MARKET CONDUCT REPORT ON EXAMINATION

OF

HEALTHNOW NEW YORK INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT **JUNE 18, 2012**

EXAMINER **PEARSON GRIFFITH**

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

June 18, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
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 30354, dated February 8,2011, attached hereto, I have made an examination into the affairs of HealthNow New York Inc., a not-for-profit health service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the home office of HealthNow New York Inc., located at 257 West Genesee Street, Buffalo, New York.

Wherever the designations the "Plan," "HealthNow," or "HNNY" appear herein, without qualification, they should be understood to indicate HealthNow New York Inc.

Wherever the designation the "HMO" appears herein, without qualification, it should be understood to indicate the Plan's health maintenance organization line of business.

Wherever the designation the "Parent" appears herein, without qualification, it should be understood to indicate HealthNow Systems, Inc., a not-for-profit holding company, and the Parent company of HealthNow New York Inc.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services. It should be noted that the New York State Insurance Department merged with the New York State Banking Department on October 3, 2011 to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2003. This market conduct examination was performed to review the manner in which HealthNow conducts its business practices and fulfills its contractual obligations to policyholders and claimants and covers the five-year period January 1, 2004 to December 31, 2008. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A review was also made to ascertain what actions were taken by the Plan with regard to comments and recommendations made in the prior market conduct report on examination.

A concurrent examination regarding the financial condition of HealthNow New York Inc., was conducted by the Department as of December 31, 2008, and a separate report on examination will be issued thereon.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicate areas of weakness and/or directly impacted the Plan's compliance with the New York Insurance

Law, New York Public Health Law and Department Regulations. Significant findings relative to this examination include the following:

- The Plan failed to maintain licenses for all agents and broker appointees, in violation of the provisions of Section 2102(a)(1) of the New York Insurance Law.

- The Plan failed to ensure that certificates of appointment were on file with the Department for each of its agents, as required by the provisions of Section 2112(a) of the New York Insurance Law.

- The Plan failed to ensure that the documentation of and the reporting of all terminated agents was on file with the Department, as required by the provisions of Section 2112(d) of the New York Insurance Law and Department Regulation No. 152.

- The Plan failed to ensure that commissions were paid only to agents and brokers from whom it had obtained valid licenses, as required by the provisions of Section 2114(a)(3) of the New York Insurance Law.

- The Plan failed to comply with its internal control procedures relative to broker of record letters for brokers, and professional liability insurance for agents.

- The Plan failed to provide written acknowledgment of grievances, in violation of the requirements of Section 4802(d) of the New York Insurance Law in two of fifteen instances in the selected sample.

- The Plan violated Sections 4303(g)(4)(A) and 4303(h)(4)(A) of the New York Insurance Law when it failed to send written notice annually, to small groups, offering make-available benefits for biologically based mental illness and benefits for children with serious emotional disturbance.

- The Plan failed to issue complete explanation of benefits statements ("EOBs") for certain denied and out of network claims to comply with the requirements of Sections 3234(b)(6) and 3234(b)(7)of the New York Insurance Law.

- The Plan failed to comply with Section 3224-a of the New York Insurance Law ("Prompt Payment Law").

The above findings are described in greater detail in the remainder of this report.

3. DESCRIPTION OF THE PLAN

HealthNow New York Inc. is a not-for-profit health service corporation organized under the provisions of the Membership Corporation Law and Article 43 of the New York Insurance Law. The Plan was incorporated in the State of New York on September 9, 1939, and commenced business on March 15, 1940. The Plan is a 100% controlled subsidiary of HealthNow Systems, Inc. ("HNS"), a New York not-for-profit corporation and non-operating holding company. HNS is the sole member of the Plan.

