

REPORT ON EXAMINATION

OF

HORIZON HEALTHCARE INSURANCE COMPANY OF NEW YORK

AS OF

JUNE 30, 2002

DATE OF REPORT

MAY 14, 2003

EXAMINER

ARCELIO VEGA

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

March 31, 2003

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Number 21869, dated May 15th, 2002, and annexed hereto, I have made an examination into the condition and affairs of Horizon Healthcare Insurance Company of New York, a for-profit accident and health insurance company licensed under the provisions of Article 42 of the New York Insurance Law, at its home office located at 1180 Avenue of the Americas, New York, New York 10036. The following report, as respectfully submitted, deals with the findings concerning the manner in which Horizon Healthcare Insurance Company of New York conducts its financial business transactions and fulfills its contractual obligations to policyholders and claimants.

Wherever the terms "Company" or "HHICNY", appear herein, without qualification, they should be understood to refer to Horizon Healthcare Insurance Company of New York.

Wherever the terms "BCBSNJ" appear herein, without qualification, they should be understood to refer to Horizon Blue Cross Blue Shield of New Jersey.

1. SCOPE OF EXAMINATION

This is the first examination of the Company. The examination covers the period February 1, 1999 to June 30, 2002. Where deemed appropriate, transactions subsequent to this period were also reviewed.

The examination comprised a complete verification of assets and liabilities as of June 30, 2002, in accordance with Statutory Accounting Principles, as adopted by the Department, and a review of income and disbursements deemed necessary to accomplish such verification. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

- History of the Company
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of Plan
- Business in force
- Claims experience
- Reinsurance
- Accounts and records
- Financial statements
- Treatment of policyholders and claimants

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

2. **EXECUTIVE SUMMARY**

The examination revealed some operational deficiencies that directly impacted the Company's compliance with the New York Insurance Law ("NYIL"). The most significant findings of this examination include the following:

- Examination findings disclosed that during the examination period, HHICNY's board of directors minutes and other documentation inadequacies gave the appearance that the Board lacked proper control over the Company's activities;
- Substantial error rates on adjudicated claims resulting from various processing deficiencies;
- Violations of Section 1505(b) of the NYIL relative to transactions with its ultimate Parent, Horizon Blue Cross Blue Shield of New Jersey ("BCBSNJ");
- Violations of Section 1712 of the NYIL relative to transactions with its immediate Parent, Horizon Healthcare of New York, Inc. (HHNY);
- Violations of Section 3224-a relative to the prompt payment of claims;
- Explanation of benefits statement do not include proper appeals language in violation of Section 3234(b) of the NYIL;

3. **DESCRIPTION OF COMPANY**

Horizon Healthcare Insurance Company of New York was originally incorporated under New York State Law on January 6, 1998, under the name of Medigroup Insurance Company (NY), a for-profit corporation licensed pursuant to Article 42 of the New York Insurance Law. On August 16, 1998, the Articles of Incorporation was amended to change the name of the corporation from Medigroup Insurance Company (NY) to Horizon Healthcare Insurance Company of New York. The Company commenced business on February 22, 1999. According to the Articles of Incorporation, the number of shares issued and outstanding shall be one hundred, having a par value of two thousand dollars (\$2,000) each for a total common capital stock of two hundred thousand dollars (\$200,000). Ownership of the Company is divided

between Horizon Healthcare Holding Corp. (formerly known as Medigroup Holding Company, Inc.) and Horizon Healthcare of New York, Inc., (“HHNY”) a domestic health maintenance organization, each of which own fifty shares of common stock purchased at \$150,000 for an initial total capital of \$300,000 (\$200,000 capital and \$100,000 paid in and contributed to surplus). Both entities are in turn owned by the ultimate parent, Horizon Blue Cross Blue Shield of New Jersey. HHICNY was established to transact and carry out the business of accident and health insurance, as defined in Section 1113(a)(3)(i) of the New York Insurance Law.

A. **Management**

Pursuant to the Company's charter and by-laws, management of the Company is vested in and exercised by its Board of Directors. The number of directors shall be no less than thirteen nor more than nineteen, of which no less than three shall be New York residents.

At June 30, 2002, the Board of Directors consisted of the following thirteen members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
William J. Marino Morris Plain, NJ	President and Chief Executive Officer Horizon Blue Cross Blue Shield of New Jersey
Christy W. Bell Chester, NJ	Senior Vice-President Horizon Blue Cross Blue Shield of New Jersey
Thomas G. Boyajy New York, NY	President and Chief Operating Officer Horizon Healthcare Insurance Company of New York
Charles R. Dees, Jr., PhD Englewood, NJ	Vice-President for Development & Public Relations The Jackie Robinson Foundation
Stephen J. Fischl, MD Summit, NJ	President Vista Health System LLC

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Vincent J. Giblin Spring Lake, NJ	Business Manager International Union of Operating Engineers, Local 68 – AFL-CIO
Kurt Giesler, Esq. New York, NY	Assistant General Counsel Horizon Blue Cross Blue Shield of New Jersey
Robert A. Marino West Caldwell, NJ	Senior Vice President Horizon Blue Cross Blue Shield of New Jersey
Michael R. McGarvey, MD New York, NY	Retired
Robert J. Pures Rivervale, NJ	Senior Vice-President Horizon Blue Cross Blue Shield of New Jersey
Jerrold Shenkman, Esq. Scarsdale, NY	Assistant General Counsel Horizon Blue Cross Blue Shield of New Jersey
James A. Skidmore, Jr. Berkeley Heights, NJ	Chairman, President and Chief Executive Officer Science Management Corp.
Peter G. Stewart, Esq. Caldwell, NJ	Partner Carella, Byrne, Bain, Gilfillan, Cechi, Stewart & Olstein of Roseland, NJ

The principal officers of the Company as of June 30, 2002 were as follows:

<u>Name</u>	<u>Title</u>
Thomas G. Boyajy	President and Chief Operating Officer
Robert A. Marino	Chief Executive Officer
Robert E. Meehan	Vice-President
Christine L. Nelson	Deputy Secretary
William J. Frantel	Treasurer

During the period under examination, the Board of Directors met twenty times.

Article 2, Section 2.07 of the bylaws states:

"The Board of Directors shall, approximately one month prior to the annual meeting of the shareholders, appoint a Nominating Committee of no fewer than three (3) Directors which shall file in writing with the Secretary of the Corporation a list of nominees for election by the shareholders as Directors of the Corporation to fill expiring terms."

During the period under examination, various individuals were elected to the board. The examiners requested the minutes of the board of directors and any committee thereof. The Company was unable to provide the nominating committee minutes.

It is recommended that the Board of Directors appoint a nominating committee prior to the annual shareholder's meeting in compliance with Article 2, Section 2.07 of the Company's bylaws.

Since commencing business, the Company has been sustaining net losses from operations and receiving an influx of capital contributions in order to maintain adequate capital and surplus. However, during the examination period, only limited financial discussions were documented in the minutes of the Board meetings. The minutes of the board do not reflect any discussions concerning the issues of losses or surplus contributions.

It is recommended that the Company's Board of Directors' underwriting and surplus discussions be documented.

The Company entered into various management services agreements with BCBSNJ, Horizon Healthcare of New York, Inc. ("HHNY"), and Horizon Healthcare Dental Services, Inc. A Tax Allocation Agreement was entered into with BCBSNJ, HHNY, and Horizon Healthcare

Holding Company, Inc. Only the management agreement with BCBSNJ dated the 1st day of November, 1998 was mentioned in the minutes. The Board of Directors' minutes do not reflect that the Tax Allocation Agreement, nor any of the other agreements, were approved by the Board (See Section 2D Holding Company herein for further detail on the service agreements).

It is recommended that all agreements within the holding company system be approved by the Board of Directors prior to implementation.

Section 1411(a) of the New York Insurance Law states:

“No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting.”

A review of the minutes of board of directors meetings disclosed that the minutes were silent regarding investments. The Company has delegated this responsibility to its ultimate parent BCBSNJ. (See Section 2D Holding Company herein for further detail on the investment activities).

It is recommended that the Company's investments be approved by its board of directors or a committee thereof in compliance with Section 1411(a) of the New York Insurance Law. It is also recommended that HHICNY's board of directors create and implement company specific policies and procedures that will enable it to approve the sales and purchases of its investments.

B. Territory and Plan of Operation

Horizon Healthcare Insurance Company of New York is licensed as a monoline accident and health insurer pursuant to Article 42 of the New York Insurance Law. Accordingly it is authorized to write the kind of business set forth in Section 1113(a)(3) of the Insurance Law. The Company currently limits its business written to the counties of New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, and Orange.

During the period February 1, 1999 through June 30, 2002, the Company experienced a net increase in policyholders. An analysis of the increase in enrollment is set forth below:

	1999	2000	2001	2002*
Enrollment, January 1	-0-	13,102	26,282	57,301
Net Gain/(Loss)	13,102	13,180	31,019	(2,436)
Enrollment, December 31*	13,102	26,282	57,301	54,865

*Enrollment for 2002 is through June 30th only.

During 2001 the increases in policies were attributed primarily to two large Association groups, ABLE and IRBA.

The Company terminated ABLE and IRBA membership in the second and third quarters of 2002. These terminations were not completely offset by gains in membership from other sources.

