

2008 EDITION

# NEW YORK

## Consumer Guide to Health Insurers



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NEW YORK CITY

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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 a health insurer based on quality of care and service.

Refer to the **Glossary of Health Insurance Terms** on pages 49-50 for commonly used terms in this Guide. The first time the term is used it will appear in **bold**.

### Data Sources

The information 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 3.
  - NYSID data are from calendar year 2007.
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 data in Section 2 and the information on HMO performance that appears in Section 3.
- DOH collects data through the New York State Department of Health's Quality Assurance Reporting Requirements (QARR) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).<sup>1</sup>
- DOH data are from calendar year 2006, 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 commercial and non-profit companies with less than \$50 million in premiums.
- The Guide does not include data for Medicare, Medicaid or self-insured plans.<sup>2</sup>
- Health insurers are listed alphabetically in the data tables, except for the Overall Complaint Ranking table on pages 51-52.
- Americhoice of NY, Inc. and UnitedHealthcare of New York do not issue individual coverage.
- QARR data is 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](http://www.ins.state.ny.us/hgintro.htm)

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

<sup>2</sup>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](http://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](http://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 complaints data. When you look at the *HMO Quality of Care and Service* section, use this table to cross-reference the HMO product to its parent company name, for comparison. For all other health insurers, the parent company name is also the HMO product name.

Parent Company Name	HMO Product Name
NYSID Name	DOH Name
<b>Community Blue (HealthNow)</b>	Blue Shield of Northeastern New York (BSNENY) (Albany area) Community Blue (Buffalo area)
<b>Excellus Health Plan, Inc. (HMO)</b>	Blue Choice is also known as Finger Lakes or Rochester Area, depending on who is reporting the data. Univera Healthcare Upstate HMO
<b>Rochester Area HMO</b>	Preferred Care
<b>NYSID data for HIP HMO also includes:</b> 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



# Understanding Health Insurance

## SECTION ONE

# Understanding Your Health Insurance Options

New Yorkers generally have three options from which to choose a health insurance plan. Pages 6 and 45 describe each of these options in greater detail.

## **Option 1 Purchase health insurance directly from an HMO (an individual plan).**

People who choose this option buy HMO or HMO/point-of-service (POS) coverage directly from an HMO. New York State requires all HMOs to offer standardized coverage to people who buy health insurance on their own.

## **Option 2 Qualify for reduced-cost health insurance through New York State programs.**

The State of New York offers a number of health care programs available for eligible individuals.

Section 4 includes details on each of the available programs.

## **Option 3 Get health insurance coverage through an employer or association.**

Many employers and associations make health insurance available for their employees, members and their families. These plans may be provided by a licensed health insurer or HMO, or they might be self-insured plans.

## How to Get Health Insurance

	Directly purchase health insurance (individual plan)	Qualify for reduced-cost health insurance through New York State programs	Get health insurance coverage through an employer or association
Insurance Options	<p><b>HMO:</b> A health insurer that contracts directly with or employs a network of doctors, hospitals and other types of providers.</p> <p><b>HMO/POS:</b> A health insurer that combines an HMO with the flexibility of being able to see out-of-network doctors.</p>	<p><b>HealthyNY</b> is a program that offers health insurance to small employers, sole proprietors and uninsured working individuals.</p> <p><b>Child Health Plus</b> is a health insurance plan for children who are under 19 years of age.</p> <p><b>Family Health Plus</b> is a health insurance program for adults between 19 and 64 years of age who are uninsured and have incomes too high to qualify for Medicaid.</p>	<p><b>Insured Plan:</b> An employer contracts with a licensed health insurer or HMO to provide coverage for its employees.</p> <p><b>Self-Insured Plan:</b> An employer establishes a fund to cover medical expenses and typically contracts with an outside party to administer the health benefits.</p> <p><b>Professional Association:</b> An association may offer its members group rates on insurance plans that are usually less expensive than individual plans.</p>
Special Considerations	<p>For a <b>pre-existing medical condition</b>, 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 or eliminated if the individual had coverage with another plan within 63 days of applying for the new coverage. It is important that insurance coverage does not lapse beyond this 63-day period. Contact NYSID or the individual health insurer for details about the pre-existing condition waiting period.</p>	<p>Individuals must meet income-based eligibility criteria, which are different for each program. See page 45 for information about who qualifies and cost. In addition, links to online enrollment resources are provided.</p>	<p>Employers and associations can offer various types of plans with different benefits and cost-sharing options.</p> <p>New York consumer protections and insurance laws (summarized on page 8) do not apply to 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.</p>

## How to Choose a Health Insurer

**Step 1: Determine the type of health coverage that best fits your needs.** Use the Comparison of Health Insurance Coverage table on page 6 to become familiar with the various types of health insurance in New York State.

**Step 2: Determine which health insurer provides coverage in your area.** If you are considering an HMO, see the table on page 32 for service areas. For other types of insurance, contact the health insurer to find out if there are participating providers in your area.

**Step 3: Decide which health insurer offers the benefits and doctors you need.** Think about your family's health care needs and choose a health insurer that best covers the services you need most. Try to estimate your needs for **specialists**, prescription drugs, well-child care and mental health services.

In an HMO, you typically receive care from a network of providers. To determine if your doctors and hospital participate, check the HMO's provider directory or call your provider's office. If you think you will need a specialist, check whether your **primary care physician** (PCP) is restricted from referring you to certain specialists.

**Step 4: Compare cost.** Compare the monthly premium of different plans, along with your out-of-pocket expenses, such as **deductibles**, co-insurance and copayments. To see and compare HMO rates, visit [www.ins.state.ny.us/ihmoindx.htm](http://www.ins.state.ny.us/ihmoindx.htm).

**Step 5: Use this Guide to see which health insurers performed best.** This Guide has information about the quality of care and services provided by New York HMOs (see Section 3), as well as complaint and appeal data for New York health insurers (see Section 2). Compare results among the health insurers you are interested in, based on Steps 1-4.

**Step 6: Integrate the information you have learned from this Guide.** Use the personal worksheet on page 5 to gather information important to you. Eliminate the health insurers that do not meet your basic requirements or that are not in your service area, then choose the health insurer that performs best on the features most important to you.



# Worksheet to Choose a Health Insurer

*This worksheet can help you organize and evaluate information about the health insurers available to you. You can use information in this Guide and in other materials you may have obtained from your employer and the health insurer to complete the worksheet. In the first column, fill in the names of the health plans you are considering and meet the criteria for access. Then put a check mark for the other criteria that the health insurer meets.*

For All Types of Health Insurers							For HMOs Only				
<p><b>Access:</b> Which health insurers are available where you live or work?</p> <p>For HMOs see page 32; for other health insurers, review the information from your employer or the health insurer.</p>	<p><b>Benefits:</b> Which health insurers offer the benefits you need and want?</p> <p>Review benefit information from your employer or the health insurer.</p>	<p><b>Health Care Provider:</b> Which health insurers include your preferred doctor or health care provider?</p> <p>Review the health insurers' physician directories and call their Customer Service Departments.</p>	<p><b>Cost:</b> Which health insurers fall within your price range?</p> <p>Review cost information from your employer or health insurers.</p> <p>Be sure to consider the amount of copays, co-insurance or deductibles.</p>	<p><b>Complaints:</b> How does the insurer rank, compared with other insurers?</p> <p>See page 12.</p>	<p><b>Prompt Pay Complaints:</b> How does the insurer rank, compared with other insurers?</p> <p>See page 16.</p>	<p><b>Internal Appeals:</b> Which health insurers have low reversal rates?</p> <p>See page 22.</p>	<p><b>External Appeals:</b> Which health insurers have low reversal rates?</p> <p>See page 26.</p>	<p><b>Access &amp; Service:</b> Look at the measures important to you. How do the HMOs you have chosen perform?</p> <p>See page 34.</p>	<p><b>Staying Healthy &amp; Living with Illness:</b> Look at the measures important to you. How do the HMOs you have chosen perform?</p> <p>See page 36.</p>	<p><b>Quality of Providers:</b> Look at the measures important to you. How do the HMOs you have chosen perform?</p> <p>See page 38.</p>	<p><b>Grievances:</b> Which HMOs have low reversal rates?</p> <p>See page 40.</p>

## Comparison of Health Insurance Coverage

The general rules presented in this table might not apply to every health insurer. Be sure to check with the health insurer or your employer to verify how the health care coverage works.

	Health Maintenance Organizations		Non-profit Indemnity Insurers and Commercial Insurers	
	<b>HMO</b> A health insurer that directly contracts with or employs a network of doctors, hospitals and other types of providers.  All care is provided by or coordinated through your PCP.	<b>HMO/POS</b> Combines an HMO with the flexibility of an out-of-network option. You may use providers in the health insurer's network or go outside of the network.	<b>Fee-for-Service (FFS)</b> You and the health insurer each pay for part of the cost for health care services you receive. There is no specific network of providers.	<b>PPO</b> Most similar to traditional FFS coverage, except that there is a network of providers. When you use an in-network provider, your cost is lower and more services are covered.
Which doctors and hospitals can you choose?	You must choose providers within the network.	You may get care from in-network or out-of-network providers.  When you go out of the network, you will usually pay more.	You may choose any provider or hospital.	You may get care from in-network or out-of-network providers.  When you use an out-of-network provider, you usually pay more.
How do you get specialty care?	You need a <b>referral</b> from your PCP to see a specialist and you must choose a specialist in the network.	You need a referral from your PCP to see an in-network specialist.  You may go to an out-of-network specialist without a referral.	You do not need a referral to see a specialist. You may choose any specialist.	You do not usually need a referral to see a specialist, but certain services may require preauthorization from your health insurer.
How do you pay for in-network services?	You pay a copayment (typically between \$20 and \$40) for a doctor's office visit and for most services.	You pay a copayment if you see an in-network provider, and there is no deductible.	There are no in-network or out-of-network options.  Your doctor or hospital charges you for services. After you pay your deductible, you are responsible for a portion of the costs, typically 20%–30% of the allowable reimbursement, known as " <b>co-insurance</b> ".	You only pay a copayment. Network providers agree not to charge more than the health insurer's allowable charge.
How do you pay for out-of-network services?	Out-of-network services are usually not covered.	You are reimbursed for services if you use an out-of-network provider, as you would be with FFS insurance. Most out-of-network services are subject to deductible and co-insurance.	Most health insurers set an allowable reimbursement for a service. For example, if your doctor charges \$125 for a visit but your insurance only allows \$100, you may be responsible for the \$25 difference, in addition to your deductibles and co-insurance.	You are reimbursed for services if you use an out-of-network provider, as you would be with FFS insurance. Most out-of-network services are subject to deductibles and co-insurance.



