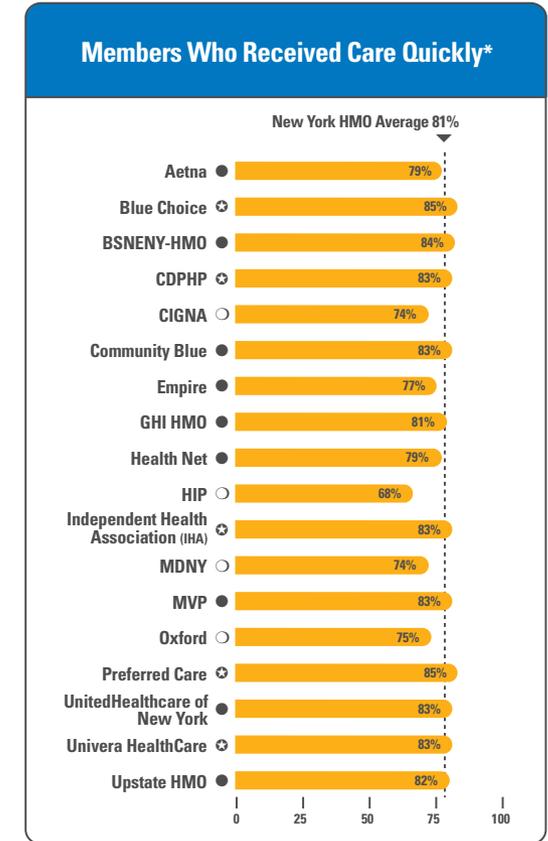
Understanding These Charts

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

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



Members rated their HMO on a scale from 0 (worst possible) to 10 (best possible). The circles in the chart are based on the number of members who gave their HMO an 8, 9 or 10 rating.



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

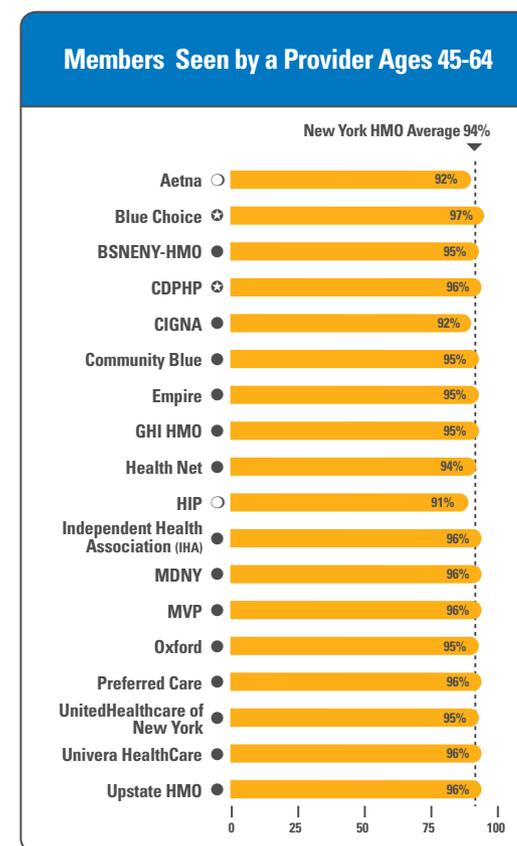
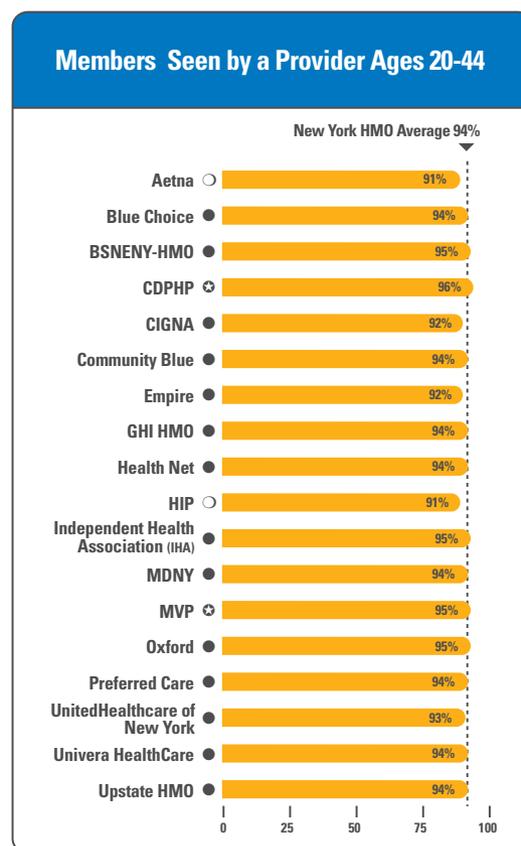
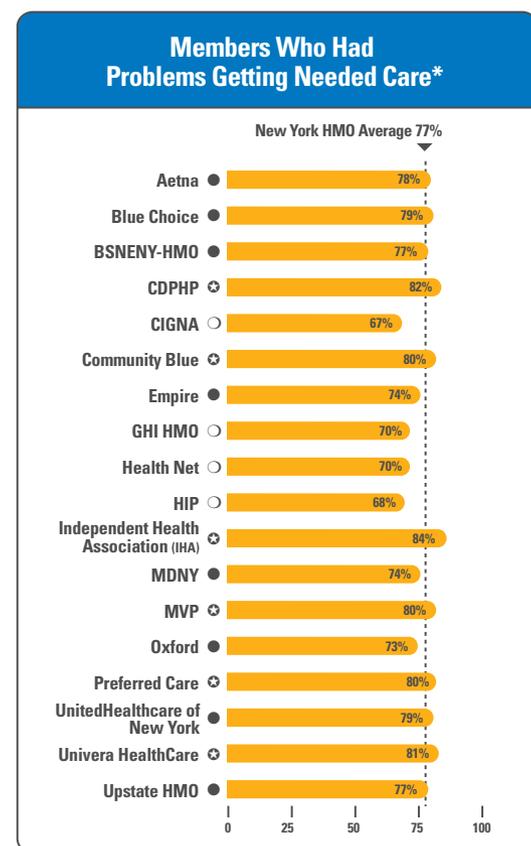
- Get needed help or advice from their doctor’s office.
- Get appointments for regular or routine care as soon as they want.
- Get care right away for an illness or injury.
- Wait no more than 15 minutes past the appointment time to see a provider.