C. **Reinsurance**

At June 30, 2002, the Company had an excess of loss reinsurance program in effect with an authorized reinsurer for its accident and health business. The policy provided is a renewal policy covering the period of January 1, 2002 through December 31, 2002. The agreement is automatically renewed unless either party gives the other at least sixty (60) days notice of its intention not to renew. The reinsurance coverage in effect is as follows:

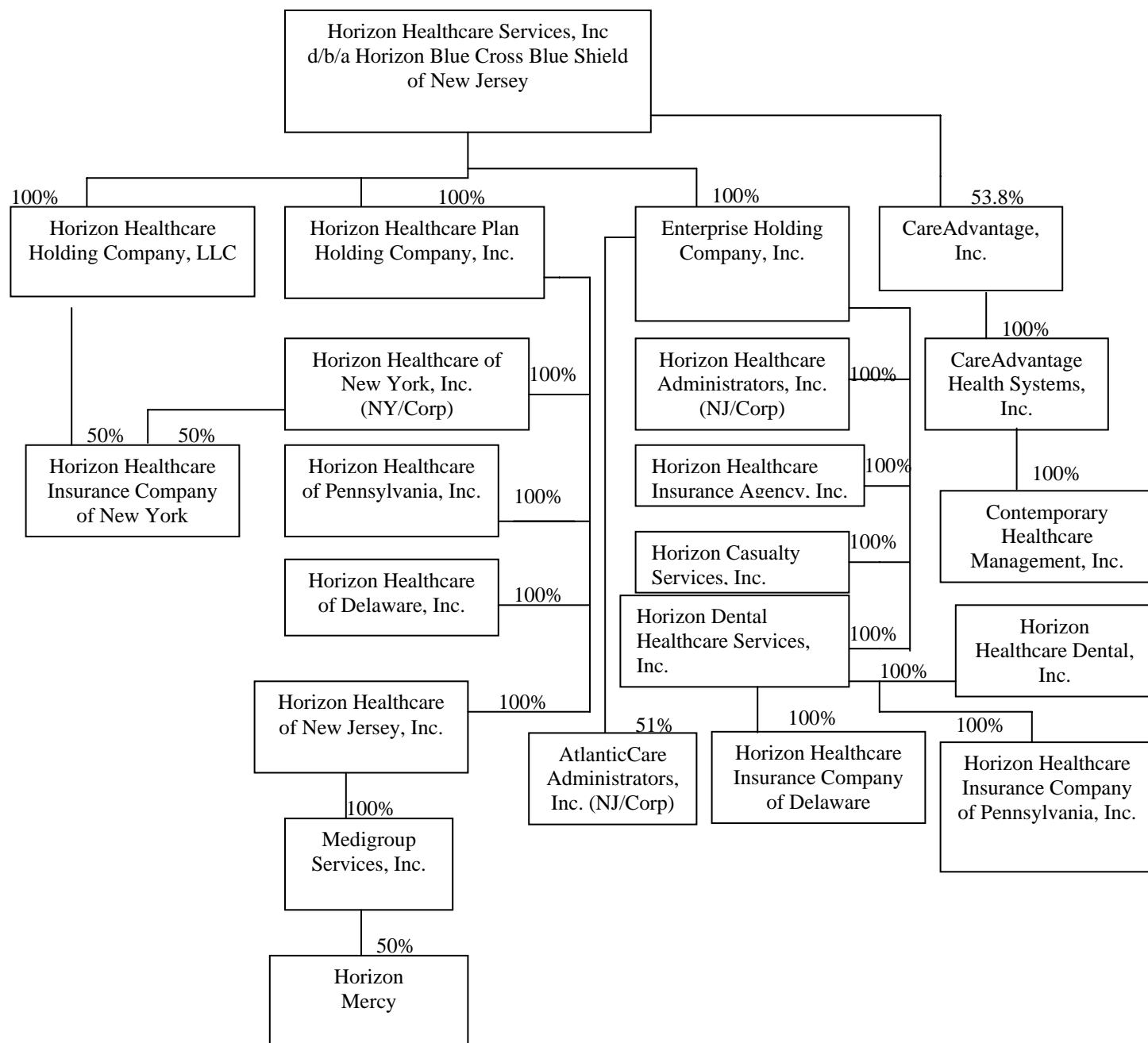
Benefit Plans Covered:	PPO, Vista Plus, EPO, Vista
Excess of Loss Retention:	\$300,000 per covered member per reinsurance period
Reinsurers Maximum Liability:	\$1,700,000 per covered member per reinsurance period
Reinsurer's Excess of Loss Claims	Claims incurred during the reinsurance period and paid during the reinsurance period or the twelve month period immediately following the end of the reinsurance period.
Accumulation Basis:	

The reinsurance agreement contains the standard clauses required by Section 1308(a) of the New York Insurance Law.

D. **Holding Company System**

Horizon Healthcare Insurance Company of New York, was incorporated on January 6, 1998 under the name of Medigroup Insurance Company. It commenced doing business on February 22, 1999. The Company is 50% owned by Horizon Healthcare Holding Company, LLC. ("HHHC") and 50% by Horizon Healthcare of New York, Inc. ("HHNY"). HHHC and HHNY are both wholly owned by the ultimate parent, Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey.

The following represents the Holding Company System as reported in Schedule Y of the Company's filed June 30, 2002 Quarterly Statement:



As a member of a holding company system, HHICNY is required to file registration statements pursuant to the requirements of Article 15 of the New York Insurance Law and Department Regulation 52 (11NYCRR 80). All pertinent filings made regarding the aforementioned statutes were reviewed, and no problem areas were encountered.

i. **Horizon Blue Cross Blue Shield of New Jersey**

On November 1, 1998, HHICNY entered into a management agreement, approved by the Department, with Horizon Blue Cross and Blue Shield of New Jersey ("Ultimate Parent"), where BCBSNJ performs certain administrative services. The services include executive and other general and administrative support; all actuarial functions; all rating and underwriting functions, preparations and issuance of all benefit contracts; development and implementation of mechanical and manual systems and procedures for the day-to-day operational requirements; provider network services; all accounting activities and other services usual to an accident and health company.

Under the section of "Payments to BCBSNJ" for services provided, the agreement states that on or about the 15th of each month BCBSNJ will submit to HHICNY an invoice for administrative services provided during the preceding month. HHICNY will pay BCBSNJ for amounts charged within fifteen (15) days of its receipt of the related invoice. The agreement was approved by the Department. The terms of the agreement as applies to payments for services rendered in the previous months are not followed by the parties involved. The Company states that in cases such as payroll, the process is to determine the annual amount at the beginning of the year and charge the appropriate companies via a journal entry each month, but HHICNY does not have a formal agreement. Subsequent to the examination period, HHICNY provided a detailed schedule of the budgeted amounts for various categories to be allocated in 2002. Advertising and general expenses are not included in the schedule. Also, due to the late receipt of the schedule, the examiner was not able to test if the rate allocated was applied to the various

categories. BCBSNJ offsets premiums received against expenses paid for each monthly period. The net amount is posted to the intercompany account “Amounts due to parent, subsidiaries and affiliates” (“Due to/Due from”), which increases or decreases the Due to/Due from account (see also the allocation write-up below). This liability account has been increasing annually from 1999, the year HHICNY commenced writing an insurance business to June 30, 2002, the date of determination. The intercompany account balances for the period under examination as reported in the applicable filed statements for calendar years 1999, 2000, 2001, and June 30, 2002 are: \$1,178,305, \$5,218,989, 6,294,371, and \$6,371,017 respectively. The Due to/Due from account was never settled in accordance with the terms of the agreement during the examination period.

It is recommended that the Company and BCBSNJ follow the terms of the contract approved by the Department.

Section 1505(d) of the New York Insurance Law states:

“The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period: (1) sales, purchases, exchanges, loans or extensions of credit, or investments, involving more than one-half of one percent but less than five percent of the insurer’s admitted assets at last year-end; (2) reinsurance treaties or agreements; (3) rendering of services on a regular or systematic basis; or (4) any material transaction, specified by regulation, which the superintendent determines may adversely affect the interests of the insurer’s policyholders or shareholders. Nothing herein contained shall be deemed to authorize or permit any transaction which, in the case of a non-controlled insurer, would be otherwise contrary to law.”

Under the caption of “General Provisions“, Item 9 “Term and Termination” states:

“The term of this agreement shall commence on the Effective Date and continue thereafter until the third anniversary of the Effective Date, unless (i) extended by mutual consent of the parties, subject to approval by the New York State Department of Insurance, or (ii) earlier terminated by

mutual consent of the parties or by either party with or without cause, upon sixty (60) days written notice to the other party...” The third anniversary of the effective date was October 31, 2001. No extension or renewal of this agreement, or any replacement was provided to the examiner.

Both companies continued to operate as though the original agreement was still in effect. It appears that as of November 1st, 2001 BCBSNJ has been performing services and HHICNY has been paying for such services without the benefit of the formalized written agreement having been extended or renewed.

It is recommended that HHICNY and BCBSNJ maintain appropriate written agreements to formalize the services to be provided along with terms, conditions and the duties, of each company, and submit them to the Department pursuant to Section 1505(d).

ii. **Tax Allocation Agreement**

Effective November 1, 1998, BCBSNJ entered into a tax allocation agreement ("Agreement") with various of its subsidiaries, including HHICNY. The Agreement requires that in the years that the company is not profitable, the consolidated federal income tax benefit be transferred back to the Company equal to the value received by BCBSNJ from its consolidated federal income tax filing.