The Plan established operations in the Albany, New York area, as a separate division, pursuant to its merger with Whole Health Insurance Network Inc., on December 30, 1992. Concurrent with the date of the merger, through May 1, 1996, the Plan operated under the corporate name, Blue Cross and Blue Shield of Western New York, Inc. The Plan subsequently effected name changes to New York Care Plus Insurance Company and to its present name of HealthNow New York Inc., on May 2, 1996 and October 1, 1998, respectively.

The Plan, as of December 31, 2008, operated under the d/b/a names of Blue Cross and Blue Shield of Western New York, within its Western New York division, HealthNow within its Central New York division and Blue Shield of Northeastern New York within its Eastern New York division. On August 1, 1985, the Plan began the operations of Community Blue, a health maintenance organization ("HMO") authorized pursuant to Article 44 of the New York Public Health Law. Community Blue, an individual practice association ("IPA") model health maintenance organization, functions as a line of business of the Plan. HNNY's HMO operations

are marketed under the name “Community Blue” in the Buffalo, New York area, and under the name “HealthNow” in the Albany, New York area.

4. ADOPTION OF PROCEDURE MANUALS – DEPARTMENT CIRCULAR LETTER NO. 9 (1999)

Department Circular Letter No. 9 (1999), dated May 25, 1999, “Adoption of Procedure Manuals”, was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and insurers licensed to write health insurance in New York State.

Department Circular Letter No. 9 (1999) states in part:

> “…It is recommended 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...”

A review of the minutes of the meetings of HealthNow’s board of directors revealed that it did not directly obtain the above mentioned certifications for 2004 and 2005 The Plan, in its response to the examination request for such information, indicated that such certifications were referenced in the minutes of the March 23, 2005 Joint Audit and Finance Committee meeting of HealthNow Systems Inc., and again in the minutes of the April 5, 2005 HealthNow Systems Inc. board of directors’ meeting, copies of which were provided to the examiner.

It was noted that although HealthNow Systems Inc. is the ultimate parent of HealthNow New York Inc., and that the composition of the parent’s board is the same as the Plan’s, the

Plan's board of directors should directly obtain the annual certifications described in Department Circular Letter No. 9 (1999).

It is recommended that the Plan's board of directors obtain annually, 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 applicable statutes, rules and regulations.

The examiner also determined that the certifications which were received by the Plan's board of directors for years 2006 through 2008 contained management assertions that the information relied upon in making such certifications may have been assembled and prepared by officers and employees, including those assigned to conduct the Plan's internal audit functions.

While reliance upon certifications from officers and employees is acceptable, management agreed to provide separate certifications to the board of directors in the future.

The examiner also determined that certain certifications made to the board of directors during the period under examination contained qualified statements that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, were in accordance with applicable statutes, rules and regulations.

Further, Department Circular Letter No. 9 (1999) states in part:

> "The board is reminded that its responsibilities to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management, administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself.

> Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations."

The examiner determined that the Plan did not provide annual certifications to the board to assure the board that claim adjudication procedures that were performed by outside parties were conducted in accordance with applicable statutes, rules and regulations.

It is recommended that the Plan revise its annual certifications to its board of directors to assure the board that the claim adjudication procedures that were performed by outside parties, and additional key areas such as underwriting and rating, and the accurate and timely reporting of all financial statement schedules and exhibits, are being conducted in accordance with applicable statutes, rules and regulations.

5. AGENTS AND BROKERS

A review was performed of HealthNow's sales distribution system. During the period covered by the examination, the Plan utilized internal and external agents and brokers.

A. Licensing

The examiner selected a sample of thirty-seven agents and three brokers for review to determine if valid licenses were on file with HealthNow, pursuant to the requirements of Section 2102(a)(1) of the New York Insurance Law.

Section 2102(a)(1) of the New York Insurance Law states:

> "No person, firm, association or corporation shall act as an insurance producer or insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

HealthNow did not maintain licenses for twelve of the thirty-seven agents sampled, in violation of the requirements of Section 2102(a)(1) of the New York Insurance Law. In addition, the examination review indicated that HealthNow provided copies of expired licenses for twenty-one of the agents and brokers in the foregoing sample.

