MARKET CONDUCT REPORT ON EXAMINATION

OF

EMPIRE HEALTHCHOICE ASSURANCE, INC.

AND

EMPIRE HEALTHCHOICE HMO, INC.

AS OF

DECEMBER 31, 2011

DATE OF REPORT **JANUARY 4, 2014**

EXAMINER **WAI WONG**

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January 4, 2014

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

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Numbers 30709 and 30711, dated June 29, 2011, attached hereto, I have made an examination into the affairs of Empire HealthChoice Assurance, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law and its wholly-owned subsidiary, Empire HealthChoice HMO, Inc., a for-profit health maintenance organization licensed under Article 44 of the New York Public Health Law, respectively, as of December 31, 2011, and submit the following report thereon.

The examination was conducted at the administrative office of Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc., located at One Liberty Plaza, New York, New York.

Wherever the designations "EHCA" or the "Company" appear herein, without qualification, they should be understood to indicate Empire HealthChoice Assurance, Inc.

Wherever the designations "EHC-HMO" or the "Plan" appear herein, without qualification, they should be understood to indicate Empire HealthChoice HMO, Inc.

Wherever the designations "Empire" or the "Companies" appear herein, without qualification, they should be understood to indicate EHCA and EHC-HMO, collectively.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the Department of Financial Services.

Concurrent examinations regarding the financial condition of Empire HealthChoice Assurance, Inc., an accident and health insurance company licensed under Art. 42 of the New York Insurance Law and Empire HMO, Inc., a health maintenance organization licensed under Article 44 of the New York Public Health Law, were made as of December 31, 2011. Separate reports thereon have been submitted.

1. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicated areas of weakness and/or directly impacted the Companies' compliance with the New York Insurance Law, Department Regulations and Circular Letters, and the New York Public Health Law.

The most significant findings relative to this examination include the following:

- Non-compliance with Section 3224-a of the NYIL - Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services ("Prompt Pay Law").
- Empire used the wrong date to determine compliance with the Prompt Pay Law.
- Empire's restrictions on employer funding of cost sharing provisions on its small group underwriting guidelines are in violation of the requirements of Section 3231(a) of the NYIL.
- Empire failed to accurately report data related to its Grievances and Utilization Appeals to the Department.
- The timeframe regarding expedited appeals used in Empire's adverse determination notices, sent out by its Third-Party Administrators, was not in compliance with the requirements of Section 4904(b) of the New York Insurance Law.
- Empire failed to ensure that its written determination notices sent out by its Third-Party Administrators, was in compliance with Section 4903(c) of the New York Insurance Law.

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

2. SCOPE OF THE EXAMINATION

The previous market conduct examination was conducted as of December 31, 2006. This examination covers the five-year period January 1, 2007 to December 31, 2011, and was

performed to review the manner in which Empire conducts its business practices and fulfills its contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

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

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

3. DESCRIPTION OF THE COMPANIES

Effective November 7, 2002, Empire Blue Cross Blue Shield converted from a New York Insurance Law Article 43 non-profit health service corporation to a New York Insurance Law Article 42 for-profit accident and health insurer, and changed its name to Empire HealthChoice Assurance, Inc. Simultaneous with the conversion, Empire Blue Cross and Blue Shield merged with its then NYIL Article 42 subsidiary, Empire HealthChoice, Inc. Empire HealthChoice, Inc. was the sole owner of Empire HealthChoice HMO, Inc., a for-profit New York domiciled health maintenance organization ("HMO"), licensed under Article 44 of the New York Public Health Law.

As a result of the conversion, a new entity, WellChoice Holdings of New York, Inc. was established. This new entity was owned by WellChoice, Inc. ("WellChoice"), which in turn owned EHCA and EHC-HMO.

On September 27, 2005, representatives of WellPoint, Inc. ("WellPoint"), a publicly traded managed care for-profit company and WellChoice announced their intention to enter into a definitive merger agreement. Under the terms of the agreement, WellPoint agreed to acquire all of the outstanding shares of WellChoice. On December 28, 2005, WellPoint completed its acquisition of WellChoice. WellChoice, Inc. ("WellChoice"), a Delaware corporation and ultimate parent of EHCA and EHC-HMO, merged with and into WellPoint Holding Corp., a direct and wholly-owned subsidiary of WellPoint; with WellPoint Holding Corp. as the surviving entity of the merger. After completion of the merger, the ultimate parent of EHCA was WellPoint.

EHCA was also the sole owner of WellChoice Insurance of New Jersey, Inc. ("WCINJ") a credit, life and health insurance company licensed in eleven states, however, the company only wrote business in New Jersey. EHC-HMO was also licensed to operate in the state of New Jersey as WellChoice HMO of New Jersey. WCINJ was dissolved on October 28, 2008 and WellChoice HMO of New Jersey surrendered its certificate of authority from New Jersey on July 7, 2008. The remaining assets and liabilities of WCINJ were merged with EHCA during 2008.

The Company continues to do business as Empire Blue Cross and Blue Shield in the State of New York and remains the Parent of Empire HealthChoice HMO, Inc.

