

MARKET CONDUCT REPORT ON EXAMINATION
OF THE
HEALTH INSURANCE PLAN OF GREATER NEW YORK
AND
HIP INSURANCE COMPANY OF NEW YORK
AS OF
DECEMBER 31, 2006

DATE OF REPORT

JULY 26, 2012

EXAMINER

WAI WONG

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

July 26, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with instructions contained in Appointment Numbers 22548 and 22549, dated October 30, 2006, annexed hereto, I have made an examination into the affairs of the Health Insurance Plan of Greater New York, a not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law, and its subsidiary, HIP Insurance Company of New York, an accident and health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2006, and submit the following report thereon.

The examination was conducted at the home office of the Health Insurance Plan of Greater New York and HIP Insurance Company of New York, located at 55 Water Street, New York, New York.

Wherever the designations the “Plan” or “HIPNY” appear herein, without qualification, they should be understood to indicate the Health Insurance Plan of Greater New York.

Wherever the designations the “Company” or “HIPIC” appear herein, without qualification, they should be understood to indicate the HIP Insurance Company of New York.

Wherever the designation “HIP” appears herein, without qualification, it should be understood to indicate the Health Insurance Plan of Greater New York and HIP Insurance Company of New York, collectively.

Wherever the designation the “Department” or appears herein, without qualification, it should be understood to indicate the New York State Department of Insurance. The New York State Department of Insurance merged with the New York State Banking Department on October 3, 2011, to become the New York State Department of Financial Services (“DFS”).

1. 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:

- HIP failed to include the provider's charge on all of its explanation of benefits statements ("EOBs"), in violation of Section 3234(b)(4) of the New York Insurance Law ("NYIL").
- HIP failed to include the forfeiture notification on all of its EOBs, in violation of Section 3234(b)(7) of the New York Insurance Law.
- HIP failed to comply with the requirements of Section 3224-a(a), (b), and (c) of the New York Insurance Law ("Prompt Pay Law"), in certain identified instances.
- HIPNY did not collect all recertification forms for renewing members in accordance with the annual recertification requirements of the Healthy New York program prescribed in Sections 362-2.5(b), and (c) of Department Regulation No. 171 (11 NYCRR 362), *The Healthy New York Program & The Direct Payment Stop Loss Relief Program*.
- HIPNY failed to send termination notices to its small group policyholders, at least 30 days prior to the end of the grace period, in violation of Section 55.2(a) of Department Regulation No. 78 (11 NYCRR 55), *Notice to Employees Concerning Termination of Group Accident and Health Insurance Policies*.
- HIPNY violated Article 49, *Utilization Review and External Appeal*, of the New York Public Health Law with regard to certain statutory requirements affecting utilization reviews and appeals.
- Certain advertisements of HIPNY failed to comply with the provisions of Section 215.6(a)(1) and (2) of Department Regulation No. 34 (11 NYCRR 215), *Advertisement of Accident and Health Insurance*.

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

2. SCOPE OF THE EXAMINATION

The previous market conduct examination was conducted as of December 31, 1998. This examination covers the period January 1, 1999 to December 31, 2006, and was performed to review the manner in which the Health Insurance Plan of Greater New York and the HIP Insurance Company of New York conduct their business practices and fulfill their contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate.

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 explanation or description.

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

Separate examinations regarding the financial condition of HIPNY and HIPIC were conducted by the Department as of December 31, 2006. These examinations resulted in separate reports being issued for HIPNY and HIPIC respectively.

3. DESCRIPTION OF THE COMPANIES

HIPIC was incorporated under the laws of the State of New York as a for-profit health insurance company on September 7, 1994. On January 12, 1995, HIPIC issued 30,000 shares of \$10 par value per share common stock to its immediate Parent, HIP Holdings, Inc., for a consideration of \$5,000,000, bringing its authorized capital to \$300,000 and contributed capital

to \$4,700,000. On June 5, 1995, the Department granted HIPIC a license to operate as an accident and health insurance company, as defined in paragraphs 3(i) and (ii) of Section 1113(a) of the New York Insurance Law. HIPIC commenced its operations in September 1995.

HIPNY is a New York State not-for-profit corporation operating under the provisions of Article 43 of the New York Insurance Law. The Plan also operates as a certified health maintenance organization (“HMO”), pursuant to the provisions of Article 44 of the New York Public Health Law. Since February 10, 2005, retroactive to January 1, 1998, HIPNY is exempt from federal income taxes under Section 501(a) of the Internal Revenue Code (“IRC”), as described in Section 501(c)(4) of the IRC. Prior to that date, HIPNY was exempt per Section 501(c)(3) of the IRC. As a result of this change in tax status, HIPNY was required to pay federal unemployment taxes.

On November 15, 2006, having received regulatory approval from the New York State Insurance Department, HIPNY agreed to an affiliation with Group Health Incorporated (“GHI”), a not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law. As a result of the transaction EmblemHealth, Inc. (“Emblem”) became the sole member and parent corporation of HIPNY, GHI and their respective subsidiaries. HIPNY and GHI named an equal number of directors to the Emblem Board.

On March 6, 2007, EmblemHealth Services Company, LLC (“EHS”) was formed by a joint venture of HIPNY and GHI, in order to integrate operations of these two entities. On January 1, 2008, items such as vendor agreements and employees were transferred to EHS. HIPNY and GHI receive management and other services from EHS. Also on that date, with the approval of the Department, HIPNY and GHI entered into a written guarantee of the liabilities of EHS.

In April 2007, a change in the New York Insurance Law was enacted to permit not-for-profit insurers such as HIPNY and GHI to convert to for-profit status. On April 16, 2007, Emblem submitted an application to the Department, to convert HIPNY and GHI to for-profit status. The application was approved by the board of directors of both HIPNY and GHI.

Under the plan of conversion submitted, Emblem would form a for-profit, publicly traded holding company, which would be the ultimate parent of HIPNY and GHI. The application calls for approximately 20% of the stock of the publicly traded holding company to be sold at the time of conversion, with the proceeds transferred to New York State. The remaining shares would be held by New York State and sold over time at the State's discretion.

As of the date of this Report, the Department has not yet issued a decision regarding the proposed conversion.

4. CLAIMS PROCESSING

The examination's claim processing review was performed to identify whether there were any systemic errors in HIP's claim processing system and to evaluate the overall accuracy and compliance environment of its claim processing procedures.

For the period January 1, 2006 to December 31, 2006, a listing of 870 HIPNY and 106 HIPIC grievance or appeal cases, whose initial determinations were overturned, was used as the population for the examiner's review. One hundred (100) HIPNY cases and forty-three (43) HIPIC cases were randomly selected and the claim transactions that triggered the grievance or appeal were reviewed. During the process of reviewing the claim transactions, the following was noted:

HIP's explanation of benefit statements ("EOB") was missing the provider's charge.

Section 3234(b)(4) of the New York Insurance Law states:

"(b) The explanation of benefits form must include at least the following:

(4) the provider's charge or rate;"

It is recommended that HIP comply with the requirements of Section 3234(b)(4) of the New York Insurance Law by including the provider's charge on all EOBs.

HIP's EOBs were missing the required disclosure notifying the consumer that rights to challenge an adverse opinion are subject to the requirements set forth by the insurer, as set forth by Section 3234(b)(7) of the New York Insurance Law (see underlined portion of citation below).

Section 3234(b)(7) of the New York Insurance Law states:

"(b) The explanation of benefits form must include at least the following:

(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."

