

2009

New York

CONSUMER GUIDE TO HEALTH INSURERS





IMAGINE

Table of Contents

About this Guide	ii
Health Plans in this Guide	iii

Section 1

Understanding Health Insurance

How to use this Guide to understand your health insurance choices

■ Understanding Your Health Insurance Options	1
■ Comparison of Health Insurance Coverage	3
■ How to Choose a Health Insurer	4
■ Worksheet to Help You Choose a Health Insurer	5
■ New York Consumer Protections	6
■ Your Right to Appeal a Health Insurer's Decision	7

Section 2

Complaint and Appeal Information for All Types of Health Insurers

How often consumers or providers complained about New York's insurers

■ Overview	9
■ Complaints	10
■ Prompt Pay Complaints	14
■ Internal Appeals	18
■ External Appeals	22

Section 3

Quality of Care and Service of HMOs

How well HMOs provided important services and how satisfied consumers are with their HMO

■ Overview	27
■ HMO Service Areas	28
■ Access and Service	30
■ Staying Healthy and Living With Illness	32
■ Quality of Providers	34
■ Grievances	36
■ NCQA Accreditation	38
■ How HMOs Pay Primary Care Physicians	39

Section 4

Health Insurance Options for Uninsured New Yorkers

Health insurance programs for small businesses and uninsured families and individuals

■ Insurance Options for Uninsured New Yorkers	41
■ HMO Participation in NY Health Insurance Programs	42

Appendices

Glossary of Health Insurance Terms	45
Overall Complaint Ranking	47

Contacts and Resources

Related Resources	50
Telephone Numbers for Health Insurers	52

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 45–46 for commonly used terms in this Guide. The first time a 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 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 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®).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 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.²
- Health insurers are listed alphabetically in the data tables, except for the Overall Complaint Ranking table on pages 47–48.
- 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

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

²For 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 three types of health insurers: **health maintenance organizations** (HMOs), non-profit indemnity insurers and commercial insurers. See page 3 for health insurer descriptions. A complete list of health insurers is on page 52. Some health 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 health insurers when reviewing data in the Guide.

Crosswalk of Select Health Insurers' Names	
For all data in Section 2 and for Grievance data in Section 3, the plan is listed as:	In Section 3, the plan is listed as:
Community Blue (HealthNow)	Blue Shield of Northeastern New York (BSNENY) (Albany area) Community Blue (Buffalo area)
Excellus Health Plan, Inc. (HMO)	Excellus BlueCross BlueShield Univera Healthcare
Rochester Area HMO	Although <i>Preferred Care</i> changed its name to <i>MVP Health Care</i> in March, the 2009 Guide uses the company's original name.

For all data in Section 2 and for Grievance data in Section 3, HIP HMO also includes data for:	In Section 3, HIP HMO includes data for:
Health Insurance Plan of Greater New York HIP Insurance Company of New York PerfectHealth Insurance Company	HMO product only

Understanding Health Insurance



Understanding your Health Insurance Options

There are generally three ways New Yorkers can obtain 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 (group insurance)
How to Get Health Insurance	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.	The State of New York offers a number of health care programs available for eligible individuals.	Many employers and associations make health insurance available for their employees or members and their families. These plans may be provided by a licensed health insurer or HMO, or they might be self-insured plans.
Insurance Options	<p>HMO: A health insurer that contracts directly with or employs a network of doctors, hospitals and other types of providers.</p> <p>HMO/POS: A health insurer that combines an HMO with the flexibility of being able to see out-of-network doctors.</p> <p>Page 2 describes health insurers in detail.</p>	<p>HealthyNY is a program that offers health insurance to small employers, sole proprietors and uninsured working individuals.</p> <p>Child Health Plus is a health insurance plan for children under 19 years of age.</p> <p>Family Health Plus 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>Page 41 describes options in detail.</p>	<p>Insured Plan: An employer contracts with a licensed health insurer or HMO to provide coverage for its employees.</p> <p>Self-Insured Plan: An employer establishes a fund to cover medical expenses and typically contracts with an outside party to administer the health benefits.</p> <p>Professional Association: An association may offer its members group rates on insurance plans that are usually less expensive than individual plans.</p>
Special Considerations	For a pre-existing medical condition , a member may have to wait up to a year for coverage of the condition if treatment was recommended or received within the 6 months prior to the date of enrollment. The waiting period may be reduced 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.	Individuals must meet income-based eligibility criteria, which are different for each program. See page 41 for information about who qualifies and cost. Links to online enrollment resources are provided.	<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 6) 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>



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 coverage works.

	Health Maintenance Organizations		Non-profit Indemnity Insurers and Commercial Insurers	
	HMO 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.	HMO/POS 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.	Fee-for-Service (FFS) 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.	PPO 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 may you choose?	You must choose providers in 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 referral 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 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 " co-insurance. "	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 deductibles 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.

How to Choose a Health Insurer

Step 1: Determine the type of health coverage that best fits your needs.

Health insurance can be obtained in different ways, depending on your situation. For example, some health insurers only offer coverage through an employer. Use the Comparison of Health Insurance Coverage table on page 3 to help you decide which health insurers to consider.

Step 2: Determine which health insurer provides coverage in your area.

If you are considering an HMO, see the table on page 28 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 own or 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. It may be helpful to make a list of medical needs you have had in the past and may need in the future.

Step 4: Determine if your doctor is in the health insurer's network.

Your doctor may not be part of every health insurer's network. To determine if your doctors and hospital participate, check the health insurer'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 5: 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. For other types of insurance, contact the individual health insurer or your employer.

Step 6: 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 7: 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

Steps 1–5: 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 table below. Identify the health insurers that meet your basic requirements.

	List the insurers you are considering.
Step 1: Which type of health insurance fits your needs? <i>See pages 1 and 3 for a comparison of insurer types.</i>	
Step 2: Which health insurers are available where you live or work? <i>See page 28 for HMOs; for other insurers, review the information from your employer or the insurer.</i>	
Step 3: Which of the health insurers offer the benefits you need and want? <i>Review the benefits information from your employer or the insurer.</i>	
Step 4: With which health insurer does your doctor participate? <i>Review the insurers' physician directories and call their Customer Service Departments.</i>	
Step 5: Which health insurance can you afford? <i>Consider the amount of copays, co-insurance or deductibles.</i>	

Step 6: Thinking about the insurers you identified in the previous steps, consider how well each performed in the following areas that are included in this Guide.

