

MARKET CONDUCT REPORT ON EXAMINATION

OF

HEALTH NET INSURANCE OF NEW YORK, INC.

AND

HEALTH NET OF NEW YORK, INC.

AS OF

DECEMBER 31, 2001

DATE OF REPORT:

JANUARY 10, 2003

Revised April 4, 2003

EXAMINER:

BRUCE BOROFSKY

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STATE OF NEW YORK
INSURANCE DEPARTMENT
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George E. Pataki
Governor

Gregory V. Serio
Superintendent

Date: April 4, 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 Numbers 21903 and 21904 dated June 6, 2002 and annexed hereto, I have made an examination into the affairs of Health Net Insurance of New York, Inc. ("HINY"), an accident and health insurance company licensed under Article 42 of the New York Insurance Law and Health Net of New York, Inc. ("HNY" or "the HMO"), a for-profit individual practice association model health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law. The statutory home office for both entities is 399 Knollwood Rd, Suite 212, White Plains, NY, 10603. The examination took place at Health Net Inc.'s main administrative office, located at 1 Far Mill Crossing, Shelton, Connecticut 06497. The following report thereon is respectfully submitted.

Whenever the term "Health Net" or "the Company" appears herein without qualification, it should be understood to refer to both HINY and HNY. Wherever a distinction needs to be made, the terms "HINY" "the HMO", or "HNY" shall be used respectively. The ultimate parent of the two entities is Health Net, Inc. (HNI or "the Parent").

1. SCOPE OF EXAMINATION

The prior examinations of HNY and HINY were conducted as of December 31, 1998. That report contained the following comment relative to the review of claims:

“... it appears that there is a significant enough risk of “prompt pay” compliance problems to warrant that a more detailed review of the claims adjudication process at PHS-NY be conducted by the Department.”

The current examination, which is restricted to the treatment of claimants, covers the period January 1, 2001 through December 31, 2001. Transactions subsequent to the examination date were reviewed where deemed appropriate.

This report is confined to the manner in which Health Net conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The report also contains comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF THE COMPANIES

HNY is a health maintenance organization (“HMO”) incorporated on April 22, 1986 under New York State Law as a for-profit corporation for the purpose of providing comprehensive health care services on a prepaid basis, and for the purpose of establishing and operating an HMO and health care delivery system. The HMO was licensed as a for-profit Individual Practice Association (IPA) Model HMO under Article 44 of the New York State Public Health Law on June 30, 1987, and began operations on that date. On October 21, 1987, the HMO attained federal qualification under Title XIII of the Public Health Service Act.

HINY was originally licensed by the Department on December 3, 1990, as Citicorp International Trade Insurance, Inc. (CITI), and commenced operations on April

2, 1991, as a domestic property and casualty insurer. CITI ceased writing new business in 1993 and all outstanding policies were either canceled or expired in accordance with their terms. On April 12, 1996, Physicians Health Services, Inc. purchased CITI from Citicorp International Trade Indemnity Inc., a subsidiary of Citicorp. CITI, which was renamed Physicians Health Services Insurance of New York, Inc. (PHSINY) remained inactive until the latter part of year 1998. In 1999, PHSINY began its first full active year in operation as a mono-line accident and health insurer. The Company changed its name to Health Net Insurance of New York, Inc. on December 17, 2001.

3. EXECUTIVE SUMMARY

The results of this examination indicate that during the examination period, Health Net had significant deficiencies in controls and procedures. The most significant of these deficiencies include the following:

- Failure by the board of directors to assure itself that the company's operations in key areas are being conducted in accordance with applicable statutes, rules and regulations;
- Significant error rates for institutional claims;
- Violations of New York Insurance Law §3224-a;
- Engaging in practices that, if not addressed by HealthNet, may result in a future finding of unfair claims settlement practices;
- Improper denial of emergency room claims;
- Failure to include appropriate language on Explanation of Benefit statements;
- Failure to include appropriate appeals language on certain claim denials.

These and other findings are symptomatic of the tendency of Health Net management to operate the New York entities as part of the greater corporation overseen by the Parent rather than as distinctly incorporated and regulated entities. The prior report on examination as of December 31, 1998 contained a similar criticism.

The examination findings are described in greater detail in the remainder of this report. Action already taken by management in response to the findings is also described herein as applicable.

4. **CIRCULAR LETTER NO. 9 (1999)**

Circular Letter No 9 (1999) reads in part:

“It is recommended that the board obtain the following certifications annually: (i) from either the company’s director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company’s general counsel a statement that the company’s current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with the applicable statutes, rules and regulations.

The Company failed to obtain such certifications during either calendar year 2000 or 2001.

Circular Letter No. 9 (1999) also notes the importance of the board adopting written procedures to enable the board to assure itself that the company’s operations in key areas are being conducted in accordance with applicable statutes, rules and regulations. When the Company was asked to produce written procedures, it advised the examiners that no procedure manuals existed and that they were not necessary because its adjudication procedures were automated. Instead, the Company prepared a claims processing manual that outlined overall procedures and did not address the New York mandates specifically.

