MARKET CONDUCT REPORT ON EXAMINATION

OF THE

HEALTH INSURANCE PLAN OF GREATER NEW YORK

AND THE HIP INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 1998

DATE OF REPORT **OCTOBER 7, 2003**

EXAMINER **STEPHEN J. WIEST**

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STATE OF NEW YORK
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George E. Pataki
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October 7, 2003

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 21492 and 21491, dated January 4, 2000, and annexed hereto, I have made a market conduct examination into the affairs of the Health Insurance Plan of Greater New York ("HIPNY"), a health service corporation licensed under the provisions of Article 43 of the New York Insurance Law and the HIP Insurance Company of New York ("HIPIC"), a subsidiary accident and health insurance company licensed pursuant to Article 42 of the New York Insurance Law, respectively, at their home office located at 7 West 34th Street; New York, New York. The following report thereon is respectfully submitted.

Wherever the terms "HIPNY" or "the Plan" appear herein, without qualification, they should be understood to refer to the Health Insurance Plan of Greater New York. Wherever the terms "HIPIC" or "the Company" appear herein, without qualification, they should be understood to refer to the HIP Insurance Company of New York. Wherever the term "HIP" appears herein, without qualification, it should be understood to refer to HIPNY and HIPIC collectively.

1. SCOPE OF EXAMINATION

An examination was performed of the manner in which HIPNY and HIPIC conduct their business practices and fulfill their contractual obligations to policyholders and claimants. This examination covers the period January 1, 1998 through December 31, 1998, however, where deemed appropriate, certain items and transactions were reviewed subsequent to this date. 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 special report on examination pertaining to certain practices and transactions regarding such items as compensation for officers and directors, involvement with political contributions, cleaning contracts, corporate automobiles, and apartment leases of the Health Insurance Plan of Greater New York, the HIP Insurance Company of New York, and their affiliated companies, was filed September 21, 2000.

2. DESCRIPTION OF COMPANIES

The Health Insurance Plan of Greater New York ("HIPNY") was incorporated in 1944 as a not-for-profit corporation. In 1967, HIPNY became a not-for-profit health service corporation as defined in Article 43 of the New York Insurance Law. Since 1978, HIPNY has also held a Certificate of Authority as a health maintenance organization ("HMO") as defined in Article 44 of the New York Public Health La w. The HIP Insurance Company of New York ("HIPIC") was incorporated in September 1994 as a for-profit corporation and it commenced operations in September 1995 as an accident and health insurance company licensed under the provisions of Article 42 of the New York Insurance Law. All outstanding shares of HIPIC common stock are owned by HIP

Holdings, Inc., a Delaware corporation that is a wholly-owned subsidiary of HIPNY. HIPIC was formed to market insurance products primarily to members of HIPNY through the use of a point-of-service ("POS") product.

Healthcare services are available to HIP members from a wide selection of physicians who either practice at a HIP medical center or a private office. HIP contracts with Independent Practice Associations ("IPAs"), medical groups and hospital-based IPAs. Physicians contracting directly with HIP or through certain IPAs are paid on a discounted fee-for-service basis. The remaining IPAs (which are referred to as "at-risk" IPAs or "delegated" IPAs) are compensated by HIP based on a capitation amount (per member per month) to cover the costs of services provided to those HIP members affiliated with an at-risk IPA. Those physicians affiliated with an at-risk IPA are paid directly by the IPA.

3. EXECUTIVE SUMMARY

The results of this examination indicate that during the examination period, HIP had deficiencies in certain controls and procedures. These deficiencies are reflected in the following areas:

- Use of agents and brokers not properly licensed per Article 21 of the New York Insurance Law
- Violations of Sections 3224-a(a), (b) and (c) of the New York Insurance Law (Prompt Pay Law)
- Failure to include language required by Section 3234 of the New York Insurance Law on explanation of benefits statements (EOBs)
- Fraud prevention and detection program
- Use of HIAA fee schedules for usual, customary, and reasonable (UCR) reimbursement
- Maintenance of underwriting files

4. SALES

Section 52.42(e) of Department Regulation No. 62 {11NYCRR 52} states:

> "The actual rate per annum may not exceed four percent of the Health Maintenance Organization approved premium for contracts sold."

Circular Letter No. 36 (1999) states in part that:

> "Any payments for additional services rendered for an HMO or an insurer by an insurance agent or broker which result in a payment to the agent or broker in excess of the maximum permissible rate, as established in the HMO's or insurer's filed premium rate manual, must be in keeping with the following guidelines…
>
> b. The additional services to be provided must be pursuant to a separate written agreement between the agent or broker and the HMO or insurer."

It was noted that HIP was in violation of the above referenced Section 52.42(e) of Department Regulation 62, in that in certain circumstances HIP paid four percent commission plus administrative fees for some services provided by agents, but at the time of the examiner's review, HIP was not able to produce a formal agreement(s) detailing the additional services to be rendered by the agents, as required by Circular Letter No. 36 (1999). The examination review of this item included agreements that were subject to, but had been initiated prior to the issuance of Circular Letter No. 36 (1999).

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.

