2009 New York

CONSUMER GUIDE TO HMOS

New York State
David A. Paterson, Governor

NEW YORK
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About this Guide

The purpose of this Guide is to:

- Inform you of 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 a 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 the complaint and appeal information that appears in Section 2 and grievance information that appears in Section 2.
   - NYSID data are from calendar year 2008.
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 the complaint and HMO performance information 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 2007, except where noted.

Details About the Data

- The Guide does not include HMOs with less than $25 million in premiums or fewer than 5,000 members.
- The Guide does not include data for Medicare, Medicaid or self-insured plans.
- HMOs are listed alphabetically in the data tables.
- QARR data are not available for Atlantis Health Plan.
- In 2007 the set of questions contained in the CAHPS survey changed from the 3.0H to the 4.0H version; therefore, data in prior reports cannot be compared to data in this report.

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**

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

[2] For information about Medicare 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.

Health Plans in this Guide

Data in this Guide are reported for **health maintenance organizations** (HMOs). A complete list of HMOs is on page 28. Some insurers are listed using different names depending on whether data are reported by the Insurance Department or by the Department of Health. Use the list to cross reference the HMOs when reviewing data in this Guide.

Crosswalk of Select HMO Names	
In Section 2, for Complaints, Grievances and External Appeals, the plan is listed as:	**In Section 2, for Access to Care and Service, Staying Healthy and Quality of Providers, the plan is listed as:**
Community Blue (HealthNow)	Blue Shield of Northeastern New York (BSNEY) (Albany area) Community Blue (Buffalo area)
Excellus Health Plan, Inc. (HMO)	Excellus BlueCross BlueShield Univera HealthCare
Rochester Area HMO	Although *Preferred Care* changed its name to *MVP Health Care* in March, the 2009 Guide uses the company's original name.

In Section 2, for Complaints, Grievances and External Appeals, HIP HMO also includes data for:	**In Section 2, for Access to Care and Service, Staying Healthy and Quality of Providers, HIP HMO includes data for:**
Health Insurance Plan of Greater New York HIP Insurance Company of New York PerfectHealth Insurance Company	HMO product only

How to Choose an HMO

A STEP-BY-STEP GUIDE

You can use information in this Guide and in other materials you may have obtained from your employer or the HMO to complete the table. Identify the HMOs that meet your basic requirements.

Step 1

When choosing among the HMOs your employer* offers or state programs for which you are eligible, use the following questions to select the HMOs most suitable for you.

	List the HMOs you are considering.
Which HMO does your doctor participate in? *Review the HMOs' physician directories online or call their Customer Service Departments.*	
Which HMO is available where you live or work? *See page 7 for HMO service areas.*	
Which benefits do the HMOs offer? *Review the benefits information from your employer, or contact the HMO for benefits information if you are buying insurance directly from an HMO. New York State requires all HMOs to offer the same benefits to people who buy health insurance on their own.*	
Which HMO can you afford? *Consider the amount of copays, co-insurance or deductibles. To see and compare HMO rates, visit www.ins.state.ny.us/ihmoindx.htm*	

*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.

1

Step 2

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

	List the HMOs you are considering.
Complaints: How does the HMO rank, compared to other HMOs? *See page 10.*	
Grievances: Which HMOs have low reversal rates? *See page 12.*	
External Appeals: How often are HMO decisions to deny care or service changed? *See page 14.*	
Access & Service: Do HMO members have access to the care and service they need? *See page 16.*	
Staying Healthy & Living with Illness: Look at the measures important to you. Which HMOs perform well? *See page 18.*	
Quality of Providers: Look at the measures important to you. Which HMOs perform well? *See page 20.*	

Step 3

Select an HMO.

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

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 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-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.	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, 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 Areas[1]

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	West-chester Area
	Includes Albany, Clinton, Essex, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.	Includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.	Includes Columbia, Delaware, Duchess, 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 Inc.			●	●	●		●	●	●
Atlantis Health Plan, Inc.					●				
CDPHP	●		●				●	●	
Community Blue (HealthNow)	●	●	●			●	●	●	
Empire HealthChoice HMO, Inc.	●		●	●	●				●
Excellus Health Plan, Inc. (HMO)	●	●	●			●	●	●	
GHI HMO Select, Inc.	●		●	●	●		●	●	●
Health Net of NY, Inc.			●	●	●				●
HIP HMO			●	●	●				●
Independent Health Association (IHA)		●							
MVP Health Plan, Inc.	●		●				●	●	●
Oxford Health Plans of NY, Inc.			●	●	●				●
Rochester Area HMO, Inc. (Preferred Care)		●				●			

[1] Service areas are current as of June 1, 2009.

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 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; in the event of a positive or negative diagnosis of cancer or a recurrence 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. As an HMO member, you can also appeal when the HMO denies a request for out-of-network service if the HMO offers an **alternate service** in-network.
- An expedited appeal if they are undergoing a course of treatment or if their doctor believes an immediate appeal is warranted.
- An external appeal by an external review organization for any final adverse determination denying coverage because a procedure, service or treatment is considered experimental, investigational, not medically necessary or an out-of-network service.

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 post-partum 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. As an HMO member, you may also appeal when the HMO denies a request for out-of-network service if it offers an alternate service in-network. You may use the HMOs internal appeal process to request that the HMO reconsider its decision. If you disagree with the result, you may 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 may 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, not medically necessary or out-of-network service.

