REPORT ON EXAMINATION

OF

MANAGED HEALTH, INC.

AS OF

DECEMBER 31, 2006

DATE OF REPORT **MARCH 2, 2010**

EXAMINER **VICTOR ESTRADA**

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

David A. Paterson
Governor

James J. Wrynn
Superintendent

March 2, 2010

Honorable James J. Wrynn
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 22588, dated May 1, 2007, attached hereto, I have made an examination into the condition and affairs of Managed Health, Inc., a not-for-profit health maintenance organization (HMO) licensed under the provisions of Article 44 of the New York Public Health Law, as of December 31, 2006, and respectfully submit the following report thereon.

The examination was conducted at the home office of Managed Health, Inc., located at 25 Broadway, New York, New York 10004.

Wherever the terms “MHI” or “the Plan” appear herein, without qualification, they should be understood to indicate Managed Health, Inc.

1. SCOPE OF EXAMINATION

MHI was previously examined as of December 31, 2001. This examination covers the five-year period from January 1, 2002 through December 31, 2006. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2006, 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 Plan's independent certified public accountants.

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

History of the Plan
Management and controls
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
Business in force
Reinsurance
Accounts and records
Financial statements
Market conduct activities

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

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

2. DESCRIPTION OF THE PLAN

Managed Health, Inc. is a not-for-profit model health maintenance organization ("HMO") incorporated under Section 402 of the New York Not-For-Profit Corporation Law and was issued a Certificate of Authority pursuant to the provisions of Article 44 of the New York Public Health Law. On August 1, 1998, Healthfirst, Inc., ("Healthfirst") a not-for-profit non-insurance entity, which is controlled in equal portions by each of the twenty-one hospitals that comprise its corporate members, was granted approval by the New York State Department of Health to acquire control of Managed Health, Inc. and the transaction was closed on that date.

MHI's home office is located at 25 Broadway, New York, New York. At this location, the functions of administration, membership services, operations and all other services are performed; with the exception of claims processing and enrollment, which are performed at MHI's office at 123 William Street, New York, New York.

MHI contracts with various healthcare providers for the provision of certain medical services to its enrollees. These healthcare providers consist primarily of Healthfirst owner hospitals ("Members") or their affiliates, together with physicians who are associated with the Members.

MHI compensates and shares risk with each of its Members and contracted hospital providers in accordance with terms of a healthcare services agreement with each Member or provider. The agreement provides for an allocation to the Member's or hospital provider's services pool, based on a percentage of premium revenue received by MHI under its agreements to service Medicare and Medicaid beneficiaries. These percentages of premium primarily range from 83% to 89%. Certain premiums for MHI's Medicaid business are allocated to the services pool at 100%.

MHI, its Members and certain contracted providers, assume the risk for healthcare service costs in the hospital services pool. To the extent there is a deficit (estimated medical expense in excess of pool funding) in the hospital services pool of a Member or contracted provider, MHI records a receivable from the Member or contracted provider.

These receivables are collected through reductions of future surpluses in the hospital services pool at the time the quarterly reconciliations are prepared. Management periodically evaluates the collectibility of receivables from Members and contracted providers. The agreements with Members and contracted providers do not relieve MHI of its obligation to pay claims to providers for healthcare services.

Certain contracted providers have elected to not take risk on their membership for certain product lines. For these providers MHI fully accepts the risk.

A. Management and Controls

Pursuant to its by-laws, the management of MHI is to be vested in a board of directors. The by-laws of MHI specify that the board shall consist of five (5) individuals, the majority of whom shall be persons nominated to serve on the board, by the board of directors of its parent, Healthfirst, Inc. Although the requisite board membership was compliant during parts of the examination period, as of December 31, 2006, the minutes of the board meetings indicated that MHI's board consisted of only three members.

At December 31, 2006, the three members of the board of directors and their principal business affiliations were as follows:

Name and Residence	Principal Business Affiliation
Thomas Bergdall New York, NY	Executive Vice President and General Counsel, Healthfirst, Inc.
James Boothe New York, NY	Chief Operating Officer, Healthfirst, Inc.
Donald L. Ashkenase Great Neck, NY	Executive Vice President, Montefiore Medical Center

A review of the attendance records at board of directors' meetings held during the period under examination revealed that meetings were generally well attended.

It is recommended that MHI complies with its by-laws by having the required number (five) of board members, the majority of whom shall be persons nominated to serve on the board by the board of directors of its parent.

The Plan's by-laws also require that at least 20% of the board shall be composed of enrollees who are neither employees of the corporation nor providers of health services. Part 98-1.11(g)(1)(iii) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)(1)) states in part:

> "…(1) Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO, except that…
>
> (iii) an HMO, PHSP, PCPCP or MLTCP may, as an alternative to or in addition to subparagraphs (i) and (ii) above, establish an enrollee advisory council which is representative of the HMO's, PHSP's, PCPCP's or MLTCP's enrollment and which has direct input to the governing authority;"

Part 98-1.11(g)(2) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)(2)) further states:

> "(2) Employees of the MCO, providers of health services or persons having a business relationship with the MCO may not serve as enrollee or consumer representatives."

MHI formed an Enrollee Advisory Council ("Council") in 2006 for the purposes of complying with the requirements of Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department. The Council functioned through 2006, but was disbanded shortly after the examination date, when an independent enrollee was appointed to the board to

fulfill the twenty percent (20%) enrollee requirement of, and in compliance with, Part 98-1.11(g)(1). It was noted that all the Council members are Medicare enrollees.