Unless otherwise noted, the findings contained herein relate to both EHCA's operations as a New York Insurance Law Article 42 insurer and EHC-HMO's operations as an Article 44 New York Public Health Law health maintenance organization.

4. CLAIMS PROCESSING

In order to evaluate the overall accuracy and compliance environment of Empire's claims processing, a review was performed by using a statistical sampling methodology to select claims processed during the period January 1, 2011 through December 31, 2011. The examiner selected a sample of hospital and medical claims and evaluated the selected claims, testing various attributes deemed necessary for successful claims processing activity.

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

The initial sample size for each population was comprised of 167 randomly selected unique 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, 668 claims were selected for this review (334 from the Company and 334 from the HMO).

Based on the error ratios found for each sample, 167 claims were reviewed on the EHCA medical review, fifty (50) claims were reviewed on the ECHA hospital review, fifty (50) claims were reviewed on the EHC-HMO medical review and one hundred (100) claims were reviewed on the EHC-HMO hospital review.

The examination review of EHCA found a calculated financial error rate of 14.97% for Medical Claims and overall claims processing financial accuracy level of 95.03% for Medical Claims. Procedural error rates were 14.97% for Medical Claims and overall claims processing procedural accuracy level of 95.03% for Medical Claims. There were no errors uncovered on the EHCA hospital claim review.

The examination review of EHC-HMO medical claims uncovered two (2) financial and procedural errors out of fifty (50) claims reviewed. The EHC-HMO hospital claim review uncovered thirteen (13) financial and procedural errors out of one hundred (100) claims reviewed. The review of the first fifty (50) EHC-HMO hospital claims resulted in a sufficient number of errors found to warrant a reviewing an additional fifty (50) claims. The additional review did not produce any significant number of errors and it was decided to end the review at one hundred (100) 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 claim transactions processed in accordance with the Companies' guidelines and/or Department statutes/regulations. An error in processing accuracy may or may not affect the financial accuracy, but a financial error is always deemed to be a procedural error.

The following are some of the claims issues noted during the examiner's review:

- As part of the EHCA medical review there were numerous instances found where claims were denied for not having an authorization to see the physician when, upon review, the authorization could be seen in the system.

- It was noted during the EHC-HMO claims review that the HMO's subscriber contract indicated that a specialist co-payment is to be charged to any physician who is not identified as a primary care physician or back up primary care physician by the subscriber. It is not clear if a general practitioner not identified as a primary care physician or back up primary care physician can be charged a specialist' co-pay under these circumstances.

- As part of the EHC-HMO hospital claims review it was noted that the HMO had an agreement with Quest Laboratories for out-patient lab work. Under this agreement providers are supposed to refer HMO subscribers to in-network labs to have their lab work done. In several instances, the providers referred the HMO subscriber to a non-participating hospital-based reference lab instead of to in-network labs, and the HMO subscriber may have been balanced billed by the non-participating hospital-based lab. It is the Department's position that subscribers should not be balanced billed in these instances.

  It is Empire's position that no balance billing should be taking place in these instances, however, contract language in the lab agreements indicate that subscribers should be balance billed in these instances. It should be noted that several claims were found where subscribers may have been balanced billed.

It is recommended that Empire establish procedures to avoid incorrect denials for lack of authorization when prior authorizations have been received to see providers.

It is recommended that Empire remove the requirement from its HMO subscriber contract that specialist co-pays be applied to any provider including a general practitioner who is not identified by the subscriber as a primary care physician or back up primary care physician.

It is also recommended that Empire clarify in its laboratory contracts that subscribers should not be balanced billed when referred by a provider to an out-of-network lab for outpatient services.

It is further recommended that Empire ensure that subscribers are not balance billed when they use an out-of-network lab for outpatient services if they have been referred to such lab by the provider.

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

Summary of Financial Claims Accuracy of Empire HealthChoice Assurance, Inc.

	Medical Transactions	Hospital Transactions
Population	6,755,741	2,374,309
Sample size	167	50
Number of transactions with errors	25	0
Calculated error rate	**14.97%**	**N/A**
Upper error limit	20.38%	N/A
Lower error limit	9.56%	N/A
Calculated transactions in error	**1,011,334**	**N/A**
Upper limit transactions in error	1,376,820	N/A
Lower limit transactions in error	645,849	N/A

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

Summary of Procedural Claims Accuracy of Empire HealthChoice Assurance, Inc.

	Medical Transactions	Hospital Transactions
Population	6,755,741	2,374,309
Sample size	167	50
Number of transactions with errors	25	0
Calculated error rate	**14.97%**	**N/A**
Upper error limit	20.38%	N/A
Lower error limit	9.56%	N/A
Calculated transactions in error	**1,011,334**	**N/A**
Upper limit transactions in error	1,376,820	N/A
Lower limit transactions in error	645,849	N/A

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

Summary of Financial Claims Accuracy of Empire HealthChoice HMO, Inc.

	Medical Transactions	Hospital Transactions
Population	2,363,684	238,003
Sample size	50	100
Number of transactions with errors	2	13
Calculated error rate	**N/A**	**N/A**
Upper error limit	N/A	N/A
Lower error limit	N/A	N/A
Calculated transactions in error	**N/A**	**N/A**
Upper limit transactions in error	N/A	N/A
Lower limit transactions in error	N/A	N/A

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

Summary of Procedural Claims Accuracy of Empire HealthChoice HMO, Inc.