	List the insurers you are considering.
For All Types of Health Insurers	
Complaints: How does the insurer rank, compared to other insurers? <i>See page 10.</i>	
Prompt Pay Complaints: How does the insurer rank, compared to other insurers? <i>See page 4.</i>	
Internal Appeals: Which health insurers have low reversal rates? <i>See page 18.</i>	
External Appeals: Which health insurers have low reversal rates? <i>See page 22.</i>	
For HMOs Only	
Access & Service: Look at the measures important to you. Which HMOs perform well? <i>See page 30.</i>	
Staying Healthy & Living with Illness: Look at the measures important to you. Which HMOs perform well? <i>See page 32.</i>	
Quality of Providers: Look at the measures important to you. Which HMOs perform well? <i>See page 34.</i>	
Grievances: Which HMOs have low reversal rates? <i>See page 36.</i>	

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 7 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, coinsurance and deductible.
- 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 denial 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

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 1 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 may also appeal when the HMO denies a request for out-of-network service if it 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 may 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 or investigational or, for HMO members, out-of-network services.

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 services 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 State Insurance Department

External Appeals
PO 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 22–25 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 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 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 New York.

Complaint and Appeal Information for All Types of Health Insurers



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 described on page 2:

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
Definition	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.
Filed by	Consumers, their designee or provider.	Consumers, their designee or provider.	Consumers or their authorized representative, which may be the provider. The provider may file on its behalf for services already provided.	Consumers or their authorized representative, which may be the provider. The provider may file on its behalf for services already provided.	Consumers or their designee.
Reviewed by	NYSID or DOH.	NYSID.	The health insurer's medical director.	State-certified, independent external review organization.	Internal HMO committee.
More information	Pages 10-13	Pages 14-17	Pages 18-21	Pages 22-25	Pages 36-37

*If you are an HMO member, you may appeal when the HMO denies a request for out-of-network service if it 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 2008. Complaints typically involve issues related to 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 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 2008. 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 (complaints resolved in favor of the member or provider) 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 2008

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)	
	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 is from 2008.

Complaints—Non-profit Indemnity Insurers 2008

Data source: NYSID

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

Non-profit Indemnity Insurer ¹	Rank 1= Best, 4= Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio
Excellus Health Plan, Inc.	3	391	104	3,433.5	0.0303
Group Health, Inc. (GHI)	4	1,378	541	2,757.7	0.1962
HealthNow NY, Inc.	2	72	26	1,373.6	0.0189
Preferred Assurance Company, Inc.	1	9	1	54.0	0.0185
TOTAL		1,850	672	7,618.8	Avg. = 0.0882

¹Dentcare Delivery Systems is not included because it does not write a comprehensive health insurance product.



Complaints—Commercial Insurers 2008

Data source: NYSID

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

Commercial Insurer	Rank ¹ 1 = Best, 29 = Worst	Total Complaints to NYSID	Upheld Complaints by NYSID	Premium (Millions \$)	Complaint Ratio
Aetna Group	27	594	200	1,248.1	0.1602
American Family Corp	21	15	5	172.0	0.0291
American Int'l Group	13	25	2	142.3	0.0141
AON Corporation	19	36	6	266.3	0.0225
CIGNA Health Group	26	158	73	690.0	0.1058
First Rehabilitation Life Ins. Co. of Am.	6	3	0	73.6	0.0000
Fortis Group	9	6	0	55.6	0.0000
GE Global Group	11	10	1	143.2	0.0070
Guardian Life Group	25	131	34	495.1	0.0687
Hartford F & C Group	2	16	0	234.6	0.0000
Health Net Inc. Group	28	244	71	363.1	0.1955
Highmark Inc.	7	1	0	67.2	0.0000
John Hancock Group	20	8	4	171.3	0.0233
Mass Mutual Life Ins. Co.	8	2	0	60.6	0.0000
Metropolitan Group	15	46	8	541.4	0.0148
Mutual of Omaha Group	10	7	0	53.2	0.0000
MVP Group	1	2	0	1,003.9	0.0000
New York Life Group	16	3	1	63.5	0.0158
Northwestern Mutual	4	1	0	79.0	0.0000
Oxford Health Ins. Inc.	24	491	102	2,161.4	0.0472
Protective Life Ins. Group	22	28	2	62.8	0.0319
Prudential of America Group	18	13	2	93.1	0.0215
Stancorp Financial Group	17	3	1	56.6	0.0177
Sun Life Asr Company of CN	3	6	0	83.7	0.0000
UnitedHealth Group	29	1,170	559	1,298.9	0.4304
Universal American Financial Corp	12	18	4	410.8	0.0097
UNUMProvident Corp Group	14	56	6	419.4	0.0143
WellPoint Inc.	23	772	202	5,261.0	0.0384
Zurich Ins. Group	5	3	0	76.7	0.0000
TOTAL		3,868	1,283	15,848.3	Avg. = 0.0810

¹If 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 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 2008. Complaints 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 2008.

- **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 2008. 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 2008

Data source: NYSID

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

HMO	Prompt Pay Ranking 1 = Best, 13 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aetna Health Inc.	10	548	157	65	635.9	0.1022
Atlantis Health Plan	12	148	98	82	66.1	 1.2406
CDPHP	1	86	16	0	648.9	0.0000
Community Blue (HealthNow)	7	91	68	31	471.8	0.0657
Empire Health Choice HMO, Inc.	6	742	391	116	1,775.3	0.0653
Excellus Health Plan, Inc. (HMO)	5	128	29	14	847.6	0.0165
GHI HMO Select, Inc.	13	355	302	177	86.5	 2.0466
Health Net of NY, Inc.	8	301	146	34	465.0	0.0731
HIP HMO	11	1,170	800	406	2,351.9	0.1726
Independent Health Association, Inc. (IHA)	3	21	3	1	485.6	0.0021
MVP Health Plan, Inc.	4	74	25	2	861.6	0.0023
Oxford Health Plans of NY Inc.	9	1,360	698	123	1,342.8	0.0916
Rochester Area HMO, Inc. (Preferred Care)	2	1	0	0	385.3	0.0000
TOTAL		5,025	2,733	1,051	10,424.3	Avg. = 0.1008

 Denotes length of bar graph shortened due to space constraints.

Prompt Pay Complaints—Non-profit Indemnity Insurers 2008

Data source: NYSID

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

Non-profit Indemnity Insurer ¹	Rank 1 = Best, 4 = Worst	Total Complaints	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Excellus Health Plan, Inc.	3	391	160	64	3,433.5	0.0186
Group Health Inc. (GHI)	4	1,378	758	382	2,757.7	0.1385
HealthNow NY, Inc.	2	72	34	19	1,373.6	0.0138
Preferred Assurance Company, Inc.	1	9	1	0	54.0	0.0000
TOTAL		1,850	953	465	7,618.8	Avg. = 0.0610

¹Dentcare Delivery Systems is not included because it does not write a comprehensive health insurance product.