While noting that about ninety-five percent (95%) of the Plan's enrollees are Medicare members and though not required by statute, MHI should consider including representation from other components of its enrolled population in the Council.

The by-laws of MHI require that there be four board meetings per year. The Plan was unable to provide any evidence showing that the required number of meetings was held during 2002.

It is recommended that MHI complies with its by-laws and holds the requisite number of board meetings.

The following were the principal officers of MHI as of December 31, 2006:

Name	Title
Paul Dickstein	Chief Executive Officer
Kelley Gelein	Secretary
Daniel S. Phillips	Vice President and Chief Financial Officer

B. Territory and Plan of Operation

MHI was granted a certificate of authority to operate in the five boroughs of New York City ("NYC") and the counties of Nassau and Suffolk for its commercial members and for its Medicare members in NYC, excluding Richmond County.

As of December 31, 2006, MHI's total enrollment of 75,823 consisted of 3 direct pay members, 14 commercial group members, 909 Healthy New York members, 2,381 Medicaid members and 72,516 Medicare members.

C. Reinsurance

As of the examination date, MHI had a stop-loss agreement with Allianz Life Insurance Company of New York to limit its losses on individual claims for its Medicare, Medicaid and commercial group enrollees. Under the terms of the stop-loss agreement, MHI will be reimbursed for certain healthcare service costs incurred for an individual enrollee in excess of the "threshold amount" within a contract year. The threshold amount for the contract year ending March 31, 2007, is $250,000. The agreement was renewed as of April 1, 2007.

In addition, by statute, MHI can receive reimbursement for specific (commercial) Direct Pay and Healthy New York members under the stop loss funds established by the New York Insurance Department ("the Department"). Under Section 4321-a of the New York Insurance Law ("Fund for standardized individual enrollee direct payment contracts"), MHI can be reimbursed for certain healthcare service costs of its Direct Pay members incurred in excess of

the $20,000 threshold amount within a contract year. The maximum reimbursement for a direct pay commercial member is $72,000.

Further, under Section 4327 of the New York Insurance Law ("Stop loss funds for standardized health insurance contracts issued to qualifying small employers and qualifying individuals"), MHI can be reimbursed for certain healthcare costs of its Healthy New York members incurred in excess of the $30,000 threshold amount within a contract year. The maximum reimbursement per claim for Healthy New York members is $63,000.

MHI's reinsurance recoveries were approximately $1,551,000 for 2006 and stop-loss premiums paid for that year were $732,500. The stop-loss agreements do not relieve MHI of its obligations to its enrollees.

D. Conflict of Interest

MHI does not have a conflict of interest policy in effect, as it utilizes the policy of its parent, Healthfirst, Inc. Said policy states:

> "On no less than an annual basis, each director will complete the attached Conflicts of Interest Questionnaire to directly disclose information regarding each director's relationship with Member Hospitals which he/she represents as well as any affiliates thereof."

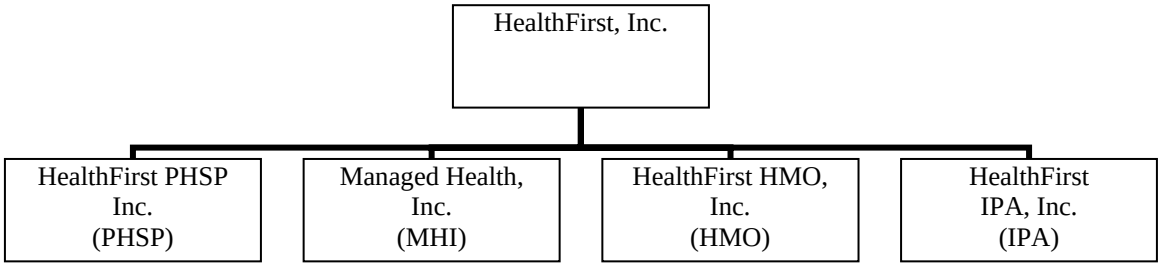
MHI was unable to provide attestation to said policy for all but one of its board members during 2006. Also, it was noted that the policy makes reference to "directors" and not members of senior management or other key employees.

It is recommended that MHI complies with its conflict of interest policy by having its board members complete the applicable conflict of interest questionnaire. It is also recommended that completed questionnaires be maintained for all board members.

E. Holding Company System

The Plan is determined to be a "controlled managed care organization ("MCO") under the definitions set forth in Part 98-1.2(k) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.2(k)). The Plan filed the holding company documents required by Part 98.1-16(e) of the Administrative Rules and Regulations of the Health Department during the examination period.

As of December 31, 2006, the Plan's holding company structure was as follows:



MHI has a management services agreement ("Agreement") with an affiliate, HF Management Services, LLC to obtain management and administrative services, including: all marketing and enrollment services, provider recruitment and provider relations services, accounting and financial services support, claims processing, financial reporting appropriate to member hospitals, maintenance of utilization and quality review programs and all data

processing services. The New York State Department of Health approved an amended and restated management services agreement between HF Management Services, LLC and MHI on May 10, 2006.

In accordance with Section 80-1.4 of Department Regulation 52 (11 NYCRR 80-1.4) - "Registration of controlled insurers", MHI is required to submit its holding company filings no later than sixty days after the filing of its annual statement, which is due April 1st. During the examination period, MHI did not submit its holding company filings under this Regulation for the years 2002 and 2004 on a timely basis. However, other filings made during the examination period were timely.

