REPORT ON EXAMINATION

OF

GHI HMO SELECT, INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT	**JULY 27, 2012**
EXAMINER	**ANDRE BLACKMAN**

TABLE OF CONTENTS

July 27, 2012

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

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30343, dated August 12, 2009, attached hereto, I have made an examination into the condition and affairs of GHI HMO Select, Inc., a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2008, and submit the following report thereon.

GHI HMO Select, Inc. is a wholly-owned subsidiary of GHI Services LLC, a wholly-owned subsidiary of Group Health, Incorporated ("GHI"), a not-for-profit health service corporation organized and licensed pursuant to the provisions of Article 43 of the New York Insurance Law.

The examination was conducted at the home office of GHI HMO Select, Inc., located at 789 Grant Avenue, Lake Katrine, New York.

Wherever the designations the “HMO” or “GHI HMO” appear herein, without qualification, they should be understood to indicate GHI HMO Select, Inc.

Wherever the designation “GHI” appears herein, without qualification, it should be understood to mean Group Health, Incorporated.

Wherever the designations “Emblem” or “EmblemHealth” appear herein, without qualification, they should be understood to indicate EmblemHealth, Inc., the ultimate parent of GHI HMO Select, Inc.

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

1. SCOPE OF THE EXAMINATION

The HMO was previously examined as of December 31, 2003. This examination covered the five-year period from January 1, 2004 through December 31, 2008. Transactions occurring 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, 2008, in accordance with Statutory Accounting Principles ("SAP") as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification and, utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants. A review 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 HMO
Management and controls
Organizational changes
Territory and plan of operation
Growth of the HMO
Business in-force
Accounts and records
Financial statements
Treatment of policyholders and claimants

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.

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

2. DESCRIPTION OF THE HMO

GHI HMO Select, Inc. d/b/a GHI HMO, commenced business on June 1, 1999, after Wellcare of New York, Inc., then a health maintenance organization licensed pursuant to Article 44 of the Public Health Law, sold its commercial business to GHI under an asset-purchase agreement. The HMO is a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, and is a wholly-owned subsidiary of GHI Services LLC, which in turn is a wholly-owned subsidiary of GHI.

On November 15, 2006, GHI and HIP were united under the leadership of the HIP Foundation, Inc. ("the Foundation"), the parent corporation of HIP, after having received regulatory approval from the New York State Insurance Department, and approval from the Boards of Directors of GHI and the Foundation. The Foundation is the sole corporate member of both companies. Also, on this date, the Foundation's name was changed to EmblemHealth, Inc. ("EmblemHealth"). At the outset, the Board of Directors of EmblemHealth included an equal number of directors from the HIP and GHI Boards of Directors.

On March 31, 2007, the New York State Legislature passed legislation as part of the New York State Budget that would allow the conversion of HIP and GHI into for-profit public companies and let the holding company EmblemHealth raise capital through the issuance of stock as a for-profit entity. As a result of the proposed conversion, The New York Public Asset Fund and The New York State Health Foundation, both created by the State of New York, will receive 100% of the fair market value of HIP and GHI determined at the time of Conversion, in the form of voting and non-voting common stock and the cash proceeds of a public offering of a

new for-profit holding company which, with its subsidiaries, will acquire or succeed to all of the assets and liabilities of HIP and GHI.

EmblemHealth Services Company, LLC ("EHS") was formed as a joint venture on March 6, 2007, to integrate various services of the corporate entities of EmblemHealth, Inc., including GHI HMO. Along with other corporate members of Emblem, the HMO receives management and other services from EHS. On January 1, 2008, GHI HMO's vendor agreements and employees were transferred to EHS. GHI HMO, along with the other Emblem corporate members, jointly guarantees the employee-related compensation liabilities of EHS.

The HMO operates as a Direct Contract Model HMO, and enters into agreements directly with individual primary care physicians or physician groups for the provision of health care services. The HMO also operates as an Independent Practice Association ("IPA") model HMO, where an enrollee's health care services are rendered by providers contracted under arrangements between the HMO and regional health care delivery networks, or IPAs.

GHI HMO offered Health Maintenance Organization, Point-of-Service, Healthy New York, Medicaid, Child Health Plus, and Family Health Plus products to a membership of 53,353 members at year-end 2008.