It is recommended that HealthNow ensure that all active producers are duly licensed to ensure compliance with the provisions of Section 2102(a)(1) of the New York Insurance Law.

B. Certificates of Appointments and Terminations

Section 2112(a) of the New York Insurance Law states:

> "(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

Section 2112(b) of the New York Insurance Law states:

> "(b) To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted."

During a review of HealthNow's process for appointing its agents, the examiner noted that the Plan did not comply with the provisions of Section 2112 of the New York Insurance Law as follows:

1. The Plan failed to issue certificates of appointment of agents; and
2. The Plan failed to file a notice of appointment with the Superintendent within fifteen days from the date the agency contract was executed (or the first insurance application was submitted).

The examiner selected a sample of thirty-seven agents and three brokers for review to determine whether the Plan filed certificates of appointment with the Department, pursuant to the requirements of Section 2112(a) and (b) of the New York Insurance Law.

The examiner requested certificates of appointment for each of the thirty-seven agents selected for review. HealthNow was unable to produce certificates of appointment for any of the thirty-seven agents selected.

It is recommended that HealthNow ensure that certificates of appointment are filed with the Department within fifteen days of appointment for each of its agents, as required by Sections 2112(a) and 2112(b) of the New York Insurance Law.

Section 2112(d) of the New York Insurance Law states in part:

> "Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause..."

Parts 243.2(a) and (b)(5) of Department Regulation No. 152 (11 NYCRR 243.2) states in part:

> "(a) In addition to any other requirement contained in Insurance Law Section 325, any other Section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part.
>
> (b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (5) A licensing record for six calendar years after the relationship is terminated for each Insurance Law licensee with which the insurer establishes a relationship. Licensing records shall be maintained so as to show clearly the dates of appointment and termination of each licensee."

During a review of HealthNow's process for terminating its agents and brokers, the examiner noted that HealthNow did not maintain its own log of agents and brokers whose certificates of appointments were terminated. In addition, the Plan failed to maintain a log of terminated certificates of appointment of agents and brokers, in accordance with the licensing record maintenance requirements of Department Regulation No. 152. Best business practices dictate that HealthNow should maintain a log of terminated certificates of appointments of agents and brokers and that such log include the reason(s) for termination.

It is recommended that HealthNow comply with the provisions of Section 2112(d) of the New York Insurance Law by maintaining documentation for and reporting all terminated insurance agents to the Department, as prescribed by such statute.

It is also recommended that HealthNow maintain a log of terminated certificates of appointment of agents and brokers, in accordance with the licensing record maintenance requirements of Department Regulation No. 152.

C. Commissions

Section 2114(a)(3) of the New York Insurance Law states:

> "No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating or selling in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article."

As described in Section 5A of this report, "Licensing", HealthNow paid commissions to agents and brokers for whom it did not maintain copies of the requisite licenses, or paid commissions to agents and brokers after their licenses had expired.

Specifically, the examiner noted that HealthNow paid commissions to six of the twelve agents and brokers in the selected sample, for which it did not obtain valid licenses. The examiner also noted that the Plan paid commissions to twelve of the twenty-one agents and brokers whose licenses had expired.

It is recommended that HealthNow comply with the provisions of Section 2114(a)(3) of the New York Insurance Law and refrain from paying commissions to agents and brokers who have not obtained valid and/or current licenses.

D. Internal Controls

The examination review of the Plan's Policy and Procedure Manual (Broker Commission) states:

> "A commission arrangement is created in order to connect the broker to the group in order to pay commission…"

A "commission arrangement" is created by an insured group appointing or replacing a broker of record and issuing a letter notifying HealthNow of the same. The examiner determined that HealthNow failed to comply with its own policy and procedure in that it could not provide the broker of record ("BOR") letters for twenty of the thirty brokers that were selected as the examiner's sample. Although a broker of record is not required by statute, it is a prudent business practice to obtain such from every broker.

