

REPORT ON EXAMINATION

OF

GHI HMO SELECT, INC.

AS OF

DECEMBER 31, 2000

DATE OF REPORT

AUGUST 17, 2001

Revised APRIL 19, 2002

EXAMINER

BRUCE BOROFSKY

TABLE OF CONTENTS

<u>ITEM NO.</u>	<u>PAGE NO.</u>
1. Scope of examination	2
2. Description of Plan	3
A. Management and controls	3
B. Territory and plan of operation	6
C. Reinsurance	7
D. Holding company system	7
E. Significant operating ratios	9
F. Investment activities	9
G. Provider / IPA arrangements and risk sharing	9
H. Schedule H	10
I. Record retention	10
3. Financial statements	12
A. Balance sheet	12
B. Statement of revenue, expenses and net worth	14
4. New York State direct pay stop-loss pool recoverable	15
5. Claims payable	15
6. Subsequent events	16
7. The effect of Statutory Accounting Principles	16
8. Market Conduct	17
A. Prompt Pay	17
B. Privacy	19
C. Explanation of benefit statements	20
D. Emergency room treatment	21
E.. Utilization review	22
F. Usual, customary and reasonable	24
G. Access Managed Health Plan	25
H. Fraud prevention and detection	26
I. Distribution systems	27
9. Summary of comments and recommendations	29



STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NY 10004

April 19, 2002

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 21520, dated April 10, 2001, annexed hereto, I have made an examination into the condition and affairs of GHI HMO Select, Inc., as of December 31, 2000, and submit the following report thereon.

The Plan is a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law. Further, it is a wholly-owned subsidiary of GHI Services LLC, which is a wholly-owned subsidiary of Group Health, Inc., a corporation licensed under the provisions of Article 43 of the Insurance Law.

The examination was conducted at the Plan's home office, located at 25 Barbarosa Lane, Kingston, NY 12401.

Wherever the designations "the Plan", "the HMO", or "GHI HMO" appear herein, without qualification, they should be understood to indicate GHI HMO Select, Inc. Wherever the designations "GHI" or "the Parent" appear herein, without qualification, they should be understood to mean Group Health, Inc., the ultimate parent of the Plan.

1. SCOPE OF EXAMINATION

The Plan was formed on June 1, 1999. This examination covered the period from June 1, 1999 through December 31, 2000. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2000 in accordance with generally accepted accounting principles (GAAP), a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners' Handbook of the National Association of Insurance Commissioners:

- History of the Plan
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of the Plan
- Business in force
- Reinsurance
- Accounts and records
- Loss experience
- Financial statements
- Treatment of policyholders and claimants

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF PLAN

In April 1999, Wellcare of New York, Inc. ("WCNY"), an HMO licensed in the State of New York, filed financial statements with the Department showing itself to be insolvent as of December 31, 1998. As a result, under the oversight of this Department and the Department of Health, on June 1, 1999, WCNY sold its commercial business, including approximately 23,000 members, to Group Health Incorporated ("GHI") for \$4,781,100. This business was established as GHI-HMO Select, Inc., a subsidiary of GHI and is a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law.

At the time GHI acquired the assets and systems of WCNY, WCNY was experiencing financial and operating distress and in need of immediate remedial attention. Due to this distress, the acquisition, under the oversight of this Department, occurred on an expedited basis.

Currently, GHI HMO's operations consist solely of non-government business. It does have the authority to begin sales of Medicare, Medicaid and Child Health Plus, but has not chosen to do so at this time.

A. Management and Controls

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board of directors consisting of not less than three members. As of the examination date, the board of directors was comprised of twelve members. The board is required to meet once for an annual meeting, but may hold special meetings as desired. The directors as of December 31, 2000 were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Frank J. Branchini New York, NY	Group Health, Inc. President
Joseph Capezza Princeton Junction, NJ	Group Health, Inc. Chief Financial Officer and Treasurer
Howard Jones Suffern, NY	Retired
Donna Lynne New York, NY	Group Health, Inc. Chief Operating Officer
Thomas Martinelli* Poughkeepsie, NY	Hudson Valley Magazine Publisher
William Mastro Brooklyn, NY	GHI HMO, Inc. Secretary and General Counsel
Susan Matthews Niskayuna, NY	e Care Partners, Ltd Chief Executive Officer.
David Mesches, MD New Paltz, NY	The Medical Center of New Paltz Chief Executive Officer
Ira Nash, MD New York, NY	Mt. Sinai Medical Center Physician
John Nelson* Saratoga Springs, NY	The Corporation of Yaddo Vice President
Daniel Rubino Bedford, NY	Wilkie, Farr, Gallagher Attorney

* Enrollee representative - per the requirement of Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10NYCRR 98-1.11(f)).

At the examination date, the Plan was in violation of Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.11(f)), which states the following:

“Within one year of the HMO receiving a certificate of authority, no less than 20 percent of the members of the governing authority shall be enrollees of the HMO. Employees of the HMO or providers of health services may not serve as enrollee representatives.”

