REPORT ON EXAMINATION

OF

HEALTH NET INSURANCE OF NEW YORK, INC.

AS OF

SEPTEMBER 30, 2008

DATE OF REPORT	**MAY 11, 2010**
EXAMINER	**JO LO HSIA**

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

David A. Paterson
Governor

James J. Wrynn
Superintendent

May 11, 2010

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30207, dated September 25, 2008, annexed hereto, I have made an examination into the condition and affairs of Health Net Insurance of New York, Inc., an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, as of September 30, 2008, and submit the following report thereon.

The examination was conducted at the administrative office of Health Net Insurance of New York, Inc., located at One Far Mill Crossing, Shelton, CT.

Whenever the designations, "HNINY" or "the Company" appear herein, without qualification, they should be understood to indicate Health Net Insurance of New York, Inc.

Whenever the designations, “HNNY” or “the HMO” appear herein, without qualification, they should be understood to mean Health Net of New York, Inc.

Whenever the designation, “the Department” appears herein, without qualification, it should be understood to indicate the New York State Insurance Department.

A concurrent examination of the Company’s affiliated health maintenance organization, Health Net of New York, Inc., was also conducted as of September 30, 2008. A separate report thereon has been submitted.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of September 30, 2003. This examination covers the five-year period from October 1, 2003 to September 30, 2008. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of September 30, 2008, in accordance with statutory accounting principles (SAP), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Company'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* (NAIC):

History of the Company
Management and controls
Corporate records
Territory and plan of operation
Growth of the Company
Business in force
Loss experience
Accounts and records
Financial statements
Market conduct activities

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.

A review was also made to ascertain what actions were taken by the Company with regard to comments and recommendations contained in prior reports on examination.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies during the examination period. The most significant findings of this examination include the following:

- The Company failed to obtain the Insurance Department's approval for its 2004 amended and restated by-laws.
- The Company failed to obtain the Insurance Department's approval prior to implementing administrative services agreements with its affiliated entities.
- The Company failed to be charged the proper allocation of direct expenses incurred during the examination period from its affiliates.
- The Company failed to comply with the requirements of Section 3224-a(a) of the New York Insurance Law (Prompt Pay Law).
- The Company violated Section 3234(b)(3) of the New York Insurance Law when it issued explanation of benefits statements (EOBs) which failed to identify the services for which the claim was made. Such issued EOBs also failed to include the appeal information required by Section 3234(b)(7) of the New York Insurance Law.
- The Company violated Article 49 of the New York Insurance Law with regard to certain statutory requirements affecting utilization reviews and appeals.
- The Company improperly paid in-network facility claims involving non-participating physicians during the examination period.
- The Company "retro-terminated" certain policies in violation of its policy provisions.

The above findings, as well as others, are described in greater detail in the remainder of this report.

3. DESCRIPTION OF THE COMPANY

The Company was originally licensed by the New York Insurance Department on December 3, 1990, as Citicorp International Trade Insurance, Inc. (CITI) and commenced operations on April 2, 1991, as a domestic property and casualty insurer domiciled in the State of New York. On April 12, 1996, Physicians Health Services, Inc. acquired CITI from Citicorp International Trade Indemnity, Inc., a subsidiary of Citicorp and changed the name to Physician Health Services Insurance of New York, Inc. The Company began its first full active year in operation as a mono-line accident and health insurer in 1999.

On July 25, 2000, the board of directors of Physician Health Services Insurance of New York, Inc. executed an Adoption of the Certificate of Charter Amendment, to convert from a New York Insurance Law Article 41 property and casualty insurance company to a New York Insurance Law Article 42 accident and health insurer, duly authorized to conduct the business of insurance in the State of New York. This amendment also deleted "Credit insurance", "Marine and inland marine insurance" and "Substantially similar kind of insurance" from the risks the Company was empowered to transact. The Company was granted a revised Certificate of Authority, effective December 17, 2001, which effected a change in name to Health Net Insurance of New York, Inc. As of the examination date, HNINY is licensed to transact "accident and health insurance" as defined in paragraph 3(i) of Section 1113(a) of the New York Insurance Law.

The Company's authorized, issued and outstanding capital consists of 1,000 shares of $1,000 par value common stock. The Company has no preferred capital stock issued or outstanding.

A. Management and Controls

The charter and by-laws of the Company provide that its corporate powers be exercised by a board of directors. The minimum number of directors per its by-laws and required by Section 1201(a)(5)(B)(v) of the New York Insurance Law is thirteen.

All of the members of the board of directors are employees of Health Net of the Northeast, Inc., the Company's immediate Parent. During the entire five-year examination period, the board met only twice. At other times, the board conducted its dealings through the adoption of resolutions, accomplished by a consent-in-writing, signed by all of the directors entitled to vote with respect to the subject matter.

The board of directors has the fiduciary responsibility to manage the business affairs of the Company. It is essential that the board meet regularly to fulfill its fiduciary responsibility. Thus, it is recommended that the board of directors meet, at a minimum, on a quarterly basis.

As of September 30, 2008, the Company's board of directors consisted of the following eleven (11) members:

Name and Residence	Principal Business Affiliation
Susan M. Aylward Shelton, CT	Director of Recovery Operations, Health Net of Northeast, Inc.
Roupen Berberian Glendale, CA	VP, CFO & Treasurer, Health Net Insurance of New York, Inc.

Name and Residence	Principal Business Affiliation
Steven V. Calabrese Irvington, NY	Medicare Officer, Health Net of Northeast, Inc.
Joseph A. Chiarella Jackson Heights, NY	Medical Director, Health Net of Northeast, Inc.
Peter E. Gladitsch Trumbull, CT	Chief Financial Officer, Health Net of Northeast, Inc.
Joseph J. Kempf, Jr. Newtown, CT	Secretary, Health Net Insurance of New York, Inc.
Paul S. Lambdin New Canaan, CT	President, Health Net of Northeast, Inc.
Julie E. Lyons North Haven, CT	Director of Compliance, Health Net of Northeast, Inc.
Helane Mandelker New York, NY	Director of Care Management, Health Net of Northeast, Inc.
Steven J. Sell Mill Valley, CA	President, Health Net Insurance of New York, Inc.
Anju Sikka MD New York, NY	Chief Medical Director, Health Net of Northeast, Inc.

Section 1201(a)(5)(B)(v) of the New York Insurance Law states in part:

> "…the number of directors, or that it shall be not less than a stated minimum nor more than a stated maximum. Except as provided in section six thousand four hundred two of this chapter the number of directors shall not be less than thirteen…"

A review of the jurat page of the filed September 30, 2008 quarterly statement revealed that the Company's board of directors consisted of thirteen directors. A review of the internal file provided by the Company indicated that the Company, in fact, had only eleven board members as of September 30, 2008, in violation of Section 1201(a)(5)(B)(v) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 1201(a)(5)(B)(v) of the New York Insurance Law and have at least the minimum required number of members on its board of directors.

It was noted that a similar recommendation was made in the prior report on examination.

In addition, Section 307(a)(2) of the New York Insurance Law states in part:

> "The superintendent shall from time to time prescribe the form of such annual statement, which may be a printed document and/or electronic media, and which may be varied as to different types of insurers, corporations…, as shall seem to him best adapted to elicit a true exhibit of the condition of each such entity, in respect to every matter which he may deem material…"

It is also recommended that the Company exercise greater prudence relative to the accuracy of the jurat page included within its filed annual statement.

As of September 30, 2008, the principal officers of the Company were as follows:

Name	Title
Steven Jackson Sell	President
Roupen Berberian	VP, CFO & Treasurer
Joseph John Kempf, Jr.	Secretary
Bret Arthur Morris	Vice President

On June 4, 2004, HNINY's Parent, Health Net of the Northeast, Inc., adopted the Company's amended and restated by-laws (the by-laws). Although the Company filed its 2004 amended and restated by-laws with this Department, it could not provide documentation indicating that such by-laws was approved by this Department.