It is recommended that HIP include the above required notification on its EOBs, in compliance with the requirements of Section 3234(b)(7) of the New York Insurance Law regarding a failure to appeal may result in loss of certain rights.

In cases where HIP made adjustments to previously processed claims, there was no reference (number) to the original claim on the newly issued EOB. A reference (number) should

be included so that a complete analysis of the claim can be performed. A similar finding was noted in the prior Market Conduct examination report as of December 31, 1998.

HIP advised that if an adjustment is required to a previously paid claim, then the original claim number will be included on the EOB as the adjustment is made to the same claim and no new number is created. For claims that are originally denied and then adjusted, a new claim number will be generated so that there will be both the original and the new claim numbers in HIP's system. For these situations, the original claim number is recorded on the adjusted claim as, confirmed during the examination, but not printed on the EOB. The new claim number appears on the EOB. Significant systems programming would be required to reflect the original claim number on the EOB and may ultimately confuse the recipient if multiple claim numbers were reported.

HIP was using the same Explanation of Change ("EOC") code (D07) for two types of denials, denials where there was no prior approval for a procedure and denials where no referral was received from a primary care physician ("PCP").

A standard HIP insurance contract states that, "*all other services [not performed by the PCP] must be referred by the member's PCP and/or approved in advance by the HIP Management Program.*" As such, obtaining an approval prior to obtaining the service can be a separate contractual requirement from obtaining the referral. At times, claims were denied where neither of these two requirements was satisfied, and at times, claims were denied if only one of the requirements was satisfied. Using EOC code D07 interchangeably for these two denials can cause confusion to the provider/member as to the exact reason a claim was denied.

Also, it does not allow HIP to track these denials, to determine whether there is an underlying issue triggering these denials.

It is recommended that HIP create separate EOCs for denials where there was no prior approval for a procedure and for denials where no referral was received from a primary care physician (“PCP”).

In response to this finding, HIP’s Claims Department removed the referral comment on its explanation of benefits statements so that the EOC code for D07 states *“These services were not pre-certified. Under the terms of your coverage no payment will be made. Do not bill the subscriber.”*

HIP uses third party vendors to perform claim coding reviews and furnish recommendations to HIP for medical claims. These vendors maintain a database of guidelines from sources including but not limited to the Centers for Medicare and Medicaid Services National Correct Coding Initiative and the American Medical Association CPT Manual. This data is used to make recommendations regarding the correct coding of procedures; the proper use of modifier rules; and services covered under global surgery rules among other technical coding information.

The examiner’s review found that such vendors recommended “bundling”, or combining, separately billed procedures and recommending that HIPIC pay for only one of the procedures in the global fee paid to out-of-network providers. In some instances, the out-of-network provider “balance billed” the HIPIC member for the remainder of the billed claim. Based on the foregoing method of pricing claims, certain subscribers filed appeals with HIPIC in regard to

their responsibility for payment. Upon HIPIC's review and receipt of additional information, most of the appeals were overturned, and HIPIC paid the non-par provider the "allowed amount", based upon the subscribers out-of-network benefits.

It is recommended that HIPIC pay all out-of-network claims in accordance with the member contract and generally accepted medical coding and billing standards.

There were three cases where HIP (two HIPNY and one HIPIC) could not provide the examiner with a grievance or appeal file for review, in violation of Department Regulation No. 152 (11 NYCRR 243), which sets forth standards of retention of records by an insurer.

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

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

(8) 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."

It is recommended that HIP retain all records for the period required by Section 243.2(b)(8) of Department Regulation No. 152.

There were three files where HIP (two HIPNY and one HIPIC) applied the incorrect office visit co-payment ("co-pay") amounts to a subscriber. In each instance, the subscriber was charged the higher specialist co-pay amount instead of the general practice co-pay amount. The error occurred during the examination period because HIP's claim system did not allow more than one specialty to be entered for each provider. Therefore, in cases where providers had more than one specialty, the system charged incorrect co-pays any time one of these providers saw a patient in a specialty other than what was entered into the system.

It is recommended that HIP take steps to correct system errors that resulted in incorrect co-pay amounts being charged to subscribers.

There was one case where HIPNY denied a claim for a possible pre-existing condition. The denial was overturned on appeal when the subscriber provided a copy of the certificate of prior coverage. It should also be noted that as part of the Prompt Pay Law review of HIPNY and HIPIC, detailed in Section 5 of this report, there were many claims pended for possible pre-existing conditions.

During the examination period, HIP's procedure was to start investigating pre-existing conditions ("PEC") only when a claim or request for prior approval of services possibly related to a PEC was received. Further, HIP's policy was to not request a certificate of prior coverage at the time of enrollment.

It is recommended that HIP conduct their PEC investigations at the time of enrollment, so that ensuing claims may be processed appropriately and in a timely manner.

In order to reduce or eliminate a pre-existing condition period for small groups, sole proprietors and direct pay members, in November 2007, HIP's Enrollment Department began to send out letters to newly enrolled subscribers, requesting a certificate of prior coverage.

The examiner's review found two cases where HIPIC incorrectly charged co-insurance and deductibles on an outpatient facility claim; co-insurance and deductible charges are only applicable to inpatient facility claims. HIPIC's claims system failed to recognize that certain professional outpatient services had co-insurance and deductibles applied that were not applicable.

It is recommended that HIPIC take steps to correct system errors that result in incorrect co-insurance or deductible amounts charged to insureds for outpatient facility claims.

In response to the examination finding, HIP created a corporate initiative named “Benefits Flexibility”. Benefits Flexibility allows HIP to identify different types of services provided at an outpatient facility. Thus, HIP is able to more accurately assess deductibles and coinsurance based on the specific type of service rendered at these facilities. The initiative was officially implemented in October of 2008.

The examiner noted one instance where HIPIC incorrectly processed an out-of-network provider claim as an in-network claim. The error was attributed to problems in the claims system’s preauthorization tables, which resulted in out-of-network services being misread as in-network. This affected only out-of-network claims and for the claims reviewed by the examiner no underpayment or additional out-of-pocket expense on the part of the member resulted from this error.

HIPIC identified the error and made the corrections in its claims system in August 2006.

5. PROMPT PAY LAW

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:

“...(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.”

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

“...(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.”

A statistical sample of claims not adjudicated within 45 days of receipt by HIP was reviewed to determine whether the payment was 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 of receipt, during the period January 1, 2006 through December 31, 2006, were segregated.

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 to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or

the manner in which services were accessed or provided, 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...”

A statistical sample of denied claims not denied within 30 days of receipt by HIP was reviewed to determine whether the denial was 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 days of receipt during the period January 1, 2006 through December 31, 2006, were segregated.

The following charts illustrate HIP’s Prompt Pay Law compliance as determined by this examination:

HIPNY - Summary of Violations of Section 3224-a(a) of the NYIL

	Medical Claims	Hospital Claims
Total population	2,557,401	370,585
Population of claim transactions adjudicated after 45 days of receipt	25,087	2,514
Sample size	167	167
Number of transactions with violations	80	21
Calculated violation rate	47.90%	12.57%
Upper violation limit	55.48%	17.60%
Lower violation limit	40.33%	7.55%
Calculated transactions in violation	12,017	316
Upper limit transactions in violation	13,918	442
Lower limit transactions in violation	10,118	190
Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected, the violation rate would fall between these limits 95 times).		