The examiner also noted that HealthNow did not adhere to the terms of its agreements with several of its agents/brokers, wherein such agreements called for agents/brokers to maintain professional liability (Errors and Omissions) insurance coverage. Specifically, HealthNow was unable to provide proof of professional liability insurance coverage for thirty-two of the forty agents and brokers selected for the examiner's sample.

In order to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), HealthNow incorporated an addendum to the agreement with its business associates. The intent and purpose of this addendum was to comply with the requirements of HIPAA. HealthNow was unable to provide three of the forty addenda to the business associate agreements that were reviewed by the examiners.

It is recommended that HealthNow comply with its internal control policies and procedures by maintaining agent and broker of record letters.

It is also recommended that HealthNow adhere to the provisions of its agent / broker agreements, by ensuring that such agents or brokers maintain professional liability (Errors and Omissions) insurance coverage.

It is further recommended that HealthNow maintain all addenda relative to its business associate agreements so that this can be used as documentation to support that it meets the requirements of the Health Insurance Portability and Accountability Act of 1996.

HealthNow indicated that it has amended its policies and procedures with regard to Agents and Brokers and has taken steps to ensure that its record keeping and files will be in compliance with the recommendations herein. These amendments have not been reviewed by the examiner.

6. GRIEVANCES AND APPEALS

Section 4802(d) of the New York Insurance Law states in part:

> "Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner..."

During a review of the Plan's compliance with New York's grievance and appeal mandates, the examiner determined that the Plan failed to send acknowledgment letters to two of

the fifteen members in the selected sample within the timeframe prescribed by Section 4802(d) of the New York Insurance Law.

It is recommended that the Plan provide written acknowledgment of a grievance within the fifteen business day time-frame prescribed by Section 4802(d) of the New York Insurance Law.

7. MANDATED BENEFITS

Section 4303(g)(2)(A) of the New York Insurance Law, relative to a health service corporation which provides for group or group remittance coverage for inpatient hospital care, states in part:

> "…a health service corporation, which provides group, group remittance or school blanket coverage for inpatient hospital care, shall provide comparable coverage for adults and children with biologically based mental illnesses. Such…health service corporation shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the contract…"

Section 4303(g)(4)(A) of the New York Insurance Law states in part:

> "…a health service corporation must make available, and…provide the coverage as specified in paragraph two of this subsection. Written notice of the availability of such coverage shall be delivered to the remitting agent or group contract holder prior to inception of such contract and annually thereafter."

Section 4303(h)(2)(A) of the New York Insurance Law, relative to a health service corporation which provides for group or group remittance coverage for physician services, states in part:

> "…a health service corporation, which provides group, group remittance or school blanket coverage for physician services, shall provide comparable coverage for adults and children with biologically based mental illness. Such …health service corporation shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the contract…"

Section 4303(h)(4)(A) of the New York Insurance Law states in part:

> "…written notice of the availability of such coverage shall be delivered to the remitting agent or group contract holder prior to inception of such contract and annually thereafter."

During the review of HealthNow's compliance with benefits mandated by New York the examiner noted that the Plan failed to comply with certain provisions of Section 4303(g)(4)(A), and Section 4303(h)(4)(A) of the New York Insurance Law ("Timothy's Law"), which require the Plan to send a written notice annually to small groups offering make-available benefits for Biologically Based Mental Illness ("BBMI") and benefits for children with Serious Emotional Disturbance ("SED").

The Plan failed to comply with the above-mentioned statutes when it did not send the requisite written notices in 2008. In 2009, the disclosure notices that the Plan issued to small groups were not in compliance with the applicable provisions of the above statutes in that such notices were a one time notice of a variety of changes in plan benefits, and did not state whether BBMI/SED coverage was contained in the reference rider and indicate that the rider is available to employees upon request. The aforementioned notice, thus, did not constitute a written notice to all small groups of the availability of BBMI/SED benefit as required under Timothy's Law.