Section 2101(a) of the New York Insurance Law defines an insurance agent as:

> "Any authorized or acknowledged agent of an insurer, fraternal benefit society or health maintenance organization…, and any sub-agent or other representative of such an agent, who acts as such in the solicitation of, negotiation for, or procurement or making of, an insurance, health

> maintenance organization or annuity contract, other than as a licensed insurance broker…"

A review of this account showed that HIP had two agents working for them who did not have agent agreements with HIP.

It is recommended that HIP have agent agreements with all its agents, and that all these agreements be fully executed in a timely manner.

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

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

Additionally, 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 or procuring in this state any new 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."

Further, Section 2116 of the New York Insurance Law states:

> "No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article."

During the period of October 1, 1998 through June 30, 1999, one company acted as an agent for HIP when in fact it did not hold an agent's license. In addition, another

company acted as a general agent for HIP without possessing an agent's license for calendar year 1998. It should be noted that the latter became a licensed agent for HIP on August 31, 1999. Further, a review of a sample of HIP's agents and brokers revealed that two agents did not possess the requisite licenses to solicit business in New York State. In view of the foregoing, it appears that HIP violated New York Insurance Law Sections 2102(a)(1), 2114(a)(3), and 2116 in that commissions were paid to insurance agents and brokers for whom HIP was not able to provide proof that they held the proper licenses.

It is recommended that HIP comply with Sections 2114(a)(3) and 2116 of the New York Insurance Law.

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.

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

> "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."

A sample of eleven entities holding general agent's agreements with HIP for calendar year 1998 was selected. It was noted that HIP failed to file certificate of appointment forms (Form AGT-1) for any of the eleven entities. However, for 1999, HIP provided evidence that it had filed AGT-1 forms for nine of the sampled entities. The two remaining agents did business through a general agent. HIP failed to file Form AGT-1 for these agents.

It is recommended that HIP institute procedures to ensure its 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.

5. HEALTHY NEW YORK

Healthy New York, which went into effect January 1, 2001, is a program designed to encourage small employers (50 or fewer employees) to offer health insurance coverage to their employees, dependents and other qualified individuals. This program created a standardized health insurance benefit package to be offered by HMOs, which is made affordable through state sponsorship, so that more uninsured small employers and uninsured employed individuals would be able to purchase health insurance coverage.

Section 4326(o) of the New York Insurance Law states that:

> "A health maintenance organization, corporation or insurer shall submit reports to the superintendent in such form and at times as may be reasonably required in order to evaluate the operations and results of the standardized health insurance program established by this section."

A review of HIPNY's implementation of this program revealed the following:

- HIPNY only had one enrolled member in Healthy New York as of March 31, 2001.

- A review of HIP's website, revealed that HIPNY advertised all of its products, except Healthy New York. After the examiner made mention of this fact to HIP, it subsequently updated its website to include the Healthy New York product.

- In addition, a phone call to HIPNY's Healthy New York "hotline" revealed that a customer representative gave out incorrect information. The representative stated that the hotline was the marketing department, and that no specific information about the Healthy New York product could be given

by calling the hotline number. However, a package regarding HIPNY's Healthy New York product was offered. It should be noted that subsequent phone calls to this hotline found that all information regarding HIPNY's Healthy New York product were correctly answered.

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

6. MONITORING OF HIP'S MEDICAL CENTERS

HIPNY is licensed as a health maintenance organization ("HMO") under Article 44 of the New York Public Health Law. Sections 98-1.12(a) and (e) of the Administrative Rules and Regulations of the Health Department (10NYCRR 98-1), relate to an HMO's quality assurance program as follows:

> "(a) An HMO shall develop and implement a quality assurance program, subject to the approval of the commissioner, that includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in health care administration and delivery to the enrollees."
>
> "(e) An HMO shall document the manner by which it examines actual and potential problems in health care administration and delivery to enrollees."

To monitor HIP's Medical Centers ("Centers"), HIPNY's Quality Assurance Division conducts comprehensive and detailed periodic site visits to all Medical Group facilities. The office site visit is an integral component of HIP's credentialing process.

During an office site visit, an assessment is made using a "Practice Site Evaluation Form" ("PSEF"). An acceptable score is 80% or greater. For scores less than 80%, the provider is notified verbally of all deficiencies and he/she must develop a corrective plan of action to be put into effect within six months. After the six-month period, a follow-up site visit is conducted to test for compliance with HIP's minimum

standards. It should be noted that HIP is also to perform a follow-up office site visit when the number of complaints exceeds established thresholds.

HIP provided the examiner with PSEFs for its facilities in Manhattan, the Bronx, and Brooklyn, but failed to provide such forms for its Queens facilities. It could not be determined by the examiner what score some of the facilities had received, because HIP failed to provide this information. It appeared as if HIP has incomplete documentation regarding the monitoring of its Centers. It should be further noted that the assessment forms provided did not mention the actual practitioner, nor did it include the particular facility's score.

Additionally, it was noted that the PSEFs required the reviewer's title and signature, as well as the designee's signature. Frequently, the reviewer's signature, and/or the designee's signature were missing. In five of its scoring sheets, the reviewer failed to provide a numerical score, however, the word "pass" was circled indicating that the entity was in compliance with HIP's Office Site Review guidelines. It should be further noted that in one of the four scoring sheets it appeared that the Center did not score at least 80%, thereby failing the review; however, the reviewer circled the word "pass".