When you can appeal: You must request an external appeal within 45 days of receiving 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 (which requires a physician's statement for experimental/investigational, out-of-network service 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
PO Box 7209
Albany, NY 12224

What you must pay: $50 (the fee is waived under certain conditions). The fee is returned to you 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, which is final and binding between you and the health insurer.

When you will get a decision: Within 30 days (plus 5 business days, if additional information is requested).

In urgent situations: An expedited appeal will be reviewed by NYSID 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 for External Appeal

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 New York.

Complaints

HOW DOES THE HMO RANK BASED ON MEMBER COMPLAINTS TO THE NYSID?

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 resolve 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 2008. 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 resolved in favor of the member or provider because the the Insurance Department determined that the HMO did not comply with its 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 2008.

**Premium data exclude Medicare and Medicaid.*

- **Complaint Ratio:** Number of upheld complaints (complaints resolved in favor of the member or provider) by NYSID, divided by the HMOs **total annual premium**. Total annual premium, a measure of an 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 have more members 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.

Complaints—HMOs 2008

Data source: NYSID and DOH

HMOs with a lower complaint ratio receive a better rank.

	Data Compiled by the New York State Insurance Department (NYSID)					Data Compiled by the NYS Department of Health (DOH)[1]	
HMO	Rank 1 = Best, 13 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions $)	Complaint Ratio	Total Complaints to DOH	Upheld Complaints by DOH
Aetna Health Inc.	11	548	137	635.9	0.2155	4	1
Atlantis Health Plan	12	148	103	66.1	1.5584	5	2
CDPHP	4	86	14	648.9	0.0216	5	0
Community Blue (HealthNow)	6	91	32	471.8	0.0678	26	2
Empire Health Choice HMO, Inc.	7	742	176	1,775.3	0.0991	6	4
Excellus Health Plan, Inc. (HMO)	5	128	31	847.6	0.0366	30	8
GHI HMO Select, Inc.	13	355	189	86.5	2.1853	8	2
Health Net of NY, Inc.	8	301	66	465.0	0.1419	19	3
HIP HMO	10	1,170	488	2,351.9	0.2075	31	12
Independent Health Association, Inc. (IHA)	2	21	2	485.6	0.0041	19	7
MVP Health Plan, Inc.	3	74	9	861.6	0.0104	9	7
Oxford Health Plans of NY Inc.	9	1,360	196	1,342.8	0.1460	25	14
Rochester Area HMO, Inc. (Preferred Care)	1	1	0	385.3	0.0000	6	1
TOTAL		5,025	1,443	10,424.3	Avg. = 0.1384	193	63

[1] DOH complaint data are from 2008.

Grievances

HOW DOES THE HMO RANK BASED ON MEMBER GRIEVANCES?

A **grievance** is when a member complains to an HMO about a denial 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. An HMO committee reviews grievances and decides whether to reverse them or uphold the denial.

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 decided 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 the HMOs 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 2008

Data source: NYSID

HMO	Filed Grievances	Closed Grievances[1]	Upheld Grievances	Reversed Grievances	Reversal Rate
Aetna Health Inc.	698	701	471	230	32.8%
Atlantis Health Plan	126	123	82	41	33.3%
CDPHP	1,468	1,486	541	945	63.6%
Community Blue (HealthNow)	433	435	223	212	48.7%
Empire HealthChoice HMO, Inc.	560	567	410	157	27.7%
Excellus Health Plan, Inc. (HMO)[2]	1,607	1,623	1,102	521	32.1%
GHI HMO Select, Inc.	187	189	99	90	47.6%
Health Net of NY, Inc.[3]	2,794	2,678	1,451	1,227	45.8%
HIP HMO	1,506	1,539	580	959	62.3%
Independent Health Association, Inc. (IHA)[2]	327	321	206	119	37.1%
MVP Health Plan, Inc.	150	151	85	66	43.7%
Oxford Health Plans of NY, Inc.[3]	11,936	11,708	5,863	5,845	49.9%
Rochester Area HMO, Inc. (Preferred Care)	174	201	47	154	76.6%
TOTAL	**21,966**	**21,722**	**11,160**	**10,566**	Avg. = 48.6%

[1] Closed grievances can exceed filed grievances in 2008 because closed grievances also include grievances filed prior to 2008.

[2] Includes grievances for Art. 43 company.

[3] Includes grievances for commercial company contracts.

2

3

External Appeals

HOW OFTEN DOES THE HMO CHANGE ITS DECISION TO DENY CARE OR SERVICES?

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, not medically necessary or an out-of-network service, you have the right to appeal the decision. 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 2008.
- **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 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 2008

Data source: NYSID

HMO	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate[1]
Aetna Health Inc.	22	7	1	14	36.4%
Atlantis Health Plan	11	5	1	5	54.5%
CDPHP	14	6	1	7	50.0%
Community Blue (HealthNow)	19	5	5	9	52.6%
Empire HealthChoice HMO, Inc.	161	73	8	80	50.3%
Excellus Health Plan, Inc. (HMO)	67	30	2	35	47.8%
GHI HMO Select, Inc.	9	4	0	5	44.4%
Health Net of NY, Inc.	107	38	6	63	41.1%
HIP HMO	83	21	8	54	34.9%
Independent Health Association, Inc. (IHA)	11	8	0	3	72.7%
MVP Health Plan, Inc.	21	9	0	12	42.9%
Oxford Health Plans of NY, Inc.	97	38	4	55	43.3%
Rochester Area HMO, Inc. (Preferred Care)	16	8	1	7	56.3%
TOTAL	**638**	**252**	**37**	**349**	Avg. = 45.3%

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

Access to Care and Service

DO HMO MEMBERS HAVE ACCESS TO THE CARE AND SERVICE THEY NEED?