It is noted that the Company subsequently re–filed its 2004 amended and restated by-laws to this Department for approval. As of the date of the report, the Company is redrafting the by-laws pursuant to recommendations made by this Department.

It is recommended that the Company obtain approval from this Department prior to the implementation of its by-law amendments.

The examination review indicated that the Company included a conflict of interest statement policy in its employment manual. The Company also answered "yes" to the general interrogatories in the annual statements filed during the examination period that asked whether the Company had an established procedure for annual disclosure to its board of directors of any material interest and affiliation on the part of any of its officers and directors. However, the Company did not obtain signed conflict of interest statements from its directors, officers and responsible employees since 2005, due to the fact that the directors are all Health Net of the Northeast, Inc.'s (HNNE), its Parent, and/or Health Net Inc.'s (HNI), its ultimate Parent's, employees. The Company has a fiduciary responsibility to its policyholders to ensure that these individuals do not use their official positions to promote an interest which is in conflict with that of the Company. It is noted that HNNE and/or HNI employees are required to sign a conflict of interest statement as a condition of their initial employment.

It is recommended that all officers, directors and key employees of the Company submit signed conflict of interest statements during each calendar year and that the Company establish a procedure for enforcing such policy.

It is also recommended that the Company exercise greater care in providing correct responses to the general interrogatories in its filed annual statements.

B. Territory and Plan of Operation

The Company is licensed in New York to write accident and health insurance as defined by Section 1113(a)(3)(i) of the New York Insurance Law.

HNINY offers accident and health insurance products via two general methods: (i) as an out-of-network companion coverage offered as part of a single point-of-service (POS) product offered in conjunction with its HMO affiliate, Health Net of New York, Inc.; and (ii) as a stand-alone preferred provider organization (PPO) group contract and exclusive provider organization (EPO) product.

In addition, the Company began offering a Medicare Part D Prescription Drug benefit product (Med. Part D product) in 2006 and a Medicare Advantage Private Fee-for-Service (PFFS) product in New York in 2007.

The following schedule shows direct premiums written and enrollment in the State of New York for the examination period:

Year	Direct Premiums Written	Enrollment
2003	$ 211,569,076	59,180
2004	220,502,967	50,854
2005	171,308,469	36,067
2006	288,695,114	114,015
2007	467,223,200	147,746
9/30/08	467,223,199	170,713

The Company experienced a rapid growth in membership during 2006 through 2008. Such growth was primarily due to increased membership in community rated small groups, Medicare Part D and Medicare Advantage PFFS business.

C. Reinsurance

The Company did not maintain stop-loss insurance coverage as of September 30, 2008.

i. Guardian Agreements

Prior to May 31, 2007, the Company and its HMO affiliate, Health Net of New York, Inc. (HNNY), were participants in marketing and reinsurance agreements with the Guardian Life Insurance Company of America (Guardian). Under the terms of the agreements, certain HMO, PPO, POS and EPO products were jointly developed and sold to small groups within the Company's and HNNY's service area. These products were distributed through the brokerage community in an integrated marketing effort, under the trade name "Healthcare Solutions".

Under the terms of the agreements, the Company wrote 100% of the PPO and EPO business and ceded 50% to Guardian. Guardian wrote 100% of the out-of-network benefits for the POS business and ceded 50% to Health Net Services (Bermuda) Ltd., the Company's affiliate.

Effective June 1, 2007, the Company and HNNY acquired Guardian's 50% interest in Healthcare Solutions for cash considerations.

The Company then entered into a new 100% quota share agreement with Guardian effective June 1, 2007, for the purpose of assuming the existing out-of-network benefits of the Healthcare Solution POS business written on Guardian's paper.

ii. Health Net Services (Bermuda), Ltd. Agreement

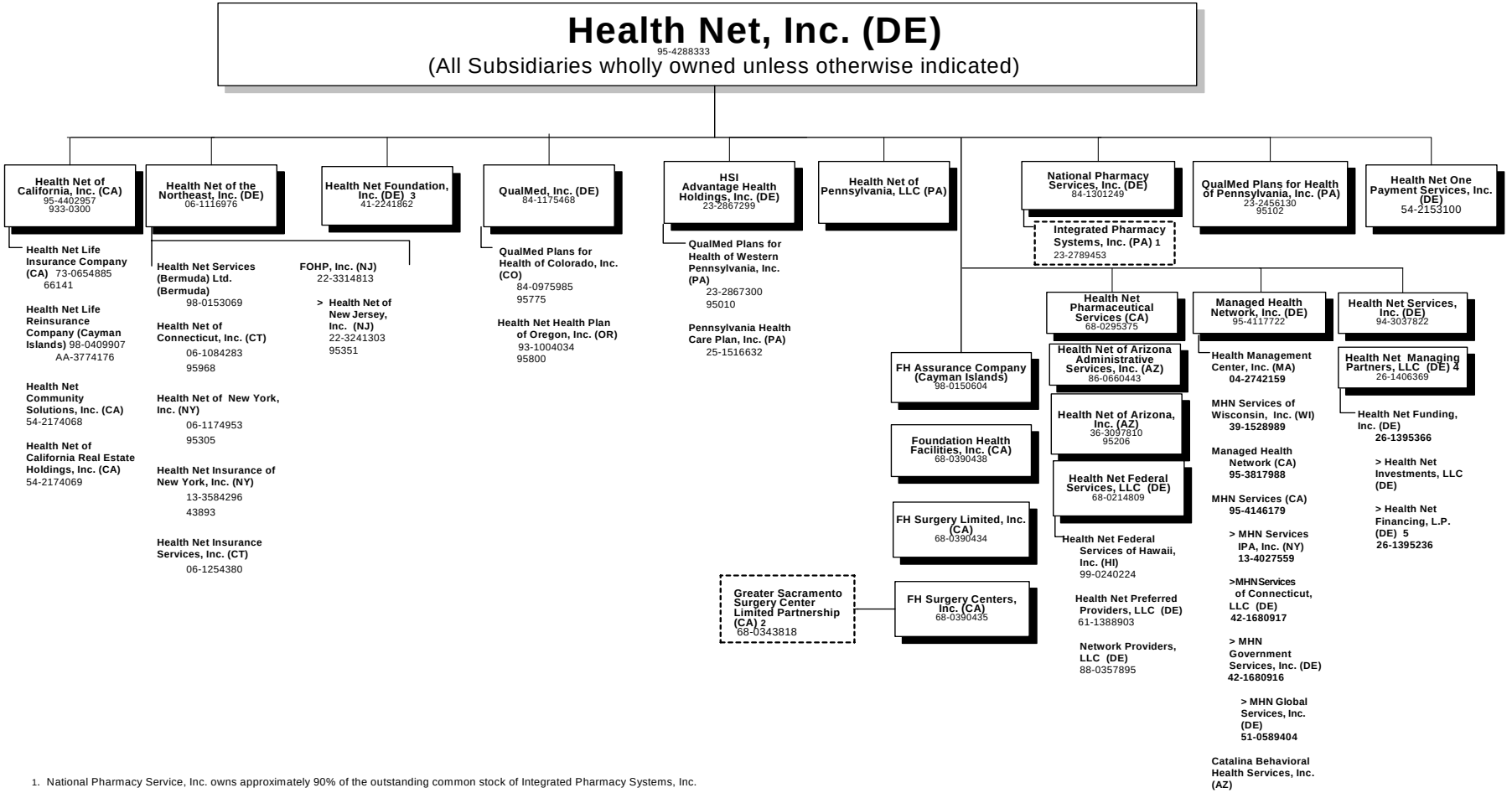
Effective June 1, 2007, the Company entered into a 50% quota share reinsurance agreement with its affiliate, Health Net Services (Bermuda) Ltd. (HNSB), an unauthorized reinsurer. Under the terms of the agreement, HNINY cedes 50% of the following product risks to HNSB: small group Exclusive Provider Organization (EPO), direct and assumed POS business, Medicare Prescription Drug Plan (PDP) and Medicare Private Fee for Service (PFFS).