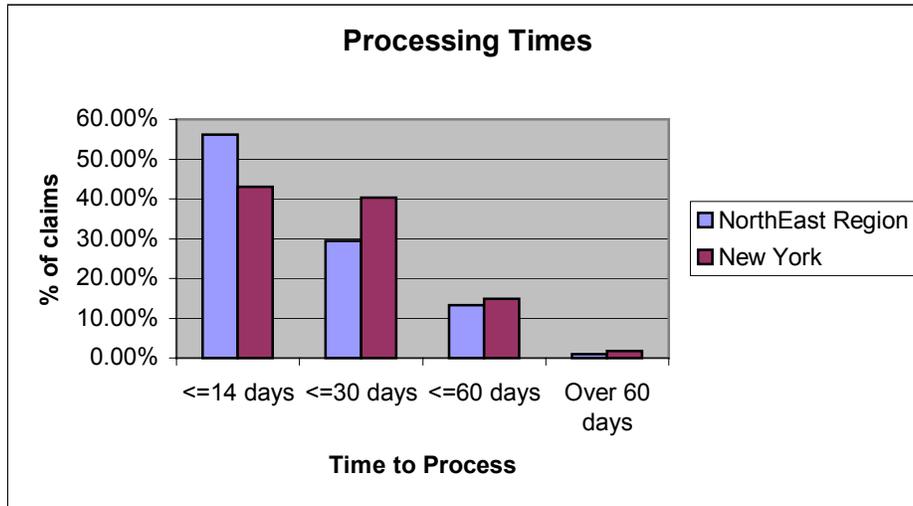
Automation of such procedures is no substitute for maintaining procedures manuals. The manuals may be maintained in electronic format, but should detail such New York mandates as the Managed Care Bill of Rights (e.g. information dissemination, accessing prompt quality care, grievance/appeal process); underwriting and rating;

external appeals; and the accurate and timely reporting of all financial statement schedules and exhibits. Such information in a consolidated form is mandatory so that customer service representatives and claim processors may provide informed responses to inquiries made by the Company's subscribers and providers.

It is noted that, during December 2002, the boards of directors for both entities approved updated claim processing manuals that include New York mandates.

It is recommended that Health Net obtain the certifications suggested by Circular Letter No. 9 (1999) and obtain annual certifications (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with the applicable statutes, rules and regulations.

It is noted additionally that neither the board nor senior management receives a "report card" detailing the accuracy or timeliness of claim adjudication for the New York entities. The reports that are prepared instead combine the results for all of the Health Net entities in the Northeast region and thus, do not represent the Company's compliance with New York laws and regulations. This may be seen in the following table, which compares the processing times for all claims during calendar year 2001 as indicated in the Management Report to those established during the examination for the New York entities through the use of the Department's ACL auditing software:



As may be seen, a significantly smaller percentage of claims are processed in 14 days or less in New York than in the region as a whole. The Board is unable to react to this finding unless they are provided with the specific data. The need for the Board to obtain New York-specific results is especially true in light of the results of the Prompt Pay sampling, discussed later in this report.

It is recommended that the Company prepare “report cards” for the New York entities outlining the timing and accuracy of claim processing.

5. CLAIM RECEIPT

Health Net recently contracted with an independent third party, ACS, to open and scan paper claims. Prior to the start of that relationship, Health Net issued several notices to providers advising them they would need to submit claims to the new address. Thereafter, paper claims inappropriately sent to Health Net were forwarded to ACS via the US Postal Service. Until November 2002, even though such claims were received by Health Net and then forwarded to the proper address, Health Net considered the receipt date for these claims to be the date the claims were received by ACS, not the date they were received by Health Net. This is improper in that the claims were in the hands of the

Claims Department the day they were originally received by them. This issue is important in that New York insurance law establishes the maximum length of time allowed adjudicating a claim. Failure to age the claim from the date that it was originally received does not permit an accurate measure thereby hampering Health Net's ability to comply with NY's Prompt Pay Requirements. It should be noted that the number of claims involved could not be ascertained.

It is recommended that paper claims inappropriately sent to Health Net instead of to the third party administrator ACS, be aged from the original received date instead of from the date the claim is received by ACS.

6. PROMPT PAY COMPLIANCE

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

§ 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(b) of the New York Insurance Law states that:

"In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to ...article forty-four of the public health law to pay a claim or make a payment for health care services

rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

§ 3224-a(c) of the New York Insurance Law states in part 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 claim.”

The examination included statistical samples for HNY and HINY to determine whether or not interest was appropriately paid pursuant to §3224-a(c) of the New York Insurance Law to those claimants not receiving payment or denials within the timeframes required by §3224-a(a) and (b) of the New York Insurance Law. Further, a separate sample for each company was selected for its “Institutional” (hospital facility) and “Encounter” (medical provider) claims systems. Accordingly, all claims that were not paid within 45 days during the period January 1, 2001 through September 30, 2001 were segregated. Further, claims from non-New York groups, non-New York providers, and Medicare claims were excluded from the population. Statistical samples of these

populations were then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate the Companies' non-compliance with New York Insurance Law §3224-a, as determined by this examination.