Data source: DOH

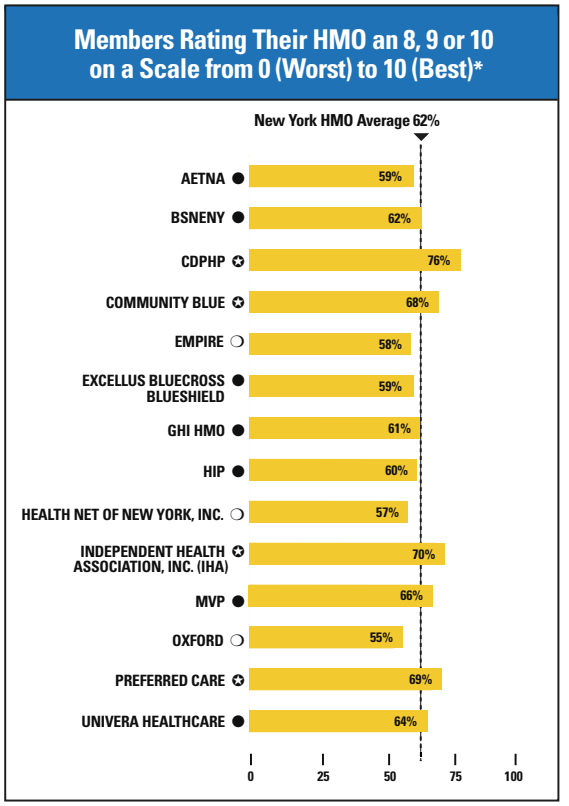
Consumers rated New York HMOs on how well they provide members with timely access to needed care and customer service.

Understanding These Charts

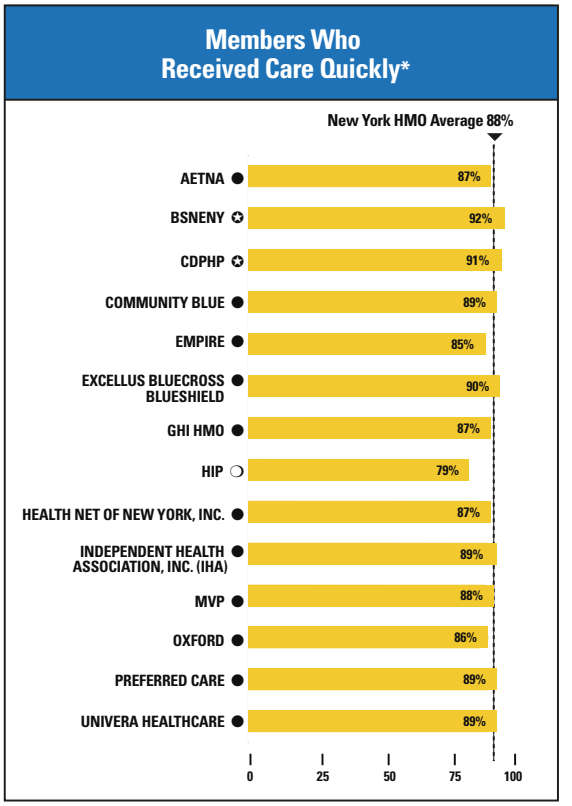
The circles in the charts show how each HMO compares to the average for all New York HMOs. Look for HMOs with a "✪" in the chart; they performed better than the New York HMO average. In other words, they had a greater percentage of satisfied members and members were more likely to be seen by a provider.

The 62% New York HMO Average for "Members Rating Their HMO…" means that on a scale of 0 (worst) to 10 (best), 62% of all HMO members gave their HMO an 8, 9 or 10 rating.

Note: *Symbols show statistically significant differences between each health insurer's score and the New York average. Statistically significant means scores varied by more than could be accounted for by chance.*
**Data are from 2008. These results cannot be compared to last year's results.*



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



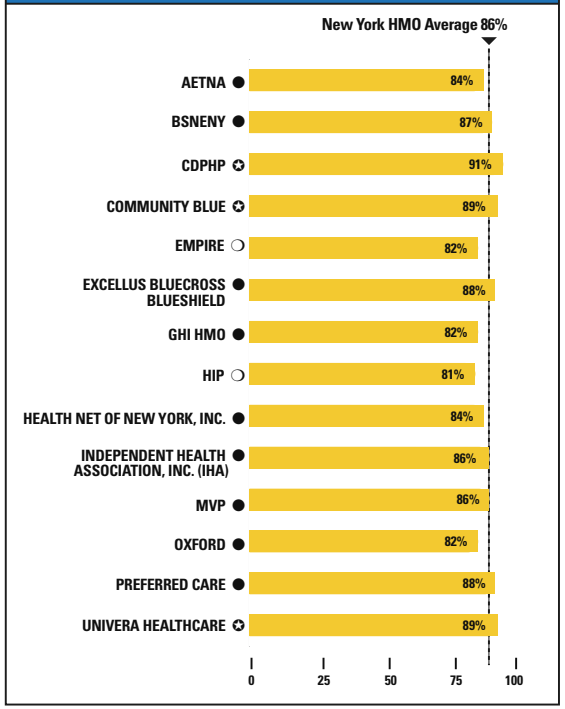
Members responded that they "usually" or "always":

- Get appointments for regular or routine care as soon as they want.
- Get care right away for an illness or injury.