## New York Consumer Protections

New York State is committed to making quality health care available to all of its residents.

Below is a summary of the laws protecting health insurance consumers in New York.

Consumers have the right to the following.

- An **external appeal** for any service denied because the health insurer considers it to be experimental, investigational or not medically necessary. If you are 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. These denials must be made by a physician or, under certain circumstances, a health care professional who would normally treat the condition. See page 9 for more details.
- A second medical opinion by an appropriate specialist for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer.
- To remain in the hospital after a mastectomy, until you and your doctor decide that you are ready to go home.
- Reconstructive surgery after a mastectomy.
- Medically necessary chiropractic visits, subject to limitations.
- Emergency ambulance services, subject to a copay only.
- Covered emergency room treatments based on the “prudent layperson” standard, which considers the presenting symptoms and the length of time symptoms have been present, not the ultimate diagnosis.
- Men are entitled to prostate cancer screening.
- 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.
- In addition to these rights, HMO members are guaranteed the following rights.
  - Access to specialists.
  - To a full, honest and confidential discussion with their physician about their medical needs.
  - To file a grievance with their HMO for any denials based on limitations or exclusions in their contract.

For more information on HMO member rights, see the Managed Care Bill of Rights on the New York Department of Health Web site: [http://www.health.state.ny.us/health\\_care/managed\\_care/billofrights/bill.htm](http://www.health.state.ny.us/health_care/managed_care/billofrights/bill.htm)

**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 2 for more information.*

## Your Right to Appeal a Health Insurer's Decision

In some cases, you have the right to appeal a health insurer's decision to deny or limit a medical service. You can appeal when a health insurer determines that the service is experimental, investigational, or not medically necessary. If you are 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. You can use the insurer's **internal appeal** process to request that the insurer reconsider its decision. If you disagree with the result, you can request an external appeal conducted by a third party not affiliated with the health insurer. 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 health insurer determines are not medically necessary, or are experimental investigational, or for HMO members, out-of-network service.

**When you can appeal:** You must request an external appeal within 45 days of receiving your health insurer's first-level internal appeal decision, or within 45 days of receipt of a letter

from your health insurer 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 health insurer's first-level appeal decision or a letter from the health insurer 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 you if the health insurer's denial is overturned in full or in part.

#### External Appeal Data

See pages 26–29 for external appeal data for health insurers.

### 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 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](http://www.ins.state.ny.us/extapp/extappqa.htm)

#### Eligibility for External Appeal

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

- The service or treatment you are seeking is not covered by your health insurer.
- Medicare is your only source of health insurance coverage.
- Your health coverage 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.



## Complaint and Appeal Information for All Types of Health Insurers

### SECTION TWO

## Overview

This guide contains information about the number of complaints and appeals filed against New York health insurers. The information is presented by the following types of health insurers, which are discussed on page 6:

1. HMOs
2. Non-profit indemnity insurers
3. Commercial insurers

The table summarizes the types of complaints and appeals reported in this Guide.

Type of data	Complaints	Prompt Pay Complaints	Internal Appeals	External Appeals	Grievances
<b>Definition</b>	Complaints to New York State about health insurers, including prompt pay complaints.	Complaints about the timely processing of a claim.	A request to a health insurer to reconsider its decision to deny coverage of a medical service that it considers experimental, investigational, or not medically necessary or for HMO members, an out-of-network service.*	An independent, third-party review of a health insurer's denial of a service considered experimental, investigational, or not medically necessary or for HMO members, an out-of-network service.*	A complaint to an HMO about denial of coverage based on limitations or exclusions in the contract.
<b>Filed by</b>	Consumers, their designee or providers.	Consumers, their designee or providers.	Consumers or their authorized representative, which may be the provider. The provider can file on its behalf for services already provided.	Consumers or their authorized representative, which may be the provider. The provider can file on its behalf for services already provided.	Consumers, or their designee.
<b>Reviewed by</b>	NYSID or DOH	NYSID	The health insurer's medical director	State-certified, independent external review organization	Internal HMO committee
<b>More information</b>	Pages 12-15	Pages 16-19	Pages 22-25	Pages 26-29	Pages 40-41

\*If you are an HMO member, you can appeal when the HMO denies a request for out-of-network service if the HMO offers an alternate service in network.

## Complaints

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

### Understanding the Charts

- **Rank:** A better rank means that the health insurer had fewer upheld complaints, relative to its size. If the ratios are the same, the health insurer with the higher premium is ranked higher.
- **Total Complaints to NYSID:** Total number of complaints closed by the Insurance Department in 2007. Complaints filed with the Insurance Department typically involve issues related to prompt payment, reimbursement, coverage, benefits, rates and premiums.
- **Upheld Complaints by NYSID:** Number of closed complaints where the Insurance Department determined that the health insurer 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 a health insurer in New York during 2007. Premiums are used to calculate the complaint ratio so that health insurers of different sizes can be compared fairly.
- **Complaint Ratio:** Number of upheld complaints by NYSID, divided by the health insurer's **total annual premium**. Total annual premium, a measure of a health insurer's size, is used to calculate the complaint ratio. Large health insurers may receive more complaints because they have more members than smaller health insurers.
- **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 2007**

Data source: NYSID and DOH

HMOs with a lower complaint ratio receive a better rank.

HMO	Data Compiled by the New York State Insurance Department (NYSID)					Data Compiled by the NYS Department of Health (DOH) <sup>1</sup>	
	Rank 1 = Best, 15 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio	Total Complaints to DOH <sup>2</sup>	Upheld Complaints by DOH
Aetna Health Inc.	10	272	89	706.3	0.1260	7	2
Americhoice of NY, Inc.	4	3	1	263.8	0.0038	0	0
Atlantis Health Plan, Inc.	15	130	82	46.3	1.7709	9	1
CDPHP	6	96	18	656.8	0.0274	14	1
CIGNA Healthcare of NY, Inc.	12	66	23	79.5	0.2893	6	4
Community Blue (HealthNow)	5	79	14	953.1	0.0147	37	3
Empire HealthChoice HMO, Inc.	8	946	163	1,906.5	0.0855	22	4
Excellus Health Plan, Inc.	7	201	53	1,825.5	0.0290	70	8
GHI HMO Select, Inc.	14	116	33	102.5	0.3218	11	1
Health Net of NY, Inc.	11	298	95	491.2	0.1934	25	8
HIP HMO	9	1,505	773	6,565.9	0.1177	44	8
Independent Health Association, Inc. (IHA)	3	27	2	600.6	0.0033	29	0
MVP Health Plan, Inc.	2	97	3	924.8	0.0032	6	2
Oxford Health Plans of NY, Inc.	13	1,828	474	1,636.3	0.2897	25	7
Rochester Area HMO, Inc. (Preferred Care)	1	17	1	354.3	0.0028	13	2
<b>TOTAL</b>		<b>5,681</b>	<b>1,824</b>	<b>17,113.5</b>	<b>Avg. = 0.2186</b>	<b>324</b>	<b>51</b>

<sup>1</sup>DOH complaint data is from 2007.

<sup>2</sup>Data represents new collection methods from all sources and cannot be compared to complaint totals reported in previous years.

**Complaints—Non-profit Indemnity Insurers 2007**

Data source: NYSID

Health insurers with a lower complaint ratio receive a better rank.

Non-profit Indemnity Insurer <sup>1</sup>	Rank 1= Best, 3= Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio
Excellus Health Plan, Inc.	2	566	215	3,309.8	0.06
Group Health, Inc. (GHI)	3	1,536	522	2,511.9	 0.21
HealthNow NY, Inc.	1	75	14	1,186.5	0.01
<b>TOTAL</b>		<b>2,177</b>	<b>751</b>	<b>7,008.2</b>	 Avg. = 0.09

<sup>1</sup>Dentcare Delivery Systems is not included because they do not write a comprehensive health insurance product.



Complaints—Commercial Insurers 2007

Data source: NYSID

Health insurers with a lower complaint ratio receive a better rank.

Commercial Insurer	Rank <sup>1</sup> 1 = Best, 29 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio
Aetna Group	27	387	148	1,151.0	0.1286
American Family Life Asr Co of NY	11	30	2	155.5	0.0129
American Int'l Group	25	34	10	144.0	0.0694
American Progressive L & H Ins Co of NY	16	23	5	274.4	0.0182
AON Corporation	19	24	5	249.7	0.0200
CIGNA Health Group	23	123	31	526.8	0.0588
CNA Insurance Group	6	11	0	53.5	0.0000
First Rehabilitation Life Ins Co of Am	10	4	1	79.1	0.0126
Fortis Group	22	11	2	56.6	0.0354
GE Global Group	1	2	0	135.7	0.0000
Geneve Holdings Inc.	7	1	0	52.7	0.0000
Guardian Life Group	26	175	48	518.3	0.0926
Hartford F & C Group	15	16	4	221.0	0.0181
HealthNet Ins of NY Inc.	28	230	91	335.4	0.2714
John Hancock Life Ins. Co.	8	14	2	168.9	0.0118
Liberty National	18	9	1	53.7	0.0186
Mass Mutual Life Ins Co.	5	1	0	56.4	0.0000
Metropolitan Group	17	67	10	537.7	0.0186
Mutual of Omaha Group	14	16	1	56.9	0.0176
New York Life Ins Co.	20	7	2	62.6	0.0319
Northwestern Mutual	3	1	0	73.2	0.0000
Oxford Health Ins Inc.	24	540	115	1,869.2	0.0615
Protective Life Ins Group	12	19	1	64.4	0.0155
Prudential Ins Co of America	9	6	1	84.1	0.0119
Standard Life Ins Co of NY	6	3	0	53.5	0.0000
Sun Life Assurance Company of CN	2	8	0	96.5	0.0000
UnitedHealth Group	29	1,087	411	1,097.2	0.3746
UNUMProvident Corp Group	13	44	7	424.3	0.0165
WellPoint Inc.	21	879	190	5,574.7	0.0341
Zurich Ins Group	4	3	0	72.7	0.0000
<b>TOTAL</b>		<b>3,775</b>	<b>1,088</b>	<b>14,299.7</b>	<b>Avg. = 0.4502</b>

<sup>1</sup>If the ratios are the same among insurers, the insurer with the higher annual premium amount receives a better rank.