The guidelines in Circular Letter 33 (1979) state in part:

“...Income taxes paid based on consolidated tax returns and intercorporate income tax allocations are transactions between related parties and as such the agreement must be fair and equitable and recognize the separate operating identity of the domestic insurer...”

Also, Items 1 and 5 in Circular Letter 33 (1979) state:

“1. Every domestic insurer which is a party to a consolidated federal income tax filing must have a definitive written agreement, approved by its Board of Directors, governing its participation therein...”

“5...All settlements shall be in cash or securities eligible as investments for such domestic insurer, at market value...”

Item 5 above is also reproduced in the Tax Allocation Agreement that was signed by all parties involved.

BCBSNJ and the Company rely on journal entries to record the tax benefits to the “Payable to parent, subsidiaries and affiliates” account. This account maintains a running balance that has not been settled since the inception of the Company.

The Agreement also provides that all settlements shall be made no later than thirty (30) days after the filing of the applicable estimated or actual Consolidated Federal Income Tax return with the IRS.

As disclosed under the caption of "Management", the Board of Directors' meeting minutes do not reflect that the Board approved the Tax Allocation Agreement. The Agreement was approved by the Department, but its terms are not being followed by BCBSNJ and HHICNY.

Federal income tax recoverable-Parent (“FIT recoverable”) is written off the books at different, inconsistent intervals: FIT recoverable for calendar years 2000 and 2001 should have

been removed from the books by September 30th of the following year. Both were only removed through journal entries in March 2002. An additional \$1,800,000 FIT recoverable for calendar year 2001 appears to have been recorded in September 2002 and removed in the same month. The above statements illustrate that the Ultimate Parent's accounting treatment that HHICNY's transactions receive, appear to be similar to the accounting treatment of a separate department or line of business.

It is recommended that the Company settle its Federal income tax recoverable account in cash or securities eligible as investments as required by the Tax Allocation Agreement and Circular Letter 33 (1979). It is also recommended that the Company follow the terms of the Tax Allocation Agreement and settle the Federal income tax recoverable within the 30 day term specified in the agreement.

iii. **Horizon Healthcare of New York, Inc.**

Section 1505(d)(3) of the New York Insurance Law states:

Section 1505(d): "...The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period..."

Subsection (3): "...rendering of services on a regular or systematic basis..."

Horizon Healthcare of New York, Inc. ("HHNY") is a fifty percent (50%) owner of HHICNY. The Notes to Financial Statement states that the majority of the administrative support for HHICNY is provided by HHNY. HHNY charged HHICNY \$4,233,586 in 1999, \$6,228,819 in 2000, and \$12,412,923 in 2001 for management services provided at cost. To provide the administrative support, HHNY allocated the services of the following number of employees during the period under examination:

<u>Year</u>	<u>Number of Employees</u>
1999	24
2000	36
2001	49

On January 1, 2002 all employees of the HHNY were transferred from the HMO to HHICNY. Since that time they have remained HHICNY employees for all purposes, including taxation. HHICNY and HHNY feed a payroll master account operated by BCBSNJ. As a result paychecks are on BCBSNJ check stock but are funded 100% by the assets of the NY companies. Separately, employees of BCBSNJ also perform services for HHICNY and HHNY companies as outlined in the service agreements between the companies.

The examiners requested the services agreement between HHICNY and HHNY for the period of January 1999 through June 30, 2002. The Company was unable to provide an agreement for the period under examination. Also, as stated above under “Allocation of Expenses” there is no formal method to allocate the intercompany expenses and certain invoices do not identify the Company to be billed. Additionally, accruals are on BCBSNJ letterhead, which in turn assigns the expenses to the New York companies.

iv. **Horizon Healthcare Dental Services, Inc.**

HHICNY entered into a management services agreement with Horizon Healthcare Dental Services, Inc. (“HHDS”) where HHDS provides certain services with respect to dental products offered and sold by HHICNY. The services began in calendar year 2000, however, the agreement was signed on July 16th 2002, and approved by the Department in July 2002. HHDS charged HHICNY \$100,888 and \$252,013 for calendar years 2000 and 2001 respectively.

It is recommended that the Company submit to the Department, for approval, all holding company service agreements prior to entering into transactions as required by Section 1505(d)(3) of the New York Insurance Law.

v. **Investments**

BCBSNJ makes investments with the Company's assets, but no formal investment agreement, between the two entities, delineating the Company's investment policy was provided to the examiners. The management services agreement that expired on October 31, 2001, contained a general provision that made reference to portfolio management, but investment guidelines were not delineated. HHICNY's filed June 30, 2002 Quarterly Statement reflects a Bond asset in the amount of \$40,991,646. A "Domestic Custody Agreement" from The Chase Manhattan Bank was provided to the examiners signed by Mr. William Frantel, Treasurer, on July 9, 1999. The agreement does not specify that it is between the bank and HHICNY. Mr. Frantel is the Treasurer for Horizon Healthcare of New York, Inc., Horizon Healthcare Insurance Company of New York, Horizon Healthcare of New Jersey, Inc., Horizon Healthcare Insurance Company of Pennsylvania, Inc., and Horizon Healthcare Insurance Company of Delaware.

It is recommended that the Company provide more detail in the management services agreement for portfolio management including investment guidelines.

vi. **Cash Accounts**

The minutes of the February 10, 1998 board of directors meeting of Medigroup Insurance Company of New York, Inc. (subsequently known as Horizon Healthcare Insurance Company of

New York), includes a resolution of the board of directors. Page 2, paragraph 6 of the resolution states:

"BE IT FURTHER RESOLVED that the proper officers of the Corporation be, and the same here are, authorized to open and maintain such checking accounts in the name of the Corporation at such banks as are deemed necessary or appropriate to the ordinary operation of the Corporation's business..."

The Company decided that it would not open any operating cash accounts. All premium received on behalf of HHICNY is deposited into a checking account titled solely to BCBSNJ. BCBSNJ invests all monies received and pays all expenses for HHICNY. The Company maintains no checking account in its own name. All checks issued by BCBSNJ are laser printed, but do not identify the individual New York Company that is making the payment. The checks contain the name "Horizon Healthcare" and the names of the two New York Companies. In certain cases only BCBSNJ's name appears as the payer.

The Company does not have a cash receipt or a cash disbursement journal, nor does it create its own bank cash reconciliation statements. The intercompany account, payable to parent, subsidiaries and affiliates, was created to reconcile intercompany cash and expenses, but has not been settled since the Company began operations. The receipt and disbursement of HHICNY cash by BCBSNJ plus other balances due to HHICNY is offset against balances owed by HHICNY to BCBSNJ and to other affiliates for services performed. The balance of the account payable to parent, subsidiaries and affiliates is maintained on a running basis and fluctuates from year to year. As of June 30, 2003, the balance of the liability account was \$6,371,017.

Section 1505(d)(3) of the New York Insurance Law states:

Section 1505(d): "...The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period..."

Subsection (3): "...rendering of services on a regular or systematic basis..."

BCBSNJ issues wire transfers from one company (business unit) to another including HHICNY. The Company provided the examiner with a spreadsheet listing the affiliates with wire transfers between them and HHICNY, and those affiliates that transact business with HHICNY. It is noted that two companies that do not have an agreement with HHICNY, Horizon Healthcare Holding Company, LLC ("HHH") (a 50% stockholder of HHICNY) and Horizon Healthcare of New Jersey, Inc. ("HHNJ") are included in the intercompany reconciliation workpaper provided by the Company. At June 30, 2002, the outstanding balance owed by HHICNY to HHNJ was \$53,960 and the amount due to HHICNY from HHH was \$205,064. However, no service agreement between HHNJ and/or HHH, and HHICNY was provided to the examiners for the period under examination or for the current period.

The examiner reviewed various wire transfers dated June 18, 2002 involving HHICNY. One wire transfer transaction for \$1,811,000 represented an intercompany transfer of funds from HHICNY to Horizon Healthcare of New Jersey, Inc. ("HHNJ"). As stated above, the Company did not provide documentation that evidences the provision of services between HHNJ and HHICNY.

It is recommended that HHICNY create service agreements with HHNJ and with HHH that formalizes any services provided between the companies. It is also recommended that such

service agreements be submitted to the New York Insurance Department for approval as required by Section 1503(d)(3) of the New York Insurance Law.

All wire transfers originally provided by HHICNY were incomplete because they did not contain a voucher or transaction number or the identity of the person sending the wire. After various inquiries, these documents were later substituted by documents that contained a voucher number, but not a number that could be traced to the statements submitted by the financial institutions. The substituted document's account numbers and bank names were altered after the wire transfers were authorized by the Company. BCBSNJ stated that their cash management department may routinely change the bank and the account, in order to get the best value for their funds.

It is recommended that the Company take steps to strengthen and improve adherence to accounting procedures and controls concerning the issuance of wire transfers. It is also recommended that the Company maintain a wire transfer log or other adequate documentation that will provide an audit trail allowing examiners to trace the flow of all wire transfers.

vii. **Allocation of Expenses**

SSAP No. 70 paragraphs 7 and 8, as applies to apportionment of shared expenses between members of a group of entities, states:

- “7. 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.”