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.

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.

7. FRAUD PREVENTION AND DETECTION

In 1994, both the US General Accounting Office (GAO), and the Health Insurance Association of America (HIAA) estimated that approximately 10% of all medical claims are fraudulent. It would be expected that the 10% amount noted above would be lower for an entity with a corporate structure such as HIP, however, it is a practical benchmark. In 1998, HIP processed 2,198,525 claims totaling about $677 million. HIP only identified approximately $2.7 million (less than one-half of one percent) in fraudulent claims in 1998.

A review was performed of the organization and structure of HIP's (Fraud) Special Investigations Unit (SIU). A review of HIP's compliance with New York Insurance Law Sections 405 and 409 and Department Regulation No. 95, with respect to the reporting of fraud cases, was also completed. A review of these items revealed the following:

- HIP's fraud prevention plan ("Plan"), filed with the New York Insurance Department in accordance with Section 409 of the New York Insurance Law, states that HIP shall limit an investigator to no more than 80 cases. However, a review of HIP's open case list, showed that three of HIP's investigators were over the 80 case limit, with 86, 109, and 195 cases, respectively. Additional staffing of the SIU would decrease the load of cases on each investigator, and help bring the caseload below the maximum level stated in the Plan.

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.

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.

- HIP's Special Investigations Unit (SIU) hotline phone number did not appear directly on its explanation of benefits (EOB) statements.

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

- HIP does not prioritize its suspected fraud cases, so that the investigations can be initiated and scheduled in the most efficient manner.

It is recommended that all suspected fraudulent cases be prioritized.

- Most of HIP's fraud case files contained certain documentation (i.e. closeout sheet, follow-up sheets, copies of cancelled checks, and other information); however, some of the open files lacked essential documentation. These case files also lacked other significant information, such as how the case was received, a description of the case, how HIP's SIU reached its conclusion, or what steps or actions were taken as a result of the investigation. Additionally, many notes were illegible.

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.

- In reviewing HIP's open and closed fraud case files, it was noted that there were three cases in which four of HIP's "ex-employees" were involved in fraudulent acts.

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

8. CLAIMS

A. General Review

A statistical random sample of eighty-four (84) claims was selected using the computer software program ACL. The objective of this sampling process was to be able to test and reach conclusions about HIP's claims practices and procedures. The population from which the sample was drawn included all of HIP's claims adjudicated in calendar year 1998 (excluding Medicare). The following was noted:

- Some payments made on claims were paid incorrectly due to HIP using an incorrect (out-of-date) HIAA fee schedule to determine usual, customary, and reasonable (UCR) payments. It appeared that although HIP did use a HIAA fee schedule, it was not the schedule in effect (up-to-date) at the time of service, thereby causing HIP to pay an incorrect UCR amount.

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

- HIP receives claims through electronic submission, as well as paper. All paper claims, when they come in for payment, are entered into HIP's QCare system. Each claim is assigned a claim number using a Julian date. It was noted in a few instances that when a claim was submitted, denied, and then resubmitted, a different claim number was given to the claim; however, the "prior" or "subsequent" claim number fields were not populated.

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.

- Some of HIP's Third Party Administrators and Delegated Entities did not acknowledge receipt of HIP's claim procedure manuals and their updates.

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.

- Certain Delegated Entities did not maintain documentation sufficient to demonstrate compliance with certain statutory requirements (i.e. "Prompt Pay Law" and "NYHCRA surcharges").

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).

- HIP's Continuous Quality Improvement Unit did not document its procedures for reviewing claims processor performance.

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

B. Prompt Pay

§3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health 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.

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

> "(a) Except in a case where the obligation of an insurer 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."

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

> "(b) 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:
>
> 1. that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
> 2. to request all additional information needed to determine liability to pay the claim or make the health care payment."

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

> "(c) …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 claims…

> When the amount of interest due on such a claim is less then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

The examination included a review of HIPNY and HIPIC claims, using ACL software, to determine whether or not interest was due, and appropriately paid pursuant to §3224-a(c) of the New York Insurance Law to those claimants not receiving payment or denials within the timeframes required by §3224-a(a) and (b) of the New York Insurance Law. The population of HIP's commercial product claims adjudicated from January 22, 1998 (the commencement date of the Prompt Pay Law) through December 31, 1998 that exceeded the Section 3224-a thresholds (e.g. were not paid within 45 days after the date of receipt) during this period, were segregated. The claims with potential Prompt Pay violations were then segregated into their respective component subsections of §3224-a ((a), (b), and (c)).

All claims identified by the examination as potential violations of the "Prompt Pay Law", were then forwarded to HIP personnel for their review. The claims determined by HIP personnel as "not being violations of the Prompt Pay Law" were returned to the examiners with an explanation stating the reason of rebuttal. The examiners accepted HIP's explanation for several categories (e.g. claims received prior to January 22, 1998, and claims paid to out-of-state providers) and removed these claims from the initial Prompt Pay violation findings. However, certain other categories designated by HIP (e.g. "duplicate submissions", "contract changes", and "hold days") were not inherently accepted by the examiners. ACL software was used by the examiners to select samples of items for these various categories of the claims that HIP deemed not to be violations of the Prompt Pay statute. The results of the review for each category were then extrapolated to the total number of claims in the category.