Prompt Pay Complaints—Commercial Insurers 2008

Data source: NYSID

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

Commercial Insurer	Rank ¹ 1 = Best, 29 = Worst	Total Complaints to NYSID	Total Prompt Pay Complaints	Upheld Prompt Pay Complaints	Premium (Millions \$)	Prompt Pay Complaint Ratio
Aetna Group	27	594	231	100	1,248.1	0.0801
American Family Corp	4	15	0	0	172.0	0.0000
American Int'l Group	21	25	8	2	142.3	0.0141
AON Corporation	22	36	11	4	266.3	0.0150
CIGNA Health Group	26	158	53	30	690.0	0.0435
First Rehabilitation Life Ins. Co. of Am.	11	3	0	0	73.6	0.0000
Fortis Group	17	6	0	0	55.6	0.0000
GE Global Group	6	10	0	0	143.2	0.0000
Guardian Life Group	25	131	37	15	495.1	0.0303
Hartford F & C Group	3	16	0	0	234.6	0.0000
Health Net Inc. Group	28	244	114	37	363.1	0.1019
Highmark Inc.	12	1	0	0	67.2	0.0000
John Hancock Group	5	8	0	0	171.3	0.0000
Mass Mutual Life Ins. Co.	15	2	0	0	60.6	0.0000
Metropolitan Group	20	46	7	2	541.4	0.0037
Mutual of Omaha Group	18	7	1	0	53.2	0.0000
MVP Group	1	2	0	0	1,003.9	0.0000
New York Life Group	13	3	1	0	63.5	0.0000
Northwestern Mutual	9	1	0	0	79.0	0.0000
Oxford Health Ins. Inc.	24	491	168	54	2,161.4	0.0250
Protective Life Ins. Group	14	28	3	0	62.8	0.0000
Prudential of America Group	7	13	0	0	93.1	0.0000
Stancorp Financial Group	16	3	0	0	56.6	0.0000
Sun Life Asr Company of CN	8	6	2	0	83.7	0.0000
UnitedHealth Group	29	1,170	850	412	1,298.9	0.3172
Universal American Financial Corp	19	18	8	1	410.8	0.0024
UNUMProvident Corp Group	2	56	0	0	419.4	0.0000
WellPoint Inc.	23	772	399	128	5,261.0	0.0243
Zurich Ins. Group	10	3	0	0	76.7	0.0000
TOTAL		3,868	1,893	785	15,848.3	Avg. = 0.0495

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

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 may also appeal when the HMO denies a request for out-of-network service if it 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 2008.
- **Closed Appeals:** Number of internal appeals that the health insurer decided by the end of 2008.
- **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, but 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 2008

Data source: NYSID

HMO	Filed Appeals	Closed Appeals ¹	Reversed Appeals	Reversal Rate
Aetna Health Inc. ²	498	488	195	40.0%
Atlantis Health Plan, Inc.	376	375	128	34.1%
CDPHP ³	454	452	153	33.8%
Community Blue (HealthNow)	252	230	72	31.3%
Empire HealthChoice HMO, Inc.	224	222	72	32.4%
Excellus Health Plan, Inc. (HMO)	784	798	401	50.3%
GHI HMO Select, Inc.	194	205	114	55.6%
Health Net of NY, Inc.	1,154	1,161	322	27.7%
HIP HMO	65	60	31	51.7%
Independent Health Association, Inc. (IHA) ³	193	190	114	60.0%
MVP Health Plan, Inc.	195	193	29	15.0%
Oxford Health Plans of NY, Inc.	2,149	2,108	784	37.2%
Rochester Area HMO, Inc. (Preferred Care)	145	146	29	19.9%
TOTAL	6,683	6,628	2,444	Avg. = 36.6%

¹ Closed internal appeals can exceed filed internal appeals in 2008 because closed internal appeals also include internal appeals filed prior to 2008.

² Includes UR data for Aetna Health Ins. Co. of NY.

³ Includes data for Art. 43 company.

Internal Appeals—Non-profit Indemnity Insurers 2008

Data source: NYSID

Non-profit Indemnity Insurer ¹	Filed Appeals	Closed Appeals ²	Reversed Appeals	Reversal Rate
Excellus Health Plan, Inc.	2,626	2,660	1,207	45.4%
Group Health, Inc. (GHI)	6,148	5,979	3,531	59.1%
HealthNow NY, Inc.	654	612	242	39.5%
Preferred Assurance Company, Inc.	32	32	9	28.1%
TOTAL	9,460	9,283	4,989	Avg. = 53.7%

¹ Dentcare Delivery Systems is not included because it does not write a comprehensive health insurance product.

² Closed internal appeals can exceed filed internal appeals in 2008 because closed internal appeals also include internal appeals filed prior to 2008.



Internal Appeals—Commercial Insurers 2008

Data source: NYSID

Commercial Insurer ¹	Filed Appeals	Closed Appeals ²	Reversed Appeals	Reversal Rate
Aetna Group ³	1,191	1,198	341	28.5%
American Family Corp	0	0	0	0.0%
American Int'l Group	2	1	1	100.0%
AON Corporation	0	0	0	0.0%
CIGNA Health Group	717	732	286	39.1%
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%
Guardian Life Group	1,617	1,572	1,228	78.1%
Hartford F & C Group	0	0	0	0.0%
Health Net Inc. Group	915	905	273	30.2%
Highmark Inc.	0	0	0	0.0%
John Hancock Life Ins. Co.	0	0	0	0.0%
Mass Mutual Life Ins. Co.	0	0	0	0.0%
Metropolitan Group	6,579	6,579	5,575	84.7%
Mutual of Omaha Group	0	0	0	0.0%
MVP Group	25	25	6	24.0%
New York Life Group	0	0	0	0.0%
Northwestern Mutual	0	0	0	0.0%
Oxford Health Ins. Co.	4,103	4,036	1,659	41.1%
Protective Life Ins. Group	0	0	0	0.0%
Prudential of America Group	0	0	0	0.0%
StandCorp Financial Group	5	5	2	40.0%
Sun Life Assurance Company of CN	0	0	0	0.0%
UnitedHealth Group	22,504	22,490	9,296	41.3%
Universal American Financial Corp	0	0	0	0.0%
UNUMProvident Corp Group	0	0	0	0.0%
Wellpoint Inc.	365	411	159	38.7%
Zurich Ins. Group	0	0	0	0.0%
TOTAL	38,036	37,967	18,833	Avg. = 49.6%

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

² Closed internal appeals can exceed filed internal appeals in 2008 because closed internal appeals also include internal appeals filed prior to 2008.

³ Aetna Health Insurance Co. of NY internal appeals are included with HMO numbers.

External Appeals

Consumers may 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 may 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 7 for more information about the external appeal process.)

Understanding the Charts

- **Total Appeals:** Total number of cases assigned 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 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 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 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%

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

External Appeals—Non-profit Indemnity Insurers 2008

Data source: NYSID

Non-profit Indemnity Insurer ¹	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ²
Excellus Health Plan, Inc. (HMO)	175	59	13	103	41.1%
Group Health, Inc. (GHI)	125	32	17	76	39.2%
HealthNow NY, Inc.	61	27	1	33	45.9%
Preferred Assurance Company, Inc.	0	0	0	0	0.0%
TOTAL	361	118	31	212	Avg. = 41.3%

¹ Dentcare Delivery Systems is not included because it does not write a comprehensive health insurance product.