The Jurat Page of the Plan’s NY Data Requirements filing as of December 31, 2000 designated a medical provider as an enrollee-representative of the board. The ineligibility of this member to serve in that position rendered the composition of the board below the required threshold for enrollee-representatives. Subsequent to this finding, the Plan appointed an additional enrollee-representative and, as of the examination date, was in compliance with the cited regulation.

The minutes of all meetings of the board of directors and committees thereof held during the examination period were reviewed. All meetings were well attended.

The examination noted that management does regularly receive reports summarizing the operations of the Plan. Further, the board appears to be in compliance with Circular Letter No. 9 (1999), relating to the adoption of procedures manuals.

The principal officers of the Plan as of December 31, 2000, were as follows:

<u>Name</u>	<u>Title</u>
Frank J. Branchini	President
William Mastro	Secretary
Joseph Capezza	Treasurer

It is recommended that the Plan continue to comply with Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.11(f)) and maintain the proper level of enrollee-representatives on the board.

B. Territory and Plan of Operation

As of December 31, 2000, the Plan held a certificate of authority to operate in the following counties of New York State:

Albany	Greene	Queens	Ulster
Bronx	Kings	Rensselaer	Warren
Broome	Montgomery	Rockland	Washington
Columbia	New York	Saratoga	Westchester
Delaware	Orange	Schenectady	
Dutchess	Otsego	Schoharie	
Fulton	Putnam	Sullivan	

The Plan does not presently write Medicare, Medicaid or Child Health Plus coverage. It does offer a Point of Service (POS) contract in addition to its standard HMO contract. The Commissioner of Health has granted approval for the Plan to provide such POS benefits under its member contracts pursuant to Section 4406(2) of the New York Public Health Law. The Plan is in compliance with the limitations and financial requirements imposed therein.

During the period June 1, 1999 through December 31, 2000, the HMO experienced a net increase in enrollment of 5,377 insureds. An analysis of the increase in enrollment is set forth below:

	<u>1999</u>	<u>2000</u>
Enrollment, June 1	23,114	21,301
Net loss	(1,813)	7,190
Enrollment, end of period	21,301	28,491

As of June 30, 2001, enrollment had increased to 29,880.

C. Reinsurance

At the examination date, the Plan was in negotiation for a reinsurance policy with a licensed insurer, Preferred Life Insurance Company of New York. Its previous coverage, with that same company, lapsed on November 30, 2000. The new policy, signed on April 17, 2001, was effective December 1, 2000. The limits of coverage are as follows:

90% in excess of \$100,000 per Member per Year for both HMO and POS members subject to a \$2,000,000 lifetime cap.

The reinsurance agreement contains all of the standard clauses required by the New York State Insurance Department.

D. Holding Company System

The Plan is a controlled HMO under the definitions set forth in Part 98-1.2(n) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.2(n)).

The structure of the Holding Company, as of the examination date, is as follows:



The Plan is party to a management agreement with GHI, its ultimate Parent.

When the Plan pays its Parent for services or products received, the invoices supporting such payment and specifying the nature of the charges are, in certain instances, reviewed by an employee of the GHI Parent. The information is maintained in an area allocated to the HMO within the Parent's New York City offices. This process does not fully meet the standards for adequate disclosure and support for transactions as set forth in Part 98-1.10(b) of the Administrative Rules and Regulations of the Health Department (10NYCRR §98-1.10(b))

Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.10(c)) states the following:

“The commissioner's and superintendent's prior approval shall be required for the following transactions between a controlled HMO and any person in its holding system: sales, purchases, exchanges, investments or rendering of services on a regular or systematic basis the aggregate of which involves 10 percent or more of the HMO's admitted assets at last year-end. Notice shall be required for such transactions of five percent or more.”

At the time the Plan was formed and assumed the health business from WellCare of New York, Inc., the Department was aware that management / administrative services would be provided on a regular basis to the Plan pursuant to a service agreement with its Parent.

It is recommended that the Plan maintain a process for review and payment for services or products received from its Parent that more fully meets the standards for adequate disclosure and support for transactions as set forth in Part 98-1.10(b) of the Administrative Rules and Regulations of the Health Department (10NYCRR §98-1.10(b))

It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.10(c)) and submit its management / expense allocation agreement to the Superintendent of Insurance for review.

Although a filed service agreement could not be located at the Department, GHI-HMO maintains that it submitted the service agreement as part of the expedited acquisition process and agrees to re-submit the agreement for the Superintendent's review.

E. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the nineteen-month period covered by this examination.

	<u>Amounts</u>	<u>Ratios</u>
Claims	\$65,535,116	96.4%
General administrative expenses	17,642,684	26.0%
Net underwriting gain (loss)	<u>(15,193,018)</u>	<u>(22.4%)</u>
Premium revenue	<u>\$67,984,782</u>	<u>100.0%</u>

F. Investment Activities

The Plan maintains its cash in two overnight sweep accounts. Funds held to meet its escrow requirements are held in a Merrill Lynch fund that is comprised solely of US Treasury Bonds.