The agreement was approved by the Department on May 23, 2007.

D. Holding Company System

As of the examination date, the Company is a wholly-owned subsidiary of Health Net of the Northeast, Inc. (Parent). The Parent is a wholly-owned subsidiary of Health Net, Inc., (ultimate Parent). The following is a chart of the Company's holding company system as of September 30, 2008:

As of 9/30/08



1. National Pharmacy Service, Inc. owns approximately 90% of the outstanding common stock of Integrated Pharmacy Systems, Inc.
2. FH Surgery Centers, Inc. owns general and limited partnership units representing slightly over 50% of the total equity of Greater Sacramento Surgery Center Limited Partnership (which specific percentage fluctuates from time to time).
3. Health Net Foundation, Inc. is a nonprofit, nonstock corporation exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.
4. Health Net Managing Partners, LLC - 75% common interest is owned by Health Net, Inc. and 25% common interest is held by Health Net One Payment Services, Inc.
5. Health Net Financing, L.P. - 100% general partnership interest is held by Health Net Funding, Inc., 100% of the Class A limited partnership interest is held by Lodgemore Holdings, Inc. and 100% of the Class B limited partnership interest is held by Health Net Investments, LLC.

Section 1505(c) of the New York Insurance Law states:

> "The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year-end."

During the examination period, the Company operated under separate administrative service agreements with its Parent company, Health Net of the Northeast, Inc. and its ultimate Parent, Health Net, Inc.

During the period of October 31, 2003 to January 31, 2004, the Company utilized an agreement (effective January 1, 2001) with Health Net of the Northeast, Inc. (HNNE), its Parent. HNINY did obtain the prior approval of this Department for this agreement as required by Section 1505(c) of the New York Insurance Law.

During the period February 1, 2004 to December 31, 2008, the Company utilized an agreement (the 2003 administrative service agreement) that was entered into with both its immediate Parent and ultimate Parent, with an effective date of February 1, 2004. This agreement was submitted to the Department in December 2003. After several revisions were made to such agreement, pursuant to recommendations made by this Department, this agreement was approved by this Department on January 5, 2006.

Later during the examination period, the Company entered into a Staffing Support Services Agreement (effective January 1, 2007) with its Parent. This agreement was submitted to this Department on April 9, 2007, and was approved by it on March 4, 2008.

The Company violated Section 1505(c) of the New York Insurance Law by failing to obtain the Superintendent of Insurance's prior approval before implementing the agreements.

Additionally, it was noted that for all the years covered by the examination, the costs associated with such administrative services agreements exceeded five percent of the Company's admitted assets at the prior year-end.

It is recommended that the Company comply with the provisions of Section 1505(c) of the New York Insurance Law by obtaining the Superintendent's prior approval for all of the administrative services agreements that the Company enters into with other members of its holding company system that involve five percent or more of its prior year-end admitted assets.

E. Underwriting Ratios

The underwriting ratios presented below are on an earned/incurred basis and encompass the five-year period covered by this examination:

Claims expenses	$1,088,049,770	81.08%
Claims adjustment expenses	39,591,433	2.95
Administrative expenses	184,857,858	13.78
Net underwriting gain	29,466,613	2.19
Premiums earned	$1,341,965,674	100.00%

F. Accounts and Records

During the course of the examination, it was noted that the Company's treatment of certain items was not in accordance with statutory accounting principles or annual statement instructions. A description of such items is as follows:

1. A review of the Company's investment transactions, the minutes of meetings and written consent of the Board indicated that there was no supporting evidential material to indicate that actions taken by the Company's management in regard to investments were authorized or approved by the board of directors as required by Section 1411(a) of the New York Insurance Law. In addition, the Company answered "yes" to General Interrogatories in all its filed Annual Statements for the period under examination as to whether the Company's purchase and sale of all investments are passed upon by either its board of directors or a subordinate committee thereof.

Section 1411(a) of the New York Insurance Law states:

> "(a) No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting."

It is recommended that the Company's board of directors authorize and approve the Company's investment transactions in accordance with the requirements of Section 1411(a) of the New York Insurance Law and that documentation supporting its actions be appended to the minutes of its meetings.

A similar recommendation was made in the prior report on examination.

The Company maintains several custodial accounts with the Bank of New York and the Bank of America. A review of the custodial agreements revealed that the agreements lacked the following safeguards and controls as set forth by the New York Insurance Department and in the

guidelines of the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners*:

> "(1) If domiciliary state law, regulation or administrative action requires a strict standard of liability for custodians of insurance company securities than that set forth in Section 2.a., then such stricter standard shall apply. An example of a stricter standard that may be used is that the custodian is obligated to indemnify the insurance company for any loss of securities of the insurance company in the custodian's custody occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction;
>
> (2) In the event of a loss of the securities for which the custodian is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced;
>
> (3) If the custodial agreement has been terminated or if 100 percent of the account assets In any one custody account have been withdrawn, the custodian shall provide written notification, within three business days of termination or withdrawal, to the insurer's domiciliary commissioner;
>
> (4) During regular business hours, and upon reasonable notice, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, its records relating to securities, if the custodian is given written instructions to that effect from an authorized officer of the insurance company;
>
> (5) The custodian and its agents, upon reasonable request, shall be required to send all reports which they receive from a clearing corporation which the clearing corporation permits to be redistributed including reports prepared by the custodian's outside auditors, to the insurance company on their respective systems of internal control;
>
> (6) To the extent that certain information maintained by the custodian is relied upon by the insurance company in preparation of its annual statement and supporting schedules, the custodian agrees to maintain records sufficient to determine and verify such information;
>
> (7) The custodian shall provide, upon written request from a regulator or an authorized officer of the insurance company, the appropriate affidavits, with respect to the insurance company's securities held by the custodian; and
>
> (8) The custodian shall secure and maintain insurance protection in an adequate amount."

It is recommended that the Company amend its custodial agreements with the Bank of New York and the Bank of America to include the requisite safeguards as set forth in the Department's Rules and in the guidelines of the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners*.

It is noted that the Company amended its custodial agreements with the Bank of New York and with the Bank of America in March 2009 and April 2009, respectively, to include the requisite safeguards, in accordance with the guidelines of the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners.*

2. Paragraph 9 of the Statements of Statutory Accounting Principles No. 70 (SSAP No. 70) of the NAIC Accounting Practices and Procedures Manual states in part:

> "…Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group."

Section 1505(a) of the New York Insurance Law states:

> "Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:
>
> (1) the terms shall be fair and equitable;
>
> (2) charges or fees for services performed shall be reasonable; and
>
> (3) expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied."

During the examination period, Health Net of the Northeast, Inc. (HNNE) and Health Net, Inc. (HNI) provided administrative services to HNINY in accordance with the administrative service agreements made between these affiliates and HNINY.

Pursuant to the terms of the agreements, all selling, general and administrative expenses, except broker and agent fees, compensation, taxes and regulatory assessments, incurred by HNNE and HNI on behalf of the Health Net affiliated insurance entities domiciled in Connecticut, New York, New Jersey, Bermuda, and Pennsylvania and those incurred by one affiliated company on behalf of another affiliate were allocated based on a set of prescribed cost

drivers. These expenses were accumulated in separate cost centers maintained by HNI and HNNE and were then allocated among each participating entity on a monthly basis.