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims not paid within forty-five days from receipt, during the period from January 22, 1998, through December 31, 1998. For HIPNY, the population of these claims is 24,710, which can be further allocated to 17,812 and 6,898 for facility and professional claims, respectively. For

HIPIC, the population of these claims is 898, which can be further allocated to 562 and 336 for facility and professional claims, respectively.

The total population of claims that were processed within the above categories during this period was 2,214,304 (2,083,757 for HIPNY and 130,547 for HIPIC). The 2,214,304 can be further allocated to 469,385 and 1,614,372 for facility and professional claims respectively, for HIPNY, and 9,622 and 120,925 for facility and professional claims respectively, for HIPIC.

After a final review by the examiners of the above claims refuted by HIP, and the removal of certain claims included in the initial determination of violations, the total estimated number of "Prompt Pay" violations determined by the examination, detailed by the various Sections of §3224-a of the New York Insurance Law is summarized as follows:

Item	Description	Section 3224-a(a)	Section 3224-a(b)	Section 3224-a(c)*	Totals
1.	**HIPNY**				
	Facility	4,755	5,068	1,862	11,685
	Professional	1,387	4,154	240	5,781
	Total HIPNY Errors	6,142	9,222	2,102	17,466

2.	**HIPIC**				
	Facility	251	19	290	560
	Professional	57	378	22	457
	Total HIPIC Errors	308	397	312	1,017
3.	**Total Errors**				
	Facility	5,006	5,087	2,152	12,245
	Professional	1,444	4,532	262	6,238
	Grand Totals	6,450	9,619	2,414	18,483

* The violations of Section 3224-a(c) noted above directly relate to and should be considered a subset of the Section 3224-a(a) violations.

The Department and HIP agree that for purposes of this report, the violations identified above represent all violations under §3224-a of the New York Insurance Law, for the population of claims adjudicated by HIP after 45 days of receipt, for the period January 22, 1998, through December 31, 1998.

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.

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.

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.

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.

C. Other Claim Processing Procedures

During the review of the sampled claims used to test for compliance with the "Prompt Pay" statute, the examination determined that certain weaknesses and/or problems with several of HIP's claims processing procedures existed. These are detailed as follows:

- When a hospital submits a claim with incorrect or incomplete information, HIP requests that the facility corrects or completes the claim by performing necessary edits or providing additional documentation. The amount of time HIP waited for the corrections or the documentation is called "hold days". The aggregate hold days were subtracted from the total number of days HIP took to make the payment. HIP stopped the clock and accumulated the hold days when the discrepancies were flagged by the claims system. Many of HIP's hospitals have access to HIP's QCare claims system and they correct errors on-line for claims with insufficient data. For these claims, HIP waits for the provider to access QCare directly and perform the necessary edits to the electronically submitted claims. Other facilities without access to the QCare system require correspondence from HIP explaining why the claim cannot be processed. HIP did not send correspondence to five providers without QCare access, advising them why their claim could not initially be processed. HIP personnel stated that currently most facilities have access to QCare.

Section 243.2(b)(4) of Department Regulation 152 requires:

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

Further, Section 216.11 of Department Regulation 64 states in part:

> "…to enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to the claim can be reconstructed by the Insurance Department examiners. Insurers shall make a notation in the file or retain a copy of all forms mailed to claimants."

HIP does not retain sufficient data in its claims system to verify the number of "hold days", for which the claim was waiting for additional documentation, including when the documentation (or data) was received. This violates the above referenced Department Regulations. In addition, reasons (edits) for placing the claim on hold are purged from the claims system once the information is received from the provider(s). Therefore, compliance with Section 3224-a of the New York Insurance Law could not be verified.

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 152 {11NYCRR 243.2(b)(4)} and Section 216.11 {11NYCRR 216.11} of Department Regulation 64 set forth standards for record retention.

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

It is also recommended that HIP comply with Part 216.11 of Department Regulation 64, which requires that all insurers maintain all data within the claim files so that the Insurance Department examiners can reconstruct the claim.

It is further recommended that HIP comply with Part 243.2(b)(4) of Department Regulation 152, by retaining such information as the dates the claim starts and ends, its hold status (including the reasons therefor), for a period of six years, or until after the filing of the report on examination, whichever is longer.

- Claims that are referred to by HIP as "payments due to contract changes" represented claims that related to contracts that had reimbursement rates that were renegotiated during 1998, but had an effective date retroactive to January 1, 1998. The claims related to these contracts were paid the first time at the old rate and later adjusted to reflect the renegotiated rates. Out of a sample of 43 of these facility claims that were selected for review, there were nineteen cases where HIP provided a contract that did not include the date the contract was signed. In twenty-four cases, no signed amendment was provided. Additionally, there were six other claims, where the original payment of a claim contained an error made by HIP. The error resulted in a second payment made to correct the previous amount paid.

The lack of maintenance of signed contracts appears to be a violation of Part 243.2 of Department Regulation 152, quoted above, which details how long records must be maintained.

It is again recommended that HIP comply with Part 243.2 of Department Regulation 152.