	Medical Transactions	Hospital Transactions
Population	2,363,684	238,003
Sample size	50	100
Number of transactions with errors	2	13
Calculated error rate	**N/A**	**N/A**
Upper error limit	N/A	N/A
Lower error limit	N/A	N/A
Calculated transactions in error	**N/A**	**N/A**
Upper limit transactions in error	N/A	N/A
Lower limit transactions in error	N/A	N/A

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).

5. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("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 30 days of receipt of a claim that is

transmitted via the internet or electronic mail or 45 days of receipt of a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified… to pay a claim submitted by a policyholder or person covered under such policy ("covered person") 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 thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

In addition, Section 3224-a(c)(1) of the New York Insurance Law states in part:

> "(c)(1) Except as provided in paragraph two of this subsection, 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… 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, and insurer or organization or corporation shall not be required to pay interest on such claim."

A statistical sample of claims not adjudicated within 30 days of receipt for claims transmitted via the internet or electronic mail or 45 days of receipt for claims submitted by other means such as paper or a facsimile by the Companies was reviewed to determine whether the claims were processed in compliance with the timeframe requirements of Section 3224-a(a) of the New York Insurance Law ("NYIL"), and if interest was required and appropriately paid

pursuant to Section 3224-a(c)(1) of the NYIL. Accordingly, all claims that were not adjudicated within the respective 30 or 45 days during the period January 1, 2011 through December 31, 2011, were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated and paid (when required).

The claim populations for the Company and EHC-HMO were separated and further divided into medical and hospital claim segments. A random statistical sample was drawn from each segment, for each entity. It should be noted that for the purpose of this analysis, medical costs characterized by Empire as "Pharmacy," "Medicare/Medicaid," "Dental," "Capitated Payments," "Federal Employees Program" and "HCRA" bulk payments, were excluded from the examiner's review.

The sample size for each population was comprised of 167 randomly selected claims. Additional random samples were generated for each group as "replacement items" in the event it was determined that a particular claim transaction selected in the initial sample needed to be excluded. Accordingly, various replacement items were appropriately utilized. In total, 668 claims were selected for this review (334 from the Company and 334 from the Plan (167 each from the medical and hospital claim segments)).

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

Empire HealthChoice Assurance, Inc.
Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	6,755,741	2,374,309
Population of claims paid past 30/45 days	41,686	35,624
Sample size	167	167
Number of claims with violations	141	128
Calculated violation rate	**84.43%**	**76.65%**
Upper violation limit	89.93%	83.06%
Lower violation limit	78.93%	70.23%
Calculated claims in violation	**35,195**	**27,306**
Upper limit claims in violation	37,488	29,589
Lower limit claims in violation	32,903	25,019

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

Empire HealthChoice Assurance, Inc.
Summary of Violations of Section 3224-a(c)(1) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	6,755,741	2,374,309
Population of claims paid past 30/45 days that are eligible for interest	10,934	18,813
Sample size	167	167
Number of transactions with violations	3	4
Calculated violation rate	**1.80%**	**2.40%**
Upper violation limit	3.81%	4.71%
Lower violation limit	N/A	.08%
Calculated transactions in violation	**197**	**452**
Upper limit transactions in violation	417	886
Lower limit transactions in violation	0	15

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

Empire HealthChoice HMO, Inc.
Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	2,363,684	238,003
Population of claims paid past 30 or 45 days	31,631	6,766
Sample size	167	167
Number of claims with violations	147	145
Calculated violation rate	**88.02%**	**86.83%**
Upper violation limit	92.95%	91.96%
Lower violation limit	83.10%	81.70%
Calculated claims in violation	**27,842**	**5,875**
Upper limit claims in violation	29,401	6,222
Lower limit claims in violation	26,285	5,528

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

Empire HealthChoice HMO, Inc.
Summary of Violations of Section 3224-a(c)(1) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	2,363,684	238,003
Population of claims paid over 45 days that are eligible for interest	9,045	4,401
Sample size	167	167
Number of claims with violations	5	4
Calculated violation rate	**2.99%**	**2.40%**
Upper violation limit	5.58%	4.71%
Lower violation limit	.41%	.08%
Calculated transactions in violation	**270**	**106**
Upper limit transactions in violation	505	207
Lower limit transactions in violation	37	4

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

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample (claims adjudicated during the period January 1, 2011 through December 21, 2011), which consisted of only those claims adjudicated over thirty days of receipt that were transmitted via the internet or electronic mail or forty-five days of receipt for claims submitted by other means such as paper or a facsimile and/or which should have incurred interest of two dollars or more based upon the examiner's calculations.

The population of claims adjudicated after thirty days for electronic submission or forty-five days for paper submission from the date of receipt for ECHA consisted of 41,686 and 35,624 medical and hospital claims, respectively, out of 6,755,741 and 2,374,309 medical and hospital claims processed, respectively, during the period under review.