A. Management and Controls

Pursuant to the HMO's charter and by-laws, management of the HMO is to be vested in a Board of Directors consisting of not less than three members. As of the examination date, the Board of Directors was comprised of eleven members. The HMO's Board members as of December 31, 2008 were as follows:

Name and Residence	Principal Business Affiliation
Frank J. Branchini New York, NY	Chairman and Chief Executive Officer, Group Health Incorporated
Yvonne Burgess-Reed New York, NY	Director of Human Resources, New York State United Teachers
Gregory Floyd New York, NY	President, International Brotherhood of Teamsters
Michael Herbert New York, NY	President and Chief Executive Officer, ConnectiCare
Howard Jones New York, NY	Retired Professor, City University of New York
Thomas Martinelli* New York, NY	Private Consultant
Susan Matthews* New York, NY	Private Consultant
John Nelson* New York, NY	Retired Vice President, The Corporation of Yaddo
Aran Ron, M.D. New York, NY	Chief Medical Officer, GHI HMO Select, Inc.
Daniel D. Rubino New York, NY	Chief Executive Officer, Capital Group, LLC
Bernard Schayes, M.D. New York, NY	Physician, Private Practice

** Enrollee Representative as required by Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York Health Department. Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York Health Department provides that, "… no less than twenty percent (20%) of the individuals comprising the Board of Directors at any time shall be enrollees of the health maintenance organization operated by the corporation."*

The minutes of all meetings of the Board of Directors and committees thereof held during the examination period were reviewed. All meetings were well attended, with each Board member attending at least one-half of the meetings they were eligible to attend.

It was noted that the HMO's management regularly receives reports summarizing the operations of the HMO, and holds regular Board meetings jointly with the HMO's Audit and Compliance committees.

According to its by-laws, the HMO's Board is required to meet once in each calendar year for an annual meeting and may hold additional special meetings as desired. This number of meetings required by the HMO's by-laws is not enough to ensure sufficient governance and proper oversight of the HMO's operations. The Board has a responsibility to meet regularly to consult and provide guidance to the HMO's management regarding the management of the business affairs of the HMO.

It was noted that the Board historically has met on at least a quarterly basis. However, it would be better corporate governance for the HMO to reflect its intentions to do so, by amending its by-laws to require the Board to meet at least quarterly.

It is recommended that the HMO's by-laws be changed to require the Board to meet at least quarterly.

The principal officers of the HMO as of December 31, 2008, were as follows:

Name	Title
Frank J. Branchini	President & Chief Executive Officer
William Mastro	Corporate Secretary
Michael Palmateer	Treasurer & Chief Financial Officer
Aran Ron, M.D.	Chief Medical Officer
William Yurkowski	Executive Director

Members of the HMO's Board have included officers of GHI, who also serve as officers of GHI HMO. During the examination period, there were three such Board members: Frank Branchini, Aran Ron, M.D. and Donna Lynne. Conflict of interest statements were received by GHI HMO from all of the GHI HMO Board members, including the aforementioned officers of GHI.

B. Territory and Plan of Operation

As of December 31, 2008, the HMO held a certificate of authority to operate in the following twenty-eight (28) counties of New York State:

Albany	Greene	Putnam	Schoharie
Bronx	Kings	Queens	Suffolk
Broome	Montgomery	Rensselaer	Sullivan
Columbia	Nassau	Richmond	Ulster
Delaware	New York	Rockland	Warren
Dutchess	Orange	Saratoga	Washington
Fulton	Otsego	Schenectady	Westchester

As of the examination date, GHI HMO's Plan offerings included its health maintenance organization commercial plan, individual in-network and out-of-network Point-of-Service ("POS") plans, Healthy NY, Medicaid, Family Health Plus and Child Health Plus plans. The HMO issues coverage under its member contracts pursuant to Section 4406(2) of the New York Public Health Law, and is in compliance with the limitations contained therein. The HMO does not presently write Medicare or Medicaid Advantage contracts.

During the period January 1, 2004 through December 31, 2008, the HMO experienced a net increase in enrollment of 17,707 persons. An analysis of the increase in enrollment is set forth below:

	2004	2005	2006	2007	2008
Enrollment, January 1st	35,646	47,556	67,830	55,669	53,202
Net Gain (Loss)	11,910	20,274	(12,161)	(2,467)	151
Enrollment, December 31st	47,556	67,830	55,669	53,202	53,353

C. Reinsurance

GHI HMO did not assume any reinsurance during the examination period.

In 2007 and 2008, the HMO ceded risk to one reinsurer, ACE American Insurance Company, LLC ("ACE"), an authorized reinsurer, covering the Commercial Health Maintenance Organization, Commercial Point-of-Service, Family Health Plus, and Child Health Plus lines of business.

In calendar years 2004 through 2006, GHI HMO ceded reinsurance to Allianz Life Insurance Company of New York ("Allianz"), an authorized reinsurer, through specific excess-of-loss reinsurance agreements. The contract with Allianz expired December 31, 2006 and reinsurance coverage with that entity was discontinued.

The reinsurance in place during the examination period was as follows:

Year	Reinsurer	Deductible	Excess of Loss	Limit
2004	Allianz	$100,000	90% xs $100,000	$1,000,000
2005	Allianz	$125,000	90% xs $125,000	$1,000,000
2006	Allianz	$125,000	90% xs $125,000	$1,000,000
2007	ACE	$400,000	90% xs $400,000	$1,000,000
2008	ACE	$400,000	90% xs $400,000	$2,000,000

Starting in 2007, the HMO entered into a reinsurance agreement with ACE. During the

examination period, the HMO's deductible increased from $100,000 to $400,000. Coinsurance is the percentage amount covered by the reinsurer after the deductible has been met. Therefore, under the terms of the specific excess-of-loss agreement with ACE, GHI HMO was reimbursed at 90% for claims paid per member, per year (excluding physician and prescription drug service costs) after the deductible was applied. Payments were subject to a $2,000,000 lifetime cap.