It is recommended that MHI continue to submit its holding company filings required by Section 80-1.4 of Department Regulation 52 on a timely basis.

F. Fidelity Bonds

A review was performed to verify the amount of fidelity coverage that MHI had in effect as of the examination date, utilizing amounts prescribed by the *Examiners Handbook of the National Association of Insurance Commissioners* ("Handbook"). While the calculation of fidelity bond policy limits is not a substitute for the risk assessment that should be made by the Plan in establishing a reasonable level of insurance coverage, the examiner determined that MHI's fidelity coverage, in the amount of $1,250,000, was below the suggested required minimum coverage amount of $1,750,000 to $2,000,000 as calculated from the Handbook.

It is recommended that MHI increase its fidelity bond coverage to at least $1,750,000, in order to meet the terms of the Examiners Handbook of the National Association of Insurance Commissioners.

G. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles, annual statement instructions and/or Department guidelines. A description of such items is as follows:

1. In its filed 2006 annual statement, MHI incorrectly calculated and reported its contingency reserves. After the Plan was notified, a revised page was submitted to the Department.

2. MHI did not maintain an internal audit department during the examination period. An entity that has no internal audit function may lack the ready means to detect errors and problems. Properly organized and effectively operated internal auditing gives management and the audit committee a way to monitor the reliability and the integrity of financial and operating information. The internal audit function thus is an important element in preventing and detecting fraudulent financial reporting and errors. Furthermore, to be effective, internal auditors must have the acknowledged support of top management and the board of directors through its audit committee. The Plan should set forth, in writing, the scope of responsibilities for the internal audit function.

It is recommended that the Plan establish and maintain an effective internal audit unit staffed with an adequate number of qualified personnel appropriate to its size.

Subsequent to the examination date, MHI's parent, Healthfirst, Inc., formed an internal audit department ("IAD") that is anticipated to cover MHI. However, the examiner did not review any aspect of the IAD's functions, particularly those purported to cover the operations of MHI.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as determined by this examination as of December 31, 2006. This is the same as the balance sheet filed by the Plan in its December 31, 2006 annual statement:

Assets	Examination	Plan
Bonds	$ 49,055,923	$ 49,055,923
Cash	149,977,828	149,977,828
Premiums receivable	27,592,610	27,592,610
Reinsurance recoverable	830,192	830,192
Receivable from affiliates	61,296	61,296
Other current assets	2,020,904	2,020,904
Total assets	$229,538,753	$229,538,753
Liabilities		
Claims payable	$114,034,503	$114,034,503
Premiums received in advance	23,051,296	23,051,296
General expenses due and accrued	273,608	273,608
Other current liabilities	3,774,132	3,774,132
Due to third party payors	6,387,222	6,387,222
Total liabilities	$147,520,760	$147,520,760
Capital and Surplus		
Gross paid in and surplus	$ 46,091,030	$ 46,091,030
Contingency reserves	35,765,043	35,765,043
Unassigned funds (surplus)	161,920	161,920
Total capital and surplus	$ 82,017,993	$ 82,017,993
Total liabilities, capital and surplus	$229,538,753	$229,538,753

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2006. The Plan is a not-for-profit HMO which falls under IRC Section 501(C)(3), which exempts the Plan from federal income tax. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Surplus

Reserves and unassigned funds increased by $55,688,795 during the examination period, January 1, 2002 through December 31, 2006, detailed as follows:

Revenue		
Net premiums earned	$1,427,616,707	
Other revenue	283,155	
Total revenue		$1,427,899,862
Expenses		
Hospital/medical benefits	716,628,243	
Other professional services	11,813,406	
Emergency room and out of area	7,215,594	
Prescription drugs	74,333,312	
Other medical and hospital	105,243,298	
True-up adjustment	103,451,001	
Risk pool balance	122,013,701	
Aggregate write-in	80,159,427	
Incentive pool	(8,853,662)	
Net reinsurance recoveries	(944,446)	
Administration expenses	202,522,244	
Total expenses		1,415,471,010
Net underwriting gain		12,428,852
Net investment income earned		16,711,428
Other income		124,936
Net income		$ 29,265,216

Changes in Surplus

	Gains in Surplus	Losses in Surplus	
Surplus per report on examination as of December 31, 2001			$26,329,198
Net income	$29,265,216		
Change in non-admitted assets	11,042,130		
Paid in surplus notes		9,989,043	
Paid in capital	5,615,295		
Paid in surplus	19,959,758		
Prior period adjustment		204,561	
Net increase in capital and net worth			55,688,795
Surplus per report on examination as of December 31, 2006			$82,017,993

4. CLAIMS PAYABLE

The examination liability of $114,034,503 for the captioned account is the same as the amount reported by the Plan in its filed annual statement as of December 31, 2006.

The examination reserve was based upon actual payments made subsequent to the examination date, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's historical payment experience, appropriately modified for current claims payment patterns. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and the analysis was conducted using statistical information contained in the Plan's internal records and in its filed annual and quarterly statements, as verified during the examination.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices 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 Plan in the following major areas:

A. Agents and brokers
B. Underwriting and rating
C. Claims processing
D. Prompt Pay Law
E. Grievances, appeals and complaints

A. Agents and Brokers

During the examination period, MHI contracted with licensed agents and brokers to sell its various health insurance products. MHI also utilized salaried employees in its internal Sales Department to generate business and enroll members in its Medicare and commercial products.