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

*Data are from 2006.

Performance Compared to the New York HMO Average

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



Members responded that they had experienced a problem getting:

- A personal doctor they were happy with.
- A referral to see a specialist.
- Care they and their doctor believed was necessary.
- Timely approval for care.

Even healthy members need to see a provider to ensure that medical problems are prevented or caught as early as possible. The chart shows the percentage of adult HMO members who had an outpatient or preventive care visit within the past 3 years, as reported by the HMO. A higher score means that more people in the HMO had a provider visit.

STAYING HEALTHY AND LIVING WITH ILLNESS

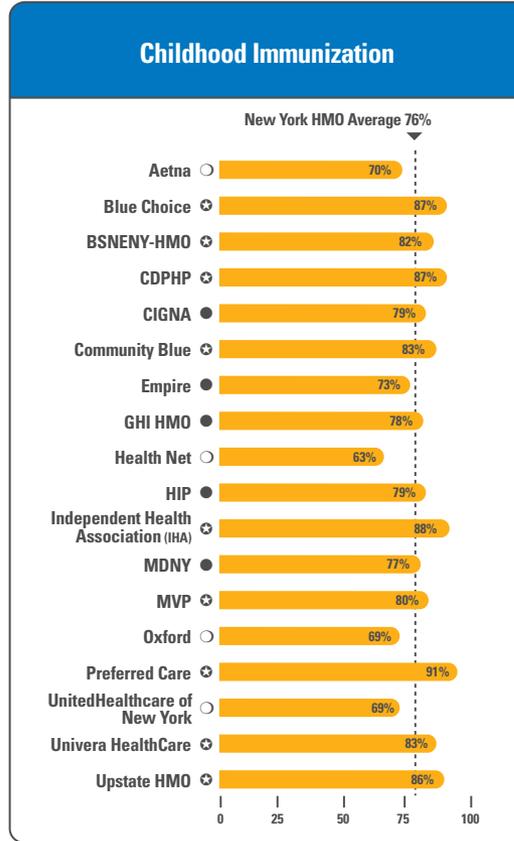
How well HMOs help members maintain good health and avoid illness