- “8. 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. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.”

BCBSNJ allocates various types of expenses (advertising, printing, telephone, consulting) to the Company, but, according to the Company, there are no formal allocation agreements. Additionally, the examiners were not provided with surveys or formulas for the allocation. Further, the identification of the Company is more difficult since most of the entities in the holding company system share the logo “Horizon Healthcare” and a substantial amount of advertisements are for “Horizon Healthcare”. Various of the allocated expenses in advertising are shared between the Company and HHNY as ninety five percent (95%) and five percent (5%) respectively. Certain general expenses are shared at eighty percent (80%) and (20%) respectively. The basis for the allocation appears to be an arbitrary percentage that is not supported with documentation. The Company states that the process is to determine the annual amount at the beginning of the year and charge the appropriate companies via a journal entry each month. It is noted that the Company wrote in excess of 99% of the two companies total premium, and Horizon Healthcare of New York, Inc. wrote approximately one-half of one percent of the combined premium.

The notes to financial statement for the June 30, 2002 Quarterly Statement state that BCBSNJ provides certain administrative services, including executive oversight, financial, legal, and human resources support. These services are allocated according to a defined formula. During the examination period, the examiners requested the formula, but the Company did not provide it. Subsequent to the examination, the Company provided a schedule listing the services

that are to be allocated and the basis for the allocation. It is noted that general expenses and advertising are not services that appear in the formula. The examiners were unable to perform substantive testing to verify the reliability of the formula.

It is recommended that the Company create a basis for the apportionment of those expenses requiring allocation in greater compliance with SSAP No. 70 paragraphs 7 and 8. It is also recommended that the Company formalize the allocation of expenses with its parent and affiliates to comply with SSAP No. 70.

Section 1217 of the New York Insurance Law requires:

“No domestic insurance company shall make any disbursement of one hundred dollars or more unless evidenced by a voucher signed by or on behalf of the payee as compensation for goods or services rendered for the company, and correctly describing the consideration for the payment. If such disbursement be for services and disbursements, such vouchers shall set forth the services rendered and itemize the disbursements; if it is in connection with any matter pending before any legislative or public body or before any government department or officer, the voucher shall correctly describe also the nature of the matter and the company's interest therein. If such a voucher is unobtainable, the disbursement shall be evidenced by a statement of an officer or responsible employee affirmed by him as true under the penalties of perjury, stating the reasons therefor and setting forth the particulars above mentioned.”

It was determined that \$241,665 in advertising invoices from the SAWTOOTH GROUP (“the Group”), which had a contract with BCBSNJ, but not with the Company, were paid by the Company. Many of the invoices reviewed do not identify the New York Company(ies) responsible for the payment. In certain cases, the examiners could not determine if the invoice amounts were the obligation of the Company. On various invoices reviewed, the Company was not specified as doing business with the Group, therefore, the examiner could not determine if the advertising expenses were incurred for the Company, or for BCBSNJ.

It is recommended that the Company comply with the requirements of Section 1217 of the New York Insurance Law. It is also recommended that the Company record the proper amounts to its advertising expense. It is further recommended that the Company report expenses that it (as opposed to its parent) has incurred.

viii. **Company's Name on EOB Form**

Among other discrepancies explained under the caption of "Explanation of Benefits" ("EOB"), the Company's EOB does not identify the company responsible for paying the claim. Instead, the holding company logo, "Horizon Healthcare" with a PO Box address, appears.

ix. **Separate Operating Identity**

Section 1505(b) of the New York Insurance Law states:

"The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties."

Further, Section 1712 of the New York Insurance Law states:

"The business operations, corporate proceedings and fiscal and accounting records of subsidiaries shall be conducted or maintained so as to assure the separate legal and operating identities of the parent corporation and subsidiary, but nothing herein shall preclude arrangements for common management or the cooperative or joint use of personnel, property, or services, otherwise consistent with this chapter. All transactions between the parent corporation and its subsidiaries shall be fair and equitable, charges or fees for services performed shall be reasonable and all expenses incurred and payments received shall be allocated to the parent corporation on an equitable basis in conformity with customary insurance accounting practices consistently applied. The books, accounts and records of each party to all such transactions shall be so maintained as to disclose clearly and accurately the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties."

The examiner concluded that based on the frequency, regularity and documentation of the above described transactions; the lack of certain formal written agreements; the inability to document the involvement of the Company's Board of Directors as well as Company officers relating to the control of HHICNY's assets; the lack of identification of the Company, and the lack of distinct record-keeping, gives the appearance that BCBSNJ, HHICNY's ultimate Parent, ran the operations of HHICNY as if it were a division of the Parent corporation, thereby failing to maintain the distinct operating identity of HHICNY as required by Sections 1505(b) and 1712 of the Insurance Law .

It is recommended that the Company comply with Sections 1505(b) and 1712 of the New York Insurance Law by taking steps to more clearly define the New York entity and by improving its compliance with Sections 1505(b) and 1712.

x. **Accounts and Records**

The examination disclosed that HHICNY classified Stop/Loss Contract Premiums (\$66,269), Multiplan expenses (\$246,911), Lab capitation (\$26,000), and a Coalition for Care lawsuit (\$17,000) as general expense liabilities. The Coalition for Care lawsuit is reclassified as a contingent liability and the Stop/Loss Contract Premiums for (\$66,269) is reclassified to the asset account Accident and health premiums due and unpaid. The other amounts (Multiplan expenses \$246,911 and Lab capitation \$26,000) appear to be unpaid claims adjustment expenses and are reclassified to such account.

It is recommended that the Company properly classify its expenses.

E. **Significant Operating Ratios**

The following ratios have been computed as of June 30, 2002, based upon the results of this examination:

Net premiums written in 2002 to Surplus as regards policyholders	3.6 to 1
Liabilities to Liquid assets (cash and invested assets less investments in affiliates)	75.9%
Premiums in course of collection to Surplus as regards policyholders	37.2%

It is noted that the Department approved the capital reserve ratio requirement from 4:1 to 8:1 applicable to the PPO and EPO products.

4. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the assets, liabilities and surplus as of June 30, 2002, as determined by this examination and as reported by the Company.

<u>Current Assets</u>	<u>Ledger</u>	<u>Not Admitted</u>	<u>Company Net Admitted</u>	<u>Examination Net Admitted</u>	<u>Surplus Increase (Decrease)</u>
Bonds	\$40,991,646	\$ 0	\$40,991,646	\$40,991,646	
Cash	- 0	0	0	0	
Short-term investments	16,225,892	0	16,225,892	16,225,892	
Accident and health premiums due and unpaid	9,331,503	1,000,743	8,330,760	8,264,491	(\$ 66,269)
Investment income due and accrued	616,587	0	616,587	616,587	
Federal and foreign tax recoverable	5,645,803	0	5,645,803	5,645,803	
State tax deposit	1,973,000	0	1,973,000	0	(1,973,000)
Intangible-Anthem Network Purchase	<u>899,998</u>	<u>899,998</u>	<u>0</u>	<u>0</u>	
Total current assets	<u>\$75,684,429</u>	<u>\$1,900,741</u>	<u>\$73,783,688</u>	<u>\$71,744,419</u>	<u>(\$2,039,269)</u>
<u>Liabilities, Capital And Surplus</u>					
<u>Current Liabilities</u>					
Claims unpaid			\$29,248,000	\$29,274,000	(\$ 26,000)
Unpaid claims adjustment expenses			1,135,930	1,382,841	(246,911)
Aggregate policy reserves			1,750,813	1,750,813	
Premiums received in advance			2,537,448	2,537,448	
Contingent liabilities			0	17,000	(17,000)
General expenses due or accrued			4,692,589	1,865,167	2,827,422
Amounts due to parent, subsidiaries and affiliates			6,371,017	6,371,017	
State income taxes payable			<u>2,652,227</u>	<u>679,227</u>	<u>1,973,000</u>
Total liabilities			<u>\$48,388,024</u>	<u>\$43,877,513</u>	<u>\$ 4,510,511</u>
<u>Surplus</u>					
Common stock			\$ 200,000	\$ 200,000	
Gross paid in and contributed surplus			87,200,000	87,200,000	
Unassigned funds			<u>(62,004,336)</u>	<u>(59,533,094)</u>	<u>\$ 2,471,242</u>
Total capital and surplus			<u>\$ 25,395,664</u>	<u>\$ 27,866,906</u>	<u>(\$ 2,471,242)</u>
Total liabilities and surplus			<u>\$73,783,688</u>	<u>\$ 71,744,419</u>	<u>\$ 2,039,269</u>

Note – The Internal Revenue Service has completed its audits of the consolidated tax returns filed on behalf of the Company through tax year 1998. No final assessment has been issued. There are no other ongoing audits. The examiner is unaware of any potential exposure of the Company to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenue, Expenses, Capital and SurplusCapital and Surplus Account

Reserves and unassigned funds increased \$27,866,906 during the examination period, January 1, 1999 through June 30, 2002, detailed as follows:

Revenue

Premiums	\$270,576,955	
Investments	4,612,450	
Change in unearned premium reserve and reserve for rate credit	<u>637,080</u>	
Total Revenue		\$ 275,826,485

Expenses

Claims incurred net of reinsurance	\$281,951,000	
Claims adjustment expenses incurred	13,143,715	
Administrative expenses incurred	<u>53,822,652</u>	
Total expenses		<u>\$348,917,367</u>
Gross operating loss		(\$ 73,090,882)
Federal and foreign income taxes incurred		<u>(15,398,984)</u>
Net loss		<u>(\$ 57,691,898)</u>

Gains and Losses to Capital and Surplus

Capital and surplus at January 1, 1999 \$ 0

	Gains (Losses) <u>in Surplus</u>	
Net loss	(\$57,691,898)	
Change in non-admitted asset	(1,900,741)	
Unrealized capital gains	59,545	
Capital paid-in	200,000	
Surplus adjustments paid-in	<u>87,200,000</u>	
Net increase in surplus fund		<u>27,866,906</u>
Surplus as regards policyholders per report on examination as of June 30, 2002		<u>\$27,866,906</u>

5. **ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID**

The examination asset of \$8,264,491 is \$66,269 less than the \$8,330,760 reported by the Company as of June 30, 2002. Expenses classified as general expenses in the amount of \$66,269 were reclassified by the examiner as accident and health premiums due and accrued (see General expenses due or accrued herein). This reclassification has no effect on surplus.