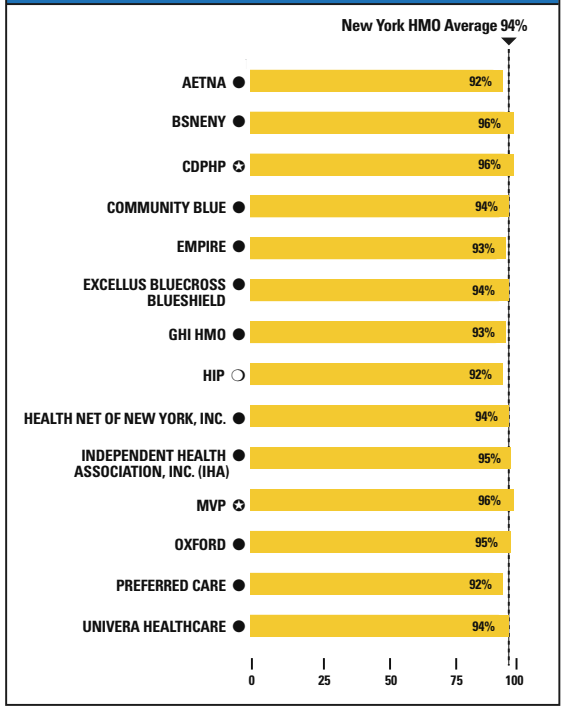
Performance Compared to the New York HMO Average

- ✪ *Higher* than the NY HMO average
- ● *Not different* from the NY HMO average
- ○ *Lower* than the NY HMO average

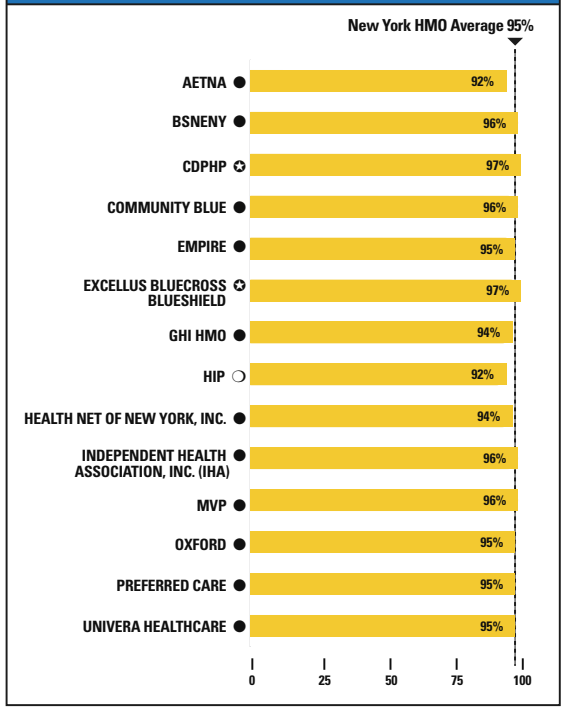
Members Who Received Needed Care*



Members Age 20-44 Seen by a Provider*



Members Age 45-64 Seen by a Provider*



Members responded that they "usually" or "always" thought it was easy to get:

- Appointments with specialists.
- Care, tests or treatment members thought they needed.

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 more people in the HMO had a provider visit.

Staying Healthy and Living With Illness

HOW WELL DOES THE HMO HELP MEMBERS MAINTAIN GOOD HEALTH AND AVOID ILLNESS?