G. Provider / IPA Arrangements and Risk Sharing

The Plan maintained relationships with four Independent Practice Associations (IPAs) during the examination period via ProMedCo (PMC), an independently owned Medical Management company that managed these IPAs. When ProMedCo filed for bankruptcy during April, 2001, the Plan reverted to existing agreements directly with the

affected providers. Although the Plan maintains that it is not liable to the individual providers for services rendered for the period it made capitated payments to the Promedco related IPAs, the Plan made a business decision to reimburse the providers directly for medical payments they are owed by PMC for services rendered to the Plan's enrollees. The liability for claims incurred prior to the examination date was estimated by the Plan to be \$323,604. The Plan maintains the right to seek reimbursement of these funds through subrogation from the estate of PMC.

H. Schedule H

Supplemental Schedule H, "Aging Analysis of Claims Unpaid", is prepared by the Plan and submitted pursuant to Section 308 of the New York Insurance Law. Such law requires that special reports requested by the Department be completed promptly and truthfully. The Plan did not include claims with dates of service prior to calendar year 2000 within its inventory of open claims in its filed Schedule H. Instead, it reported those claims in the category "Unreported Claims and Other Reserves." The amount involved was \$31,000, and the Company maintains that the error was inadvertent.

It is recommended that the Plan properly account for its unpaid claims within Schedule H, "Aging Analysis of Claims Unpaid", as required by Insurance Law §308(a) and by the instructions to that document.

I. Record Retention

The Plan is in violation of Section 243.2(b) of Department Regulation 152, which states the following:

"Except as otherwise required by law or regulation, an insurer shall maintain:

- (4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination, in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.

During the examination period and until notified by the examiner, the Plan utilized a procedure carried over from WCNY whereby claims that contained improper information were rejected by the system and no record of these claims was maintained.

Until July 2001, the Plan's Record Retention Policy established a standard whereby claim authorizations were to be maintained for only two years and claim denials were to be maintained for only four years.

It is recommended that the Plan comply with Part 243.2(b) of Department Regulation 152 and maintain a complete record of its rejected claims.

It is noted that, as of the date of this report, the Plan has made changes to comply with this recommendation.

3. FINANCIAL STATEMENTS

The following compares the assets, liabilities and net worth as determined by this examination to those reported by the Plan in its December 31, 2000 filed Annual Statement:

A. Balance Sheet

	<u>Examination</u>	<u>Plan</u>	<u>Net Worth Increase (Decrease)</u>
<u>Assets</u>			
Current assets:			
Cash	\$ 1,384,619	\$ 1,384,619	\$
Premiums Receivable	1,259,548	1,259,548	
Investment Income Receivables	4,576	4,576	
Amounts due from affiliates	91,507	91,507	
Reinsurance recoverables on paid Losses	90,987	90,987	
Prepaid expenses	289,967	289,967	
Other current assets	111,500	111,500	
Restricted Escrow Reserve Interest Receivable	78,366	78,366	
NYS Direct Pay Stop Loss Pool Recoverable	300,000	424,098	\$ (124,098)
Total current assets	<u>\$ 3,611,070</u>	<u>\$ 3,735,168</u>	<u>\$ (124,098)</u>
Other assets:			
Restricted Escrow Reserve	\$ 2,859,000	\$ 2,859,000	\$
Goodwill	4,712,151	4,712,151	
Security Deposit	20,414	20,414	
Total other assets	<u>\$ 7,591,565</u>	<u>\$ 7,591,565</u>	<u>\$</u>
Property and equipment:			
EDP Equipment	\$ 883,759	\$ 883,759	\$
Total property and equipment	<u>\$ 883,759</u>	<u>\$ 883,759</u>	<u>\$</u>
Total assets	<u>\$ 12,086,394</u>	<u>\$ 12,210,492</u>	<u>\$ (124,098)</u>

<u>Liabilities</u>	<u>Examination</u>	<u>Plan</u>	<u>Net Worth Increase (Decrease)</u>
<u>Current Liabilities:</u>			
Accounts payable	\$ 1,312,630	\$ 1,312,630	\$
Claims payable	6,080,048	5,725,001	(355,047)
Unearned premiums	960,243	960,243	
	<hr/>	<hr/>	<hr/>
Total current liabilities	\$ 8,352,921	\$ 7,997,874	\$ (355,047)
	<hr/>	<hr/>	<hr/>
Total liabilities	\$ 8,352,921	\$ 7,997,874	\$ (355,047)
	<hr/>	<hr/>	<hr/>
<u>Net worth:</u>			
Common Stock	\$ 10	\$ 10	\$
Paid in surplus	10,500,000	7,641,000	2,859,000
Surplus notes	5,350,000	5,350,000	
Contingency reserves	2,859,000	2,859,000	
Retained earnings/fund balance	(14,975,537)	(11,637,392)	\$ (3,338,145)
	<hr/>	<hr/>	<hr/>
Total net worth	\$ 3,733,473	\$ 4,212,618	\$ (479,145)
	<hr/>	<hr/>	<hr/>
Total liabilities and net worth	<u>\$ 12,086,394</u>	<u>\$ 12,210,492</u>	