New York Insurance Law §3224-a(a)

	HNY Encounter	HNY Institutional	HINY Encounter	HINY Institutional
Total Population	1,698,590	106,540	556,704	34,481
Eligible Population	12,470	8,447	5,195	2,878
Sample Size	167	167	167	167
Part (a) violations	112	164	116	164
Calculated Error Rate	<u>67.07%</u>	<u>98.20%</u>	<u>69.46%</u>	<u>98.20%</u>
Upper Error limit	74.19%	100%	76.45%	100.00%
Lower Error limit	59.94%	96.19%	62.48%	96.19%
Upper limit Claims in error	9,252	8,447	3,971	2,878
Lower limit Claims in error	7,474	8,235	3,246	2,768

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.)

New York Insurance Law §3224-a (c)

	HNY Encounter	HNY Institutional	HINY Encounter	HINY Institutional
Total Population	1,698,590	106,540	556,704	34,481
Eligible Population	12,470	8,447	5,195	2,878
Sample Size	167	167	167	167
Part (c) violations	15	4	11	1
Calculated Error Rate	<u>8.98%</u>	<u>2.40%</u>	<u>6.59%</u>	<u>.60%</u>
Upper Error limit	13.32%	4.71%	10.35%	1.77%
Lower Error limit	4.65%	.08%	2.82%	0%
Upper limit Claims in error	1,661	398	538	51
Lower limit Claims in error	579	6	147	0

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

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims paid over forty-five days from receipt during the period from January 1 through December 31, 2001. The total population of claims that were processed within the above four categories during the same twelve-month period was 2,396,324 (as detailed in the New York Insurance Law §3224-a(a) chart of page 9).

New York Insurance Law §3224-a(b) violations were established through the isolation of all claims that were not paid within 45 days took more than thirty (30) days to either deny or for the Company to seek additional information. The results of this data extraction revealed the following number of New York Insurance Law §3224-a(b) violations against the total population of claims in the population:

New York Insurance Law §3224-a (b)

	HNY Encounter	HNY Institutional	HINY Encounter	HINY Institutional
Eligible Population	1,698,590	106,540	556,704	34,481
# of violations	92,076	20,638	23,882	6,197
Calculated Error Rate	<u>5.42%</u>	<u>19.38%</u>	<u>4.29%</u>	<u>17.98%</u>

It is recommended that Health Net take steps to ensure it is in compliance with all aspects of New York Insurance Law §3224-a.

During the New York Insurance Law §3224-a testing, the following issues were noted:

- The Company pays interest to all providers, including those providers who operate outside of New York. Such providers are exempted from coverage under New York Insurance Law §3224-a, and as such, the payment of interest to those providers increases unnecessarily the expenses of the Company; expenses that

will ultimately be passed along to the policyholders. It is noted that these providers may be subject to “prompt pay” requirements in the states where they are located.

- During the examination period, it was noted that Health Net paid interest on many claims when none was due. Included within this population were 487 claims that paid a total of \$3,176.15 in interest on claims that either had no payment due or were denied. Additionally, many claims overpaid the amount of interest that was required. The Company indicates these errors were the result of a faulty program edit that has since been repaired. This assertion has not been verified. .

It is recommended that the Company calculate and pay the appropriate amount of interest only when it is due.

Prior to this examination, Health Net was found to be in violation of Section 3224-(a) of the New York Insurance Law for prompt pay violations cited by the Department’s Consumer Services Bureau. The HMO executed stipulations resulting in fines covering the following periods:

4/27/99 to 7/31/99	\$3,300
8/1/99 to 11/30/99	\$5,500
12/1/99 to 12/31/00	\$93,500

7. CLAIM PROCESSING

This review was performed by using a statistical sampling methodology covering the examination period in order to evaluate the overall accuracy and compliance environment of Health Net’s claims processing. In order to achieve the goals of this review, claims were segregated into two primary populations:

- a) Health Net of New York, Inc.; and
- b) Health Net Insurance Company of New York, Inc.

These primary populations were then further divided into hospital or institutional and medical or encounter claims segments for each of the above entities. Therefore, a total of four groups were established. A random statistical sample was drawn from each of the four groups. It should be noted that for the purpose of this examination, those medical costs characterized as Medicare, Medicaid capitation, or self-insured were excluded. Non-New York lines of business were also excluded.

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

The sample size for each of the four populations described herein was comprised of 167 randomly selected claims. Additional random samples were also generated as “replacement items” when it was determined that particular claims within the sample should not be tested (i.e., claim reversals resulting from errors). Accordingly, various replacement items were appropriately utilized. In total, 668 claims for the scope period were selected for review. This reflects 334 claims for HNY and 334 claims for HINY.

The term “claim” can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a “claim,” which is defined by Health Net as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It was possible, through the computer

systems used for this examination, to match or “roll-up” all procedures on the original form into one line, which is the basis of the Department’s statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by Health Net for the period January 1, 2001 through December 31, 2001.

The examination review revealed that overall claims processing financial accuracy levels were 95.81% for HNY Encounter, 89.82% for HNY Institutional, 91.02% for HINY Encounter and 79.64% for HINY Institutional respectively. Overall claims processing procedural accuracy levels were 90.42% for HNY Encounter, 65.87% for HNY Institutional, 90.42% for HINY Encounter, and 56.89% for HINY Institutional respectively. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with Health Net’s claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy.