HIPNY - Summary of Violations of Section 3224-a(c) of the NYIL

	Medical Claims	Hospital Claims
Total population	2,557,401	370,585
Population of claim transactions adjudicated after 45 days of receipt that are eligible for interest	7,926	1,829
Sample size	167	167
Number of transactions with violations	11	6
Calculated violation rate	6.59%	3.59%
Upper violation limit	10.35%	6.42%
Lower violation limit	2.82%	.77%
Calculated transactions in violation	522	66
Upper limit transactions in violation	820	117
Lower limit transactions in violation	224	14
Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected, the violation rate would fall between these limits 95 times).		

HIPNY - Summary of Violations of Section 3224-a(b) of the NYIL

	Medical Claims	Hospital Claims
Total population	2,557,401	370,585
Population of claim denials, denied after 30 days of receipt	34,790	2,525
Sample size	167	167
Number of transactions with violations	158	98
Calculated violation rate	94.61%	58.68%
Upper violation limit	98.04%	66.15%
Lower violation limit	91.19%	51.21%
Calculated transactions in violation	32,915	1,482
Upper limit transactions in violation	34,108	1,670
Lower limit transactions in violation	31,725	1,293
Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected, the violation rate would fall between these limits 95 times).		

HIPIC - Summary of Violations of Section 3224-a(a) of the NYIL

	Medical Claims	Hospital Claims
Total population	99,562	8,716
Population of claim transactions adjudicated After 45 days of receipt	2,552	194
Sample size	167	167
Number of transactions with violations	123	126
Calculated violation rate	73.65%	75.45%
Upper violation limit	80.33%	81.98%
Lower violation limit	66.97%	68.92%
Calculated transactions in violation	1,880	146
Upper limit transactions in violation	2,050	159
Lower limit transactions in violation	1,709	134
Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected, the violation rate would fall between these limits 95 times).		

HIPIC - Summary of Violations of Section 3224-a(c) of the NYIL

	Medical Claims	Hospital Claims
Total population	99,562	8,716
Population of claim transactions adjudicated after 45 days of receipt that are eligible for interest	1,098	140
Sample size	167	140
Number of transactions with violations	27	85
Calculated violation rate	16.17%	60.71%
Upper violation limit	21.75%	60.71%
Lower violation limit	10.58%	60.71%
Calculated transactions in violation	178	85
Upper limit transactions in violation	239	85
Lower limit transactions in violation	116	85
Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected, the violation rate would fall between these limits 95 times).		

HIPIC - Summary of Violations of Section 3224-a(b) of the NYIL

	Medical Claims	Hospital Claims
Total population	99,562	8,716
Population of claim denials, denied after 30 days of receipt	2,060	149
Sample size	167	149
Number of transactions with violations	159	104
Calculated violation rate	95.21%	69.80%
Upper violation limit	98.45%	69.80%
Lower violation limit	91.97%	69.80%
Calculated transactions in violation	1,961	104
Upper limit transactions in violation	2,028	104
Lower limit transactions in violation	1,895	104
Note: The upper and lower violation limits represent the range of potential violations (e.g., if 100 samples were selected, the violation rate 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 over forty-five days from receipt, or denied over thirty days from date of receipt, and where applicable, those claims which incurred interest of two dollars or more, based upon the examiner's review of claims adjudicated during the period January 1, 2006 through December 31, 2006.

The claim populations for the HIPNY and HIPIC were divided into medical and hospital segments. A random statistical sample was drawn from each segment, for each entity. It should be noted that for the purpose of this analysis, medical costs characterized by HIP as "Medicare/Medicaid", "Capitated Payments", "Self Insured", as well as other claims not under the regulatory authority of the Department for Prompt Pay purposes were excluded from the examiner's review. After removal of these claims, the total number of claims adjudicated in 2006 from which the HIPNY sample was drawn was 2,927,986. The total number of claims adjudicated in 2006 from which the HIPIC sample was drawn was 108,278.

The population of claims adjudicated over forty-five days from date of receipt for HIPNY consisted of 27,601 total medical and hospital claims out of 2,927,986 total medical and hospital claims extracted for review during the period under review. The population of claims which incurred interest of two dollars or more consisted of 9,755 medical and hospital claims combined out of 2,927,986 total medical and hospital claims extracted for review, during the period under review. The population of claims that were denied over thirty calendar days from the date of receipt consisted of 37,315 medical and hospital claims out of 2,927,986 total medical and hospital claims extracted for review , during the period under review.

The population of claims adjudicated over forty-five days from date of receipt for HIPIC consisted of 2,746 medical and hospital claims combined out of 108,278 total medical and hospital claims extracted for review, during the period under review. The population of claims which incurred interest of two dollars or more consisted of 1,238 medical and hospital claims out of 108,278 total medical and hospital claims extracted for review, during the period under review. The population of claims that were denied over thirty calendar days from date of receipt consisted of 2,209 medical and hospital claims out of 108,278 total medical and hospital claims extracted for review, during the period under review.

It is recommended that HIP take steps to ensure that the provisions of §3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with.

It is also recommended that HIP take steps to ensure that the provisions of §3224-a(b) of the New York Insurance Law, regarding the prompt adjudication of claims, are fully implemented and complied with.

It is further recommended that HIP take steps to ensure that the provisions of §3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with.

6. UNDERWRITING AND RATING

A. Healthy New York

HIPNY provided a listing of 1,435 Healthy New York policies that were issued or renewed from January 1, 2006 through December 31, 2006. A sample of eighteen (18) files was selected for review.

A review of HIPNY's Healthy New York applications found that the mailing address on the Department's website was different from the one listed in HIPNY's Healthy New York application forms. The mailing address on the Department's website is 55 Water Street, New York, NY 10041. The mailing address on HIPNY's Healthy New York application forms is P.O. Box 2793, New York, NY 10116 for individuals and sole proprietors, and P.O. Box 2806, New York, NY 10116, for small employers.

It is recommended that HIPNY notify the Department of the updated addresses for its Healthy New York applications.

Subsequent to the exam date, HIPNY notified the Department of its updated P.O. Box addresses for its Healthy New York applications and updated the Department's website with the correct address.

Sections 362-2.5(a), (b) and (c) of Department Regulation No. 171 (11 NYCRR 362-2.5) state:

“(a) Health maintenance organizations and participating insurers shall, at least 90 days prior to the annual renewal date, provide any forms necessary for recertification.

(b) Health maintenance organizations and participating insurers shall annually collect certifications of continued eligibility for the Healthy New York Program and shall be responsible for examination of such certifications to verify that small employers and individuals participating in the program continue to meet eligibility requirements and continue to comply with the terms of the program. Health maintenance organizations and participating insurers shall determine whether the small employer and individual participants continue to meet the requirements for participation in the Healthy New York Program and shall provide written notice of such determination within two weeks of receipt of the annual recertification.

(c) The failure of an employer or individual to provide written certification demonstrating continued eligibility and continued compliance with the terms of the Healthy New York Program shall be a basis for nonrenewal of a qualifying health insurance contract.”

Of the eighteen (18) 2006 Healthy New York underwriting files reviewed by the examiner to review HIPNY’s adherence to the prescribed annual recertification requirements noted above, thirteen (13) files were renewed in 2006. The examiner requested copies of the recertification forms for these files. It appears that enrolled members failed to timely submit to HIPNY their recertification forms.

HIPNY failed to obtain Health New York recertification forms for eleven (11) out of the thirteen (13) because subscribers did not respond and return their forms. In all these cases, the member submitted payment of premium and HIPNY made the determination to continue enrollment without gap in coverage while the recertification process proceeded.

It is recommended that HIPNY collect all recertification forms for all of its Healthy New York renewals, in compliance with the requirements of Sections 362-2.5(a), (b) and (c) of Department Regulation No. 171.