² Rate includes "reversed-in-part" decisions.



External Appeals—Commercial Insurers 2008

Data source: NYSID

Commercial Insurer ¹	Total Reviews	Reversed Reviews	Reversed in Part	Upheld Reviews	Reversal Rate ²
Aetna Group	93	22	13	58	37.6%
American Family Corp	0	0	0	0	0.0%
American Int'l Group	0	0	0	0	0.0%
AON Corporation	0	0	0	0	0.0%
CIGNA Health Group	20	14	0	6	70.0%
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%
Guardian Life Group	16	7	2	7	56.3%
Hartford F & C Group	0	0	0	0	0.0%
Health Net Inc. Group	31	9	4	18	41.9%
Highmark Inc.	0	0	0	0	0.0%
John Hancock Group	0	0	0	0	0.0%
Mass Mutual Life Ins. Co.	0	0	0	0	0.0%
Metropolitan Group	32	16	2	14	56.3%
Mutual of Omaha Group	0	0	0	0	0.0%
MVP Group	0	0	0	0	0.0%
New York Life Group	0	0	0	0	0.0%
Northwestern Mutual	0	0	0	0	0.0%
Oxford Health Ins. Co.	208	80	13	115	44.7%
Protective Life Ins. Group	0	0	0	0	0.0%
Prudential of America Group	0	0	0	0	0.0%
StanCorp Financial Group	0	0	0	0	0.0%
Sun Life Assurance Company of CN	0	0	0	0	0.0%
UnitedHealth Group	309	125	11	173	44.0%
Universal American Financial Corp	0	0	0	0	0.0%
UNUMProvident Corp Group	0	0	0	0	0.0%
Wellpoint Inc.	154	63	6	85	44.8%
Zurich Ins. Group	0	0	0	0	0.0%
TOTAL	863	336	51	476	Avg. = 44.8%

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

² Rate includes "reversed-in-part" decisions.

Quality of Care and Service for HMOs

3



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 28): 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 30–31): 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 32–33): How well HMOs deliver preventive services and keep members healthy.
- **Quality of Providers** (pages 34–35): How HMO members rated their personal doctor; the percentage of physicians certified by a medical board (**board certified**).
3. **Grievances** (pages 36–37): How often HMO members or providers complained directly to their HMO about denials based on contract limitations or exclusions.
4. **NCQA Accreditation** (page 38): 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
5. **How HMOs Pay Primary Care Physicians** (page 39): The different ways HMOs compensate PCPs for providing care to members.



HMO Service Areas¹

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

HMO	Albany Area	Buffalo Area	Hudson Valley Area	Long Island Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Westchester Area
	Includes Albany, Clinton, Essex, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.	Includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.	Includes Columbia, Delaware, 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)		•				•			

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



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.

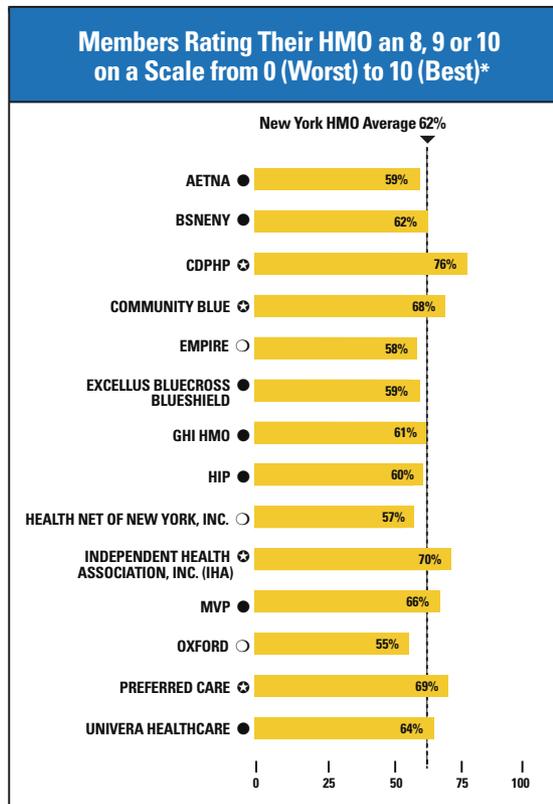
Understanding These Charts

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; 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.

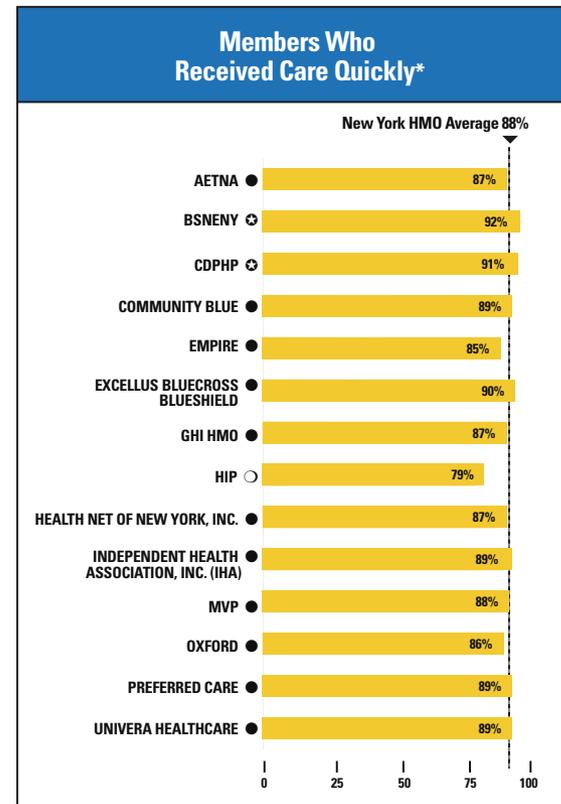
*Data are from 2008. These results cannot be compared to last year’s results.