An outline of the reinsurance agreement in effect at December 31, 2008, is as follows:

Type of Reinsurance Coverage	Coverage	Cession	Reinsurer
Specific Excess-of-Loss	Commercial HMO	90% excess of $400,000 up to $2,000,000	ACE American Insurance Company, LLC
Specific Excess-of-Loss	Healthy NY	90% excess of $400,000 up to $2,000,000	ACE American Insurance Company, LLC
Specific Excess-of-Loss	FHP HMO	90% excess of $400,000 up to $2,000,000	ACE American Insurance Company, LLC
Specific Excess-of-Loss	Child Health Plus	90% excess of $400,000 up to $2,000,000	ACE American Insurance Company, LLC

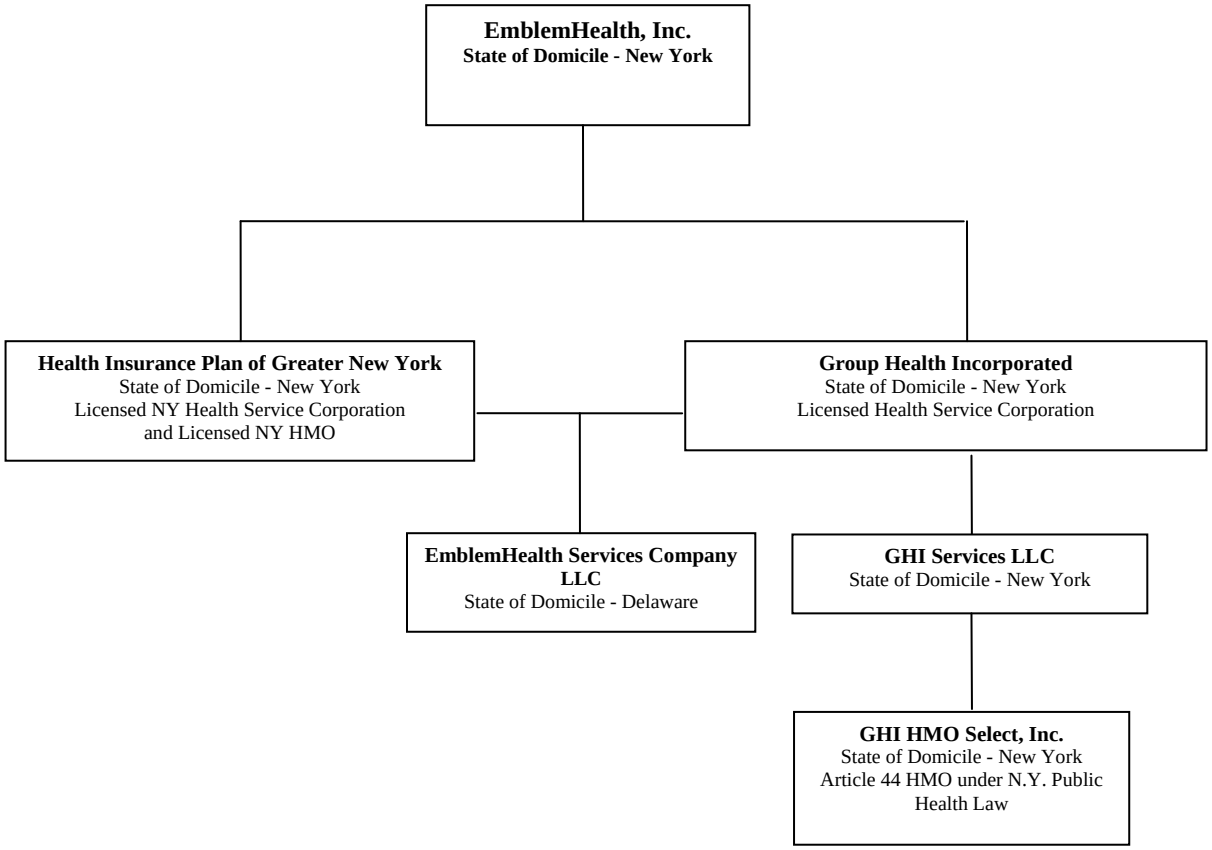
Subsequent to December 31, 2008, a reinsurance contract change was adopted. The new contract with ACE reimburses the HMO for 90% per covered person for claims in excess of the deductible, $400,000, on those claims received prior to October 1, 2009. After October 1, 2009, ACE reimbursed 50% of paid claims in excess of the $400,000 deductible. In addition, the lifetime cap was reduced from $2,000,000 to $1,000,000 per covered member, for all lines of business.

The reinsurance agreements with Allianz and ACE contained the insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

D. Holding Company System

GHI HMO is a controlled HMO under the definitions set forth in Part 98-1.2(l) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.2(l)). The HMO 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. The HMO is a wholly-owned subsidiary of GHI Services, LLC, which in turn is a wholly-owned subsidiary of GHI.