Relative to financial accuracy, Health Net states that it does not review or measure financial accuracy solely on the basis of the number of times claims are processed incorrectly, regardless of amount. It gauges financial accuracy based upon the overall dollar error of claims processed during a specified period. This results in a higher internal financial accuracy rate since it places greater emphasis on the financial magnitude of the errors, rather than on the number of instances of errors

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

Summary of Financial Claims Accuracy

	HNY Encounter	HNY Institutional	HINY Encounter	HINY Institutional
Claim Population	1,698,590	106,540	556,704	34,481
Sample Size	167	167	167	167
Number of claims with Financial Errors	7	17	15	34
Calculated Error Rate	4.19%	10.18%	8.98%	20.36%
Upper Error limit	7.23%	14.77%	13.32%	26.47%
Lower Error limit	1.15%	5.59%	4.65%	14.25%
Upper limit Claims in error	122,826	15,732	74,145	9,126
Lower limit Claims in error	19,571	5,959	25,861	4,914

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Summary of Procedural Accuracy

	HNY Encounter	HNY Institutional	HINY Encounter	HINY Institutional
Claim Population	1,698,590	106,540	556,704	34,481
Sample Size	167	167	167	167
Number of claims with Procedural Errors	16	57	16	72
Calculated Error Rate	9.58%	34.13%	9.58%	43.11%
Upper Error limit	14.04%	41.32%	14.04%	50.62%
Lower Error limit	5.12%	26.94%	5.12%	35.6%
Upper limit Claims in error	238,565	44,026	78,188	17,456
Lower limit Claims in error	86,913	28,702	28,485	12,276

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.)

In summary, of the 668 claims reviewed, 161, or 24.1%, contained one or more claims processing procedural errors. Of the 668 claims, 73, or 10.9% of the 668 claims reviewed, contained one or more financial errors.

During the process of reviewing claims within the various claim adjudication samples, it was noted that there were a number of policies or practices followed by the Company in its claim adjudication process that resulted in errors that adversely impacted members or providers. Although the nature and frequency of the individual errors does not appear to rise to the level of unfair claims settlement Practices, as defined in New York Insurance Law 2601(a), in the aggregate the frequency of these errors must be addressed by HealthNet to avoid such a finding in the future

The following are examples of errors found during HealthNet's claim processing review:

- When the Company receives a claim from a participating institution that includes both, a contracted set of procedures and a procedure or code that requires additional information or support, the Company pays only that portion of the claim it has sufficient information to respond to. It does not specifically deny or discuss the unpaid portions of the claim in its Explanation of Benefit statements. An example of this is when an implant is billed on a surgical claim. Health Net will pay the surgical portion of the claim, but fail to advise the provider of the need for an invoice for the implant. This is also a violation of the Prompt Pay law, which requires notification of missing information within 30 days of the receipt of the claim.
- As noted above, institutional claims are not paid line by line. Instead, a determination is made on the claim as a whole. When such claims are denied, certain otherwise payable procedures may also be inappropriately denied. An example of this is a claim with multiple X-rays, including a mammogram. Under NY State law, no authorization is needed for a mammogram. If an authorization is needed for the other procedures, the entire claim, including the mammogram, will be denied for lack of an authorization.

It is recommended that Health Net adjudicate all institutional claims on a line by line basis, paying or requesting additional information, as appropriate.

- During the examination period and until May 2002, Health Net maintained a policy whereby it systematically denied claims submitted for unauthorized treatment from members with Point of Service coverage, when many of those claims could have been paid with a penalty applied. Only when such claims were re-submitted did Health Net consider the claims using the member's out-of-network benefit. Such treatment led to a systematic violation of Prompt Pay part (a) in those cases that the Company had the necessary information to pay the claims but did not.

It is recommended that Health Net re-open all claims from members with Point of Service coverage that were denied for a lack of authorization and reconsider those claims using the member's out-of-network benefit. Further, where such claims are eligible for interest under New York's Prompt Pay law, such interest should be paid.

- Health Net's policy in regard to clinic care is that all such care requires an authorization, regardless of whether the facility submitting the claim is a participating provider. The reason is that Health Net maintains such claims are not actually from the facilities in question, but from a non-participating ancillary organization within the facility. As such, the policy indicates that clinic claims submitted on behalf of members without Point of Service coverage are to be denied, whereas such claims submitted on behalf of members with Point of Service coverage are to be paid after consideration for deductible and co-insurance. An example of the implications of this policy is when a member receives a mammogram at a clinic within a participating hospital. Even though, under NY Insurance law, a mammogram does not require an authorization, and the claim has been submitted by the participating hospital, the claim will be

denied as being from a non-participating clinic, and thus, according to Health Net, requires an authorization. It should be noted that Health Net's policy in regard to clinics is not communicated anywhere to either members or to providers. Therefore, these claims should not be denied in this manner. If a claim is submitted by a participating provider, Health Net cannot make the determination that certain types of treatment are excluded from their participatory agreement unless those exclusions are communicated within the agreement itself. Further, if such clinics are to be held as not being a party to the participatory agreements between itself and its member hospitals, Health Net has an obligation to notify its members of that fact. Further, in such cases, the claims should be denied due to the services being performed by a facility other than the one submitting the claim, not for a lack of authorization.