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

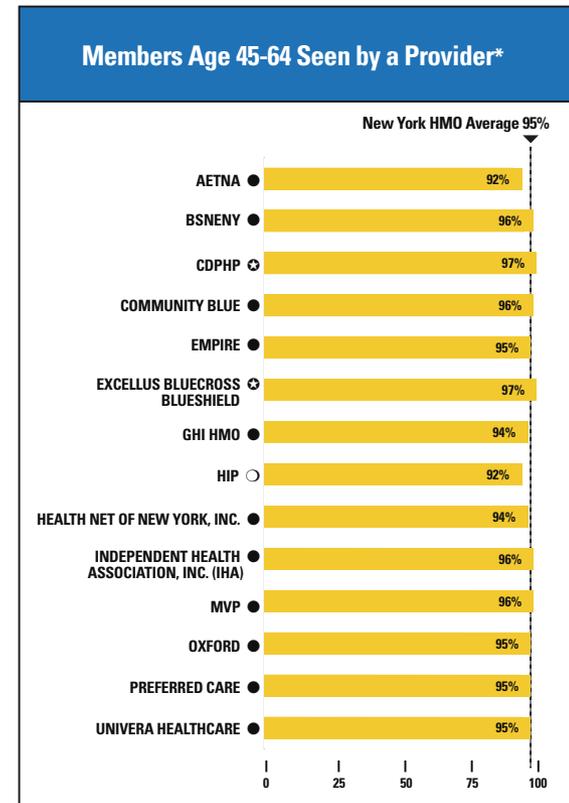
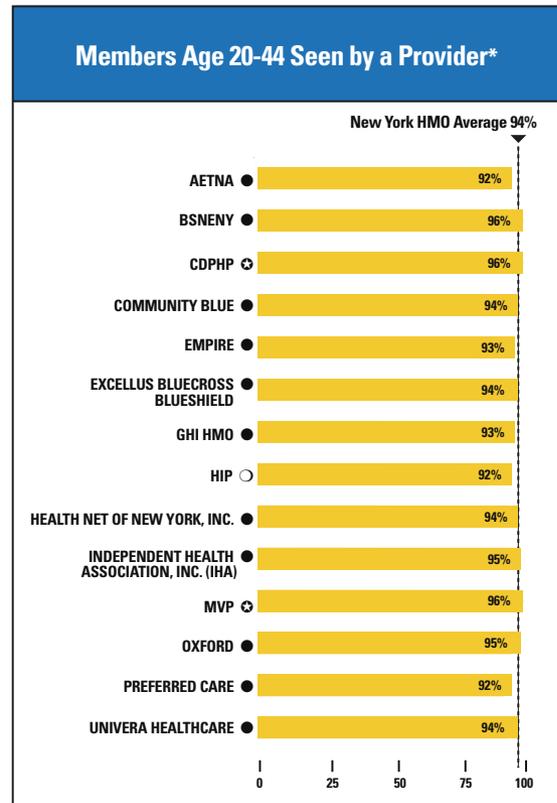
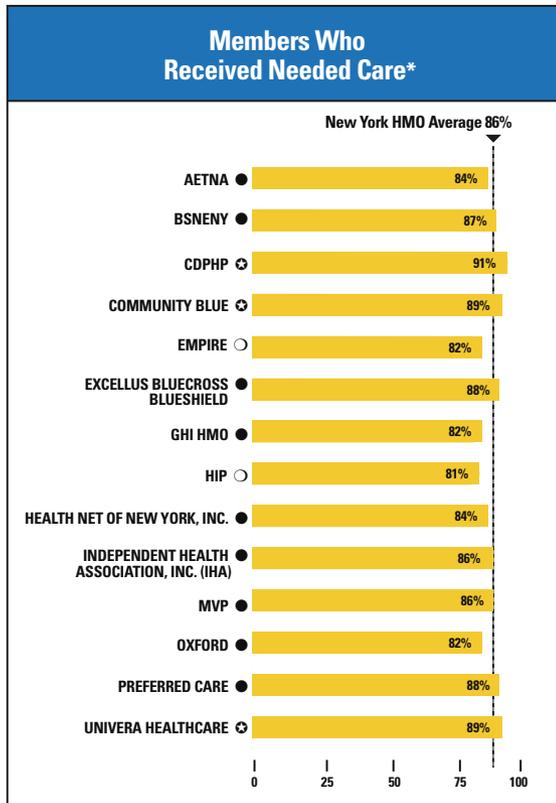
Performance Compared to the New York HMO Average

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



Members 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.



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

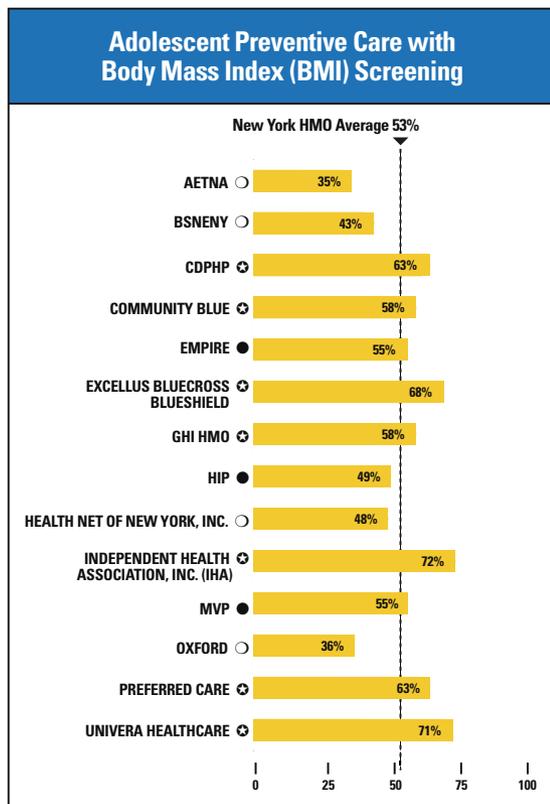
Data source: DOH

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

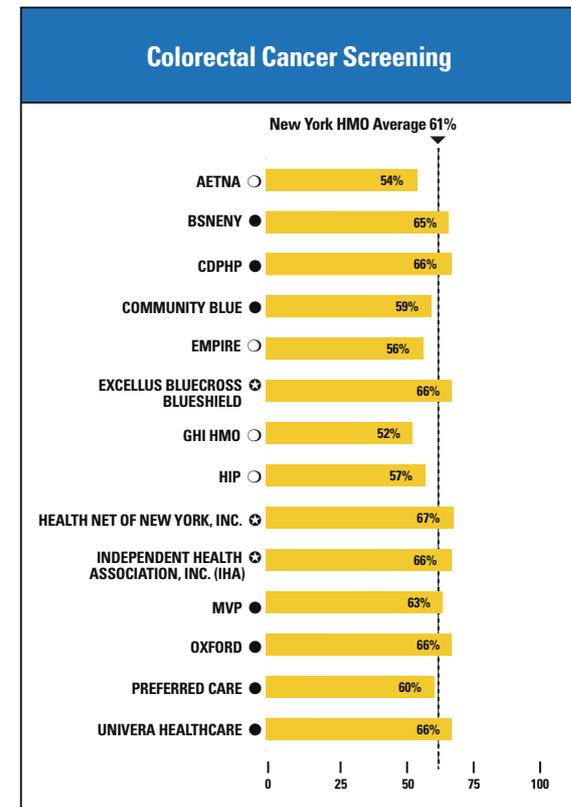
Note: Symbols show statistically significant differences between each health insurer’s score and the New York average. Statistically significant means scores varied by more than could be accounted for by chance. Plans showing the same percentage can have different circles, and thus perform at different 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.