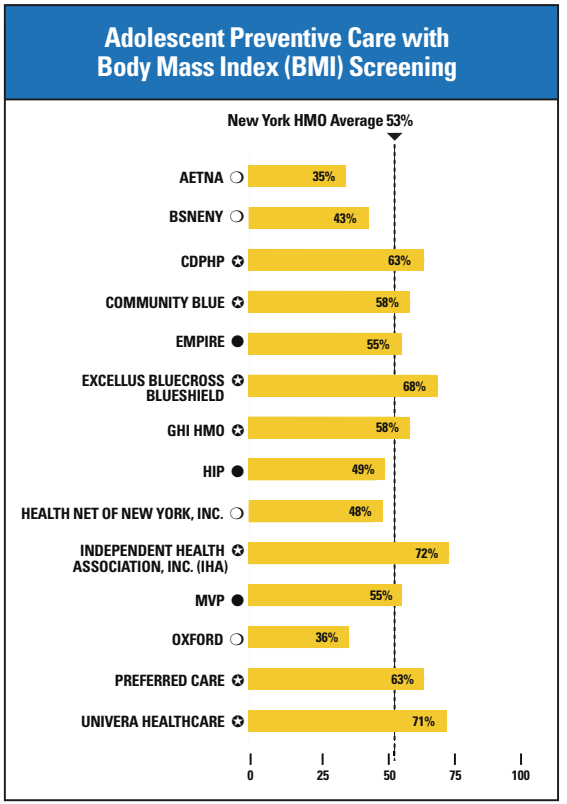
Data source: DOH

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

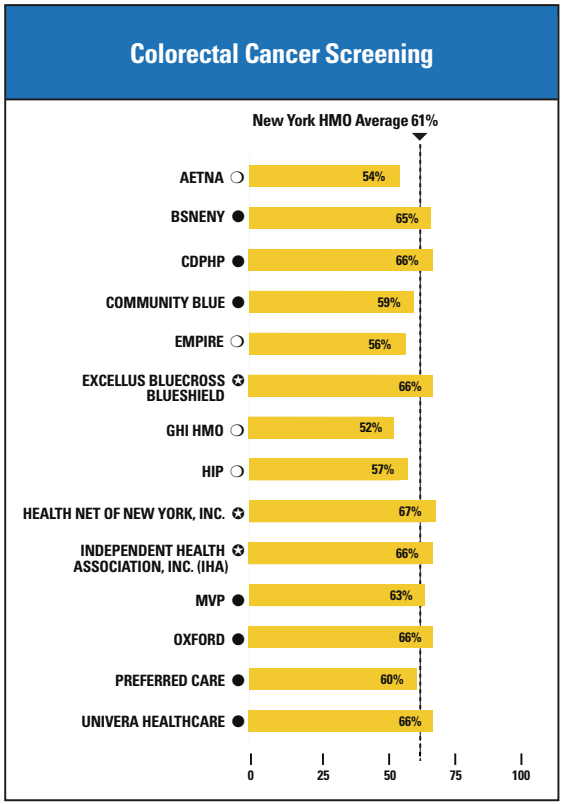
Understanding These Charts

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; they performed better than the New York HMO average. In other words, they had a greater percentage of members who received these services.

Note: *Symbols show statistically significant differences between each health insurer'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 plans' eligible-population size differences (i.e., denominators) were used to calculate the rates.*



The Centers for Disease Control and Prevention (CDC) states that overweight children and adolescents are more likely to become obese as adults. Assessing body mass index (BMI) allows health care professionals to identify adolescents at high risk and implement preventive care. HMOs were rated on the percentage of adolescents ages 14–18 who had a least one well-care visit with a PCP or OB/GYN during 2007 and had documentation of a BMI or BMI percentile.

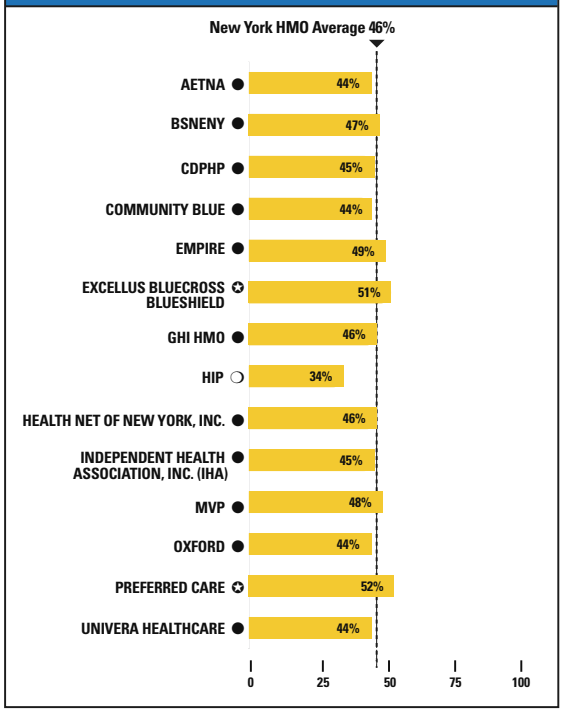


Colorectal cancer affects both men and women of all racial and ethnic groups, and is most often found in people age 50 or older. Screening can find precancerous polyps—abnormal growths in the colon or rectum—so that they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage when it can be successfully treated. HMOs were rated on the percentage of adults, ages 50–80, who had appropriate screening for colorectal cancer.

Performance Compared to the New York HMO Average

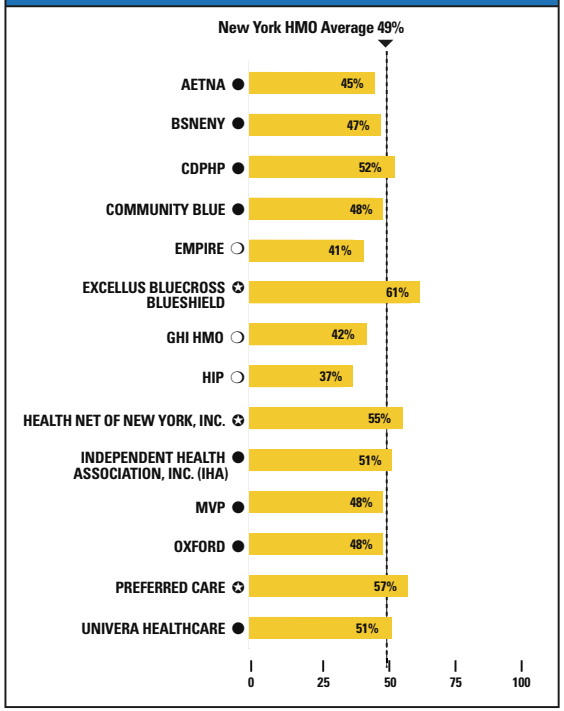
- ✪ *Higher* than the NY HMO average
- ● *Not different* from the NY HMO average
- ○ *Lower* than the NY HMO average