## Prompt Pay Complaints

Consumers and providers can file complaints with the Insurance Department when they believe a health insurer is not processing claims in a timely manner. These complaints are called **prompt pay complaints**.

New York requires all health insurers to:

- Pay undisputed claims within 45 days of receipt, *or*
- Request all additional information from the consumer or the provider, if necessary, within 30 days of receipt of the claim, *or*
- Deny the claim within 30 days of receipt.

Providers may be less willing to participate with health insurers that do not process claims on a timely basis. A severe claims payment problem may indicate that the health insurer has financial problems.

NYSID has established a dedicated hotline for consumers and providers to file prompt pay complaints at **800-358-9260**.

### Understanding the Charts

- **Rank:** A better rank means that the health insurer had fewer upheld prompt pay complaints, relative to its size. If the ratios are the same, the health insurer with the higher premium is ranked higher.
- **Total Complaints:** Total number of complaints closed by the Insurance Department in 2007. Complaints to the Insurance Department typically involve issues about prompt payment, reimbursement, coverage, benefits, rates and premiums.
- **Total Prompt Pay Complaints:** Total number of prompt pay complaints closed by the Insurance Department in 2007.

- **Upheld Prompt Pay Complaints:** Number of closed prompt pay complaints where the Insurance Department determined the health insurer was not processing claims in a timely manner.
- **Premium\*:** Dollar amount of premiums generated by a health insurer in New York in 2007. Premiums are used to calculate the prompt pay complaint ratio so that health insurers of different sizes can be compared.
- **Prompt Pay Complaint Ratio:** Number of upheld prompt pay complaints divided by a health insurer's total annual premium. Large health insurers might receive more complaints because they have more members and pay more claims than smaller health insurers.

*\*Premium data exclude Medicare and Medicaid.*

**Prompt Pay Complaints—HMOs 2007**

Data source: NYSID

HMOs with a lower prompt pay complaint ratio receive a better rank.

HMO	Prompt Pay Ranking 1 = Best, 15 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aetna Health Inc.	9	272	132	56	706.3	0.0793
Americhoice of NY, Inc.	4	3	2	1	263.8	0.0038
Atlantis Health Plan, Inc.	15	130	76	61	46.3	 1.3173
CDPHP	6	96	17	9	656.8	0.0137
CIGNA Healthcare of NY, Inc.	11	66	25	9	79.5	0.1132
Community Blue (HealthNow)	5	79	18	5	953.1	0.0052
Empire HealthChoice HMO, Inc.	8	946	450	110	1,906.5	0.0577
Excellus Health Plan, Inc.	7	201	72	28	1,825.5	0.0153
GHI HMO Select, Inc.	14	116	56	21	102.5	0.2048
Health Net of NY, Inc.	12	298	189	76	491.2	0.1547
HIP HMO	10	1,505	1,045	628	6,565.9	0.0956
Independent Health Association, Inc. (IHA)	2	27	3	0	600.6	0.0000
MVP Health Plan, Inc.	1	97	28	0	924.8	0.0000
Oxford Health Plans of NY, Inc.	13	1,828	918	330	1,636.3	0.2017
Rochester Area HMO, Inc. (Preferred Care)	3	17	3	0	354.3	0.0000
<b>TOTAL</b>		<b>5,681</b>	<b>3,034</b>	<b>1,334</b>	<b>17,113.5</b>	<b>Avg. = 0.1508</b>

 Denotes length of bar graph shortened due to spatial constraints.

**Prompt Pay Complaints—Non-Profit Indemnity Insurers 2007**

Data source: NYSID

*Health insurers with a lower prompt pay ratio receive a better rank.*

Non-profit Indemnity Insurer <sup>1</sup>	Rank 1 = Best, 3 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Excellus Health Plan, Inc.	2	566	244	147	3,309.8	0.04
Group Health, Inc. (GHI)	3	1,536	735	301	2,511.9	0.12
HealthNow NY, Inc.	1	75	18	8	1,186.5	0.01
<b>TOTAL</b>		<b>2,177</b>	<b>997</b>	<b>456</b>	<b>7,008.2</b>	<b>Avg. = 0.06</b>

<sup>1</sup>Dentcare Delivery Systems is not included because they do not write a comprehensive health insurance product.



Prompt Pay Complaints—Commercial Insurers 2007

Data source: NYSID

Health insurers with a lower prompt pay ratio receive a better rank.

Commercial Insurer	Rank <sup>1</sup> 1 = Best, 30 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aetna Group	28	387	166	86	1,151.0	0.0747
American Family Life Asr Co of NY	4	30	3	0	155.5	0.0000
American Int'l Group	27	34	15	8	144.0	0.0555
American Progressive L & H Ins Co of NY	20	23	11	1	274.4	0.0036
AON Corporation	22	24	9	4	249.7	0.0160
CIGNA Health Group	25	123	55	17	526.8	0.0323
CNA Insurance Group	17	11	0	0	53.5	0.0000
First Rehabilitation Life Ins Co of Am	21	4	1	1	79.1	0.0126
Fortis Group	13	11	0	0	56.6	0.0000
GE Global Group	5	2	0	0	135.7	0.0000
Geneve Holdings Inc.	18	1	0	0	52.7	0.0000
Guardian Life Group	26	175	70	24	518.3	0.0463
Hartford F & C Group	2	16	0	0	221.0	0.0000
HealthNet Ins of NY Inc.	29	230	116	61	335.4	0.1819
John Hancock Life Ins. Co.	3	14	0	0	168.9	0.0000
Liberty National	15	9	3	0	53.7	0.0000
Mass Mutual Life Ins Co.	14	1	0	0	56.4	0.0000
Metropolitan Group	19	67	6	1	537.7	0.0019
Mutual of Omaha Group	12	16	4	0	56.9	0.0000
New York Life Ins Co.	11	7	0	0	62.6	0.0000
Northwestern Mutual	8	1	0	0	73.2	0.0000
Oxford Health Ins Inc.	24	540	209	47	1,869.2	0.0251
Protective Life Ins Group	10	19	4	0	64.4	0.0000
Prudential Ins Co of America	7	6	0	0	84.1	0.0000
Standard Life Ins Co of NY	16	3	0	0	53.5	0.0000
Sun Life Assurance Company of CN	6	8	1	0	96.5	0.0000
UnitedHealth Group	30	1,087	566	242	1,097.2	0.2206
UNUMProvident Corp Group	1	44	0	0	424.3	0.0000
Wellpoint Inc.	23	879	424	118	5,574.7	0.0212
Zurich Ins Group	9	3	0	0	72.7	0.0000
<b>TOTAL</b>		<b>3,775</b>	<b>1,663</b>	<b>610</b>	<b>14,299.7</b>	<b>Avg. = 0.0231</b>

<sup>1</sup>If ratios are the same among health insurers, the health insurer with the higher annual premium amount receives a better rank.

“Motivation is what gets you started...”





...habit is what keeps you going.”

Jim Ryon

## Internal Appeals

An internal appeal or **utilization review (UR)** occurs when a consumer asks a health insurer to reconsider its refusal to pay for a medical service that the health insurer considers experimental, investigational or not medically necessary. If you are 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. Health insurers are required to have appeals reviewed by medical professionals. Common internal appeals involve the medical necessity of hospital admissions, length of hospital stays and use of certain medical procedures.

### Understanding the Charts

- **Filed Appeals:** Number of internal appeals submitted to the health insurer by consumers and providers in 2007.
- **Closed Appeals:** Number of internal appeals that the health insurer was able to reach a decision on by the end of 2007.
- **Reversed Appeals:** Number of closed internal appeals that the health insurer decided in favor of the consumer. If an internal appeal decision is reversed on appeal, the health insurer agrees to pay for the service or procedure.
- **Reversal Rate:** Percentage of reversed appeals divided by closed appeals.

#### Keep in Mind:

Pay specific attention to a health insurer 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 health insurer makes its initial decisions correctly, so fewer decisions require reversal, but an unusually low reversal rate may indicate that the health insurer does not give appropriate reconsideration to initial decisions.
- A high reversal rate may indicate that a health insurer’s internal appeal process is responsive to consumers. However, an unusually high reversal rate may indicate that the health insurer’s process for making initial medical necessity decisions is flawed.
- The number of internal appeals filed may be higher for health insurers that actively promote the appeal process and encourage members to appeal denied services.

**Internal Appeals—HMOs 2007**

Data source: NYSID

HMO	Filed Appeals	Closed Appeals <sup>1</sup>	Reversed Appeals	Reversal Rate
Aetna Health Inc. <sup>2</sup>	697	701	216	30.8%
Americhoice of NY, Inc.	0	0	0	0.0%
Atlantis Health Plan, Inc.	298	282	105	37.2%
CDPHP <sup>3</sup>	464	464	150	32.3%
CIGNA Healthcare of NY, Inc.	148	163	80	49.1%
Community Blue (HealthNow)	480	485	179	36.9%
Empire HealthChoice HMO, Inc.	258	254	87	34.3%
Excellus Health Plan, Inc. <sup>3</sup>	1,416	1,449	539	37.2%
GHI HMO Select, Inc.	279	271	150	55.4%
Health Net of NY, Inc.	1,617	1,664	552	33.2%
HIP HMO	49	91	63	69.2%
Independent Health Association, Inc. (IHA) <sup>3</sup>	205	210	135	64.3%
MVP Health Plan, Inc.	199	200	42	21.0%
Oxford Health Plans of NY, Inc.	4,892	4,950	1,961	39.6%
Rochester Area HMO, Inc. (Preferred Care)	177	179	81	45.3%
<b>TOTAL</b>	<b>11,179</b>	<b>11,363</b>	<b>4,340</b>	<b>38.2%</b>

<sup>1</sup> Closed internal appeals can exceed filed internal appeals in 2007 because closed internal appeals also include internal appeals filed prior to 2007.

<sup>2</sup> Includes internal appeals for Aetna Health Ins. Co. of NY.

<sup>3</sup> Includes internal appeals for Art. 43 company managed care contracts.

**Internal Appeals—Non-Profit Indemnity Insurers 2007**

Data source: NYSID

Non-profit Indemnity Insurer	Filed Appeals	Closed Appeals	Reversed Appeals	Reversal Rate
Excellus Health Plan, Inc.	1,827	1,807	635	35.1%
Group Health, Inc. (GHI)	5,961	6,000	3,584	59.7%
HealthNow NY, Inc.	549	558	205	36.7%
<b>TOTAL</b>	<b>8,337</b>	<b>8,365</b>	<b>4,424</b>	<b>52.9%</b>

<sup>1</sup> Dentcare Delivery Systems is not included because they do not write a comprehensive health insurance product.