It was noted that the expense allocation methodology HNNE and HNI used during the examination period failed to recognize the direct expenses on the individual invoice level. Direct expenses relating to only one or two entities in the region were included in cost centers which were then allocated to all of the entities within a region. The following are some of the examples the examiner reviewed:

- Direct media marketing expenses for Health Net Insurance of Connecticut, Inc. were included within cost center 36108 which were allocated among all Health Net tri-state affiliates based on weighted membership.
- Direct sponsorship expenses and direct small group marketing expenses for Health Net of New York, Inc. and Health Net Insurance of New York, Inc. were included within cost centers 36074 and 36103, respectively, which were allocated among all Health Net affiliates in the tri-state area based on weighted membership.

It is recommended that HNINY record direct expenses in accordance with Paragraph 9 of SSAP No. 70 of the NAIC Accounting Practices and Procedures Manual.

It is also recommended that expenses incurred be allocated to the Company on an equitable basis in accordance with the requirements of Section 1505(a) of the New York Insurance Law.

The Company reported that as result of its 2009 review, beginning in January 2010, cost center 36108 is being fully allocated to the Connecticut entity.

It is recommended that HNNE and HNINY continue to review and refine the allocation methodologies used to distribute expenses across cost centers.

3. Paragraph 12(b) of the Statements of Statutory Accounting Principles No. 47 (SSAP No. 47) of NAIC Accounting Practices and Procedures Manual states in part:

> "12. The statutory financial statements shall provide the following…
>
> (b) Information with regard to the profitability to the administrator of all ASC plans and the uninsured portions of partially insured plans for which the reporting entity serves as an ASC administrator;
>
> For the total and each category separately provided: **(**i) gross reimbursement for medical cost incurred, (ii) gross administrative fees accrued, (iii) other income or expense (including interest paid to or received from plans), (iv) gross expenses incurred (claims and administrative), and (v) total net gain or loss from operations."

The Company failed to disclose the required financial information regarding the gross reimbursement for medical costs incurred for its Administrative Service Contracts (ASC) plans in the "Notes to the Financial Statements" section of its filed annual statements during the examination period, in accordance with Paragraph 12(b) of SSAP No. 47 of the NAIC Accounting Practices and Procedures Manual.

It is recommended that HNINY comply with Paragraph 12(b) of SSAP No. 47 of the NAIC Accounting Practices and Procedures Manual by disclosing all required financial information relative to its ASC business, including the gross reimbursement for medical costs incurred relative to its ASC business, within the "Notes to the Financial Statements" section of its annual statement filings.

4. A review of five of HNINY's premium receivable accounts with credit balances indicated that the Company failed to issue refunds to two (COBRA) members who were terminated more than a year ago. In addition, the Company failed to resolve an account credit aged over 120 days for one group account. These were exceptions to the Company's policy which requires that refunds be issued and credits be resolved in a timely manner.

It is recommended that HNINY comply with its own policy by issuing premium refunds and resolving credits for its premium receivable accounts within specified timeframes.

It is also recommended that the Company review its premium receivable accounts and refund all monies owed plus any accrued interest thereon.

G. Department Regulation No. 164

Part 101.4(c) of Department Regulation No. 164 (11 NYCRR 101.4(c)) states in part:

> "An insurer who uses a capitation arrangement to transfer all or part of its financial risk to a health care provider must do so by means of a contract approved by the Superintendent…"

Part 101.3(c) of Department Regulation No. 164 (11 NYCRR 101.3(c)) states:

> "The term 'financial risk transfer' shall mean the contractual assumption of liability by health care provider by means of a capitation arrangement for the delivery of specified health care services to subscribers of the insurer."

CareCore National, LLC (CCN) had a risk transfer agreement with the Company whereby it provided capitated radiology services to HNINY's members and performed administrative services for HNINY's claims.

The Company indicated that there was no written agreement between HNINY and CCN. CCN provided services to HNINY in accordance with the agreement CCN had with Health Net of New York, Inc., the Company's affiliate.

The Company also indicated that there were no written policies in place to ensure that contracts were being reviewed and approved by the Company before obtaining services from its vendors.

It is recommended that HNINY comply with Part 101.4(c) of Department Regulation No. 164 (11 NYCRR 101.4(c)) by signing a written agreement with CCN and filing the agreement with the Department for approval.

It is also recommended that HNINY implement procedures to ensure that contracts are reviewed and approved before obtaining services from its vendors.

H. Abandoned Property Law

Section 1316(3) of the New York Abandoned Property Law states:

> "Within thirty days following the filing of the report of abandoned property with the comptroller pursuant to subdivision two of this section, the insurer shall cause to be published a list of such abandoned property in the same manner as that prescribed for life insurance companies by section seven hundred two of this chapter."

The Company is required by Section 1316(3) of the New York Abandoned Property Law to annually publish a list of names and last known addresses of persons appearing to be entitled to abandoned property and to file proof of such publication with the Office of the State Comptroller.

Section 1315(1-a) of the New York Abandoned Property Law states:

> "Any amount representing outstanding checks issued on and after July first, nineteen hundred seventy-four in payment for goods or for services, and owing in this state, or held by any corporation (other than a public corporation), joint stock company, individual, association of two or more individuals, committee or business trust in this state, and which has remained unclaimed by the owner of such amount for three years, shall be deemed abandoned property."

Section 1315(1-a) of the New York Abandoned Property Law requires that certain unclaimed vendor payments, outstanding checks and escrow amounts, or gift certificates which are unclaimed for more than three (3) years be reported to the Office of the State Comptroller of the State of New York by March 10th of each year. Such reports shall comprise all abandoned property held by the Company at the close of business on December 31st, each year.

An examination review of the Company's filed Abandoned Property Reports indicated that HNINY failed to file a separate report for miscellaneous unclaimed property, in compliance with the provisions of Section 1315(1-a) of the New York Abandoned Property Law for the period 2003 to 2005.

Furthermore, the Company failed to provide documentation that it annually published a list of names and last known address of persons appearing to be entitled to abandoned cash amounts, in compliance with the provisions of Section 1316(3) of the New York Abandoned Property Law for the years ended 2003 and 2004.

It is recommended that the Company comply with the requirements of Section 1315(1-a) of the New York Abandoned Property Law by filing a separate report for miscellaneous unclaimed property.

It is also recommended that the Company maintain documentation showing that it published the information required by Section 1316(3) of the New York Abandoned Property Law.

Section 1316(2) of the New York Abandoned Property Law states:

> "Such abandoned property shall be reported to the comptroller annually on or before the first day of April. Such report shall be in such form and manner as the comptroller may prescribe."

Although HNINY was able to provide a copy of a cancelled check as evidence of its filing of the 2003 Abandoned Property Report, it was not able to provide a copy of the actual Preliminary Report for 2003.