B. Statement of revenue, expenses and net worth

Reserves and unassigned funds increased \$3,733,473 during the examination period, June 1, 1999 through December 31, 2000, detailed as follows:

Revenues

Premiums	\$ 67,984,782	
Net investment income	104,806	
Other income	541,820	
		<u>541,820</u>
Total revenue		\$ <u>68,631,408</u>

Expenses

Medical and hospital expenses		
Physicians' services	\$ 23,350,166	
Other professional services	51,935	
Outside referrals	12,180,861	
Emergency room, out-of-area	2,164,704	
Inpatient	11,503,679	
Drug expense	13,098,181	
Other expense	1,987,993	
NYHCRA Public Goods Pool	1,553,138	
NYS Demographic Pool	436,359	
NYS SMC Pool	(103,310)	
NYS Direct Pay Stop Loss Pool	(424,098)	
Less:		
Reinsurance expenses, net of recoveries	<u>(264,492)</u>	
Total Medical and hospital expenses	\$ 65,535,116	

Plan Administration

Administrative expenses	17,642,684	
Total Plan administration expenses	<u>17,642,684</u>	
Total expenses		\$ <u>83,177,800</u>
Net operating income/(loss)		\$ (14,546,392)
Provision for Federal Income Tax		<u>2,909,000</u>
Net income/(loss)		\$ <u><u>(11,637,392)</u></u>

Net worth as of June 1, 1999			\$	0
	<u>Gains in</u>	<u>Losses in</u>		
	<u>Net Worth</u>	<u>Net Worth</u>		
Net income/(loss)		\$ (11,637,392)		
Change in common stock	\$	10		
Net increases in paid in surplus		10,500,000		
Net increase in surplus notes		5,350,000		
Changes in retained earnings		(479,145)		
Net increase in net worth				<u>3,733,473</u>
Net worth per examination as of December 31, 2000			\$	<u><u>3,733,473</u></u>

4. NEW YORK STATE DIRECT PAY STOP LOSS POOL RECOVERABLE

The examination asset of \$300,000 is \$124,098 less than the \$424,098 amount reported by the Plan in its filed annual statement as of December 31, 2000.

This account represents receivables from a pool established by New York State for the Direct Pay market. The program acts as reinsurance for certain high value claims. If the claims submitted by the various insurers exceed the pool of available dollars, the claims are paid on a pro rata basis. The examination asset is based upon the most recent available information from the State's program administrator. The Plan established its estimate, based upon the best available information at the time that the year-end 2000 Annual Statement was prepared.

5. CLAIMS PAYABLE

The examination liability of \$6,080,048 is \$355,047 greater than the \$5,725,001 amount reported by the Plan in its filed annual statement as of December 31, 2000.

The examination liability was determined by the Department based upon data available through June 2001.

6. SUBSEQUENT EVENTS

Subsequent to the examination, ProMedco, a medical management company with four Independent Practice Association (IPA) subsidiaries utilized by the Plan, filed for bankruptcy. Although the Plan maintains that it is not liable for services rendered for the period it made capitated payments to the Promedco related IPAS, the Plan has agreed to reimburse providers for medical payments they are owed by PMC for services rendered to the Plan's enrollees. The liability as of the termination of the contract, March 31, 2001, for claims incurred prior to the examination date was estimated by the Plan to be \$323,604. This amount appears to be a reasonable estimation. The Plan has indicated it expected the total liability for all claims incurred prior to March 31, 2001 to be approximately \$1,000,000.

The Plan maintains the right to seek reimbursement for these funds from the estate of PMC through subrogation.

7. THE EFFECT OF STATUTORY ACCOUNTING PRINCIPLES

Effective January 1, 2001, the Plan will be required to comply with new accounting rules established by the National Association of Insurance Commissioners (NAIC) and the Department, as modified by Department Regulation 172. These accounting rules may result in changes in the way certain assets and liabilities are to be reported.

This examination conducted an analysis to determine the effect of the new accounting rules on the Plan's December 31, 2000 net worth. The analysis concluded that, had the new rules been in place as of the examination date, the Plan's net worth would have decreased \$340,950. This decrease would have been the result of the following changes:

Non-admission of computer software	\$22,151
Prepaid expenses	274,694
Addition of premium deficiency reserves	44,105
Total	<u>\$340,950</u>

It is noted that, subsequent to this exam, in the first half of 2001, the Plan has suffered underwriting losses. The first and second quarterly statements issued by the Plan, however, do not include a premium deficiency reserve. As such, it is recommended that the Plan calculate a premium deficiency reserve.

8. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Plan conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was directed at the practices of the Plan in the following major areas:

- A. Claims
- B. Underwriting
- C. Rating
- D. Third Party Administrators
- E. Sales and Advertising

The major findings of this review are noted below:

A. Prompt Pay

New York Insurance Law §3224-a, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services”. Subsections (a) through (c) respectively require all insurers to: pay undisputed claims within forty-five days of receipt; request additional information within thirty days; and calculate / pay interest (in excess of two dollars) if undisputed claims are not paid within forty-five days of receipt.

In order to test the Plan's compliance with these subsections, three statistical samples were drawn from the population of non-capitated claims paid between July 1, 1999 and December 31, 2000.

The review disclosed compliance problems relative to Sections 3224-a (a), (b), and (c), as well as other problems in the processing of claims. The Plan maintains that most of the problems discovered during the examination relate to problems that the Plan inherited from WCNY or to issues that arose due to the expedited nature of the acquisition process. The Plan further maintains that these issues have since been resolved, and it has provided a timeline of changes / enhancements made to the claims processing systems in 2000 and 2001. However, the nature of the problems corrected by these "fixes" have not been detailed by the Plan and their effectiveness in resolving the problems noted has not been verified by examination.

Based upon the above, a more current and detailed review of the current claims adjudication process at GHI-HMO, Inc. is appropriate. In lieu of drawing specific conclusions herein relative to claims / prompt pay practices during the twenty month examination period following the acquisition of WellCare of New York members, the Department will conduct a more detailed review of claims adjudication in general, and compliance with Section 3224-a ("Prompt Pay Law") specifically, at a later date.

The Plan encourages its providers to submit claims electronically, instead of through the US Mail. The process used to do this is referred to as Electronic Data Interface ("EDI"). The Plan utilizes the services of Envoy Corporation, an EDI Company. Envoy is the first step in the claims receipt process. Upon receipt of an EDI claim, Envoy verifies that all necessary information to process the claim is present before forwarding it on to GHI-HMO. Claims that are not complete are rejected and sent back to the sender. While providers are free to select any EDI intermediary, those intermediaries are then obligated to send the claims on to Envoy, GHI-HMO's EDI Company of choice. The Plan does not consider the receipt date for prompt pay compliance to be the date the claim was received by Envoy. Consequently, GHI-HMO

only counts the days it processes a claim after receipt of it from Envoy in determining compliance with NY Insurance Law §3224-a. As its agent, the claim should be deemed to be received by GHI-HMO on the date it is received by Envoy.

It is recommended that the Plan age electronically submitted claims from the date they are received by Envoy, their third-party EDI partner for prompt pay compliance purposes.

B. Privacy

The Plan's policy on Disclosure and Confidentiality stipulates that proper identification is required before information concerning medical records can be provided over the telephone. However, the policy stipulates that the only information that is required is as follows:

- a. Member inquiries: Name, phone number and relationship
- b. Provider inquiries: Name, title, phone number and facility name.

This information is insufficient to confirm a caller's identity. As such, the Plan could be violating the privacy rights of its members. When this was pointed out to the Plan, they indicated that it was a regular business practice to obtain the member's Social Security Number before medical information is discussed. This practice, if formally added to the policy, would satisfy the privacy provisions.

It is recommended that the Plan change its Disclosure and Confidentiality written policy to require the member's Social Security Number or other unique identifier before medical information is provided over the telephone.

It is noted that subsequent to the examination date, the Plan changed its policy to comply with this recommendation.

C. Explanation of Benefit Statements

New York Insurance Law §3234 requires the Plan to provide the insured or subscriber with an explanation of benefits form (EOB) in response to the filing of any claim unless such service is provided by a facility or provider participating in the insurer's program *and* full reimbursement for the claim is paid by the insurer directly to the participating facility or provider.

The examination revealed that the Plan does not send EOBs to its members when claims submitted by its participating providers have been denied for administrative purposes, such as for late submission. In these cases the members are "held harmless" and are not responsible for payment. Because full reimbursement has not been made for these claims, EOBs should be provided to the subscribers. This is to ensure that both parties involved are aware that the providers cannot attempt to collect any unpaid portion of the bill from the subscriber.

It is recommended that the Plan issue Explanation of Benefit forms to its subscribers when claims submitted by participating providers have been denied for administrative purposes.

The Plan's claim adjudication systems assigns denial codes that automatically dispense EOBs based upon the code assigned. In many cases, the explanations are not clear or the EOBs dispensed are improper in relation to the assigned code. An example of this is a retrospective denial of an experimental treatment. This would result in a denial as D5 "Not a covered service". This is an unclear explanation and, as such, is a violation New York Insurance Law Section 3234(a)(6) which requires that all EOBs must contain the following:

"a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed."

It is recommended that the Plan reviews its denial codes in order to clarify the explanations used and to eliminate obsolete or misleading codes.

It is recommended the Plan comply with New York Insurance Law §3234(a)(6) and indicate clearly the cause of claims denied due to the treatment being experimental in nature.