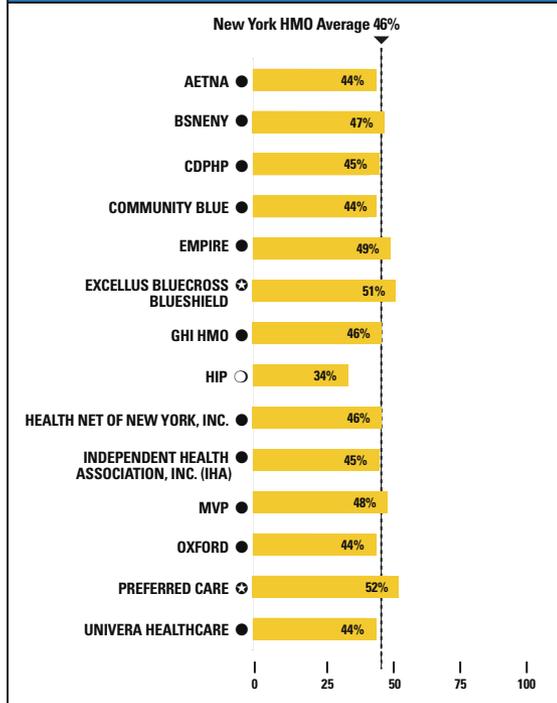
Performance Compared to the New York HMO Average

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



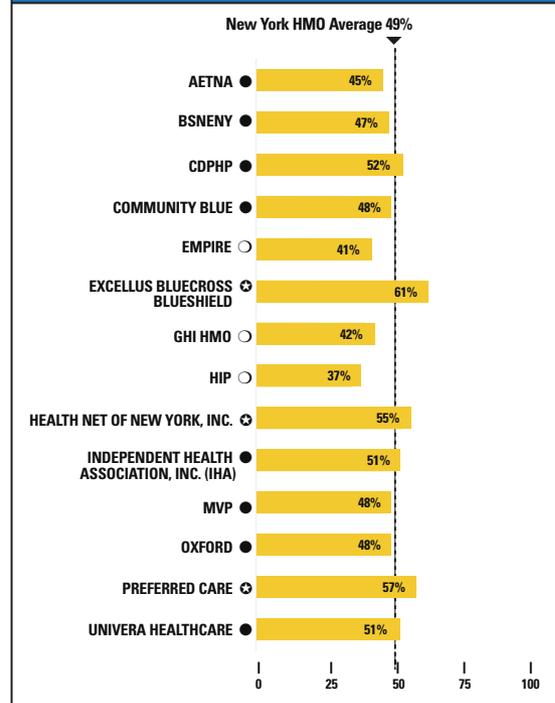
Colorectal cancer affects both men and women of all racial and ethnic groups, and is most often found in people ages 50 or older. Screening can find precancerous polyps—abnormal growths in the colon or rectum—so that they can be removed before turning into cancer. Screening also helps find colorectal 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.

Antidepressant Medication Management: Effective Continuation Phase Treatment



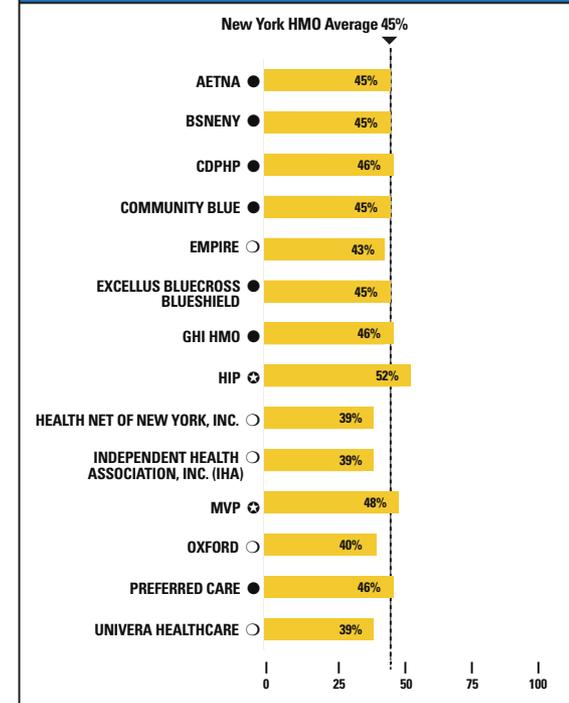
Depression, even the most severe cases, is a highly treatable disorder. Patients should take regular doses of antidepressants for at least 3 to 4 weeks in order to experience the full beneficial effects. Patients should continue taking the medication for the time specified by their doctor, even if they are feeling better, in order to prevent a relapse of the depression. HMOs were rated on the percentage of members ages 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. HMOs were rated on the percentage of sexually active young women ages 16–20 who had at least one test for Chlamydia.

Quality of Providers

Data source: DOH

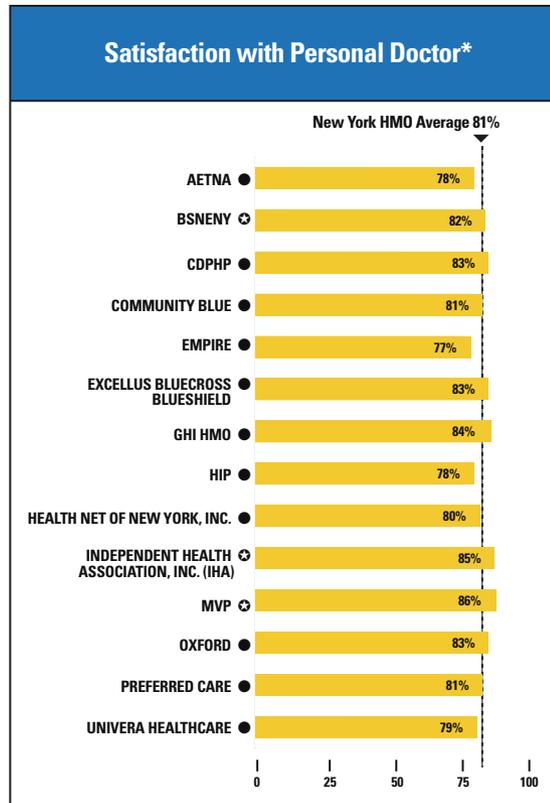
The quality, stability and availability of physicians in an HMO provider network can affect the overall quality of care delivered to HMO members.

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, 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.