It is recommended that HNINY maintain copies of its filed Reports, as evidence of its compliance with Section 1316(2) of the New York Abandoned Property Law.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination, with that reported by the Company as of September 30, 2008:

Assets	Examination	Company	Surplus Increase (Decrease)
Bonds	$ 57,787,887	$ 57,787,887	
Common stocks	17,621,150	17,621,150	
Cash, cash equivalents and short-term investments	41,821,092	41,821,092	
Receivables for securities	918,284	918,284	
Aggregate write-ins for invested assets	10,424,284	10,424,284	
Investment income due and accrued	655,087	655,087	
Premiums and considerations	23,579,748	23,579,748	
Amounts receivable relating to uninsured plans	9,847,875	9,847,875	
Current federal and foreign income tax recoverable and interest thereon	1,764,427	1,764,427	
Net deferred tax asset	1,284,413	1,284,413	
Receivables from parent, subsidiaries and affiliates	2,451,616	2,451,616	
Health care and other amounts receivable	13,385,866	13,385,866	
Total assets	$ 181,541,729	$ 181,541,729	

Liabilities	Examination	Company	Surplus Increase (Decrease)
Claims unpaid	$ 44,521,540	$ 38,624,222	$ (5,897,318)
Aggregate health policy reserves	9,900,000	0	(9,900,000)
Unpaid claims adjustment expenses	817,805	817,805	
Premiums received in advance	8,732,866	8,732,866	
General expenses due or accrued	2,088,860	2,088,860	
Remittances and items not allocated	1,619,495	1,619,495	
Amounts due to parent, subsidiaries and affiliates	9,284,809	9,284,809	
Payable for securities	994,010	994,010	
Aggregate write-ins for other liabilities	12,845,581	12,845,581	
Total liabilities	$ 90,804,966	$ 75,007,648	$ (15,797,318)
Capital and Surplus			
Common capital stock	$ 1,000,000	$ 1,000,000	
Gross paid-in and contributed surplus	18,486,594	18,486,594	
Surplus notes	26,321,000	26,321,000	
Unassigned funds	44,929,169	60,726,487	(15,797,318)
Total capital and surplus	90,736,763	106,534,081	(15,797,318)
Total liabilities, capital and surplus	$ 181,541,729	$ 181,541,729	

Note: The Internal Revenue Service completed its audits of the consolidated income tax returns filed on behalf of the Company for tax years 2003 to 2005. All material adjustments, if any, made subsequent to the date of the audit and arising from said audits, are reflected in the financial statements included in this report. In addition, the IRS has completed its audit for tax years 2006 and 2007. Adjustments, arising from such IRS audit, were made to the 2007 consolidated tax return which resulted in a refund of $696,290. No potential liabilities were reported. The examiner is unaware of any potential exposure of the Company to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus increased $39,672,922 during the five-year examination period, October 1, 2003 through September 30, 2008, detailed as follows:

Revenue		
Net premium income	$ 1,341,965,674	
Net investment income	14,904,066	
Change in unearned premium reserves	5,356,978	
Total revenue		$ 1,362,226,718
Expenses		
Medical and hospital	$ 1,368,973,114	
Reinsurance expenses net of recoveries	(260,925,416)	
Claims adjustment expenses	39,591,433	
General administrative expenses	184,857,858	
Increase in reserves for life and accident and health contracts	(4,200,610)	
Aggregate write-ins for other income and expenses	12,452,189	
Total expenses		$ 1,340,748,568
Net income before federal and foreign income taxes		37,275,468
Federal and foreign taxes incurred		16,316,082
Net income		$ 5,162,068

Change in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination as of September 30, 2003			$ 51,063,841
Net income	$ 5,162,068		
Change in net deferred income tax	5,339,166		
Change in non-admitted assets		$ 10,116,077	
Change in surplus notes	26,321,000		
Change in paid-in surplus	15,685,971		
Dividends to stockholders		2,700,000	
Aggregate write-ins for gains in surplus		19,206	
Net increase in capital and surplus			39,672,922
Capital and surplus, per report on examination as of September 30, 2008			$ 90,736,763

5. UNPAID CLAIMS

The examination liability of $44,521,540 is $5,897,318 more than $38,624,222 reported by HNINY in its filed September 30, 2008 quarterly statement.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Company's experience in projecting the ultimate cost of claims incurred on or prior to September 30, 2008.

6. PREMIUM DEFICIENCY RESERVE

The Company reported no liability under this caption as of the examination date. This examination has established the captioned liability in the amount of $9,900,000.

It was noted that the Company had incurred an underwriting loss of $8.9 million as of September 30, 2008. As result, the above premium deficiency reserve was established in accordance with the provisions of Paragraph 18 of the Statements of Statutory Accounting Principles No. 54 (SSAP No. 54) of the NAIC Accounting Practices and Procedures Manual, which states:

> "When the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started."

It is recommended that HNINY comply with the provisions of Paragraph 18 of SSAP No. 54 of the NAIC Accounting Practices and Procedures Manual by establishing the requisite liability.

7. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Company conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at the practices of the Company in the following major areas:

A. Prompt Pay Law
B. Usual, customary and reasonable fees
C. Explanation of benefits statements
D. Utilization review
E. Grievances
F. Retro-termination of policies
G. Disclosure of information
H. Agents and brokers
I. Schedule H – Aging analysis of unpaid claims
J. Department Circular Letter No. 9 (1999)
K. Out-of-network claims
L. Record retention
M. Passport contracts

A. Prompt Pay Law

A review to test for compliance with the Prompt Pay Law was performed by using a statistical sampling methodology covering claims processed during the period January 1, 2008 to September 30, 2008.

The claim population for the Company was divided into medical and hospital claim segments. A random statistical sample was drawn from each segment. It should be noted for the purpose of this analysis, that medical costs characterized as Pharmacy, Medicare, Capitated Payments, and HCRA bulk payments were excluded. In addition, claims for non New York providers were excluded.

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (Prompt Pay Law) requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

Section 3224-a(a) of the New York Insurance Law states in part:

> "…such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

Section 3224-a(c) of the New York Insurance Law states in part:

> "…any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest …When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

Two statistical samples (one for medical and one for hospital) of claims not adjudicated within 45 days of receipt by HNINY were reviewed to determine whether payments were made in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. Accordingly, all claims that were not adjudicated within 45 days, during the period January 1, 2008 through September 30, 2008, were segregated. A statistical sample of each population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:

Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population	1,457,974	4,716
Population of claim transactions adjudicated past 45 days	14,567	712
Sample size	167	167
Number of claims with violations	104	71
Calculated violation rate	**62.28%**	**42.51%**
Upper violation limit	69.63%	50.01%
Lower violation limit	54.92%	35.02%
Calculated claims in violation	**9,072**	**303**
Upper limit transactions in violation	10,143	356
Lower limit transactions in violation	8,001	249

Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected the rate of violations would fall between these limits 95 times).

Summary of Violations of Section 3224-a(c) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population	1,457,974	4,716
Population of claim transactions adjudicated past 45 days	14,567	712
Sample size	167	167
Number of claims with violations	26	10
Calculated violation rate	**15.57%**	**5.99%**
Upper violation limit	21.07%	9.59%
Lower violation limit	10.07%	2.39%
Calculated claims in violation	**2,268**	**43**
Upper limit transactions in violation	3,069	68
Lower limit transactions in violation	1,467	17

Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected the rate of violations would fall between these limits 95 times).

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt and those claims which incurred two dollars or more of interest based upon the examiner's calculations, during the period January 1, 2008 through September 30, 2008.

The population of claims adjudicated over forty-five days from date of receipt for the Company consisted of 14,567 medical claims and 712 hospital claims out of 1,457,974 medical claims and 4,716 hospital claims processed, or 0.99% of the medical claims and 15.10% of the hospital claims processed during the period under review.

It is recommended that HNINY take the necessary steps to ensure compliance with Sections 3224-a(a) and (c) of the New York Insurance Law.

Section 3224-a(b) of the New York Insurance Law states in part:

> "In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due … an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim."

Two statistical samples (one for medical and one for hospital) of claims not denied within 30 calendar days of receipt by HNINY were reviewed to determine whether the denial was made in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all denied claims that were not denied within 30 calendar days during the period January 1, 2008 through September 30, 2008, were segregated. A statistical sample of each population was then selected to determine whether the claims were adjudicated in accordance with Section 3224-a(b) of the New York Insurance Law.

The population of claims denied past thirty calendar days from date of receipt for the Company consisted of 6,164 medical claims and 10 hospital claims out of 1,457,974 medical claims and 4,716 hospital claims processed.