It is recommended that Health Net re-open all claims from clinics within participating hospitals and re-adjudicate those claims without any restrictions on the place of service.

- Health Net has acknowledged that, during the examination period and until November 2001, it did not uniformly enforce its policy regarding the timeliness of claim submission. This policy establishes a set period of time after the date of service for providers to submit claims. In many cases claims exceeding these deadlines were denied, while in others the claims were paid. Although no trend was noted, this arbitrary application of a processing guideline amounts to a discriminatory policy. The Company maintains the timeliness of submission policy is now being consistently enforced, but this assertion has not been verified.

It is recommended that Health Net retroactively pay all institutional claims that were denied for untimely filing during the period prior to its uniform enforcement of those rules.

- The Companies policy in regard to claims for newborns requires that, if the child is not enrolled at the time the claim has been received, the claim is to be pended until thirty-one days have passed since the birth of the child. This policy has a deleterious effect on Health Net's members because if the member inadvertently neglected to purchase coverage, the notification delay caused by the intentional pending may lead to a situation where the member is denied the ability to retroactively obtain the desired coverage. While the Company maintains that it is their practice to allow retroactive enrollment, the delay may still have the effect of moving the enrollment date beyond the date in which coverage is mandated.
- Health Net's policy regarding the submission deadline for claims from non-institutional participating providers is 90 days. Health Net also maintains an unofficial policy, however, whereby it will allow such claims to be accepted and paid for a twelve-month period. The unofficial policy contains a stipulation that it is not to be communicated to Health Net's providers. It goes on to state that if a provider is advised of the ninety day deadline and complains about another claim that was paid in greater than ninety days, the customer service representative is to apologize and reverse the paid claim. This situation is tantamount to a discriminatory practice in that not all claims are treated the same.

It is recommended that Health Net uniformly apply its policy regarding the timeliness of claim submitted by non-institutional providers.

- In many cases, the first submissions of a claim were denied as being duplicates and identical claims that were subsequently received were paid. This activity circumvents enforcement of the Prompt Pay laws because the date counted as received is not the first date that the claim was received.

It is recommended that Health Net adjudicate identical claims filed multiple times in the order of their receipt. In the event that an initial filing lacks sufficient information to process a claim, and a secondary submission is received prior to the adjudication of the original, then the original submission should be denied with an explanation indicating that that submission was incomplete, and referencing the claim that was paid.

- Health Net's Passport contract requires that members obtain a referral to see any specialist other than an obstetrician or a gynecologist. This requirement was not enforced during calendar year 2001. On July 1 of that year, the Company issued a directive to its claim adjudicators indicating that the requirement had been removed. This requirement, however, is still contained within the Health Net contract. Health Net has an obligation to fully enforce its contract requirements or submit revisions to its member contracts for approval by the Department.

It is recommended that Health Net eliminate unenforced contract provisions from its member contracts.

- Health Net denied claims when information in the provider's file either was misread or had not been updated in a timely manner. Health Net has an obligation to re-adjudicate such claims after the error has been found or after the system has been updated. It is noted that a policy has been put in place requiring that claims be reprocessed in the event of an error, however, no such policy exists for claims denied before a provider's file has been updated.

It is recommended that Health Net reprocess claims denied as a result of delays in updating a provider's file.

- Other patterns of errors noted during the examination of claims included denials for a lack of authorization when such authorization existed, payments to providers that were not consistent with the contractual amounts, and claims that remained unpaid after being transferred between the two adjudication engines, Encounter and Institutional.

It is recommended that Health Net re-adjudicate all claims found to be errors within the Department's adjudication sampling. Additionally, the Company should pay interest on such claims when it is due.

It is recommended that Health Net have its Internal Auditors conduct a claims audit for the New York entities to ensure that policies and procedures are being properly applied.

8. EMERGENCY CARE

§3216(i)(9) and §3221(k)(4)(A) of the New York State Insurance Law requires that health insurance contracts permit emergency room treatment using a prudent person standard.

§3216(i)(9) of the New York State Insurance Law "Individual accident and health insurance policy provisions" states in part:

"(9) Every policy which provides coverage for inpatient hospital care shall also include coverage for services to treat an emergency condition in hospital facilities. An "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.."

§3221(k)(4)(A) of the New York Insurance Law “Group or blanket accident and health insurance policies; standard provisions” states in part:

“(4) (A) Every group policy delivered or issued for delivery in this state which provides coverage for inpatient hospital care shall include coverage for services to treat an emergency condition provided in hospital facilities, except that this provision shall not apply to a policy which cover persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state. (B) In this paragraph, an "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.”

During the examination period and until July 2002, the Company automatically approved or denied emergency room treatment utilizing a pre-established set of procedures. This is a violation of the referenced laws in that, under the proper circumstances, many of the procedures defined by Health Net as ineligible for emergency room treatment could be construed as emergencies by a prudent layperson.

It is recommended that the Company re-open all claims with emergency room denials and offer subscriber appeals.