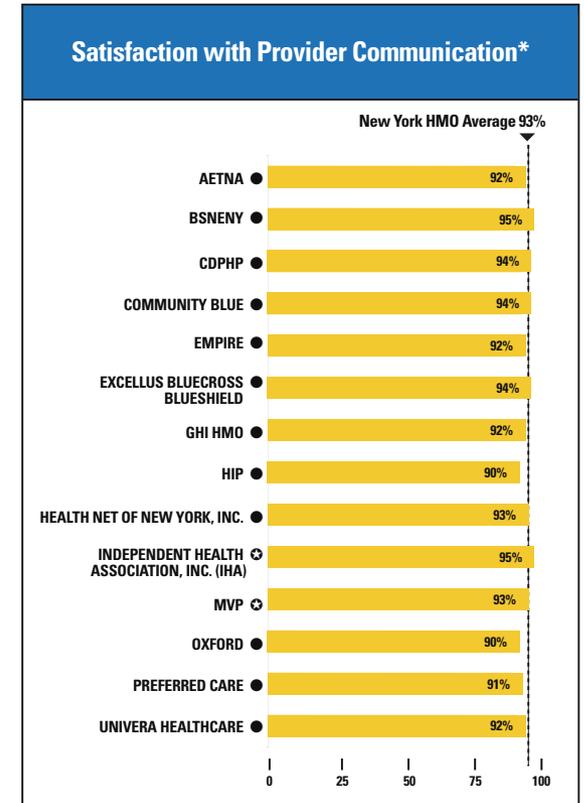
*Data are from 2008.



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.

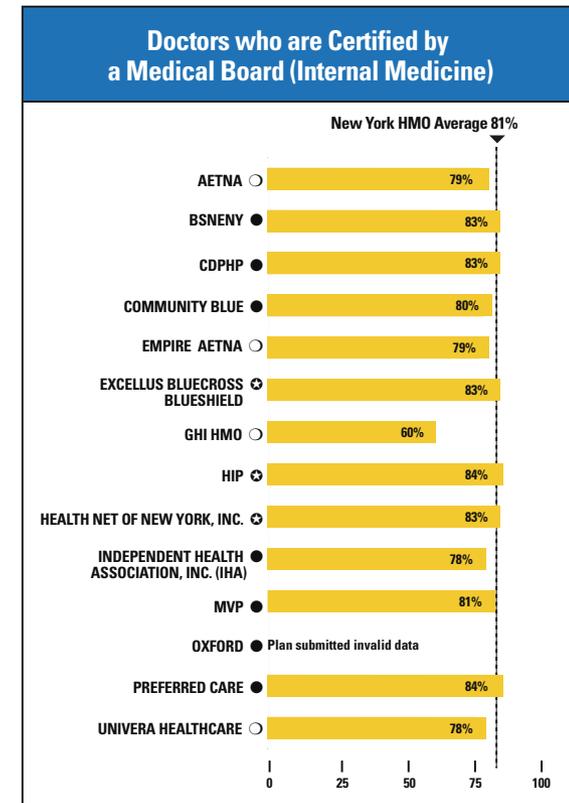
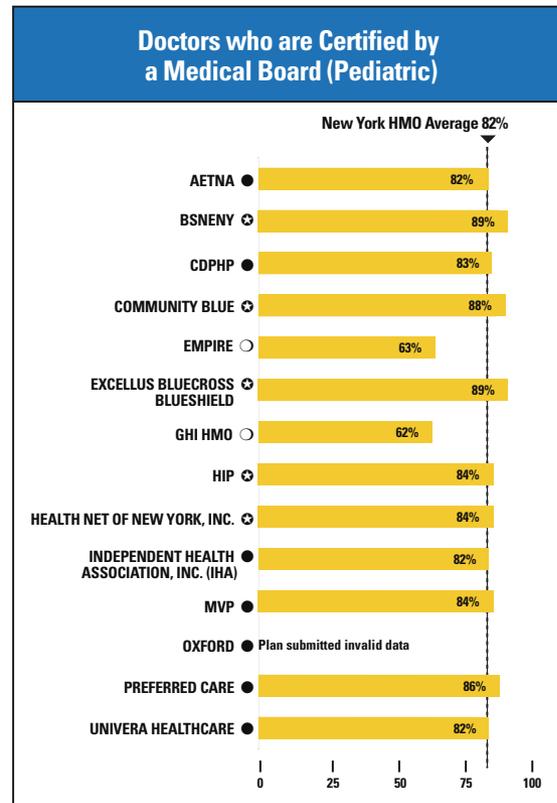
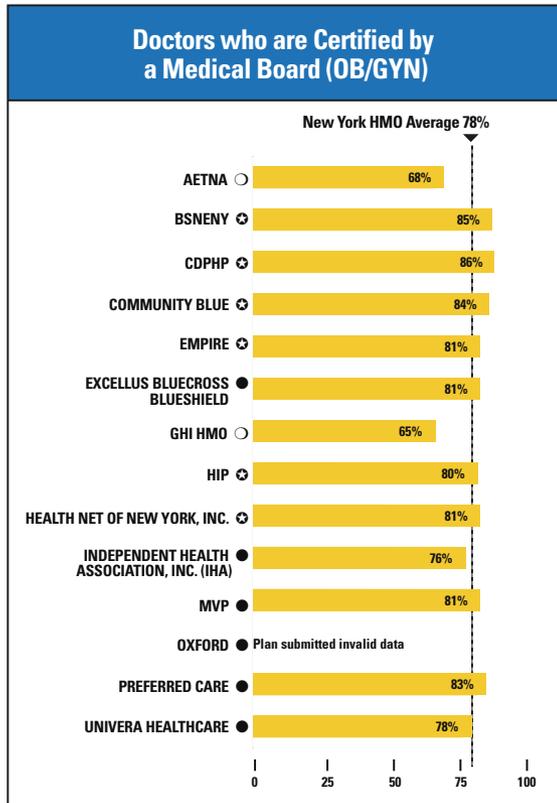
Performance Compared to the New York HMO Average

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



Members 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.



To be board certified, doctors must receive additional training and pass an exam in their specialty. While board certification is not a guarantee of quality, it shows that a 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.

Grievances

A **grievance** is when a member complains to a health insurer about a denial based on limitations or exclusions in the contract. Medical necessity issues are internal appeals, not grievances. (See page 18 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. An internal HMO committee reviews grievances and decides whether to reverse or uphold a 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 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 the HMO's 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.

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 also 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 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 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.

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 iii.

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.

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 one method is “best” or “right.” 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 consumers are billed for the difference between what their 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 consumers use the services of out-of-network providers under a PPO or POS arrangement.

Health Insurance Options for Uninsured New Yorkers



Insurance Options for Uninsured New Yorkers

New Yorkers that do not have health insurance can either:

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

	Programs Offered by New York State			Purchase Insurance Coverage
Program	HealthyNY	Child Health Plus	Family Health Plus	HMO Plan or HMO/POS Plan
Who Qualifies?	Small employers, sole proprietors and working uninsured individuals who meet income limits.	Children 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.
Cost	HealthyNY benefits are the same for each HMO, but monthly premiums 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 28 to determine which HMOs operate in your area. Rates can be found at www.ins.state.ny.us/ihmoindx.htm
Enrollment	Call this toll-free number: 866-HEALTHY-NY (866-432-5849), or visit the Web site at www.HealthyNY.com	Call this toll-free number: 800-698-4KIDS (800-698-4543) or visit the Web site at http://www.health.state.ny.us/nysdoh/chplus/index.htm	Contact your local Social Services district office about Family Health Plus or visit the Web site at http://www.health.state.ny.us/nysdoh/fhplus/index.htm	Individuals may enroll in either an HMO or HMO/POS plan at any time and may not be denied coverage for health reasons. A pre-existing medical condition may require a waiting period. See page 1 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.	✓		
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		✓	✓



Glossary of Health Insurance Terms

Overall Complaint Ranking



Glossary of Health Insurance Terms

Commonly used 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 health insurer's network.