Antidepressant Medication Management: Effective Continuation Phase Treatment



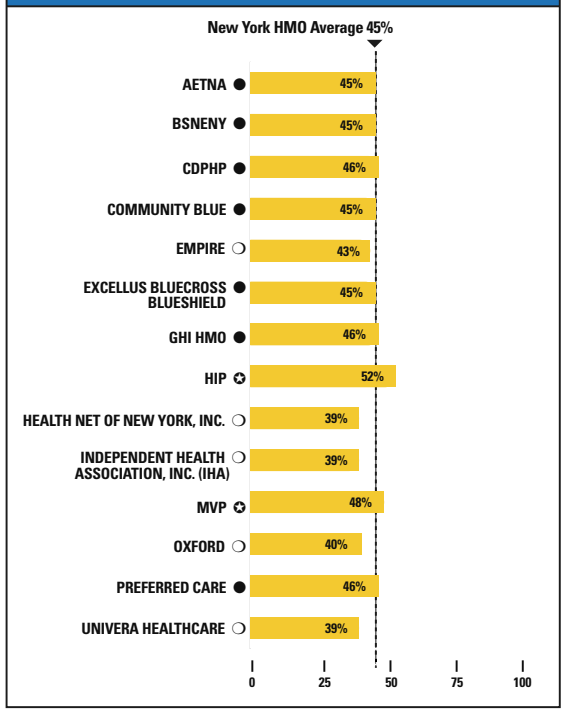
Depression, even the most severe cases, is a highly treatable disorder. Patients should take regular doses of antidepressants for at least 3 to 4 weeks in order to experience the full beneficial effects. Patients should continue taking the medication for the time specified by their doctor, even if they are feeling better, in order to prevent a relapse of the depression. HMOs were rated on the percentage of members age 18 and older who were diagnosed with depression and remained on medication for at least 6 months.

Flu Shots for Adults Ages 50-64



The single best way to prevent the flu is for individuals to get an influenza vaccination (flu shot) each fall. Patients should try to get the flu shot in September or as soon as the vaccine is available. HMO members ages 50–64 who reported that they had an influenza vaccination after September 1, 2007.

Chlamydia Screening for Females Ages 16-20



Chlamydia is a common sexually transmitted disease (STD) caused by bacteria. Even though symptoms of Chlamydia are usually mild or not present, serious problems that cause irreversible damage, including infertility, can occur "silently" before a woman ever knows she has an infection. When found, Chlamydia can be easily treated and cured with antibiotics. HMO's were rated on the percentage of sexually active young women ages 16–20 who had at least one test for Chlamydia.

Quality of Providers

HOW IS THE QUALITY OF HMO PROVIDERS DETERMINED?

Data source: DOH

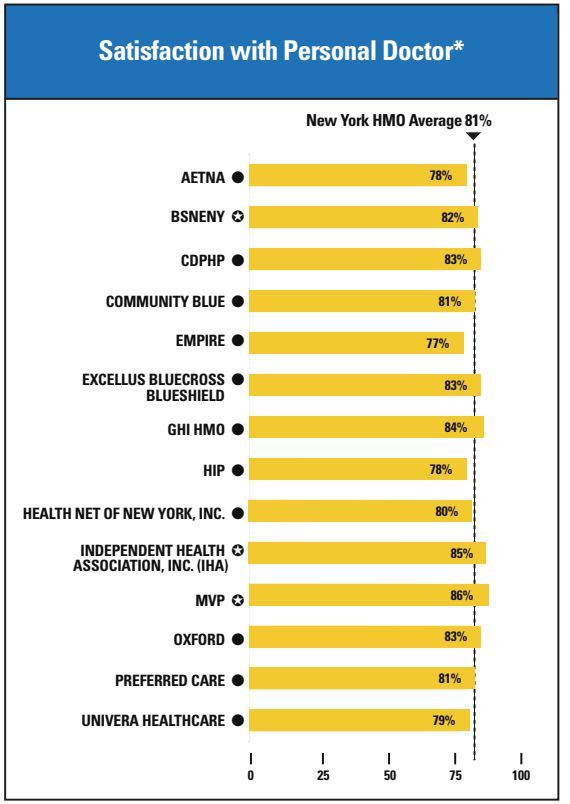
The quality, stability and availability of physicians in an HMO provider network can affect the overall quality of care delivered to HMO members.

Understanding These Charts

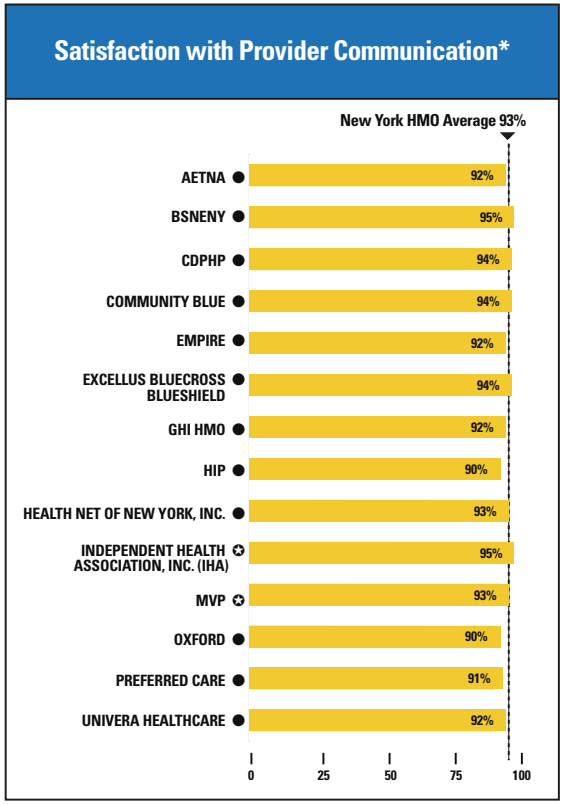
Look for the HMOs that have "✪" in the chart; they performed better than the New York HMO average.