A review of MHI's sales practices, agents' and brokers' licensing and related processes was conducted during the examination. It was noted that there were areas of non-compliance as detailed below:

Section 2102(a)(1) of the New York Insurance Law prohibits any person, firm or corporation from acting as an insurance agent or broker without the requisite license. Said statute states:

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

Managed Health, Inc. utilized some employees that were not licensed as agents to solicit and enroll new members. As approximately ninety-five percent (95%) of the Plan's business is Medicare, this practice principally involved the enrollment of members into the Plan's Medicare Advantage program; whereby the sales representative received a one-time payment for each new member enrolled. Section 2101 of the New York Insurance Law defines the term "insurance agent" and denotes an exemption to the licensing of any regular salaried officer or employee of a licensed insurer under certain conditions.

Specifically, Section 2101(a)(1) of the New York Insurance Law states in pertinent part that the term "insurance agent" shall not include any regular salaried officer or employee of a licensed insurer if:

> "…such officer or employee does not receive a commission or other compensation for his services which commission or other compensation is directly dependent upon the amount of business done;"

Since MHI's employees are compensated in a manner that is directly dependent upon the volume of business produced, they are deemed to be "insurance agents" as defined by the above statute, and are thus required to obtain the requisite license required by Section 2101(a)(1) of the New York Insurance Law.

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, negotiating or selling in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article."

With respect to its internal sales personnel, it should be noted that MHI was unable to provide evidence that one hundred and five (105) persons, or forty-eight percent (48%) of its internal sales force were properly licensed as agents.

In view of the foregoing, MHI violated Sections 2102(a)(1) and 2114(a)(3) of the New York Insurance Law in that commissions (sales based compensation) were paid to unlicensed internal sales representatives that met the classification of an "agent", as defined above.

It is recommended that MHI ensure that its employees who earn a commission or fee based on sales/enrollments obtain the requisite license in compliance with Section 2102(a)(1) of the New York Insurance Law, and that the Plan act in compliance with Section 2114(a)(3) of the New York Insurance Law by ensuring that commissions (sales based compensation) are only paid to licensed agents.

It should be noted that the prior report on examination as of December 31, 2001 contained similar findings and made recommendations similar to those noted above. After the release of the 2001 examination report, MHI asked that the 2001 findings be reconsidered by

the Department, citing jurisdictional uncertainty of the applicability of state laws to the federal Medicare program. The examination's findings were subsequently supported by an opinion of the Department's Office of General Counsel ("OGC"), dated August 1, 2003, which specifically addressed the licensing/compensation requirements of the Plan's Medicare sales force. However, shortly after the opinion was issued, federal law changed again with the enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA"). As a result of the change in federal law, MHI again requested that the Department reconsider its position. At this time, MHI also requested a formal opinion on federal preemption from the federal Centers for Medicare and Medicaid Services ("CMS"). The Department's OGC, in an opinion issued January 1, 2005, upheld its opinion from 2003, which supported the aforementioned examination findings regarding the Plan's agents' licensing violations. CMS did not respond directly to MHI's request for an opinion on the issue, but in August 2005 issued marketing guidelines that recommended that Medicare sales agents be licensed if they were to receive commissions or bonuses.

In August 2003, MHI provided written correspondence to the Department noting that all existing Medicare sales representatives, engaged in the procurement of Medicare+Choice applications from potential members, would be licensed as insurance agents and duly appointed by MHI in accordance with applicable Insurance Laws by October 15, 2003. In January 2004, MHI then wrote to the Department to note the challenges that were hindering its ability to comply with the aforementioned Insurance Laws regarding agents' licensing, including the length of time the licensing process took and a licensing examination that covered subject matter entirely distinct from a Medicare sales representative's background and

training. In this letter MHI noted that the remaining unlicensed Medicare sales representatives would be licensed by March 2004 and appointed by April 2004.

In May 2007, as part of its correspondence regarding the upcoming examination as of December 31, 2006, MHI sent another letter to the Department. This letter noted that until March 1, 2007, MHI had continued to pay compensation to its Medicare sales representatives, some of whom were not licensed, based on the number of individuals enrolled, in violation of the abovementioned statutes and the findings contained herein, as well as those in the report on examination as of December 31, 2001.

It is recommended that the Plan provide complete and accurate information when communicating with this Department.

The Plan's management and board of directors are reminded of their fiduciary responsibility to provide proper oversight of the Plan's operations and to determine that they are being conducted in accordance with applicable statutes, rules and regulations.

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."

MHI violated Section 2112(a) of New York Insurance Law in that no certificates of appointment were on file for any of its insurance agents as prescribed by statute.

It is recommended that MHI complies with the requirement of Section 2112(a) of the New York Insurance Law and file certificates of appointment for its insurance agents with the Department. It is also recommended that the Plan maintain evidence of such filings.

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

> "Every insurer, fraternal benefit society or health maintenance organization…doing business in this state shall, upon termination of the certificate of appointment…of any insurance agent licensed in this state, 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 Plan could not provide any evidence to the examiner that it notified the Department of terminated agents as required by the above statute. Accordingly, it appears that MHI violated Section 2112(d) of New York Insurance Law in that it did not report any of its terminated agents to the Department.

It is recommended that MHI complies with the requirements of Section 2112(d) of the New York Insurance Law by reporting its terminated agents to the Department.

In October 2007, subsequent to the date of examination, the New York State Department of Health and Office of the New York State Attorney General conducted an investigation of the Plan's parent, Healthfirst, Inc., in regard to certain marketing and agents' compensation practices. Healthfirst, Inc. entered into a settlement of the investigation in August 2008.