Complaint: When a consumer or provider makes a formal expression of dissatisfaction about a health insurer to the State of New York.

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 in PPOs for services received outside the network.

Experimental/Investigational: Services that health insurers or HMOs have 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 health insurer considers to be experimental, investigational or not medically necessary. If you are an HMO member, you may 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 a 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 a denial 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 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 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 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 a health plan.

Pre-Existing Condition Waiting Period: The time during which a 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 a member 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 (e.g., cardiology, dermatology, gastroenterology) other than primary care. 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 rank 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 in its category as well as the overall rank.

Name	Rank ¹	Upheld Complaints by NYSID	Total Complaints to NYSID	Premium (Millions \$)	Overall Complaint Ratio
MVP Group ^c	1	0	2	1,003.9	0.0000
Rochester Area HMO, Inc. (Preferred Care) ^h	2	0	1	385.3	0.0000
Hartford F & C Group ^c	3	0	16	234.6	0.0000
Sun Life Asr Company of CN ^c	4	0	6	83.7	0.0000
Northwestern Mutual ^c	5	0	1	79.0	0.0000
Zurich Ins. Group ^c	6	0	3	76.7	0.0000
First Rehabilitation Life Ins. Co. of Am. ^c	7	0	3	73.6	0.0000
Highmark Inc. ^c	8	0	1	67.2	0.0000
Mass Mutual Life Ins. Co ^c	9	0	2	60.6	0.0000
Fortis Group ^c	10	0	6	55.6	0.0000
Mutual of Omaha Group ^c	11	0	7	53.2	0.0000
Independent Health Association, Inc. ^h	12	2	21	485.6	0.0041
GE Global Group ^c	13	1	10	143.2	0.0070
Universal American Financial Corp ^c	14	4	18	410.8	0.0097
MVP Health Plan, Inc. ^h	15	9	74	861.6	0.0104
American Int'l Group ^c	16	2	25	142.3	0.0141
UNUMProvident Corp Group ^c	17	6	56	419.4	0.0143
Metropolitan Group ^c	18	8	46	541.4	0.0148
New York Life Group ^c	19	1	3	63.5	0.0158
Stancorp Financial Group ^c	20	1	3	56.6	0.0177
Preferred Assurance Company, Inc. ⁿ	21	1	9	54.0	0.0185
HealthNow NY, Inc. ⁿ	22	26	72	1,373.6	0.0189
Prudential of America Group ^c	23	2	13	93.1	0.0215
CDPHP ^h	24	14	86	648.9	0.0216
AON Corporation ^c	25	6	36	266.3	0.0225
John Hancock Group ^c	26	4	8	171.3	0.0233
American Family Corp ^c	27	5	15	172.0	0.0291
Excellus Health Plan, Inc. ⁿ	28	104	391	3,433.5	0.0303

Insurer Categories

^h HMO

^c Commercial Insurer

ⁿ Non-profit Indemnity Insurer

¹The 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.

Note: Small insurers and small HMOs are not included. Please consult *Details About the Data* on page ii.



Overall Complaint Ranking

(continued)

Name	Rank ¹	Upheld Complaints by NYSID	Total Complaints to NYSID	Premium (Millions \$)	Overall Complaint Ratio
Protective Life Ins. Group ^c	29	2	28	62.8	0.0319
Excellus Health Plan, Inc. (HMO) ^h	30	31	128	847.6	0.0366
WellPoint Inc. ^c	31	202	772	5,261.0	0.0384
Oxford Health Ins. Inc. ^c	32	102	491	2,161.4	0.0472
Community Blue (Health Now) ^h	33	32	91	471.8	0.0678
Guardian Life Group ^c	34	34	131	495.1	0.0687
Empire Health Choice HMO, Inc. ^h	35	176	742	1,775.3	0.0991
CIGNA Health Group ^c	36	73	158	690.0	0.1058
Health Net of NY, Inc. ^h	37	66	301	465.0	0.1419
Oxford Health Plans of NY Inc. ^h	38	196	1,360	1,342.8	0.1460
Aetna Group ^c	39	200	594	1,248.1	0.1602
Health Net Inc. Group ^c	40	71	244	363.1	0.1955
Group Health Inc. (GHI) ^h	41	541	1,378	2,757.7	0.1962
HIP HMO ^h	42	488	1,170	2,351.9	0.2075
Aetna Health, Inc. ^h	43	137	548	635.9	0.2155
UnitedHealth Group ^c	44	559	1,170	1,298.9	0.4304
Atlantis Health Plan ^h	45	103	148	66.1	1.5584
GHI HMO Select, Inc. ^h	46	189	355	86.5	2.1853
TOTAL		3,398	10,743	33,891.4	Avg. = 0.1003

Insurer Categories

- ^h HMO
- ^c Commercial Insurer
- ^h Non-profit Indemnity Insurer

¹The 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.

Note: Small insurers and small HMOs are not included. Please consult *Details About the Data* on page ii.

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 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
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
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*)

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 6).

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
- **Child Health Plus:** Health insurance program for children 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
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 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 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

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 information about 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



Telephone Numbers for Health Insurers

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
Excelsus 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

Non-profit Indemnity Insurers	
Excelsus 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 ^a	
Aetna Group	860-273-0123
American Family Life	800-366-3436
American Int'l Group	877-800-8691
American Progressive	800-332-3377
AON Corporation	800-951-6206
CIGNA Health Group	800-244-6224
CNA Insurance Group (Encompass Insurance)	800-262-9262
First Rehabilitation Life Ins. Co. of America	800-365-4999
GE Global Group	800-844-6543
Guardian Life Insurance	888-482-7342
Health Net Insurance of NY	800-848-4747
Highmark Inc.	800-332-0366
John Hancock Mutual Life Ins. Company	800-732-5543
Mass Mutual Life Ins. Co.	800-272-2216
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
Protective Life Ins. Group	800-866-3555
Prudential Insurance Company of America	800-828-0153
Long Term Care Coverage	800-732-0416
Standard Life Ins. Co.	800-426-4332
Sun Life Assurance Co. of CN	800-786-5433
UnitedHealth Group	800-705-1691
UNUMProvident Life Group	800-858-6843
Wellpoint Inc.	800-261-5962
Zurich-American Insurance Companies	800-382-2150

^a Commercial insurers generally do not offer health insurance coverage to individuals.