The following chart illustrates the Company's compliance with Section 3224-a(b) of the New York Insurance Law as determined by this examination:

Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population	1,457,974	4,716
Population of claim transactions denied beyond 30 days	6,164	10
Sample size	167	10
Number of claims with violations	55	8
Calculated violation rate	**32.93%**	**80.00%**
Upper violation limit	40.06%	N/A*
Lower violation limit	25.81%	N/A*
Calculated claims in violation	**2,030**	**N/A***
Upper limit transactions in violation	2,469	N/A*
Lower limit transactions in violation	1,591	N/A*

Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected the rate of violations would fall between these limits 95 times).

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims denied past thirty calendar days from receipt, during the period January 1, 2008 through September 30, 2008.

It is recommended that HNINY take the necessary steps to ensure compliance with Section 3224-a(b) of the New York Insurance Law.

The Company was advised by this Department in a prior report on examination, as of December 31, 2001, that it should not deny claims for lack of authorization with regard to members with POS coverage, without considering the member's out-of-network benefits first. It was noted that although the Company reprocessed those claims identified in the prior market conduct examination, the examiners during this examination, noted claims which continued to be

denied for lack of authorization without consideration of the member's POS out-of-network benefits.

It is recommended that HNINY refrain from denying POS claims for lack of authorization without consideration of the member's POS out-of-network benefits.

It is noted that HNINY performed a remediation of such affected claims in 2009, as result of its self-initiated investigation into this area.

B. Usual, Customary and Reasonable Fees

When a member with Point-of-Service coverage visits a non-participating provider, the amount that the member or his provider is reimbursed is established using an adopted Usual, Customary and Reasonable (UCR) fee formula.

The Company's Point-of-Service contract refers to the basis of Usual, Customary and Reasonable (UCR) fee formulas as follows:

> "UCR is based largely on data compiled and reviewed by outside agencies, which determine customary charges for services within a certain geographic location. The charges will vary by provider specialty and specific service(s) rendered."

The nationwide database which the Company used to establish its UCR fees is prepared by Ingenix Inc. (Ingenix). It is known as the Prevailing Healthcare Charges System (PHCS). Ingenix publishes amendments to its PHCS fee schedule on a semi-annual basis.

A sample of sixty out-of-network claims was reviewed by the examiner to determine if these claims were priced accurately, in accordance with the group's benefits and fee schedules.

The review indicated that three claims were paid at the 70th percentile of PHCS, although the respective groups from which the claims originated had purchased contracts which stated that the UCR fees would be paid at the 80th percentile of PHCS (at a higher amount).

Further inquiry revealed that there were numerous instances between January 1, 2005 and December 31, 2007, in which HNINY paid out-of-network claims at the 70th percentile of PHCS, though groups had contracts requiring the 80th percentile. The Company identified this issue in late 2007. As a result, UCR benefits for 1,207 groups were not installed correctly. It is noted that approximately 15,000 out-of-network claims were filed by members of these 1,207 groups during the years in which such error occurred.

Part 216.6(a) of Department Regulation No. 64 (11 NYCRR 216.6(a)) states in part:

> "…it shall be the duty of every insurer to offer claimants, or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions."

It is recommended that HNINY comply with Part 216.6(a) of Department Regulation No. 64 (11 NYCRR 216.6(a)) and process claims in accordance with contract provisions. The Company reported that it performed remediation of the affected claims in 2009.

In February 2008, the New York Attorney General's office conducted an industry-wide investigation into allegations that the Ingenix database intentionally skewed "usual and customary" rates downward, through faulty data collection, poor pooling procedures, and a lack of audits. In January 2009, as a result of the investigation, the Attorney General reached an agreement with UnitedHealth Group, Inc., which owns the Ingenix database. Under the terms of

the agreement, the database of billing information operated by Ingenix will be closed. A qualified nonprofit organization will be created. The nonprofit organization will establish a new, independent database to help determine fair out-of-network reimbursement rates for consumers throughout the United States.

As part of a settlement with the New York Attorney General's office, the Company, agreed to stop using the Ingenix database to set its out-of-network reimbursement rates for physicians when a new database is established.

C. Explanation of Benefits Statements

As part of the review of HNINY's claims practices and procedures, an analysis of its Explanation of Benefits statements (EOBs) sent to subscribers was performed. An EOB is an important link between the subscriber and HNINY. It should clearly communicate to the subscriber that HNINY has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers.

Section 3234(b) of the New York Insurance Law states:

> "The explanation of benefits form must include at least the following:
>
> (1) the name of the provider of service the admission or financial control number, if applicable;
> (2) the date of service;
> (3) an identification of the service for which the claim is made;
> (4) the provider's charge or rate;
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;

(6) 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; and

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification."

The Explanation of Benefits statements (EOBs) issued by HNINY during the examination period failed to properly identify the services for which the claim was made as required by Section 3234(b)(3) of the New York Insurance Law.

Effective November 17, 2008, the Company made changes to its EOBs to more clearly reflect the services performed.

Furthermore, it is noted that for emergency room claims, when the claims were paid at less than the billed amount, the Company did not specifically communicate this action or identify the member's responsibility in its explanation of benefits statements, in violation of Section 3234(b)(6) of the New York Insurance Law.

Section 3234(b)(7) of the New York Insurance Law requires EOBs to include a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought, along with a notification that failure to comply with these requirements may lead to forfeiture of a consumer's right to challenge a claim denial.

Prior to September 2006, the Company's EOBs contained "forfeiture" wording, which appeared to mirror the requirements prescribed by Section 3234(b)(7) of the New York Insurance Law, however, the examiner questioned the specific wording contained in the EOB.

Subsequent to September 2006, HNINY revised its EOBs; however, the new versions of its EOBs failed to contain the specific forfeiture wording prescribed by Section 3234(b)(7) of the New York Insurance Law.

The Company reported that in August 2009, it reinserted wording, which it believed met the requirements of Section 3234(b)(7) of the New York Insurance Law.

It is recommended that HNINY issue EOBs that are in compliance with the requirements of Sections 3234(b)(3), (6) and (7) of the New York Insurance Law.

D. Utilization Review

(i) Prospective Reviews

Section 4903(b) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

A total of twenty (20) prospective utilization review files, which were performed by either the Company or its third party administrators, were selected and reviewed for compliance with Section 4903(b) of the New York Insurance Law. For one HNINY file, the Company failed to generate a letter after the determination was rendered as required by Section 4903(b) of the New York Insurance Law.

It is recommended that HNINY comply with the provisions of Section 4903(b) of the New York Insurance Law.

(ii) Concurrent Reviews

A total of thirty-one (31) concurrent utilization review files, which were performed by either the Company or its third party administrators, were selected and reviewed for compliance with Section 4903(c) of the New York Insurance Law.

Out of the thirty-one files reviewed, nineteen (19) files were found to be in violation of Section 4903(b) of the New York Insurance Law. The following was also noted:

- For eighteen (18) files, the Company failed to provide verbal notification to the member after the determination was rendered.
- For five (5) files, the Company failed to provide written notification to the member after the determination was rendered.

In addition, HNINY's policy allows for an additional three (3) days to provide written notification for verbal notification, in addition to the three provided for such notice as required by Section 4903(c) of the New York Insurance Law.

It is recommended that HNINY update its policy on concurrent utilization reviews to effectuate compliance with Section 4903(c) of the New York Insurance Law. It is also recommended that HNINY process its concurrent utilization reviews in accordance with Section 4903(c) of the New York Insurance Law.

(iii) Retrospective Appeals

Section 4904(a) of the New York Insurance Law states:

> "An insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, may appeal an adverse determination rendered by a utilization review agent."

A total of ten (10) retrospective appeals, which were performed either by the Company or its third party administrators, were selected and reviewed for compliance with Section 4904(a) of the New York Insurance Law.