<sup>2</sup> Closed internal appeals can exceed filed internal appeals in 2007 because closed internal appeals also include internal appeals filed prior to 2007.



Internal Appeals—Commercial Insurers 2007

Data source: NYSID

Commercial Insurer <sup>1</sup>	Filed Appeals	Closed Appeals <sup>2</sup>	Reversed Appeals	Reversal Rate
Aetna Group <sup>3</sup>	1,304	1,248	294	23.6%
American Int'l Group	0	0	0	0.0%
American Progressive L & H Ins Co of NY	0	0	0	0.0%
American Family Life Asr Co of NY	0	0	0	0.0%
AON Corporation	0	0	0	0.0%
CIGNA Health Group	668	688	295	42.9%
CNA Insurance Group	0	0	0	0.0%
First Rehabilitation Life Ins Co of Am	0	0	0	0.0%
Fortis Group	0	0	0	0.0%
GE Global Group	0	0	0	0.0%
Geneve Holdings Inc.	0	0	0	0.0%
Guardian Life Group	1,698	1,718	1,262	73.5%
Hartford F & C Group	0	0	0	0.0%
HealthNet Ins of NY Inc.	848	850	278	32.7%
John Hancock Life Ins. Co.	0	0	0	0.0%
Liberty National	0	0	0	0.0%
Mass Mutual Life Ins Co.	0	0	0	0.0%
Metropolitan Group	6,351	6,351	5,420	85.3%
Mutual of Omaha Group	6	6	2	33.3%
New York Life Ins Co.	0	0	0	0.0%
Northwestern Mutual	0	0	0	0.0%
Oxford Health Ins Inc.	1,329	1,355	488	36.0%
Protective Life Ins Group	0	0	0	0.0%
Prudential Ins Co of America	0	0	0	0.0%
Standard Life Ins Co of NY	2	2	1	50.0%
Sun Life Assurance Company of CN	0	0	0	0.0%
UnitedHealth Group	1,080	1,083	303	28.0%
UNUMProvident Corp Group	0	0	0	0.0%
Wellpoint Inc.	553	502	182	36.3%
Zurich Ins Group	0	0	0	0.0%
<b>TOTAL</b>	<b>13,839</b>	<b>13,803</b>	<b>8,525</b>	<b>61.8%</b>

<sup>1</sup> Many of the commercial companies do not write traditional comprehensive health insurance products and therefore they have no internal appeals.

<sup>2</sup> Closed internal appeals can exceed filed internal appeals in 2007 because closed internal appeals also include internal appeals filed prior to 2007.

<sup>3</sup> Aetna Health Insurance Co. of NY internal appeals are included with HMO numbers.

## External Appeals

Consumers can request an external appeal when a health insurer denies health care services on the basis that services are experimental, investigational or not medically necessary. If you are 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. Before requesting an external appeal, you must complete the health insurer's first-level internal appeal process, or you and your health insurer 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 assigned to an external appeal organization in 2007.
- **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 health insurer's decision not to cover a service or procedure.
- **Reversal Rate:** Percentage of cases in which the external appeal organization decided to change the health insurer's denial of 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 a health insurer does not make appropriate coverage decisions.*

**External Appeals—HMOs 2007**

Data source: NYSID

HMO	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate <sup>1</sup>
Aetna Health Inc.	36	14	1	21	41.7%
Americhoice of NY, Inc.	0	0	0	0	0.0%
Atlantis Health Plan, Inc.	15	7	1	7	53.3%
CDPHP	15	7	0	8	46.7%
CIGNA Healthcare of NY, Inc.	4	2	0	2	50.0%
Community Blue (HealthNow)	31	13	2	16	48.4%
Empire HealthChoice HMO, Inc.	132	68	8	56	57.6%
Excellus Health Plan, Inc.	178	66	8	104	41.6%
GHI HMO Select, Inc.	5	1	1	3	40.0%
Health Net of NY, Inc.	55	17	2	36	34.5%
HIP HMO	29	10	4	15	48.3%
Independent Health Association, Inc. (IHA)	14	4	0	10	28.6%
MVP Health Plan, Inc.	19	7	0	12	36.8%
Oxford Health Plans of NY, Inc.	128	51	9	68	46.9%
Rochester Area HMO, Inc. (Preferred Care)	10	6	0	4	60.0%
<b>TOTAL</b>	<b>671</b>	<b>273</b>	<b>36</b>	<b>362</b>	<b>46.1%</b>

<sup>1</sup>Rate includes "reversed-in-part" decisions.

**External Appeals—Non-Profit Indemnity Insurers 2007**

Data source: NYSID

Non-profit Indemnity Insurer <sup>1</sup>	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate <sup>2</sup>
<b>Excellus Health Plan, Inc.</b>	162	68	5	89	 45.1%
<b>Group Health, Inc. (GHI)</b>	135	43	14	78	 42.2%
<b>HealthNow NY, Inc.</b>	60	20	2	38	 36.7%
<b>TOTAL</b>	<b>357</b>	<b>131</b>	<b>21</b>	<b>205</b>	 42.6%

<sup>1</sup> Dentcare Delivery Systems is not included because they do not write a comprehensive health insurance product.

<sup>2</sup> Rate includes “reversed-in-part” decisions.

External Appeals—Commercial Insurers 2007

Data source: NYSID

Commercial Insurer <sup>1</sup>	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate <sup>2</sup>
Aetna Group	71	29	3	39	45.1%
American Int'l Group	0	0	0	0	0.0%
American Progressive L & H Ins Co of NY	0	0	0	0	0.0%
American Family Life Asr Co of NY	0	0	0	0	0.0%
AON Corporation	0	0	0	0	0.0%
CIGNA Health Group	20	9	2	9	55.0%
CNA Insurance Group	0	0	0	0	0.0%
First Rehabilitation Life Ins Co of Am	0	0	0	0	0.0%
Fortis Group	0	0	0	0	0.0%
GE Global Group	0	0	0	0	0.0%
Geneve Holdings Inc.	0	0	0	0	0.0%
Guardian Life Group	18	7	0	11	38.9%
Hartford F & C Group	0	0	0	0	0.0%
HealthNet Ins of NY Inc.	50	20	3	27	46.0%
John Hancock Life Ins. Co.	0	0	0	0	0.0%
Liberty National	0	0	0	0	0.0%
Mass Mutual Life Ins Co.	0	0	0	0	0.0%
Metropolitan Group	25	16	0	9	64.0%
Mutual of Omaha Group	1	0	1	0	100.0%
New York Life Ins Co.	0	0	0	0	0.0%
Northwestern Mutual	0	0	0	0	0.0%
Oxford Health Ins Inc.	151	49	11	91	39.7%
Protective Life Ins Group	0	0	0	0	0.0%
Prudential Ins Co of America	0	0	0	0	0.0%
Standard Life Ins Co of NY	0	0	0	0	0.0%
Sun Life Assurance Company of CN	0	0	0	0	0.0%
UnitedHealth Group	127	55	7	65	48.8%
UNUMProvident Corp Group	0	0	0	0	0.0%
Wellpoint Inc.	218	97	14	107	50.9%
Zurich Ins Group	0	0	0	0	0.0%
<b>TOTAL</b>	<b>681</b>	<b>282</b>	<b>41</b>	<b>358</b>	<b>47.4%</b>

<sup>1</sup>Many of these commercial companies do not write traditional comprehensive health insurance products and thus have no external review appeals.

<sup>2</sup>Rate includes "reversed-in-part" decisions.



## Quality of Care and Service for HMOs

### SECTION THREE

## Overview

This section contains information that applies only to HMOs and not to all types of health insurers. On the following pages, you will find information about these topics.

1. **HMO Service Areas** (page 32)—Find HMOs that offer services near where you live or work.
2. **HMO Performance**—How well the HMO you selected performed in specific areas.
  - **Access and Service** (pages 34–35): How members rated their HMO; their ability to get needed care and to get care quickly; and what percentage of HMO members saw a provider within the past 3 years.
  - **Staying Healthy and Living With Illness** (pages 36–37): Shows how well HMOs deliver preventive services and keeps members healthy.

- **Quality of Providers** (pages 38–39): How HMO members rated their personal doctor or nurse and the percentage of physicians certified by a medical board (**board certified**).

3. **Grievances** (pages 40–41): How often HMO members or providers complained directly to the HMO about denials based on contract limitations or exclusions.

4. **NCQA Accreditation** (page 42): Lists the accreditation status of New York's HMOs, as determined by NCQA, an independent, non-profit organization that evaluates HMOs. For more information on NCQA, visit [www.ncqa.org](http://www.ncqa.org).

5. **How HMOs Pay Primary Care Physicians** (page 43): Explains the different ways HMOs compensate PCPs for providing care to members.



**HMO Service Areas<sup>1</sup>**

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, Schenectady, 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.
<b>Aetna Health Inc.</b>			•	•	•		•	•	•
<b>Atlantis Health Plan, Inc.</b>					•				
<b>CDPHP</b>	•		•				•	•	
<b>CIGNA Healthcare of NY, Inc.</b>			•	•	•				•
<b>Community Blue (HealthNow)</b>	•	•	•			•	•	•	
<b>Empire HealthChoice HMO, Inc.</b>	•		•	•	•				•
<b>Excellus Health Plan, Inc.</b>	•	•	•			•	•	•	
<b>GHI-HMO Select, Inc.</b>	•		•	•	•		•	•	•
<b>Health Net of NY, Inc.</b>			•	•	•				•
<b>HIP HMO</b>			•	•	•				•
<b>Independent Health Association (IHA)</b>		•							
<b>MVP Health Plan, Inc.</b>	•		•				•	•	•
<b>Oxford Health Plans of NY, Inc.</b>			•	•	•				•
<b>Rochester Area HMO, Inc. (Preferred Care)</b>		•				•			

<sup>1</sup>Service areas are current as of June 1, 2008.