B. Small Group Terminations

Section 55.2(a) of Department Regulation No. 78 (11 NYCRR 55.2) states in part:

“An insurer who intends to terminate a group policy or contract of accident, or health, or accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificate holders under a group policy shall give the policyholder at least 30 days prior written notice of its intent to terminate coverage...”

A sample of eight (8) “reminder” letters and “termination” letters for terminated small groups was reviewed. For seven (7) of the eight (8) files, the first notice (the reminder letter) sent to the groups advising them of HIPNY’s intent to terminate the policy for nonpayment of premium, were all sent less than 30 days prior to the end of the grace period, in violation of Section 55.2(a) of Department Regulation No. 78 (11 NYCRR 55.2).

It is recommended that HIPNY comply with the provisions of Section 55.2(a) of Department Regulation No. 78 and send all reminder notices at least 30 days prior to the end of the grace period.

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

“(b) Except as otherwise required by law or regulation, an insurer shall maintain:

(8) 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.”

In three (3) of the eight (8) cases detailed above, HIPNY could not provide copies of either the reminder letter or the termination letter, in violation of Section 243.2(b)(8) of Department Regulation No. 152.

It is again recommended that HIPNY comply with the requirements of Section 243.2(b)(8) of Department Regulation No. 152 and maintain all required records for at least six years.

7. UTILIZATION REVIEW AND APPEALS

Sections 4902, 4903 and 4904 of the Public Health Law set forth the minimum utilization review program standards and requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents respectively, for HMOs licensed under Article 44 of the Public Health Law. Thus, these statutes apply to HIPNY, an Article 43 insurer with a line of business HMO. Comparable sections of Article 49 of the New York Insurance Law contain the same requirements for insurers licensed under Article 42 of the New York Insurance Law such as HIPIC.

HIP provided the examiner with utilization review and utilization review appeal logs for the period January 1, 2006 through December 31, 2006, for cases involving HIP and several of its contracted delegated entities. HIP delegates to certain of its contracted providers, utilization review and utilization review appeal responsibilities. These contracted providers include: CareCore, Healthcare Partners, Montefiore IPA, Inc., CMO the Care Management Company, LLC (“CMO”) and Prism. Utilization review and utilization review appeal cases conducted by HIP and the above contracted providers were reviewed by the examiner:

A. Utilization Review (“UR”)

i. HIPNY

From a log of 12,830 utilization review cases closed during January and June of 2006, twenty (20) randomly selected HIPNY utilization review files were reviewed by the examiner. Eleven (11) of the twenty (20) cases were prospective reviews, and the remaining nine (9) cases were concurrent reviews.

Section 4903(3) of the New York Public Health Law states in part:

“(3) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider...and shall provide notice of such determination to the enrollee or the enrollee’s designee, which may be satisfied by notice to the enrollee’s health care provider, by telephone and in writing within one business day of receipt of the necessary information...”

One (1) concurrent review case was handled in violation of Section 4903(3) of New York Public Health Law, when HIPNY failed to send the written notice of determination to the provider within one business day.

It is recommended that HIPNY comply with Section 4903(3) of the New York Public Health Law and provide the written notice of determination within the required timeframe.

ii. HIPNY/CareCore National LLC (“CareCore”)

From a log of 6,432 utilization review cases closed during January and June of 2006, fifteen (15) randomly selected HIPNY/CareCore utilization review files were reviewed by the examiner. All fifteen cases were prospective reviews.

Section 4903(2) of the New York Public Health Law states:

“(2) 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 enrollee or enrollee’s designee and the enrollee’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

In two (2) out of the fifteen (15) cases reviewed by the examiner, CareCore failed to provide a notice of determination within three business days by telephone and in writing either to the enrollee/enrollee’s designee or the provider, in violation of Section 4903(2) of the New York Public Health Law.

It is recommended that HIPNY and CareCore comply with the requirements of Section 4903(2) of the New York Public Health Law and provide notices of determination within three business days by telephone and in writing to the enrollee/enrollee’s designee and the provider in regard to prospective reviews.

iii. HIPNY/ Heritage Northeast Medical Management, Inc. (“Healthcare Partners”)

From a log of 12,068 utilization review cases closed during January and June of 2006, the examiner randomly selected and reviewed twenty (20) HIPNY/Healthcare Partners utilization review files. Of the twenty (20) cases selected nineteen (19) were prospective reviews, while the remaining case was a concurrent review.

Section 4903(2) of the New York Public Health Law states:

“(2) 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 enrollee or enrollee’s designee and the enrollee’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

In eleven (11) out of the twenty (20) cases reviewed, the examiner found that Healthcare Partners violated Section 4903(2) of the New York Public Health Law, when it faxed their utilization review decisions to the providers, in lieu of the requirement that the utilization review agent provide, “notice of a determination to the enrollee or enrollee’s designee and the enrollee’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

It is recommended that HIPNY and Healthcare Partners provide a determination notice by telephone and in writing to the enrollee or enrollee’s designee and the enrollee’s health care provider within three business days of receipt of the necessary information, in compliance with Section 4903(2) of the New York Public Health Law.

iv. HIPNY/CMO the Care Management Company, LLC (“CMO”)

From a log of 623 utilization review cases closed during January and June of 2006, ten (10) HIPNY/CMO utilization review files were randomly selected and reviewed by the examiner. Of the ten (10) cases, five (5) were concurrent reviews, and the other five (5) were prospective reviews.

Section 4903(2) of the New York Public Health 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 enrollee or enrollee’s designee and the enrollee’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

There were two (2) cases where CMO failed to send out the determination letter or contact the enrollee or his/her provider by phone, in violation of Section 4903(2) of the New York Public Health Law.

It is recommended that HIPNY and CMO provide all verbal and written notices to the enrollee or his/her provider in order to comply with Section 4903(2) of the New York Public Health Law.

Section 4903(3) of the New York Public Health Law states in part:

“A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee’s designee, which may be satisfied by notice to the enrollee’s health care provider, by telephone and in writing within one business day of receipt of the necessary information...”

There was one instance where CMO failed to make a determination within one business day, in violation of Section 4903(3) of the New York Public Health Law.

It is recommended that HIPNY and CMO comply with Section 4903(3) of the New York Public Health Law and provide all notices of determination within one business day.

Section 4903(5)(b) of the New York Public Health Law states in part:

“(5) Notice of an adverse determination made by a utilization review agent shall be in writing and must include...”

(b) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article...”

The examiner found one file where CMO approved only three skilled nursing visits, instead of the five visits requested, without issuance of an adverse determination notice, in violation of Section 4903(5)(b) of the New York Public Health Law.

It is recommended that HIPNY and CMO provide all notices of adverse determination where required, in compliance with the requirements of Section 4903(5)(b) of the New York Public Health Law.

As noted previously, Department Regulation No. 152 (11 NYCRR 243) sets forth standards of retention of records by an insurer.

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

“(b) Except as otherwise required by law or regulation, an insurer shall maintain:

(8) 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.”

There were (2) cases where HIPNY/CMO could not provide copies of the “End of Day” report (report to the provider showing a complete listing of UR files that HIPNY/CMO had completed their review for this provider during the day) as proof of written notification to the provider. According to HIPNY/ CMO copies of the “End of Day” reports are only kept for 2 months.

It is recommended that HIPNY/CMO comply with the provisions of Section 243.2(b)(8) of Department Regulation No. 152 and maintain all required records for at least six calendar years.

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

“(2) 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.”