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. 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 plans' eligible-population size differences (i.e., denominators) were used to calculate the rates.*

**Data are from 2008.*



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

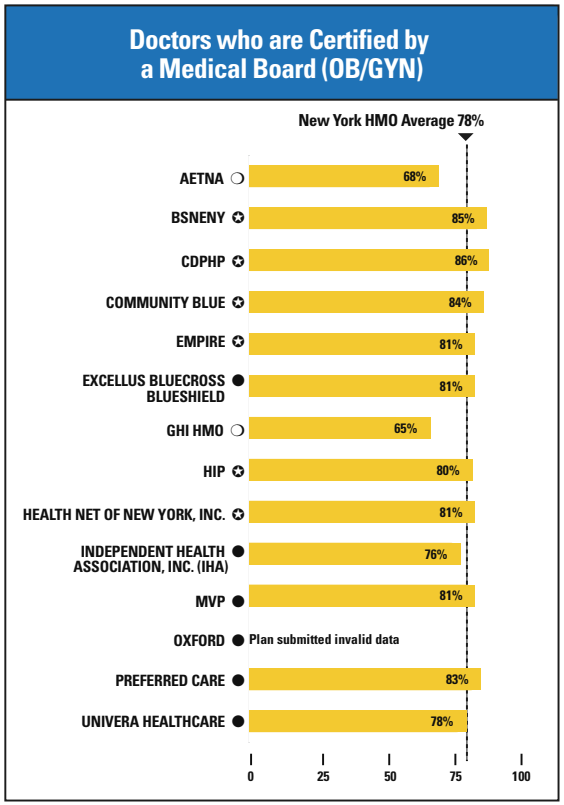


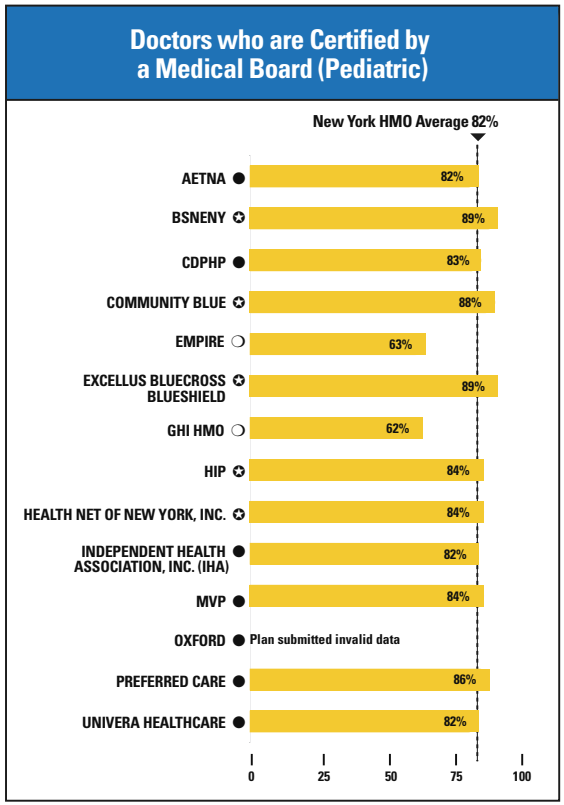
Members responded that their doctors or health care provider "usually" or "always":

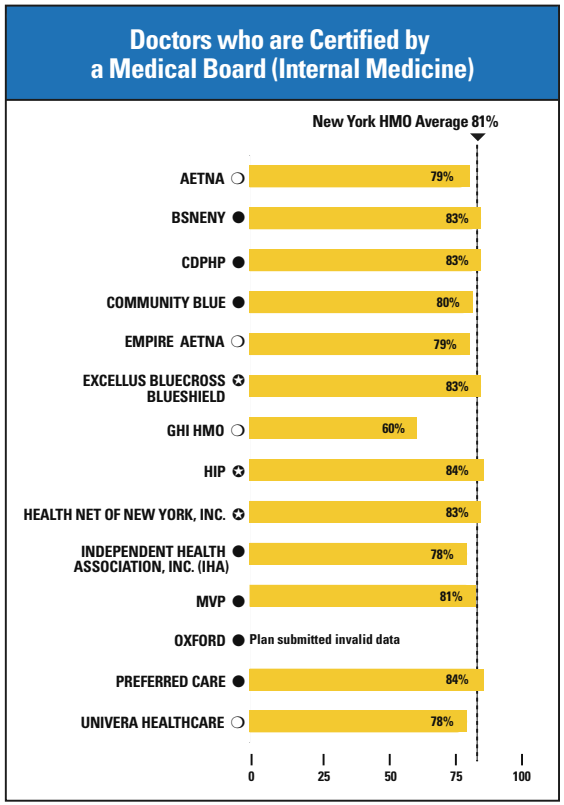
- Listen carefully to them.
- Explain things in a way they understand.
- Show respect for what they have to say.
- Spend enough time with them during visits.

Performance Compared to the New York HMO Average

- ✪ *Higher* than the NY HMO average
- ● *Not different* from the NY HMO average
- ○ *Lower* than the NY HMO average







To be a 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 doctor has knowledge that the specialty board considers necessary. The chart shows the percentage of internal medicine doctors, OB/GYNs and pediatricians who are board certified. A higher percentage means the HMO has more board-certified doctors in the practice areas listed.