## Access and Service

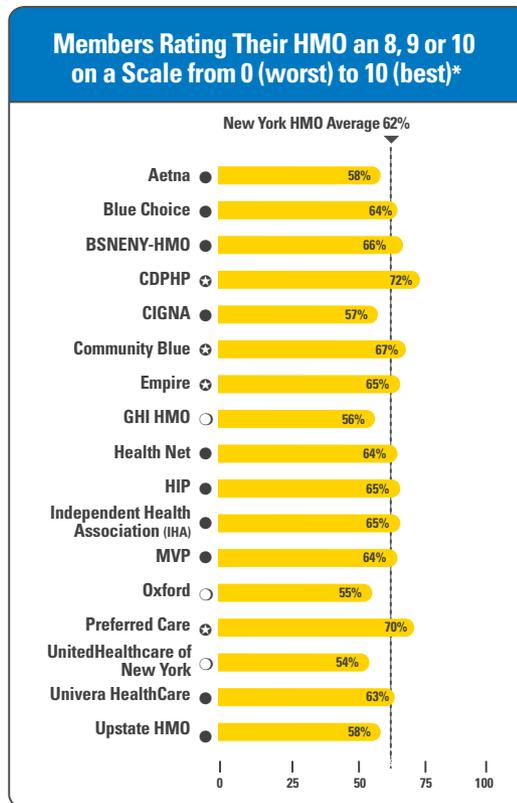
Data source: DOH

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 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.



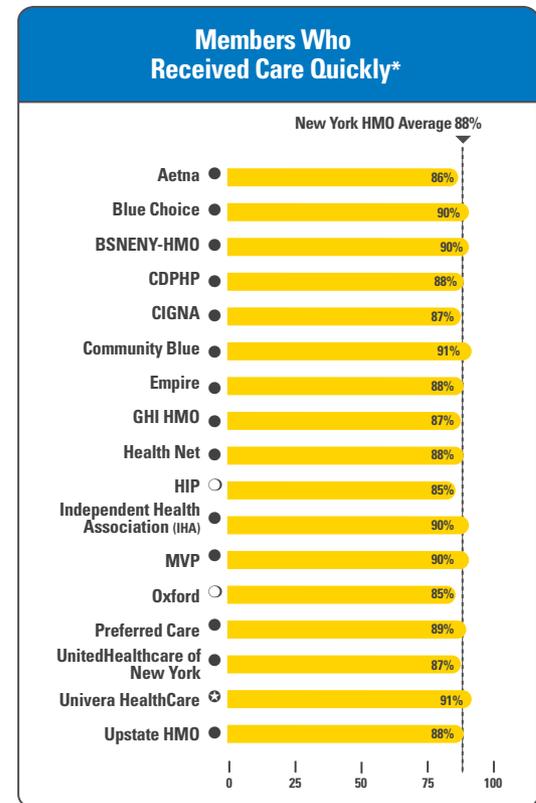
Members rated their HMO on a scale from 0 (worst possible) to 10 (best possible). The circles in the chart are based on the number of members who gave their HMO an 8, 9 or 10 rating.

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.

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

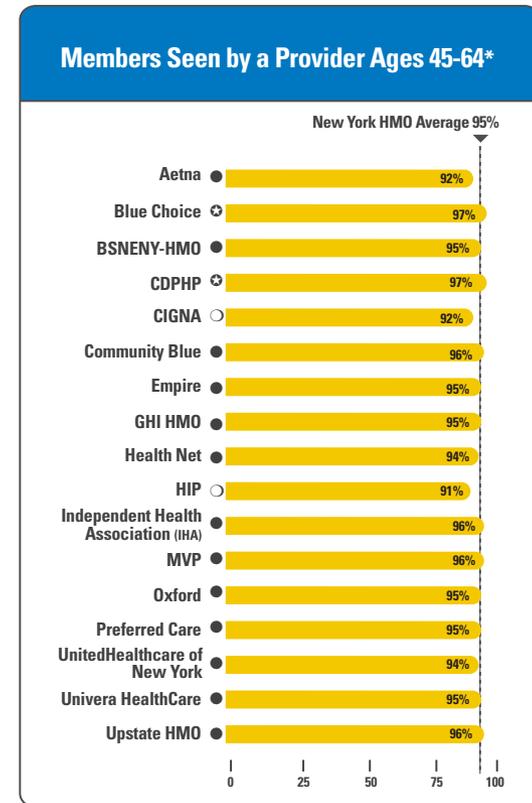
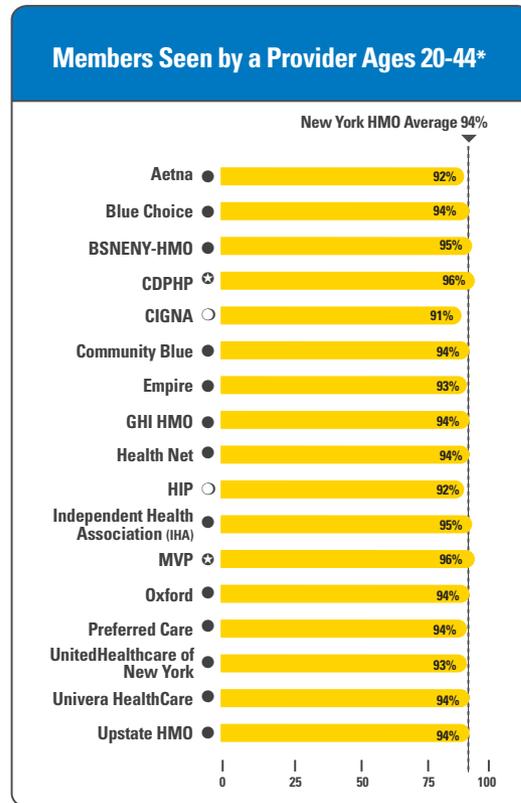
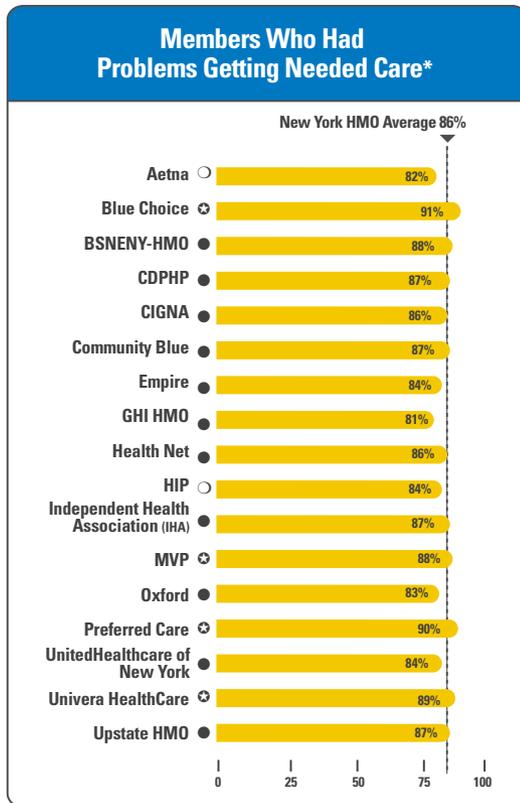
- ★ Higher than the NY HMO average
- Not different than the NY HMO average
- Lower than the NY HMO average



- 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, be performing 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 2007.



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

Data source: DOH

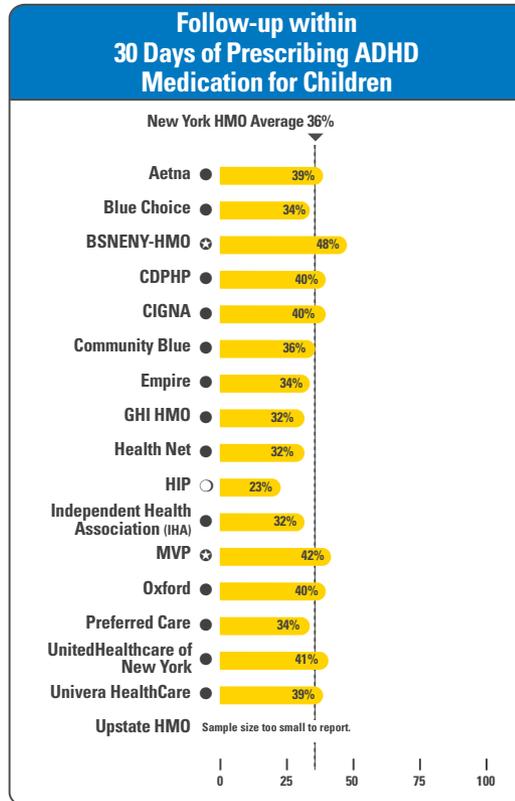
New York HMOs were rated on how well they help people maintain good health and recover from illness.

### Understanding These Charts

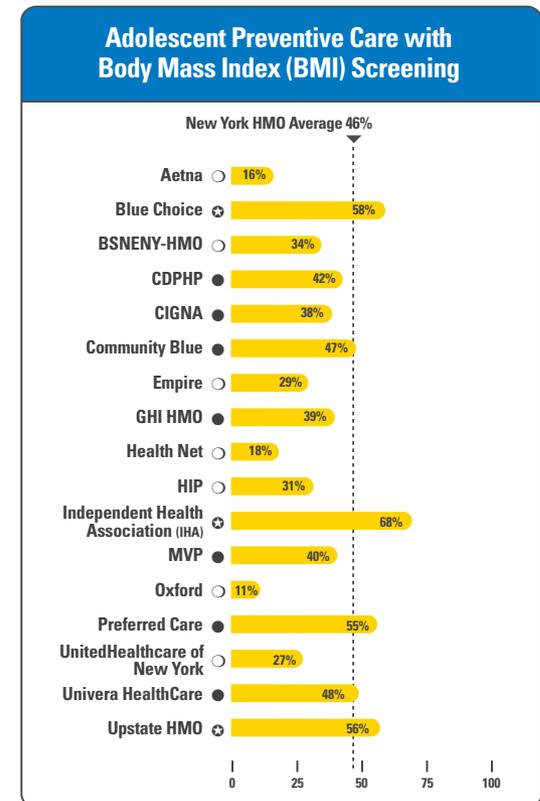
The circles in the charts show how each HMO compares to the average for all New York HMOs. Look for HMOs with a “★” in the chart; these HMOs performed better than the New York HMO average. In other words, they had a greater percentage of members who received these services.