The examiner determined that the number of violations with regard to the above statutes

for the year ending December 31, 2008 was 3,103 and the number of violations for the year ending December 31, 2009 was 7,063.

The Department acknowledges that the Plan has resolved this finding by a separate Stipulation with the Department and that no further action shall be undertaken against the Plan under this Report with respect to this particular finding.

Notwithstanding the Stipulation it is recommended that the Plan comply with the provisions of Sections 4303(g)(4)(A) and 4303(h)(4)(A) of the New York Insurance Law, by sending such required written notices to the Plan's small groups on an annual basis. It is also recommended that such notices contain the information required by Sections 4303(g)(2)(A) and 4303(h)(2)(A) of the New York Insurance Law.

8. CLAIMS PROCESSING

A claims review was performed using a statistical sampling methodology covering the period January 1, 2008 through December 31, 2008, to evaluate the overall accuracy and compliance environment of HealthNow's claims processing. The claim populations for the Plan and its HMO line of business were divided into medical and hospital claim segments. A random statistical sample was drawn from each segment for the HMO and other than HMO lines of business, except for the items detailed below, to test for verification of compliance with certain specified areas, including: eligibility, fee schedules, co-payments, deductibles, treatment plan authorization, denied claims, and explanation of benefits statements ("EOBs"). It should be noted for the purpose of this analysis, that those medical costs characterized as Pharmacy,

Medicare/Medicaid, Dental, Capitated Payments, Federal Employees Program subscribers and HCRA bulk payments were excluded from this review.

The sample size for each population was comprised of 50 randomly selected unique claim transactions. In total, 200 claims were selected for this review (50 hospital and 50 medical from the Plan, and 50 hospital and 50 medical from the HMO line of business). Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim transaction was processed in accordance with the Plan's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. A financial error is considered a procedural error.

Section 3234(a) of the New York Insurance Law states in part:

> "Every insurer…is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits."

In addition, Section 3234(b) of the New York Insurance Law states in part:

> (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 has been made.

During the process of reviewing the claim transactions within the various claim

adjudication samples, the following was noted:

- The Plan failed to issue complete explanation of benefits statements ("EOBs") for certain denied and out of network claims to comply with the requirements of Sections 3234(b)(6) and 3234(b)(7)of the New York Insurance Law.
- The Plan failed to issue payments on some claims, although there were amounts owed as detailed from the adjudication process. In addition, the Plan failed to issue the requisite explanation of benefits statements in these instances.
- The Plan overpaid the interest that was owed on one claim that was adjudicated, in violation of New York's Prompt Pay Law.

Based on the claims review that was conducted during the examination, the Plan generated EOBs for denied and out of network claims that lacked the requisite wording required by Section 3234(b)(7) of the New York Insurance Law.

The Plan confirmed that when the system receives a request for a particular member's EOB from a prior time period, the system can only produce the current format of the EOB information, which format includes the current notification of appeal rights in effect. Thus it is not possible to produce an exact copy of the relevant EOBs as requested during the examination period. The Plan stated that due to system upgrades for EOBs first issued on and after April 12, 2010, it now has the ability to obtain a copy of the exact EOB issued during a prior period with the applicable notification language at the time of issue.

It is recommended that the Plan issue complete explanation of benefits statements to its insureds or subscribers in all instances in which claims are denied because the insured or subscriber was terminated, and for out of network claims, in compliance with the requirements of Sections 3234(b)(6) and 3234(b)(7) of the New York Insurance Law.

9. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("PROMPT PAY LAW")

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

> "(a) Except 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 submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, 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."

In addition, Section 3224-a(c) of the New York Insurance Law states:

> "(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, 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 on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. 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."

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" (the "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.