B. Underwriting and Rating

A review of MHI's underwriting and rating procedures was performed. The examiner randomly selected invoices used for MHI's "direct pay" and small group enrollment. The examiner's review revealed that the billing statements did not reflect MHI's rates on file with the Department.

Section 4308(b) of the New York Insurance Law states in 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…"

It should be noted that the rates charged were less than those filed by MHI and the total number of enrollees impacted by this billing error was a small component of MHI's membership, as follows:

Year	**2002**	**2003**	**2004**	**2005**	**2006**
Membership	298	35	23	19	17

Thus, the enrollees were not materially harmed and the total underpayment of premiums did not adversely impact MHI.

It is recommended that MHI complies with the requirements of Section 4308(b) of the New York Insurance Law by charging rates that have been filed with and approved by the Department.

C. Claims Processing

A review of MHI's claims practices and procedures was performed by using a statistical sample covering claims paid during the period of January 1, 2006 through December 31, 2006, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiners selected a sample of 167 claims, which included both hospital and medical claims.

The statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually, or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each claim in the sample.

The term "claim" can be defined in a myriad of ways. For the purpose of this report, a "claim" as defined by the Plan, is a grouping of all line items (e.g., procedures or services) on any one claim form as entered into its claims processing system. It was possible, through the computer program used for this examination, to match or "roll-up" all procedures on the claim form into one item, which was the basis of the Department's statistical sample of claims or the sample unit. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by the Plan for the period January 1, 2006 through December 31, 2006.

The examination review of the Plan's claims determined a financial error rate of 7.19% (for hospital and medical claims combined), resulting in an overall claims processing financial accuracy level of 92.81%. The procedural error rate was determined to be 20.36% (for hospital and medical claims combined), thus the overall claims processing procedural accuracy level was 79.64%. MHI established key performance indicators for quality at 99% for procedural and financial accuracy.

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim transaction was processed in accordance with the Plan's claim processing 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 as both a financial error and a procedural error. In summary, of the one hundred and sixty-seven (167) combined hospital and medical claims reviewed, twelve (12) contained financial errors and there were thirty-four (34) procedural errors.

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

Summary of Financial Claims Accuracy

Total claim population	10,872
Sample size	167
Number of claims with errors	12
Calculated error rate	7.19%
Upper error limit	11.10%
Lower error limit	3.27%
Calculated claims in error	782
Upper limit claims in error	1,207
Lower limit claims in error	355

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

Total claim population	10,872
Sample size	167
Number of claims with errors	34
Calculated error rate	20.36%
Upper error limit	26.47%
Lower error limit	14.25%
Calculated claims in error	2,213
Upper limit claims in error	2,877
Lower limit claims in error	1,549

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).

The following represents claims processing errors and issues discovered by the examiner during the abovementioned claims review:

- Incorrect calculation of claim payment;
- Misapplication of co-payments;
- Misapplication of Medicare relative value schedule;
- The wrong fee schedule was applied and/or the fee schedule was loaded improperly (resulting in improper pricing of the claim).

It is recommended that MHI review its controls in regard to errors that were determined to be occurring on a frequent basis.

It is recommended that MHI provide further training to individuals responsible for processing Healthy New York claims.

D. Prompt Pay Law

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

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

> "…(a) Except in a case where the obligation of an insurer…to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

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

> "… 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."

From the same population of claims reviewed in the prior section of this report the examiner isolated all claims (combined hospital and medical claims) not paid within 45 days of receipt to test for compliance with Section 3224-a(a) of the New York Insurance Law, and to further determine if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. There were 116 claims processed in 2006 that took the Plan more than 45 days to pay. Accordingly, all claims that were not paid within 45 days of receipt (Section 3224-a(a)) during 2006 were segregated. All 116 claims were reviewed to determine whether the claims were in violation of Section 3224-a(a) of the New York Insurance Law and whether they were subject to interest as required by Section 3224-a(c) of the New York Insurance Law.

Of the 116 claims paid after 45 days of receipt, the Plan was able to provide valid explanations to the examiner for fifty-seven (57) claims that were ultimately not deemed violations of Section 3224-a(a) of the New York Insurance Law. Thus, fifty-nine (59) claims were deemed to be prompt pay violations and nine (9) of these claims were determined to be interest eligible. Interest was not paid by MHI for any of these claims, resulting in violations of Section 3224-a(c) of the New York Insurance Law.

The following charts illustrate MHI's compliance with Sections 3224-a(a) and 3224-a(c) of the New York Insurance Law, respectively, as determined by this examination:

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

Total claim population	10,872
Population of claims paid after 45 days of receipt	116
Sample size	116
Number of claims with violations	59
Calculated violation rate	50.86%
Upper limit	Not Applicable
Lower limit	Not Applicable
Calculated claims in violation	59
Upper limit claims in violation	Not Applicable
Lower limit claims in violation	Not Applicable

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

Total claim population	10,872
Population of claims paid after 45 days of receipt	116
Sample size	116
Number of claims with violations	9
Calculated violation rate	7.76%
Upper limit	Not Applicable
Lower limit	Not Applicable
Calculated claims in violation	9
Upper limit claims in violation	Not Applicable
Lower limit claims in violation	Not Applicable

It is again noted that the errors above relate to the population of 116 claims used for the review, which consisted of only claims adjudicated in 2006 that were not paid within forty-five days from receipt. The total population of claims that were processed during 2006 was 10,872.