Data source: DOH

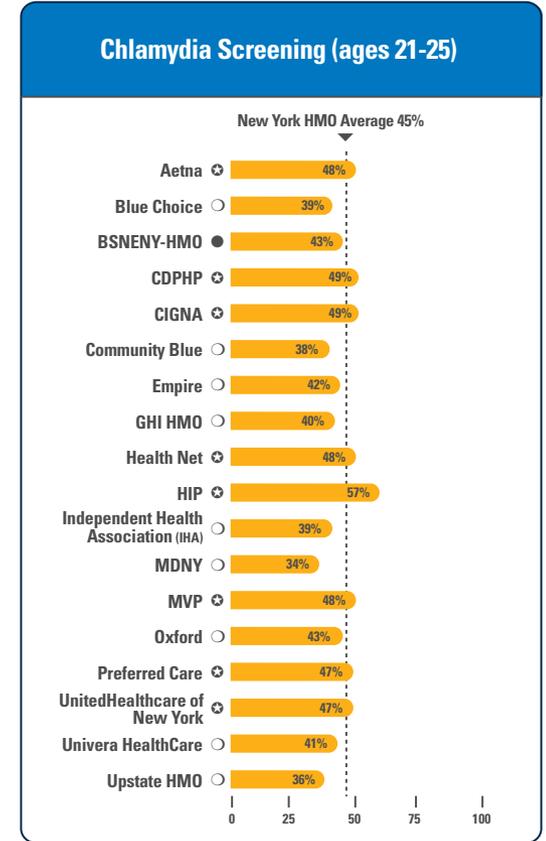
New York HMOs were rated on how well they help people maintain good health and recover from illness.

Understanding These Charts

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



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



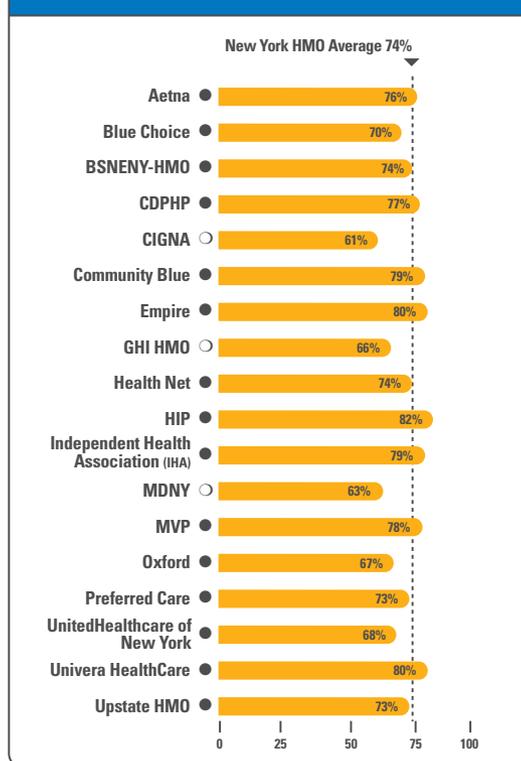
Chlamydia is the leading cause of preventable infertility and can lead to pelvic inflammatory disease. Women with chlamydial infections often do not have symptoms, so routine screening and treatment is essential. HMOs were rated on the percentage of sexually active young women who had at least one test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

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

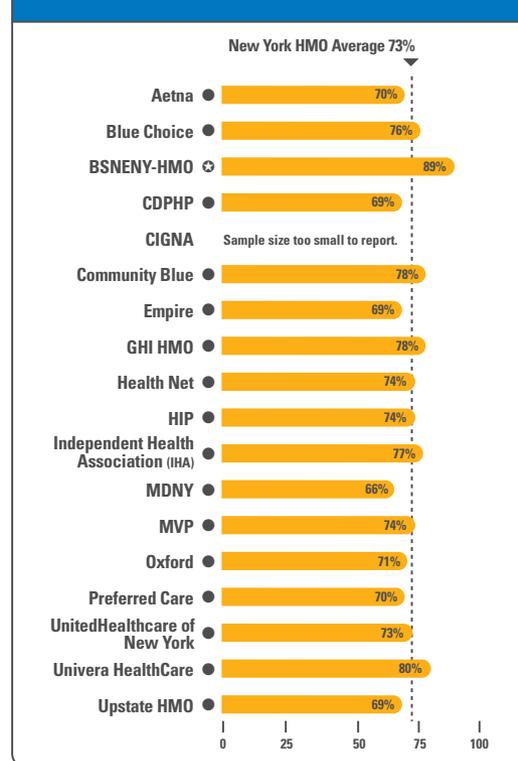
Performance Compared to the New York HMO Average