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

- ★ Higher than the NY HMO average
- Not different than the NY HMO average
- Lower than the NY HMO average

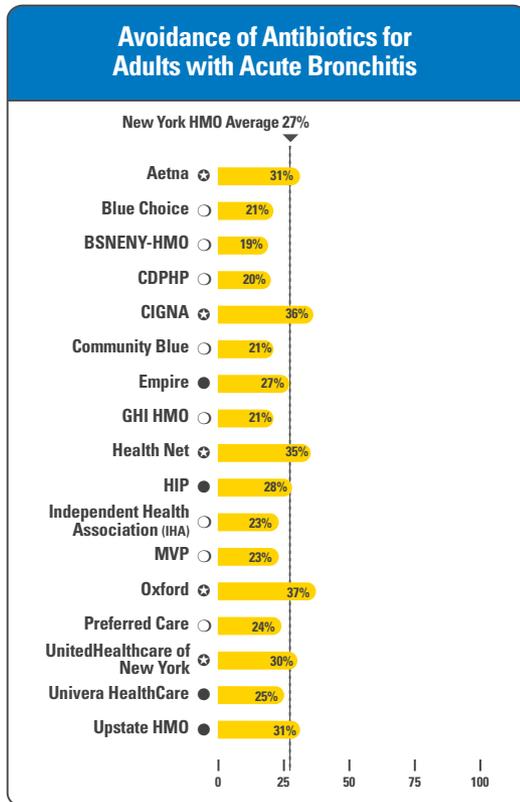


Medications used to treat Attention Deficit/Hyperactivity Disorder (ADHD) have known side effects and, like all medications, need to be closely monitored. Close supervision fosters early detection and response to any problematic side effects from medication. HMOs were rated on the percentage of children ages 6 to 12 with a new prescription for ADHD medication who had one follow-up visit during the 30 days after beginning the medication.

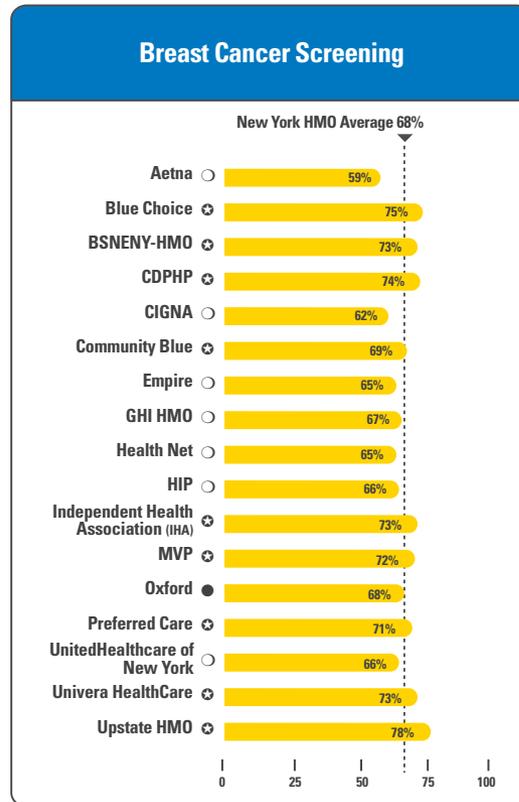


The Centers for Disease Control and Prevention (CDC) states that overweight children and adolescents are more likely to become obese as adults. Assessing Body Mass Index (BMI) allows health-care professionals to identify adolescents at high risk and implement preventive care. HMOs were rated on the percentage of adolescents aged 14-18 who had a least one well-care visit with a PCP or OB/GYN during 2006 and had documentation of a BMI or BMI percentile.

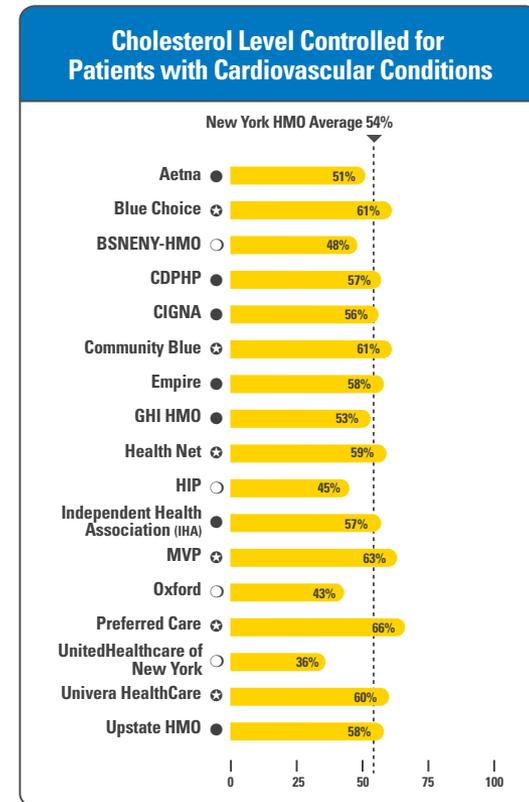
Notes: Symbols show statistically significant differences between each HMO's score and the New York average. "Statistically significant" means scores varied by more than could be accounted for by chance. Plans showing the same percentage can have different circles, and thus, be performing at different 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.



Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. Antibiotics are not recommended for the treatment of adults with acute bronchitis who do not have another condition or other infection for which antibiotics may be appropriate. HMOs were rated on the percentage of healthy adults, ages 18 to 64, with acute bronchitis who did not receive a prescription for antibiotics.



The earliest sign of breast cancer is often an abnormality detected on a mammogram before it can be felt by the woman or a health care professional. HMOs were rated on the percentage of women between the ages of 42 and 69 who had a mammogram in the past two years.



Individuals with cardiovascular disease can reduce their risk of the disease worsening and premature death by managing cholesterol levels. HMOs were rated on the percentage of members, who had a heart attack, or heart surgery, or heart related procedures, or have had a diagnosis of ischemic vascular disease within the last year and received a cholesterol screening test whose cholesterol level LDL-C result was < 100mg/dL (recommended level of control).

## Quality of Providers

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.

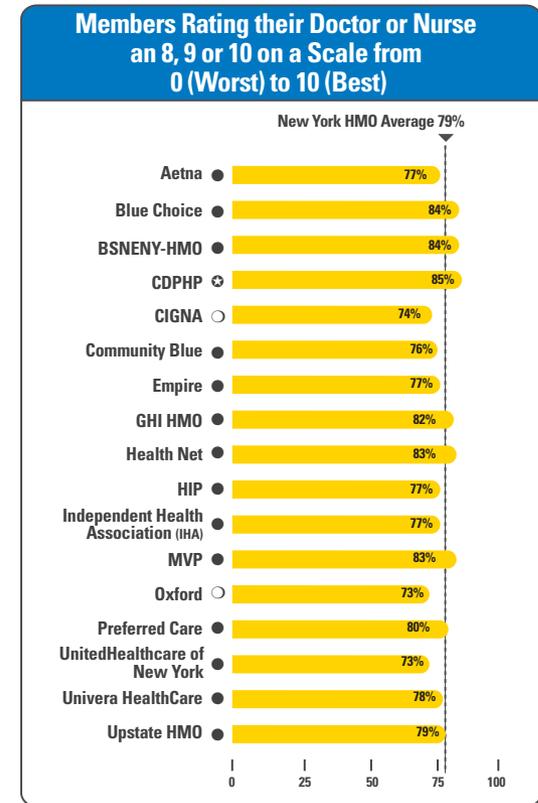
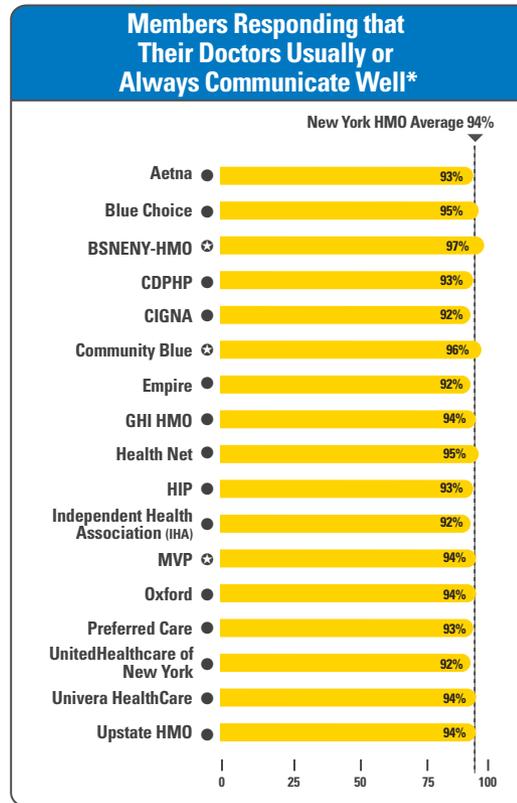
Note: Physician Turnover, which was reported in prior years, will no longer be reported as it was retired from the QARR and HEDIS measurement sets.

### Understanding These Charts

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

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

- ⊕ **Higher** than the NY HMO average
- **Not different** than the NY HMO average
- **Lower** than the NY HMO average