- Another area reviewed during the examination involved claims HIP deemed "duplicate submissions". A sample of forty-three claims that were denied by HIP using certain denial codes were reviewed to verify if the claims were submitted twice for payment, and were in fact duplicate claim submissions.

Four of the claims sampled by the examiners were not duplicate submissions. Additionally, the original claim was denied in eleven instances. The eleven claims were resubmitted by the providers and paid by HIP after the resubmission, while the original claim was still in the system as an unpaid claim.

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.

D. Explanation of Benefits Statements

As part of the review of HIP's claims practices and procedures, an analysis of its explanation of benefits statements ("EOBs") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider, and HIP. It should clearly communicate to the subscriber the manner in which HIP has processed a claim and the results and available remedies to the results of such processing.

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

> The explanation of benefits form must include at least the following:
>
> (1) the name of the provider of service, the admission or financial control number, if applicable;
> (2) the date of service;
> (3) an identification of the service for which the claim is made;
> (4) the provider's charge or rate;
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of

> benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

A review of the explanation of benefits statements used by HIP revealed the following deficiencies as regards compliance with the above statute:

- The name and address of the providers were not reflected on the EOBs. HIP not providing this information could hinder the ability of the subscriber to determine if the charges represent the actual site of and/or the actual services rendered. This is a violation of Section 3234(b)(1) of the New York Insurance Law, quoted above.

- The EOBs reviewed did not provide a description of submitted charges. Therefore, the subscriber cannot determine what the provider is submitting charges for. This could lead to fraud by the providers, who could easily submit charges for services that were not performed and get paid for them. This is a violation of Section 3234(b)(3) of the New York Insurance Law, quoted above.

- None of the EOBs reviewed displayed the annual deductible and/or coinsurance status of the subscriber. A summary of the year-to-date deductible and coinsurance information should be provided to the subscriber. In addition, some of HIP's EOBs contained a "not covered" column. In some cases, amounts appeared in this column; however, it was not clear if the subscriber was liable for the payment of these amounts, or if the amounts appeared in this column because the provider billed an amount that exceeded their agreed upon "capped" amount. This is a violation of Section 3234(b)(5) of the New York Insurance Law, quoted above.

- It should be noted that in some cases where the full payment requested by the provider was not paid, the EOB did not indicate a specific explanation as for

the reason. This is a violation of Section 3234(b)(6) of the New York Insurance Law, quoted above.

- HIP has a 45-day time limit, which it details in its subscribers' handbook, in which a subscriber can file an appeal to a denial of coverage; such information is not noted on HIP's EOB statements. This is a violation of Section 3234(b)(7) of the New York Insurance Law, quoted above. There was no examination finding that HIP failed to provide members at least 45 days to file an appeal of a denial of coverage.

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.

In addition, the review of HIP's explanation of benefits statements revealed the following deficiencies:

- None of the EOBs reviewed displayed the date the claim was received by HIP. This information is necessary so that the length of the processing cycle time can be determined.

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.

- 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 completed.

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.

- HIP's EOBs do not contain any reference to contact the New York Insurance Department for complaints or other inquiries.

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

E. Provider Status

HIP has a computer system (MSL) which it uses to store all of their respective contracted doctors' histories and other related information. It was noted that only HIP's Provider Relations Department has access to this database, because the information is deemed confidential. The information, once loaded on the MSL system, is then downloaded and populated into HIP's QCare (subscriber mainframe system) system. This information includes disciplinary actions, however, upon examination of HIP's QCare system, it was noted that a doctor who was terminated by HIP was still listed as being eligible for payment as a HIP practicing physician.

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.

In addition, a review of HIP's "list of disciplined physicians" from December 1998 – January 1999, was completed by the examination. The list included 12 physicians. The Office of Professional Medical Conduct (the "OPMC") e-mails the list to HIP on a monthly basis. It is important to note that HIP stated that it also checks the OPMC's website on a weekly basis. Upon reviewing the OPMC's monthly listing of disciplined doctors for December 1998 – January 1999, the examiner noted the following:

- There was a little more than a month's time (February 17, 1999 – March 22, 1999), from when a doctor's license was revoked, to the time it was posted onto HIP's QCare system.

- A contract for one of HIP's doctors was terminated by HIP, however, the QCare system listed the doctor as still being eligible for payment as a HIP participating physician.

- HIP stated that two doctors on the list were never participating HIP doctors, however, HIP's QCare system reflected that these doctors were in fact participating doctors for HIP.

- A notation on HIP's QCare system regarding the death of one of its participating physicians in March of 2000 was not made until September 2000. It was further noted that this physician's date of birth and sex were incorrectly inputted into HIP's QCare system.

- It should be noted that HIP experienced an incident of fraud when one of its contracted doctors died, and members of his staff signed his name to claim forms.

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

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.

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.

F. Experimental and/or Investigational Procedures

HIP's contracts with its subscribers include certain limitations and exclusions. These exclusions include services HIP will not pay for, or provide benefits for because they are deemed to be "experimental" and/or "investigational" treatments. A review of this practice by the examination revealed the following:

Section 4303(z) of the New York Insurance Law states in part:

> "No contract issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation shall exclude coverage of a health care service…, rendered or proposed to be rendered to an insured on the basis that such service is experimental or investigational…, provided that coverage of the patient costs of such service has been recommended for the insured by an external appeal agent upon an appeal conducted pursuant to subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter."