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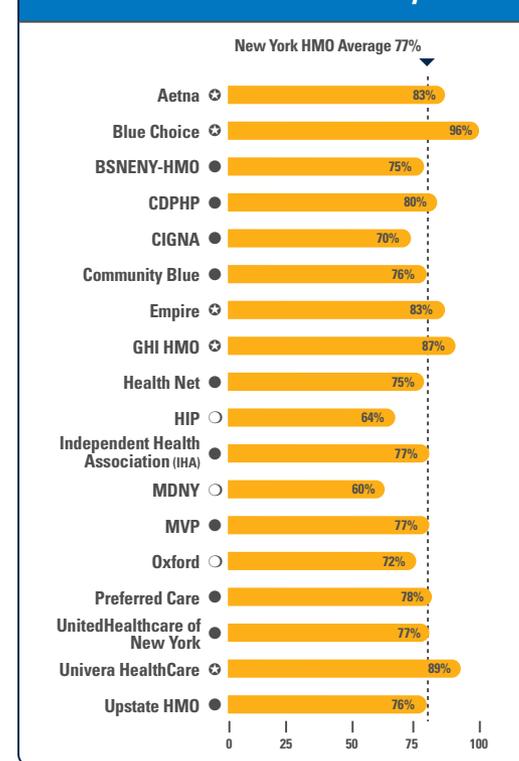
Advising Smokers to Quit



Persistence of Beta-Blocker Treatment



Follow-Up After Hospitalization for Mental Illness Within 30 Days



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

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

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

QUALITY OF PROVIDERS

How the quality of HMO providers is determined

Data source: DOH

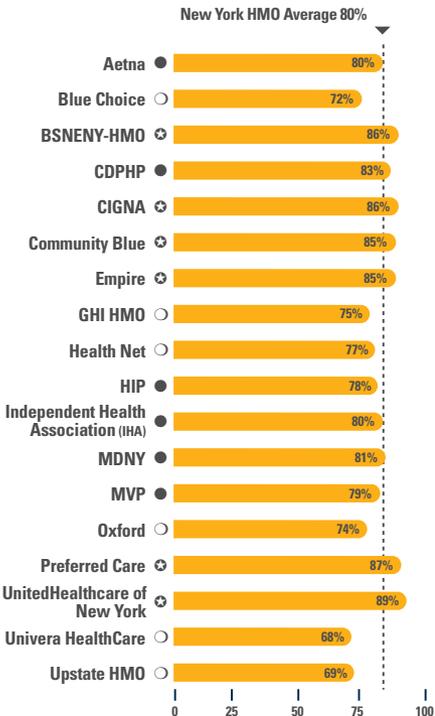
The quality, stability and availability of physicians in an HMO provider network can impact the overall quality of care delivered to HMO members.

Understanding These Charts

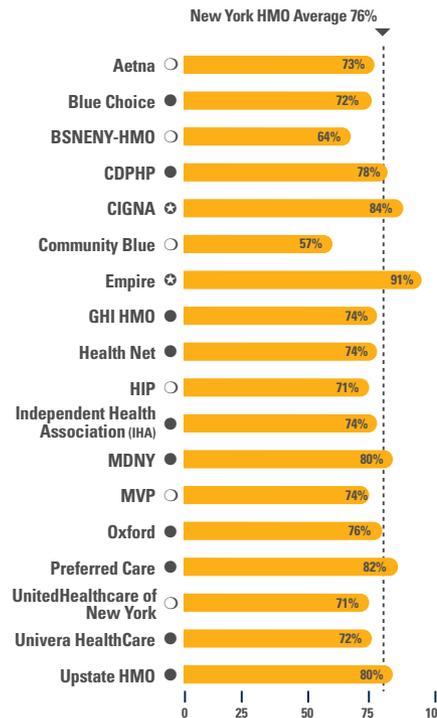
Look for the HMOs that have “⊕” in the chart; these HMOs performed better than the New York HMO average.