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
	HealthyNY	**Child Health Plus**	**Family Health Plus**	**HMO Plan or HMO/POS Plan**
How to Get Health Insurance	Small employers, sole proprietors and working uninsured individuals who meet income limits.	Children under 19 years of age who do not have other health insurance. Eligibility criteria were expanded in 2007, 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.
Insurance Options	HealthyNY benefits are the same for each HMO, but monthly premiums will vary. This program is designed to be more affordable than other insurance options.	Depending on your family's 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
Special Considerations	Call this toll-free number: 866-HEALTHYNY (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 one year for coverage of any condition for which treatment was recommended or received within the 6 months prior to the date of enrollment. The waiting period may be reduced or eliminated if the member had coverage under another health plan within 63 days of applying for the new coverage. It is important that insurance coverage does not lapse beyond the 63-day period. Contact NYSID or the individual HMO for details about the pre-existing condition waiting period.

HMO Participation in NY Health Insurance Programs

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

HMO	HealthyNY	Child Health Plus	Family Health Plus
Aetna Health Inc.	✔		
Atlantis Health Plan, Inc.	✔		
CDPHP	✔	✔	✔
Empire HealthChoice HMO, Inc.	✔	✔	
Excellus Health Plan Inc. (HMO)	✔	✔	✔
GHI-HMO Select, Inc.	✔	✔	✔
Health Net of NY, Inc.	✔		
HealthNow NY, Inc.	✔	✔	✔
HIP HMO	✔	✔	✔
Independent Health Association, Inc. (IHA)	✔	✔	✔
MVP Health Plan, Inc.	✔	✔	✔
Oxford Health Plans of NY, Inc.	✔		
Rochester Area HMO, Inc. (Preferred Care)	✔		
United Healthcare 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 must 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 meets 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 hprc.ncqa.org.

HMO NCQA Accreditation Status as of July 2009

Note: *HMO names in this table may differ from HMO names listed in other sections of this Guide. See the table on page 8.*

HMO	NCQA Accreditation Status[2]
Aetna Health Inc.	****
Atlantis Health Plan, Inc.	—
CDPHP	****
Community Blue (HealthNow)	****
Empire HealthChoice HMO, Inc.	****
Excellus Health Plan, Inc. (HMO)	****
GHI-HMO Select, Inc.	****
Health Net of NY, Inc.	****
HIP HMO	***
Independence Health Association, Inc. (IHA)	****
MVP Health Plan, Inc.	****
Oxford Health Plans of NY, Inc.	***
Rochester Area HMO, Inc. (Preferred Care)	****

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

[2] Accreditation status does not include Medicare or Medicaid products.

Terms You Should Know

HEALTH INSURANCE TERMS IN THIS GUIDE

Alternate Service: In-network service offered by an HMO to treat a condition as an alternate to a requested out-of-network service.

Co-Insurance: Some insurance coverage requires members to pay a percentage of the cost of covered medical services, usually 20 percent to 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 be written by other types of insurers, such as life insurers and property/casualty insurers, which offer products similar to those provided by non-profit indemnity insurers. (*See Non-Profit Indemnity Insurer.*) Benefits are subject to deductibles and significant out-of-pocket costs unless members use preferred providers in the insurer's network.

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

Copayment: A flat fee required by HMOs that members must pay for specific services. 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 begins paying for services. Deductibles are common in FFS plans and in PPOs.

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

External Appeal: A review of a denial of health care services the HMO considers to be experimental, investigational, not medically necessary or an out-of-network service. 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, investigational or out-of-network service denials through the HMO. If the appeal is not decided in your favor, you are entitled to request an external appeal. (*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 as needed. Although many HMOs require members to see doctors and other providers in the HMO provider network, some (POS Plans) offer members the option to go out-of-network. 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

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

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 may receive services 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 enrolling in the plan.

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 or eliminated if a member was previously covered by another health plan within 63 days of applying for the new 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 employer 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., cardiology, dermatology, gastroenterology). HMO members usually need a referral from their PCP to see a specialist.

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

Contacts and Resources

Questions About this Guide?

Contact:
NYSID 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

Problem with Your HMO?

First, contact your HMO's Member Services Department to try to resolve the issue. If the problem is not resolved 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, not medically necessary or out-of-network services, contact:

NYSID External Appeals
PO Box 7209
Albany, NY 12224
www.ins.state.ny.us/extapp/extappqa.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?

- **HealthyNY:** 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 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 uninsured adults between 19 and 64 years of age who 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)
http://www.aging.ny.gov/healthbenefits/
800-701-0501

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

Related Sources

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

Looking for HMO Rates?
To view the rates charged by HMOs, visit www.ins.state.ny.us/ihmoindx.htm

2008 New York Managed Care Plan Performance Report
This report is published by DOH and contains the most recent information from member satisfaction surveys, standardized quality measures and providers in the plans' networks. To obtain a copy, call 518-486-9012 or download the report from: http://www.health.state.ny.us/health_care/managed_care/reports/eqarr/2008/index.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

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 http://hprc.ncqa.org/

HMO Telephone Numbers

HMOs	
Aetna Health Inc.	800-435-8742
Atlantis Health Plan	866-747-8422
CDPHP	800-777-2273
Community Blue (HealthNow)	800-544-2583
Empire HealthChoice	800-261-5962
Excellus Health Plan, Inc. (HMO)	800-462-0108
GHI HMO Select, Inc.	877-244-4466
Health Net of NY, Inc.	800-848-4747
HIP HMO	800-447-8255
Independent Health Association (IHA)	800-453-1910
MVP Health Plan, Inc.	888-687-6277
Oxford Health Plans of NY, Inc.	800-969-7480
Rochester Area HMO, Inc. (Preferred Care)	800-950-3224

EXCELSIOR