The structure of the holding company as of the examination date is as follows:



The HMO is party to a management services agreement with GHI, approved by the New York State Health Department, that grants access to the use of GHI's management services,

including, but not limited to: hiring, budgeting, marketing, underwriting, fraud detection, and disaster recovery. Emblem Health Services Company, LLC ("EHS") assumed the vendor agreements and employees from GHI HMO in January 2008. In addition, GHI HMO receives management and other services from EHS subject to an Inter-company Administrative Services Agreement, approved by the New York State Health Department and filed with the New York State Insurance Department. Such inter-company agreement states that EHS will provide services to GHI HMO in the areas of: accounting, banking, treasury operations, investment, underwriting, rate and forms filing, claims processing, utilization review, information systems, personnel services, public relations, and provider credentialing.

GHI HMO entered into an Inter-company Tax Allocation Agreement with GHI and GHI Services, LLC that was effective June 1, 1999. At the time of the previous examination, it was noted that the HMO had not obtained formal approval from the Department relative to such agreement. Such agreement was subsequently filed with the Department and was approved by the Department on March 7, 2006.

Part 98-1.10(c) of the Rules and Regulations of the New York State Health Department states, in part:

> "(c)…Thirty days prior notice to the commissioner and…the superintendent, is required before entering into the following transactions between a controlled MCO and any person in its holding company system: a reinsurance agreement or an agreement for rendering services on a regular or systematic basis…"

Department Circular Letter No. 33 (1979) requires that every domestic insurer notify the Department within 30 days of electing to participate in a consolidated tax return, and submit a copy of the tax allocation agreement with such notification.

Department Circular Letter No. 33 (1979) states in part:

> "Pursuant to the provisions of Section 27 of the Insurance Law every domestic insurer is directed to notify this Department within 60 days of this circular letter if it participates in a consolidated tax return and to submit a copy of its tax allocation agreement with such notification. Any domestic insurer which currently does not participate in a consolidated tax return shall file a copy of its tax allocation agreement with this Department within 30 days of electing to do so. Furthermore, notification to this Department should be given within 30 days of any amendment to or termination of a tax allocation agreement…"

It is recommended that the HMO effectuate controls to ensure that all agreements are filed with the Department in accordance with the requirements of Part 98-1.10(c) of the Rules and Regulations of the New York State Health Department and, with regard to tax allocation agreements, in accordance with Department Circular Letter No. 33 (1979).

The HMO reported on its balance sheet, as of December 31, 2008 an amount of $5,350,000 for surplus notes (Section 1307 Loans) received from GHI. Additionally, the HMO appropriately reported aggregate interest of $3,766,368 relative to such loan amount within a footnote to its 2008 balance sheet and within its filed annual statements during the period under review.

E. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the five-year period covered by this examination:

	Amounts	Ratios
Claims	$755,825,390	88.92%
Claim adjustment expenses	28,013,360	3.30%
General administrative expenses	87,875,501	10.34%
Net underwriting loss	(21,703,603)	(2.55)%
Premium Revenue	$850,010,648	100.00%

The following ratios were computed as of December 31, 2008, based upon the financial performance results of the HMO:

Ratio	2008
Net Change in Capital and Surplus	(26.52)%
Liquid Assets & Receivables to Current Liabilities	112.60%
Premium and Risk Revenue to Capital and Surplus	14.1 to 1
Medical Loss Ratio	90.82%
Combined Loss Ratio	107.60%
Administrative Expense Ratio	15.06%
Profit Margin Ratio	(5.80)%

The above ratios fall beyond the benchmark ranges set forth in the Fast Analysis Solvency Tools ("FAST") scoring ratios of the National Association of Insurance Commissioners ("NAIC"). These ratios reflect the underwriting losses of the HMO during the examination period.

F. Investment Activities

The HMO has a written investment policy with specific guidelines as to the quality, maturity and the diversification of investments. The HMO's investments are reviewed and approved quarterly by its Board of Directors.

G. Accounts and Records

The HMO is subject to the terms of an Inter-company Management Services Agreement ("MSA") with GHI, identified as a management services organization ("MSO") within the agreement, dated March 1, 2007. As part of that agreement, GHI provides management services (see Item 2D of this Report) to the HMO in exchange for a fee described in 'Exhibit A' of the agreement. Exhibit A of the MSA reads in part:

> *"…Plan shall pay MSO a fee equal to the costs incurred by MSO in providing the services specified in Section 3 of this Agreement. Fees shall be consistent with the requirements of NAIC SSAP No. 70; fees will be determined based upon actual costs and will not be based upon losses or gains. MSO shall allocate a portion of any of its costs not solely attributable to the Plan, including overhead costs, in accordance with customary industry standards and accounting practices. Without limiting the generality of the foregoing, a portion of the cost of salaries and other benefits payable to the MSO employees who provide services to the Plan shall be allocated to the Plan in accordance with the percentage of such employees' time spent on Plan activities..."*

The HMO accrues the management fee as a payable to GHI, and in turn, uses the accrued amount as an offset to actual expenses within its expense allocation methodology. In addition to this accounting of the management fee, the HMO includes certain other accruals within its allocation methodology; such as: advertising, accrued salaries and benefits, other intangible expenses, and local prepaid taxes.