These violations were exacerbated by the issuance of the Company's Fall 2002 member newsletter. That newsletter contained an article clarifying the difference between Emergent Care and Urgent Care without discussing the Prudent Layperson Standard as defined within NY Insurance Law. The definition of Urgent Care within the newsletter contained a list of diagnoses that Health Net deemed to be urgent, and thus, non-emergency. Health Net will not pay for treatment it deems to be non-emergency in an emergency room setting. The list included headache, persistent cough and earache, each of which could, under the proper circumstances, be considered emergencies by a prudent layperson. Further, the member letter did not note the HMO's policy regarding the denial of urgent care in an emergency room setting.

It is recommended that Health Net send a revision to its members clarifying member rights under New York Insurance Law.

Certain screens within the electronic system used by claim adjudicators to establish member benefits specify that members must complete the pre-authorization process for all emergency admissions. For HINY, this is a violation of New York Insurance Law 4905(m), which states in part:

“In no event shall an insured, an insured’s designee, or an insured’s health care provider, any other health care provider, or any other person or entity be required to inform or contact the utilization review agent prior to the provision of emergency care, including emergency treatment or emergency admission.”

HNY is required to adhere to a similar standard under Public Health Law §4905(14). Providing improper information to claim adjudicators may result in claims being settled using rules in violation of New York Law.

It is recommended that Health Net ensure that the benefit screens on its claim system reflect the appropriate requirements for each level of care.

9. USUAL, CUSTOMARY AND REASONABLE

When a member with Point of Service coverage visits a non-participating provider, the amount that the member or his provider is reimbursed is established using a Usual, Customary and Reasonable (UCR) formula.

The Health Net Point of Service contract and the Guardian Health Care Solutions contract define Usual, Customary and Reasonable as follows:

The amount we determine to be the reasonable charge for a particular service in the geographical area in which it is performed based upon: (1) a percentile of a modified nationwide database applicable to the specific type of licensure of Provider (e.g. hospital, physician, Provider, laboratory, etc.); and/or (2) certain industry standards (e.g. multiple surgical rules and assistant surgeon charge, etc.)

The nationwide database by which Health Net establishes its UCR is prepared by the Health Insurance Association of America (HIAA/Ingenix). HIAA/Ingenix publishes updated versions of its manuals semi-annually.

This examination revealed that Health Net is utilizing, as its base, the HIAA/Ingenix data from 1998 for dates of service during 2001 and until present. The Company only revises its database to reflect procedures not previously listed.

Health Net's failure to use the current reimbursement rates published by HIAA / Ingenix may result in providers being reimbursed less than should be defined as a usual, customary and reasonable reimbursement. The result is that Health Net policyholders must pay a larger portion of their medical bills out of their own pockets.

It is recommended that, effective in 2003, Health Net update its UCR database on a regular basis to ensure that the most recently available data is utilized in establishing Usual, Customary and Reasonable reimbursement amounts.

Subsequent to the examination date, effective January 1, 2003. Health Net updated its UCR database to reflect 2002 HIAA/ Ingenix reimbursement rates.

It is further recommended that Health Net submit a plan acceptable to the Department, to reprocess, where appropriate, claims that were paid utilizing data that was not current at the time the claim was settled.

Health Net has been in contact with the Department and will be submitting a plan to resolve this matter.

10. EXPLANATION OF BENEFIT STATEMENTS

New York Insurance Law Section 3234(a) states the following:

“Every insurer, including health maintenance organizations ... is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy...”

During the examination, the Company was not able to provide copies of the explanation of benefit forms (EOBs) given to subscribers. Instead, the Company provided documents that appeared to be prepared at the time of the examination in that the dates on those documents were concurrent with the examiner’s request and a heading was appended to the document reading as follows:

“PER YOUR REQUEST, PHS HAS SUMMARIZED YOUR BENEFITS INFORMATION FOR YOU.”

As a result, the only assurance the examiners were able to obtain that the Company was in compliance with the requirements of §3234(a) was an internal document provided by the Company indicating that EOBs were issued for such claims. This is discussed further within Section 12 of this report.

New York Insurance Law §3234(c) creates an exception to the requirements for the issuance of an EOB established in New York Insurance Law §3234(a) as follows:

“[insurers] shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer’s program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid directly to the participating facility or provider.”

Health Net is in violation of New York Insurance Law §3234(a) in that it has acknowledged that it does not send EOBs to its insureds or subscribers when claims from participating providers have been denied for administrative purposes such as “late filing”, “treatment not authorized” and “Missing CPT code”. EOB’s are necessary in these cases

because full reimbursement has not been made and the member has a need to be advised of their liability or lack of liability for such claims.

It is recommended that Health Net comply with NY Insurance Law §3234(a) and send EOB's to its insureds or subscribers when claims from participating providers have been denied for administrative purposes such as "late filing", "treatment not authorized", and "missing CPT code".

New York Insurance Law §3234(b)(3) requires that all EOBs include an identification of the service for which the claim is made. Health Net is in violation of this requirement in that the EOBs it sends do not identify the services performed. Instead, the EOBs only include the general category of care such as "Outpatient" or "Inpatient". The Company maintains it does not itemize the treatment in order to protect the privacy of the subscriber. This reasoning is unacceptable in that it denies the subscriber information needed in order to establish whether an appeal or complaint is warranted.