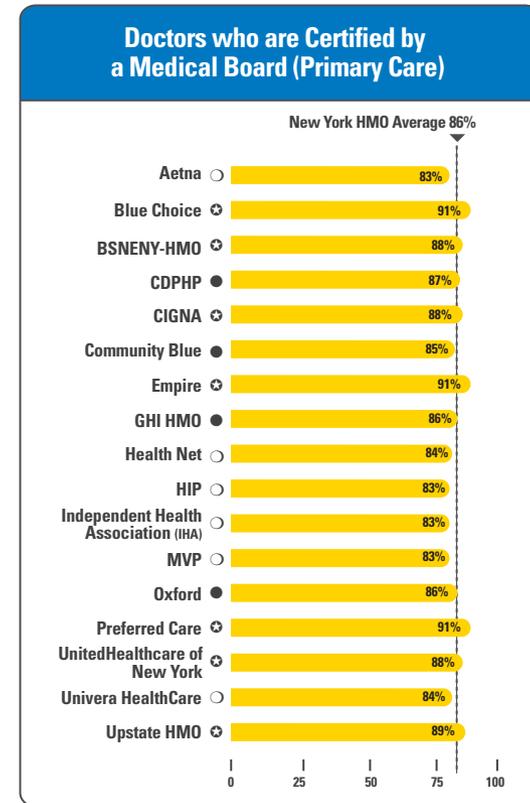
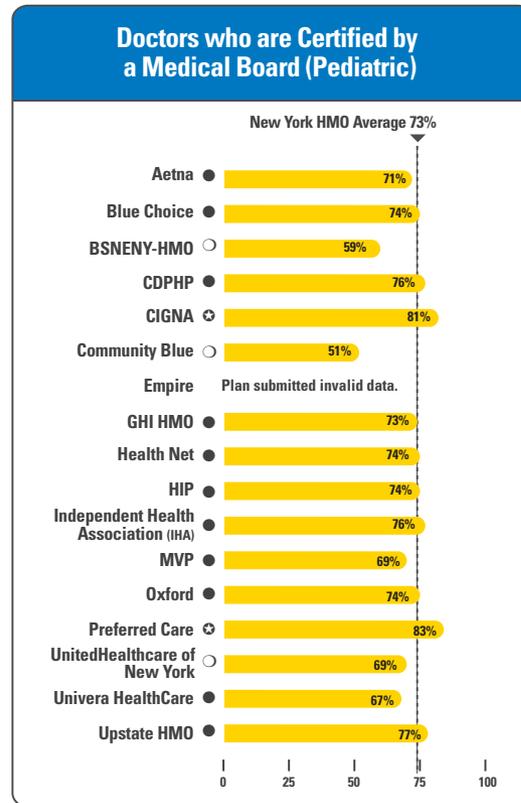
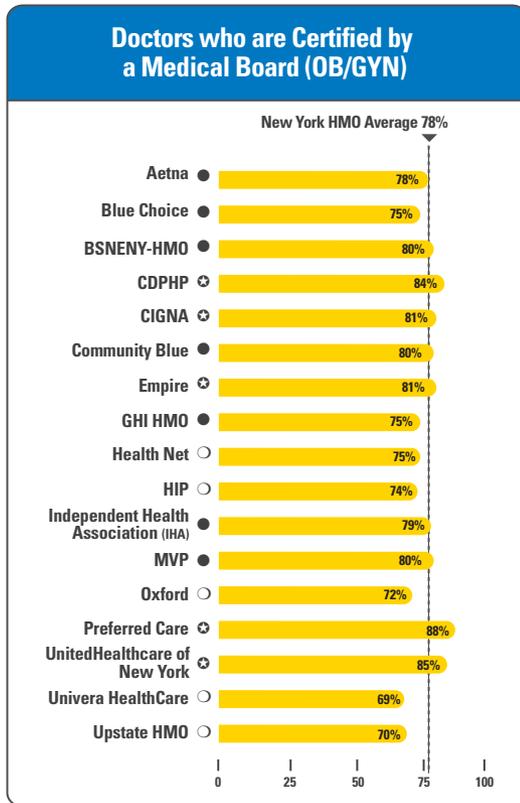
Members responded that their doctors or health-care providers “usually” or “always”:

- 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.

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, be performing 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 2007.



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.

## Grievances

A **grievance** is when a member complains to a health insurer about denials based on limitations or exclusions in the contract. Medical necessity issues are internal appeals, not grievances. (See page 22 for information on internal appeals.) 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 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 that the HMO decided in favor of the consumer or provider.

#### Keep in Mind:

Pay specific attention to a 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 2007**

Data source: NYSID

HMO	Filed Grievances	Closed Grievances <sup>1</sup>	Upheld Grievances	Reversed Grievances	Reversal Rate
Aetna Health Inc.	848	876	281	595	32.1%
Americhoice of NY, Inc.	0	0	0	0	0.0%
Atlantis Health Plan, Inc.	417	405	193	212	47.7%
CDPHP <sup>2</sup>	1,966	1,977	1,271	706	64.3%
CIGNA Healthcare of NY, Inc.	176	199	103	96	51.8%
Community Blue (HealthNow)	668	678	351	327	51.8%
Empire HealthChoice HMO, Inc.	574	553	81	472	14.6%
Excellus Health Plan, Inc. <sup>2</sup>	2,042	2,081	592	1,489	28.4%
GHI HMO Select, Inc.	199	200	104	96	52.0%
Health Net of NY, Inc. <sup>3</sup>	2,974	3,123	1,772	1,351	56.7%
HIP HMO	1,701	1,693	1,050	643	62.0%
Independent Health Association, Inc. (IHA) <sup>2</sup>	687	685	292	393	42.6%
MVP Health Plan, Inc.	209	238	84	154	35.3%
Oxford Health Plans of NY, Inc. <sup>3</sup>	9,883	10,057	5,543	4,514	55.1%
Rochester Area HMO, Inc. (Preferred Care)	199	210	58	152	27.6%
<b>TOTAL</b>	<b>22,543</b>	<b>22,975</b>	<b>11,775</b>	<b>11,200</b>	<b>52.2%</b>

<sup>1</sup>Closed grievances can exceed filed grievances in 2007 because closed grievances also include grievances filed prior to 2007.

<sup>2</sup>Includes grievances for Art. 43 company managed care contracts.

<sup>3</sup>Includes grievances for indemnity contracts.

## 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<sup>®1</sup>) 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 the 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.**

### HMO NCQA Accreditation Status as of July 2008

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

HMO	NCQA Accreditation Status <sup>2</sup>
Aetna Health Inc.	****
Americhoice of NY, Inc.	—
Atlantis Health Plan, Inc.	—
BSNEY-HMO (Albany)	****
CDPHP	****
CIGNA Healthcare of NY, Inc.	****
Community Blue (HealthNow)	****
Empire HealthChoice HMO, Inc.	****
GHI-HMO Select, Inc.	****
Health Net of NY, Inc.	****
HIP HMO	****
Independence Health Association, Inc. (IHI)	****
MVP Health Plan, Inc.	****
Oxford Health Plans of NY, Inc.	****
Rochester Area HMO, Inc. (Preferred Care)	****
Univera HealthCare	****
UnitedHealthcare of New York	***
Upstate HMO	****

<sup>1</sup>HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>2</sup>Accreditation status does not include Medicare or Medicaid products.

## NCQA's Online Health Plan Report Card

To learn more about NCQA Accreditation and to get detailed information about plan performance, look at NCQA's consumer-friendly, online Health Plan Report Card at <http://hprc.ncqa.org>.

## How HMOs Pay Primary Care Physicians

New York HMOs pay PCPs in a variety of ways; a typical HMO uses more than one method. No method is the best or right way. Ask your doctor if you have questions or concerns about how your HMO pays PCPs.

### Payment Methods

- **Fee for Service:** The HMO pays PCPs for each office visit, procedure and test. Payment is usually based on an allowable fee or usual and customary reimbursement.

#### Allowable Fee or Usual and Customary Reimbursement (UCR):

The maximum amount a health insurer will pay for a service or procedure. Out-of-network services are normally paid based on this amount.

- **Capitation:** The HMO pays PCPs the same amount every month for every member under their primary care, regardless of the services a member receives. Supporters of capitation believe it gives physicians the incentive to keep people healthy through preventive care in order to avoid costly illnesses; others believe it creates an incentive to avoid providing necessary but expensive services.
- **Bonus:** The HMO pays PCPs additional amounts if they meet quality, customer-service or cost-saving goals.

- **Withhold:** The HMO holds a portion of the PCP's payment to cover unexpected services such as specialty care, laboratory services or hospitalization. If patients do not use these services, the HMO returns the withheld amount to the physician. Some believe that this method helps reduce unnecessary expenses; others believe it discourages providers from offering necessary services.

**Balance Billing:** A billing practice in which you are billed for the difference between what your insurer pays and the fee that the provider normally charges. **Balance billing is prohibited under most HMO contracts in New York**, but may arise when you use the services of out-of-network providers under a PPO or POS arrangement.



## Health Insurance Options for Uninsured New Yorkers

### SECTION FOUR

## 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).

Program	Programs Offered by New York State			Purchase Insurance Coverage
	HealthyNY	Child Health Plus	Family Health Plus	HMO Plan or HMO/POS Plan
<b>Who Qualifies?</b>	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 was 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.
<b>Cost</b>	HealthyNY benefits are the same for each HMO, but monthly premiums you have to pay will vary. This program is designed to be more affordable than other insurance options.	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 32 to determine which HMOs operate in your area.  Rates can be found at <a href="http://www.ins.state.ny.us/ihmoindx.htm">www.ins.state.ny.us/ihmoindx.htm</a>
<b>Enrollment</b>	Call this toll-free number: 866-HEALTHY-NY (866-432-5849), or visit the Web site at <a href="http://www.HealthyNY.com">www.HealthyNY.com</a>	Call this toll-free number: 800-698-4KIDS (800-698-4543) or visit the Web site at <a href="http://www.health.state.ny.us/nysdoh/chplus/index.htm">http://www.health.state.ny.us/nysdoh/chplus/index.htm</a>	Contact your local Social Services district office about Family Health Plus or visit the Web site at <a href="http://www.health.state.ny.us/nysdoh/fhplus/index.htm">http://www.health.state.ny.us/nysdoh/fhplus/index.htm</a>	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 medical condition may require a waiting period, see page 2 for more details.

## 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.	✓		
BlueCross BlueShield of Western New York (Community Blue)	✓		✓
BlueShield of Northeastern New York (BSNENY)	✓	✓	✓
CDPHP	✓	✓	✓
CIGNA Healthcare of NY, Inc.	✓		
Empire HealthChoice HMO, Inc.	✓	✓	
Excellus Health Plan (Rochester)	✓	✓	✓
Excellus Health Plan (Upstate 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)	✓		
Univera Healthcare	✓	✓	✓
UnitedHealthcare of New York (Americhoice)		✓	✓





## Glossary of Health Insurance Terms Overall Complaint Ranking

### APPENDICES

# Glossary of Health Insurance Terms

## Commonly used health insurance terms in this Guide

**Alternate Service:** Service other than the one requested that your HMO offers in-network to treat your condition.

**Co-Insurance:** Some insurance coverage requires you 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. 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 preferred providers within the health insurers network.

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

**Copayment:** A flat fee required by some health insurers that members must pay for specified 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 PPOs (when services are received outside the network).

**Experimental/Investigational:** Services that your health insurer or HMO have 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 health insurer considers to be experimental, investigational or not medically necessary. If you are an HMO member, you can also appeal when the HMO denies a request for an out-of-network service if the HMO offers an alternate service in network. The review is conducted by an external review organization not affiliated with the health insurer 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 health insurer 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 for HMO members, out-of-network service denials through your health insurer. 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 a health insurer 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 patients 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). HMO plans require members to get a PCP referral before seeing a specialist. (See *Primary Care Physician, Point of Service Plan and Specialist*.)