For two (2) HNINY files reviewed, in instances where the provider filed the appeal, HNINY required the member's consent. HNINY's policy requires the member's consent in order for the provider to proceed with the appeal process for the adverse determination on retrospective reviews. However, Section 4904(a) of the New York Insurance Law allows the provider to appeal adverse determinations without the member's consent for retrospective utilization reviews.

It is recommended that HNINY update its policy on retrospective appeals to effectuate compliance with Section 4904(a) of the New York Insurance Law.

E. Grievances

(i) Provider Grievances

The Company's Administrative and Clinical Appeals Process and Administrative Appeal (Grievance) process for New York providers indicates the following:

> "Health Net shall issue a final determination letter within 60 days of receipt of all of the information necessary to reach a determination."

A total of thirty-nine (39) provider grievance files were selected and reviewed for compliance with the Company's established policy and procedures. For eight (8) files, HNINY did not respond within 60 days of receipt of the grievance, as required by its own policy.

It is recommended that HNINY respond to grievance filings in a timely manner (60 days), in compliance with its own policy.

(ii) Member Grievances

The Company's Executive Response Unit (ERU), during the examination period, processed complaints or disputes regarding HNINY's policies and procedures in the areas of claim processing, customer service, provider service, quality of care or vendor related issues. The following was the Company's policy on Executive Response Unit Complaint Process:

"Turnaround time standard is thirty (30) days."

A total of ten (10) member grievances was selected and reviewed for compliance with HNINY's own policy and procedures. It was found that one (1) member's grievance filed with the Company's Executive Response Unit (ERU), was not resolved within 30 days of receipt of the grievance, in accordance with the Company's own policy and procedures.

It is recommended that HNINY comply with its own policy and procedures by responding to its ERU complaints in a timely manner (30 days).

F. Retro-termination of Policies

As mentioned previously in this report, effective June 1, 2007, the Company and its affiliate, HNNY, terminated their joint venture, Healthcare Solutions, with the Guardian Life Insurance Company of America (Guardian), by purchasing Guardian's 50% interest in Healthcare Solutions. As a result, premium payments for Healthcare Solutions products

erroneously mailed to Guardian were forwarded to the Company or its HMO affiliate, HNNY. It is the Company's policy to terminate insurance policies when premiums are not received within the grace period, which is 30 days after the due date.

A review of policyholder cancellations relative to the former Healthcare Solutions group members indicated that the Company failed to promptly cancel the Healthcare Solutions group policies when premiums were not received within the 30-day grace period, in accordance with its own policy and procedures. Instead, policies were "retro-terminated" up to 45 days or more back to the last day for which the premium was paid in full. The members were harmed by this since the Company stopped paying claims incurred during the retro-period.

The aforementioned action resulted in complaints to this Department's Consumer Services Bureau (CSB). Further inquiry by the CSB indicated that a total of 386 groups were not promptly retro-terminated in accordance with the Company's policy. The issue has been remediated by the Company, following CSB's recommendations. Claims affected by the improper retro-terminations were subsequently paid.

In addition, a review of policyholder terminations for five (5) direct-pay policies indicated that HNINY failed to promptly retro-terminate one (1) policy when the premium was not received during the 30-day grace period. The policy was retro-terminated 49 days, back to the last day for which the premium was paid in full.

It is recommended that HNINY promptly terminate policies when premiums are not received within the allowed grace period. In this regard, it is recommended that the Company review and pay all appropriate claims between the period premiums were paid and the date the policy was terminated.

G. Disclosure of Information

Section 3217-a(a)(3)(D) of the New York Insurance Law states in part:

> "... (3) a description of utilization review policies and procedures, used by the insurer including…
> (D) the right to reconsideration…"

A review of HNINY's POS and EPO Evidences of Coverage sent to members of its group policies indicated that the Company failed to comply with Section 3217-a(a)(3)(D) of the New York Insurance Law when its disclosure of information failed to include the member's right to reconsideration, in its description of its utilization review policy and procedures.

It is recommended that HNINY comply with Section 3217-a(a)(3)(D) of the New York Insurance Law by including the member's right to reconsideration in the Company's description of its utilization review policy and procedures within its disclosure information.

H. Agents and Brokers

During the examination period, HNINY failed to file commission schedules with this Department for small group products in accordance with Section 4235(h)(1) of the New York Insurance Law.

Section 4235(h)(1) of the New York Insurance Law states:

> "Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state."

It is recommended that HNINY comply with Section 4235(h)(1) of the New York Insurance Law by filing its commission schedules with this Department.

I. Schedule H – Aging Analysis of Claims Unpaid

A review of the Company, its third party administrators (TPAs) and its independent practice associations (IPAs): Health Net Pharmaceutical Services, Inc., OrthoNet, Inc., Managed Health Network Services IPA, Inc., Landmark Healthcare IPA of NY, Inc. and CareCore National, LLC prompt pay claim data for 2007, and the reconciliation of such data to Schedule H, indicated that the following prompt pay violations were not reported in the Company's Schedules H during the examination period:

- Total number of late institutional claims and the total amount of interest paid for institutional claims.
- Total number of late TPA/IPA claims and the total amount of interest paid for the claims processed and paid by Health Net's TPAs and IPAs.

Department Circular Letter No. 12 (2000) states in part:

> "The purpose of this Circular Letter is to remind HMOs and insurance companies that they are ultimately responsible for compliance with the prompt pay law, despite any contractual delegation of the claims payment process. This includes not only compensation to the provider for the delay in paying the claim (interest) but also any sum to be paid to this Department as penalty for late payments…"

Department Circular Letter No. 12 (2000) states that prompt pay violations incurred by the insurer's TPAs are the direct responsibility of the insurer and should be recorded as such in all filings and reports to this Department, regardless of who actually pays the interest or processes the claim.

It is recommended that HNINY exercise due care to ensure that the information reported in its Schedule H is complete and accurate. It is also recommended that the Company comply with Department Circular Letter No. 12 (2000) by including applicable prompt pay violations for its TPA and IPA claims in its filed Schedule H.

J. Department Circular Letter No. 9 (1999)

Department Circular Letter No. 9 (1999) requires that:

> "…the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations."

The Company failed to obtain such certifications during the examination period.

It is recommended that HNINY obtain the annual certifications as required by Department Circular Letter No. 9 (1999).

K. Out-of-Network Claims

In 2007, the Office of the New York Attorney General (AG) received consumer complaints against HNINY, HNNY, and HNNE (collectively Health Net) and its practice of covering in-network facilities and providers under the out-of network benefits when a point-of service member was admitted by an out-of-network provider. These members were therefore responsible for higher coinsurance and deductible payments.

Health Net made its determinations based on the following language in the member's Evidence of Coverage (EOC), which is the contract between the Company and the member:

> "IMPORTANT NOTICE: Except in an emergency or a second medical opinion for cancer, all Covered Services outlined in this EOC must be provided and arranged by an Advantage Platinum Physician or Advantage Platinum Specialty Provider or with Prior Authorization by us."

Section 2601(a) of New York Insurance Law states in part:

> "No insurer doing business in this state shall engage in unfair claim settlement practices…"

The AG initiated an investigation and concluded that Health Net's EOC for its Point-of-Service Products, failed to adequately disclose Health Net's practice of covering an in-network facility under the out-of-network benefits when the member is admitted to that facility by an out-of-network provider. Thus, Health Net's EOCs for the Point-of-Service Product has the capacity to mislead consumers. The AG therefore found that Health Net was in violation of Section 63(12) of the New York Executive Law, Section 349(a) of the New York General Business Law and Section 2601(a) of the New York Insurance Law.