There were four (4) cases in violation of the above Regulation. In three (3) of the cases (prospective review) the verbal/telephonic notification of the utilization review determinations to the member and/or the provider was not documented. For one (1) of these files (concurrent review), as described above, five requested skilled nurse visits were reduced to three visits as a result of a review by the CMO. The review process was not documented.

It is recommended that HIPNY/CMO comply with the requirements of Section 243.3(a)(2) of Department Regulation No. 152, by documenting all non-paper communications, transactions or events.

Section 243.2(d) of Department Regulation No. 152 (11 NYCRR 243) states:

“(d) An insurer shall require, by contract or other means, that a person authorized to act on its behalf in connection with the doing of an insurance business, including a managing general agent, an administrator, or other person or entity, shall comply with the provisions of this Part in maintaining records that the insurer would otherwise be required to maintain. Notwithstanding the above, the insurer shall be responsible if the person or entity fails to maintain the records in the required manner.”

HIPNY is in violation of the above section, as it is responsible for the actions of its contracted/delegated entities, such as CMO (failure to retain proper records).

It is recommended that HIPNY ensure that its delegated entities comply with the requirements of Department Regulation No. 152.

B. Utilization Review Appeals

i. HIPNY Utilization Review Appeals

From a log of 1,300 utilization review appeal cases resolved during March, June, September and December of 2006, a random sample of thirty (30) utilization review appeal files were selected and reviewed by the examiner.

Section 4904(3)(b) of the New York Public Health Law states in part:

“3. A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the enrollee, the enrollee’s designee and, where appropriate, the enrollee’s health care provider, in writing, of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include...

(b) a notice of the enrollee’s right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of insurance as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.”

There were four (4) files where HIPNY failed to include the notice of external appeal rights with its determination notices, in violation of the requirements of Section 4904(3)(b) of the New York Public Health Law.

It is recommended that HIPNY comply with the requirements of Section 4904(3)(b) of the New York Public Health Law, by providing external appeal rights on all determination notices.

ii. HIPNY/CMO

From a log of twenty (20) utilization review appeal cases closed during 2006, a sample of eleven (11) utilization review appeal files was selected and reviewed by the examiner. The following is the summary of the review:

Section 4904(4) of the New York Public Health Law states:

“(4) Both expedited and standard appeals shall only be conducted by clinical peer reviewers provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.”

In four (4) of the eleven (11) cases, the initial utilization review was an administrative denial (lack of clinical information) signed by a medical doctor. For the subsequent appeal of all four (4) cases, the additional information provided was reviewed and approved by the same medical doctor who performed the initial utilization review, in violation of Section 4904(4) of the New York Public Health Law.

It is recommended that HIPNY comply with the requirements of Section 4904(4) of the New York Public Health Law and require that a utilization review appeal be reviewed by a clinical peer reviewer, other than the clinical peer reviewer who rendered the initial adverse determination.

In four (4) of the eleven (11) cases, there was an inconsistency in regard to the wording in the provider appeal instructions document and the provider appeal acknowledgement letter. The provider appeal acknowledgement letter stated that, “providers have forty-five days to file an appeal from the date that CMO, The Care Management Company, LLC rendered the adverse determination”; while, the provider appeal instructions document stated that the provider “must submit the request for appeal within forty-five (45) days of receipt of the initial, written adverse determination.”

It is recommended that HIPNY revise the applicable letter template to ensure consistency in the timeframes.

In six (6) of the eleven (11) cases, the appeal review sheet signed by the clinical peer reviewer was not dated. It is imperative that the appeal review sheet be dated to reflect the actual date of determination. This piece of information is essential for determining compliance with Section 4904(3) of the New York Public Health Law, which requires that, “the utilization review agent shall notify the enrollee, the enrollee’s designee and, where appropriate, the enrollee’s health care provider, in writing, of the appeal determination within two business days of the rendering of such determination.”

It is recommended that HIPNY put in place procedures to ensure that the clinical peer reviewer date his/her sign-off on the appeal review sheet.

8. ADVERTISING

The examiner reviewed HIP's advertising documentation for the period January 1, 2006 through December 31, 2006, to ascertain compliance with Department Regulation No. 34 (11 NYCRR 215), "*Rules Governing Advertisements of Accident and Health Insurance*".

Section 215.6(a)(1) of Department Regulation No. 34, (11 NYCRR 215.6) states in part:

"No advertisement shall omit information or use words, phrases, statements or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements."

Section 215.6(a)(2) of New York Regulation 34 (11 NYCRR 215.6) states in part:

"No advertisement shall contain or use words or phrases such as, "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help pay your hospital and surgical bills," "this policy will help fill some of the gaps that medicare and your present insurance leave out," "this policy will help to replace your income" (when used to express loss of time benefits), or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy."

A. Telemarketing Scripts

A HIP HMO Direct Pay and Choice Plus Direct telemarketing script was found to be in violation of Section 215.6(a)(2) of Department Regulation No. 34 (11 NYCRR 215.6) and Section 4323(c) of the New York Insurance Law for describing benefits to the customer as "comprehensive."

It is recommended that all advertisements comply with Section 215.6(a)(2) of Department Regulation No. 34 and discontinue use of the phrase “comprehensive”.

B. Printed Advertisements

The direct mail and print magazine advertisements for the New York City groups (group contracts for New York City employees) did not have the advertisement release or period date marked on them. These advertisements advertise features such as co-payments, deductibles and payroll deductions that may be subject to change. For example, New York City Metropolitan Transit Authority workers did not start paying payroll premium deductions until 2007.

It is recommended that HIP’s advertisements include a “valid through date” marked on them, in order to ensure that the references are timely and unambiguous and in compliance with Section 215.6(a)(1) of Department Regulation No. 34.

The direct mail and print magazine advertisements for the New York City groups also did not contain clarifications on the phrase, “\$0 payroll deductions”. The advertisement of “\$0 payroll deductions” might be misleading in regard to the cost of the plan.

It is recommended that, where restrictions apply, the advertisement include language stating that: “limitations, and exclusions may apply on some services” and “ask for a summary of benefits for details”, in order to comply with the requirements of Section 215.6(a)(1) of Department Regulation No. 34.

HIPNY utilized an advertisement that noted the National Committee for Quality Assurance (“NCQA”) stated that HIPNY was rated “Excellent” for HMO and POS plans. This advertisement failed to specify the year(s) the NCQA statistics rating was based on. The

advertisement did not specify that, “according to The State of Healthcare Quality 2005, report by the NCQA, the HIPNY HMO Medicaid plan was ranked 25th!” According to the NCQA 2006 accreditation status, HIPNY HMO and POS plans were given a score of 82.7 and a rank of 172. The NCQA report did not specify that HIPNY was given an “Excellent” rating.

It is recommended that advertisements specify the source of the statistics/ratings, as well as the date of the accreditation in order to comply with the requirements of Section 215.6(a)(1) of Department Regulation No. 34.

It is also recommended that HIPNY discontinue the use of the “Excellent” NCQA rating in its direct mail and print magazine advertisements, unless it is supported by the source.

9. PRODUCER LICENSING

The examiner performed a review of HIPNY’s initiated agent terminations for the period January 1, 2002 through December 31, 2006. HIPNY terminated 62 agents during this period.

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

“(d) 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. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known

address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication.”

There were three (3) instances where an agent was terminated by HIPNY, but the Department’s Licensing Bureau did not have any record of an agent termination by HIPNY, nor were the termination notices for the three (3) agents available in HIPNY’s files.

It is recommended that when applicable HIPNY file all termination notices with the Department, in compliance with the requirements of Section 2112(d) of the New York Insurance Law.

It is also recommended that HIPNY keep records of its terminated agents and the termination notices, in accordance with the provisions of Section 243.2(b)(8) of Department Regulation No. 152, as quoted above.

10. GRIEVANCES AND APPEALS

HIPIC provided a log which contained 254 grievance files to the examiner. The files covered the period January 1, 2006 through December 31, 2006. A sample of twenty-five (25) files was selected by the examiner to determine compliance with HIPIC’s policies and procedures in regard to its handling of grievances. The following was determined:

In one (1) of the twenty-five (25) cases reviewed, HIPIC failed to send an acknowledgement letter to the insured, in response to a filing of a grievance.

It is recommended that HIPIC send out all required acknowledgement letters in response to a grievance filing within fifteen days as required by its grievance procedures.

11. SPECIAL INVESTIGATIONS UNIT

As per HIP's fraud plan, filed with the Department pursuant to the requirements of Section 409 of the New York Insurance Law, a Special Investigations Unit ("SIU") was established in 1998. Reporting to the President and Chief Operating Officer, the SIU is separate from and independent of the underwriting and claims function. The SIU is tasked with the responsibility of developing a corporate anti-fraud prevention, detection, and investigation function, while maintaining a complementary relationship with applicable government agencies.

According to HIP's fraud plan, the SIU is to be staffed with ten members, headed by a Managing Director. A Manager is to oversee six investigators, two support staff members, and is to report to the Managing Director. As of December 31, 2007, the SIU was only staffed by five investigators, two support staff and the Managing Director.

It is recommended that HIPNY's fraud plan be updated on a more timely basis to reflect actual staffing.

As part of the examiner's review of HIP's SIU, a breakdown was requested in regard to the dollar value of savings reported in HIP's 2006 "409(g) filing" ("Annual SIU Report"), submitted to the Department. A review of the data indicated that the SIU recorded two types of savings from fraud investigations. One type was "recoveries", where the SIU recorded dollar amounts (\$1.2 million) actually recovered in 2006 from fraud investigations, regardless of when the investigation(s) occurred. The other type of savings was preventive, where fraudulent claims (\$4.0 million) were prevented from being paid due to investigations by the SIU. For the preventive savings, the SIU did not have any procedures in place to record when the savings were considered to have occurred, or what was actually prevented.

It is recommended that policies and procedures be updated to define the accounting of savings from SIU activities.

12. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT

The prior market conduct report contained fifty-six (56) comments and recommendations (page numbers refer to the prior Market Conduct Report):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Sales</u>	
1. It is recommended that HIP comply with Section 52.42(e) of Department Regulation No. 62 and Circular Letter No. 36 (1999) as regards the payment of commissions.	4
<i>HIP has complied with this recommendation.</i>	
2. It is recommended that HIP have agent agreements with all its agents, and that all these agreements be fully executed in a timely manner.	5
<i>HIP has complied with this recommendation.</i>	
3. It is recommended that HIP comply with Sections 2114(a)(3) and 2116 of the New York Insurance Law.	6
<i>HIP has complied with this recommendation.</i>	
4. Further, it is recommended that HIP institute procedures that require all general agents to provide HIP with a copy of all licenses of their agents and brokers that represent HIP or write business for HIP.	6
<i>HIP has complied with this recommendation.</i>	
5. It is recommended that HIP institute procedures to ensure compliance with Section 2112(a) of the New York Insurance Law with respect to filing the required certificate of appointment forms for both general agents, and agents/brokers writing through general agents.	7
<i>HIP has complied with this recommendation.</i>	

ITEM NO.**PAGE NO.**Healthy New York

6. It is recommended that HIPNY institutes proper procedures and training for its employees that staff its Healthy New York hotline. 8

HIP has complied with this recommendation.

Monitoring of HIP's Medical Centers

7. It is recommended that the issues regarding HIP's lack of compliance with its guidelines, and failure to review all of its applicable sites and provide complete and detailed documentation regarding the site visits, be referred to the New York State Department of Health for further action. 9

HIP has complied with this recommendation.

8. It is further recommended that the issues regarding site-scoring forms not being reviewed by appropriate members of HIP's management, as relates to the compliance with HIP's guidelines, and the proper resolution of deficiencies noted, be referred to the New York State Department of Health for further action. 10

HIP has complied with this recommendation.

Fraud Prevention and Detection

9. It is recommended that HIP comply with the fraud prevention plan it filed with the Superintendent and limit its investigators to the amount of cases specified in said Plan. 10

HIP has complied with this recommendation.

10. It is further recommended that HIP adequately staff its Special Investigations Unit (SIU), so that it can effectively combat healthcare fraud, and so that potential areas of fraud can be detected and investigated more effectively. 11

HIP has complied with this recommendation.

ITEM NO.**PAGE NO.**Fraud Prevention and Detection (cont'd.)

11. It is recommended that HIP's SIU hotline phone number appear directly on all of its explanation of benefits ("EOB") statements. 11

HIP has complied with this recommendation.

12. It is recommended that all suspected fraudulent cases be prioritized. 11

HIP has complied with this recommendation.

13. It is recommended that HIP improve the organization of its fraud case files to ensure that complete documentation is contained therein, and that all notes are written in a legible manner so that it is easy to follow the actions that have been taken or need to be taken by the SIU staff. Also, proper documentation will assist HIP in taking action against the perpetrator of the fraud. 11

HIP has complied with this recommendation.

14. It is recommended that HIP take aggressive steps to increase its efforts to prevent and detect employee-related fraud. 12

HIP has complied with this recommendation.

Claims – General Review

15. It is recommended that HIP use the most recent HIAA (Ingenix) fee schedules when paying a claim, on a UCR basis. 12

HIP has complied with this recommendation.

16. It is recommended that for all claims that were initially denied and resubmitted, that the prior and subsequent claim number(s) fields on the QCare system be populated with said information. 13

HIP has complied with this recommendation.

ITEM NO.**PAGE NO.**Claims – General Review (cont'd.)

17. It is recommended that HIP require its Third Party Administrators and Delegated Entities to acknowledge receipt of and compliance with HIP's claim procedure manuals and their updates. 13

HIP has complied with this recommendation.

18. It is recommended that HIP require its Delegated Entities to maintain documentation that demonstrates compliance with statutory requirements (i.e. Prompt Pay Law and NYHCRA surcharges). 13

HIP has complied with this recommendation.

19. It is recommended that HIP's Continuous Quality Improvement Unit document its procedures for reviewing claims processor performance. 13

HIP has complied with this recommendation.

Prompt Pay

20. It is recommended that HIP create procedures to ensure that outstanding claims in its claims system be paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law. 17

HIP has not complied with this recommendation. A similar recommendation is made in this Report.

21. It is recommended that HIP implement the necessary procedures and training in order to ensure compliance with §3224-a(a) of the New York Insurance Law. 17

HIP has complied with this recommendation.

ITEM NO.**PAGE NO.**Prompt Pay

22. It is recommended that HIP implement the necessary procedures to ensure compliance with §3224-a(b) of the New York Insurance Law and send out requisite notifications within 30 days where applicable. 18

HIP has not complied with this recommendation. A similar recommendation is made in this Report.

23. It is recommended that HIP comply with §3224-a(c) and calculate interest due on all claims paid after 45 days of receipt. It is also recommended that HIP pay any calculated interest amount that is equal to, or in excess of \$2. 18

HIP has not complied with this recommendation. A similar recommendation is made in this Report.

Other Claim Processing Procedures

24. It is recommended that HIP ensure that correspondence is sent to those providers without on-line access to the QCare system and preserve copies of the request and the resulting supporting documentation as evidence of its actions. Section 243.2(b)(4) of Department Regulation No. 152 {11 NYCRR 243.2(b)(4)} and Section 216.11 {11 NYCRR 216.11} of Department Regulation No. 64 set forth standards for record retention. 19

HIP has complied with this recommendation.

25. It is recommended that HIP maintain all elements of a claim that evidences compliance with Section 3224-a of the New York Insurance Law. 20

HIP has complied with this recommendation.

26. It is also recommended that HIP comply with Part 216.11 of Department Regulation No. 64, which requires that all insurers maintain all data within the claim files so that the Insurance Department examiners can reconstruct the claim. 20

HIP has complied with this recommendation.

ITEM NO.**PAGE NO.**Other Claim Processing Procedures (cont'd.)

27. It is further recommended that HIP comply with Part 243.2(b)(4) of Department Regulation No. 152, by retaining such information as the dates the claim starts and ends, its hold status (including the reasons therefore), for a period of six years, or until after the filing of the report on examination, whichever is longer. 20

HIP has complied with this recommendation.

28. It is again recommended that HIP comply with Part 243.2 of Department Regulation No. 152. 21

HIP has complied with this recommendation.

29. It is again recommended that HIP create procedures to ensure that outstanding claims in its claims system be paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law. 21

HIP has complied with this recommendation.

Explanation of Benefits Statements

30. It is recommended that HIP comply with Sections 3234(b)(1), (3), (5), (6) and (7) of the New York Insurance Law, as regards the contents of its explanation of benefits statements. 23

HIP has not complied with Section 3234(b)(7) of this recommendation. A similar recommendation is made in this Report.

31. It is recommended that HIP display the date the claim was received by it on all EOBs so that the length of the processing cycle time is determined. 23

This recommendation is no longer applicable.

ITEM NO.**PAGE NO.**Explanation of Benefits Statements

32. It is recommended that HIP record a reference number (to the original claim) on its subsequently generated EOBs, when an adjustment is made to a previously processed claim. 24

This recommendation is no longer applicable.

33. It is recommended that HIP include a reference to contact the New York Insurance Department for complaints or other inquiries. 24

HIP has complied with this recommendation.

Provider Status

34. It is recommended that disciplinary information reported on the MSL system be correct and consistent with the information reported on HIP's QCare system; so that when a claim comes in for payment, only doctors eligible for payment are paid, and doctors not eligible for payment are flagged or removed from the system. 24

This recommendation is no longer applicable. HIP has replaced the MSL system.

35. It is recommended that HIP take immediate steps to thoroughly review the status of its participating physicians. 25

This recommendation is no longer applicable. HIP has replaced the MSL system.

36. It is also recommended that procedures be established so that notation of disciplinary actions for HIP's participating physicians are recorded (timely) on HIP's QCare system. 26

This recommendation is no longer applicable. HIP has replaced the MSL system.

ITEM NO.**PAGE NO.**Provider Status (cont'd.)

37. It is further recommended that HIP update all information pertaining to its contracted physicians on its QCare system on a timely basis, and that the information be inputted correctly. 26

This recommendation is no longer applicable. HIP has replaced the MSL system.

Experimental and/or Investigational Procedures

38. It is recommended that HIP maintain a listing of all procedures it considers experimental and/or investigational. 27

HIP has complied with this recommendation.

39. It is recommended that as regards claims denied by HIP for being experimental and/or investigational, and which are similar in nature to claims subsequently overturned on appeal, HIP should make a “good faith effort” (the Department recognizes the fact that although claims may be very similar in nature, each claim needs to be decided on its own merit) to pay these claims (for claims received on the same day, or after the receipt date of the claim which was overturned). 27

HIP has complied with this recommendation.

Underwriting and Rating

40. It is recommended that HIP comply with the provisions of Section 4308(b) of the New York Insurance Law by charging the rates filed with the Insurance Department. 29

HIP has complied with this recommendation.

ITEM NO.**PAGE NO.****Underwriting and Rating**

41. It is recommended that the recoupment of all funds owed to HIP as the result of a rating error or guaranteed rate be collected immediately, and that HIP comply with the provisions of Section 52.42 of Department Regulation No. 62 by settling any shortfalls or overages within 12 months after the expiration of the policy. 29

HIP has complied with this recommendation.

42. It is recommended that HIP comply with Section 4308(g)(2) of the New York Insurance Law by notifying subscribers of their rate increases at least 30 days before they are effective. 30

HIP has complied with this recommendation.

43. It is further recommended that HIP retain better documentation as regards its compliance with the timely rate notification of its subscribers as required by Section 4308(g)(2) of the New York Insurance Law. 30

The delegation of responsibility by HMOs and Article 43 Corporations to employers, associations, and TPAs is currently being reviewed by the Department's Office of General Counsel.

HIP has complied with this recommendation.

44. It is further recommended that HIP determine whether any of its subscribers are due a refund/credit as a result of it not complying with the requirements of Section 4308(g)(2), and remit the same. 31

HIP has complied with this recommendation. Refunds/credits were applied over several years rather than at once.

ITEM NO.**PAGE NO.**Utilization Review

- | | | |
|-----|--|----|
| 45. | It is further recommended that HIP initiate procedures to include as part of its agreements with TPAs and Associations, a provision that such TPAs and Associations demonstrate compliance with the Section 4308(g)(2) rate notice requirements. | 31 |
| | <i>HIP has complied with this recommendation.</i> | |
| 46. | It is recommended that HIP maintain its Anticipated Care logs in a legible manner. It is further recommended that all records be maintained in an easily discernable manner so that compliance can be determined. | 34 |
| | <i>HIP has complied with this recommendation.</i> | |
| 47. | It is recommended that HIP implement proper procedures in order to meet its Anticipated Care hotline telephone service goals. | 34 |
| | <i>HIP has complied with this recommendation.</i> | |
| 48. | It is recommended that HIP take immediate steps to modify its reporting system so that each entity (HIPNY & HIPIC) can be determined. | 34 |
| | <i>HIP has complied with this recommendation.</i> | |
| 49. | It is recommended that HIP's FAD letters include the subscriber's coverage type, the date of service, and the name of the provider as required by Department Regulation No. 166. | 35 |
| | <i>HIP has complied with this recommendation.</i> | |
| 50. | It is recommended that proper procedures be taken to ensure that all applicable documents be enclosed with the FAD letters. | 35 |
| | <i>HIP has complied with this recommendation.</i> | |

ITEM NO.**PAGE NO.**External Appeals

51. It is recommended that HIP include the proper documented clinical rationale to its subscribers. 37

HIP has complied with this recommendation.

Complaints and Grievances

52. It is recommended that HIP exercise greater care in maintaining its ongoing central complaint log, when referencing which company the received complaint is directed against. 37

HIP has complied with this recommendation.

53. It is recommended that HIP comply with the requirements of Circular Letter No. 11 (1978) in that all initial Insurance Department inquiries be forwarded to the attention of the designated officer. 37

HIP has complied with this recommendation.

54. It is recommended that HIP comply with Section 216.4 of Department Regulation No. 64 and Circular Letter No. 11 (1979), by responding to Department inquiries within the prescribed ten (10) business day period. 39

HIP has complied with this recommendation.

Schedule M

55. It is recommended that HIP exercise greater care when filling out Schedule M (Annual Data Requirements) and filing it with this Department. 39

HIP has complied with this recommendation.

HIP-TALK

56. It is recommended that HIP institute appropriate measures to ensure that its members who call its HIP-TALK hotline receive a timely response to their inquiries. 40

HIP has complied with this recommendation.

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Claims Processing</u>	
i. It is recommended that HIP comply with the requirements of Section 3234(b)(4) of the New York Insurance Law by including the provider’s charge on all EOBs.	7
ii. It is recommended that HIP include the above required notification on its EOBs, in compliance with the requirements of Section 3234(b)(7) of the New York Insurance Law regarding a failure to appeal may result in loss of certain rights.	7
iii. It is recommended that HIP create separate EOCs for denials where there was no prior approval for a procedure and for denials where no referral was received from a primary care physician (“PCP”).	9
iv. It is recommended that HIPIC pay all out-of-network claims in accordance with the member contract and generally accepted medical coding and billing standards.	10
v. It is recommended that HIP retain all records for the period required by Section 243.2(b)(8) of Department Regulation No. 152.	10
vi. It is recommended that HIP take steps to correct system errors that resulted in incorrect co-pay amounts being charged to subscribers.	11
vii. It is recommended that HIP conduct their PEC investigations at the time of enrollment, so that ensuing claims may be processed appropriately and in a timely manner.	11
viii. It is recommended that HIPIC take steps to correct system errors that result in incorrect co-insurance or deductible amounts charged to insureds for outpatient facility claims.	12
B. <u>Prompt Pay Law</u>	
i. It is recommended that HIP take steps to ensure that the provisions of §3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with.	19

<u>ITEM</u>	<u>PAGE NO.</u>
B. <u>Prompt Pay Law (cont'd.)</u>	
ii. It is also recommended that HIP take steps to ensure that the provisions of §3224-a(b) of the New York Insurance Law, regarding the prompt adjudication of claims, are fully implemented and complied with.	19
iii. It is further recommended that HIP take steps to ensure that the provisions of §3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with.	19
C. <u>Underwriting and Rating</u>	
i. It is recommended that HIPNY notify the Department of the updated addresses for its Healthy New York applications.	20
ii. It is recommended that HIPNY collect all recertification forms for all of its Healthy New York renewals, in compliance with the requirements of Section 362-2.5(a), (b) and (c) of Department Regulation No. 171.	21
iii. It is recommended that HIPNY comply with the provisions of Section 55.2(a) of Department Regulation No. 78 and send all reminder notices at least 30 days prior to the end of the grace period.	22
iv. It is again recommended that HIPNY comply with the requirements of Section 243.2(b)(8) of Department Regulation No. 152 and maintain all required records for at least six years.	23
D. <u>Utilization Review and Appeals</u>	
i. It is recommended that HIPNY comply with Section 4903(3) of the New York Public Health Law and provide the written notice of determination within the required timeframe.	24
ii. It is recommended that HIPNY and CareCore comply with the requirements of Section 4903(2) of the New York Public Health Law and provide notices of determination within three business days by telephone and in writing to the enrollee/enrollee's designee and the provider in regard to prospective reviews.	25

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Utilization Review and Appeals (cont'd.)</u>	
iii. It is recommended that HIPNY and Healthcare Partners provide a determination notice by telephone and in writing to the enrollee or enrollee's designee and the enrollee's health care provider within three business days of receipt of the necessary information, in compliance with Section 4903(2) of the New York Public Health Law.	26
iv. It is recommended that HIPNY and CMO provide all verbal and written notices to the enrollee or his/her provider in order to comply with Section 4903(2) of the New York Public Health Law.	27
v. It is recommended that HIPNY and CMO comply with Section 4903(3) of the New York Public Health Law and provide all notices of determination within one business day.	27
vi. It is recommended that HIPNY and CMO provide all notices of adverse determination where required, in compliance with the requirements of Section 4903(5)(b) of the New York Public Health Law.	28
vii. It is recommended that HIPNY/CMO comply with the provisions of Section 243.2(b)(8) of Department Regulation No. 152 and maintain all required records for at least six calendar years.	28
viii. It is recommended that HIPNY/CMO comply with the requirements of Section 243.3 (a)(2) of Department Regulation No. 152, by documenting all non-paper communications, transactions or events.	29
ix. It is recommended that HIPNY ensure that its delegated entities comply with the requirements of Department Regulation No. 152.	29
x. It is recommended that HIPNY comply with the requirements of Section 4904(3)(b) of the New York Public Health Law, by providing external appeal rights on all determination notices.	30
xi. It is recommended that HIPNY comply with the requirements of Section 4904(4) of the New York Public Health Law and require that a utilization review appeal be reviewed by a clinical peer reviewer, other than the clinical peer reviewer who rendered the initial adverse determination.	31

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Utilization Review and Appeals (cont'd.)</u>	
xii. It is recommended that HIPNY revise the applicable letter template to ensure consistency in the timeframes.	32
xiii. It is recommended that HIPNY put in place procedures to ensure that the clinical peer reviewer date his/her sign-off on the appeal review sheet.	32
E. <u>Advertising</u>	
i. It is recommended that all advertisements comply with Section 215.6(a)(2) of Department Regulation No. 34 and discontinue use of the phrase “comprehensive”.	33
ii. It is recommended that HIP’s advertisements include a “valid through date” marked on them, in order to ensure that the references are timely and unambiguous and in compliance with Section 215.6(a)(1) of Department Regulation No. 34.	34
iii. It is recommended that, where restrictions apply, the advertisement include language stating that: “limitations, and exclusions may apply on some services” and “ask for a summary of benefits for details”, in order to comply with the requirements of Section 215.6(a)(1) of Department Regulation No. 34.	34
iv. It is recommended that advertisements specify the source of the statistics/ratings, as well as the date of the accreditation in order to comply with the requirements of Section 215.6(a)(1) of Department Regulation No. 34.	34
v. It is also recommended that HIPNY discontinue the use of the “Excellent” NCQA rating in its direct mail and print magazine advertisements, unless it is supported by the source.	35
F. <u>Producer Licensing</u>	
i. It is recommended that when applicable HIPNY file all termination notices with the Department, in compliance with the requirements of Section 2112(d) of the New York Insurance Law.	36
ii. It is also recommended that HIPNY keep records of its terminated agents and the termination notices, in accordance with the provisions of Section 243.2(b)(8) of Department Regulation No. 152, as quoted above.	36

<u>ITEM</u>		<u>PAGE NO.</u>
G.	<u>Grievance and Appeals</u>	
	It is recommended that HIPIC send out all required acknowledgement letters in response to a grievance filing within fifteen days as required by its grievance procedures.	36
H.	<u>Special Investigations Unit</u>	
i.	It is recommended that HIPNY's fraud plan be updated on a more timely basis to reflect actual staffing.	37
ii	It is recommended that policies and procedures be updated to define the accounting of savings from SIU activities.	37

Appointment No. 22548

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Wai Wong

as a proper person to examine into the affairs of the

Health Insurance Plan of Greater New York

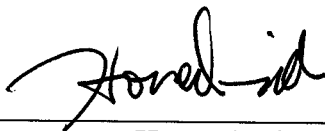
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 30th day of October 2006



Howard Mills
Superintendent of Insurance



Appointment No. 22549

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Wai Wong

as a proper person to examine into the affairs of the

HIP Insurance Company of New York

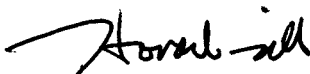
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 30th day of October 2006



Howard Mills
Superintendent of Insurance