The Plan maintains that it has complied with this recommendation, but this has not been reviewed and verified by examination

D. Emergency Room Treatment

The Plan initially continued a policy inherited from WCNY, and until May 2000, the Plan utilized an emergent care policy that required enrollees to obtain authorization for certain treatment in an emergency room. In 2,307 cases, the failure to obtain such authorization resulted in, at a minimum, the initial denial of these claims.

Section 3216(i)(9) and §3221(k)(4)(A) of the New York State Insurance Law requires that health insurance contracts permit emergency room treatment using a prudent person standard.

During June 2000, the Plan instituted a new policy that eliminated the requirement that enrollees obtain authorization for emergency room treatment unless such treatment does not meet a prudent person standard of care. However, it did not retroactively review closed claims to find and overturn inappropriate denials. Nor did the Plan consider such claims to be eligible for interest under NY Insurance Law §3224-a.

It is recommended that the Plan reviews and overturns emergency room claims denied inappropriately due to a lack of authorization. Additionally, it is recommended that the Plan calculates and pays interest as applicable on those claims whose payment was delayed awaiting such authorization.

The Plan maintains it has adjusted all emergent care claims where it was informed that a member was billed, although that has not been verified by examination.

E. Utilization Review

The Utilization Review procedures followed by the Plan allow two appeals for claims denied as not medically necessary. Additionally, under New York State Public Health Law Article 49, Title II, “Right to External Appeal”, enrollees are granted the right to a review performed by a panel of clinical practitioners independent of the Plan. In order to qualify for this external review, the claim in question must have been denied upon appeal as not medically necessary.

A sample of appealed claims was selected for review to determine the Plan’s compliance with New York Public Health Law Article 49, Utilization Review and External Appeal.

The Plan was in violation of Public Health Law §4903(5)(b), which requires that an adverse determination include instructions on how to initiate standard and expedited appeals, in that the letters it sent to providers did not fully explain appeal rights. The Plan revised the letter in May 2000.

New York Public Health Law establishes specific criteria for the information included in letters that deny appeals. Such denials are called Final Adverse Determinations, and are defined by New York Public Health Law §4900(4)(d) as follows:

“an adverse determination which has been upheld by a utilization review agent with respect to a proposed health care service following a standard appeal ...”

This definition renders denial of a first-level medical necessity appeal as the final adverse determination. Because the Plan has two levels of appeals, it is required under Part 410.9(e)(0) of Department Regulation 166 (11NYCRR 410.9(e)(9)) to include the following in its appeals denial letters:

“...a clear statement written in bolded text that the forty-five day time frame for requesting an external appeal begins upon receipt of the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested and, that by choosing to request a second level of internal appeal, the time may expire for the insured to request an external appeal.”

The examination revealed that the Plan violated this requirement in that the majority of final adverse determination letters it sent to providers did not contain such a notice. Nor did the letters include an external review application or a description of the external review process as required by the Regulation. This may have misled providers about their rights to external appeal and may have resulted in providers losing that right. The Plan maintains it is now in compliance with this requirement, although, the examiner has not reviewed and confirmed this assertion.

An examination of a sample of appeals also revealed that on several claims, the Plan waited as long as one month after the acknowledgment letter was sent to request the pertinent medical records. As noted above in Public Health Law §4903(5), the denial letter should have indicated that, if an appeal were desired, the medical records would be needed.

It is recommended that the Plan continue to comply with New York Public Health Law §4903(5)(b) and issue adverse determination letters to its providers that contain all of the required appeals language.

It is recommended that the Plan comply with Part 410.9(e)(9) of Department Regulation 166 (11NYCRR 410.9(e)(9)) and include a bolded statement in the medical necessity denial letters it sends to its providers informing them that choosing a second internal appeal might cause the time to file an external appeal to expire. It is further recommended that such denials include an application for and description of the external review procedure.

The Plan maintains that most of the problems discovered during the examination relate to problems that the Plan inherited from WCNY or to issues that arose due to the expedited nature of the acquisition process. The Plan further maintains that these issues have since been resolved, and it has provided a timeline of changes / enhancements made to the claims processing systems. Improvements subsequent to the completion of the examination will be verified during a future examination.

F. Usual, Customary and Reasonable

The Plan does not adhere to its own contract with regard to the payment of Usual and Customary charges.

The Plan's contract states the following:

“Medically Necessary services will be covered even if not authorized by the Enrollee's Primary Care Physician. Payment is subject to the Out-of-Network Deductible and will be based on usual and customary rates. The payment will be the lesser of the charge or the amount which would have covered in full 80% of similar services rendered by other providers in the same area in the prior period based on the HIAA fee schedule.”

The fee schedules utilized by the Plan are updated by HIAA bi-annually to reflect updated charges. The Plan, however, only updates its systems once per year. Additionally, it takes the Plan up to three months to load that data. This renders the data out-of date and thus, inaccurate.

It is recommended that the Plan update its schedule of Usual and Customary charges in conformity with the changes made by HIAA in order to fulfill the obligations under its contract.