The population of claims paid after thirty days for electronic submission or forty-five days for paper submission from the date of receipt for forty-five days from the date of receipt for EHC-HMO consisted of 31,631 and 6,766 medical and hospital claims, respectively, out of 2,363,684 and 238,003 medical and hospital claims processed, respectively, during the period under review.

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

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

A review was also performed as to the manner in which the Companies handled the denial of claims and requested additional information needed to determine liability to pay a claim.

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

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven 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..."

A statistical sample of claims denied more than 30 days after receipt by the Companies was reviewed to determine whether the denial/request for information exceeded the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims that were denied past 30 days after receipt during the period January 1, 2011 through December 31, 2011, were segregated. A statistical sample of this population was then selected to determine whether the claims were properly denied, as required by statute.

The following charts illustrate the Companies' compliance with Section 3224-a(b) of the New York Insurance Law, as determined by this examination:

Empire HealthChoice Assurance, Inc.
Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	6,755,741	2,374,309
Population of claims adjudicated over 30 days	111,104	62,933
Sample size	167	167
Number of claims with violations	24	31
Calculated violation rate	**14.37%**	**18.56%**
Upper violation limit	19.69%	24.46%
Lower violation limit	9.05%	12.67%
Calculated claims in violation	**15,966**	**11,680**
Upper limit claims in violation	21,876	15,393
Lower limit claims in violation	10,055	7,974

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

Empire HealthChoice HMO, Inc.
Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	2,363,684	238,003
Population of claims adjudicated over 30 days	29,126	5,169
Sample size	167	167
Number of claims with violations	16	36
Calculated violation rate	**9.58%**	**21.56%**
Upper violation limit	14.04%	27.79%
Lower violation limit	5.12%	15.32%
Calculated claims in violation	**2,790**	**1,114**
Upper limit claims in violation	4,089	1,436
Lower limit claims in violation	1,491	792

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

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims that were denied more than thirty days from receipt.

The population of claims denied more than thirty days from the date of receipt for ECHA consisted of 111,104 and 62,933 medical and hospital claims, respectively, out of 6,755,741 and 2,374,309 medical and hospital claims processed, respectively, during the period under review.

The population of claims denied more than thirty days from the date of receipt for EHC-HMO consisted of 29,126 and 5,169 medical and hospital claims, respectively, out of 2,363,684 and 238,003 medical and hospital claims processed, respectively, during the period under review.

It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(b) of the New York Insurance Law, regarding the prompt denial of claims/requests for information are fully implemented and complied with.

It was noted during the prompt pay review that Empire used the claim adjudication date rather than the paid date of the claim to calculate the prompt pay timeframe and related interest for certain claims. In many cases the adjudication date was several days earlier than the paid date. This resulted in the incorrect number of days used in determining whether interest (and how much interest) was due on the claim.

Empire stated the errors were the result of changes made to their claim system in order to comply with the Health Care Reform Law ("HCRL"). Prior to implementation of the HCRL and the 30 day electronic claim payment requirement (effective January 1, 2010 under NY 2009

AB8402-SB5472 - Managed Care Reform Law), Empire was paying some of its professional providers on a two-week payment cycle (every fourteen (14) days) and used the adjudication date to calculate Prompt Payment interest. At that time, interest was calculated correctly because Empire's claims system was programmed to allow payments to its professional providers to flip to a daily payment cycle for claims greater than twenty-seven (27) days old. This allowed payment to be made on the same day the claim was adjudicated. As a result, interest was being paid starting on day forty-three (43) resulting in some prompt pay interest overpayments (for claims paid in less than 45 days).

When the Managed Care Reform Law became effective on January 1, 2010, Empire implemented the 30 day electronic claim payment requirement, however, Empire did not adjust the electronic professional claims payment cycle to flip to a daily pay cycle when interest had been calculated on a claim greater than twelve (12) days old (to allow payments to be made in less than thirty-days (30) days). Empire acknowledged that some examples of these PPL interest underpayments were discovered during this examination..

As part of Empire's corrective action plan the following changes were made to Empire's claims systems:

- System code changes to rectify the provider payment cycle issue were implemented on January 11, 2013.
- A claims analysis was conducted for the period January 1, 2010 to January 11, 2013 to determine the total number of providers/ members owed additional interest.
- A process is being developed to pay any additional interest to those providers/members impacted.

It is recommended that Empire establish procedures to ensure that the proper date is used to identify claims for Prompt Pay Law compliance, including the calculation of interest owed on overdue claims.

6. UNDERWRITING

Restrictions on Subsidization of Cost Sharing

Part 360.3 of Department Regulation No. 145 (11 NYCRR 360.3) states in part:

> "(a) No insurer may restrict or limit eligibility for individual or small group policies except in the following ways:
>
> (1) Insurers may issue policies only to or through groups recognized under Sections 4235(c)(1)(A), (B), (D), (H), (K), (L) and (M) and 4237 of the Insurance Law…
>
> (2) An employer's required time period of employment before coverage under the employer's plan takes effect.
>
> (3) A required number of work hours to qualify as an employee…
>
> (4) Geographical limitations as set forth in the premium rate filing and approved by the Superintendent…
>
> (5) Overinsurance rules filed with the Health and Life Policy Bureau and approved by the Superintendent…
>
> (6) Where licensed health maintenance organizations and licensed insurers offering plans with a limited provider network have applied to the Superintendent and been granted a temporary waiver of the requirement for open enrollment…
>
> (7) Issuance of policies of Medicare Supplement Insurance may be conditioned upon the enrollment of the applicant in both Part A and Part B of Medicare.
>
> (8) Where a small group offers more than one health care plan to its employees or members, rules may be established controlling the transfer between the health care plans so long as transfer is permitted no less than once each calendar year.
>
> (9) Where an eligible employee or member or dependent or spouse of such employee or member rejects initial enrollment… rules may be established limiting future enrollment to specified time periods.
>
> (10) An insurer may limit changes in coverage initiated by an individual or small group, either by changing policies or adding or deleting riders, to an anniversary date or other regular interval...
>
> (11) A rule limiting eligibility where an individual or small group has had health insurance coverage terminated within the previous 12 months for failure to pay premiums."

Empire had in place the following underwriting provision in their small group application forms and their underwriting guidelines. The employer funding restriction disqualified small groups from coverage if the employer paid part of the employee's cost share responsibilities.

> *"NOTE: In order for this application to be accepted by Empire, your group (i) may NOT subsidize any portion of your covered members' cost sharing responsibilities, such as copayments and /or member coinsurance (sometimes referred to as a "Gap Plan") and (ii) may NOT fund more than 40% toward the member deductible amount. The offer of either a Gap Plan or funding of more than 40% toward member deductible disqualifies a group from eligibility for Empire small group coverage. By signing below, you are certifying that you do not offer a "Gap Plan" or fund more than 40% of the member deductible amount."*

The abovementioned provision was in violation of Part 360.3 of Department Regulation No. 145 because it did not comply with any of the eligibility restrictions allowed by the Regulation. Empire subsequently, at the direction of the Department's Consumer Assistance Unit, removed the language from its application forms and discontinued the employer funding restrictions when underwriting small groups; however, the provision was still in Empire's small group underwriting guidelines.

It is recommended that Empire comply with the requirements of Part 360.3 of Department Regulation No. 145 by removing the restriction on employer funding of cost sharing provisions from its small group underwriting guidelines.

Subsequent to the examination date, Empire informed the Department that it revised its small group underwriting guidelines so that it complies with Department Regulation No. 145.

7. REPORTING OF GRIEVANCES AND UTILIZATION REVIEW APPEAL DATA

A review of the 2011, Exhibit of Grievances and Utilization appeals for Empire HealthChoice Assurance, Inc. and Schedule M for Empire HealthChoice HMO, Inc. found that both companies had been under reporting the total number of utilization review appeals on their respective filed exhibit and/or schedule. Additionally, Empire HealthChoice HMO, Inc. had also been under reporting the total number of grievances on its filed schedule.

After reviewing the reporting tool used by Empire to compile the Exhibit of Grievances and Utilization Review Appeals and Schedule M, Empire determined that not all lines of business were being captured and not all appropriate grievances and appeals were identified. The logic that was originally set-up for the Exhibit of Grievances and Utilization Review Appeals and Schedule M reporting did not capture all the appropriate lines of business as well as the related grievances and/or appeals. In addition, due to some system migrations within the Grievances and Appeals Department, additional lines of business were inappropriately being excluded from the required Exhibit of Grievances and Utilization Review Appeals and Schedule M reporting, thus compounding the issue.

Empire confirmed which lines of businesses should be reported on the Exhibit of Grievances and Utilization Review Appeals and Schedule M and whether the reporting should be capturing appeals/grievances of insured members and/or providers. As noted by Empire, the Exhibit of Grievances and Utilization Review Appeals and Schedule M should report the following information:

- Grievances and appeals should be tracked for all insured lines of business, with the exception of FEP and Medicare Advantage, including those reported to specialty vendors.

- Grievances and appeals should be reported for insured members only. That is, provider grievances unrelated to a specific member's claim need not be tracked and reported.
- UR appeals for both providers (concerning covered services provided to the insured) and insured members are to be reported.

On January 7, 2013, the Companies contacted the Department to discuss the matter above. The Department agreed with the Company's corrective action plan.

It is recommended that Empire report the correct data on its Exhibit of Grievances and Utilization appeals and Schedule M filings.

8. UTILIZATION REVIEW

Sections 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum utilization review program standards and requirements of utilization review determinations for prospective, concurrent and retrospective reviews and appeals of adverse determinations by utilization review agents, respectively, for insurers, such as EHCA, licensed under Article 42 of the New York Insurance Law. Comparable sections of Article 49 of the New York Public Health Law contain the same requirements for HMOs licensed under Article 44 of the Public Health Law and thus would be applicable to EHC-HMO. For ease of reading, the findings detailed herein refer to the New York Insurance Law. However, unless otherwise noted, the violations are applicable to the comparable statutory citations of Article 49 of the New York Public Health Law (for EHC-HMO).

In addition to the review of EHCA and EHC-HMO utilization review and utilization review appeal practices, a review was conducted of third-party administrators or affiliates who conduct these services for Empire, including American Specialty Health Networks, Inc.