6. **STATE TAX DEPOSIT**

The Company reported an admitted asset in the amount of \$1,973,000 as of June 30, 2002. Pursuant to this examination, the admitted asset has been eliminated. HHICNY also set up a liability, "State income taxes payable", in the amount of \$2,652,227 that includes the \$1,973,000 for this account. The examiner offsets this item against the liability. There is no effect on surplus.

7. **CLAIMS UNPAID**

The examination liability of \$29,274,000 is \$26,000 greater than the \$29,248,000 reported by the Company as of June 30, 2002. The examination reserve was determined by a Department actuary and was based upon actual payments made through September 2003, plus an estimate of claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Company's past experience in projecting the ultimate cost of claims incurred on or prior to June 30, 2002, and still outstanding as of June 30, 2002. The

\$26,000 difference represents laboratory expenses classified by the Company as general expenses. This reclassification has no effect on surplus.

8. **UNPAID CLAIMS ADJUSTMENT EXPENSES**

The examination liability of \$1,382,841 is \$246,911 greater than the \$1,135,930 reported by the Company as of June 30, 2002. Expenses classified as general expenses in the amount of \$246,911 were reclassified by the examiner as unpaid claims adjustment expenses (see General expenses due or accrued herein). This reclassification has no effect on surplus.

9. **GENERAL EXPENSES DUE OR ACCRUED**

The examination liability of \$1,865,167 is \$2,827,422 less than the \$4,692,589 reported by the Company as of June 30, 2002. At December 31, 2001, HHICNY accrued a commission reserve in the amount of \$2,471,242. In April 2002, the Company paid commission bonuses to agents in the amount of \$1,221,300, and according to HHICNY, overestimated this account by the remainder of \$1,249,942. Both the payment and the remainder continued to be carried in the books at June 30, 2002. Subsequent to the “as of” examination period, the \$2,471,242 were reversed from this account.

It is recommended that the Company not report items already paid as liabilities in its filed annual or quarterly statements.

The remaining general expenses due or accrued consist of reclassified liabilities items explained under the caption of "Holding Company System" in the amount of \$356,180 as follows:

<u>Description</u>	<u>Amount</u>	<u>Reclassified As</u>
• Multiplan expenses	\$246,911	Claims adjustment expenses
• Stop/Loss Contract premiums	66,269	Accident and health premiums due and unpaid
• Lab capitation	26,000	Claims unpaid
• Contingent liabilities	<u>17,000</u>	Contingent liabilities
• Total reclassified liabilities	<u>\$356,180</u>	

The above reclassifications have no effect on surplus.

10. **CONTINGENT LIABILITY**

The Company reported no liability under this caption as of June 30, 2002. This examination has established the contingent liability to be \$17,000. This liability is a reclassification representing a Coalition for Care lawsuit explained in item 9, above. There is no effect on surplus.

11. **STATE INCOME TAXES PAYABLE**

The examination liability of \$679,227 is \$1,973,000 less than the \$2,652,227 reported by the Company as of June 30, 2002. The difference of \$1,973,000 results from an offset of the asset "State tax deposit" for \$1,973,000 explained herein. There is no effect on surplus.

12. **MARKET CONDUCT ACTIVITIES**

In the course of the examination, a review was made of the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

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

- A. Claims
- B. Explanation of benefits
- C. Advertising
- D. Sales
- E. Complaints
- F. Grievances
- G. Fraud Detection and Prevention

Following are the examiners' findings:

A. **Claims**

The examination procedures included selecting two statistically valid samples (a medical or professional and a hospital or institutional sample) for reviewing various claims attributes to ensure that the policyholders claims were processed properly in order to safeguard policyholders'

interests. Two samples were also selected to determine that all claims were paid in a timely basis in compliance with Section 3224-a of the New York Insurance Law. The Company provided a file with 1,244,546 records that constituted the institutional and professional claims. The types of claims selected for the samples were the claims processed by NASCO in the amount of \$74,934,694, which represented the most material amount for the Company.

The NASCO claims are fee-for-service claims processed for BCBSNJ, which includes HHICNY. NASCO has electronic connectivity with every Blue Cross Blue Shield Plan in the United States, and BCBSNJ has an agreement with NASCO to administer benefits for employees in their state on the NASCO Processing System.

The data file received from the Company consisting of 1,244,546 records, when summarized, involved 357,855 professional claims, 23,121 institutional claims, and 129 dental and hearing claims for a total of 381,105 claims. The samples selected for this examination did not include dental or hearing claims.

i. **Prompt Pay**

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” requires all insurers to pay undisputed claims within forty-five days of receipt.

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

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

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

“...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 a claim.”

The examination objectives included extracting all institutional and professional claims that were paid more than forty-five days from the date of receipt by the Company to verify compliance with Section 3224-a of the New York Insurance Law. The population of professional claims meeting the over forty-five days criteria numbered 2,293 professional claims out of a total 357,855 claims processed, which represents 0.64% of claims paid. Also, 356 institutional claims out of a total 23,121 claims processed, which represents 1.54% of claims paid, met the over 45 days criteria. Two samples of 167 claims each were selected to perform substantive testing. The examiners requested that the two samples selected from the extracted population be reviewed by the Company to verify their findings. The Company did not refute the examiners' findings as they apply to Section 3224-a(a), and (c).

The following charts summarize the Prompt Pay Law findings of the examination as it applies to Section 3224-a(a) and 3224-a(c):

Section 3224-a(a):

Type of Claims	Medical	Hospital
Claim Population	2,293	356
Sample Size	167	167
Number of Claims with Errors	167	167
Calculated Error Rate	100%	100%
Upper Error Limit	100%	100%
Lower Error Limit	100%	100%
Upper Limit Claims in Error	2,293	356
Lower Limit Claims in Error	2,293	356

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

It is recommended that HHICNY comply with Section 3224-a(a) and pay its claims in a timely manner.

Section 3224-a(c):

Type of Claims	Number In Sample	Number of Violations in Sample	Percent
Professional	167	4	2%
Institutional	167	38	23%
Total	334	42	

Department Regulation 152 {11NYCRR 243.2}(b)(7) states:

“...(b) Except as otherwise required by law or regulation, an insurer shall maintain:...”

“...(7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset, ownership, and source documents, for six calendar years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer.”

HHICNY's response to the Prompt Pay Sample as applies to the payment of interest involved providing the examiner with a "Prompt Pay Report" (including the majority of the interest checks) for each claim where interest was due of \$2.00 or more. The checks representing interest are issued separately from the claim checks (normally on a monthly basis). The Company was unable to document thirty-eight (38) institutional and three (3) professional Prompt Pay Law interest checks to the examiners. The "Prompt Pay Report" included the check number and amounts of the missing checks. As stated under the caption of "Separate Legal and Operating Identity" the Company does not maintain a checking account hence there is no monthly reconciliation. HHICNY could not determine if the checks were not presented to the bank and are still outstanding or if they simply were unable to find the checks. It is noted that checks issued do not identify which company is responsible for the payment.

It is recommended that the Company complies with Department Regulation 152 {11NYCRR 243.2}(b)(7) and properly maintains all Prompt Pay Law interest checks for a period of six years or until after the filing of a report on examination.

Subsequent to the examination period, HHICNY stated that BCBSNJ implemented a new system known as Universal Payment System ("UPS"). UPS combines patient payment information from most products, including the Prompt Pay interest due on a claim, on a single statement. The NASCO claims payment system determines the claims that are over forty-five days, calculates the interest amount due, and transfers the claim payment and interest amount to UPS where both parts of the claim are paid with one check. Only a description of the system

was available to the examiners, and UPS was not available for review during the period that the examiners were on site.

Our review of the claims system in use during the examination period revealed that the system records receipt date in the following manner: When the claim is first received by the Company, the system records the original receipt date of the claim. Any subsequently received communication or other adjustment to the original claim results in the system revising the last two digits of the claim number and recording the date of the subsequent transaction as the new “receipt” date. It is the Company’s position that a revision of the “receipt” date does occur in certain instances, predominantly when adjustments are involved.