G. Access Managed Care Plan

GHI-HMO's chiropractic Third Party Administrator (TPA), Access Managed Health Care ("Access"), was examined to determine its compliance with New York Insurance Law. Additionally, the Plan has conducted an audit of Access. The arrangement with Access was inherited from WelCare of New York.

The examination disclosed the following problems with Access:

- Access is not in compliance with the requirements of NY Public Health Law 4903(3) in that a number of claims took longer than one business day to approve.
- The participating provider agreement utilized by Access stipulates that all claims must be submitted within 30 days of the date of service. However, claims may not be submitted until authorization for treatment has been granted. Improper delays in granting such authorization, as noted above result in delays and reduces the time the provider has to submit said claim. Further, the deadline is based upon the date the claim is received by Access, not the date it is sent. When claims are sent over a weekend, as many as seven days may go by before the claim is received.
- Access does not have the capability to accept claims electronically.

During the period January 1, 2001 through July 18, 2001, 318 claims were denied for being submitted late. Fifty-two of these claims were late by seven days or less.

It is recommended that the Plan examine its contract with Access to address the issues identified above.

Subsequent to the examination, the Plan has indicated that it will not continue its relationship with Access, and the contract will terminate effective July 1, 2002.

H. Fraud Prevention and Detection

Under Department Regulation 95 (11 NYCRR Part 86.6), the Plan is required to maintain a fraud prevention plan and special investigations unit. Under the current system, detection of fraud is handled by the Plan, while the Parent has the responsibility for investigations.

Employees within the Plan's Claim Processing Department attend an annual training meeting on Fraud Detection and are responsible for the Plan's fraud detection efforts. After processing, claims are randomly audited for accuracy and fraud by the Audit Department. While this methodology for auditing claims may occasionally be successful in locating fraudulent claims, it will not be effective in locating systematic fraud. Additionally, the Plan does not utilize any software designed to locate fraudulent trends within its claim processing systems.

The Plan represents that it does review patterns of practice on a post-payment basis, although this was not reviewed or confirmed by the examiner.

During the examination period, two allegations of fraud were detected and investigated by the Plan. This result is less than the estimated four percent of HMO claims deemed by the Department's Frauds Bureau to be potentially.

It is recommended that the HMO evaluate its Fraud Prevention Plan to determine how it might be strengthened.

I. Distribution Systems

New York Insurance Law §2112(a), states the following:

“Every...health maintenance organization... shall file a certificate of appointment... in order to appoint insurance agents to represent such ...health maintenance organization.”

On nine occasions, the Plan failed to notify the Department after it had appointed agents. Instead, it appointed the agents under the name of its Parent, GHI.

It is recommended that the Plan complies with New York Insurance Law §2112(a) and file certificates of appointment for its internal sales staff.

Subsequent to the examination date, the Plan maintains it has submitted the change to the Department, naming GHI-HMO as the organization appointing the agents.

New York Insurance Law §2112(d), requires the Department be notified upon the termination of the aforementioned certificates of appointment.

On one occasion, the Plan failed to notify the Department after an agent in its employ was terminated. It is noted that the Plan did notify the Department of the termination under the name of its Parent, GHI.

It is recommended that the Plan complies with New York Insurance Law §2112(d) and notifies the Department upon the termination of its filed certificates of appointment.

Subsequent to the examination date the Plan maintains it has forwarded the termination notice to the Department.

The Plan is in violation of New York Insurance Law §2114(a)(3), which states:

“No...health maintenance organization doing business in this state...shall pay any commission or other compensation to any person... for services in soliciting or procuring in this state... any new health maintenance organization contract, except to a licensed accident and health insurance agent of such... health maintenance organization...”

This section of the Law requires Plan employees to have licenses if they will be soliciting business and earn income on a commission basis. During calendar year 2000, the Plan utilized eleven such employees. Of these, three were unlicensed.

It is recommended that the Plan complies with New York Insurance Law §2114(a)(3) and only pays commissions to licensed agents.

The Plan maintains a commission policy that as written could result in violations of Part 52.42(e) of Department Regulation 62 (10NYCRR Part 52.42(e)), which limits the payment of commissions for non-POS business to four percent of premiums, with certain exceptions. This policy could result in violations of the aforementioned statute in that, at certain premium levels, agents and brokers are eligible for commissions in excess of the four- percent limit. However, no evidence of excess commission payments was noted during the examination period.

It is recommended that the Plan change its commission policy to ensure it is in compliance with Part 52.42(e) of New York Regulation 62 (10NYCRR Part 52.42(e)).