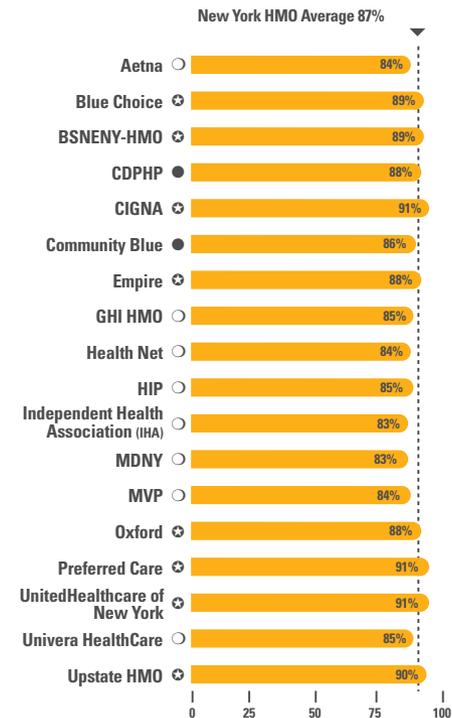
Doctors who are Certified by A Medical Board-OB/GYN



Doctors who are Certified by a Medical Board-Pediatrician



Doctors who are Certified by a Medical Board-Primary Care



To be board certified, a doctor must receive additional training and pass an exam in his or her specialty. While board certification is not a guarantee of quality, it shows that the physician has knowledge that the specialty board considers necessary. The chart shows the percentage of PCPs, obstetricians/gynecologists (OB/GYN) and pediatricians who are board certified. A higher percentage means the HMO has more board-certified physicians in the practice areas listed.

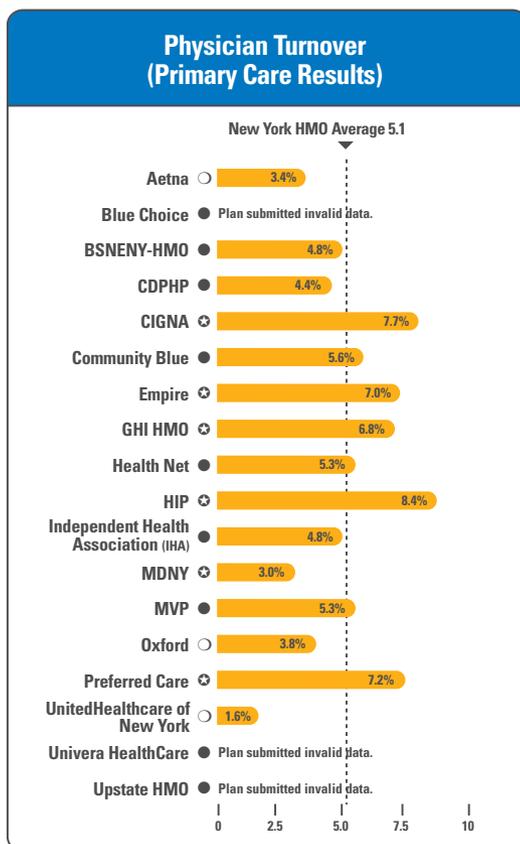
Note: There are times when it is appropriate for HMOs to contract with physicians who are not board certified, as in the case of older physicians trained before board certification was available. In addition, an HMO covering a rural area may have a lower percentage of board-certified physicians, since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