("ASH"), American Imaging Management, Inc. ("AIM"), OrthoNet, LLC, ("OrthoNet") and Anthem Utilization Management Services, Inc. ("AUMSI"), an Empire affiliate that performs utilization review services for both medical and behavioral health services.

The adverse determination notices sent out by OrthoNet and Anthem Utilization Management Services, Inc. did not fully comply with the requirements of Section 4904(b) of the New York Insurance Law.

Section 4904(b) of the New York Insurance Law states in part:

> "...Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal..."

OrthoNet's adverse utilization review determination notices state, *"decisions for expedited appeals will be made within 72 hours of receipt of the appeal."* OrthoNet's adverse utilization appeal determination letter states that, *"if a delay in the health care service would pose an imminent or serious threat to the health of the patient, or when the health care provider believes an immediate appeal is warranted, we will expedite the appeal and make a decision within 72 hours based on the available information."*

Anthem Utilization Management Services, Inc.'s, notices state, *"if an expedited appeal is warranted, you will receive a decision within 72 hours based on the available information."*

It is recommended that OrthoNet change the language on its adverse determination letters and make determinations within two business days of receiving the required information on expedited appeals to comply with the requirements of Section 4904(b) of the New York Insurance Law.

It is also recommended that Anthem Utilization Management Services, Inc. change the language on its adverse determination letters and make determinations within two business days of receiving the required information on expedited appeals to comply with the requirements of Section 4904(b) of the New York Insurance Law.

Section 4903(b) of the New York Insurance 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 insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

American Imaging Management, Inc. failed to notify the insured or the insured's designee and the insured's health care provider by telephone in 2 out of 25 prospective cases reviewed, in violation of Section 4903(b) of the New York Insurance Law.

OrthoNet, LLC failed to provide written notice of determination to insured or the insured's designee and the insured's health care provider within three business days of receipt of all necessary information in 1 out of 10 prospective cases reviewed, in violation of Section 4903(b) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(b) of the New York Insurance Law.

Section 4903(c) of the New York Insurance Law states in part:

> "A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information…"

For behavioral health services, Anthem Utilization Management Services, Inc., failed to provide written notice of determination to the insured or insured's designee and the insured's health care provider within one business day of receipt of the necessary information in 2 out of 10 concurrent cases reviewed, in violation of Section 4903(c) of the New York Insurance Law.

Anthem Utilization Management Services, Inc. failed to provide notice of determination to the insured or the insured's designee and the insured's health care provider via telephone within one business day of receipt of the necessary information in 1 out of 20 concurrent cases reviewed, in violation of Section 4903(c) of the New York Insurance Law.

Anthem Utilization Management Services, Inc. failed to provide written notice of determination to the insured or the insured's designee and the insured's health care provider within one business day of receipt of the necessary information in 4 out of 20 concurrent cases reviewed, in violation of Section 4903(c) of the New York Insurance Law.

OrthoNet, LLC failed to provide written notice of determination to the insured or insured's designee and the insured's health care provider within one business day of receipt of the necessary information in 1 out of 20 concurrent cases reviewed, in violation of Section 4903(c) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(c) of the New York Insurance Law.

Section 4903(d) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

Anthem Utilization Management Services, Inc. failed to provide written notice of determination to the insured or insured's designee and the insured's health care provider within thirty days of receipt of the necessary information in 1 out of 10 retrospective cases reviewed, in violation of Section 4903(d) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(d) of the New York Insurance Law.

Section 4904(b) of the New York Insurance Law states in part:

> "A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this article or (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination…"

In 1 of 10 files reviewed, OrthoNet, LLC, failed to comply with a request from the member for an expedited review of the member's case and instead treated the case as a standard appeal, in violation of Section 4904(b) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(b) of the New York Insurance Law.

Section 4904(c) of the New York Insurance Law states in part:

> "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 insured 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 insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination…"

For behavioral health services, Anthem Utilization Management Services, Inc., failed to notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination in 1 out of 15 utilization appeal cases reviewed, in violation of Section 4904(c) of the New York Insurance Law.

OrthoNet failed to notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination in 5 out of 10 utilization appeal cases reviewed, in violation of Section 4904(c) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law.

Section 4904(c)(1) of the New York Insurance Law states in part:

> "…The notice of the appeal determination shall include:
> (1) 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..."

In 4 out of 10 cases reviewed, OrthoNet's written notices of determination did not include the clinical rationale for the determination.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(c)(1) of the New York Insurance Law.

Part 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."

For behavioral health services, Anthem Utilization Management Services, Inc., failed to maintain documentation that it notified the insured or insured's designee and the insured's health care provider by telephone in 7 out of 10 prospective review cases.

Additionally, for behavioral health services, Anthem Utilization Management Services, Inc., failed to maintain documentation that it notified the insured or insured's designee and the insured's health care provider by telephone in 6 out of 10 concurrent review cases.

A review of 5 retrospective review cases from OrthoNet, found that OrthoNet was using the date it received the e-mail from Empire staff with the retrospective review information as the date all the necessary case information was received. As these reviews are done on behalf of Empire by OrthoNet the date of receipt should be the date Empire received all the required information which was not communicated to OrthoNet by Empire. Due to this the correct date of receipt could not be determined for these 5 cases.