It is recommended that Health Net comply with NY Insurance Law §3234(b)(3) and include an identification of the service for which the claim is made.

New York Insurance Law §3234(b)(7) requires that all EOB's include the following:

"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 or a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification is made."

Health Net is in violation of this requirement in that its EOB's do not include any of the required information. Instead, the EOBs direct subscribers to their member ID cards in order to obtain the necessary information.

It is recommended that Health Net comply with NY Insurance Law §3234(b)(7) and include on its EOBs 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 or a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification is made.

11. UTILIZATION REVIEW

New York law defines an adverse determination as a determination by a utilization review agent that an admission, extension of stay or other health care service, upon review based on the information provided, is not medically necessary. New York Insurance Law §4903(e) states the following:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include...
(2) instructions on how to initiate standard appeals and expedited appeals...”

HINY is in violation of this subsection, while HNY is in violation of New York Public Health Law §4903, which contains an identical requirement. The reason for these violations is that the initial letters of retroactively determined adverse determinations that Health Net sent to its members for emergency room claims during the examination period contained no language on rights of appeals.

It is recommended that Health Net comply with the applicable laws and include appeals language in all of its initial retroactive denials for medical necessity.

New York Insurance Law §4904(c), in part, states the following:

...The notice of the appeal determination shall include ... (2) a notice of the insured's right to an external appeal together with a description.. of the external appeal process...and the time frames for such external appeals.

HINY is in violation of this subsection, while HNY is in violation of New York Public Health Law §4904, which contains an identical requirement. The reason for these violations is that the letters Health Net submits to its providers after a denial on an appeal of adverse determination do not include the required information. These letters are also a violation for HINY of Part 410.9(e)(8) of New York Regulation 166, which reiterates these requirements.

Further, the letters that Health Net sends to its providers after a denial of an initial appeal of adverse determination are misleading because they state that that initial appeal completes the Health Net provider appeal process, when Health Net does in fact have a second level appeal for providers.

It is recommended that Health Net comply with New York law and include the appropriate appeals language in all adverse determination notices sent to providers.

12. RECORD RETENTION

Part 243.2(b) of Department Regulation 152 (11NYCRR243) establishes the requirement that all “policy records, applications and contracts, claim files, licensing records, financial records or any other record be maintained for six calendar years.” Health Net’s record retention policy establishes limits in violation of this regulation in that its policy requires that such records be maintained for five years.

Additionally, as noted within Section 10 herein, the examiners were not able to obtain copies of the EOBs that the Company sent under the requirements of New York Insurance Law §3234. The Company explained that this was because the production of

EOBs is outsourced to a third party vendor and that, as such, original copies cannot be produced and reproductions cannot be made without “a substantial expenditure of time and resources.” This is a violation of Regulation 152 as described above.

It is recommended that Health Net establish a record retention policy in compliance with Part 243.2(b) of Department Regulation 152 (11NYCRR243), and maintain all records for a minimum of six years.

13. CIRCULAR LETTER NO. 5 (2002)

New York Insurance Department Circular Letter No. 5 (2002) reads as follows:

“It is imperative that the information posted on the Department’s website accurately reflect the premium rate charged or quoted by each insurer or HMO.”

During the examination it was discovered that there were discrepancies between the premium rates charged by Health Net and the rates posted on the Department’s website. These discrepancies involved the Healthy New York program and the Direct Pay program. While two of the discrepancies noted were the result of rounding differences, one was the result of a transcription error.

It is recommended that the Company comply with Circular Letter No. 5 (2002) and ensure that the rates posted on the Department website are accurate.

14. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>CIRCULAR LETTER NO. 9 (1999)</u>	
i. It is recommended that Health Net obtain the certifications suggested by Circular Letter No. 9 (1999) and obtain annual certifications (i) from either the company’s director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company’s general counsel a statement that the company’s current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with the applicable statutes, rules and regulations.	5
ii. It is recommended that the Company prepare “report cards” for the New York entities outlining the timing and accuracy of claim processing.	6
B. <u>CLAIM RECEIPT</u>	
i. It is recommended that paper claims inappropriately sent to Health Net instead of to the third party administrator ACS, be aged from the original received date instead of from the date the claim is received by ACS.	7
C. <u>PROMPT PAY COMPLIANCE</u>	
i. It is recommended that Health Net take steps to ensure it is in compliance with all aspects of New York Insurance Law §3224-a.	10

<u>ITEM</u>	<u>PAGE NO.</u>	
ii.	It is recommended that the Company calculate and pay the appropriate amount of interest only when it is due.	11
D.	<u>CLAIM PROCESSING</u>	
i.	It is recommended that Health Net adjudicate all institutional claims on a line by line basis, paying or requesting additional information, as appropriate.	16
ii.	It is recommended that Health Net re-open all claims from members with Point of Service coverage that were denied for a lack of authorization and reconsider those claims using the member's out-of-network benefit. Further, where such claims are eligible for interest under New York's Prompt Pay law, such interest should be paid.	16
iii.	It is recommended that Health Net re-open all claims from clinics within participating hospitals and re-adjudicate those claims without any restrictions on the place of service.	17
iv.	It is recommended that Health Net retroactively pay all institutional claims that were denied for untimely filing during the period prior to its uniform enforcement of those rules.	18
v.	It is recommended that Health Net uniformly apply its policy regarding the timeliness of claim submitted by non-institutional providers.	18