### Internal Appeal or Utilization Review (UR):

When a consumer asks a health insurer to reconsider its refusal to pay for a medical service it considers experimental, investigational, not medically necessary or for HMO members, out-of-network. (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 they use a preferred provider network.

**Point of Service (POS) Plan:** A type of coverage in which members can choose to 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 a health plan.

**Pre-Existing Condition Waiting Period:** The time during which the health insurer 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 the individual was previously covered by another 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 health insurer 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 health insurer'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 health insurer from all policies during a calendar year, excluding Medicaid and Medicare.

# Overall Complaint Ranking

The table shows the overall rankings of all New York insurers (HMOs, non-profit indemnity insurers and commercial insurers), based on complaints closed by the New York State Insurance Department. Since comparing different types of health insurers is not an “apples to apples” type of comparison, consider a health insurer’s rank within its category along with this overall rank.

Name	Rank <sup>1</sup>	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio	Insurer Categories
GE Global Group <sup>C</sup>	1	2	0	135.7	0.0000	<sup>H</sup> HMO <sup>C</sup> Commercial Insurer <sup>N</sup> Non-profit Indemnity Insurer
Sun Life Assurance Company of CN <sup>C</sup>	2	8	0	96.5	0.0000	
Northwestern Mutual <sup>C</sup>	3	1	0	73.2	0.0000	
Zurich Ins Group <sup>C</sup>	4	3	0	72.7	0.0000	
Mass Mutual Life Ins Co. <sup>C</sup>	5	1	0	56.4	0.0000	
CNA Insurance Group <sup>C</sup>	6	11	0	53.5	0.0000	
Standard Life Ins Co. of NY <sup>C</sup>	6	3	0	53.5	0.0000	
Geneve Holdings Inc. <sup>C</sup>	7	1	0	52.7	0.0000	
Rochester Area HMO, Inc. (Preferred Care) <sup>H</sup>	8	17	1	354.3	0.0028	
MVP Health Plan, Inc. <sup>H</sup>	9	97	3	924.8	0.0032	
Independent Health Association, Inc. (IHA) <sup>H</sup>	10	27	2	600.6	0.0033	
Americhoice of NY, Inc. <sup>H</sup>	11	3	1	263.8	0.0038	
HealthNow NY, Inc. <sup>N</sup>	12	75	14	1,186.5	0.0100	<p><sup>1</sup>The chart ranks health insurers and HMOs by complaint ratio. If the ratios are the same, the health insurer with the higher premium amount ranks higher.</p> <p>Note: Small insurers and small HMOs are not included. Please consult <i>Details About the Data</i> on page ii.</p>
John Hancock Life Ins. Co. <sup>C</sup>	13	14	2	168.9	0.0118	
Prudential Ins Co of America <sup>C</sup>	14	6	1	84.1	0.0119	
First Rehabilitation Life Ins Co of Am <sup>C</sup>	15	4	1	79.1	0.0126	
American Family Life Asr Co of NY <sup>C</sup>	16	30	2	155.5	0.0129	
Community Blue (HealthNow) <sup>H</sup>	17	79	14	953.1	0.0147	
Protective Life Ins Group <sup>C</sup>	18	19	1	64.4	0.0155	
UNUMProvident Corp Group <sup>C</sup>	19	44	7	424.3	0.0165	
Mutual of Omaha Group <sup>C</sup>	20	16	1	56.9	0.0176	
Hartford F & C Group <sup>C</sup>	21	16	4	221.0	0.0181	
American Progressive L & H Ins Co of NY <sup>C</sup>	22	23	5	274.4	0.0182	
Metropolitan Group <sup>C</sup>	23	67	10	537.7	0.0186	
Liberty National <sup>C</sup>	24	9	1	53.7	0.0186	
AON Corporation <sup>C</sup>	25	24	5	249.7	0.0200	
CDPHP <sup>H</sup>	26	96	18	656.8	0.0274	

# Overall Complaint Ranking

(continued)

Name	Rank <sup>1</sup>	Total Complaints	Upheld Complaints	Premium (Millions \$)	Overall Complaint Ratio	Insurer Categories
Excellus Health Plan, Inc. <sup>H</sup>	27	201	53	1,825.5	0.0290	<sup>H</sup> HMO
New York Life Ins Co. <sup>C</sup>	28	7	2	62.6	0.0319	<sup>C</sup> Commercial Insurer
Wellpoint Inc. <sup>C</sup>	29	879	190	5,574.7	0.0341	<sup>N</sup> Non-profit Indemnity Insurer
Fortis Group <sup>C</sup>	30	11	2	56.6	0.0354	
CIGNA Health Group <sup>C</sup>	31	123	31	526.8	0.0588	
Excellus Health Plan, Inc. <sup>N</sup>	32	566	215	3,309.8	0.0600	
Oxford Health Ins Inc. <sup>C</sup>	33	540	115	1,869.2	0.0615	
American Int'l Group <sup>C</sup>	34	34	10	144.0	0.0694	
Empire HealthChoice HMO, Inc. <sup>H</sup>	35	946	163	1,906.5	0.0855	
Guardian Life Group <sup>C</sup>	36	175	48	518.3	0.0926	
HIP HMO <sup>H</sup>	37	1,505	773	6,565.9	0.1177	
Aetna Health Inc. <sup>H</sup>	38	272	89	706.3	0.1260	
Aetna Group <sup>C</sup>	39	387	148	1,151.0	0.1286	
Health Net of NY, Inc. <sup>H</sup>	40	298	95	491.2	0.1934	
Group Health, Inc. (GHI) <sup>N</sup>	41	1,536	522	2,511.9	0.2100	
HealthNet Ins of NY Inc. <sup>C</sup>	42	230	91	335.4	0.2714	
CIGNA Healthcare of NY, Inc. <sup>H</sup>	43	66	23	79.5	0.2893	
Oxford Health Plans of NY, Inc. <sup>H</sup>	44	1,828	474	1,636.3	0.2897	
GHI HMO Select, Inc. <sup>H</sup>	45	116	33	102.5	0.3218	
UnitedHealth Group <sup>C</sup>	46	1,087	411	1,097.2	0.3745	
Atlantis Health Plan, Inc. <sup>H</sup>	47	130	82	46.3	1.7709	
<b>TOTAL</b>		<b>11,633</b>	<b>3,663</b>	<b>38,421.3</b>	<b>Avg. = 0.1001</b>	

 Denotes length of bar graph shortened due to spatial constraints.

## 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](http://www.ins.state.ny.us/hgintro.htm)

### Problem with Your Health Insurer?

First contact your health insurer'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](http://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 health insurer considers them experimental, investigational, not medically necessary, or for HMO members, an out-of-network service, contact:

#### NYSID External Appeals

PO Box 7209  
Albany, NY 12224-0209  
[www.ins.state.ny.us/extapp/extappqa.htm](http://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](http://www.health.state.ny.us)  
800-206-8125 (*quality of care*)

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 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](http://www.HealthyNY.com)
- **Child Health Plus:** Health insurance program for children who are under 19 years of age.  
800-698-4KIDS (800-698-4543)  
<http://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  
<http://www.health.state.ny.us/nysdoh/fhplus/index.htm>

## 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](http://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](http://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



### **Consumer Guide to HMOs**

This printed guide includes information and data comparing HMO performance and premiums, complaint data and tips on how to choose an HMO. Visit [www.nyshmoguide.org](http://www.nyshmoguide.org) for an interactive version of the guide and to look at historical complaint data.

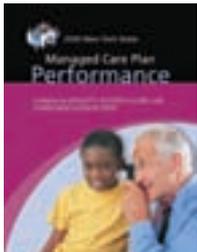


### **HealthyNY Web Site**

This site includes information on HealthyNY coverage, eligibility criteria and information for uninsured New Yorkers. Visit [www.HealthyNY.com](http://www.HealthyNY.com)

### **Looking for HMO Rates?**

To view the rates charged by HMOs, visit [www.ins.state.ny.us/ihmoindx.htm](http://www.ins.state.ny.us/ihmoindx.htm)



### **2007 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/2007](http://www.health.state.ny.us/health_care/managed_care/reports/eqarr/2007)

### **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](http://www.insurancehelpny.com)



## Telephone Number

HMOs	
Aetna Health Inc.	800-435-8742
Atlantis Health Plan, Inc.	866-747-8422
CDPHP	800-777-2273
CIGNA Healthcare of NY, Inc.	800-345-9458
Community Blue (HealthNow)	800-544-2583
Empire HealthChoice	800-261-5962
Excellus	
Finger Lakes HMO	800-462-0108
Upstate HMO	800-462-0108
Univera	800-337-3338
GHI-HMO Select, Inc.	877-244-4466
Health Net of New York, 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 (Preferred Care)	800-950-3224
UnitedHealthcare of New York	800-705-1691

Non-profit Indemnity Insurers	
CDPHP Universal Benefits	800-777-2273
Excellus Health Plan, Inc.	800-847-1200
Group Health, Inc. (GHI)	800-444-2333
HealthNow New York, Inc.	800-888-0757
Independent Health Benefits Corporation	800-453-1910

Commercial Insurers <sup>a</sup>	
Aetna Group	860-273-0123
American Family Life	800-366-3436
Assurant Group	800-223-1969
CIGNA Health Group	800-345-9458
Citigroup	800-221-4584
CNA Insurance Group (Encompass Insurance)	800-262-9262
Combined Life Ins Co. of New York	800-951-6206
Empire HealthChoice Assurance, Inc.	800-261-5962
First Rehabilitation Life Ins Co. of America	800-365-4999
First UNUM Life Insurance Co.	800-233-1969
Fortis Group	800-745-7100
GE Global Group	800-844-6543
Guardian Life Insurance	888-482-7342
Hartford F & C Group	860-547-5000
Health Net Insurance of New York	800-848-4747
John Hancock Mutual Life Ins Company	800-732-5543
Metropolitan Group	800-MetLife
Mutual of Omaha Group	800-775-6000
MVP Health Ins Co.	888-687-6277
New York Life Insurance Company	800-695-9873
Oxford Health Insurance Company	800-969-7480
Prudential Insurance Company of America	800-828-0153
Long Term Care Coverage	800-732-0416
Union Labor	
Group	888-294-5787
Individual	877-820-7448
UnitedHealth Group	800-705-1691
UnumProvident Life Group	800-858-6843
Zurich-American Insurance Companies	800-382-2150

<sup>a</sup> Commercial insurers generally do not offer health insurance coverage to individuals.