Section 410.9(a) of Department Regulation 166 states in part:

> "Health care plans shall be responsible for compliance with all applicable requirements of Article 49 of the Insurance Law and with the following:
>
> (a) Insured requests for experimental or investigational health care services that would otherwise be a covered benefit except for the health care plan's determination that the health care service is experimental or investigational shall be subject to utilization review pursuant to Title I of Article 49 of the Insurance Law."

- HIP does not maintain a complete listing of procedures it considers experimental and/or investigational. This practice could result in HIP failing to comply with above statutes. In addition, it makes it difficult to ensure consistency in its decision-making, and for subsequent review and audit.

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

- HIP's policy in regard to a claim being deemed experimental and/or investigational and later being deemed to be a covered benefit, is that only the claim that is appealed is paid. If, however, another claim similar in nature to the one that was appealed is received (on the same day or after the receipt date of the initial claim being appealed), it is not reviewed to determine whether it could also be paid.

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).

9. UNDERWRITING AND RATING

A review was conducted to determine HIP's compliance with applicable New York State Insurance Laws and Regulations pertaining to its rates, contracts, and policy riders marketed to the public for the years 1999 and 2000. The review revealed the following problem areas:

Section 4308(b) of the New York Insurance Law states in pertinent part:

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof."

For one of the groups ("Group") reviewed, it was discovered that HIP failed to include in the rate calculations for 1997 and 1998, a rate for Class II dependent coverage.

This omission, by HIP's own account, caused a combined $1,178,000 shortfall in premium income to HIP for these two years. HIP made a "business decision" to recoup this shortfall over two (2) years to make the rate increase more acceptable to the Group. To recoup this entire shortfall in 1999, a rate increase of 15.4% would have been required. HIP instead decided upon an 8.4% increase in 1999, and a projected 9.4% increase in 2000.

HIP's practice, as described above, constitutes a violation of Section 4308(b) of the New York Insurance Law. In addition, the Group received a guaranteed rate pursuant to Section 52.42(b) of Department Regulation 62 {11NYCRR 52}.

Further, Section 52.42(b) of Department Regulation 62 allows for said guaranteed rates only in cases where there is an approved guaranteed rate rider in effect, and where settlement of the premium difference is completed within twelve months of the end of the contract year.

HIP's Group Remittance Agreement ("Agreement") with the Group, provided for a guaranteed rate subject to an adjustment in the following year's premium (including taking into account changes in enrollment levels). The Agreement had been properly filed with the Department per the above Regulation and did provide that, "settlement of the account must occur no later than twelve months after the end of the prior contract year or upon termination of the contract, if earlier." However, HIP did not adhere to this provision in allowing two years for full recoupment.

In addition to the situation detailed above, during the review of the underwriting folder for the Group, an internal (HIP) memorandum noted that the file contained insufficient documentation to support the charged rate and it failed to explain how the rates billed were derived.

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.

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(b)(3)(ii)(b) of Department Regulation 62 by settling any shortfalls or overages within 12 months after the expiration of the policy.

HIP's Actuarial Department determines the annual Direct Pay premium rates and its Marketing Department then drafts the appropriate letters for each applicable product (Direct Pay in this case). After HIP's Actuarial, Legal and Customer Services Departments approve the premium renewal notices, they are mailed directly to the Direct Pay members. The mailing date is to be at least thirty (30) days prior to renewal.

Section 4308(g)(2) states in pertinent part:

> "No rate increase may be imposed unless at least thirty days advance written notice of such increase has been provided to each contract holder and subscriber."

HIP provided template "form letters" rather than the actual letters addressed to individual members for the 1999 and 2000 direct pay rate increases. These form letters contained the dates December 1, 1998 and November (no date listed) 1999.

HIP did provide a copy of a mailroom document showing a bulk mailing (purportedly the 30 day notices). However, the examiners were unable to verify compliance with the above captioned statute due to the lack of complete documentation.

A review was also made of the rate increase notices for HIP's group subscribers that are enrolled through Associations and whose benefits are administered through their third party administrator. This review revealed that HIP could not provide the documentation needed to verify compliance with the 30 day requirement of Section 4308(g)(2) of the New York Insurance Law.

HIP explained its reason for not having the premium rate increase notice for the Association members by stating it is the responsibility of the Associations to which they belong or their third party administrators ("TPA"), to provide this notice.

However, it is HIP's responsibility to comply with the 30 day rate notice requirement of the captioned statute with respect to all subscribers. Such responsibility cannot be fully delegated to the Associations or their TPAs, which are not subject to the licensing and oversight of the Insurance Department, without adequate oversight by HIP. Further, the examination was never provided with a copy of HIP's agreement with the TPA/Association detailing this arrangement. It was also noted that HIP does not keep individual rate sheets for these Groups; the TPA maintains them.

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.

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.

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.

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 same.

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.

10. UTILIZATION REVIEW

Utilization Reviews are used to determine whether services are medically necessary. The review may be prospective (approval before receiving medical services), concurrent (approval while member is receiving medical services), or retrospective (approval after member has received medical services). The utilization review process is designed to assure that companies and their designees that provide or perform utilization services comply with standards and criteria for the structure and operation of the utilization review process. Article 49 of both the New York Public Health Law and the New York Insurance Law prescribe the requirements of a company's utilization program. A review of the captioned item revealed the following problem areas:

Section 4901(a) of the New York Insurance Law ("Reporting requirements for utilization review agents") states:

> "(a) Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section."

Section 4901(a) of the New York Public Health Law, which also applies to HIPNY, contains similar language.

Further, HIP's Care Management Program (CMP) states in part that:

> "The CMP, in compliance with the 1997 New York State HMO Reform Bill, registers with the Department of Health and files reports every two (2) years summarizing utilization managing activities. The biennial report describes the CMP…"

HIP maintained that the Department of Health exempted it from filing the required biennial report, since the Department of Health audits them on an annual basis. When written communication of this allowed practice was requested, HIP did not have

any; however, the examiners received written confirmation from the Department of Health allowing this practice.

Sections 4903(a)(1), (2), and (3) of the New York Insurance Law ("Utilization review determinations") state:

> "(a) Utilization review shall be conducted by:
>
> (1) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;
>
> (2) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and
>
> (3) A clinical peer reviewer where the review involves an adverse determination."

Sections 4903(1)(a) and (b) of the New York Public Health Law, which also apply to HIPNY, contain similar language.

The examiners requested a listing of HIP's utilization reviewers for calendar years 1999 and 2000. HIP provided the list for 2000, but was unable to provide a list for 1999.

Sections 4901(b)(10)(i) and (ii) of the New York Insurance Law ("Reporting requirements for utilization review agents") state in part:

> "(b) Such report shall contain a description of the following:
>
> (10) Provisions to ensure that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:
>
> (i) not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone

> calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received; or
>
> (ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subsection (a) of section four thousand nine hundred three of this title or an expedited appeal filed pursuant to subsection (b) of section four thousand nine hundred four of this title, on a twenty-four hour a day, seven day a week basis."

Sections 4901(2)(j)(i) and (ii) of the New York Public Health Law, which also apply to HIPNY, contain similar language.

HIP has an Anticipated Care hotline that is available 24 hours a day, 7 days a week, including holidays. HIP maintains that when someone calls this hotline they always speak to a person, and never a machine. Furthermore, when someone calls the Anticipated Care hotline, HIP personnel record the information in daily telephone logs. These logs are then reviewed by a supervisor, and entered into HIP's computer database. It was noted by the examiners that many of these logs were illegible.

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.

HIP's year 2000 goals in regard to its Anticipated Care hotline were detailed in its telephone service (2000) worksheet, which detailed targets to be met in the year 2000. The goal for calls answered was "greater than 95%", "less than 5%" for abandoned calls, "less than 30 seconds" for the average speed of answered calls, and "greater than 95%" for calls transferred. It should be noted that HIP did not meet any of the aforementioned goals in regard to its Anticipated Care hotline, during the period of June 2000 through December 2000. Actual results were 92.6% for calls answered, 7.4% for abandoned calls, 79 seconds for average speed of answered calls, and 90% for calls transferred.

Further, HIP could not differentiate which cases belonged to HIPNY and which ones belonged to HIPIC.

It is recommended that HIP implement proper procedures in order to meet its Anticipated Care hotline telephone service goals.

It is recommended that HIP take immediate steps to modify its reporting system so that each entity (HIPNY & HIPIC) can be determined.

A review of HIP's utilization review files revealed the following:

- HIP's subscriber handbook states, that for utilization reviews, when an appeal is filed in regard to a coverage decision that HIP or its delegated entities had made, HIP or its delegated entity is to provide a written acknowledgment within 5 days, letting the subscriber know that the subscriber's appeal letter had been received. It should be noted that in some instances in which HIP's delegated entity was sent an appeal letter, documentation could not be provided to the examiner showing that an acknowledgment letter was sent to the subscriber within the prescribed time period.

Section 410.9(e) of Department Regulation 166 states in part:

> "(e) Each notice of a final adverse determination of an expedited or standard utilization review appeal under Section 4904 of the Insurance Law shall be in writing, dated and include the following:
>
> (4) the insured's coverage type;
>
> (7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service."

It was noted that HIP's final adverse determination (FAD) letter did not provide the subscriber's coverage type, the date of service, or, in many cases, the name of the provider as required by Section 410.9(e) of Department Regulation 166.

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 166.

It is recommended that proper procedures be taken to ensure that all applicable documents be enclosed with the FAD letters.

11. EXTERNAL APPEALS

Beginning July 1, 1999, New Yorkers were entitled to an independent external review of a claim for which they received a denial of coverage for, based on medical necessity or because the service was deemed experimental and/or investigational. It is the responsibility of medical professionals (certified external appeal agents), who are not affiliated with the HMO or health insurer to review the case and issue a determination. For calendar year 2000, HIP reported 25 external review cases. A review of these cases by the examiner revealed the following:

- The New York State Insurance Department publishes an annual Health Consumer Guide ("Guide"), which compares health insurers by different categories. For calendar year 1999, this Guide assessed a health industry average reversal rate of 54% for external reviews. It should be noted that a reversal rate over the average reversal rate, may indicate that the insurer is not making appropriate coverage decisions. HIP's reversal rate was 60% (15 out of 25 cases reversed).