<u>ITEM</u>	<u>PAGE NO.</u>
vi. It is recommended that Health Net adjudicate identical claims filed multiple times in the order of their receipt. In the event that an initial filing lacks sufficient information to process a claim, and a secondary submission is received prior to the adjudication of the original, then the original submission should be denied with an explanation indicating that that submission was incomplete, and referencing the claim that was paid.	19
vii. It is recommended that Health Net eliminate unenforced contract provisions from its member contracts.	19
viii. It is recommended that Health Net reprocess claims denied as a result of delays in updating a provider's file.	19
ix. It is recommended that Health Net re-adjudicate all claims found to be errors within the Department's adjudication sampling. Additionally, the Company should pay interest on such claims when it is due.	20
x. It is recommended that Health Net have its Internal Auditors conduct a claims audit for the New York entities to ensure that policies and procedures are being properly applied.	20
E. <u>EMERGENCY CARE</u>	
i. It is recommended that the Company re-open all claims with emergency room denials and offer subscriber appeals.	21

<u>ITEM</u>	<u>PAGE NO.</u>	
ii.	It is recommended that Health Net send a revision to its members clarifying member rights under New York Insurance Law.	22
iii.	It is recommended that Health Net ensure that the benefit screens on its claim system reflect the appropriate requirements for each level of care.	22
F. <u>USUAL, CUSTOMARY AND REASONABLE</u>		
i.	It is recommended that, effective in 2003, Health Net update its UCR database on a regular basis to ensure that the most recently available data is utilized in establishing Usual, Customary and Reasonable reimbursement amounts.	23
	Subsequent to the examination date, effective January 1, 2003. Health Net updated its UCR database to reflect 2002 HIAA/ Ingenix reimbursement rates.	
ii.	It is further recommended that Health Net submit a plan acceptable to the Department, to reprocess, where appropriate, claims that were paid utilizing data that was not current at the time the claim was settled.	23
	Health Net has been in contact with the Department and will be submitting a plan to resolve this matter.	

ITEM**PAGE NO.****G. EXPLANATION OF BENEFITS**

- | | | |
|------|---|----|
| i. | It is recommended that Health Net comply with NY Insurance Law §3234(a) and send EOB's to its insureds or subscribers when claims from participating providers have been denied for administrative purposes such as "late filing", "treatment not authorized", and "missing CPT code". | 25 |
| ii. | It is recommended that Health Net comply with NY Insurance Law §3234(b)(3) and include an identification of the service for which the claim is made. | 25 |
| iii. | It is recommended that Health Net comply with NY Insurance Law §3234(b)(7) and include on its EOBs 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 or a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification is made. | 26 |

H. UTILIZATION REVIEW

- | | | |
|----|---|----|
| i. | It is recommended that Health Net comply with the applicable laws and include appeals language in all of its initial retroactive denials for medical necessity. | 26 |
|----|---|----|

<u>ITEM</u>		<u>PAGE NO.</u>
ii.	It is recommended that Health Net comply with New York law and include the appropriate appeals language in all adverse determination notices sent to providers.	27
I.	<u>RECORD RETENTION</u>	
i.	It is recommended that Health Net establish a record retention policy in compliance with Part 243.2(b) of Department Regulation 152 (11NYCRR243), and maintain all records for a minimum of six years.	28
J.	<u>CIRCULAR LETTER NO. 5 (2002)</u>	
i.	It is recommended that the Company comply with Circular Letter No. 5 (2002) and ensure that the rates posted on the Department website are accurate.	28

Appointment No. 21903

**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:

Bruce Borofsky

as a proper person to examine into the affairs of the

Health Net of New York, Inc.

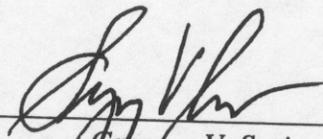
and to make a report to me in writing of the said

Company

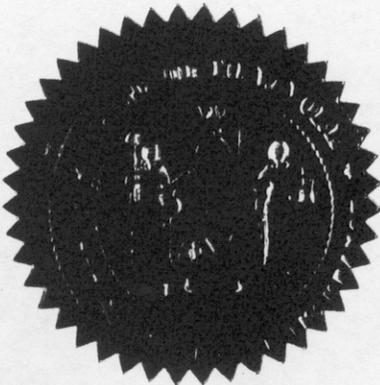
with such information as he shall deem requisite.

*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 6th day of June 2002



Gregory V. Serio
Superintendent of Insurance



Appointment No. 21904

**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:

Bruce Borofsky

as a proper person to examine into the affairs of the

Health Net Insurance of New York, Inc.

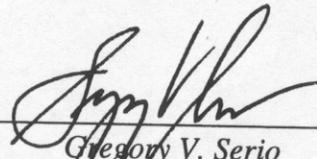
and to make a report to me in writing of the said

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 6th day of June 2002



Gregory V. Serio
Superintendent of Insurance