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>MANAGEMENT AND CONTROLS</u>	
1. It is recommended that the Plan continue to comply with Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.11(f)) and maintain the proper level of enrollee-representatives on the board.	6
B. <u>HOLDING COMPANY SYSTEM</u>	
1. It is recommended that, pursuant to Part 98-1.10(b) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.10(b)), the Plan maintain its books, accounts and records so as to clearly and accurately disclose the nature and details of all transactions.	8.
2. It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.10(c)) and submit its management / expense allocation agreement to the Superintendent of Insurance for review.	9
Although a filed service agreement could not be located at the Department, GHI-HMO maintains that it submitted the service agreement as part of the expedited acquisition process and agrees to re-submit the agreement for the Superintendent's review.	
C. <u>SCHEDULE H</u>	
1. It is recommended that the Plan account for its unpaid claims reported in Schedule H, "Aging Analysis of Claims Unpaid", as required by NYIL §308(a) and by the instructions to that document	10

D. RECORD RETENTION

1. It is recommended that the Plan comply with Part 243.2(b) of Department Regulation 152 and maintain a complete record of its rejected claims. 11

It is noted that, as of the date of this report, the Plan has made changes to comply with this recommendation.

E. THE EFFECT OF STATUTORY ACCOUNTING PRINCIPLES

1. It is recommended that the Plan calculate a premium deficiency reserve. 17

F. PROMPT PAY

1. It is recommended that the Plan age electronically submitted claims from the date they are received by Envoy, their third-party EDI partner for prompt pay compliance purposes. 19

G. PRIVACY

1. It is recommended that the Plan change its Disclosure and Confidentiality written policy to require the member's Social Security Number or other unique identifier before medical information is provided over the telephone. 19

It is noted that subsequent to the examination date, the Plan changed its policy to comply with this recommendation.

H. EXPLANATION OF BENEFIT STATEMENTS

1. It is recommended that the Plan Explanation of Benefit forms to its subscribers when claims submitted by participating providers have been denied for administrative purposes. 20

2. It is recommended that the Plan reviews its denial codes in order to clarify the explanations used and to eliminate obsolete or misleading codes. 21
3. It is recommended the Plan comply with New York Insurance Law §3234(a)(6) and indicate clearly the cause of claims denied due to the treatment being experimental in nature. 21

The Plan maintains that it has complied with this recommendation, but this has not been reviewed and verified by examination

I. EMERGENCY ROOM TREATMENT

1. It is recommended that the Plan reviews and overturns emergency room claims denied inappropriately due to a lack of authorization. Additionally, it is recommended that the Plan calculates and pays interest as applicable on those claims whose payment was delayed awaiting such authorization. 21

The plan maintains it has adjusted all emergent care claims where it was informed that a member was billed, although that has not been verified by examination.

J. UTILIZATION REVIEW

1. It is recommended that the Plan continue to comply with New York Public Health Law §4903(5)(b) and issue adverse determination letters to its providers that contain all of the required appeals language. 23
2. It is recommended that the Plan comply with Part 410.9(e)(9) of 23

Department Regulation 166 (11NYCRR 410.9(e)(9)) and include a bolded statement in the medical necessity denial letters it sends

to its providers informing them that choosing a second internal appeal might cause the time to file an external appeal to expire. It is further recommended that such denials include an application for and description of the external review procedure.

K. USUAL, CUSTOMARY AND REASONABLE

1. It is recommended that the Plan update its schedule of Usual and Customary charges in conformity with the changes made by HIAA in order to fulfill the obligations under its contract. 24

L. ACCESS MANAGED CARE PLAN

1. It is recommended that the Plan examine its contract with Access to determine whether Access is in conforming to its own contract regarding electronic acceptance of claims and, if so, take appropriate action. 25

Subsequent to the examination, the Plan has indicated that it will terminate its relationship with Access, effective July 1, 2002.

M. FRAUD PREVENTION AND DETECTION

1. It is recommended that the HMO evaluate its Fraud Prevention Plan to determine how it might be strengthened. 26

N. DISTRIBUTION SYSTEMS

1. It is recommended that the Plan complies with New York Insurance Law §2112(a) and file certificates of appointment for its internal sales staff. 27

Subsequent to the examination date, the Plan maintains it has submitted the change to the Department naming GHI-HMO as the organization appointing the agents.

2. It is recommended that the Plan complies with New York Insurance Law §2112(d) and notifies the Department upon the termination of its filed certificates of appointment. 27

Subsequent to the examination date the Plan maintains it has forwarded the termination notice to the Department.

3. It is recommended that the Plan complies with New York Insurance Law §2114(a)(3) and only pays commissions to licensed agents. 28
4. It is recommended that the Plan change its commission policy to ensure it is in compliance with Part 52.42(e) of New York Regulation 62 (10NYCRR Part 52.42(e)). 28

Respectfully submitted,

Bruce Borofsky
Associate Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

Bruce Borofsky, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Bruce Borofsky

Subscribed and sworn to before me
This _____ day of _____ 2002

Appointment No. 21520

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

GHI HMO Select Inc.

and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the
name and affixed the official Seal of this Department, at
the City of New York,

this 10th day of April 2000



NEIL D. LEVIN

Superintendent of Insurance

A handwritten signature in black ink, appearing to be "Neil D. Levin", written over a horizontal line.

(by) Deputy Superintendent