It is recommended that HNINY comply with Section 2601(a) of the New York Insurance Law by revising its policy and discontinuing its practice of covering in-network facilities under the out-of-network benefits when the service was arranged by an out-of-network provider.

It should be noted that Health Net executed an Assurance of Discontinuance with the New York AG on June 4, 2009, in which it agreed to revise its claim processing policy to adjudicate claims of in-network physicians through the member's in-network benefits, regardless of whether the facility at which the member is treated is in-network or out-of-network and perform claims' remediation.

Health Net completed its remediation on all affected claims in September 2009.

L. Record Retention

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243) states:

> "Any other-record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review. Any other-record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

Part 243.3(a)(2) of Department Regulation No. 152 (11 NYCRR 243) states:

> "Where the original record was not a paper document, an insurer shall be able to produce information or data which accurately represents a record of communications between a person or entity and the insurer or accurately reflects a transaction or event."

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243) requires that the insurer keep its records for six calendar years from their creation or until after the filing of a report on examination. Part 243.3(a)(2) of Department Regulation No. 152 also requires the insurer to be able to produce documentation or data which accurately represents a record of communication between a person or entity and the insurer or accurately reflects a transaction or event. The following HNINY violations of Department Regulation No. 152 were noted:

- The Company failed to document that determination letters were sent to the members and/or providers within one business day of receipt of the necessary information for six (6) HNINY concurrent utilization files the examiner reviewed for compliance with Section 4903(c) of New York Insurance Law as noted in Section D of this report.
- The Company failed to provide to the examiner a copy of the complaint letter for one (1) member's grievance file.

It is recommended that the Company comply with Parts 243.1(b)(8) and 243.3(A)(2) of Department Regulation No. 152.

M. Passport Contracts

It was noted in the previous market conduct examination report that HNINY Passport contract requires that members obtain a referral to see any specialist other than an obstetrician or a gynecologist. This requirement was not enforced during calendar year 2001. On July 1st of that year, the Company issued a directive to its claim adjudicators indicating that the requirement had been removed. This requirement, however, is still contained within the HNINY contract. HNINY has an obligation to fully enact its contract requirements and submit revisions to its member contracts for approval by the Department.

The previous market conduct report recommended that HNINY eliminate unenforced contract provisions from its member contracts. It was noted the Company did not withdraw the unenforced contract provisions from its filing with this Department. Instead, the Company discontinued selling group referral plans in 2007. Currently there are only 917 members enrolled in the New York Passport Direct Pay and Individual Plan which continues to contain the aforementioned referral wording.

It is again recommended that HNINY eliminate unenforced contract provisions from its policy contracts.

8. SUBSEQUENT EVENTS

On July 20, 2009, Health Net, Inc. and UnitedHealth Group Incorporated entered into a Stock Purchase agreement to acquire the licensed subsidiaries of Health Net of the Northeast, Inc., which includes HNINY. This acquisition agreement was approved by the Department on December 11, 2009.

9. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior market conduct report on examination, as of December 31, 2001, contained the following twenty-six (26) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
	Circular Letter No. 9 (1999)	
1.	It is recommended that Health Net obtain the certifications suggested by Circular Letter No. 9 (1999) and obtain annual certifications (i) from either the Plan's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the Plan's general counsel a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with the applicable statutes, rules and regulations. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	5
2.	It is recommended that the Plan prepare "report cards" for the New York entities outlining the timing and accuracy of claim processing. *The Company has complied with this recommendation.*	6
	Claim Receipt	
3.	It is recommended that paper claims inappropriately sent to Health Net instead of to the third party administrator ACS, be aged from the original received date instead of from the date the claim is received by ACS. *The Company has complied with this recommendation.*	7

ITEM NO. **PAGE NO.**

ITEM NO.		PAGE NO.
10.	It is recommended that Health Net uniformly apply its policy regarding the timeliness of claim submitted by non-institutional providers. *The Company has complied with this recommendation.*	19
11.	It is recommended that Health Net adjudicate identical claims filed multiple times in the order of their receipt. In the event that an initial filing lacks sufficient information to process a claim, and a secondary submission is received prior to the adjudication of the original, then the original submission should be denied with an explanation indicating that that submission was incomplete, and referencing the claim that was paid. *The Company has complied with this recommendation.*	19
12.	It is recommended that Health Net eliminate unenforced contract provisions from its member contracts. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	19
13.	It is recommended that Health Net reprocess claims denied as a result of delays in updating a provider's file. *The Company has complied with this recommendation.*	19
14.	It is recommended that Health Net re-adjudicate all claims found to be errors within the Department's adjudication sampling. Additionally, the Plan should pay interest on such claims when it is due. *The Company has complied with this recommendation.*	20
15.	It is recommended that Health Net have its Internal Auditors conduct a claims audit for the New York entities to ensure that policies and procedures are being properly applied. *The Company has complied with this recommendation.*	20

ITEM NO. **PAGE NO.**

The prior financial report on examination as of September 30, 2003, contained the following fifteen (15) comments and recommendations (page numbers refer to the prior report on examination:

ITEM NO.		PAGE NO.
	Management	
1.	It is recommended that the Company comply with the provisions of its by-laws and the provisions of Section 1201(a)(5)(B)(v) of the New York Insurance Law by maintaining the requisite number of members of the board of directors. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	6
2.	It is also recommended that the Company exercise prudence by reporting an accurate schedule of directors in its statements filed with the Department pursuant to Section 307(a)(2) of the New York Insurance Law. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	6
	Administrative Services Agreement	
3.	It is recommended that HNINY comply with the provisions of Section 1505(a) of the New York Insurance Law by ensuring that the terms of the financial transactions of its Administrative Service Agreement are fair and equitable at the time of the transactions, charges or fees for services performed are reasonable, and expenses incurred and payments received are allocated on an equitable basis in conformity with customary accounting practices consistently applied. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	13

ITEM NO.		PAGE NO.
4.	It is also recommended that the Company comply with the provisions of Sections 1505(c) and (d) of the New York Insurance Law by notifying, and/or seeking and obtaining the Superintendent's prior approval for the Administrative Services Agreement entered into with Health Net of the Northeast, Inc. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	13
	Conflict of Interest Policy	
5.	It is recommended that all officers and directors submit signed conflict of interest statements during each calendar year and that the Company establish a procedure for enforcing such policy. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	14
6.	It is also recommended the board of directors adhere to its fiduciary responsibility by properly overseeing and handling any conflicts disclosed. *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	14
	Accounts and Records	
7.	It is recommended that the board of directors authorize and approve the Company's investment transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law and that documentation supporting their actions be appended to the minutes of their meetings. A similar recommendation was made in the prior report on examination *The Company has not complied with this recommendation. A similar recommendation is contained in this report.*	15

ITEM NO. **PAGE NO.**

ITEM NO. **PAGE NO.**

Fraud Prevention

13. It is recommended that the Company comply with the terms and conditions of the fraud plan approval letter dated September 16, 2004. 30

The Company has complied with this recommendation.

14. It is also recommended that the Company add appropriate staff to its fraud investigation unit so that fraud can be investigated and prevented more effectively in accordance with the provisions of Section 409(b)(1) of the New York Insurance Law. 30

The Company has complied with this recommendation.

15. It is further recommended that the Company comply with the provisions of Section 405(a) of the New York Insurance Law as regards suspected fraudulent transactions by submitting to the Insurance Department Frauds Bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transactions and the parties involved as the superintendent may require. 30

The Company has complied with this recommendation.

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. 30207

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **Eric R. Dinallo** , Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Jo-Lo Hsia

as a proper person to examine into the affairs of the

Health Net Insurance of New York, Inc.

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

Company

with such information as she shall deem requisite.

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

this 25th day of September, 2008

Eric R. Dinallo
Superintendent of Insurance