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

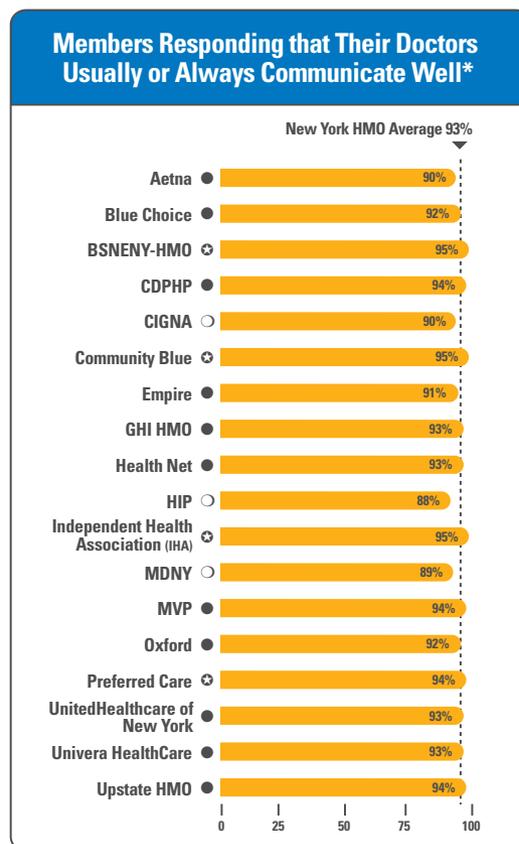
*Data are from 2006.

Performance Compared to the New York HMO Average

- ★ Significantly **better** than the NY HMO average
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- Significantly **worse** than the NY HMO average

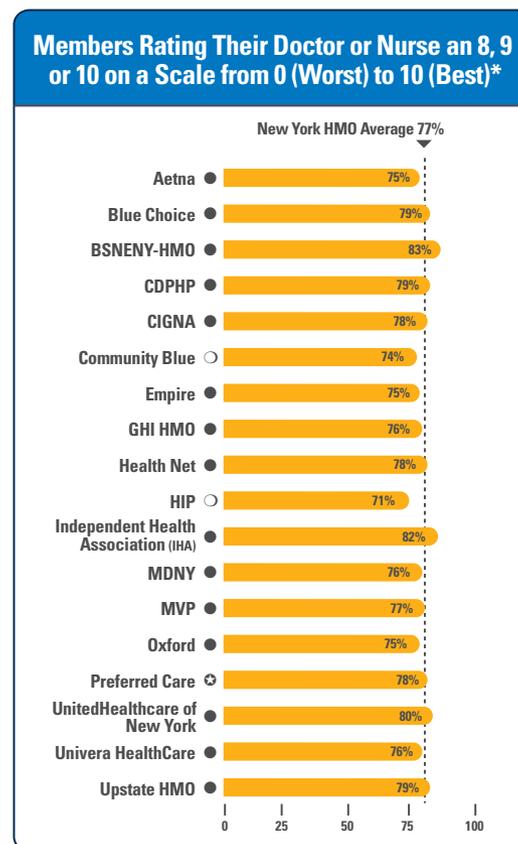


Going to the same doctor over time makes it easier to receive better and more coordinated care. If most doctors remain in an HMO physician network, members are less likely to need to change doctors. The chart shows the percentage of PCPs who left the HMO's network in 2005. A lower percentage means the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



Members responded that their doctors or health care providers "usually" or "always":

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



Members rated their doctor or nurse on a scale from 0 (worst possible) to 10 (best possible). The circles are based on the percentage of members who gave their HMO an 8, 9 or 10 rating.

AVAILABLE INSURANCE OPTIONS FOR UNINSURED NEW YORKERS

New Yorkers that do not have health insurance can either:

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

	Programs Offered by New York State			Purchase Insurance Coverage
Program	Healthy NY	Child Health Plus	Family Health Plus	HMO Plan or HMO/POS Plan
Who Qualifies?	Small employers, sole proprietors and working uninsured individuals who meet income limits.	Children who are under 19 years of age and do not have other health insurance. Governor Spitzer signed a law in 2007 that expanded the eligibility criteria, making this program available to more children.	Adults between 19 and 64 years of age who are uninsured and whose income is too high to qualify for Medicaid.	Uninsured adults and families who are not eligible for other programs.
Cost	Healthy NY benefits are the same for each HMO, but monthly premiums you have to pay will vary.	Depending on your family's gross income, you may have to pay a monthly contribution to enroll in Child Health Plus. Families that insure a child through this program do not have to pay copayments to receive services.	There is no cost to participate in Family Health Plus. There are no premiums or deductibles. Modest copayments apply to some services.	You can purchase either of these benefit packages from HMOs operating in your area. See page 7 to determine which HMOs operate in your area. Rates can be found at www.ins.state.ny.us/ihmoindx.htm
Enrollment	Call this toll-free number: 866-HEALTHY-NY (866-432-5849), or visit the Web site at www.HealthyNY.com	Call this toll-free number: 800-698-4KIDS (800-698-4543) or visit the Web site at http://www.health.state.ny.us/nysdoh/chplus/index.htm	Contact your local Social Services district office about Family Health Plus or visit the Web site at http://www.health.state.ny.us/nysdoh/fhplus/index.htm	Individuals may enroll in either an HMO or HMO/POS plan at any time and may not be denied coverage for health reasons. A pre-existing condition may require a waiting period.*