It is recommended that the Plan review and revise its procedures in order to improve its compliance with Section 3224-a(a) of the New York Insurance Law.

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

It is further recommended that the Plan 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.

During the examiner's testing for compliance with the Prompt Pay Law, it was noted that MHI unilaterally offset claims for providers who were in a "negative balance" (owed MHI funds for claims reversals, etc.), without any notification or explanation to the providers. The Department's Consumer Services Bureau also informed the Plan some time in 2007 that this practice was in violation of Section 3224-b of the New York Insurance Law**.**

Subsequent to the examination date, on August 3, 2008, MHI instituted a corrective action plan to address the above matter and to comply with the requirements of Section 3224-b of the New York Insurance Law – "Rules relating to the processing of health claims and overpayments to physicians", which became effective January 1, 2007.

Section 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."

During the examination of MHI, the examiner selected a sample of one hundred and sixty-seven (167) claims to review compliance with Section 3224-a(b) of the New York Insurance Law. The review was established through the isolation of all claims that took the Plan more than thirty (30) days to either deny or to seek additional information for claims adjudicated during the period January 1, 2006 through December 31, 2006.

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

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

Total claim population	10,872
Population of claims adjudicated after 30 days of receipt	1,598
Sample size	167
Number of claims with violations	164
Calculated violation rate	98.20%
Upper limit	100%
Lower limit	96.19%
Calculated claims in violation	1,569
Upper limit claims in violation	1,598
Lower limit claims in violation	1,537

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 recommended that MHI complies with the requirements of Section 3224-a(b) of the New York Insurance Law.

It is also recommended that the Plan review and revise its procedures in order to improve its compliance with Section 3224-a(b) of the New York Insurance Law.

The main reason for the high error rate of the above component of the Prompt Pay Law appeared to be that the Plan did not retain sufficient information to document requests for additional information. In fact, MHI was unable to demonstrate that any such correspondence was sent out on any of the claims reviewed by the examiner in regard to the abovementioned testing of compliance with Section 3224-a(b) of the New York Insurance Law.

Section 243.2(b)(4) of Department Regulation 152 (11 NYCRR 243.2(b)(4)) states in part:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain its 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 (11 NYCRR 216.11) 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 either make a notation in the file or retain a copy of all forms mailed to claimants."

It is recommended that MHI complies with Section 243.2(b)(4) of Department Regulation 152 by retaining all documentation necessary to verify its compliance with Section 3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer.

It is also recommended that MHI complies with the requirements of Section 216.11 of Department Regulation 64 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.

E. Grievances, Appeals and Complaints

A review of complaints filed with the Insurance Department for the examination period was performed to verify compliance with Circular Letter No. 11 (1978). MHI failed to maintain a log for complaints received through the New York State Insurance Department's Consumer Services Bureau as required by the referenced Circular Letter.

When the examiner brought this matter to the attention of MHI personnel, the requisite complaint log was created by the Plan. However, the examiner was unable to reconcile MHI's listing of complaints to the Insurance Department's Consumer Services Bureau listing. The Department's listing reported 168 complaints filed, whereas MHI's log contained only 17 complaints.

It is recommended that the Plan update its complaint log to include all complaints received through the Insurance Department.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2001, contained twenty-seven comments and recommendations, as follows (page number refers to the prior report):

ITEM NO.		PAGE NO.
	Management	
1.	It is recommended that MHI evaluate the participation of its board members and determine whether they should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of Managed Health, Inc. MHI has complied with this recommendation.	7
	Conflict of Interest	
2.	It is recommended that MHI adopt a formal code of ethics and require that its directors and officers annually sign such statements. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	9
	Report of Independent Certified Public Accountants	
3.	It is recommended that MHI comply with Section 307(b) of the New York State Insurance Law and submit to the Department, the independent auditor's financial statements, complete with the reconciliation for the differences between amounts reported in the filed annual statements and the amounts reported in the independent auditor's financial statements. MHI has complied with this recommendation.	11

ITEM NO.		PAGE NO.
	Fidelity Bonds	
4.	It is recommended that MHI increase its fidelity bond coverage to at least the amount of $1,250,000 in order to comply with the amount called for in the Examiners Handbook. MHI has complied with this recommendation. However, due to the growth of the Plan, its fidelity bond coverage should be increased accordingly. A similar recommendation is contained in this report.	12
	Accounts and Records	
5.	It is recommended that the Plan include assets supporting escrow deposits in the balance sheet account(s). MHI has complied with this recommendation.	12
	Balance Sheet	
6.	It is recommended that the HMO comply with Section1307 of the New York Law and add a footnote to page 3 of its annual and quarterly statements filed with the Department, showing the HMO's outstanding 1307 loan and interest accrued thereon. This recommendation no longer applies. MHI did not report any Section1307 loans during the examination period	14
	Claims Payable	
7.	It is recommended that MHI track the development of the prescription drug component of its claim reserves separately from its other claim reserve components. MHI has complied with this recommendation.	16
8.	It is recommended that MHI adequately disclose, in its filed annual and quarterly financial statements, incurred claims in the absence of the "pool structure". Correct reporting would allow for improved monitoring of the adequacy of its liabilities. MHI has complied with this recommendation.	17