It is recommended that Empire provide OrthoNet with the date it receives all the required information for retrospective review cases and that OrthoNet uses that date as the initial date of receipt for the retrospective review to comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152.

9. GRIEVANCES AND APPEALS

Section 4408-a of the New York Public Health Law sets forth the minimum requirements of grievance and appeals procedures for HMOs licensed under Article 44 of the Public Health Law and thus would be applicable to EHC-HMO.

For non-managed care products sold by EHCA a review was performed to determine if the Company was following its written grievance and appeal procedures and Department statutes and regulations, as applicable. A review of EHCA grievance and appeals procedures found that they mirror the requirements of the New York Public Health Law.

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

> "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…"

In 2 out of 25 cases reviewed, EHC-HMO failed to acknowledge receipt of the grievance within 15 business days of receipt of the grievance, due to a failure to code the received information as a grievance, in violation of Section 4408-a(4) of the Public Health Law.

In 3 out of 25 cases reviewed, EHCA failed to acknowledge receipt of the grievance within 15 business days of receipt of the grievance, due to a failure to code the received information as a grievance, in violation of EHCA's written grievance and appeal procedures.

It is recommended that EHC-HMO comply with the requirements of Section 4408-a(4) of the New York Public Health Law and acknowledge receipt of all grievances within 15 business days of receipt of the grievance.

It is also recommended that EHCA comply with its internal grievance requirements and acknowledge receipt of all grievances within 15 business days of receipt of the grievance.

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

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

In 1 out of 25 cases, EHC-HMO failed to maintain documentation that the Plan had provided written acknowledgement of a grievance filing as required by Part 243.2(b)(8) of Department Regulation No. 152.

It is recommended that EHC-HMO comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 and maintain documentation of all required grievance notices.

Empire's grievance and appeal procedures for health plan members and providers in New York state in part:

> *"All grievances shall be resolved in an expeditious manner, and in any event, no more than…*
> *c. 45 days after receipt of all necessary information in all other instances."*

In 1 out of 25 cases, EHCA failed to resolve a grievance case within 45 days of receipt of all the necessary information, in contravention of EHCA's grievance procedures.

It is recommended that EHCA resolve all grievance cases within 45 days of receipt of all necessary information in compliance with its internal grievance procedures.

10. DEPARTMENT COMPLAINTS

A listing of 7,036 complaints filed and closed in 2011 against Empire was received from the Department's Consumer Services Bureau. A sample of twenty complaints was reviewed.

Section 2404 of the New York Insurance Law states in part:

> "The superintendent is empowered to examine and investigate into the affairs of any person in order to determine whether the person has violated or is violating section two thousand four hundred three of this article. In the event any person does not provide a good faith response to a request for information from the superintendent, within a time period specified by the superintendent of not less than fifteen business days, as part of an examination or investigation initiated by the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance, or health maintenance organization coverage…"

Empire failed to respond to the Department's request for additional information within fifteen (15) business days on one (1) of the twenty (20) complaint files reviewed.

It is recommended that Empire comply with the requirements of Section 2404 of the New York Insurance Law by responding to complaints within 15 business days.

11. SPECIAL INVESTIGATIONS UNIT

A review of Empire's Special Investigation Unit was conducted to review Empire's compliance with Article 4 of the New York Insurance Law.

For the years 2008 to 2010, Empire's Special Investigations Unit ("SIU") reported lower numbers of fraud cases in the Department's web based Fraud Case Management System ("FCMS"), compared to what was reported in its NYIL Section 409(g) filings.

After an audit in 2010 conducted by Empire's SIU, Empire discovered that some fraud cases were not reported to the FCMS system in 2008 and 2010, but were instead reportedin 2011. This resulted in a greater number of reported fraud cases in the FCMS system in 2011 compared to what was reported in Empire's 2011 409(g) fraud report filed with the Department.

It is recommended that Empire report the correct number of fraud cases to the Department's Fraud Case Management System.

12. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT ON EXAMINATION

The prior market conduct report on examination contained twenty-seven (27) comments and recommendations detailed as follows (page numbers refer to the prior report on examination).

ITEM NO.		PAGE NO.
	Sales, Marketing and Advertising	
1.	It is recommended that, where appropriate, the Companies provide linked information in Spanish on their website, in order to prevent any communication problems with Spanish-speaking members or prospective members. *Empire has complied with this recommendation.*	8
2.	It is recommended that Empire comply with the provisions of Department Regulation No. 34 and provide specific references for any statistics used in advertisements and that the Companies refrain from using vague terms in their advertisements. *Empire has complied with this recommendation.*	9
	Agents and Brokers	
3.	It is recommended that Empire maintain current licenses on file for all active producers to ensure compliance with the provisions of Section 2116 of the New York Insurance Law. *Empire has complied with this recommendation.*	11
4.	It is recommended that Empire ensure that certificates of appointments are filed with the Department for each of its agents, as required by Section 2112(a) of the New York Insurance Law. The Companies should also ensure that commission payments are made only to agents that have been appointed by Empire. *Empire has complied with this recommendation.*	11

ITEM NO. **PAGE NO.**

Agents and Brokers (Cont'd.)