*For a pre-existing condition, a member may have to wait up to a year for coverage of the condition if treatment was recommended or received within the 6 months prior to the date of enrollment. The waiting period may be reduced if the individual was previously covered and applied within 63 days of expiration of coverage. It is important that insurance coverage does not lapse beyond this point. Contact NYSID or the individual health insurer for details about the pre-existing condition waiting period.

HMO PARTICIPATION IN NEW YORK STATE PROGRAMS

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

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

NCQA ACCREDITATION

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

What Is NCQA Accreditation?

NCQA Accreditation evaluates aspects of HMOs that are important but are generally difficult for people to determine on their own. NCQA has a team of doctors and health care experts who conduct a comprehensive review of a health plan's systems and structure against more than 60 different standards. Plans also have to submit clinical performance measures (known as HEDIS^{®1}) as part of the accreditation process. HEDIS data are precisely defined, which makes it possible to compare the performance of HMOs on an "apples-to-apples" basis. NCQA assigns 1 of 5 possible accreditation outcomes based on a plan's performance.

******Excellent:** The health plan demonstrates levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results that are in the highest range of national or regional performance.

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

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

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

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

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

NCQA's Online Health Plan Report Card

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

HMO NCQA Accreditation Status as of July 2007

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

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

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

²Accreditation status does not include Medicare or Medicaid.



TERMS YOU SHOULD KNOW

Health insurance terms in this guide

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

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

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

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

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

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

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

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

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

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

Health Maintenance Organization (HMO)

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

TERMS YOU SHOULD KNOW CONTINUED



Internal Appeal or Utilization Review

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

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

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

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

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

Pre-Existing Condition Waiting Period:

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

Preferred Provider Organization (PPO):

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

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

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

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

Self-Insured Health Plan: In this type of plan, an employer pays for employees' health care costs out of a fund that the company has set aside for medical expenses. Employers may contract with an outside organization, often an insurance company, to administer the plan. Under a federal statute known as ERISA, the U.S. Department of Labor has authority over self-insured employer health plans; therefore, New York's consumer protection and insurance laws do not apply.

Specialist: A doctor who is trained in and practices a specific type of medicine other than primary care (e.g., cardiologist, dermatologist, gastroenterologist). HMO members usually need a referral from their PCP to see a specialist.

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

CONTACTS AND RESOURCES

Questions About This Guide?

Contact:

NYSID Consumers Service Bureau

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

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

Problem with Your HMO?

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

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

NYSID Consumer Services Bureau

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

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

NYSID External Appeals

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

For issues concerning HMO quality of care, contact:

New York State Department of Health

Office of Managed Care
Bureau of Managed Care Certification and Surveillance-Complaint Unit
Corning Tower, Rm. 1911
Albany, NY 12237
www.health.state.ny.us
800-206-8125 (*quality of care*)

Questions About Programs for the Uninsured?

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

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

United States Department of Labor

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

For issues concerning insurance fraud, contact:

NYSID Insurance Frauds Bureau

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

Questions About Medicare and Medicaid?

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

Centers for Medicare & Medicaid Services

www.medicare.gov
800-MEDICARE (800-633-4227)

New York State Office for the Aging Health Insurance Information Counseling & Assistance Program (HIICAP)

www.hiicap.state.ny.us
800-701-0501

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



RELATED RESOURCES

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.

HealthyNY Web Site

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

Looking for HMO Rates?

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

2006 New York Managed Care Plan Performance Report

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

Insurance help for the seriously ill (and their caregivers)

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

HMO TELEPHONE NUMBERS

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