A statistical sample of claims not adjudicated within 45 days of receipt by the Plan was reviewed to determine whether the claim was processed in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law ("NYIL"), and if interest was required, and appropriately paid, pursuant to Section 3224-a(c) of the NYIL. Accordingly, all claims that were not adjudicated within 45 days during the period January 1, 2008 through December 31, 2008, were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated.

The claim populations for the Plan and its HMO line of business were separated and further divided into medical and hospital claim segments. A random statistical sample was drawn from each segment, for each entity.

The sample size for each population was comprised of 167 randomly selected unique claims. Additional random samples were generated for each group as "replacement items" in the event it was determined that a particular claim transaction selected in the sample was to be excluded. Accordingly, various replacement items were appropriately utilized. In total, 668 claims were selected for this review, 334 from the Plan and 334 from the Plan's HMO line of business, with 167 medical and 167 hospital claims reviewed, respectively for each entity.

The following charts illustrate the Plan's compliance with the Prompt Pay Law, as determined by this examination:

HNNY (Excluding HMO Line of Business) - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	3,962,555	622,175
Population of claims adjudicated after 45 days of receipt	144,768	40,325
Sample size	167	167
Number of claims with violations	67	47
Calculated violation rate	**40.12%**	**28.14%**
Upper violation limit	47.55%	34.96%
Lower violation limit	32.69%	21.32%
Calculated claims in violation	**58,081**	**11,349**
Upper limit claims in violation	68,843	14,099
Lower limit claims in violation	47,319	8,599

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

HNNY (Excluding HMO Line of Business)- Summary of Violations of Section 3224-a(c) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	3,962,555	622,175
Population of claims adjudicated after 45 days of receipt	144,768	40,325
Sample size	167	167
Number of claims with violations	0	0
Calculated violation rate	N/A	N/A
Upper violation limit	N/A	N/A
Lower violation limit	N/A	N/A
Calculated claims in violation	N/A	N/A
Upper limit claims in violation	N/A	N/A
Lower limit claims in violation	N/A	N/A

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

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

	Medical Claims	Hospital Claims
Total population of claims	1,636,307	335,099
Population of claims adjudicated after 45 days of receipt	66,962	25,394
Sample size	167	167
Number of claims with violations	56	52
Calculated violation rate	**33.53%**	**31.14%**
Upper violation limit	40.69%	38.16%
Lower violation limit	26.37%	24.11%
Calculated claims in violation	**22,454**	**7,907**
Upper limit claims in violation	27,249	9,691
Lower limit claims in violation	17,660	6,124

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

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

	Medical Claims	Hospital Claims
Total population of claims	1,636,307	335,099
Population of claims adjudicated after 45 days of receipt	66,962	25,394
Sample size	167	167
Number of claims with violations	1	0
Calculated violation rate	**0.60%**	**0%**
Upper violation limit	1.77%	0%
Lower violation limit	N/A	0%
Calculated claims in violation	**401**	**0**
Upper limit claims in violation	1,185	0
Lower limit claims in violation	N/A	0

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

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated after forty-five days from receipt and/or such claims adjudicated during the period January 1, 2008 through December 31, 2008, which should have incurred interest of two dollars or more based upon the examiner's calculations.

The population of claims adjudicated after forty-five days from the date of receipt for HNNY consisted of 144,768 and 40,325 medical and hospital claims, respectively, out of 3,962,555 and 622,175 medical and hospital claims processed, respectively, during the period under review.

The population of claims paid after forty-five days from the date of receipt for HNNY-HMO consisted of 66,962 and 25,394 medical and hospital claims, respectively, out of 1,636,307 and 335,099 medical and hospital claims processed, respectively, during the period under review.

The Plan has made improvements with regard to the payment of all claims within forty-five days and the payment of appropriate interest in those instances where interest is due. However, the Plan was not fully compliant with the provisions of Sections 3224-a(a) and (c) of the New York Insurance Law at the time of examination.

It is recommended that the Plan fully comply with the requirements of Section 3224-a(a) of the New York Insurance Law and make appropriate payment of all claims within the forty-five day period provided by the aforementioned section of the Insurance Law.

It is further recommended that the Plan fully comply with the requirements of Section 3224-a(c) and pay appropriate interest in those instances where the interest calculated pursuant to the aforementioned section of the Insurance Law is $2.00 or more.

10. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT ON EXAMINATION

The prior report on examination contained the following eighteen (18) comments and recommendations regarding market conduct items (The page numbers included in the table below refer to the prior report on examination).

ITEM NO.		PAGE NO.
	Section 3224-a of the New York Insurance Law (Prompt Pay Law)	
1.	It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five day period provided by the aforementioned section of the Insurance Law where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law. *The Plan has not fully complied with this recommendation. A similar recommendation is included within this report on examination.*	36
2.	It is further recommended that the Plan pay appropriate interest in those instances where the interest calculated pursuant to Section 3224-a(c) of the New York Insurance Law is $2.00 or more and where there is not an appropriate reason for delay in payment as specified in Sections 3224-a(a) and (b) of the New York Insurance Law. *The Plan has not fully complied with this recommendation. A similar recommendation is included within this report on examination.*	36
	Commissions to Brokers	
3.	It is once again recommended that the Plan, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to its brokers in excess of its commission rates filed with this Department. *The Plan has complied with this recommendation.*	37

ITEM NO. **PAGE NO.**

Notification of Rate Increases

4. It is recommended that the Plan abide by the provisions of Section 4308(g)(2) of the New York Insurance Law and provide at least thirty (30) days advance written notice of a rate increase to each contract holder and subscriber. 37

The Plan has complied with this recommendation.

Response to New York Insurance Department Inquiries

5. It is recommended that the Plan comply with the provisions of New York Insurance Department Regulation 64 Part 216.4(b) and respond within 10 days from date of receipt of an inquiry from the Insurance Department. 38

The Plan has complied with this recommendation.

Experience Rating

6. It is recommended that Plan calculate experience rated group premiums using only approved formulas in compliance with the requirements of Part 52.40 of Department Regulation 52 (11 NYCRR 52.40). 39

The Plan has complied with this recommendation.

Sales and Advertising

7. It is recommended that the Plan comply with the requirements of Department Regulation 34 (11 NYCRR 215.11) in its advertising. 39

The Plan has complied with this recommendation.

N.Y. Schedule M Reporting

8. It is recommended that the Plan reconcile the amounts reported in N.Y. Schedule M of its Annual Statement Data Requirements for Health Maintenance Organizations to the underlying utilization review appeals logs. 40

The Plan has complied with this recommendation.

ITEM NO. **PAGE NO.**

ITEM NO. **PAGE NO.**

Infertility Mandated Claims

15. It is recommended that the Plan re-review its claims data for the period, from September 1, 2002 to present, and identify and appropriately pay all infertility mandated claims, including non-injectible infertility drug claims that were incorrectly processed. It is also recommended that appropriate payment of prompt payment interest be included within such adjusted claim payments. 48

The Plan has complied with this recommendation.

Health Benefits

16. It is recommended that the Plan comply with New York Insurance Law Section 4224(c) and discontinue its coverage of fitness club membership until such time as the benefits therein are made part of the member contracts and are appropriately rated. 49

The Plan has complied with this recommendation.

Underwriting – Sole Proprietor

17. It is recommended that the Plan comply with the underwriting guidelines for enrollment of sole proprietors as set forth in Section 4317(f)(3) of the New York Insurance Law 50

The Plan has complied with this recommendation.

APPENDIX A - HMO OPERATIONS

Commissions to Brokers

18. It is once again recommended that the HMO, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to its brokers in excess of its commission rates filed with this Department. 76

The Plan has complied with this recommendation.

11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Appointment No. **30354**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine into the affairs of the

HealthNow New York, Inc.

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

HMO

with such other information as he 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 8th day of February, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR