THE CONSUMERS' GUIDE TO NEW YORK'S MANAGED CARE

BILL OF RIGHTS

EDITION 2.1 SEPTEMBER 2001

This guide explains how to use the rights and protections that New York State grants health care consumers—laws that help improve your access to health care and help resolve problems with health insurance companies.

Not all rights apply to all plans; look for this symbol ☛ at the beginning of each section; it will tell you which type of health insurance plan each right applies to.

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YOUR RIGHT TO

Information About a Health Care Plan

All types of health insurance plans must provide specific information to every member and to anyone who is thinking about becoming a member. This information will help you decide if the plan will meet your needs. New York State law requires that plans put this information in the member handbook or in the member contract. Other information will be provided to you only if you request it.

☛ All plans must tell you, automatically:

- What the plan covers. This includes what benefits the plan will pay for, the dollar amount limits, and any other limits (both annually and over a lifetime) including the number of allowed visits that the plan will pay for; what they won't pay for, and how the plan defines "medical necessity". ***Plans will only pay for benefits considered to be medically necessary.***
- The requirements for prior authorization, that is, when a benefit must be approved by the plan for payment before you can receive it.
- The Utilization Review (UR) procedures, including the plan's toll-free number, how long it will take, your right to appeal the decision and how to appeal, your right to pick someone to represent you, your right to an external appeal, a description of the external appeal process including how long it will take (see UR and External appeal sections for details)
- The Grievance Procedures including the plan's toll-free number, how long it will take, your right to appeal the decision and how to appeal, your right to pick someone to represent you. (see Grievance section for details)
- What your costs for the health plan are, including co-payments, deductibles, care that is not covered or when you see a HCP who is not in the MCO's network.
- How to choose and how to change a HCP, and how to tell if a particular HCP is accepting new patients.
- How members of a health plan may participate in the plan's policy-making.
- How the plan meets the needs of people who have trouble communicating in English.
- How Emergency Care is covered.
- Descriptions of how MCOs pay HCPs for their services.
- The mailing addresses and phone numbers members need to get information about the plan or authorizations by the plan for benefits.

☛ Managed Care Organizations must also tell you:

- That you can get a referral to a provider outside the MCO's network, and how to get that referral, when your MCO's network doesn't include someone with the training and experience you need.
- That you can get a standing referral to a specialist if you need ongoing care from that specialist.
- That people with life-threatening or degenerative & disabling diseases or conditions who need special medical care over a long period of time may ask for a referral to a specialist who will then act as their PCP.
- That people with the health problems described above can be referred to a specialty care center.
- The names and addresses for all HCPs and facilities, such as hospitals, clinics and labs, that are in the plan's network.

☛ If you ask, all plans provide this information—<u>but only if you ask</u>:

- Whether the plan will pay for a certain drug. (You also have the right to inspect the list of drugs the plan will pay for, the formulary.)
- If you request it in writing, specific clinical review criteria for a particular condition or disease and how these criteria are used. The clinical review criteria are the guidelines a plan uses when approving benefits.
- What hospitals a HCP is affiliated with.
- Information about consumer complaints about the plan that have been filed with the New York State Department of Insurance and with the plan.
- The procedures the plan uses to decide whether drugs, devices or treatments in clinical trials are investigational or experimental.
- A list of the board of directors, officers, owners or partners.
- The most recent annual financial statement.
- The most recent direct pay (individual) subscriber contract.
- The procedures for protecting the confidentiality of information about members.
- Written procedures describing the plan's quality assurance program.

HEALTH CARE

Terms & Phrases

PLAN: Refers to any type of health insurance plan. This can be a standard insurance plan (known as indemnity or fee-for-service) or a managed care plan. In some cases, usually when your employer is a large company, a company has set up a health insurance plan of its own. These plans are called self-insured plans and fall under federal guidelines known as ERISA and are exempt from New York law. To find out if your plan is this type, check with your employer or union.

MCO: Managed Care Organization: A health insurance plan that uses primary care providers (PCP) and a specific list of health care providers (the plan's network) whose services are covered under the plan.

HCP: Health Care Provider: Any licensed health care professional. This term applies not only to doctors but also to nurses, social workers, etc.

PCP: Primary Care Provider: The health care professional who coordinates your health care needs if you are enrolled in an MCO.

BENEFIT: A medical service, test or treatment, a medical device or a prescription drug.

GRIEVANCE: A formal complaint or disagreement you or your Health Care Provider make with your MCO.

UTILIZATION REVIEW (or "UR"): The process used by plans to decide whether or not a benefit is "medically necessary."

YOUR RIGHT TO

Question a Decision Made by Your Plan

Whenever you have a problem or a disagreement with your plan about your health care or your coverage, you can file a formal complaint to get the plan to meet your needs.

There are different ways to file complaints. One process is called a "Grievance Procedure." If you are in a Managed Care Organization (MCO), New York State law has defined grievance procedures that all MCOs must follow. Other types of plans have developed their own grievance procedures that are described in the plan's member materials.

The other process for filing a complaint is called a "Utilization Review" (UR). New York State law has defined procedures that all health insurance plans, including MCOs, must follow.

Which process you use depends on what type of plan you're in, what kind of problem you have, the reason your plan used in denying you coverage, and whether you're on Medicare or Medicaid *(if you are receiving Medicare or Medicaid, see pages 8-10)*.

By law, many of the complaints consumers have are handled by processes that are internal to the individual plan. That is, the plan itself decides whether to cover a treatment, test or referral—and the plan also has the final say if you appeal their decision. In these instances the plan is judge and jury.

But, there are certain types of health plan decisions that New Yorkers are able to appeal to an independent, external reviewer. *See page 7 for details.*

You should *always* file a complaint if you have a problem or disagreement with your plan. Plans do reconsider—and each reconsideration is done by different staff people within the plan. The more determined you are, the more likely it is that your problem will be resolved in your favor. Remember, the squeaky wheel gets the grease.

Also, if your disagreement fits the guidelines for an external appeal, you will need to go through the plan's internal process first before you can go to someone outside your plan to review the decision.

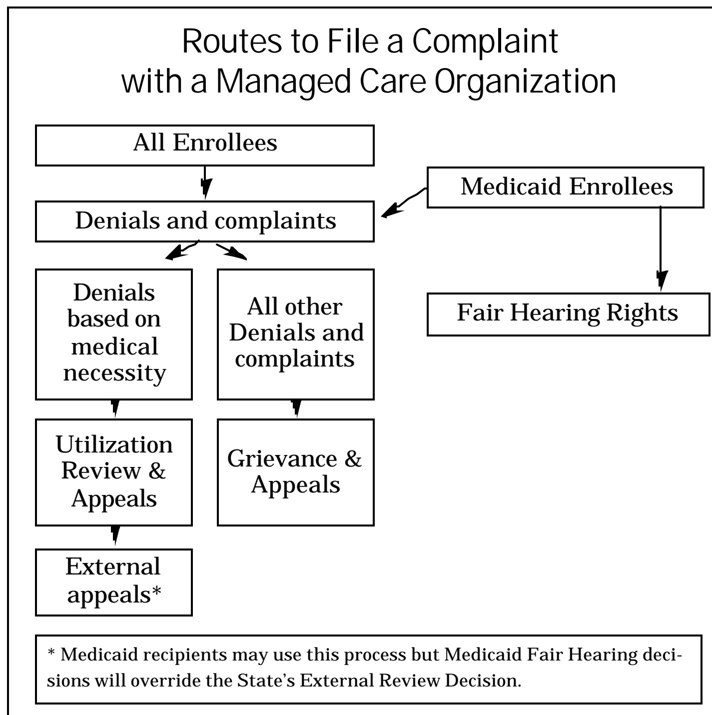
Keep in mind, you can always, at any point, file a complaint about your plan with the State agencies below:

For any problem related to the quality of your health care, such as not being able to get a referral to care you need, contact the ***State Department of Health Managed Care Hot-Line at 800-206-8125*** or write to: New York State Department of Health, Bureau of Managed Care, Complaint Unit, Room 1911, Corning Tower, Empire State Plaza, Albany, NY 12237.

For problems related to payments for benefits, contact the ***State Insurance Department*** by calling their ***Consumer Services Bureau at 800-342-3736*** or write to: New York State Insurance Department, Consumer Service Bureau, 25 Beaver St., New York, NY 10004.

For problems where you think a law has been broken or fraud might be involved, contact the ***Attorney General's Health Care Bureau at 1-800-771-7755.***

If you receive your health insurance through your employer, it's a good idea to tell the Personnel or Employee Benefits Dept. whenever you have a problem with your plan. They can be your best ally because they represent all the company's employees enrolled in the plan. As a result, your employer probably has more leverage with your plan than you have.



YOUR RIGHT TO

Emergency Room Care

☛ Applies to <u>all types</u> of health insurance plans.

You don't need approval from your PCP or your plan before you go to the emergency room if:

Your symptoms start suddenly, and are so severe or painful that a "prudent layperson" (a thoughtful, ordinary person) with an average knowledge of medicine and health, could expect that not getting immediate medical attention would cause serious health problems or damage to your body.

For example, if you have severe chest pain and you go to the emergency room because you think you are having a heart attack, even if you are only diagnosed with serious indigestion, the plan must pay for your emergency room visit.

In the case of mental health problems: if you or someone else, again, acting as a "prudent layperson," thinks you would harm yourself or someone else.

Filing a Grievance

☛ Available to members of managed care organizations only.

Anytime you have a complaint or a problem with your MCO you have a grievance and can file a formal grievance to get your MCO to change its decision. Grievances can be about anything, for example, if you think you had to wait too long to get an appointment with a HCP or if you feel you were treated badly by a HCP. The grievance procedures are used in cases where the MCO decides that your complaint or problem is not a question of medical necessity. The law sets up the way your MCO must handle your grievance.

Your MCO must tell you how to file a grievance any time it denies a request for a referral or decides that it won't pay for a service or treatment that you or your HCP asked for. It must also tell you how to file a grievance in its member handbook. If the denial is based on medical necessity, your MCO must tell you how to use the UR procedures. *(See page 5)*

When an MCO refuses to pay for care or denies you a referral that you and/or your HCP feel you need, the MCO must tell you how to file a grievance. This is called ***A Notice of Grievance***. It has to include:

- A description of the grievance process.
- How to file a grievance.
- How long each part of the grievance process takes.
- Your right to pick someone to help you (your representative).
- How to use the grievance process if you have trouble communicating in English.

You can file your grievance by telephone when:

- Your MCO or your HCP denies you a referral to a treatment, test or service you and/or your HCP think you need: for example, a referral to a specialist.
- Your MCO decides it won't pay for a benefit you think it should pay for.

For these types of grievances, your MCO must have a toll-free grievance phone number, answered by real people, 5 days a week, during normal business hours. After hours, the MCO must have a way for you to leave a message (voice mail, answering machine, etc.) and the MCO must return your call within 1 business day. For example, if you leave a message on Wednesday night, the MCO has to call you back on Thursday.

Your MCO may ask you to sign a written acknowledgment of your grievance which the MCO sends you. The acknowledgment will describe your complaint. You should read this carefully and change your MCO's description of your complaint if it's not accurate. Your MCO will not start to process your complaint until you sign and return this acknowledgment unless waiting for you to return the acknowledgment would increase the risk to your health.

Some grievances must be filed in writing:

Other than denials of referrals or benefits, your MCO may ask you to file a grievance in writing; for example, if you are complaining about the length of time you had to wait to get an appointment with a HCP. In these cases, your MCO will ask you either to write a letter or to fill out a form that the MCO will supply. After your MCO receives your letter or completed form, your MCO must tell you what information they need in order to make a decision.

How the grievance process works:

Your MCO must send you a written notice that they received your grievance ***within 15 days*** of the date they received it. This notice must include the name, address and phone number of the person(s) or department that will make the decision about your grievance. The decision will be made by one or more qualified people who work for your MCO. If your grievance involves a health question, one of these people must be a licensed, certified or registered health care professional.

How long does the decision process take?

Within 48 hours after you call and reported your grievance by phone, and after the receipt of all necessary information, if a delay in their decision would significantly increase the risk to your health, the MCO must call you on the phone with their decision. Your MCO has to follow that up in writing within 3 business days. This is called an expedited decision.

Within 30 days after you returned the signed acknowledgment your MCO provided and all necessary information has been supplied, when a delay would not increase the risk to your health and your grievance is about the MCO denying you a referral or refusing to pay for a benefit.

Within 45 days in writing in all other cases, such as billing problems.

The MCO's written decision about your complaint is called a Grievance Determination. It must include:

- The reasons for the decision.
- If it's a medical matter, the medical basis for the decision.
- How to appeal if you disagree.
- The forms you'll need to file an appeal.

BASIC RULES

When you have a complaint

☛ Whenever you have a problem or file a complaint, keep written records of:

NAMES AND PHONE NUMBERS of the people you contacted and the date you contacted each of those people.

WHAT HAPPENED DURING THE CONVERSATION: what steps that person said they would take; what steps you took.

COPIES OF ALL PAPERS, notices or letters, with dates on them, that you sent or that were sent to you.

You have the right to appeal a Grievance Determination

You can appeal your MCO's decision. Don't give up! Sometimes MCOs change a decision because a person has shown how seriously she/he takes the problem by filing an appeal.

Your MCO must give you at least ***60 days*** to appeal. All appeals are in writing (by letter or by a form the MCO supplies); you cannot appeal orally.

Once you send your MCO an appeal, your MCO has 15 days to send you a written acknowledgment that the MCO received your appeal. This written acknowledgment must include:

- The name, address and phone number of the person(s) deciding your appeal. This cannot be the same person who decided your grievance. In health questions, this person or people must be health care professionals, including at least one person who has expertise in that particular health field. If it's not a health question, then the appeal person has to be a higher level staff person than the one who originally decided against you.
- Any other information the MCO needs to make its decision.

How long does the appeal process take?

Within 2 business days the MCO must tell you its decision, if a delay would significantly increase the risk to your health.

Within 30 days in writing, in all other cases.

The MCOs written decision about your appeal is called an Appeals Notice. It must include the reasons for the decision, and, if it's a medical matter, the medical basis for the decision.

Your right to complain to New York State:

At any time, before, during or after you have gone through your MCO's grievance and appeals processes, you can file a complaint with the *State Department of Health Managed Care Hot-Line: 800-206-8125* for complaints about the quality of your care or with the *State Insurance Department Consumer Services Bureau: 800-342-3736* for problems about payment for benefits or with the *Attorney General's Health Care Bureau: 1-800-771-7755.*

Remember, you can file a complaint with the Department of Health, the Insurance Department or the Attorney General's Health Care Bureau at any point in the processes described in this guide and anytime you have a problem with your plan.

Tell your MCO that you know you can file a complaint with the State. This may encourage your MCO to consider your appeal carefully. The law says that MCOs cannot punish you or your HCP or anyone who advocates for you for filing a grievance or an appeal.

Records of grievances

Your MCO must keep a record of every grievance filed, including: the dates grievances and appeals were filed, the decisions and the dates they were made, the titles of the people who made the decisions and their credentials.

MCOs must report yearly to the State Health Department the number of grievances each has dealt with. In these reports information must be kept confidential that might identify you.

Every year The New York State Insurance Department compiles a report on complaints made about health insurance plans called The Annual Health Insurance Complaint Rankings. You can get a copy from: The New York State Insurance Department, Office of Public Affairs, 160 Broadway, New York, NY 10013, 212-602-0428.

If you request it, your MCO must tell you how many grievances it has received each year. It must also tell you how many of the grievances it decided in the enrollees favor. The number of grievances filed with an MCO can help you decide which MCO you may want to join.

Utilization Review

☛ Available to members of all health plans.

These are the procedures all plans, no matter what type, use to determine whether to allow a benefit, treatment or referral that you or your HCP requests based on whether that benefit, treatment or referral is medically necessary. If the plan denies a benefit, treatment or referral because the plan says it is not medically necessary, you have the right to question the plan's decision through the UR appeal process. The plan must tell you how to file a UR appeal when they make this kind of decision. The plan's UR procedures must also be described in your member handbook or contract.

The medical director, a licensed physician, must supervise and oversee the UR process. The details of the plan's procedures must be filed with the State Health Department and available to you and to your HCPs.

How to use the Utilization Review Process:

Your health plan must have a toll free phone number, answered by real people, at least 5 days a week, during normal business hours. After hours, the plan must have a way for you to leave a message (voice mail, answering machine, etc.) and the plan must return your call within 1 business day. For example, if you leave a message on Friday night, the plan has to call you back on Monday.

If your HCP wants to extend your stay in a hospital or specialty care center (for example, a cancer institute or rehabilitation center) she/he must be able to contact a UR person at the plan for approval 24 hours a day, 7 days a week.

Who performs the Utilization Review (UR)?

The law says that people who are trained in intake and trained to collect information and who are supervised by a licensed HCP can take an initial request for UR. If the UR approves your or your HCP's request, that decision can be made by a licensed HCP.

But, if the plan denies your or your HCP's request, which is known as an adverse determination, then that decision must be made by a physician, or, if the request was made by another type of HCP, the decision must be made by a licensed HCP who is in the same or similar field as the provider who requested the benefit. For example, if the request was made by a social worker, the adverse determination must be made by a social worker at the plan or by a physician. Physicians can always make adverse determinations.

How long does the UR process take?

After the plan receives all the information it needs to make a decision, it has to let you or your representative, (your representative can be your HCP), and your HCP know the plan's decision:

- ***Within 1 business day*** by phone and then in writing if it's for services that you are already receiving and you or your HCP feels you need to continue (for example, more days in the hospital). When your plan lets you and your HCP know, the plan must tell both of you how many more services the plan approved, if any, (for instance, the number of added days in the hospital), the new total of services approved, the date these services begin and the next date that the plan will review whether these services continue to be medically necessary.
- ***Within 3 business days***, after the plan has received all necessary information and then in writing, if it concerns pre-approving a benefit or referral.
- ***Within 30 days*** when it's a decision about a benefit that you've already received: for example, your doctor did a procedure and the plan later decides it won't pay for it because the UR decides it was not medically necessary.

If the plan doesn't respond to the request in the time frames listed above, the plan will be considered to have denied the benefit, treatment or referral (an adverse determination) and you can immediately appeal this denial to the plan.

What happens in an Adverse Determination?

Your health plan's decision to deny a benefit that you or your provider requested because the plan says it is not medically necessary is called an adverse determination. In adverse determinations the plan must send you a ***Notice of Denial***. It must be in writing and include:

- The reasons with the medical explanation, if any;
- That you and your representative can request the clinical review criteria (medical standards) the plan used to make that decision;
- How to appeal the decision and what information the plan needs for your appeal;
- Your right to an external appeal.

Reconsideration of Adverse Determinations

If the UR staff at the plan made their decision without talking it over with the HCP who recommended your benefit or referral, the HCP can request that the plan reconsider its decision:

Within 1 business day, the HCP who requested the benefit, treatment or referral and the UR person who made the original decision must discuss it. After the discussion, the UR person must notify the HCP of his/her decision.

You and your provider have the right to appeal an Adverse Determination.

All appeals will be handled by a plan staff person who did not make the original decision. If a doctor requested the benefit that was denied, the plan staff person who handles your appeal must be a doctor in the same or similar specialty. There are two kinds of appeals, expedited and standard.

How long does the Expedited Appeal process take?

An appeal can be decided quickly where the request is for continued or extended services (for example, more days in the hospital) or for more services for someone having ongoing treatment (for example, more rehabilitation therapy after a stroke).

An expedited appeal is also allowed in any situation where your provider believes it is necessary. But there are no expedited appeals for benefits that you have already received.

- ***Within 1 business day*** after the UR people at your plan receive an expedited appeal, you or your representative and your HCP must be able to get in touch with a UR staff person who has the qualifications described above.
- ***Within 2 business days***, after the plan receives all necessary information, a decision must be made.

If, after an expedited appeal, the plan makes an adverse determination and denies what you or your HCP wanted, you can request an external appeal.

How long will a Standard Appeal take?

You have at least ***45 days*** after the plan notifies you of an adverse determination and you've been given all the information you need to file an appeal. It is up to the plan to decide if you have to appeal in writing or by phone.

- ***Within 15 days*** after you file your appeal, the plan has to send you a written acknowledgment of the appeal.
- ***Within 60 days***, after the plan receives all the necessary information, the plan must make a decision.
- ***Within 2 business days*** after making their decision, the plan must let you, your representative, and your HCP (when that's appropriate) know their decision.

The notice of the decision about either your expedited or standard appeal must include the reasons and, when an adverse determination is upheld, the medical explanation. It must also include your right to file an external appeal, how to request an external appeal from the State Insurance Dept., including the forms you and your provider must submit to the Insurance Department, the Insurance Department's toll-free number, a description of the external appeal process, including how long the process will take.

If the plan fails to respond to your appeal within the time frames listed above, the plan's decision to deny coverage is reversed.

YOUR RIGHT TO

An External Appeal

New York State law allows consumers to file an external appeal when a health care plan denies some types of health services.

The external appeal will be conducted by health care professionals who have no connection to your plan, your health care provider or the health care facility involved in your care. The external appeal agent's decision will be binding.

Consumers will be able to request an external appeal if:

- Your plan denies any part of a benefit because the plan says it is not medically necessary; or
- Your plan denies a benefit because the plan says it is experimental; or
- Your plan denies a benefit because it is a clinical trial.

Providers will be able to request this external appeal when the plan denies payment for a service already provided (retrospective review) because the plan says it was not medically necessary.

To be able to use the external appeal process:

- You or your provider (where this applies) must have gone through the internal appeals procedure and received a denial, called a final adverse determination, or;
- You and the plan have agreed to waive the internal appeals procedure.

You must request an external appeal from the State Insurance Department in writing:

Within 45 days of the date of the final adverse determination you receive, or when you and your plan agree to waive the internal appeal process.

When your plan sends you a final adverse determination, the plan will send you information from the State that describes the external appeal process, including the forms you and your provider must send to the Insurance Dept. to request an external appeal and the fee, if any, you must pay to start this process. You must pay the fee and send in the forms within 45 days of receiving your plan's final adverse determination.

If you do not receive the information or forms or you have questions about the external appeal process, including whether you are eligible, ***call the Insurance Dept. at 800-400-8882.***

Within 45 days of receiving the final adverse determination from your plan, you or your provider can submit any information to document your case. If the information you or your provider submits is substantially different from the information the plan had when it made its decision, the plan has 3 days to reconsider its decision.

There are 2 kinds of appeals, expedited and standard.

How long will a standard appeal take?

- ***Within 30 days*** the independent reviewer will make a decision. You and your plan will be notified within 2 business days of the decision being made.
- ***Five additional days***, if the reviewer needs additional information.

In some cases the appeal can be expedited:

- The review will be completed in ***3 days*** if your doctor states that a delay would pose an imminent or serious threat to your health. Every reasonable effort will be made to notify you and your plan of the decision immediately by telephone or fax. This will be followed immediately by a written notice.

What criteria will the external reviewer use in making the decision about medical necessity?

The law says that the decision will be based on ***whether the plan acted reasonably, with sound medical judgment and in your best interest***. Reviewers will take the following into consideration when making their decisions:

- The plan's clinical standards;
- Information provided concerning your health condition;
- Your attending doctor's recommendation;
- Generally accepted practice guidelines of government health agencies, national and professional medical societies, boards and associations.

How do I qualify for a external review based on a denial because the plan says the benefit is experimental or investigational?

An external appeal may be filed when any treatment or medical service is denied because the plan says it is "experimental or investigational." This includes participating in a clinical trial and access to an "off label drug," a medication that has been approved by the FDA for one condition, but not for the condition for which you are filing the appeal. To qualify your doctor must certify that:

- You have a life-threatening or disabling condition or disease. (A disabling disease or condition means, in this case, that your illness must match the definition of "disabled person" in the social service law; generally, a condition which prevents you from working) AND,
- Standard medical services have been ineffective or would be medically inappropriate OR,
- There isn't a more beneficial treatment covered by your plan OR,
- There is a clinical trial available to you.

Your doctor must also recommend this treatment or clinical trial and give his or her reasons including 2 documents from available medical and scientific evidence or that the proposed benefit is a clinical trial.

The external reviewers will approve experimental or investigational treatments based on:

- The scientific and medical evidence that the treatment proposed is likely to be more beneficial than any standard treatment OR,
- The reviewer confirms that the proposed treatment is a clinical trial that is likely to benefit you.

Notice of the decision will include the reason for the decision and, where the plan's final adverse determination is upheld, the clinical rationale. The decision will:

- Be binding on both you and your plan (unless you or the plan decide to go to court),
- Not expand your covered benefits or change your plan's rules (e.g. prior-authorization, reimbursement rates) as described in your contract, and
- Be admissible in court.

Will the External Appeal cost me anything?

You may be asked by your plan to pay $50 to file an external appeal. You must send a check, made out to your health plan, to the State Insurance Department ***within 45 days*** of receiving the final adverse determination. This check will be returned to you if the external appeal is in your favor. You will not be charged the $50 if you are on Medicaid, Child Health Plus or cannot afford to pay.

If You are on Medicaid

Medicaid recipients may use this external appeal process, but the decisions of Medicaid Fair Hearings (*see page 10*) will override the decisions of this State external appeal.

How do I Apply for an External Appeal?

The external appeals must be in writing according to procedures developed by New York State on a form approved by New York State. To find out how to file an external appeal, consumers should call the ***State Insurance Department (800-400-8882) or visit their website at www.ins.state.ny.us.***

If you have a question about whether you can file an external appeal, contact the State Insurance Department. The Insurance Dept. will randomly assign your case to an external review agent. The agent will have a phone line available 24 hours a day to handle questions about your external appeals.

YOUR RIGHT TO

File a Grievance or an Appeal if You Are in a Medicare HMO

If you are on Medicare and enroll in a managed care organization, your MCO must provide all the services you are entitled to under Medicare. Medicare, under Federal law, requires MCOs to follow defined grievance and appeal procedures that differ from grievance and appeal procedures in other types of MCOs.

Medicare Grievances:

If you are questioning a MCO denial of health care you need or payment for health care you've received, you should always file an appeal. You can file a grievance for other kinds of complaints or problems with your MCO. Grievances can be about anything other than a denial of health care or payment for services. For example, if you think you had to wait too long to get an appointment with a provider or if you feel you were treated badly by a provider you should file a grievance. Each MCO sets its own procedures for handling your grievance. Read your member handbook to find out your MCO's procedures. Grievances are not reviewed by any agency outside the MCO, so it's important to file an appeal if you need medical coverage.

Medicare Appeals:

Medicare has both standard and expedited appeal procedures. The expedited procedures will allow you, in some cases, to get a decision quickly.

In both expedited and standard procedures, your appeal is reviewed first byby the MCO. After your appeal has been reviewed internally by your MCO, if you still don't get everything you asked for, your appeal will automatically be reviewed by the Center for Health Dispute Resolution (CHDR). CHDR is a private company that contracts with Medicare to review all MCO appeals.

Here are the Medicare rules for resolving appeals:

When your appeal is about your MCO denying any type of Medicare or HMO-covered benefit or service, or for payment of a Medicare covered service, whether you received the care within or outside your MCO because your MCO refused to provide it, the appeal can be resolved through the following two processes:

Expedited Medicare review:

You can get a quick MCO decision about a MCO denial of care within 72 hours if your health or ability to function at a maximum level could be seriously harmed by waiting for a standard decision.

Ask your doctor to request or support your expedited decision. Your doctor can do this by telephone. If your doctor makes the request or supports your request, the MCO must expedite the decision.

You or your representative can also make the request for an expedited review in writing or orally over the telephone, without support from your doctor or other HCP. In this situation the MCO will decide whether your condition calls for an expedited decision. If the MCO decides not to expedite your case, the MCO must notify you and give you a written explanation of the reasons for its decision. Your case will then be decided in the standard time frame. You can file a Medicare grievance about the denial of an expedited appeal, but don't forget that it is an internal MCO procedure. Medicare grievances differ from the grievance procedures described on page 4 of this Guide. (*Contact the organizations listed in the box at right for help with Medicare grievances and appeals.*)

For more information about Medicare & MCOs, contact:

- The Medicare Rights Center: 800-333-4114 (Monday through Thursday, 9 a.m.-2 p.m.).
- New York StateWide Senior Action Council, Patient's Rights Hotline: 800-333-4374 or 212-316-9393.
- The Department of Health Managed Care Hotline: 800-206-8125.
- The New York State Office for the Aging: 800-342-9871 or 518-474-5731.
- Your local Office for the Aging.

If the MCO expedites your review, it must inform you of its decision by phone within 72 hours of receiving the request. Within two working days of making their decision, the MCO must follow-up the phone call with a letter.

If the request for an expedited decision is from a HCP who is not in the MCO's network, then the 72 hour rule begins after the HCP has supplied all the medical information necessary for the MCO to make a decision. The MCO has to let you know within 72 hours of the request if the HCP has not supplied the needed information.

The 72 hour deadline for making a decision can be extended for 10 working days in the following cases:

- When a delay would benefit you. (for example, for more tests or a consultation).
- If you request a delay (for example, to gather information).

If the MCO denies the requested care, the MCO must automatically forward your case within 24 hours of making the decision to CHDR. CHDR will then make an expedited decision in the same time frames described above.

As with standard Medicare appeals, if CHDR agrees with your MCO to deny the requested care, you are entitled to an ALJ hearing. ALJ hearings can take a year to schedule, making them less useful in situations where you need care quickly.

Standard Medicare review:

If you do not qualify for an expedited Medicare review, you may use the regular Medicare review process, as follows:

You must first appeal the decision through the MCO's appeals procedures. If you are appealing a denial of care, the MCO must make a decision within 30 days; if you are appealing a denial of payment for care already received, the HMO must make a decision within 60 days. Then, if your MCO still denies the benefit, referral or payment, the MCO must automatically forward your complaint or disagreement to the CHDR.

CHDR will review the MCO's decision and issue a ruling within the same time frames listed above. If CHDR agrees with your MCO to deny the health care or payment for the care, you can appeal further by requesting an Administrative Law Judge Hearing (ALJ). You must request a hearing within 60 days after you receive the CHDR decision. Usually, you must appear in person for this hearing. ALJs often take 1 year to schedule.

Medicare rules take precedence over New York State law. *Contact the organizations listed on page 8* for possible changes to the procedures described in this Guide or if you have other questions about Medicare and managed care.

For people on Medicare, please remember, once you join an MCO, you can no longer get your health care through fee-for-service Medicare. For the time being, you can disenroll (drop out of) any Medicare MCO at any time and return to fee-for-service Medicare.

YOUR RIGHTS IF YOU RECEIVE Medicaid

☛ New York State law requires many people who receive Medicaid to enroll in an MCO. In some areas of the state, people on Medicaid will be required to join MCOs. Some people will not be required to join MCOs.

For some people on Medicaid, joining an MCO is voluntary:

- You live in an area where there are not at least 2 MCOs.
- You are in a residential alcohol/substance abuse treatment facility.
- Most people with mental retardation or developmental disabilities (contact your local ARC or UCP for specifics).
- You are disabled and in a special home care waiver program.
- You are a Native American.
- You receive both Medicaid and Medicare.
- You have a chronic medical condition and are receiving ongoing care from a specialist who is not in any Medicaid MCOs' network.
- You have HIV/AIDS.
- You receive SSI.
- You are homeless.
- You are an adult or child with serious mental illness.
- If plans can't provide a PCP who speaks your language.
- If there are no PCPs within 30 minutes travel from your home.
- For good cause.

Some groups of Medicaid recipients will not be able to join MCOs:

- You receive care through a Long-Term Home Health Care Program.
- You are in a state psychiatric facility or residential facility for children.
- You are in a nursing home or hospice facility.
- You are expected to be Medicaid eligible for less than six months.
- Foster Children.

Contact the organizations listed at the end of this section for up-to-date information—the categories of people who either may or may not join an MCO could change over the next year.

If you join a Medicaid MCO, hold on to your Medicaid card. You will need it to get prescription drugs, medical supplies, over-the-counter medications when a doctor prescribes them and certain other benefits which may include family planning, transportation and dental care.

For people with HIV who receive Medicaid:

Currently Medicaid recipients with HIV and their children are not required to enroll in MCOs. Soon there will be Special Needs Plans (SNPs) in some parts of the State for people with HIV. SNPs will have to provide comprehensive services for HIV. If there is an HIV SNP in your part of the State, you and your children will have to choose between an HIV Special Needs Plan (SNP) and a regular Medicaid MCO. If you live in a part of the State where there are no HIV SNPs, you won't have to join a Medicaid managed care plan.

If you do enroll in a Medicaid MCO SNP you have the same rights that all consumers have as described in this guide.

For More Information about HIV SNPs contact:
- NYS AIDS Coalition: 518-426-2396
- NYS Department of Health AIDS Institute: 518-486-1383.

People on Medicaid who are enrolled in MCOs have the same rights as all consumers under the Managed Care Consumer's Bill of Rights described in this guide.

In addition, there are other rules that apply to people on Medicaid enrolled in MCOs:
- You have the right to change your MCO.
- The rules for when and how often you can switch from one MCO to another vary based on where you live and whether you picked a plan or were assigned to one. Contact the organizations listed at the end of this section to find out which time frames apply to you.

You have the right to change your PCP:
- ***Within 30 days*** of your first visit with that PCP. However, most MCOs let you change your PCP whenever you want to.
- After that initial time period, only once every 6 months.

You have the right to see your HCP within 1 hour of your scheduled appointment time.

Medicaid MCOs cannot discriminate against you because of your health problems or disabilities, or because you are on Medicaid. Also, MCOs can not discriminate against you for filing complaints or grievances.

Your Right to Information: Along with the information that MCOs must give all consumers in the member handbook or member contract, MCOs that serve people on Medicaid must also provide the following information to Medicaid recipients:
- How the plan addresses the needs of people who are visually or hearing impaired.
- Notice of your right to a Medicaid Fair Hearing and to Aid Continuing whenever a health service or benefit is denied.
- For women, notice of your right to self-refer for women's health needs, at no additional cost to you, to any women's health care provider of your choice whether that HCP is in your MCO's network or outside that network.

Your right to a health care provider who will meet your needs:
The Commissioner of Health has established specific standards that Medicaid MCOs must meet.These standards are included in the contracts Medicaid MCOs sign with the Department of Social Services. These standards spell out acceptable:
- Ratios of HCPs to patients.
- Travel distances and travel times to HCPs.
- Waiting times to get an appointment or a referral to an HCP.

Medicaid managed care consumer complaint rights:

People on Medicaid have the same rights as other consumers as outlined in the sections on Grievance Procedures and Utilization Review. In addition, people receiving Medicaid have the right to have their complaints resolved through the Medicaid Fair Hearing process which is external to all health insurance plans. When you request a Fair Hearing you can request Aid Continuing, that is, that ongoing care continue during the Fair Hearing process.

Here is how the process works:
- Your MCO notifies you that a Medicaid service or benefit has been denied, suspended or discontinued.
- You have 60 days to request a Fair Hearing, but
- If you want Aid Continuing you must request a Fair Hearing within 10 days of the date on the notice from your MCO. If you do not get a written notice, you can get Aid Continuing at any time.

Request a Fair Hearing even if you think that your MCO made a mistake. You can always cancel your request later if your complaint is resolved to your satisfaction before the hearing date. Most Medicaid notices say you can request a conference or a hearing. Always request a hearing, because you can only get Aid Continuing if you request a hearing.
To ask for a Fair Hearing contact:
NYS Dept. of Health,
PO Box 1930, Albany, NY 12201,
518-474-8781 or 212-417-6550.

If you are disabled or too ill to attend a Fair Hearing, you can request a home hearing. The Department of Health (DOH) will schedule either:
- A hearing that your representative attends, or
- A telephone hearing, or
- A paper hearing.

You get to choose which type of hearing.If you don't get everything you asked for from that hearing, DOH will automatically schedule a home hearing in your home with Aid Continuing.

For More Information About Medicaid & MCOs contact:
- Dept. of Health Managed Care Hotline: 800-206-8125
- Legal Aid Society's Health Law Unit, 212-577-3575, TTY/TDD 212-577-3581, or upstate call toll free: 888-500-2455
- New York Legal Assistance Group: 212-750-0800, ext. 153
- NYC Managed Care Helpline: 800-505-5678
- Greater Upstate Law Project: 800-724-0490
- Community Service Society Helpline: 212-614-5400
- Legal Action Center (for questions about alcohol and drug treatment): 800-299-4121.
- Your local legal services or legal aid office.

A WOMAN'S RIGHT TO

Women's Health Care Services

☛ Applies to Managed Care Organizations only.

Any woman enrolled in an MCO can self-refer, that is, make appointments without a referral from a PCP or the MCO, 2 times a year to any ob/gyn in the MCO's network, for routine women's health care. In addition, an enrollee can self-refer for:

- Any ob/gyn care related to pregnancy
- Preventive and primary ob/gyn services to deal with a health problem found during an ob/gyn visit.
- Treatment of an acute gynecological condition.

The plan may not charge you any more for these services than would be normally charged if the plan made the referral.

For women in Medicaid MCOs:

Your MCO must let you know that at no additional cost to you, you have the same rights as all female consumers in MCOs, plus you can go to any women's health care provider you choose, even if that provider is outside the plan's network, for:

- All types of birth control.
- Sterilization.
- Testing and treatment for sexually transmitted diseases(STDs).
- Testing for women's health problems including anemia, cervical cancer, hypertension, breast disease, pregnancy and pelvic problems.
- Abortions.
- Education and counseling related to the list above.
- HIV testing; pre-test and post-test counseling when it is part of a regular women's health services visit.

If your MCO cannot provide you with a women's health service, they must tell you where you can go to get this service at no extra cost to you.

YOUR RIGHT TO

Information From Your Health Care Provider

☛ Applies to all health plans.

If you request it, a HCP must give you information about her/his qualifications, training and experience.
A health plan cannot punish or forbid a HCP from:

- Fully informing you or your representative of all the treatments, therapies, consultations or tests that apply to your condition or disease, even if your plan does not cover them.
- Explaining how the plan's requirements and limitations affect you.
- Advocating on your behalf.
- Reporting to the State a plan's practices that the HCP believes has affected the quality of health care.

YOUR RIGHT TO

A Doctor or Health Care Provider Who Will meet Your Needs

☛ Applies to Managed Care Organizations only.

Your Right to an MCO With Enough Health Care Providers:

- MCOs must have enough HCPs within a reasonable distance from where its members live to meet the members' needs.
- Every member must have a choice of at least three (3) PCPs, primary care providers.

The Health Commissioner must look at the following to decide if the MCO can meet the needs of the people it says it wants to serve:

- The requirements in the Americans with Disability Act,
- Whether an MCO is able to meet the needs of people who have trouble communicating in English or are from different cultures, and
- Complaints about waiting times to get appointments or referrals to HCPs.

Your right to specialty care:

■ ***Out-of-network referrals:***
If your MCO, consulting with your primary care provider, decides that the MCO doesn't have a provider in their network with the training and experience you need, the MCO must refer you out of their network at no extra charge to you. This decision must be part of a treatment plan approved by the MCO.

■ ***Standing Referrals to Specialists:***
If the MCO, consulting with your PCP and your specialist, decides that you need ongoing care from that specialist, you can get a series of referrals at one time so you don't have to go back and get a new referral from your PCP each time you need to see the specialist. This is called a standing referral.

For people with life-threatening or disabling & degenerative diseases or conditions:
If you need specialized medical care over a long period of time, you can, at no extra cost to you:

- Get a referral to a specialist who will then act as your PCP and coordinate your care.
- Get a referral to a specialty care center (such as a cancer institute).

Either of these must be part of a treatment plan that your MCO has approved after consulting with you, your specialist, your PCP, and the MCO's medical director.

Your right to continue to see your current health care provider

When you join an MCO, if you are getting ongoing treatment from a provider who is not in that MCO's network, the MCO must pay for you to continue seeing your provider, as long as your provider meets the MCO's requirements and agrees to their payment rates, in the following 2 cases only:

- If you have a life threatening or disabling & degenerative disease AND you are undergoing a course of treatment for it, you can continue to see your current provider for ***up to 60 days***.
- If you are in the second or third trimester of pregnancy, you can continue seeing your current HCP through your delivery and for a period of time after your delivery, ***usually 60 days***.

When your HCP leaves the plan if you are getting ongoing treatment from that provider, the MCO must pay for you to continue seeing that provider, (except if the HCP has left or been dismissed for fraud, imminent harm to patient care or State sanctions), as long as your provider meets the MCO's requirements and agrees to their payment rates, for:

- ***Up to 90 days*** after you've been notified that your provider is no longer in the plan
- If you are in the second or third trimester of pregnancy, through your delivery and for a period of time after your delivery, ***usually 60 days***.

YOUR RIGHT TO

Preventive Care for Your Children

☛ Applies to all types of plans.

There are no co-payments allowed for immunizations or any other preventive health services for children under 19 years old.

If your children have no health insurance, you may be eligible for a New York State program called Child Health Plus which provides health insurance coverage for children through age 18. For more information call 1-800-698-4KIDS.

YOUR RIGHTS FOR THOSE

With Serious or Chronic Conditions

☛ Applies to all types of plans.

Because of your special health care needs, there are certain parts of this law that you should pay close attention to.

For enrollees or people thinking about enrolling in any plan, you may want to investigate the following information a plan must give you if you request it:

- Whether the plan will pay for a certain drug, and the right to inspect the list of drugs the plan will pay for, known as the formulary.
- A description of the procedures the plan follows to decide whether drugs, devices or treatments are experimental or investigational. Plans may not cover these so you may want to find out exactly what the plan will and won't cover. But, even if a plan decides not to cover a benefit, you may be able to get coverage through New York State's external appeal process. *Read that section on pages 7-8 carefully.*
- The clinical review criteria for a particular condition or disease and a description of how the plan uses that criteria to decide what benefits and referrals are covered. The plan must also tell you what other types of clinical information the plan might review in making a decision.
- The hospital affiliations of particular health care providers.
- Benefit limits and prior authorization requirements; this information must be given to you without your requesting it.

Also, you can ask any licensed HCP to provide you with information on her or his qualifications, training and experience, including participation in continuing education programs. This information will help you decide if a particular HCP can meet your needs.

Read over the section in this Guide called, "Your Right to an External Appeal" on pages 7 and 8. If your plan denies you needed care because the plan says it is not medically necessary or because the plan says it is experimental/investigational or a clinical trial, you can ask the State for an external appeal. These appeals will be decided by independent, external reviewers with medical expertise who may overturn your plan's decision.

☛ Applies only to Managed Care Organizations.

See pages 11-12 for an explanation of your right to:

- Out-of-network referrals;
- Standing referrals to specialists;
- Having a specialist act as your PCP or getting a referral to a specialty care center if you have a life-threatening or disabling and degenerative disease or condition.

Your Right to Continue Seeing your Current HCP:
See pages 11 and 12 of this guide for an explanation of your rights when you enroll in an MCO or when your provider leaves your MCO.

YOUR RIGHT TO

Purchase Health Coverage

If you do not have health insurance you are guaranteed the right to purchase health coverage in New York. New York law requires HMOs to sell every individual a health insurance policy.

The law provides important consumer protections in those policies, including:

- You can not be charged more because you have a health problem. Uniform premium rates are set for each HMO in each area of New York.
- The benefit package is comprehensive so it will meet the needs of most consumers, including people who have serious health problems.
- HMOs must offer individual consumers the choice of a Point of Service (POS) plan. POS options are more expensive but they allow you to go to HCPs outside the HMO's network at higher out-of-pocket costs to you. If you use the POS option, the HMO will usually charge you a deductible and then the HMO will pay a percentage of the "usual and customary" cost of the benefit which may be considerably less than what a provider charges.
- Rules are set on when a HMO must cover a pre-existing health condition. (*See details on page 14.*)
- You are guaranteed, by Federal law, the right to renew your policy, as long as you pay your premiums, don't move out of the plan's service area or commit fraud.

Shop around for coverage. The State Insurance Department publishes a book which lists all the HMOs that sell individual coverage, including their phone numbers. To get the book, ***call 1-800-342-3736*** and ask for the ***"Consumer's Guide for Standard Individual HMO and Point of Service Coverage."***

Health Insurance for Children through age 18:

If your children have no health insurance, you may be eligible for a New York State program called Child Health Plus which provides health insurance coverage for children through age 18. For many families, Child Health Plus policies are much less expensive than regular HMO policies, since New York State pays part of the cost (depending on income). ***For more information about Child Health Plus call 1-800-698-4KIDS.***

Health Insurance for Adults between the ages of 19 and 64:

If you have no health insurance, you may be eligible for a new New York State program called Family Health Plus, which will provide health insurance coverage for adults. The program is expected to begin in October 2001. It will provide free insurance for adults who qualify and is funded by both the State and the Federal governments. ***For more information about Family Health Plus, call the NYS Department of Health toll free: 877-934-7587.***

YOUR RIGHT TO

Continue Your Health Coverage if You Lose or Change Your Job

☛ Applies to all types of plans.

A federal law known as COBRA provides health insurance protection for people who lose their health insurance for a variety of reasons. COBRA applies to all plans, even self-insured plans that are normally exempt from state laws.

If you received your health insurance through your employer and your employer had 20 or more employees, your employer must continue to offer group health insurance to you and your dependents after you lose your insurance. You have to pay the full cost of the policy and may be charged an additional 2%, but this may be less expensive than buying private insurance. You should compare the cost of continuing coverage under COBRA with buying an individual HMO plan described above.

New York State Law expands this coverage to include employers with as few as 2 employees.

Your right to purchase coverage under COBRA is limited to 18 months after you lose your insurance (29 months for people on Social Security Disability). COBRA covers:

- Workers who lost their jobs or had their hours sharply reduced.
- These workers' spouses and dependents.
- Coverage is expanded to 36 months for spouses and dependents who lose insurance coverage because of an insured employee's death, divorce, legal separation or if the dependents lose coverage because they reached the age when coverage through the parent(s) ends.

Managed Care Consumer Assistance Programs (MCCAP)

There are a number of MCCAPs in New York State that provide free help to New Yorkers with health insurance problems, including denials of care. MCCAPs are listed by the area each serves.

Broome & Tioga Counties: Citizen Action Binghamton: 607-723-1350 or call toll free 877-706-2227 or email: MCCAP2@hotmail.com. This program also provides education and training for consumers, advocates and providers on consumer rights in health care.

Nassau County: The Long Island Progressive Coalition: 516-616-3345 or email: mccapli@hotmail.com. This program also provides education and training for consumers, advocates and providers on consumer rights in health care.

New York City: The Community Service Society coordinates a NYC program that contracts with community-based organizations to provide assistance with managed care problems in a variety of languages. Call 212-614-5400, TTY/TDD 212-505-5522 for assistance and/or referral to the MCCAP agency that can help you.

Statewide:

The Legal Aid Society's Health Law Unit provides free legal advice to individuals, providers and advocates who have problems with managed care plans. In New York City call: 212-577-3575, TTY/TDD 212-577-3581 or upstate call toll free: 888-500-2455.

The Medicare Rights Center (MRC) operates a statewide hotline for people with Medicare and their caregivers to get help with health care questions and problems. The hotline is open Monday to Thursday from 9am to 2pm at toll-free: 800-333-4114.

YOUR RIGHT TO

Coverage for Pre-existing Conditions

☛ Applies to all types of plans.

A major nightmare for people who lose health insurance or change health plans is whether the new plan will include coverage for pre-existing conditions.

The federal Health Insurance Portability & Accountability Act (HIPAA), backed up by New York State law, provides important protections for people with existing health problems who switch health insurance plans. The federal law applies to all plans, even self-insured plans.

A pre-existing condition is a condition which has been diagnosed or for which you have received treatment in the past six months. These are the only conditions for which an insurance company can impose limits. (If you received treatment earlier than the last six months - but did not receive any treatment or care during the past six months - the insurance company can not impose any pre-existing condition limits).

- In order to qualify for the protections on pre-existing conditions you must not allow your health insurance coverage to lapse for more than 63 days.
- If you have had continuous coverage for one-year before switching health plans there is no exclusion for pre-existing conditions.
- A plan must cover all conditions—including pre-existing conditions—after one year.
- You get a credit towards that year for every month in the previous year that you had continuous coverage. For example, if you work at one job for 11 months and then move to a new employer and the new employer has a 12 month pre-existing condition limit - then the new plan must give you credit for the 11 months.

How to order more copies of this *Consumers' Guide*:

- The first copy of the Guide is free.
- To order one copy use this form or call: (518) 465-4600.
- For quantity orders, please use this form:
  The charge for quantity orders is:
  2-99 copies @ 25 cents a copy.*
  100 or more copies @ 20 cents a copy.*
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  $____ enclosed in a check to "PPEF".

Name: ______________________________________

Organization: ________________________________

Address: ____________________________________

City: ____________________ State: _____ Zip: _______

Phone: (   ) _______________ Fax: _______________

- Mail to: NY Guide, PPEF, 94 Central Avenue, Albany, NY 12206.
- Orders may also be placed by faxing (518)465-2890 or by emailing PPEF@citizenactionny.org.

Please include a VISA or MasterCard number and expiration date with fax or email orders.

Card Number: ____________________ Expires: _____

AS A CONSUMER OR A HEALTH CARE PROVIDER,

We'd like to hear from you!

We need to know about your problems with managed care and health insurance to make sure New York's new managed care law is working—so please fill out the form below or call and tell us about any problems you've had with managed care or health insurance.

Return to:
Managed Care Problem Form
Public Policy Education Fund
94 Central Avenue, Albany NY 12206
(518) 465-4600
800-636-BILL (2455)

PLEASE NOTE: If you wish, your identifying information will be kept confidential, but we would like to be able to contact you, so please print your:

Name:

Day phone (   )   Evening phone (   )

Address:

Did this problem happen to you?

If this problem happened to someone else, can we contact that person and how do we do that?

Can we use your name with your story? (yes, no, maybe: call me)

WHAT HAPPENED? Briefly describe the specific problem, and, if you can, the dates.

Did you contact your ***plan*** to resolve the problem? If so, what happened?

Did you contact the State Dept. of Health, the Insurance Dept. or the Attorney General? If so, who and what happened?

Did you turn to anyone else for help? Who and what happened?

How was the problem resolved?

Feel free to attach additional pages.

Citizen Action of New York
94 Central Avenue
Albany, NY 12206

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HERE'S THE

Consumers' Guide to New York's Managed Care Bill of Rights

YOU REQUESTED!

IT USED TO BE that decisions about your health care were between you and your doctor or other health care provider. Your health insurance company didn't interfere; it just paid the bills. But that's no longer true. In the new world of health care—called managed care—your insurance company often makes health care decisions. Your health care insurance company decides whether to approve the health care procedures and treatments recommended by your doctor or other health care provider.

In 1996 New York State passed a law which we call The Managed Care Consumers' Bill of Rights. This law, and other laws, provide rights and protections to consumers to improve your access to health care and help you resolve problems with your health insurance company.

The Consumers' Guide to New York's Managed Care Bill of Rights explains key features of New York's laws in simple terms. The Guide also describes other important rights, including rights for consumers who have chronic illnesses or disabilities, for women and children, for consumers who are covered by Medicare and Medicaid, and rights for people seeking to purchase health insurance.

We need your help! We want to understand if these laws are working. Please fill out the form on page 15 of this booklet and tell us about your experience with managed care. By collecting the experiences of New Yorkers throughout our State, we can learn how well the law is working-and what else needs to be done to improve consumer protections.

Sincerely,

Richard Kirsch
Research Director, PPEF

The Public Policy and Education Fund is a research and education institute that focuses on a variety of consumer issues including health care and campaign finance reform. To make a tax-deductible contribution, mail to PPEF, 94 Central Ave., Albany, NY 12206.

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