The Company provided a computerized claim file for the period of time requested by the examiners. As a result of the foregoing system’s characteristics relating to the receipt date, the examiner could not readily identify all of the claims that were paid after forty-five (45) days from the date the original claim was received. In many cases, the original receipt date does not appear in the computerized file provided to the examiners since the original claim was processed in a period of time prior to the period of time reflected in the computer file examined. As a result, the population of claims found by the examiners to be over 45 days could not be fully determined. For the period of January 1st through June 30th, 2002, the population of claims over 45 days that could be determined consisted of 2,293 professional (0.6% of all professional claims) and 356 institutional (1.5% of all institutional claims). The number of claims in violation of Section 3224-a(a) may have been higher if the examiner had been able to readily determine the original receipt date in all cases.

It is recommended that HHICNY maintain its claims records in a manner that allows for the time of processing from the receipt date to be readily determined and examined. It is also recommended that the Company configure its claim processing system to achieve the foregoing result.

ii. **Claims Attributes**

From a population of 357,855 professional and 23,121 institutional claims, two statistical samples of 167 claims each were selected to test various financial and procedural attributes. HHICNY relied mostly on the Multiplan provider network. In order for the examiner to verify that the contracted payment rates were being used, it was requested that HHICNY provide the Multiplan, Inc. contracts and the payment of claims schedule. Some of the contracts requested were not provided to the examiners. The rate schedules in most cases were missing or the rates received were not for the dates of service of the claims paid during the period of January 1 through June 30, 2002. The documents received for the professional providers were providers' profiles, not contracts. As a result, the examiner was unable to determine if the rates charged by Multiplan, Inc. were the correct contract rates.

It is recommended that the Company assure that its contractors create and maintain the proper documentation with its providers.

Most of the errors found applied to claims denied and then paid or to claims that were paid incorrectly and subsequently adjusted. Most claims fell under the following descriptions:

Financial and Procedural Errors:

Item	Descriptions	Professional	Institutional	Total
A.	Claims processed incorrectly as out-of-network should have been processed in-network.	8	2	10
B.	A medical emergency was not paid, but claim was adjusted and paid subsequently.	1		1
C.	Member services (child not added to policy, coverage not updated, incorrect name entered, system was not updated, incorrect amount entered, etc.)	13	9	22
D	Paid over 45 days late.		2	2
	Total	22	13	35
	Procedural errors	22	14	36
	Total financial and procedural errors	44	27	71

It is recommended that HHICNY verify the reliability of the data inputted into its claims processing system.

Each financial error above resulted in a procedural error either as an incorrect or delayed manual input, system input, incorrect denial, etc. Therefore, the 35 errors result in 70 errors (35 financial errors plus 35 procedural errors). Additionally, one more institutional procedural error was found where the original claim submission was denied as a duplicate on the 30th day from the claim's received date. The 2nd submission was received a week later after the first submission and was paid on the same day the original claim was denied. Furthermore the claimant's address in the system and the address on the claim form did not match.

Financial Errors:

Type of Claims	Medical	Hospital
Claim Population	357,855	23,121
Sample Size	167	167
Number of Claims with Errors	22	13
Calculated Error Rate	13.17%	7.78%
Upper Error Limit	18.3%	11.85%
Lower Error Limit	8.04%	3.72%
Upper Limit Claims in Error	65,499	2,739
Lower Limit Claims in Error	28,786	860

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.)

Procedural Errors:

Type of Claims	Medical	Hospital
Claim Population	357,855	23,121
Sample Size	167	167
Number of Claims with Errors	22	14
Calculated Error Rate	13.17%	8.38%
Upper Error Limit	18.3%	12.59%
Lower Error Limit	8.04%	4.18%
Upper Limit Claims in Error	65,499	2,910
Lower Limit Claims in Error	28,786	966

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.)

B. Explanation of Benefits Forms

As part of the review of Horizon Healthcare's claims practices and procedures, an analysis of the Explanation of Benefits statements ("EOB") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, and/or

provider and Horizon HealthCare. It should clearly communicate how Horizon processed a particular claim. It should correctly describe the charges submitted, the date the claim was received, the amounts allowed for the services rendered, and any balance owed to the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers. The following were noted:

The name of the Company issuing the EOB is not included on the EOB. Instead the holding company logo "Horizon Healthcare" with a PO Box address appears.

It is recommended that the Company identify itself in its EOBs.

§3234(b)(7) of the New York Insurance Law states in part:

"(b) The explanation of benefit statement form must include at least the following:"

"(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

Horizon Healthcare does not include the above requisite information on its EOBs. Therefore, subscribers and/or providers are not being properly informed of their appeal rights. During the period of January 1, 2002 through June 30, 2002, the lack of information on the subscribers' appeal rights affected 151,330 denied claims. Also, approximately 31,142 claims that were paid between January 1 and June 30, 2002, were reduced by coordination of benefits or a deductible amount and henceforth were partially paid by the Company.

The Company acknowledged this finding and advised the examiner that as of September 2002, appropriate appeals language was added to their EOB's. The Company stated that prior to September 2002, appeals language was included in an envelope stuffer with the EOB. Upon review of the stuffer, it was determined that the appeals language

included was not in compliance with the above section because it did not address the part of NYIL §3234(b)(7) which states: "...and notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

Subsequent to the period under examination, the Plan provided the examiners with an EOB with a date of service of November 8th, 2002. The appeals language included "...FILE THE REQUEST WITHIN 180-DAYS OF RECEIPT OF THIS EOB OR FORFEIT YOUR RIGHT TO APPEAL OUR CLAIMS DECISION..." The wording differs with NYIL §3234(b)(7) which states: "...and notification that failure to comply with such requirements may lead to forfeiture..."

It is recommended that the Company change the language on the EOB to conform with Section 3234(b)(7) of the New York Insurance Law.

Additionally, the language consists of one paragraph addressing three areas: "For Coverage Decisions Review", "For Mental Health, Alcohol/Substance Abuse Claims", and "For Coverage Decisions Based On Utilization Management Guidelines". The wording is confusing and compressed. Also, the name of the Company is difficult to identify as it appears in fine print above the larger easier to read holding company logo, "Horizon Healthcare".

It is recommended that the Company create its EOBs in a form that is easy to read and understand. It is also recommended that the Company's identity be substituted for the holding company logo.

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

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

It is recommended that HHICNY display the date the claim was received by it on all EOBs so that the length of the processing cycle time can be determined.

C. **Advertising**

A review of HHICNY advertising, for the period under examination, revealed the following:

HHICNY advertises in both English and Chinese. In their advertisements, the Company quoted prices by using a “random survey of actual facility claims submitted by in-network hospitals”. The Company was unable to substantiate the rates quoted with specific claims. At the request of the examiners the Company created a second random sample the result of which was inconsistent with their advertising.

In the above referenced advertisements, the Company made no indication as to how the statistics of their pricing were derived. This is a violation of Part 215.9(c) of Department Regulation No. 34, which states:

“ The source of any statistics used in an advertisement shall be identified in such advertisement.”

It is recommended that the Company be in compliance with Part 215.9(c) of Department Regulation No. 34 and identify the source of all statistics used in its advertisements.

Part 215.1 of Department Regulation 34 {11 NYCRR 215.1} states:

“The purpose of this Part is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and health insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards of conduct in the advertising of accident and health insurance in a manner which prevents unfair competition

among insurers and is conducive to the accurate presentation and description to the insurance buying public of policies of such insurance offered through various advertising media.”

In its advertisement, HHICNY made statements such as:

- An advertisement directed to HHICNY’s brokers includes the statement that HHICNY pays the “highest commissions in the marketplace”.
- “As one of New York’s fastest growing companies, our expanded provider network, value-added programs and focus on world class customer service make HHICNY the Company of choice in the marketplace”.

Material provided by the Company was inadequate to support the above. Therefore they did not comply with Part 215.1.

It is recommended that the Company comply with Part 215.1 of Department Regulation 34.

Department Regulation 34 {11 NYCRR 215.13(a)} states:

“The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all its advertisements. An advertisement shall not use a trade name, any insurance group designation, name of the parent company or the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.”

It was noted that in at least two instances HHICNY did not identify itself in its advertisements. The logo of the ultimate parent was used which could cause confusion to a consumer as to who the actual insurer is.

It is recommended that the Company disclose the name of the New York licensed insurer placing the advertisement as required by Part 215.13(a) of Department Regulation 34.

A review of HHICNY's five advertising contracts revealed one had expired in 2001, prior to the date of the examination. Another contract, under which the Company paid for advertising did not include HHICNY as a signed party. The contract was between the advertising agency and HHICNY's ultimate parent.

It is recommended that the Company keep updated contracts that it holds with its advertising agencies. It is further recommended that the Company obtain an amended agreement to include itself with the agencies under contract.

Section 1712 of the New York Insurance Law states:

"The business operations, corporate proceedings and fiscal and accounting records of subsidiaries shall be conducted or maintained so as to assure the separate legal and operating identities of the parent corporation and subsidiary, but nothing herein shall preclude arrangements for common management or the cooperative or joint use of personnel, property, or services, otherwise consistent with this chapter. All transactions between the parent corporation and its subsidiaries shall be fair and equitable, charges or fees for services performed shall be reasonable and all expenses incurred and payments received shall be allocated to the parent corporation on an equitable basis in conformity with customary insurance accounting practices consistently applied. The books, accounts and records of each party to all such transactions shall be so maintained as to disclose clearly and accurately the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties."