Paragraphs 8 and 9 of the Statement of Statutory Accounting Principles ("SSAP") No. 70 of the NAIC Accounting Practices and Procedures Manual state in part:

> "(8) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios.
>
> (9) Any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses…"

The HMO uses total direct expenses as the basis to allocate inter-company management fee charges. Under this methodology, the HMO uses these direct expenses to allocate a net credit (reimbursement) relating to the inter-company service agreement. The HMO includes all expenses (including credit balances) in its direct expense allocation methodology. The effect of the HMO's treatment of the "credit balances" in its calculation could reduce the basis with which those expenses are allocated. The impact of the allocated amounts does not rise to the level of a material change in reported amounts. However, the inclusion of the credit balances in the allocation of direct expenses by the HMO is a methodology that may not yield the most accurate result.

It is recommended that the HMO revise its accounting treatment of certain accrued expense items (i.e., credit balances) contained in the reconciliation of items settled under its Inter-company Management Services Agreement, in order to produce more accurate financial statement reporting results.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination to those reported by the HMO in its December 31, 2008 filed annual statement:

	Examination	HMO	Surplus Increase/ (Decrease)
Assets			
Bonds	$ 22,408,425	$ 22,408,425	
Stocks	1,325,230	1,325,230	
Cash, cash equivalents, and short-term investments	3,325,881	3,325,881	
Investment income due and accrued	106,809	106,809	
Uncollected premiums	13,126,766	13,126,766	
Amounts recoverable from reinsurers	180,000	180,000	
Current federal and foreign income tax recoverable and interest thereon	1,363,137	1,363,137	
Net deferred tax asset	163,131	163,131	
Receivables from parent, subsidiaries and affiliates	42,712	42,712	
Health care receivables	2,693,131	2,693,131	
Aggregate write-ins for other than invested assets	6,862,730	6,862,730	
Total assets	$ 51,597,952	$ 51,597,952	

	Examination	HMO	Surplus Increase/ (Decrease)
Liabilities			
Claims unpaid	$ 20,094,357	$ 25,579,618	$ 5,485,261
Accrued medical incentive pool and bonus amounts	122,980	122,980	
Unpaid claims adjustment expenses	945,158	945,158	
Aggregate health policy reserves	3,063,876	3,063,876	
Premiums received in advance	1,847,431	1,847,431	
General expenses due or accrued	3,767,685	3,767,685	
Amounts withheld or retained for the account of others	69,058	69,058	
Amounts due to parent, subsidiaries and affiliates	1,901,089	1,901,089	
Payable for securities	1,025,375	1,025,375	
Aggregate write-ins for other liabilities	409,382	409,382	
Total liabilities	$ 33,246,391	$ 38,731,652	$ 5,485,261
Capital and Surplus			
Common capital stock	$ 10	$ 10	
Gross paid in and contributed surplus	47,640,000	47,640,000	
Surplus notes	5,350,000	5,350,000	
Contingency reserves	15,490,385	15,490,385	
Unassigned funds (surplus)	(50,128,833)	(55,614,094)	$ 5,485,261
Total capital and surplus	$ 18,351,562	$ 12,866,301	$ 5,485,261
Total liabilities, capital and surplus	$ 51,597,953	$ 51,597,953	

Note 1: The Internal Revenue Service did not audit the tax returns filed by the HMO for the period of the examination. The examiner is unaware of any potential exposure of the HMO to any further assessment, and no liability has been established herein relative to such contingency.

The November 2006 affiliation between HIPNY and GHI did not change the federal consolidated group of GHI and GHI HMO. As HIPNY is a 501(c)(4) federally tax exempt entity, it is ineligible to be included in a federal consolidated return. Upon the affiliation, the GHI federal consolidated group was not terminated nor did any HIPNY entity become a part of the GHI consolidated group.

Note 2: No liability appears in the balance sheet for loans totaling $5,350,000 and interest accrued thereon in the amount of $3,766,368 as of December 31, 2008. The loans were granted pursuant to Section 1307 of the New York Insurance Law. Repayment of such principal and interest shall only be made out of free and divisible surplus, subject to the prior approval of the Superintendent of Insurance.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased $12,394,683 during the five-year examination period, January 1, 2004 through December 31, 2008, detailed as follows:

Revenue		
Total premium revenue		$ 850,010,648
Expenses		
Hospital/medical benefits	$ 558,932,227	
Other professional services	20,100	
Outside referrals	59,224,104	
Emergency room, out-of-area	24,001,974	
Prescription drugs	100,976,465	
Other hospital and medical	29,625,750	
Increase in reserves for accident and health contracts	3,063,876	
Incentive pool	407,968	
Net reinsurance recoveries	(20,427,074)	
Total hospital and medical expenses	$ 755,825,390	
Claims adjustment expenses	28,013,360	
General administrative expenses	87,875,501	
Total underwriting deductions		871,714,251
Net underwriting loss		$ (21,703,603)
Net investment gain		4,786,363
Net income before federal income taxes		$ (16,917,240)
Federal income taxes incurred		(3,566,675)
Net loss		$ (13,350,565)

Change in Capital and Surplus

Capital and surplus, per prior report on examination, as of December 31, 2003			$ 5,956,879
	Gains in Surplus	Losses in Surplus	
Net loss		$ 13,350,565	
Change in net deferred tax assets	$ 19,096,482		
Changes in non-admitted assets		19,776,234	
Surplus paid-in	26,425,000		
Net increase in surplus			$ 12,394,683
Capital and surplus, per report on examination, as of December 31, 2008			$ 18,351,562

4. CLAIMS UNPAID

The examination liability of $20,094,357 for the above captioned account is $5,485,261 less than the $25,579,618 reported by the HMO as of December 31, 2008.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements as verified by the examiner. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2008.

5. MARKET CONDUCT ACTIVITIES

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

The general review was directed at practices of the HMO in the following major areas:

A. Prompt Pay Law
B. Claims processing
C. Complaints, grievances and appeals

The major findings of this review are noted below.

A. Prompt Pay Law

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

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

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

> "…(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

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 un-disputed claims are not paid within forty-five days of receipt, interest may be payable.

In June 2006, GHI HMO entered into a negotiation with Health Quest's network, a consortium of hospitals and allied service providers located in the Hudson Valley, that involved three separate written agreements addressing the terms of the settlement and concluded with a claims settlement agreement with final terms in January 2008. The terms of the agreements related to disputed claims payments to the hospitals of the Health Quest network made by GHI HMO between September 2006 and September 2008.

GHI HMO noted that Health Quest's claims, "*were adjusted after the release of a lump sum payment amount of $809,825 to reflect a pro rata share of the full settlement amount and no interest (per the requirements of Section 3224-a(c) of the NYIL) was applied to the claim record*

as the full amount of settlement was applied to each of the respective paid lines on the claim." The absence of the paid interest sum or dates upon which interest could be substantiated were not recorded in the system and the Department was unable to determine compliance with Section 3224-a of the New York Insurance Law.

It was noted that the HMO did not retain sufficient information to report all relevant claims payment data, including claims associated with settlements and interest payments.

Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2(b)(4)) states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received."

Further, Part 216.11 of Department Regulation No. 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 a 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 the HMO take the necessary steps to capture all relevant claim payment data, including prompt payment interest, in its claims system to demonstrate compliance with the requirements of Section 3224-a of the New York Insurance Law.

It is also recommended that the HMO comply with Part 243.2(b)(4) of Department Regulation No. 152 by retaining all documentation necessary to verify its compliance with Section 3224-a 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 further recommended that HMO comply with the requirements of Part 216.11 of Department Regulation No. 64 by retaining all aspects of its claims information that will enable the HMO to report all relevant claims payment data, including settlements.

B. Claims Processing

Section 4325(b) of the New York Insurance Law states:

> "(b) No corporation organized under this article shall by contract, written policy or written procedure prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such corporation which the provider believes may negatively impact upon the quality of or access to patient care."

Section 4406-c(3) of the New York Public Health Law states:

> "(3) No health care plan shall by contract, written policy or written procedure prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such health care plan which the provider believes may negatively impact upon the quality of, or access to, patient care."

As previously mentioned, claims settlements were negotiated between GHI HMO and Health Quest's network of providers. These negotiations resulted in written agreements that defined the terms for claims settlements. Within the January 2008 claims settlement agreement, one clause included a section that would preclude Health Quest from filing any complaints with the New York State Insurance Department. Further, the clause requires, Health Quest to *"formally request DOI to permit the withdrawal of any and all written complaints that may have been previously filed with DOI arising out of or relating to the settled claims."*

The claims settlement agreement further provided, in pertinent part:

> *"…Health Quest will refrain from filing written and/or verbal complaints, if any, with the New York State Department of Insurance (DOI) or any other regulatory body arising out of or relating to the Settled Claims and shall formally request DOI to permit the withdrawal of any and all written complaints that may have been previously filed with DOI arising out of or relating to the settled claims. With respect to all other claims covered under this Agreement, Health Quest shall refrain from filing written and/or verbal complaints, if any, with the DOI or any other regulatory body arising out of or relating to such claims, provided GHI has complied with the obligations with respect to such claims under this Agreement..."*

The Department takes the position that the provision stated above, as utilized by GHI HMO in its claims settlement agreement with Health Quest, violates Section 4325(b) of the New York Insurance Law, and as utilized by GHI HMO, the provision also violates New York Public Health Law Section 4406-c(3).