5. It is recommended that Empire comply with the provisions of Section 2112(d) of the New York Insurance Law by maintaining documentation for and reporting all terminated insurance agents to the Department, as prescribed by statute. 13

Empire has complied with this recommendation.

6. It is also recommended that Empire maintain a log of terminated certificates of appointments of agents and brokers in accordance with the recordkeeping requirements of Department Regulation No. 152. 13

Empire has complied with this recommendation.

Utilization Review

7. It is recommended that Empire revise its policy in regard to utilization review determinations involving health care services requiring pre-authorization by clearly delineating when the state or federal statutory timeframes should be applied to a particular pre-service claim. 15

Empire has complied with this recommendation.

8. It is recommended that Empire revise its policy in regard to utilization review determinations involving health care services which have been delivered, by clearly delineating when the state or federal statutory timeframes should be applied to a particular post-service claim. 16

Empire has complied with this recommendation.

9. It is again recommended that Empire revise its policy to clearly delineate whether the state or federal statute should be applied to a particular claim. 17

Empire has complied with this recommendation.

10. It is again recommended that Empire revise its policy to clearly delineate whether the state or federal statute should be applied to a particular claim. 18

Empire has complied with this recommendation.

ITEM NO.		PAGE NO.
	Utilization Review (Cont'd.)	
11.	It is recommended that Empire comply with the requirements of Section 4904(c) of the New York Insurance Law. *Empire has not fully complied with this recommendation. A similar recommendation is contained herein.*	19
12.	It is recommended that Empire amend its Utilization Review procedures to clearly note which statute is applicable to a specific situation. *Empire has complied with this recommendation.*	20
13.	Though Empire contends that it has adopted these policies – it should formally document that these policies were in fact adopted by EHCA and EHC-HMO. *Empire has complied with this recommendation.*	20
14.	It is recommended that Empire complies with the provisions of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law. Subsequent to the date of this examination, Empire provided documentation to show that it was in compliance with the provisions of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law. *No further action is required.*	21
15.	It is also recommended that Empire complies with the provisions of Part 243.2(a) of Department Regulation No. 152, by retaining copies of all utilization review statements that are required to be filed with the Superintendent of Insurance and/or the Commissioner of Health. *Empire has complied with this recommendation.*	21
16.	It is recommended that Empire comply with the provisions of Section 4903(e) of the New York Insurance Law and revise its *Notification of Utilization Review Determination* policy (URA-03) accordingly. *Empire has complied with this recommendation.*	22

ITEM NO.		PAGE NO.
	Utilization Review (Cont'd.)	
17.	It is recommended that Empire expressly comply with the provisions of Department Regulation No. 166 and revise its policy in regard to utilization review *Appeals of Adverse Determinations* (URA-04) to also include insurers that are licensed pursuant to Articles 42 and 43 of the New York Insurance Law. *Empire has complied with this recommendation.*	23
	Grievances and Appeals	
18.	It is recommended that Magellan, which acts on behalf of Empire as a third party administrator ("TPA"), comply with the requirement of Section 4802(d)(2) of the New York Insurance Law by ensuring that resolutions to grievances filed are rendered within the statutorily mandated 30-day period after receipt of all necessary information. Empire, which is responsible for Magellan's violations of statute, should ensure Magellan's compliance with applicable requirements. *Effective January 1, 2008, Empire no longer used Magellan as a third-party administrator (TPA). No further action is required.*	24
19.	It is also recommended that Magellan revise statements on its acknowledgement letters to members to correctly state that New York Insurance Law requires Health Plans to determine an appeal or grievance within 30 days and **not** 60 days as currently stated. *Effective January 1, 2008, Empire no longer used Magellan as third-party administrator (TPA). No further action is required.*	24
20.	It is recommended that all grievances received by Empire or its TPA(s) include the proper date stamp to reflect the day that the Companies receive such documents. *Empire has not fully complied with this recommendation. A similar recommendation is contained herein.*	24

ITEM NO. **PAGE NO.**

Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Services ("Prompt Pay Law") (Cont'd.)

25. It is also recommended that Empire take steps to ensure that the provisions of Section 3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with. 31

Empire has not fully complied with this recommendation. A similar recommendation is contained herein.

26. It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(b) of the New York Insurance Law, regarding the prompt denial of claims/requests for information are fully implemented and complied with. 34

Empire has not fully complied with this recommendation. A similar recommendation is contained herein.

27. It is recommended that Empire facilitate the examination process by informing the examiner of relevant operation protocols in a timely manner. 35

Empire has complied with this recommendation.

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____
Wai Wong
Associate Insurance Examiner

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

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

_____/S/_____
Wai Wong

Subscribed and sworn to before me
this _____ day of_____2012.

Appointment No. **30711**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Wai Wong

as a proper person to examine into the affairs of the

Empire Healthchoice HMO, Inc.

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

HMO

with such other information as he shall deem requisite.

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

This 29th day of June, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR

Appointment No. **30709**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Wai Wong

as a proper person to examine into the affairs of the

Empire Healthchoice Assurance, Inc.

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

Company

with such other information as he shall deem requisite.

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

This 29th day of June, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR