

REPORT ON EXAMINATION

OF

MANAGED HEALTH, INC.

AS OF

DECEMBER 31, 2001

DATE OF REPORT

JANUARY 10, 2003
Revised June 2, 2003

EXAMINER

VICTOR ESTRADA

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STATE OF NEW YORK
INSURANCE DEPARTMENT
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NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

June 2, 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 the directions contained in Appointment Number 21752, dated August 1, 2001, annexed hereto, I have made an examination into the condition and affairs of Managed Health, Inc., a not-for-profit health maintenance organization licensed under Article 44 of the Public Health Law at its home office located at 25 Broadway, New York, New York 10004. The following report as respectfully submitted, deals with the findings concerning the manner in which Managed Health, Inc. conducts its financial business transactions and fulfills its contractual obligations to policyholders and claimants.

Whenever the terms "MHI", "the HMO" or "the Plan" appear herein, without qualification, they should be understood to refer to Managed Health, Inc.

1. SCOPE OF EXAMINATION

MHI was previously examined as of December 31, 1993. This examination covers the period from January 1, 1994 through December 31, 2001. Transactions subsequent to this period were reviewed where deemed appropriate.

The examination comprised a verification of assets and liabilities as of December 31, 2001, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by MHI's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

- History of the Plan
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of the Plan
- Reinsurance
- Accounts and records
- Financial statements
- Market conduct activities

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

2. **DESCRIPTION OF PLAN**

Managed Health, Inc. is a not-for-profit group model health maintenance organization (“HMO”) incorporated under Section 402 of the New York Not-For-Profit Corporation Law and was issued a Certificate of Authority pursuant to the provisions of Article 44 of the Public Health Law. On August 1, 1998, HealthFirst, Inc., a not-for-profit non-insurance entity, comprised of twenty-one hospitals, which owns various medical service and administration companies, was granted approval by the New York Department of Health to acquire control of Managed Health, Inc. The transaction was closed on August 21, 1998.

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

MHI contracts with various healthcare providers for the provision of certain medical services to its enrollees. These healthcare providers consist primarily of HealthFirst owner hospitals (“Members”) or their affiliates, and a limited number of providers selected by each Member. Other hospitals may also choose to participate under similar risk sharing terms as the preceding type of hospitals.

In accordance with contractual arrangements with the Members, MHI created two distinct pools to share risk with each of the hospitals, the hospital services pool and the non-hospital services pool. Funds deposited into the hospital services pool are used for payment of inpatient and certain other specified claims for which MHI is at risk.

The amount allocated to the hospital services pool (currently equal to 60% of the per member per month (PMPM) allocation for Medicare premiums and 42% of premium for commercial members) is determined, in part, based upon actuarial projections of inpatient utilization multiplied by a per diem amount of \$1,120. The contract further specifies, however, that actual claims will be paid to the participating hospital at a \$500 per diem level, thus accumulating a significant reserve for the unpaid portion of these claims. The remainder of the PMPM allocation (40% for Medicare and 58% for commercial) is placed into a non-hospital services pool from which MHI pays all claims other than the above-specified hospital services. The participating hospital is at risk for the cost of the non-hospital services to the extent that the contract provides that the amounts allocated to the hospital services pool may be reduced if MHI reasonably determines that the non-hospital services pool is insufficient to pay claims for non-hospital providers; thereby shifting the risk for the poor non-hospital results to the participating hospitals (“pool risk adjustment”). If the non-hospital services account is sufficient to cover medical expenses, the entire hospital services pool is ultimately distributed to the participating hospitals.

MHI entered into two consecutive written contracts with the 1199 National Benefit Fund for Home Care Employees (“1199”) to provide comprehensive health benefits to 1199 members. The first agreement covered the period from September 1, 2000 to June 30, 2001, and a shared risk pool was established within the hospital services pool to cover tertiary care and a portion of out-of-network inpatient claims for 1199 members. The second agreement covered the period from July 1, 2001 to November 30, 2001, and provided that MHI bear the full risk for all 1199 members’ medical costs. The second agreement further provided that 1199 make additional premium payments equivalent to an amount where the cost of covered services (“Covered Services”), defined in the agreement, exceeded a contracted percentage (88%) of premiums paid to MHI. Conversely, if the contracted percentage of premiums paid to MHI were to exceed Covered Services, MHI was to return the excess amount as a premium refund to 1199. The contract also provided for a 12% loading for administrative expenses and profit margin

At December 31, 2001, MHI had estimated that the cost of Covered Services, including claims incurred that had not yet been reported to MHI for the 1199 contract exceeded the contracted percentage of premium payments paid to MHI by approximately \$10,300,000, and this resulted in additional premiums receivable from 1199. Subsequent to the examination date the Plan received \$9.5 million. MHI reported overall net revenue on the 1199 contract, primarily attributable to administrative expenses incurred by MHI that were less than the 12% expense and profit margin built into the contract.

A. Management

Pursuant to its by-laws, the management of MHI is vested in a board of directors. The by-laws of MHI specify that the board shall consist of five individuals, the majority of whom shall be persons nominated to serve on the board by the board of directors of its parent, HealthFirst, Inc. The by-laws also require that at least 20% of the board shall be composed of enrollees who are neither employees of the corporation nor providers of health services. Section 98.1-11(f) of the Administrative Rules and Regulations of the Health Department requires that at least 20% of the board shall be composed of enrollees who are neither employees of the corporation nor providers of health services. MHI has complied with this requirement.

At December 31, 2001, the five members of the board of directors, together with their principal business affiliations were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Paul Dickstein New York, NY	HealthFirst, Inc. President & CEO
Gilbert Marchany Bronx, NY	HealthFirst, Inc. SVP
Donald L. Ashkenase Great Neck, NY	Executive VP, Montefiore Medical Center
Leonard Aubrey Mamaroneck, NY	President & CEO, NYU Downtown Hospital
Richard Murcott* East Norwich, NY	Self employed

*Enrollee representative – per the requirement of Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department {11 NYCRR 98-1.11(f)}.

A review of the attendance records at board of directors' meetings held during the period under examination revealed that meetings were generally well attended. However, Stanley Breznoff, and Donald Ashkenase, failed to attend any of the board meetings they were eligible to attend. Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the HMO. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Board members who fail to attend at least one-half of the board's meetings, unless appropriately excused, do not fulfill such criteria. It should be noted that subsequent to the examination date, Leonard Aubrey and Stanley Breznoff resigned from the board of directors.

The by-laws of MHI were amended in 1998 to provide that the Chairman, and Chairman of the Finance Committee of its parent corporation, HealthFirst, Inc., would serve *ex officio* as directors of MHI. These directors were authorized by the same resolution to designate "alternates", who could attend board meetings with the full authority to act in their absence. Thus, it has been the practice of MHI to have participation of the designated alternates as individuals with full proxy power to act on all issues. All designated alternates have been senior employees of the same participating hospital as the director who has made the designation. The attendance records reflect that where a director did not attend a meeting, his designated alternate attended on his behalf.

It is recommended that MHI evaluate the participation of its board members and determine whether they should resign or be replaced. Furthermore, in selecting

prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of Managed Health, Inc.

The following were the principal officers of MHI as of December 31, 2001:

<u>Name</u>	<u>Title</u>
Paul Dickstein	President
Kelley Gelein	Secretary
Thomas Bergdall	SVP/General Counsel

B. Territory and Plan of Operation

As of December 31, 2001, MHI held a certificate of authority to operate in the following counties of New York State:

Bronx	Queens
Kings	Richmond
Nassau	Suffolk
New York	

MHI's enrollment consisted of 173 direct pay members, 374 commercial group members, 14 Healthy New York members and 17,126 Medicare members at December 31, 2001.

Prior to November 30, 2001, commercial membership included approximately 77,000 "1199" members. Commercial group membership decreased from 76,954 to the above mentioned levels as of November 30, 2001, when "1199" terminated its group contract with MHI.

C. Reinsurance

At the examination date, MHI maintained a reinsurance policy from ACE American Insurance Company, an authorized reinsurer.

Coverage was provided for 90% of eligible services for loss as to each member during the agreement term in excess of a \$75,000 deductible. Additionally, the maximum reinsurance coverage payable under the agreement for eligible charges as to any one member was \$925,000.

The reinsurance agreement contains the standard clauses required by the New York State Insurance Department.

D. Conflict of Interest

MHI does not maintain a code of ethics, nor does it require its officers or directors to annually sign conflict of interest statements.

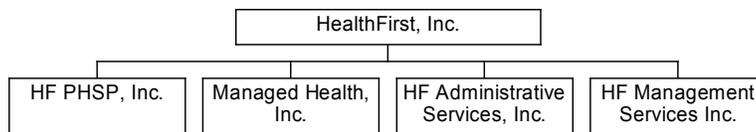
It is recommended that MHI adopt a formal code of ethics and require that its directors and officers annually sign conflict of interest statements.

It should be noted that subsequent to the examination date, in October 2002, MHI provided the examiners with an adopted conflict of interest and disclosure policy, which is applicable to its board and officers.

E. Holding Company System

MHI is a controlled HMO under the definition set forth in Part 98-1.10 of the Administrative Rules and Regulations of the Health Department. HealthFirst, Inc., (“the Organization”) a not-for-profit corporation, was incorporated on March 22, 1993 as a hospital-owned and organized managed care entity. On August 1, 1998, HealthFirst, Inc. was granted approval to acquire control of Managed Health, Inc. and the transaction was closed on August 21, 1998. Section 1307 loans in the amount of \$2.6 million were received by MHI from HealthFirst, Inc. in 1999 and \$7.4 million from “1199” in 2000. Approval was granted by the Superintendent to repay the \$2.6 million loan from HealthFirst on October 21, 2002. Repayment for the \$2.6 million was made on November 12, 2002. Approval was granted to repay the \$7.4 million loan from “1199” on June 11, 2002. Repayment was made on September 10, 2002

As of December 31, 2001, the Holding Company structure was as follows:



MHI has an administrative services agreement (“Agreement”) with HealthFirst, Inc. to obtain management and administrative services, including (where applicable): all marketing and enrollment services, provider recruitment and provider relations services, accounting and financial services support, claims processing, appropriate financial reporting to member hospitals, maintenance of utilization and quality review programs

and all data processing services. The New York State Department of Health approved the Agreement between HealthFirst, Inc. and MHI on August 1, 1998.

F. Report of Independent Certified Public Accountants

MHI's report of independent auditors for its financial statements as of December 31, 2001 and prior years did not contain a reconciliation for the differences between the amounts reported in MHI's filed annual statement and the amounts reported in the auditor's reports, as required by §307(b) of the New York Insurance Law, which states in part:

“...an insurer may comply by filing statements prepared in accordance with generally accepted accounting principles, provided that appropriate reconciliation is made of the differences between net income and capital and surplus reported on that basis and reported in the annual statutory statement filed with the superintendent.”

It is recommended that MHI comply with §307(b) of the New York State Insurance Law and submit to the Department, the independent auditor's financial statements, complete with the reconciliation for the differences between amounts reported in the filed annual statements and the amounts reported in the independent auditor's financial statements.

G. Fidelity Bonds

A review was performed to verify the amount of fidelity coverage that MHI had in effect as of the exam date, utilizing amounts prescribed by the Examiners Handbook of the National Association of Insurance Commissioners (“Examiners Handbook”). While the calculation of fidelity bond policy limits is not a substitute for the risk assessment that

should be made by the Plan in establishing a reasonable level of insurance coverage, findings revealed that MHI's coverage was below the required minimum coverage amount of \$1,250,000 to \$1,500,000, as calculated from the Examiners Handbook. The Plan maintains coverage in the amount of \$1,000,000.

It is recommended that MHI increase its fidelity bond coverage to at least the amount of \$1,250,000, in order to comply with the amount called for in the Examiners Handbook.

H. Accounts and Records

The asset supporting the Escrow deposit required by Part 98-1.11(e) of the Department of Health Administrative Rules and Regulations {11NYCRR 98-1} was incorrectly reported in the Plan's balance sheet. The account title, "asset whose use is limited" is not a proper title. Assets supporting the escrow deposit should be included in the proper cash and/or investment accounts.

It is recommended that the Plan include assets supporting escrow deposits in the proper balance sheet account(s).

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination and as reported by the Plan in its filed December 31, 2001 annual statement:

<u>Assets</u>	<u>Examination</u>	<u>Plan</u>	<u>Net Worth Increase (Decrease)</u>
Cash	\$64,277,932	\$64,277,932	
Health care receivables	12,192,675	13,990,480	\$(1,797,805)
Asset whose use is limited	<u>7,307,723</u>	<u>7,307,723</u>	
Total assets	<u>\$83,778,330</u>	<u>\$85,576,135</u>	<u>\$(1,797,805)</u>
<u>Liabilities</u>	<u>Examination</u>	<u>Plan</u>	<u>Net Worth Increase (Decrease)</u>
Claims unpaid	\$44,078,879	\$44,078,879	
Premiums received in advance	11,399,880	11,399,880	
General expenses	820	820	
Amounts due to parent	226,872	226,872	
Other current liabilities	<u>1,742,681</u>	<u>1,742,681</u>	
Total liabilities	<u>\$57,449,132</u>	<u>\$57,449,132</u>	
<u>Net Worth</u>			
Gross paid in and contributed surplus	\$ 27,763,327	\$ 27,763,327	
Surplus notes*	9,989,043	9,989,043	
Contingency reserves	7,307,724	7,307,724	
Unassigned funds (surplus)	<u>\$(18,730,896)</u>	<u>\$(16,933,091)</u>	<u>(1,797,805)</u>
Total net worth	<u>26,329,198</u>	<u>28,127,003</u>	<u>\$(1,797,805)</u>
Total liabilities and net worth	\$ <u>83,778,330</u>	<u>\$85,576,135</u>	

No liability appears in the balance sheet for a loan in the amount of \$9,989,043. This loan was granted pursuant to Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of the loan shall be made out of free and divisible surplus, subject to the prior approval of the Superintendent of Insurance of the State of New York.

The HMO did not include the required language from Section 1307 of the New York Insurance Law, shown above, on its filed financial statements during the examination period.

It is recommended that the HMO comply with §1307 of the New York Insurance Law and add a footnote to page 3 of its annual and quarterly statements filed with the Department, showing the HMO's outstanding §1307 loan and interest accrued thereon.

During 2002, the §1307 loans were repaid. In the event MHI obtains another §1307 loan, it should comply with the requirements of §1307 of the New York Insurance Law.

For the period under examination, the Internal Revenue Service has not performed any audits of the Plan's tax returns. The examiner is unaware of any potential exposure of the Plan to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Net Worth

Reserves and unassigned funds increased \$25,474,838 during the examination period, January 1, 1994 through December 31, 2001, detailed as follows:

<u>Revenue</u>		
Premiums	\$ 473,339,100	
Net investment income	6,129,552	
Aggregate write-ins	26,798,271	
Other revenues	<u>508,729</u>	
Total revenue		<u>\$506,775,652</u>
<u>Expenses</u>		
Total medical and hospital expenses	\$ 436,930,279	
Administration expenses	<u>72,306,886</u>	
Total expenses		<u>509,237,165</u>
Loss		(2,461,513)
Extraordinary gain		<u>2,082,837</u>
Net Loss		<u>\$ (378,676)</u>

Changes in Net Worth

Net worth per examination as of December 31, 1993 \$ 854,360

	<u>Gains in Net Worth</u>	<u>Losses in Net Worth</u>	
Net loss		\$ (378,676)	
Increase in paid in surplus	\$21,963,327		
Increase in contributed surplus	5,800,000		
Increase in surplus notes	7,989,043		
Change in non-admitted assets		(10,803,764)	
Aggregate write ins for changes in net worth	<u>904,908</u>		
Total gains and losses	<u>\$36,657,278</u>	<u>\$(11,182,440)</u>	
Net increase in net worth			<u>25,474,838</u>

Net worth December 31, 2001
per Report on Examination \$26,329,198

4. HEALTH CARE RECEIVABLES

The examination asset of \$12,192,675 is \$1,797,805 less than the \$13,990,480 reported by the Plan in its filed Annual Statement as of December 31, 2001.

The examination non-admitted \$1,797,805 of the reported asset primarily due to downward adjustments negotiated between MHI and "1199" subsequent to the examination date. In addition, the Plan made additional adjustments to its stop-loss allowance for doubtful accounts that were not incorporated in its filed annual statement.

5. CLAIMS PAYABLE

The examination liability of \$44,078,879 is the same as the amount reported by the Plan in its filed Annual Statement as of December 31, 2001.

The examination analysis was conducted using statistical information contained in the Plan's internal records and in its filed annual and quarterly statements, as well as information provided by the Plan. Such analysis utilized the Plan's historical payment run-off pattern, appropriately modified to claims incurred in 2001.

During this review it was noted that the HMO does not establish a reserve for prescription drugs.

It is recommended that MHI track the development of the prescription drug component of its claim reserves separately from its other claim reserve components.

As part of the claims review process, the examiners requested a reconciliation of Schedule F (Claims Payable) as contained in the Plan's 2001 Annual New York Data Requirements in order to verify the integrity of the reported data. The examiners encountered a considerable delay in waiting for MHI to provide such information.

The initial request for a reconciliation of claims paid to Schedule F, "Section 3-Analysis of Unpaid Claims - "Previous Year" was made by the examiners in a meeting with MHI personnel on March 5, 2002. Despite frequent follow-up requests, a properly completed reconciliation was not provided to the examiners until June 6, 2002.

As a result of the claims review, including receipt of said reconciliation, it was noted that the HMO did not complete Schedule F properly as set forth in the annual statement instructions. Specifically:

- MHI does not adequately report total incurred claims, before application of the "pool risk adjustment" (see pages 3 and 4, herein) in its annual and quarterly financial statements filed with the Department, so as to adequately disclose claims incurred in the absence of the pool structure.

It is recommended that MHI adequately disclose, in its filed annual and quarterly financial statements, incurred claims in the absence of the "pool structure". Correct reporting would allow for improved monitoring of the adequacy of its liabilities.

It is recommended that MHI prepare Schedule F, Section 3 of its Annual New York Data Requirements, and Schedule 3 of its Quarterly New York Data Requirements filing properly as respects the following:

1. Report actual cash disbursed at the provisional payment (per diem) for hospital claims on the applicable line in Columns 1 and 2 of Schedule F, Section 3.
2. Report interim pool disbursements to hospitals on line 8 in Columns 1 and 2 of Schedule F, Section 3.
3. Calculate an estimated hospital claims unpaid liability based upon lag analysis using: a) the provisional per diem rate; and b) the estimated full Board approved inpatient target per diem as described earlier herein. Report the resulting estimated hospital claims liability calculated in a), on the applicable line in Columns 3 and 4 of Schedule F, Section 3. Report the difference between the liability calculated in a) and b), on line 8 in Columns 3 and 4 of Schedule F, Section 3.
4. Report any hospital and non-hospital pool funds in excess of the total calculated claims unpaid liability, on line 8, "Other", in Columns 3 and 4 of Schedule F, Section 3.
5. Report any adjustments in the claims liability resulting from the application of pool risk adjustments on line 10, "Medical Incentive Pool Adjustments", in Columns 3 and 4 of Schedule F, Section 3.

It is further recommended, that the Plan correct and resubmit Schedule F, Section 3 as of December 31, 2001 and for its 2002 quarterly filings.

- MHI does not properly reflect development of the prior year's claim liability in Schedule F, Section 3 of the Annual New York Data Requirements and Schedule 3 of its Quarterly New York Data Requirements, in that it reports current year development as equal to the prior year's reported liability.

It is recommended that in Column 1 of Schedule F, Section 3 in the Annual New York Data Requirements and Column 1 of Schedule 3 in the Quarterly Data Requirements, the HMO report actual claims paid in the current year and incurred in the prior year. Any interim pool disbursements to hospitals made in the current year for prior year experience should be reported on line 8 in Column 1. Further, Column 3 should reflect as unpaid claims, any excess pool liability remaining (line 8 – “Other”) and any pool risk adjustment (line 10 – Medical Incentive Pool), recorded in the current year for prior year incurred dates.

The above comments and recommendations also apply to MHI's completion of Part 2B of the Underwriting and Investment Exhibit in its NAIC Health Annual Statement filings.

6. MARKET CONDUCT

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

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

- A. Agents and brokers
- B. Claims processing (including Prompt Pay Law and utilization review)
- C. Schedule H preparation
- D. Fraud prevention and detection
- E. Grievances, appeals and complaints

The following are the examiners' findings:

A. Agents and Brokers

As permitted by Article 21 of the New York Insurance Law, MHI contracted with licensed agents and brokers to generate business on certain health insurance contracts. MHI also utilized salaried employees in its internal Sales Department to assist in the solicitation and enrollment of members in its Medicare and commercial products.

A review of MHI's sales practices and agents' and brokers' licensing information was conducted as detailed below:

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

Said statute states:

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

Managed Health, Inc. utilized unlicensed employees to solicit members. §2101 of the New York Insurance Law defines the term “insurance agent” and denotes an exemption to the licensing of any “regular salaried officer or employee of a licensed insurer” under certain conditions.

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

“such officer or employee does not receive a commission or other compensation for his services which commission or other compensation is directly dependent upon the amount of business obtained.”

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

Additionally §2114(a)(3) of the New York Insurance Law states:

“No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting or procuring in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article.”

With respect to internal sales personnel, it should be noted that MHI was unable to provide evidence that one hundred and fifty persons, or 83% of its internal sales force was properly licensed.

In view of the foregoing, it appears that MHI violated New York Insurance Law §2102(a)(1) and §2114(a)(3) in that commissions were paid to unlicensed internal sales representatives.

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

§2112(a) of New York Insurance Law states:

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

MHI violated New York Insurance Law §2112(a) in that no certificates of appointment were on file for any of its insurance agents as prescribed by statute. Furthermore, no agency contract was on file for 4 of the 10 contracts requested by the examiners.

It is recommended that MHI comply with New York Insurance Law, §2112(a) and file all certificates of appointment for its insurance agents with the Department as prescribed by statute, and that it maintain evidence of such filings.

New York Insurance Law, §2112(d) states in part:

“...Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall upon termination of the certificate of appointment of any insurance agent licensed with 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.”

No evidence of notification to the Department of terminated producers was provided by MHI. Accordingly, it appears that MHI violated New Insurance Law §2112(d) in that it did not report any of its terminated insurance agents to the Department.

It is recommended that MHI comply with New York Insurance Law, §2112(d) and report terminated insurance agents to the Department as prescribed by statute.

B. Claims Processing

i. Overall Claims Accuracy

A review of MHI's claims practices and procedures was performed by using a statistical sample covering claims paid during the period of January 1, 2001 through December 31, 2001, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiners selected a sample of 167 claims, which included medical claims along with non-member hospital claims.

The statistical random sampling process 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.

Exam findings indicate that there are some internal control and claims processing deficiencies within MHI's claims processing system. These deficiencies appear to have some impact on MHI's ability to process claims with minimal errors on a timely basis. An estimated overall processing procedural accuracy level of 89.82% for MHI's Medical and Hospital claims combined is indicated based upon the results of the examination review. 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 MHI's claim processing guidelines. An error in processing accuracy may or may not affect the financial accuracy. There were no financial errors.

In summary, of the 167 claims reviewed, nineteen contained claims processing procedural errors. There were no financial errors. MHI has currently established key performance indicators for quality of 98.23% and 98.18% for procedural and financial accuracy, respectively. The examination findings show a 8.41% gap for procedural accuracy.

The following chart illustrates the procedural claims accuracy findings summarized above:

Summary of Procedural Accuracy

Claim population	619,851
Sample size	167
Number of claims with procedural errors	17
Calculated error rate	10.18%
Upper error limit	14.77%
Lower error limit	5.59%
Upper limit claims in error	91,526
Lower limit claims in error	34,671

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

The following represents examples of claims processing findings and issues:

- There were ten claims where the examiners were unable to verify the fee schedule used to pay the claim, since the fee schedules were modified, but no documentation supporting said modifications were maintained.
- The plan does not maintain claim files as required, however most information, with the exception of fee schedules, was available and provided to the examiners, which was sufficient to support or justify the ultimate claim determination.

Department Regulation 152 {11NYCRR 243.2(b)(4)} states:

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

“(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and other disposition of the claim, including the dates that forms and other documents were received.”

It is recommended that the Plan comply with Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify the fee schedules used to pay claims, for a period of six years, or until after the filing of the report on examination, whichever is longer.

- In addition, there were seven claims that were manually adjusted, and were paid without any documentation. It appears that the Plan had some problems with system edits and claim examiners improperly overriding the claims system to pay claims that were already paid.

It is recommended that MHI implement the proper controls in order to prevent claims from being overridden without proper authority and documentation.

ii Prompt Pay Law

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

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

“(a) Except in a case where the obligation of an insurer to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis

supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered.”

§3224-a(c) of the New York Insurance 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 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.”

Examination procedures included choosing a statistical sample to determine whether claims were paid within 45 days of receipt pursuant to §3224-a(a) of the New York Insurance Law, and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. There were 18,820 claims in 2001 that took more than 45 days to pay. Accordingly, all claims that were not paid within 45 days during 2001, and may have had interest payable in an amount that would have exceeded the two-dollar threshold were segregated. A statistical sample of 167 claims was selected from this population to determine whether the claims were in violation of §3224-a(a) and whether they were subject to interest as required by §3224-a(c).

Of the 167 claims selected, the Plan provided valid explanations for 62 that were not violations of §3224-a(a). Of the remaining 105 claims, 15 claims were found to be

interest eligible. Interest due was properly paid for all of these claims. Therefore, no violations of §3224-a(c) were noted.

The results of the review for compliance with §3224-a(a) are as follows:

<u>TYPE OF CLAIM</u>	<u>NUMBER OF CLAIMS SELECTED *</u>	<u>NUMBER OF CLAIMS THAT VIOLATE §3224-a(a)</u>	<u>ERROR RATIO</u>
HOSPITAL & MEDICAL	167	105	62.8%

Note: * The number of claims over 45 days from the overall population amounted to 18,820. Thus, a statistical sample of 167 randomly selected claims produced a sample with a confidence level of 95% and error rate of 5%. This is within accepted ranges for valid claims sampling techniques.

It is noted that the error rate above relates to the population of 18,820 claims used for the sample, which consisted of only claims adjudicated in 2001 that were not paid within forty-five days from receipt. The total population of claims that were processed during 2001 was 619,851.

It was noted that the operations of the Plan's claims processing office were adversely affected by its proximity to the World Trade Center disaster of September 11, 2001. However, the examiner did not perform any specific procedures to determine the impact of the events of September 11, on the Plan's compliance with Section 3224-a(a) of the New York Insurance Law.

It is recommended that MHI comply with Section 3224-a(a) of the New York Insurance Law.

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

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

MHI was unable to demonstrate that any such correspondence was sent out on any of the claims reviewed.

It is recommended that MHI comply with §3224-a(b) of the New York Insurance Law and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: (1) that it is not obligated to pay the claim, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine liability to pay the claim.

It is further recommended that MHI complies with Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify its compliance with §3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer.

iii. Utilization review

§4902, §4903, and §4904 of the New York State Public Health Law set forth the minimum utilization review program standards and requirements of utilization review determinations and appeals of adverse determinations by utilization review agents, respectively.

All utilization reviews performed during 2001 were administered by HealthFirst's Medical Management Department. MHI reported nineteen cases in its 2001 filed New York Data Requirements. All files were reviewed to determine compliance with §4902, §4903 and §4904 of the New York State Public Health Law.

§4904(3) of the New York State Public Health Law states:

“(3). A utilization review agent must establish a period of no less than 45 days after receipt of notification by the enrollee of the initial utilization review and receipt of all necessary information to file an appeal from said determination. The utilization review agent must ...and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal.”

It is noted that for five of the nineteen files reviewed (26%), MHI failed to complete the utilization review appeals within sixty days.

It is recommended that MHI comply with §4904(3) of the New York State Public Health Law and complete utilization review appeals within 60 days of receipt of the information necessary to conduct the appeal.

iv. Explanation of Benefits Statements (“EOB”)

As part of the review of MHI’s claims practices and procedures, an analysis of the “EOBs” sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and MHI. It should clearly communicate to the subscriber and/or provider that MHI has processed a claim and how that claim was processed. The EOB should also correctly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other carriers.

Overall, MHI’s EOBs are easy to read and understand. However, the following was noted:

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

“(b) The explanation of benefits form must include at least the following...

(7)...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.”

Contrary to the above provision of the Insurance Law, MHI does not include the aforementioned requisite information on its EOBs. Accordingly, subscribers and/or providers are not being properly informed of their appeal rights.

It is recommended that MHI modify its EOBs to comply with §3234(b)(7) of the New York Insurance Law.

C. Schedule H

A review of MHI's Schedule H ("Aging Analysis of Claims Unpaid") in its filed annual statement with the Department for year-end 2001, evidenced MHI's inability to adequately ascertain the aging of its unpaid claims.

To illustrate the problem, it was noted that, as of December 31, 2001, MHI filed the following data with respect to Schedule H ("Aging Analysis of Claims Unpaid"):

Managed Health, Inc., December 31, 2001 Schedule H- Aging of Claims Unpaid

SECTION 1 OF FILED SCHEDULE H PER MHI						
Account	1-30 Days	31-60 Days	61-90 Days	91-120 Days	91-120 Days	Total
1.2 Aggregate Accounts Not Individually Listed	\$10,827,370	\$6,126,890	\$677,677	\$256,683	\$1,011,820	\$18,900,440
SECTION 1 OF SCHEDULE H PER EXAMINATION						
1.2 Aggregate Accounts Not Individually Listed	9,660,341	1,431,073	1,505,439	1,035,590	5,851,418	19,680,194
Difference	\$(1,167,029)	\$(4,695,817)	\$827,762	\$778,907	\$4,839,598	\$779,754

SECTION 2 OF FILED SCHEDULE H PER MHI			
	1-45 Days	Over 45 Days	Total
Payable to Physicians	\$7,952,120	\$881,655	\$8,833,776
Payable to Hospitals	8,215,529	1,851,135	10,066,664
Totals (REPORTED)	\$16,167,649	\$2,732,791	\$18,900,439
SECTION 2 OF SCHEDULE H PER EXAMINATION			
Payable to Physicians	\$4,506,672	\$1,331,581	\$5,838,252
Payable to Hospitals	5,966,942	7,875,000	13,841,942
TOTALS (REVISED)	10,473,614	9,206,581	19,680,194
Difference	\$(5,694,035)	\$6,473,790	\$779,755

MHI reported claims which were “paid” after year-end 2001, rather than those received but unpaid at year end 2001, and aged such paid claims from the date of receipt to the date of payment.

It is recommended that MHI take the necessary steps to enable it to complete its Schedule H (“Aging Analysis of Claims Unpaid”) in accordance with the Annual Statement instructions.

D. Fraud Prevention and Detection

A review was performed of the organization and structure of MHI’s Special Investigation Unit, and its compliance with §405 of the New York Insurance Law and Department Regulation 95 (11NYCRR 86), with respect to the reporting of fraud cases to the Department. As a result, the following was noted:

As of June 11, 2001, MHI’s Special Investigation Unit consisted of only one person, the Manager. MHI expended \$69,850 on the SIU and recovered \$20,000 in 2002 for services that appeared to be fraudulent. Additionally, there was \$776,171 recoverable due to duplicate claims payment.

The total number of cases reviewed by MHI was erroneously reported to the Department’s Frauds Bureau. The Plan had 4,395, but 4,662 were reported; however, only one actual case of fraud was submitted to the Department’s Frauds Bureau.

MHI paid over \$50 million and \$200 million dollars in claim payments in 2000 and 2001, respectively. Both the General Accounting Office (“GAO”) and the Health Insurance Association of America (“HIAA”) estimate that approximately 10% of all medical claims are fraudulent. MHI was able to identify as fraudulent and recoup less than 1% of total claim payments for 2000 and 2001, respectively. It should be noted that due to MHI’s structure, the aforementioned 10% appears too high, however, it appears that MHI should be recouping more than 1% of the claim amounts it pays.

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

E. Grievances, Appeals and Complaints

A review of grievances and appeals filed with MHI for 2001 was performed to ascertain compliance with Article 4408-a of the New York State Public Health Law (“Grievance Procedure”).

During 2001, MHI reported 1,041 grievances and appeals. Upon review, it was found that 1,033 should have been reported. This discrepancy was due to an oversight on the part of the Plan. Fourteen files were arbitrarily selected for review by the examiners. It was noted that for seven of the grievances, MHI closed the cases and sent out correspondence saying that although they were investigating the grievance, they were closing the file at the current time.

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

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

“4. Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:

(i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee’s health:

(ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract: and

(iii) forty-five days after the receipt of all necessary information in all other instances.”

MHI did not provide a timely written acknowledgement to the member within 15 business days of receipt of the grievance in six of the fourteen grievance files reviewed (42%), as required by §4408-a(4) of the New York State Public Health Law.

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

MHI failed to resolve grievances within forty-five days on seven of fourteen files (50%) pertaining to issues other than questions of coverage as required by §4408-a(4)(iii) of the New York State Public Health Law.

It is recommended that MHI take steps to assure that all grievances are resolved within the 45 days allowed by Law.

A review of complaints filed with the Insurance Department for the examination period was performed to verify compliance with Circular Letter #11 (1978). MHI failed to maintain a log for complaints received through the New York State Insurance Department's Consumer Services Bureau as required by the Circular Letter.

When the examiner brought Circular Letter #11 (1978) to the attention of MHI personnel, a complaint log was created, as is required by the Circular Letter. However, the examiners were unable to reconcile MHI's listing of complaints to the Insurance Department's Consumer Service Bureau listing. The Department listing had 205 complaints filed, whereas MHI's log had only 101 complaints listed.

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

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained sixteen comments and recommendations as follows (page numbers refer to the prior report):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	<p><u>Capital Contributions</u></p> <p>It is recommended that MHI request CHP to infuse the remaining portion of the Section 1307 loan agreement or apply to the Superintendent to nullify the final \$500,000 infusion.</p> <p>It should be noted that subsequent to the date of the prior examination, CHP effectively infused the capital contribution by executing a section 1307 loan agreement in the amount of \$1,219,391.</p>	8
2.	<p><u>Reinsurance</u></p> <p>It is recommended that MHI ensure that all claim recoveries are remitted directly to itself.</p> <p>It is recommended that MHI review the administration and transactions relating to reinsurance and maintain a record of all claim reimbursements remitted by the reinsurer.</p> <p>MHI has complied with these recommendations.</p>	9 9

ITEM NO.PAGE NO.

- | | | |
|----|---|----|
| 3 | <p><u>Conflict of Interest</u></p> <p>It is recommended that MHI distribute conflict of interest statements annually and that a conflict of interest committee be established to oversee the policy guide and handle any information disclosed on the policy statement.</p> <p>MHI did not comply with this recommendation. A similar recommendation is made in this report.</p> <p>It is recommended that such committee keep minutes of proceedings and report thereon to the full board.</p> <p>MHI has complied with this recommendation.</p> | 10 |
| 4. | <p><u>The New York Health Care Alliance</u></p> <p>It is recommended that the Board of Directors of MHI make a good faith business decision in deciding whether or not to attempt to recoup all monies advanced to the New York Health Care Alliance. Such decision should consider the opinion of the HMO's legal counsel as to the likelihood and amount of recoupment and the projected cost of recoupment or any material adverse business effect caused by the attempted recoupment.</p> <p>Due to the acquisition of MHI by HealthFirst in August 1998, and the negotiation of settlement between parties, this recommendation no longer applies.</p> | 12 |
| 5. | <p><u>Management Agreements</u></p> <p>It is recommended that MHI seek the Commissioner's approval to assign the contract to Managed Health Services, Inc. in accordance with the terms of the management contract.</p> | 14 |

ITEM NO.PAGE NO.

Subsequent to the examination date, MHI submitted to NYS department of Health a revised management and administrative agreement between MHI and CHP. This agreement is currently under review.

It is recommended that MHI compensate CHP in accordance with the terms of its management agreement.

14

It is further recommended that MHI recalculate its management fees payable to CHP in accordance with the terms of the aforementioned contract and make any necessary adjustments resulting therefrom.

14

MHI has complied with these recommendations.

6. Accounts and Records

It is recommended that MHI establish and maintain a system of accounts receivable with proper ledgers, sub-ledgers, billing and collection records, aging of accounts receivable reports and schedules.

16

MHI has complied with this recommendation.

7. Vouchers for Disbursements

It is recommended that MHI retain copies of paid invoices along with the supporting voucher for disbursement.

17

MHI has complied with this recommendation.

8. Accounting and Procedures Manual

It is recommended that MHI prepare and maintain an accounting procedures manual.

17

MHI has complied with this recommendation.

<u>ITEM NO.</u>		<u>PAGE NO.</u>
9.	<u>Accounting and Finance Personnel</u>	
	It is recommended that MHI retain supporting documentation relative to any amounts charged for services that are provided to MHI.	18
	MHI has complied with this recommendation.	
10.	<u>Annual Statement Filing</u>	
	It is recommended that MHI exercise greater care in the preparation of the New York Data Requirements and the Association Edition Annual Statement.	19
	MHI has complied with this recommendation.	
11.	<u>Report of Independent Accountants</u>	
	It is recommended that MHI comply with §307(b) of the New York State Insurance Law and submit to the Department, the Independent Auditors Financial Statements, complete with the reconciliation of the differences between the amounts reported in the filed annual statements and the amounts reported in the Independent Auditors Financial Statements.	20
	MHI did not comply with this recommendation. A similar recommendation is made in this report.	
12.	<u>Premium Receivable</u>	
	It is recommended that MHI diligently pursue overdue balances in accordance with the terms of the subscriber contracts, or terminate the group as required by contract.	25
	It is recommended that MHI comply with the requirements of 10 NYCRR 98.11(b).	25

ITEM NO.PAGE NO.

MHI has complied with these recommendations.

13. Restricted Cash and Other Assets

It is recommended that MHI properly calculate and report its restricted cash in accordance with 10 NYCRR Part 98.11(e).

26

MHI has complied with this recommendation.

14. Furniture and Equipment

It is recommended that MHI exercise greater care in maintaining records for furniture and equipment to substantiate the amounts reported in the filed annual statement.

26

MHI has complied with this recommendation.

15. Accounts Payable

It is recommended that MHI exercise greater care in accruing all expenses incurred as of the end of the reporting year.

27

It is recommended that all bank transfers have the appropriate written authorization.

27

MHI has complied with these recommendations.

16. Treatment of Policyholders and Claimants

It is recommended that appropriate action be taken by the Department relative to MHI issuing a contract to enrollees for membership in a comprehensive health services plan without first obtaining a certificate of authority from the Commissioner pursuant to §4402 of the Public Health Law.

30

It is recommended that action be taken by the Department relative to the premiums charged in violation of §4308 of the New York Insurance Law.

30

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>		<u>PAGE NO.</u>
A.	<u>Management</u>	
	It is recommended that MHI evaluate the participation of its board members and determine whether they should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of Managed Health, Inc.	7
B.	<u>Conflict of Interest</u>	
	It is recommended that MHI adopt a formal code of ethics and require that its directors and officers annually sign conflict of interest statements.	9
	It should be noted that subsequent to the examination date, in October 2002, MHI provided the examiners with an adopted conflict of interest and disclosure policy, which is applicable to its board and officers.	
C.	<u>Report of Independent Certified Public Accountants</u>	
	It is recommended that MHI comply with §307(b) of the New York State Insurance Law and submit to the Department, the independent auditor's financial statements, complete with the reconciliation for the differences between amounts reported in the filed annual statements and the amounts reported in the independent auditor's financial statements.	11

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Fidelity Bonds</u>	
It is recommended that MHI increase its fidelity bond coverage to at least the amount of \$1,250,000, in order to comply with the amount called for in the Examiners Handbook.	12
E. <u>Accounts and Records</u>	
It is recommended that the Plan include assets supporting escrow deposits in the proper balance sheet account(s).	12
F. <u>Balance Sheet</u>	
It is recommended that the HMO comply with §1307 of the New York Insurance Law and add a footnote to page 3 of its annual and quarterly statements filed with the Department, showing the HMO’s outstanding §1307 loan and interest accrued thereon.	14
During 2002, the §1307 loans were repaid. In the event MHI obtains another §1307 loan, it should comply with the requirements of §1307 of the New York Insurance Law.	
G. <u>Claims Payable</u>	
i. It is recommended that MHI track the development of the prescription drug component of its claim reserves separately from its other claim reserve components.	16
ii. It is recommended that MHI adequately disclose, in its filed annual and quarterly financial statements, incurred claims in the absence of the “pool structure”. Correct reporting would allow for improved monitoring of the adequacy of its liabilities.	17
iii. It is recommended that MHI prepare Schedule F, Section 3 of its Annual New York Data Requirements, and Schedule 3 of its Quarterly New York Data Requirements filing properly (i.e. reflecting actual claim payments at the “reduced level” actually paid, indicating the balances remaining in the “pools”).	18

<u>ITEM</u>	<u>PAGE NO.</u>
iv. It is further recommended, that the Plan correct and resubmit Schedule F, Section 3 as of December 31, 2001 and for its 2002 quarterly filings.	18
v. It is recommended that in Column 1 of Schedule F- Section 3, in the Annual New York Data Requirements, and Column 1 of Schedule 3 in the Quarterly Data Requirements, the HMO report actual claims paid in the current year and incurred in the prior year. Any interim pool disbursements to hospitals made in the current year for the prior year experience should be reported on line 8 in Column 1. Further, Column 3 should reflect as unpaid claims any excess pool liability remaining (line 8 – “Other”) and any pool risk adjustment (line 10 – Medical Incentive Pool), recorded in the current year for prior year incurred dates.	19
<p>The above comments and recommendations also apply to MHI’s completion of Part 2B of the Underwriting and Investment Exhibit in its NAIC Health Annual Statement filings.</p>	
H. <u>Agents and Brokers</u>	
i. It is recommended that MHI ensure that its employees who earn a commission or fee based on sales maintain the requisite license in compliance with New York Insurance Law §2102(a)(1), and that the Plan act in compliance with New York Insurance Law §2114(a)(3) to ensure that commissions are only paid to licensed agents.	22
ii. It is recommended that MHI comply with New York Insurance Law, §2112(a) and file all certificates of appointment for its insurance agents with the Department as prescribed by statute, and that it maintain evidence of such filings.	23
iii. It is recommended that MHI comply with New York Insurance Law, §2112(d) and report terminated insurance agents to the Department as prescribed by statute.	23

<u>ITEM</u>	<u>PAGE NO.</u>
I. <u>Claims Processing</u>	
i. It is recommended that the Plan comply with Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify the fee schedules used to pay claims, for a period of six years, or until after the filing of the report on examination, whichever is longer.	26
ii. It is recommended that MHI implement the proper controls in order to prevent claims from being overridden without proper authority and documentation.	26
J. <u>Prompt Pay Law</u>	
i. It is recommended that MHI comply with Section 3224-a(a) of the New York Insurance Law.	28
ii. It is recommended that MHI comply with §3224-a(b) of the New York Insurance Law and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: (1) that it is not obligated to pay the claim, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine liability to pay the claim.	29
iii. It is further recommended that MHI complies with Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify its compliance with §3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer.	29
K. <u>Utilization review</u>	
It is recommended that MHI comply with §4904(3) of the New York State Public Health Law and complete utilization review appeals within sixty days of receipt of the information necessary to conduct an appeal.	30

<u>ITEM</u>	<u>PAGE NO.</u>
L. <u>Explanation of Benefits Statements (“EOB”)</u>	
It is recommended that MHI modify its EOBs to comply with §3234(b)(7) of the New York Insurance Law.	31
M. <u>Schedule H</u>	
It is recommended that MHI take the necessary steps to enable it to complete its Schedule H (“Aging Analysis of Claims Unpaid”) in accordance with the Annual Statement instructions.	33
N. <u>Fraud Prevention and Detection</u>	
It is recommended that MHI exercise due care in preparing its Annual Report to ensure that it accurately reflects all fraudulent cases.	34
O. <u>Grievances, appeals and complaints</u>	
i. It is recommended that MHI not close a grievance file prior to completion of its review.	35
ii. It is recommended that MHI provide a written acknowledgement for grievances filed as required by §4408-a(4) of the New York State Public Health Law.	35
iii. It is recommended that MHI take steps to assure that all grievances are resolved within the 45 days allowed by Law.	36
iv. It is recommended that the HMO update its complaint log to include all complaints received through the Insurance Department.	36

Respectfully submitted,

Victor Estrada,
Senior Insurance Examine

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

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

Victor Estrada

Subscribed and sworn to before me
this ____ day of _____ 2003.

Appointment No. 21752

**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:

Victor Estrada

as a proper person to examine into the affairs of the

MANAGED HEALTH, INC.

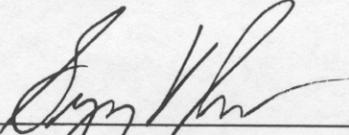
and to make a report to me in writing of the said

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 1st day of August 2001



Gregory V. Serio
Superintendent of Insurance