All invoices and corresponding payments for advertising expenses for the period of January 1, 2002 through June 30, 2002 were reviewed. In most instances the checks used to pay the invoices contained the names of both HHICNY and its parent. Two checks were drawn with the name "Horizon Healthcare of Pennsylvania, Inc.". The financial statements contained in this report reflect an adjustment for the two aforementioned checks.

It is again recommended that the Company comply with Section 1712 of the New York Insurance Law to assure that the Company maintains an adequately distinct separate legal and operating identity.

Part 215.17(a) of Department Regulation No. 34 states:

“Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisements of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.”

The above cited deficiencies indicate that HHICNY failed to maintain complete advertising files. Therefore they failed to comply with Part 215.17(a) of Department Regulation No. 34.

It is recommended that the Company comply with Part 215.17(a) of Department Regulation No. 34 and maintain a complete file containing every printed, published or prepared advertisement for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

D. **Sales**

Pursuant to Article 21 of the New York Insurance Law, HHICNY is authorized to utilize independent insurance agents and brokers in its primary distribution system. Only general agents

write business directly with the Company, all other brokers and agents write business through contracted general agents. The examiners were provided with a list of 1,363 agents and brokers. Also, the Insurance Department provided a list of 76 agents writing business with HHICNY. Only one name appeared on both the Company's and the Department's lists. All other agents from the Department list did not appear on the Company's list. The Department also provided the examiners with a list of ten terminated agents. Six agents' names from the terminated list appeared on the list of seventy-six names from the Department's list. The ten terminated agents' names did not appear on the Company's listing of 1,363 agents. There appears to be a large inconsistency between the agents working on behalf of the Company and the agents' records maintained by the Department.

The examiners selected a sample of twenty-five (25) agents from the Company's agents' list. The examiner's findings as regards the sample follows:

1. Three out of the twenty-five producers sampled belonged to New Jersey brokers who did not write New York business. Sixteen out of twenty-two agents consisted of two brokers and fourteen agents who wrote business in New York. A license for each of the sixteen producers in the sample was provided to the examiners.

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

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

Licenses for the remaining six agents and brokers in the sample were not provided to the examiners. The Company states that the producers whose licenses were omitted did not write business in New York.

It is recommended that the Company comply with Section 2102(a)(1).

Section 2103(e)(2) of the New York Insurance Law states:

- “(e)Before any original insurance agent’s license is issued there shall be on file in the office of the superintendent the following documents:
- (2) a certificate of appointment by the insurer, fraternal benefit society or health maintenance organization stating that it has satisfied itself that the named applicant, and each sub-licensee, is trustworthy and competent to act as such an insurance agent and that such insurer, society or health maintenance organization will appoint such applicant to act as its agent in reference to the doing of such kind or kinds of insurance or health maintenance organization business as is specified in the written application, if the license applied for is issued by the superintendent. Such certificate shall be subscribed by an officer or managing agent of such insurer, society or health maintenance organization and affirmed by him as true under the penalties of perjury.”

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

“Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization.”

2. The Company failed to file a certificate of appointment form (“Form AGT-1”) during the period under examination for the fourteen licensed agents and the six agents whose licenses were not provided. HHICNY provided certificates of appointment dated August 2, 2002, subsequent to the period under examination, for all fourteen agents and the two brokers in the sample. Brokers do not have to be appointed with the Department. The Company did not provide certificates of appointment for any of their employees who write health business for the Company. It was noted that the notice of appointment or termination of an agent

that were provided was incomplete: license numbers and/or date of birth blanks were not filled in.

It is recommended that HHICNY be in compliance with Sections 2103(e)(2) and 2112(a) of the New York Insurance Law and submit Form AGT-1 to the Department.

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

“Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall, upon termination of the certificate of appointment of any insurance agent licensed in this state, forthwith file with the superintendent a statement, in such form as the superintendent may prescribe, of the facts relative to such termination and the cause thereof. Every statement made pursuant to this subsection shall be deemed a privileged communication.”

3. HHICNY submitted a list of eight terminated agents. Termination forms were not submitted for the eight individuals at the time the company/agent relationship was severed. Subsequent to the period under examination, on November 1, 2002, the Company provided the termination forms dated the same date for the eight individuals.

It is recommended that HHICNY comply with Section 2112(d) of the New York Insurance Law.

E. **Complaints**

The examiners reviewed the Company's procedure for processing subscriber and other related complaints. The Company stated that there have been no recorded complaints for Horizon Healthcare of New York, Inc. for the period under examination. Most complaints received at the Department are against Horizon Healthcare. The Explanation of Benefits have the name of at least two companies (Horizon Healthcare Insurance Company of New York and

Horizon Healthcare of New York, Inc.). Horizon Healthcare could be confused as a third company by a subscriber. When a subscriber submits a complaint to the Department, in various cases the individual company that provided the coverage is not identified. Throughout this Report on Examination, it is noted that the ultimate parent of the Company does not maintain separate identities of its New York subsidiaries.

The examiners were provided with a complaint listing, from the Department's Consumer Services Bureau, for the Indemnity Company (HHICNY) and the HMO. The listing shows that HHICNY received 79 complaints and the HMO, 61. A review of the NAIC I-Site also shows complaint data for both companies, but it should be noted that this data is provided to the NAIC I-Site by this Department.

HHICNY Circular Letter 11 (1978) ("CL 11") offers guidelines that the Company may rely on to maintain a log to register and monitor all complaint activity. HHICNY maintains an electronic log in its system to monitor complaint activities. The table below indicates the CL 11 recommended fields for the complaint log and the fields that the company currently has in its electronic log.

Required fields from circular letter 11 (1978)	Company fields (Y/N)
1. Date complaint received	Y
2. Name of Complainant and the policy or claim number	Y
3. Insurance Department file number	Y
4. The responsible internal division e.g. Personal lines underwriting	N
5. Person in the company with who the complainant has been dealing	N

6. Person to whom the matter has been referred for review.	N
7. Date of such referral	N
8. Date of correspondence to the Insurance Departments Consumer Services Bureau	Y
A. Acknowledgement (if any)	Y
B. Date of any substantive response	Y
C. The chronology of further contacts with the Department	Y
9. The subject matter of the complaint	Y
10. The results of the complaint investigation and the action taken	Y
11. Remarks about internal remedial action taken as a result of the investigation	Y

Fields 4, 5, 6, and 7 are missing from the electronic log.

It is recommended that all fields mentioned in the guidelines of Circular Letter 11 (1978) be included in the company's electronic complaint Log maintained within its IS systems or otherwise.

Part 243.2(b)(6) of Department Regulation 152 {11 NYCRR 243.2(b)(6)} states that an insurer shall maintain:

"A complaint record required to be maintained under Chapter IX of this Title for six calendar years after all elements of the complaint are resolved and the file is closed."

The Company provided the examiners with a log of fifteen complaints that were received directly from subscribers in 2002. The company stated that prior to 2002, all complaints received by the Company, either in written or verbal form, were documented in an electronic

worksheet on their processing system. Due to systems limitation a complete report could not be generated.

It is recommended that HHICNY keep a log of all complaints, including direct complaints to the Company. It is also recommended that the company comply with Part 243.2(b)(6) of Department Regulation 152.

As a matter of procedure, the Consumers Services Bureau includes a cover letter requesting a reply within fifteen (15) days from the date of the letter for any complaint it submits to HHICNY. The Department did not receive a reply for eleven (11) complaints necessitating follow-up letters to be sent. The Department did receive replies to the follow-up letters.

It is recommended that the Company adopt procedures to reply in a timely manner to the Department's inquiries.

F. **Grievances**

The Company provided the examiner with seven complete grievances filed during the examination period. Upon review of the grievance files, it could not be determined which grievances were for Horizon Healthcare of New York, Inc. ("the HMO"), and which ones were for HHICNY.

It is recommended that the Company take the immediate and necessary steps to modify its reporting system so those grievances applicable for each company, (the HMO or HHICNY), can be determined.

G. **Fraud Detection and Prevention**

A review was performed of the organization and structure of Horizon Healthcare's Fraud Prevention division. The Company's compliance with New York Insurance Law Section 405 and Department Regulation 95 with respect to the reporting of fraud cases to the Department was also reviewed. In addition, the Company's procedures to assess compliance with New York Insurance Law Section 409 were reviewed. In September 1996, the Insurance Law was amended by adding a new Section 409 that requires every insurer writing 3,000 or more policies covering automobile, workers' compensation, accident or health insurance to file a fraud prevention plan with the Superintendent.

Section 409 states in part:

"Every insurer writing...individual, group, or blanket accident and health insurance policies issued, or issued for delivery in this state, except for insurers that write less than three thousand of such policies...shall file with the Superintendent a plan for detection, investigation, and prevention of fraudulent activities affecting policies issued or issued for delivery in this state...The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigations unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims function of an insurer, and shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent..."

Every insurer required to file a fraud prevention plan shall report to the superintendent on an annual basis, no later than January fifteenth, describing the insurer's experience, performance and cost effectiveness in implementing the plan utilizing such forms as the superintendent may prescribe. The plan must include name, title, job description, and geographical location of each investigator in the Special Investigations Unit and territory to which the investigator is assigned. The plan should also include provisions for in-service training programs for investigative,

underwriting and claims staff in identifying and evaluating suspected insurance fraud; development of public awareness programs; and development of a fraud detection and procedures manual.