ITEM NO.		PAGE NO.
9.	It is recommended that MHI prepare schedule F, Section 3 of its Quarterly New York Data Requirements filing properly (i.e. reflecting actual claim payments at the "reduced level" actually paid, indicating the balances remaining in the "pools"). MHI has complied with this recommendation.	18
10.	It is further recommended, that the Plan correct and resubmit Schedule F, Section 3 as of December 31, 2001 and for its 2002 quarterly filings. MHI has complied with this recommendation.	18
11.	It is recommended that in column 1 of Schedule F - Section 3, in the annual New York data Requirements, and Column 1 of Schedule 3 in the Quarterly data Requirements, the HMO report actual claims paid in the current year and incurred in the prior year. Any interim pool disbursements to hospitals made in the current year for the prior year experience should be reported on line 8 in Column 1. Further, Column 3 should reflect as unpaid claims any excess pool liability remaining (line 8 –"Other") and any pool risk adjustment (line 10 – Medical Incentive Pool), recorded in the current year for prior year incurred dates. The above comments and recommendation also apply to MHI's completion of Part 2B of the Underwriting and Investment Exhibit in its NAIC Health Annual Statement filings. MHI has complied with this recommendation.	19
	Agents and Brokers	
12.	It is recommended that MHI ensure that its employees who earn a commission or fee based on sales maintain the requisite license in compliance with New York Insurance Law, Section 2102(a)(1), and that the Plan act in compliance with New York Insurance Law, Section 2114(a)(3) to ensure that commissions are only paid to licensed agents and brokers. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	22

ITEM NO.		PAGE NO.
13.	It is recommended that MHI comply with New York Insurance Law, Section 2112(a) and file all certificates of appointment for its insurance agents with the Department as prescribed by statute, and that it maintain evidence of such filings. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	23
14.	It is recommended that MHI comply with New York Insurance Law, Section 2112(d) and report terminated insurance agents to the Department as prescribed by statute. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	23
	Claims Processing	
15.	It is recommended that the Plan comply with Section 243.2(b)(4) of Department Regulation 152 {11 NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify the fee schedules used to pay claims, for a period of six years, or until after the filing of the report on examination, whichever is longer. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	26
16.	It is recommended that MHI implement proper controls in order to prevent claims from being overridden without proper authority and documentation. MHI has complied with this recommendation.	26
	Prompt Pay Law	
17.	It is recommended that MHI comply with Section 3224-a(a) of the New York Insurance Law. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	28

ITEM NO.		PAGE NO.
18.	It is recommended that MHI comply with Section 3224-a(b) of the New York Insurance Law 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, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine liability to pay the claim. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	29
19.	It is further recommended that MHI complies with Section 243.2(b)(4) of Department Regulation 152 {NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify its compliance with Section 3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer. MHI has not complied with this recommendation. A similar recommendation is contained in this report.	29
	Utilization Review	
20.	It is recommended that MHI comply with Section 4904(3) of the of the New York State Public Health Law and complete utilization review appeals within sixty days of receipt of the information necessary to conduct and appeal. MHI has complied with this recommendation.	30
	Explanation of Benefits Statements (“EOB”)	
21.	It is recommended that MHI modify its EOB’s to comply with Section 3234(b)(7) of the New York Insurance Law. MHI has complied with this recommendation.	31
	Schedule H	
22.	It is recommended that MHI take the necessary steps to enable it to complete its Schedule H (“Aging Analysis of Claims Unpaid”) in accordance with the Annual Statement instructions. MHI has complied with this recommendation.	33

ITEM NO. **PAGE NO.**

Fraud Prevention and Detection

23. It is recommended that MHI exercise due care in preparing its Annual Report to ensure that it accurately reflects all fraudulent cases. 34

This recommendation no longer applies. MHI's enrollment level has been reduced below the threshold which requires it to submit an Annual Report.

Grievances, Appeals and Complaints

24. It is recommended that MHI not close a grievance file prior to completion of its review. 35

MHI has complied with this recommendation.

25. It is recommended that MHI provide a written acknowledgement for grievances filed as required by Section 4408-a(4) of the New York State Public Health Law. 35

MHI has complied with this recommendation.

26. It is recommended that MHI take steps to assure that all grievances are resolved within 45 days allowed by law. 36

MHI has complied with this recommendation.

27. It is recommended that the HMO update its complaint log to include all complaints received through the Insurance Department. 36

MHI has not complied with this recommendation. A similar recommendation is contained in this report.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

Victor Estrada

Victor Estrada
Senior Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

VICTOR ESTRADA, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Victor Estrada

Victor Estrada

Subscribed and sworn to before me 2010
this 4th day of March ~~2009~~.

Charles T. Lovejoy

Charles T. Lovejoy
Notary Public, State of New York
No. 31-4798952
Qualified in New York County
Commission Expires 1-26-14

Appointment No. ***22588***

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Victor Estrada

as a proper person to examine into the affairs of the

Managed Health, Inc.

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

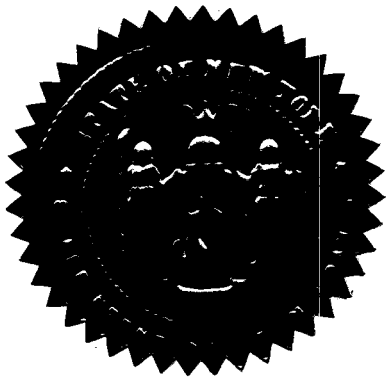
Plan

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 1st day of May 2007

Eric R. Dinallo
Superintendent of Insurance



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

David A. Paterson
Governor

James J. Wrynn
Superintendent

EXPRESS MAIL
March 4, 2010

Elizabeth St. Clair
SVP and General Counsel
Healthfirst
25 Broadway
New York, NY 10011

Dear Ms. St. Clair:

Inasmuch as no hearing was requested to the Report on Examination of Managed Health, Inc. as of December 31, 2006, it has been adopted by this Department, made an official document thereof, and filed as of the date of this letter pursuant to Section 311 of the New York Insurance Law and will be posted on the Department's web site.

Your attention is directed to the provisions of Section 312 of the New York Insurance Law which require that a complete copy of the Report, together with all recommendations and statements relating thereto, be furnished by the insurer to each member of the Board of Directors and that each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such Report. Kindly advise this Department when you have complied with the above requirements.

Please indicate, no later than March 15, 2010, what action the Company has taken or proposes to take in order to comply with the recommendations contained in the Report. A specific response to each recommendation should be provided in the order that it appears in the Report.

Very truly yours,

Arcelio Vega
Associate Insurance Examiner
Health Bureau

Memorandum

To: Anthony Spagli

From: Arcelio Vega

Date: March 4, 2010

Subject: Report on Examination of Managed Health, Inc.
Report Date: March 4, 2010
Condition: December 31, 2006

Attached hereto you will find the following:

(1) Original of the above mentioned Report.

(2) Copy of letter stating that the Report will be placed on file in this Department as of the date of this memo.

Please notify the Health Bureau when the Report has been placed on file.

Cc by email:
Mr. Wiest
Mr. Scharff
Mr. Estrada
Ms. Lawson
Mr. Blaize
File

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

David A. Paterson
Governor

James J. Wrynn
Superintendent

March 4, 2010

Ms. Valencia Lloyd, Director
New York State Department of Health
Bureau of Alternative Delivery Systems
Empire State Plaza
Corning Tower
Room 1911
Albany, NY 12237

Dear Ms. Lloyd:

Please be advised that pursuant to Section 311 of the Insurance Law, the enclosed Report on Examination of Managed Health, Inc. as of December 31, 2006 was filed as of the date of this letter.

Very truly yours,

Arcelio Vega
Associate Insurance Examiner
Health Bureau

Sean Nataro, MPH, JD
Vice President
Associate General Counsel

healthfirst

25 Broadway
New York, NY 10004
Tel: 212.801.1504
Fax: 646.313.4644
Email: snataro@healthfirst.org
Website: *www.healthfirstny.com*

REPORT ON EXAMINATION

OF

MANAGED HEALTH, INC.

AS OF

DECEMBER 31, 2006

Received on behalf of Managed Health, Inc.
March 4, 2010
SEAN NATARO.

DATE OF REPORT **MARCH 2, 2010**

EXAMINER **VICTOR ESTRADA**

Stephen Wiest/HLT/NYC/SIDNY
03/02/2010 10:58 AM

To Arcelio Vega/HLT/NYC/SIDNY@NYSInsurance
cc Eugene Bienskie/HLT/NYC/SIDNY@NYSInsurance, Louis Felice/HLT/ALB/SIDNY@NYSInsurance, Michael Scharff/HLT/NYC/SIDNY@NYSInsurance, Sylvia
bcc
Subject MHI 12-31-06 ROE

Arcelio,

Please find attached the captioned report. The Plan has accepted the report (with agreed to changes since the initial draft) and it can be sent with the standard transmittal letter tomorrow. We had the closing conference last year so nothing to cancel. The contact info is below. Since MHI is a 3 minute walk, you can hand deliver if you prefer. Thanks.

Elizabeth St. Clair
SVP and General Counsel
Healthfirst
25 Broadway
New York, NY 10011

MHI FINAL 12-31-06 ROE 3-02-10.doc

Arcelio Vega/HLT/NYC/SIDNY
03/04/2010 09:29 AM

To Daniel Sheridan/HLT/NYC/SIDNY@NYSInsurance
cc
bcc
Subject Managed Health, Inc. (NAIC 95284) as of December 31, 2006, dated March 2, 2010, and filed March 4, 20100

Attached find the filed report on examination of Managed Health, Inc. (NAIC 95284) as of December 31, 2006, dated March 2, 2010, and filed March 4, 2010. Please process for posting to the web. Thank you.

Arcelio Vega
Health Bureau
212-480-5244

Your role is: UpdateHEALTH

Home Menu

Examiner Billing: Update Exam Number

On this page, you may update the details for an existing Exam Number. Only active Exam Numbers may be updated.

The following fields may be modified:
NAIC Number
Exam Type
From Date (only to dates within the original year)
To Date
As-of Date
Examiner in Charge

Updates are allowed. Elements in gray may be updated.

Exam Number:	H C 2007 2
Exam Status:	**Closed**
NAIC Number:	95284
Suggestions:	95284 - MANAGED HEALTH, INC. (EBMASTER)
Company Name:	MANAGED HEALTH, INC. (EBMASTER)
Address:	MANAGED HEALTH, INC. 25 BROADWAY, 9TH FLR NEW YORK, NY 10004
Bureau:	H - Health
Exam Type:	C - Combination
From Date:	03/05/2007 **Previous Start Date:** 03/05/2007
To Date:	03/04/2010 **Previous End Date:** 03/04/2010
As Of Date (Optional):	12/31/2006 **Previous As Of Date:** 12/31/2006
Examiner In Charge:	ESTRADA, VICTOR
Last modified:	03/08/2010