Finally, such a provision is against public policy as it seeks to inhibit enforcement of New York Insurance Law Section 3224-a, as cited in the Prompt Pay Law section of this Report.

It is recommended that GHI HMO refrain from including any wording within its provider settlement agreements that may violate Section 4325(b) of the New York Insurance Law and/or

Section 4406-c(3) of the New York Public Health Law, and refrain from phrases that (attempt to) preempt, prohibit or restrict any health care provider from filing a complaint, filing a report to, or commenting to an appropriate governmental body regarding the policies or practices of the HMO.

C. Complaints, Grievances and Appeals

A review of the complaints, grievances and appeals filed with the HMO for the period January 1, 2008 through December 31, 2008 was performed by the examiner to ascertain compliance with Section 4408-a ("Grievance Procedure") of the New York Public Health Law.

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

> "14. An organization shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the enrollee's acknowledgment of the grievance, if any; the determination made by the organization including the date of the determination and the titles and, in the case of a clinical determination, the credentials of the organization's personnel who reviewed the grievance…"

The examiner selected a sample of 25 each of complaints, grievances, and appeals. Each file was reviewed for pertinent documentation and its compliance with applicable statutory rules and regulations. Upon the review of the sampled complaint files, it was determined that some of the "executive-level" complaints should have been processed as grievances, instead of as complaints. These "executive-level" complaints were actually grievances submitted by a GHI HMO subscriber, referred to a GHI HMO executive, and handled internally at the HMO as a complaint. While limited instances occurred from our sample, a review of these complaint files

raised concerns about denial of benefits for authorized services, which fall under Section 4408-a of the New York Public Health Law.

Grievances submitted by subscribers, when in fact handled as complaints, limits the protections available to the subscriber under Section 4408 of the New York Public Health Law.

In the sample selected, the examiner identified files processed as "executive-level" complaints from Magellan Behavioral Health, a third-party vendor for mental health claims and benefit administration. GHI HMO reviewed the files and concurred that these cases should have been categorized as grievances rather than as "executive-level" complaints.

It is recommended that GHI HMO ensure that its third-party vendors comply with the requirements of Section 4408-a(14) of the New York Public Health Law relative to the identification, classification and processing of complaints and grievances.

It is also recommended that GHI HMO review the procedures for classifying member inquiries as "executive-level" complaints, and where necessary, make corrections to ensure that proper classification and availability of statutory allowances of complaints and grievances are made.

The HMO indicated that it has implemented a corrective action plan, whereby the issue, designating member grievances as executive-level complaints, was addressed with the vendor,

Magellan Behavioral Health, and as part of regular meetings and annual oversight audits, GHI HMO will continue to monitor the grievance and complaint review processes.

6. SUBSEQUENT EVENTS

As of March 31, 2009, subsequent to the examination date, GHI HMO reported itself insolvent. The Department met with key officers of GHI, the Parent of GHI HMO, and GHI HMO officers to discuss the poor financial condition of GHI HMO. These officers explained that the insolvency was mainly due to the poor underwriting results for the state-sponsored government programs and as a result, the HMO needed to establish a large premium deficiency reserve ("PDR").

In order to cure the HMO's insolvency, on March 27, 2009, GHI contributed $7 million to GHI HMO, allowing the HMO to meet its minimum capital and surplus requirements. Subsequently, on June 30, 2009, GHI funded GHI HMO, via a capital contribution, an additional $10 million. Thus, during the first six months of 2009, GHI made total capital contributions to GHI HMO of $17 million. However, the HMO reported an impairment of $(3,715,121) as of June 30, 2009. In 2009, GHI HMO discontinued its participation in a New York State sponsored Medicaid program which resulted in a significant reduction of the premium deficiency reserves reported for Medicaid products as of December 31, 2009.

The HMO reported approximately $26.5 million capital and surplus at December 31, 2010, down approximately $3.1 million from $29.8 million reported at December 31, 2009. Such $26.5 million capital and surplus as of December 31, 2010 was in excess of the HMO's required contingent reserve $4,724,129.

The Department approved a merger of the GHI HMO and Connecticare of New York, Inc., on January 26, 2011. As a result of such merger, the capital and surplus of GHI HMO was increased by $6,693,945.

As of June 30, 2011, the HMO reported capital and surplus in the amount of $38,094,030. Such amount was in excess of the HMO's required contingent reserve $4,724,129.

During 2009, Emblem proposed to merge GHI HMO into GHI and concurrently transfer GHI HMO members to HIP-HMO via an asset purchase agreement. HIP-HMO is a non-profit HMO line of business of the Health Insurance Plan of Greater New York, an affiliated Article 43 corporation. This proposed merger has been held in abeyance, at Emblem's request.

On December 1, 2009, the HMO began to withdraw from participation in state sponsored programs in certain New York counties where the HMO was losing money; this resulted in a decline in enrollment of approximately 21,000 members as of December 31, 2009. In addition, the HMO withdrew participation from other unprofitable New York counties effective January 1, 2010 and April 1, 2010.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination of the HMO, as of December 31, 2003, contained the following nineteen (19) recommendations (page numbers refer to the prior report on examination:

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that the annual shareholder's meeting be held within the required five month period, or that a quorum of the HMO's board prepare a written resolution agreeing to waive the meeting (the by-laws of the HMO would need to be amended to explicitly allow for this waiver) or modify the by-laws to change the timeframe within which to hold the meeting.	5
	The HMO has complied with this recommendation.	
2.	It is recommended that business transactions directly or indirectly involving board members and the HMO, particularly where a potential conflict of interest is noted on a filed questionnaire, should be discussed with and approved by the HMO's board or appropriate committee.	7
	The HMO has complied with this recommendation.	
	Reinsurance	
3.	It is recommended that the HMO amend its reinsurance agreement to include proper Continuity of Benefits and Conversion Coverage provisions.	9
	The HMO has complied with this recommendation.	
4.	It is further recommended that the Plan amend the Out-of-Area Conversion Coverage provision to allow for 31 days to purchase conversion contracts.	10
	The HMO has complied with this recommendation.	

ITEM NO. **PAGE NO.**

Holding Company System

5. It is recommended that the HMO comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(c)) and submit its Administrative Services Agreement to the Commissioner of Health and the Superintendent of Insurance for review and approval. 14

The HMO has complied with this recommendation.

6. Although the Tax Allocation Agreement meets Department guidelines, it is recommended that the Agreement be formally re-submitted to this Department and the Department of Health for review, and that a formal approval be obtained from each Department. 15

The HMO has complied with this recommendation.

Investment Activities

7. It is recommended that the Plan comply with Sections 1404 and 1409(a) of the New York Insurance Law and not have investments in securities of any one institution in excess of ten percent of its admitted assets. 18

The HMO has complied with this recommendation.

Accounts and Records

8. It is recommended that the Plan not enter into any barter or similar arrangements and that it complies with all applicable accounting principles and statutes when booking its premium accounts. 20

The HMO has complied with this recommendation.

9. It is recommended that the inter-company accounts be settled in a timely manner, in accordance with the terms set forth in the underlying agreement(s). 21

The HMO has complied with this recommendation.

ITEM NO.		PAGE NO.
	Claims Processing	
10.	It is recommended that the HMO take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider providing retraining to individuals who process claims.	28
	The HMO has complied with this recommendation.	
	Prompt Pay	
11.	It is recommended that the HMO create procedures to ensure that outstanding claims in its claims system be paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law.	33
	The HMO has complied with this recommendation.	
12.	It is also recommended that the HMO implement the necessary procedures and training in order to ensure compliance with Section 3224-a(a) of the New York Insurance Law.	33
	The HMO has complied with this recommendation.	
13.	It is also recommended that the HMO implement the necessary procedures to ensure compliance within Section 3224-a(b) of the New York Insurance Law and send out requisite notification within 30 days where applicable.	33
	The HMO has complied with this recommendation.	
14.	It is further recommended that the HMO comply with Section 3224-a(c) of the New York Insurance Law and calculate interest due on all claims paid after 45 days of receipt.	33
	The HMO has complied with this recommendation.	

ITEM NO. **PAGE NO.**

Explanation of Benefits Statements ("EOBs")

15. It is recommended that the HMO comply with Section 3234(c) of the New York Insurance Law and send an EOB to its subscribers where the services are rendered by an out-of-network provider, regardless of whether the services are fully paid or not. 35

The HMO has complied with this recommendation.

16. It is also recommended that the HMO comply with Section 3234(c) of the New York Insurance Law and send an EOB to the subscriber whenever a claim is denied or modified. 35

This matter regarding the issuance of EOBs was raised in the prior report on examination. At that time the Department and the Plan agreed that no action be taken on this matter pending issuance of industry-wide guidance. The Department issued Circular Letter No. 7 (2005) regarding Explanation of Benefits (EOB) Requirements on March 24, 2005. After reviewing this Circular Letter, GHI HMO established a task force to implement changes to its EOB statements.

The HMO has complied with this recommendation.

Reimbursement of Out-of-Network Claims (Fee Schedule)

17. The fee schedules utilized by the Plan are updated by HIAA (now known as Ingenix) twice a year to reflect updated charges; once to reflect primary updates and a subsequent one to reflect secondary changes. The Plan, however, only updates its systems once per year (primary update). 36

The HMO has complied with this recommendation.

Advertising

18. It is recommended that the HMO comply with Section 13(a) of Department Regulation 34 (11 NYCRR 215.13) and clearly distinguish the identity of the company providing the health care coverage. 37

The HMO has complied with this recommendation.

ITEM NO.		PAGE NO.
19.	It is recommended that the HMO establish its own web-site or that there be a way to identify itself as a separate entity from its parent company in all advertising. *The HMO has complied with this recommendation.*	37

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. **30343**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Andre Blackman

as a proper person to examine into the affairs of the

GHI HMO Select, 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 12th day of August, 2009

Kermitt J. Brooks
Acting Superintendent of Insurance