The Company has complied with the above, and its plan was approved December 31, 2002.

The examiners conducted a walk-through of the Company's Special investigation Unit ("SIU"). The SIU consists of a staff of 24, of which 23 are located in Newark, New Jersey, and one senior investigator, occupies a cubicle at the New York City office. A review of the New Jersey personnel's work area revealed that they were physically separated from the Company's personnel, however, the New York based investigator's work area is not physically separated from Horizon's other personnel. Given the confidentiality of the information that the investigator has, the investigator should have a work area that is physically separated from other Company's personnel. This is also stated in the Company's approved Fraud Prevention Plan.

It is recommended that the New York investigator be physically separated from Horizon's other personnel.

The examiner requested and received a list of all of the company's open and closed suspected fraudulent case files. From this list the examiner chose a sample of 21 files for review.

The examiner reviewed the Investigation files. Different investigators had different ways of maintaining suspected fraudulent case files. The following was noted:

1. The examiner could not determine which files were for which Horizon Company (i.e. HHICNY, BCBSNJ, Horizon Healthcare of New York, Inc.). There was no distinction made in the file.
2. Some of the files lacked certain documentation (i.e. case status sheet, investigative memorandum, or detailed summary sheet).
3. Other files, it appeared that the investigator would write anywhere. It was noted that some files had pertinent details written on the outside folder of the file. It was also noted that additional information was written on scrap paper, some of which had drawings on them.
4. The documentation for each file should be readily accessible and securely attached, in a folder labeled with the case file name and number, so that no documentation is at risk of being lost. It should be noted that some of the case files had documentation that was unattached to the folders, while other files had documentation that was just rubber banded together.

It is recommended that procedures be developed for maintaining consistency in suspected fraudulent case files. It is further recommended that these procedures be written and distributed to all investigators.

13. Summary of Comments and Recommendations

<u>ITEM NO.</u>	<u>Description</u>	<u>PAGE NO.</u>
A.	<u>Management</u>	
i	It is recommended that the Board of Directors appoint a nominating committee prior to the annual shareholder's meeting in compliance with Article 2, Section 2.07 of the Company's bylaws.	6
ii	It is recommended that the Company's Board of Directors' underwriting and surplus discussions be documented.	6
iii	It is recommended that all agreements within the holding company system be approved by the Board of Directors prior to implementation.	7
iv	It is recommended that the Company's investments be approved by its board of directors or a committee thereof in compliance with Section 1411(a) of the New York Insurance Law.	7
v	It is also recommended that HHICNY's board of directors create and implement company specific policies and procedures that will enable it to approve the sales and purchases of its investments.	7
B.	<u>Holding Company System</u>	
i	It is recommended that the Company and BCBSNJ follow the terms of the contract approved by the Department.	12
ii	It is recommended that HHICNY and BCBSNJ maintain appropriate written agreements to formalize the services to be provided along with terms, conditions and the duties, of each company, and submit them to the Department pursuant to Section 1505(d).	13
iii	It is recommended that the Company settle its Federal income tax recoverable account in cash or securities eligible as investments as required by the Tax Allocation Agreement and Circular Letter 33 (1979).	15

<u>ITEM NO.</u>		<u>PAGE NO.</u>
iv	It is also recommended that the Company follow the terms of the Tax Allocation Agreement and settle the Federal income tax recoverable within the 30 day term specified in the agreement.	15
v	It is recommended that the Company submit to the Department, for approval, all holding company service agreements prior to entering into transactions as required by Section 1505(d)(3) of the New York Insurance Law.	17
vi	It is recommended that the Company provide more detail in the management services agreement for portfolio management including investment guidelines.	17
vii	It is recommended that HHICNY create service agreements with HHNJ and with HHH that formalizes any services provided between the companies.	19
viii	It is also recommended that such service agreements be submitted to the New York Insurance Department for approval as required by Section 1503(d)(3) of the New York Insurance Law.	19
ix	It is recommended that the Company take steps to strengthen and improve adherence to accounting procedures and controls concerning the issuance of wire transfers.	20
x	It is also recommended that the Company maintain a wire transfer log or other adequate documentation that will provide an audit trail allowing examiners to trace the flow of all wire transfers.	20
xi	It is recommended that the Company create a basis for the apportionment of those expenses requiring allocation in greater compliance with SSAP No. 70 paragraphs 7 and 8.	22
xii	It is recommended that the Company comply with the requirements of Section 1217 of the New York Insurance Law.	23
xiii	It is also recommended that the Company record the proper amounts to its advertising expense.	23
xiv	It is further recommended that the Company report expenses that it (as opposed to its parent) has incurred.	23

<u>ITEM NO.</u>		<u>PAGE NO.</u>
xv	It is recommended that the Company comply with Sections 1505(b) and 1712 of the New York Insurance Law by taking steps to more clearly define the New York entity and by improving its compliance with Sections 1505(b) and 1712.	24
xvi	It is recommended that the Company properly classify its expenses.	24
C.	<u>General Expenses Due or Accrued</u>	
	It is recommended that the Company not report items already paid as liabilities in its filed annual or quarterly statements.	29
D.	<u>Prompt Pay</u>	
i	It is recommended that HHICNY comply with Section 3224-a(a) and pay its claims in a timely manner.	34
ii	It is recommended that the Company complies with Department Regulation 152 {11NYCRR 243.2}(b)(7) and properly maintains all Prompt Pay Law interest checks for a period of six years or until after the filing of a report on examination.	35
E.	<u>Claim Attributes</u>	
i	It is recommended that HHICNY maintain its claims records in a manner that allows for the time of processing from the receipt date to be readily determined and examined.	37
ii	It is also recommended that the Company configure its claim processing system to achieve the foregoing result.	37
F.	<u>Explanation of Benefits Forms</u>	
i	It is recommended that the Company identify itself in its EOBs.	40
ii	It is recommended that the Company change the language on the EOB to conform with Section 3234(b)(7) of the New York Insurance Law.	41
iii	It is recommended that the Company create its EOBs in a form that is easy to read and understand.	41

ITEM NO.**PAGE NO.**

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|----|------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| iv | It is also recommended that the Company's identity be substituted for the holding company logo. | 41 |
| v | It is recommended that HHICNY display the date the claim was received by it on all EOBs so that the length of the processing cycle time can be determined. | 42 |

G.**Advertising**

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|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| i | It is recommended that the Company be in compliance with Part 215.9(c) of Department Regulation No. 34 and identify the source of all statistics used in its advertisements. | 42 |
| ii | It is recommended that the Company comply with Part 215.1 of Department Regulation 34. | 43 |
| iii | It is recommended that the Company disclose the name of the New York licensed insurer placing the advertisement as required by Part 215.13(a) of Department Regulation 34. | 43 |
| iv | It is recommended that the Company keep updated contracts that it holds with its advertising agencies. | 44 |
| v | It is further recommended that the Company obtain an amended agreement to include itself with the agencies under contract. | 44 |
| vi | It is again recommended that the Company comply with Section 1712 of the New York Insurance Law to assure that the company has a separate legal and operating identity. | 45 |
| vii | It is recommended that the Company comply with Part 215.17(a) of Department Regulation No. 34 and maintain a complete file containing every printed, published or prepared advertisement for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. | 45 |

H.**Sales**

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|---|--------------------------------------------------------------------|----|
| i | It is recommended that the Company comply with Section 2102(a)(1). | 47 |
|---|--------------------------------------------------------------------|----|

<u>ITEM NO.</u>	<u>PAGE NO.</u>
ii It is recommended that HHICNY be in compliance with Sections 2103(e)(2) and 2112(a) of the New York Insurance Law and submit Form AGT-1 to the Department.	48
iii It is recommended that HHICNY comply with Section 2112(d) of the New York Insurance Law.	48
I. <u>Complaints</u>	
i It is recommended that all fields mentioned in the guidelines of Circular Letter 11 (1978) be included in the company's electronic complaint Log maintained within its IS systems or otherwise.	50
ii It is recommended that HHICNY keep a log of all complaints, including direct complaints to the Company.	51
iii It is also recommended that the company comply with Part 243.2(b)(6) of Department Regulation 152.	51
iv It is recommended that the Company adopt procedures to reply in a timely manner to the Department's inquiries.	51
J. <u>Grievances</u>	
It is recommended that the Company take the immediate and necessary steps to modify its reporting system so those grievances applicable for each company, (the HMO or HHICNY), can be determined.	51
K. <u>Fraud Detection and Prevention</u>	
i It is recommended that the New York Investigator be physically separated from Horizon's other personnel.	53
ii It is recommended that procedures be developed for maintaining consistency in suspected fraudulent case files.	54
iii It is further recommended that these procedures be written and distributed to all investigators.	54

Appointment No. 21869

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, **GREGORY V. SERIO**, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Arcelio Vega

as a proper person to examine into the affairs of the

**Horizon Healthcare Insurance Company
Of New York**

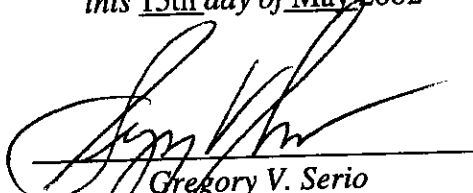
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 15th day of May 2002



Gregory V. Serio
Superintendent of Insurance

