REPORT ON EXAMINATION

OF

UNITEDHEALTHCARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 2003

DATE OF REPORT	**JANUARY 11, 2008**
EXAMINER	**WAI WONG**

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

Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

January 11, 2008

Honorable Eric R. Dinallo
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 22139, dated January 30, 2004, attached hereto, I have made an examination into the condition and affairs of UnitedHealthcare of New York, Inc., a for-profit health maintenance organization (HMO) licensed pursuant to the provisions of Article 44 of the Public Health Law, as of December 31, 2003, and submit the following report thereon.

The examination was conducted at UnitedHealthcare of New York, Inc. offices located at 2 Penn Plaza, New York, NY and 450 Columbus Blvd., Hartford, Connecticut. UnitedHealthcare of New York, Inc. is a wholly-owned subsidiary of United HealthCare Services, Inc., which is a wholly-owned subsidiary of UnitedHealth Group Incorporated.

Whenever the terms “the HMO” or “UHcNY” appear herein, without qualification, they should be understood to mean UnitedHealthcare of New York, Inc. Whenever the terms “the Parent”, or “UHG” appear herein, without qualification, they should be understood to mean UnitedHealth Group Incorporated.

A concurrent examination was made of United HealthCare Insurance Company of New York, Inc., an affiliated accident and health company, licensed under the provisions of Article 42 of the New York Insurance Law. A separate report thereon has been submitted.

1. SCOPE OF EXAMINATION

UnitedHealthcare of New York, Inc. was previously examined as of December 31, 1999. The current examination covered the period from January 1, 2000 through December 31, 2003. Transactions subsequent to this period were reviewed where deemed appropriate.

The examination comprised a verification of assets and liabilities as of December 31, 2003 in accordance with Statutory Accounting Principles (SAP), as adopted by the Department, and a review of income and disbursements deemed necessary to accomplish such verification. The examination also utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants.

A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

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

A review was also made to ascertain what action was taken by the HMO with regard to comments and recommendations made in the prior report on examination.

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

2. DESCRIPTION OF HMO

UnitedHealthcare of New York, Inc. is a for-profit health maintenance organization (HMO) licensed pursuant to Article 44 of the Public Health Law. The HMO was originally incorporated on July 10, 1986, as MetLife HealthCare Network of New York, Inc., a health maintenance organization licensed in the State of New York. The HMO was an indirect wholly-owned subsidiary of Metropolitan Life Insurance Company and commenced business on January 1, 1987. The HMO was granted a Certificate of Authority under the provisions of Article 44 of the New York Public Health Law, effective July 31, 1987, to operate as a "for-profit" independent practice association ("IPA") model health maintenance organization (HMO). Its operating territory included the five boroughs of New York City and the counties of Nassau, Suffolk and Westchester.

On January 2, 1997, the HMO changed its name to UnitedHealthcare of New York, Inc.

The HMO is a direct wholly-owned subsidiary of UnitedHealthcare, Inc., which is a wholly-owned subsidiary of UHG, the ultimate parent.

UnitedHealthcare of New York, Inc. and UnitedHealthcare of Upstate New York, Inc. (formerly know as Travelers Health Network, Inc.) merged effective December 31, 2002. The merged HMO, which retained the name UnitedHealthcare of New York, Inc., is currently

licensed for commercial business in nineteen counties of New York State and is licensed to write Medicaid in eleven counties.

In October 2005, UnitedHealthcare of New York, Inc. began a market/product withdrawal from the HMO markets where it was licensed to write business. This market withdrawal was completed on October 1, 2006 and as of the date of this report; the HMO's license no longer contains commercial business. Furthermore, business no longer exists on the UnitedHealthcare of Upstate New York, Inc. license.

A. Management

Pursuant to the HMO's charter and by-laws, management of the HMO is to be vested in a board of directors the number of which is to be determined by action of a majority of shareholders. At December 31, 2003, the board of directors consisted of four members as follows:

Name and Residence	Principal Business Affiliation
*Camille Cava Wantagh, NY	Parsons Brinkerhoff, New York, NY
Craig W. Keyes New York, NY	President & Chief Executive Officer, UnitedHealthcare of New York, Inc.
Amy K. Knapp New York, NY	Chairman, UnitedHealthcare of New York, Inc
Robert J. Sheehy Edina, MN	Executive Vice-President, UnitedHealthcare of New York, Inc.

*Enrollee representative – Part 98-1.11(g) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)), requires that a minimum of twenty percent (20%) of the board of directors of an HMO be comprised of enrollee representatives. The HMO is in compliance with said Regulation.

A review of the meetings held during the period covered by this examination, indicated that board meetings were generally well attended with all of the directors attending at least 50% of the board meetings they were eligible to attend.

The principal officers of the HMO as of December 31, 2003 were as follows:

Name	Title
Amy K. Knapp	Chairman
Craig W. Keyes, M.D.	President & Chief Executive Officer
Robert W. Oberrender	Treasurer
Donald A. Powers	Chief Financial Officer
Michael J. McDonnell	Secretary
Christina R. Palme-Krizak	General Counsel

B. Territory and Plan of Operation

The HMO has been granted a Certificate of Authority to serve the commercial populations of the five boroughs of New York City, Cayuga, Dutchess, Herkimer, Madison, Nassau, Oneida, Onondaga, Orange, Oswego, Putnam, Rockland, Suffolk, Ulster and Westchester counties and the Medicaid populations of the five boroughs of New York City, Herkimer, Nassau, Oneida, Onondaga, Oswego, and Westchester counties.

The HMO provides coverage by means of its subscriber contracts. Subscribers to the HMO select a participating physician who acts as their primary care physician (PCP). This PCP refers subscribers to other participating HMO physicians when particular medical specialties are required. The HMO's PCPs contract individually or by group with the HMO, by means of participating agreements. Payments to primary care physicians are both on a fee-for-service and capitated basis.

The HMO also contracts with independent practice associations (IPAs), hospitals and other ancillary providers to render health care services to its enrollees. The HMO pays "capitation" or negotiated fees for services rendered by these providers. Upon visiting a participating HMO physician for medical services, subscribers are responsible for a varying range of co-payments, depending on the contract that covers the member.

Subscriber contracts provide for emergency treatment and/or hospitalization, without authorization from the primary care physician, when the subscriber's medical condition requires such treatment. Emergent care treatment may be acquired within or outside the HMO's operating area.

HMO members may opt for out-of-network coverage through the purchase of a Point-of-Service (POS) Plan. This plan provides coverage through an affiliate, United HealthCare Insurance Company of New York, Inc. Other options available to members include dental and long-term care coverage written by affiliated insurers of the HMO.

C. Reinsurance

At January 1, 2003, the HMO ceded business through a reinsurance agreement in effect with a New York licensed insurer, Reliastar Life Insurance Company. The reinsurer provides coverage as follows:

90% in excess of $250,000 per member per diem for commercial and point-of-service members, subject to a $1,000,000 lifetime cap;

90% in excess of $175,000 per member per diem for Medicare members, subject to a $1,000,000 lifetime cap; and

90% in excess of $150,000 per member per diem for Family Health Plus and Child Health Plus members, subject to a $1,000,000 lifetime cap.

There is no reinsurance coverage for Medicaid members.

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

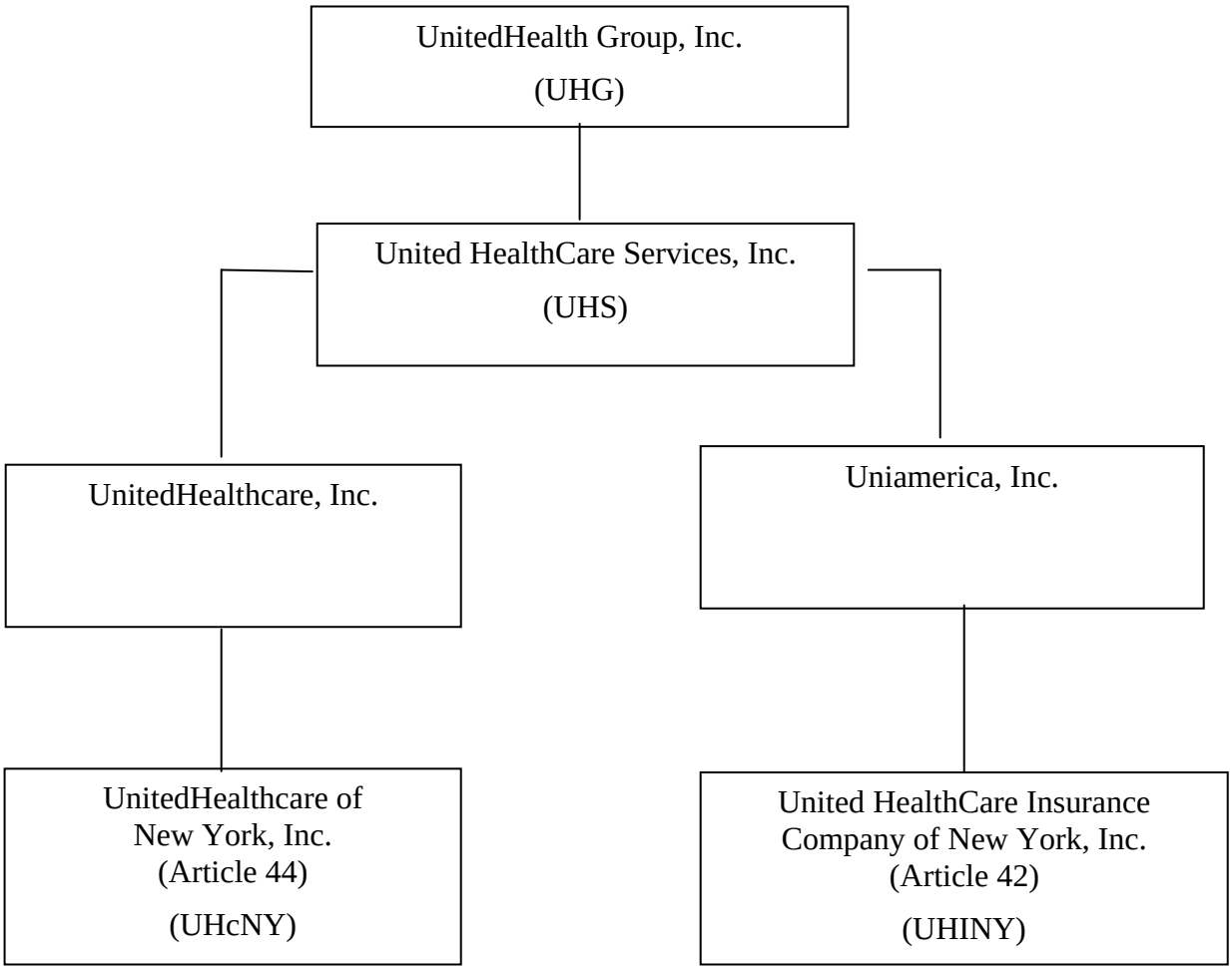
D. Enrollment

During the period January 1, 2000 through December 31, 2003, the HMO experienced a net increase in enrollment of 48,794 insureds. An analysis of the increase in enrollment is set forth below:

	2000	2001	2002	2003
Enrollment, Jan. 1	89,906	106,047	119,733	128,353
Net gain	16,141	13,686	8,620	10,347
Enrollment, Dec. 31	106,047	119,733	128,353	138,700

E. Holding Company System

The HMO is a wholly-owned subsidiary of UnitedHealthcare, Inc. The ultimate Parent is UnitedHealth Group, Inc. The following chart depicts the HMO's relationship with its parent companies and United HealthCare Insurance Company of New York, Inc. its affiliated New York-licensed accident and health company at the examination date:



The Parent has an additional 160 subsidiaries not shown within this diagram. Those entities range from HMO's registered and operating in other states to health care providers and reinsurers.

The HMO has various agreements in effect with its affiliates. The following is a description of such agreements:

- United HealthCare Services, Inc. ("UHS") provides administrative, financial and managerial services to the HMO for a fee based on estimates of actual costs of providing the services. This agreement is explained in more detail below.

- The Specialized Care Services companies are a series of eleven UnitedHealth Group, Inc. affiliates which provide specialized benefits to the UnitedHealth Group companies. Some of the services provided include dental, vision, mental health and physical therapy coverage. Some of the Specialized Care Services companies the HMO has agreements with include the following:

    - ♦ United Behavioral Health, Inc., provides employee assistance, mental health and substance abuse services for the HMO's enrollees.
    - ♦ American Chiropractic Network (ACN) Group Independent Practice Association of New York, Inc., provides network development and management for chiropractic, complementary and alternative medicine benefits.

- Ingenix, provides services related to healthcare information systems including anti-fraud and recovery services for the HMO.

- Ovations and its affiliate Evercare, provide services and products for insureds age 50 and over for the HMO's Medicare eligible members.

Pursuant to Part 98-1.10 of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10), each of the above agreements have been approved by the Superintendent of Insurance and the Commissioner of the Department of Health.

F. Management Agreement

Under the terms of a management agreement between United HealthCare Services, Inc. ("UHS") and the HMO, UHS provides financial, management, accounting, underwriting, marketing, legal, medical provider, member services, medical management, agency development, employee management and benefit, information systems, and other general and administrative services. United HealthCare Services, Inc. also provides claims services, including case management services and review of claim services to the HMO, through Uniprise, a United HealthGroup, Inc. Company. The HMO pays UHS a management fee equal to the actual costs of UHS for providing these services. If the actual cost is not determinable, there will be an allocation of actual costs to the HMO on an equitable basis in conformity with customary accounting practices.

G. Underwriting Ratios

The underwriting ratios presented below are on an earned/incurred basis and encompass the period January 1, 2000 through December 31, 2003:

	Amounts	Ratios
Medical expenses incurred	$1,142,458,541	83.90%
Claims adjustment expenses incurred	69,160,573	5.08%
Administrative expenses incurred	120,113,512	8.82%
Net underwriting gain	30,024,425	2.20%
Premiums earned	$ 1,361,757,051	100.00%

H. Custodial Agreement

The HMO maintains a custodial agreement with State Street Bank to protect its securities. A review of this agreement found that it does not contain all of the safeguards recommended by the Department. First, the agreement does not require the bank to maintain in-force Bankers Bond Insurance. Second, the agreement does not specify that written instructions from the HMO to the bank be signed by two authorized officers. Finally, the custodial agreement does not allow the HMO the opportunity to obtain the most recent report on the review of the custodian's system of internal controls.

Since the custodial agreement is deficient in regard to certain recommended provisions, it may not provide the HMO with sufficient security.

It is recommended that the HMO amend its custodial agreement with Street Bank to include the following:

- The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the HMO 60 days written notice of any material change in the form or amount of such insurance for termination of this coverage.
- Written instructions hereunder shall be signed by any two of the HMO's authorized officers specified in a separate list for this purpose. This list will be furnished to the bank from time to time and signed by the treasurer or an assistant and certified under the corporate seal by the secretary or an assistant secretary.
- The agreement should have a provision that would give the HMO the opportunity to secure the most recent report on the review of the custodian's system of internal control, pertaining to custodian record keeping, as issued by internal or independent auditors.

I. Section 1307 Loan

- A "surplus note" of $5.5 million was issued on December 1, 1998 by the HMO's affiliate, United HealthCare Insurance Company of New York, Inc. and is included on the balance sheet as a component of capital and surplus pursuant to Section 1307 of the New York Insurance Law. The HMO repaid $2 million of this amount on March 3, 2000; no liability appears in UHcNY's annual statement for the remaining loan balance of $3,500,000 and the $1,217,000 accrued interest thereon. Section 1307 of the New York Insurance Law requires that these amounts may be repaid only with the permission of the Superintendent of Insurance.

The HMO placed the following footnote in its annual statement filing at December 31, 2003. Surplus note issued on December 1, 1998 at 6% interest in the amount of $5.5M.

J. Accounts and Records

During the course of the examination, it was noted that the HMO's treatment of certain items was not in accordance with Statutory Accounting Principles or Annual Statement Instructions. A description of such items is as follows:

1. The HMO reported investment income due and accrued from various investments and bank accounts on line 8, “receivables for securities,” of its 2003 annual statement filing, rather than line 11, “investment income due and accrued.” Further, the HMO did not report this amount on the interest due and accrued column of schedule DA of its filed 2003 annual statement, and the amount is not included in the total net investment income earned reported on the statement of revenue and expenses, nor on the exhibit of net investment income.

It is recommended that the HMO properly report investment income due and accrued on its annual statement filings made with this Department.

2. The HMO had a capitation agreement with University Medical Associates at Syracuse, which includes Family Medicine Medical Group, Pediatric Medical Service Group and the Department of Medicine Medical Service Group. The agreement allowed the HMO to withhold 15% of each month’s capitation fee until certain performance criteria set forth in the agreement were satisfied. The HMO expensed the fees when they were released rather than when they were withheld. SSAP No. 5 requires that the fees be expensed by the HMO when they were withheld. As of June 15, 2004, the HMO’s new contract with the above listed groups do not contain capitation fee withhold provisions.

It is recommended that the HMO comply with the requirements of SSAP No. 5 and expense capitation fees when they are withheld.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2003. This is the same as the balance sheet filed by the HMO.

	Examination	HMO
Assets		
Bonds	$ 84,476,823	$ 84,476,823
Cash, cash equivalents and short-term investments	23,249,320	23,249,320
Receivable for securities	8,490	8,490
Investment income due and accrued	996,664	996,664
Uncollected premiums and agents' balances in course of collection	26,949,929	26,949,929
Amounts recoverable from reinsurers	34,118	34,118
Net deferred tax asset	2,982,200	2,982,200
Receivable from parent, subsidiaries and affiliates	3,013,926	3,013,926
Other receivables	737,022	737,022
Total assets	$ 142,448,492	$ 142,448,492

Liabilities, Capital and Net Worth	Examination	HMO
Liabilities:		
Claims unpaid	$ 62,280,474	$ 62,280,474
Accrued medical incentive pool and bonus amounts	167,186	167,186
Aggregate health policy reserves	6,815,342	6,815,342
Aggregate health claim reserves	938,961	938,961
Premiums received in advance	9,553,984	9,553,984
General expenses due or accrued	570,890	570,890
Current federal and foreign income tax payable and interest thereon	445,120	445,120
Amounts withheld or retained for the account of others	50,152	50,152
Payable for securities	4,093,047	4,093,047
Aggregate write-ins for other liabilities	1,120,463	1,120,463
Total liabilities	$ 86,035,619	$ 86,035,619
Net Worth		
Common capital stock	100	100
Preferred capital stock	8,000,000	8,000,000
Gross paid in and contributed surplus	18,459,187	18,459,187
Surplus notes	3,500,000	3,500,000
Unassigned funds (surplus)	26,453,586	26,453,586
Total capital and surplus	56,412,873	56,412,873
Total liabilities, capital and net worth	$ 142,448,492	$ 142,448,492

Note 1: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the HMO through tax year 2003. The examiner is unaware of any potential exposure of the HMO to any tax assessments and no liability has been established herein relative to such contingency.

Note 2: Pursuant to Section 1307 of the New York Insurance Law, no liability appears in the statement for loans in the amount of $5,500,000 of principal and $1,217,000 of interest accrued thereon. The principal and interest may be repaid only with the permission of the Superintendent of Insurance.

B. Statement of Revenue and Expenses and Net Worth

Operations for the period from January 1, 2000 to December 31, 2003 produced an increase in net worth of $ 26,942,954 detailed as follows:

Revenue:		
Net premium income	$ 1,361,757,051	
Change in unearned premium reserves and reserve for rate credits	11,527,113	
Aggregate write-ins for non-health revenues	9,439	
Net investment income earned	17,471,028	
Net realized capital gains or (losses)	209,554	
Net reinsurance recoveries	684,250	
Incentive pool, withhold adjustments and bonus amounts	4,630,584	
Total revenue		$ 1,396,289,019
Medical and Hospital Expenses:		
Total hospital and medical	$ 1,056,474,512	
Other professional services	17,963,290	
Emergency room and out-of-area	563,132	
Prescription drugs	60,918,705	
Aggregate write-ins for other hospital and medical	6,250,547	
Aggregate write-ins for other income or expenses	288,355	
Total medical and hospital expenses		$ 1,142,458,541
Administrative expenses:		
Claims adjustment expenses		69,160,573
General administrative expenses		120,113,512
Total underwriting expenses		1,331,732,626
Net income before federal income taxes		64,556,393
Federal and foreign incomes taxes incurred		(22,280,886)
Net income		$ 42,275,507

Change in Net Worth

	Gains in Net Worth	Losses in Net Worth	
Combined net worth of UnitedHealthcare of New York, Inc. and UnitedHealthcare of Upstate New York, Inc per reports on examination as of December 31, 1999			$ 29,469,919
Net income	$ 42,275,507		
Change in non-admitted assets	5,039,350		
Change in unauthorized reinsurance		$ 3,961,941	
Decrease in surplus notes		2,000,000	
Cumulative effect in changes in accounting principle	435,427		
Change in deferred income tax		1,570,969	
Increase/decrease in contingency reserves	2,947,014		
Dividends to stockholders		13,100,000	
Aggregate write ins for changes in retained earnings		2,822,482	
Aggregate write-ins for gains in surplus		298,952	
Net increase in net worth			$ 26,942,954
Net worth per report on examination as of December 31, 2003			$ 56,412,873

4. CLAIMS RESERVES

The examination liability of $62,280,474 is the same as the amount reported by the HMO in its 2003 filed Annual Statement.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through June 30, 2004 plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2003, that were still outstanding at June 30, 2004.

5. MARKET CONDUCT

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

A. Claims processing
B. Prompt Pay Law
C. Denied claims
D. Explanation of benefits statements
E. Schedule M
F. Grievances
G. Utilization review
H. Utilization review appeals
I. Appointment of agents
J. Commission payments
K. Fraud prevention and detection

A. Claims Processing

A review of claims adjudicated by the HMO was performed by using a statistical sampling methodology covering claims processed during the period January 1, 2003 through December 31, 2003 in order to evaluate the overall accuracy and compliance environment of UHcNY's claims processing environment.

The claim population for the HMO was divided into medical and hospital claim segments. A random statistical sample was drawn from each segment. It should be noted for the purpose of this analysis, those medical costs characterized as Pharmacy, Medicare/Medicaid, Dental, Capitated Payments, and HCRA bulk payments were excluded.

The sample size for each population (one for medical claims and one for hospital claims) was comprised of 167 randomly selected claim transactions. Additional random samples were generated for each group as "replacement items" in the event it was determined a particular claim transaction selected in the sample should be excluded. Accordingly, various replacement items were appropriately utilized. In total, 334 claims were selected for review.

The examination review of the HMO found a calculated financial error rate of 9.58% for medical claims and 30.54% for hospital claims and overall claims processing financial accuracy levels were 90.42% for medical claims and 69.46% for hospital claims. Procedural error rates were 10.78% for medical claims and 32.34% for hospital claims and overall claims processing procedural accuracy levels were 89.22% for medical claims and 67.66% for hospital claims.

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times claim transactions were processed in accordance with the HMO's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such, it is counted both as a financial error and a procedural error.

The following charts illustrate the financial and procedural claims accuracy findings summarized above:

Summary of Financial Claims Accuracy

	Medical Claims	Hospital Claims
Population	349,658	13,318
Sample size	167	167
Number of claims with errors	16	51
Calculated error rate	**9.58%**	**30.54%**
Upper error limit	14.04%	37.52%
Lower error limit	5.12%	23.55%
Calculated claims in error	**33,497**	**4,067**
Upper limit claims in error	49,092	4,997
Lower limit claims in error	17,902	3,136

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

Summary of Procedural Claims Accuracy

	Medical Claims	Hospital Claims
Population	349,658	13,318
Sample size	167	167
Number of claims with errors	18	54
Calculated error rate	10.78%	32.34%
Upper error limit	15.48%	39.43%
Lower error limit	6.08%	25.24%
Calculated claims in error	**37,693**	**4,307**
Upper limit claims in error	54,127	5,251
Lower limit claims in error	21,259	3,361

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

During the process of reviewing the claim transactions within the various claim adjudication samples, the following was noted:

- There were several instances where CPT code 36415 for collection of blood was inappropriately denied. The HMO found the incorrect denials were caused by a system error which showed the code as not separately payable.

It is recommended that UHcNY take steps to correct any system errors that resulted in incorrect denials of CPT code 36415 and that it re-adjudicates claims to determine if additional payments are necessary.

- The HMO's direct pay conversion policies are administered by vendors who verify the subscriber's eligibility information. Several claims were denied because the UHcNY claim processing system showed the subscriber's policy as cancelled. This was caused by the failure of UHcNY's previous vendor, NCO, to supply the correct policy information for some subscribers, to Conexis, UHcNY's vendor as of January 1, 2003.

It is recommended that UHcNY take steps to ensure that its current vendor Conexis has the correct policy information for its subscribers and that it re-adjudicates claims to determine if additional payments are necessary.

- There were several instances where a hospital (HCRA) surcharge amount was either paid incorrectly or not at all on laboratory claims.

It is recommended that UHcNY review all claims paid for the period January 1, 2003 to December 31, 2003 where a HCRA surcharge was applicable, and determine whether the HCRA surcharge was applied and paid correctly.

- The HMO has the following procedures in place to pay claims for services rendered outside the United States. Any travel related claims over $2,500 and expatriate claims over $10,000 are referred to the Special Investigations Unit. Other items that are reviewed on claims submissions for evidence of fraud include dates of service and other medical information not matching within the records and claims that are from countries known to be a high risk for fraud or abuse activities. The first criteria for determining whether a claim is referred to the Special Investigation Unit is the dollar threshold, however claims are reviewed regardless of the dollar threshold.

  Typically, service outside of the United States is difficult to confirm, so insurance fraud is easier to commit; providers are often unknown and their credentials cannot be confirmed. Further, the possibility for collusion is high. For these reasons, the dollar threshold for claims may not provide adequate protection against fraud.

It is recommended that the HMO re-evaluate the level at which foreign claims will be referred to its special investigation unit oversight group for investigation prior to payment.

B. 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:

> "(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:

> "(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."

Two statistical samples (one for hospital claims and one for medical claims) of claims not adjudicated within 45 days of submission to the HMO were 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, 2003 through December 31, 2003 were segregated. A statistical sample of each population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

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

Summary of Violations of Section 3224-a(a)

	Medical Claims	Hospital Claims
Total population	349,658	13,318
Population of claims adjudicated past 45 days of receipt	5,515	474
Sample size	167	167
Number of claims with errors	149	165
Calculated error rate	**89.22%**	**98.80%**
Upper error limit	93.92%	100%
Lower error limit	84.52%	97.15%
Calculated claims in error	**4,920**	**468**
Upper limit claims in error	5,180	474
Lower limit claims in error	4,661	460

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

Summary of Violations of Section 3224-a(c)

	Medical Claims	Hospital Claims
Total population	349,658	13,318
Population of claims paid past 45 days of receipt (that are eligible for interest)	3,118	374
Sample size	167	167
Number of claims with errors	2	38
Calculated error rate	**1.20%**	**22.75%**
Upper error limit	2.85%	29.11%
Lower error limit	0.0%	16.40%
Calculated claims in error	**37**	**85**
Upper limit claims in error	89	109
Lower limit claims in error	0	61

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

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt (for Section 3224-a(a)), and those claims which incurred interest of two dollars or more (for Section 3224-a(c)), based upon the examinations calculations for claims adjudicated by the HMO during the period January 1, 2003 through December 31, 2003.

The population of claims adjudicated after forty-five days from date of receipt for the HMO consisted of 5,515 medical and 474 hospital claims out of 349,658 medical and 13,318 hospital claims processed during the period under review. The population of claims which incurred interest of two dollars or more consisted of 3,118 medical and 374 hospital claims out of 349,658 medical and 13,318 hospital claims processed during the period under review.

The HMO's claim processing system calculates interest due on a claim from the date a claim is overdue, through the adjudication date, plus two additional days, to allow time to mail the payment. During the review it was found that some claims were mailed later or earlier then the two days allowed for. Depending on the size of the payment, this could result in a significant difference in the interest payment.

Seven of the thirty-seven Prompt Pay interest errors uncovered during the examiners review of hospital claims were the result of incorrect interest payment amounts.

During the review of Prompt Pay for claims where interest was due, the HMO reprocessed and paid interest on many of the sampled claims if they found the claim was initially processed incorrectly.

It is recommended that the HMO review its Prompt Pay procedures to improve its compliance with Section 3224-a(a) of the New York Insurance Law.

It is also recommended that the HMO implement the necessary procedures and training in order to ensure compliance with Section 3224-a(a) of the New York Insurance Law.

It is further recommended that the HMO comply with Section 3224-a(c) of the New York Insurance Law and calculate interest due on all applicable claims paid after 45 days of receipt.

As the result of Prompt Pay reviews by this Department's Consumer Services Bureau, the HMO entered into several Stipulations with the Department. As part of the stipulation agreements, the Consumer Services Bureau requires companies to reprocess and pay all late claims received as complaints by the Bureau over the six month period of its review and reprocess all late claims for an additional three month period afterward. The Stipulations dated November 6, 2003 and April 14, 2004 between the HMO and the Department required the HMO to conduct a review of overdue claims for the period's January 1, 2003 to June 30, 2003 and October 1, 2003 to December 31, 2003.

It is recommended that the HMO reprocess all claims adjudicated during the period January 1, 2003 to December 31, 2003 that were not covered by the Stipulations noted above, for compliance with Section 3224-a(a) of the New York Insurance Law and pay any interest owed pursuant to Section 3224-a(c) of the New York Insurance Law.

C. Denied Claims

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..."

An initial review of denied claims was completed by the examiner from a data file provided by the HMO. A sample of fifty medical claims and a sample of fifty hospital claims with a "zero payment" were reviewed to determine UHcNY's compliance with the above statue.

The review found that thirty-five out of the fifty medical claim denials and thirty-six out of the fifty hospital claim denials selected were not actually denials, but were adjustments of previously processed claims. These claims had been processed in prior years and when adjustments were made to the claim such as an additional payment on a claim due to a change in rates or from an additional review of the claim, the original claim payment was backed out of the system resulting in a zero payment as the adjusted claim payment amount was entered into the system. These claim adjustments were included in the data and were picked up as zero payments for claims processed in 2003. After numerous attempts by the examiner and the HMO to review and stratify the data, it was determined that an accurate review of UHcNY's denied claims could not be done.

It is recommended that UHcNY put in place procedures that allow the claim system to differentiate between claim adjustments that create zero payments and actual denied claims.

It is recommended that the HMO create procedures to ensure that outstanding claims in its claims system are 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 ("EOB")

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

The samples selected for analyzing EOBs were the same hospital claims sample and medical claims sample used for the claims processing review noted above.

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

> "(b) 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."

The EOB statements do not provide a sufficient description of the submitted charges. In many cases, non-specific terms such as "medical services", "laboratory services" or "radiology services", are routinely used to describe the submitted charges. If UHcNY would display the five digit Current Procedural Technology (CPT) codes, the codes identifying the service for which the claim is made, on its EOB along with a brief description, a satisfactory explanation of the submitted charges could be provided to the subscriber.

It is recommended that the HMO display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes.

E. Schedule M

The HMO's Schedule M filed in its annual statement reported 122 grievance cases filed and closed in 2003, however, according to the grievance register provided to the examiner by the HMO, there were 533 grievance cases filed and closed in 2003. The HMO could not explain why there was a difference of 411 cases.

It is recommended that the HMO report all grievance cases on its Schedule M filed with the Department.

The HMO's Schedule M filed in its annual statement reported 43 utilization review appeals filed and closed in 2003. The HMO did not report any external appeals filed in its 2003 annual statement filing. According to the utilization review register provided by the HMO there were 132 utilization review appeals and four external appeals filed and closed in 2003. The HMO could not explain the difference of 89 utilization review cases and four external appeal cases.

It is recommended that the HMO report all utilization review and external appeal cases on its Schedule M, filed with the Department.

F. Grievances

A review of grievances and appeals filed with the HMO for the period January 1, 2003 through December 31, 2003 was performed to ascertain compliance with Section 4408-a ("Grievance Procedure") of the New York Public Health Law.

During the period under review, UHcNY provided a listing of 448 grievances; however, the listing did not specify how many of these grievances went to a second level appeal. Twenty files were randomly selected for review and if the grievance went to a second level appeal, such appeal was reviewed as well. This resulted in the review of twenty grievances and two appeals. It was noted that ten of the grievances reviewed pertained solely to a question of covered benefits, while the remaining ten concerned issues other than coverage of benefits.

United Behavioral Health (UBH), an affiliate of UHcNY which provides employee assistance, mental health and substance abuse service for the HMO's enrollees recorded 85 additional grievances during the period. As with the listing for UHcNY, the amount of

grievances that went to a second level appeal could not be determined. Five files were randomly selected for review and if the grievance went to a second level appeal, such appeal was reviewed as well. This resulted in the review of five grievances and one appeal.

Section 4408-a(2)(a) of the New York Public Health Law states:

> "An organization shall provide to all enrollees written notice of the grievance procedure in the member handbook and at any time that the organization denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract; provided, however, that nothing herein shall be deemed to require a health care provider to provide such notice. In the event that an organization denies a service as an adverse determination as defined in article forty-nine of this chapter, the organization shall inform the enrollee or the enrollee's designee of the appeal rights provided for in article forty-nine of this chapter."

One of the twenty (5%) UHcNY files reviewed resulted in an adverse determination due to a utilization review. The HMO failed to provide the appeal rights required by Section 4408-a(2)(a) of the New York Public Health Law for adverse determinations as a result of the utilization review.

It is recommended that the HMO provide the appeal rights specified by Section 4408-a(2)(a) of the New York Public Health Law.

Section 4408-a(4) of the New York Public Health Law states:

> "Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:
>
> (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health;

> (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and
>
> (iii) forty-five days after the receipt of all necessary information in all other instances."

The HMO did not provide a written acknowledgement within 15 business days on fourteen of the twenty (70%) UHcNY grievances files reviewed, as required by Section 4408-a(4) of the New York Public Health Law.

The HMO failed to resolve grievances within thirty days on five of the ten (50%) UHcNY files reviewed that pertained to covered benefits, as required by Section 4408-a(4)(ii) of the New York Public Health Law.

The HMO failed to resolve grievances within forty-five days on three of the ten (30%) UHcNY files reviewed that pertained to issues other than questions of coverage as required by Section 4408-a(4)(iii) of the New York Public Health Law.

It is recommended that the HMO provide a written acknowledgement within 15 business days for grievances filed as required by Section 4408-a(4) of the New York Public Health Law.

It is also recommended that the HMO comply with the requirements of Section 4408-a(4)(ii) of the New York Public Health Law by resolving grievances within thirty days when the grievance pertains to questions of covered benefits.

It is further recommended that the HMO comply with the requirements of Section 4408-a(4)(iii) of the New York Public Health Law by resolving grievances within forty-five days when the grievance pertains to issues other than questions of covered benefits.

Section 4408-a(7) of the New York Public Health Law states:

> "The notice of a determination shall include: (i) the detailed reasons for the determination; (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination; and (iii) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal."

The HMO failed to provide the procedures for the filing of an appeal of the determination on two of the twenty (10%) UHcNY files reviewed as required by Section 4408-a(7) of the New York Public Health Law.

It is recommended that the HMO comply with the requirements of Section 4408-a(7) of the New York Public Health Law by providing the procedures for the filing of an appeal of a grievance determination on its notices of adverse determination.

Section 4408-a(14) of the New York Public Health Law states:

> "An organization shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the enrollee's acknowledgment of the grievance, if any; the determination made by the organization including the date of the determination and the titles and, in the case of a clinical determination, the credentials of the organization's personnel who reviewed the grievance. If an enrollee files an appeal of the grievance, the file shall include the date and a copy of the enrollee's appeal, the determination made by the organization including the date of the determination and the titles and, in the case of clinical determinations, the credentials, of the organization's personnel who reviewed the appeal."

The HMO failed to maintain the necessary documentation on eight of the twenty (40%) UHcNY grievance files reviewed as required by Section 4408-a(14) of the New York Public Health Law.

The HMO failed to maintain the necessary documentation on one of two (50%) second level UHcNY appeal files reviewed as required by Section 4408-a(14) of the New York Public Health Law.

The HMO failed to maintain the necessary documentation on one of five (20%) UBH grievance files reviewed as required by Section 4408-a(14) of the New York Public Health Law.

It is recommended that the HMO comply with the requirements of Section 4408-a(14) of the New York Public Health Law and retain all necessary required documentation for its grievance files.

G. Utilization Review

Sections 4902, 4903 and 4904 of the New York Public Health Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents respectively for an HMO licensed under Article 44 of the New York Public Health Law.

For the period January 1, 2003 through December 31, 2003, UHcNY provided the examiners with logs of utilization reviews for UHcNY and for United Behavioral Health, Inc. (UBH), an affiliate of UHcNY which provides employee assistance, mental health and substance abuse service for the HMO's enrollees.

The HMO provided separate utilization review logs for UHcNY and United Behavioral Health, Inc. The UHcNY log contained 52 prospective or concurrent review denials while the UBH log contained 45 prospective or concurrent review denials. Ten files were randomly

selected for UHcNY and five files were randomly selected for United Behavioral Health, Inc. to determine compliance with Article 49 of the New York Public Health Law.

It is noted that all 10 of the UHcNY files selected were prospective review files. Three of the UBH files selected were prospective review files and two were concurrent review files.

Section 4900(8)(e) of the New York Public Health Law states in part:

> "8. Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. For the purposes of this article none of the following shall be considered utilization review:..
> (e) Any determination of any coverage issues other than whether health care services are or were medically necessary."

The review found that four of the ten (40%) UHcNY utilization review cases reviewed were related to network gap issues and did not meet the definition of "utilization review" under Section 4900(8)(e) of the New York Public Health Law.

It is recommended that the HMO accurately classify its cases described as utilization review.

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."

The remaining six (60%) UHcNY prospective review files reviewed failed to provide a notice of determination within three business days by telephone and in writing to the

enrollee/enrollee's designee and the provider as required by Section 4903(2) of the New York Public Health Law.

All three (100%) of the UBH prospective review files reviewed failed to provide a notice of determination within three business days by telephone and in writing to the enrollee/enrollee's designee and the provider as required by Section 4903(2) of the New York Public Health Law.

It is recommended that the HMO and UBH 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 provider on prospective reviews.

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

> "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. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date."

Both (100%) of the UBH concurrent review files reviewed failed to provide a notice of determination within one business day by telephone and in writing to the enrollee/enrollee's designee and the provider as required by Section 4903(3) of the New York Public Health Law.

It is recommended that UBH comply with the requirements of Section 4903(3) of the New York Public Health Law and provide notices of determination within one business day by telephone and in writing to the enrollee/enrollee's designee and provider on concurrent reviews.

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

> "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;..."

Five of the six (80%) UHcNY prospective review files reviewed failed to provide notice on how to initiate expedited appeals as required by Section 4903(5)(b) of the New York Public Health Law.

The review of the UHcNY prospective adverse determination notices found that the adverse determination notices contained different time frames to file utilization review appeals. Four (4) of the files provided 60 days, three (3) provided 180 days, one (1) provided 45 days notice which is the minimum number of days required by the New York Public Health Law. Additionally, it should be noted that the number of days provided for two (2) files could not be determined.

It is recommended that the HMO comply with the requirements of Section 4903(5) of the New York Public Health Law and provide notice on how to initiate expedited appeals on its notices of adverse determination.

It is recommended that the HMO comply with the requirements of Section 4903(5) of the New York Public Health Law and provide the proper standard time frame for filing appeals to adverse determinations.

H. Utilization Review Appeals

The HMO provided a log containing 132 utilization review appeals of UHcNY for the period January 1, 2003 through December 31, 2003. Fifteen files were randomly selected from this list for review by the examiners. A utilization review log could not be provided for UBH so the utilization review appeals for the five files selected for the adverse utilization review determination were selected for review. The files were reviewed to determine compliance with Article 49 of the New York Public Health Law.

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

> "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:
>
> (a) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and
>
> (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."

Seven out of the fifteen (47%) utilization review appeal files for UHcNY failed to provide written acknowledgement of the filing of the appeal within 15 days as required by Section 4904(3) of the New York Public Health Law.

Three out of the fifteen (20%) utilization review appeal files for UHcNY failed to provide the enrollee notice of the appeal determination within 2 business days of the rendering of such determination as required by Section 4904(3) of the New York Public Health Law.

Four out of the fifteen (27%) utilization review appeal files for UHcNY failed to make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal as required by Section 4904(3) of the New York Public Health Law.

Three out of the fifteen (20%) utilization review appeal files for UHcNY failed to inform the enrollee of the right to an external appeal including the description and the time frame for such external appeal as required by Section 4904(3)(b) of the New York Public Health Law.

It is recommended that the HMO comply with the requirements of Section 4904(3) of the New York Public Health Law and provide written acknowledgement within 15 days of receipt of an appeal of a utilization review determination.

It is recommended that the HMO comply with the requirements of Section 4904(3) of the New York Public Health Law and provide the enrollee with notice of the appeal determination within 2 business days of the rendering of such determination.

It is recommended that the HMO comply with the requirements of Section 4904(3) of the New York Public Health Law and complete the utilization review determination within sixty days of the receipt of information necessary to conduct the appeal.

It is recommended that the HMO comply with the requirements of Section 4904(3)(b) of the New York Public Health Law and inform the enrollee of the right to an external appeal, including the description and the time frame for such external appeals.

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

> "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."

Three out of the fifteen (20%) utilization review appeal files for UHcNY failed to use a clinical reviewer to review the utilization review appeals as required by Section 4904(4) of the New York Public Health Law.

It is recommended that the HMO comply with the requirements of Section 4904(4) of the New York Public Health Law and use a clinical reviewer to evaluate the utilization review appeals.

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."

The HMO failed to maintain the necessary documentation for one of the five (20%) UBH utilization review files reviewed, as required by Section 243.2(b)(8) of Department Regulation 152 (11 NYCRR 243).

The HMO failed to maintain the necessary documents for fourteen of the fifteen (93%) UHcNY utilization review files reviewed, as required by Section 243.2(b)(8) of Department Regulation 152 (11 NYCRR 243).

It is recommended that the HMO comply with the requirements of Section 243.2(b)(8) of Department Regulation 152 (11 NYCRR 243) and retain all documentation for its utilization review cases for at least 6 calendar years

I. Appointment of Agents

The HMO provided a listing of 5,848 agents active as of December 31, 2003 and 1,793 terminated agents from January 1, 2003 to December 31, 2003. Separate samples of 167 active agents and 167 terminated agents were selected and reviewed against the active and terminated listings provided by the Department's Licensing Bureau.

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."

The Department had no record of certificates of appointments for 119 out of the 167 (71%) sampled agents listed as being active by UHcNY on the list provided. The HMO was able to provide documentation that 71 of the 119 (60%) were appointed. The HMO could not provide documentation that the other 48 agents (29%) were appointed.

It is recommended that the HMO comply with Section 2112(a) of the New York Insurance Law and file certificates of appointments for all agents.

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

> "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."

The Department had no record for 166 out of 167 (99.40%) agents sampled whose appointments UHcNY had listed as terminated for the period January 1, 2003 to December 31, 2003. Of these 166 agents, 103 (62%) were sixty day letter terminations, 50 (30%) were mailing address terminations and 13 (8%) were terminations that were not reported to the Department because of miscellaneous errors. These are detailed as follows:

The sixty-day letter termination errors were caused through the implementation by UHcNY (on November 30, 2002) of a new process, called the "sixty-day letter process" which monitored the expiration of non-perpetual licenses based on the most current license end date entered in UHcNY's Producer Credentialing Information System (PCIS). The system automatically sent a letter to a producer requesting a copy of their current renewal license sixty

days prior to the expiration date on file in PCIS. If the license was not updated in PCIS with the new expiration date based on the renewal copy, the system automatically terminated the appointment.

The HMO failed to include its appointment vendor SIRCON in the initial electronic processing of terminations. For this reason the producer appointments within the scope of the sixty-day letter process appeared as terminated in UHcNY's records only. As of December 14, 2003 UHcNY modified the sixty-day letter process to transmit the terminations to the Department using its vendor SIRCON.

The mailing address terminations were the result of UHcNY "data clean" up initiative implemented by the HMO several times from June 2003 to February 2004 to terminate producers which the HMO inherited through its mergers and business transformation from Travelers and MetraHealth. Many of these producers whose records were converted from the Travelers and MetraHealth companies contained various data integrity issues, such as missing tax identification numbers, invalid license and appointment information, or missing mailing addresses. The HMO terminated the appointments of producers with effective dates prior to January 1, 2001, if the data was missing from the producer's record.

The HMO did not report the terminations to the Department. It did not believe the terminations could have been processed since original appointments were not submitted to the Department and converted producer records were missing the data necessary for the Department to process the transactions correctly.

It is recommended that the HMO report all appointment terminations to the New York State Insurance Department in order to comply with the requirements of Section 2112(d) of the New York Insurance Law.

It is recommended that UHcNY improve its record keeping as regards to agents and brokers certificates of appointments and licensing.

The HMO uses two types of external agents. The first type of external agent it uses is "individual independent agents" who represents the HMO in sales of small group and individual policies. The second type it utilizes is "general agents", or agencies that consist of multiple salespersons. General agents represent the HMO in the sale of small group medical insurance. Currently, the HMO utilizes a written agreement between itself and its general agents to clearly spell out the rights and responsibilities of the agency. This practice serves to protect the HMO in its relationship with the general agents. It is noted, however, that there are no such written agreements between the HMO and the individual agents.

It is recommended that the HMO initiate a formal written agreement with its individual independent agents.

J. Commission Payments

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

> "Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers…"

Part 52.42(e) of Department Regulation 62 (11 NYCRR 52.42) states in part:

> "(e) Commission or fees payable by health maintenance organizations to an insurance broker as authorized by 10 NYCRR Part 98. A health maintenance organization (HMO) issued a certificate of authority pursuant to article 44 of the Public Health Law… may, as authorized by 10 NYCRR Part 98, pay commissions or fees to a licensed insurance broker. No licensed insurance broker shall receive such commissions or fees from an HMO, unless the HMO has filed the actual rate to be paid and included the anticipated expenses for such payments to insurance brokers in its application to amend its community premium rates pursuant to the provisions of section 4308 of the Insurance Law. Such rate shall be incorporated into the HMO's premium rate manual. The actual rate per annum may not exceed four percent of the HMO's approved premium for the contract sold."

A listing of commission payments made by the HMO for the period January 1, 2003 to December 31, 2003 was provided. The listing contained 774 producers and a summary amount paid to each for the year as well as the commission percentage for the year. The listing showed that 56 of the producers appeared to receive commission payments in excess of 4% for the year and further inquiries were made for these producers.

Of the fifty-six (56) producers reviewed there were seven cases where the commission paid deviated from the filed commission rate. The remaining cases where commission payments exceeded the 4% limitation were the result of commission payments for non-New York based groups and payments for HMO groups which had a point of service option (POS) where the HMO's affiliate, United HealthCare Insurance Company of New York, was able to pay an additional 2% commission above the standard 4% commission rate.

There was one producer who received a seven percent commission on two separate groups with a POS option, in excess of the six percent maximum rate for large group product as filed with the Department. There were six producers who received commission payments (on

seven groups) in excess of the 4% limitation for small group products as filed with the Department.

It is recommended that the HMO comply with Section 4235(h)(1) of the New York Insurance Law and put in place procedures to ensure that commission payments do not exceed the HMO's filed rates.

It is recommended that UHcNY comply with the four percent commission rate payment limitation of Part 52.42(e) of New York Insurance Department Regulation 62.

K. Fraud Prevention and Detection

Ingenix Recovery Services investigates medical claims for UnitedHealthcare of New York, Inc., and functions as the internal vendor of these services.

Ingenix Recovery Services, a division within Ingenix, offers products and services internally, to other companies within United Health Group, and to external clients, which include compliance research and monitoring, detection technology, investigation and recovery services (collection of financial loss caused by insurance fraud), training, consulting and subrogation.

Ingenix Recovery Services is located in two primary sites: Hartford, Connecticut and Minneapolis, Minnesota and focuses most of its fraud detection efforts at the physician and other health care provider levels; that is, identifying the suspected physicians/providers and reviewing their claims prospectively prior to payment, and post-payment for potential recovery cases.

Ingenix Recovery Services is comprised of several units, totaling over 100 personnel (not including management), who conduct or support the investigative process, and are comprised of: prospective and recovery investigators, case development analysts, data mining analysts, associate investigators (or investigative assistants), and clinical personnel, who focus on detecting and investigating fraudulent and abusive claim payments. Not all of these personnel investigate or support the claims investigation process involving New York providers.

Ingenix Recovery Services Investigators, review New York fraud claim referrals. New York fraud claim referrals are investigated by the Northeast Regional Team of Ingenix Recovery Services Investigators, which is comprised of seven personnel who dedicate approximately 95% of their time and resources to New York providers.

Section 86.6(c) of Department Regulation No. 95 (11 NYCRR 86.6) states:

> "Persons employed by Special Investigations Units as investigators or by an independent provider of investigative services under contract with an insurer shall be qualified by education and/or experience which shall include:
>
> (1) an associate's or bachelor's degree in criminal justice or a related field; or
>
> (2) five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies; or
>
> (3) seven years of professional investigation experience involving economic or insurance related matters; or
>
> (4) an authorized medical professional to evaluate medical related claims."

Though an additional number of over ninety (90) personnel are potentially available for investigating or supporting the investigative process involving New York physicians/providers, only those investigators from other teams or units from within Ingenix Recovery Services, who are qualified under Regulation 95, Section 86.6(c) (11 NYCRR 86.6), are permitted to work on such cases.

Section 405(a) of the New York Insurance Law states:

> "(a) Any person licensed pursuant to the provisions of this chapter, and any person engaged in the business of insurance in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent insurance transaction is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require. The insurance frauds bureau shall accept reports of suspected fraudulent insurance transactions from any self insurer, including but not limited to self insurers providing health insurance coverage or those defined in section fifty of the workers' compensation law, and shall treat such reports as any other received pursuant to this section."

United HealthCare Insurance Company of New York, Inc. and UnitedHealthcare of New York, Inc. (including Ovations Insurance Solutions), and the Empire Plan insure 1,440,381 members and they receive/process 31,113,083 claims annually, as indicated in the 2003, Section 409(g) Annual Anti-Fraud Report filed with the Department.

The 2003 Anti-Fraud Report filing contained the combined data for both United HealthCare Insurance Company of New York and UnitedHealthcare of New York. The report indicated that the companies reviewed 1,091 cases in 2003, a decrease of 805 cases from its 2002 filing. The companies reported 1,298 cases closed in 2003 from cases filed in 2003 and prior. Out of the 1,091 cases reviewed, only 139 IFB-1 forms, forms used for reporting suspected fraudulent activities, were filed with the Insurance Department's Frauds Bureau reporting fraudulent transactions.

Section 86.6(b)(3) of Department Regulation 95 states:

> "(b) The Plan shall include the following provisions:
>
> (3) The rationale for the level of staffing and resources being provided for the Special Investigations Unit which may include, but is not limited to, the following objective criteria such as number of policies written and individuals insured in New York, number of claims received with respect to New York insureds on an annual basis, volume of suspected fraudulent New York claims currently being detected, other factors relating to the vulnerability of the insurer to fraud, and an assessment of optimal caseload which can be handled by an investigator on an annual basis."

Section 86.6(b)(3) of Department Regulation 95 states that one of the criteria used to determine the adequacy of staffing of a Special Investigation unit is to compare claims to investigators. The companies generated over 31 million claims in 2003 and only had seven full time investigators.

It is the contention of the Department that the companies staffing level of seven full time examiners is inadequate with a base of 1.4 million members. In addition the number of fraud cases reviewed detected decreased by 42% from 1,896 in 2002 to 1,091 in 2003. Clearly, an increase in the number of investigators would increase fraud detection and prevention.

It is recommended that the HMO adequately staff its Special Investigations Unit, so that it can effectively detect, investigate and prevent fraud.

UnitedHealthcare of New York, Inc. provided a listing of 342 cases opened and closed in 2003 to the examiners. A review was performed on 20 randomly selected cases from this listing.

The following are the findings of the review:

- There was no indication whether IFB-1 forms were filed on any of the cases.
- There was no indication on the closed cases that a supervisor reviewed the case before it was closed.

It is recommended that UHcNY comply with its procedures to ensure that IFB-1 forms are filed with the Department when required and that the files document when such filings occur.

It is recommended that UHcNY put in place procedures to ensure that all cases are reviewed by a supervisor before the case is closed.

6. SUBSEQUENT EVENTS

In October 2005, UnitedHealthcare of New York, Inc. began a market/product withdrawal from the HMO markets where it was licensed to write business. This market withdrawal was completed on October 1, 2006 and as of the date of this report; the HMO's license no longer contains commercial business. Furthermore, business no longer exists on the UnitedHealthcare of Upstate New York, Inc. license.

7. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The previous examinations contained recommendations for both UnitedHealthcare of Upstate New York, Inc. and UnitedHealthcare Insurance Company of New York, Inc. The HMO's merged in 2002 and the following shows the recommendations which have not been complied with for each HMO for the financial and market conduct examinations.

UnitedHealthcare of Upstate New York, Inc.:

There was one comment and recommendation from the prior report on examination as of December 31, 1999 that the HMO has not complied with. They are repeated herein as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
1.	It is recommended that the HMO amend its custodial agreement to include the following: • A provision requiring the bank to have and maintain Bankers Blanket Bond Insurance of the broadest form available for commercial banks. Further, the bank should be required to give 60 days written notice to the HMO of any material change in the form or amount of such coverage. • A provision indicating to the bank that written instructions given to the bank by the HMO are to be signed by at least two of its Authorized Officers. Said officers will be authorized in a list that will be furnished to the bank as necessary and signed by the treasurer or an assistant treasurer and certified under the corporate seal by the secretary or an assistant secretary. • A provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors.	12-13

ITEM NO.		PAGE NO.
	The HMO has not complied with this recommendation and a similar recommendation is made herein. Subsequent to the date of the examination, in March 2007, the Company provided documentation to show that the aforementioned agreement has been amended to contain the suggested wording.	12-13

UnitedHealthcare of New York, Inc.

There was one recommendation from the prior report on examination as of December 31, 1999 that the HMO has not complied with. It is repeated herein as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
1.	It is recommended that the HMO amend its custodial agreement to include the following: • A provision requiring the bank to have and maintain Bankers Blanket Bond Insurance of the broadest form available for commercial banks. Further, the bank should be required to give 60 days written notice to the HMO of any material change in the form or amount of such coverage. • A provision indicating to the bank that written instructions given to the bank by the HMO are to be signed by at least two of its authorized officers. Said officers will be authorized in a list that will be furnished to the bank as necessary and signed by the treasurer or an assistant treasurer and certified under the corporate seal by the secretary or an assistant secretary. • A provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors. The HMO has not complied with this recommendation and a similar recommendation is made herein. Subsequent to the date of the examination, in March 2007, the Company provided documentation to show that the aforementioned agreement has been amended to contain the suggested wording.	12

UnitedHealthcare of New York, Inc.

There were five comments and recommendations from the prior market conduct report on examination as of December 31, 1999, that the HMO has not complied with. They are repeated herein as follows (page numbers refer to the prior report). Additionally, there was a special market conduct exam conducted as of March 31, 2003 and a report was issued thereon. The HMO has complied with all comments and recommendations from that report:

ITEM NO.		PAGE NO.
	Sales/Underwriting	
1.	It is recommended that the HMO initiate a written agreement with its individual producers. Additionally, it is recommended that the Upstate HMO formalize an agreement with its general agents. The HMO has not complied with this recommendation and it is repeated herein. Subsequent to the date of the examination, effective April 2005, the Company provided documentation to demonstrate that it has instituted policies and procedures to ensure written agreements with producers.	13
2.	It is recommended that UnitedHealthcare of Upstate New York, Inc. file certificates of appointment for each of its agents as required by New York Insurance Law Section 2112(a). The HMO has not fully complied with this recommendation and it is repeated herein.	14
3.	It is recommended that the HMO improve its record keeping as regards agents and brokers. The HMO has not fully complied with this recommendation and it is repeated herein. Subsequent to the date of the examination, effective April 2005, the Company provided documentation to demonstrate that it has developed a process of imaging all appropriate agent and broker documentation.	15

ITEM NO.		PAGE NO.
	Claim Processing	
4.	It is recommended that the HMO re-evaluate the level at which foreign claims will be referred to its fraud oversight group for investigation prior to payment. The HMO has not complied with this recommendation and a similar recommendation is repeated herein.	20
5.	It is recommended that the HMO display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes. The HMO has not complied with this recommendation and it is repeated herein.	23

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	**Custodial Agreement**	
	It is recommended that the HMO amend its custodial agreement with Street Bank to include the following: • The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the HMO 60 days written notice of any material change in the form or amount of such insurance of termination of this coverage. • Written instructions hereunder shall be signed by any two of the HMO's authorized officers specified in a separate list for this purpose. This list will be furnished to the bank from time to time and signed by the treasurer or an assistant and certified under the corporate seal by the secretary or an assistant secretary. • The agreement should have a provision that would give the HMO the opportunity to secure the most recent report on the review of the custodian's system of internal control, pertaining to custodian record keeping, as issued by internal or independent auditors.	12
B.	**Accounts and Records**	
i.	It is recommended that the HMO properly report investment income due and accrued on its annual statement filings made with this Department.	14
ii.	It is recommended that the HMO comply with the requirements of SSAP No. 5 and expense capitation fees when they are withheld.	14

Appointment No. ***22139***

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***GREGORY V. SERIO***, 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

UNITED HEALTHCARE OF NY

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 *January 2004*

Gregory V. Serio
Superintendent of Insurance