Section 4913(a) of the New York Insurance Law ("Conflict of interest") states:

> "(a) No external appeal agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any external appeal pursuant to this title, shall have any material professional affiliation, material familial affiliation, material financial affiliation, or other affiliation prescribed pursuant to regulation, with any of the following:
>
> (1) health care plan;
>
> (2) any officer, director, or management employee of the health care plan;
>
> (3) any health care provider, physician's medical group, independent practice association, or provider of pharmaceutical products or services or durable medical equipment, proposing to provide or supply health service;
>
> (4) the facility at which the health service would be provided;
>
> (5) the developer or manufacturer of the principal health service which is the subject of the appeal; or
>
> (6) the insured whose health care service is the subject of the appeal, or the insured's designee."

- It was noted in one instance that the clinical rationale given to a subscriber was, "that the procedure was not medically necessary." However, the clinical rationale in the subscriber's case file was stated as being, "HIP failed to follow appropriate procedures in issuing the member's appeal rights."

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

12. COMPLAINTS AND GRIEVANCES

A review of HIP's ongoing central complaint log indicated that the claims were not separated by corporate entity (HIPNY or HIPIC), therefore, it could not be determined which company a complaint applied to.

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.

Circular Letter No. 11 (1978) requires that:

> "The responsibility of the internal department specifically designated to investigate and resolve complaints filed by consumers with the New York State Insurance Department's Consumer Services Bureau should be vested in a corporate officer who is also entrusted with the duty of executing the Insurance Department's directives. All initial Insurance Department inquires should be forwarded to the attention of the designated officer whose department it is to investigate and reply to the New York State Insurance Department's Consumer Services Bureau and be available to the Bureau for any further contact."

HIP stated that the Vice President of General Administration, is the HIP officer responsible for the Grievances and Appeals Department, however, a review of inquiries from the Insurance Department revealed that they were not forwarded on to her, but to two other HIP employees.

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

Circular Letter No. 11 (1978) further requires the establishment of an internal consumer services department of a company. This department is to be specifically designated to investigate and resolve complaints filed by consumers with the Insurance Department's Consumer Services Bureau (CSB). In addition, this department is also required to maintain an ongoing central log to register and monitor all complaint activity.

This complaint log is to maintain the following information:

1. Listing of the responsible internal division dealing with the complaint.
2. Contact person whom the complainant is/was dealing with.
3. Name of the person within the company to whom the matter was referred to for review.
4. Date of referral listed.
5. Dates of correspondence to the NYSID's CSB.
6. Date of acknowledgement from the CSB.
7. Date of any substantive response.
8. Chronology of any further contact with the NYSID.

9. Mention of the subject matter of complaint.
10. Information regarding the results of the complaint investigation and the action taken.
11. Remarks regarding internal remedial action taken as a result of the investigation.

HIP's central complaint log maintains the information listed above on-line, however, a single report listing all of the above fields is not routinely generated. Further, HIP's Feedback Tracking System, a computer-based log is used to record and track complaints/grievances received, and to identify recurring issues so that corrective actions may be taken.

Further, Circular Letter No. 11 (1979) and Section 216.4 of Department Regulation 64 {11NYCRR 216.4}, state in pertinent part:

> "Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall within ten business days, furnish the Department with the available information requested respecting the claim…"

Although it is required that HIP provide a written response to an inquiry within ten (10) business days to the Insurance Department, a review of HIP's files, by the examiner revealed that HIP was delinquent 33.33% of the time.

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

13. SCHEDULE M

HIP's "Schedule M - Grievances and Utilization Review Appeals Health Insurance Contracts Excluding HMO Contracts" ("Schedule") - for its New York Supplement filing as of December 31, 2000, contained errors in the reporting of

utilization cases involving its managed care contracts. It was noted that HIP erroneously included all contracts on this Schedule. However, only basic contracts should have been reported on this Schedule, and all other Utilization Review cases should have been reported in Schedule M of its Association Blank (annual statement).

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

14. HIP-TALK

HIP has a toll-free member services hotline, which provides specific information about a member's health coverage and services. The hotline is manned by phone advocates and also an interactive voice response, which allows members to call in and verify their membership status, change their address, or order forms or ID cards with the option of speaking to someone or using the automated phone system.

The prior report on examination commented that HIP should institute appropriate measures to ensure that HIP-TALK responds in a timely manner to its members' telephone inquiries. Therefore, a study of the hotline was conducted for this examination. HIP stated that the average time for a HIP operator to answer a call was 2 minutes; however, the study conducted by the examiner noted the average time for an operator to answer a call was over 6 minutes.

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.

15. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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M. External Appeals

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

N. Complaints and Grievances

i. 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

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

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

O. Schedule M

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

P. HIP-TALK

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

Appointment No. 21492

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Stephen Wiest

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 condition of the said

Company

with such other information as he shall deem requisite.

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

this 4th *day of* January *2000*

NEIL D. LEVIN
Superintendent of Insurance

(by) *Deputy Superintendent*

Appointment No. 21491

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Stephen Wiest

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 condition of the said

Company

with such other information as he shall deem requisite.

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

this 4th *day of* January 2000

NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent