MARKET CONDUCT REPORT ON EXAMINATION

OF

EMPIRE HEALTHCHOICE ASSURANCE, INC

AND

EMPIRE HEALTHCHOICE HMO, INC.

AS OF

MARCH 31, 2003

DATE OF REPORT	**JULY 23, 2004** **Revised July 18, 2005**
EXAMINER	**WAI WONG**

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

George E. Pataki
Governor

Howard Mills
Superintendent

July 18, 2005

Honorable Howard Mills
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 Appointments 21985 and 21986 dated January 17, 2003 and annexed hereto, I have made an examination into the condition and affairs of Empire HealthChoice Assurance, Inc. an accident and health insurer licensed under Article 42 of the New York Insurance Law and Empire HealthChoice HMO, Inc. a for-profit health maintenance organization licensed under Article 44 of the New York State Public Health Law. The following report, as respectfully submitted, deals with the manner in which Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc. conduct their business practices and fulfills their contractual obligations to policyholders and claimants.

Whenever the term "Empire" appears herein without qualification, it should be understood to mean Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc. Whenever the term "the Company" appears herein without qualification, it should be understood to mean Empire HealthChoice Assurance, Inc. Whenever the term "the HMO" appears herein without qualification, it should be understood to mean Empire HealthChoice HMO, Inc.

1. SCOPE OF EXAMINATION

An examination was performed of the manner in which Empire conducts its business practices and fulfills its contractual obligations to policyholders and claimants. This "Market Conduct" examination covers the period January 1, 2002 to the date of this report. The primary purpose of this report is to assist Empire's management in addressing problems that are of such a critical nature that immediate corrective action is required. Accordingly, this report contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

Effective on November, 2002, Empire Blue Cross and Blue Shield converted from an Article 43 health service corporation to an Article 42 for-profit accident and health insurer, and changed its name to Empire HealthChoice Assurance, Inc. Simultaneously with the conversion, Empire Blue Cross and Blue Shield merged with its Article 42 subsidiary. The Company continues to do business as Empire Blue Cross and Blue Shield in the State of New York. The Company is the owner of Empire HealthChoice HMO, Inc., an Article 44 HMO. The Company is a wholly-owned subsidiary of WellChoice Holdings of New York, Inc., which in turn, is wholly-owned by WellChoice, Inc. a for-profit, publicly traded holding company. Unless otherwise noted, the findings contained herein concerning the Company relate to its operations as an Article 42 insurer.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicate areas of weakness and/or directly impacted Empire's compliance with the New York Insurance Law and the New York Public Health Law. The most significant findings of this examination include the following:

- Evaluation and Management Re-Coding Program – Empire recodes certain medical claims to a less complex level of care based upon the diagnosis reported, without conducting utilization reviews pursuant to Article 49 of the New York Insurance Law.

- Cosmetic Denials - Empire did not conduct utilization reviews pursuant to Article 49 of the New York Insurance Law for certain claims submitted by healthcare providers, and automatically denied the claims based upon presumption that the procedure was cosmetic in nature .

- Adoption of Procedure Manuals - Empire did not obtain an annual certification as recommended in Circular Letter #9 (1999) that the company's current claims adjudication procedures are in accordance with applicable statutes, rules and regulations.

- Commission Payments To Agents And Brokers - In certain instances the HMO paid commissions of 5% on premiums received in violation of Department Regulation 62.

- Agents and Brokers - Empire did not maintain current licenses on file for all of their active producers in compliance with §2116 of the New York State Insurance Law; did not obtain or file all certificates of appointments with the Department as required by §2112(a) of the New York State Insurance Law.

- Disclosure Of Information - The HMO's HMO/POS handbook did not contain the appeal information required by §4408(1)(c)(v) of the New York Public Health Law.

- Grievances And Appeals - The HMO did not comply with §4408-a(4) of the New York Public Health Law regarding notification and resolution requirements for certain grievances and appeals.

- Utilization Review - Empire failed to comply with §4903 of the New York State Insurance and Public Health Law regarding notification, written acknowledgements and appeal processes for certain claims subject to utilization review.

- Mandated Benefits - Contrary to §4303(z) of the New York State Insurance Law, the HMO did not include the required language relative to experimental or investigational

procedures in its group HMO contract.

- Fraud Department - It is the contention of the Department that the Empire companies staffing level in its Fraud Department is inadequate.

- Claims Processing - Several instances were noted wherein Empire failed to reprocess claims in a timely manner in cases where the claim had previously been suspended for failure to submit a co-ordination of benefits form or a student questionnaire after the forms were subsequently received.

- Prompt Settlement of Claims - Empire failed to fully comply with the provisions of §3224-a(a) and a(c) of the New York State Insurance Law ("Prompt Pay Law").

The above findings, as well as others, are described in greater detail in the remainder of this report.

3. ADOPTION OF PROCEDURE MANUALS - CIRCULAR LETTER No. 9 (1999)

Circular Letter No. 9 (1999), dated May 25, 1999, "Adoption of Procedure Manuals," was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and insurers licensed to write health insurance in New York State.

Circular Letter No. 9 (1999) recommends that the board obtain a certification 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 applicable statutes, rules and regulations.

A review of the Company's board of director's minutes revealed that the Company was not obtaining the aforementioned annual certifications. The Company, upon consulting with outside counsel, decided to forego the annual certification and instead provide ongoing reports regarding the status of operations and compliance through the Audit Committee. Additionally, the Company maintains that a "Compliance Update" is included on the agenda of every Audit Committee meeting.

It is recommended that the Company obtain the annual certifications pursuant to Circular Letter No. 9 (1999).

4. AGENTS AND BROKERS

A review was performed of Empire's sales distribution system. For the period under review, Empire provided a listing of 4,363 external producers, which consisted of both agents and brokers.

A. Agents Licensing and Certificates of Appointments

A sample of forty agents were selected for review to determine if valid licenses were on file with Empire and that certificates of appointments were filed with the Department pursuant to Section 2116 of the New York Insurance Law.

§2116 of the New York State Insurance Law states:

> "No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article."

Empire did not maintain valid licenses for five of the forty agents sampled in violation of §2116 of the New York State Insurance Law. Empire maintains that the licenses for the agents were lost at the World Trade Center in 2001 and the agents failed to respond to Empire's request to submit a new license. However, it is noted that of the five agents wherein Empire did not maintain a license on file, two of the agents were verified as having a valid license according to records on file with the Department. Empire agrees that it did not maintain current licenses for the remaining three agents at the time of audit. However, for those three producers, commissions were not paid beyond the expiration date of their license on file with Empire.

It is recommended that Empire maintain current licenses on file for all of their active producers to ensure continued compliance with §2116 of the New York State Insurance Law.

Certificates of appointment for each of the forty agents selected for review were requested from Empire. Empire was only able to produce certificates of appointment for six of the forty agents selected for review. Additionally, Empire provided evidence of five other appointments that were transacted online via the Department's website. Empire stated the certificates of appointment paperwork for the other 29 appointment letters were lost at the World Trade Center in 2001. The examiners were able to determine that appointment letters were on file with the Department for twenty-three of the other thirty agents through the listing provided by the Department's Licensing Bureau. The Department had no record that the remaining six agents had certificates of appointments. The examination review disclosed that two of these agents received commission payments from Empire.

§2112(a) of the New York State 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."

It is recommended that Empire ensure that certificates of appointments are on file with the Department for each of its agents as required by §2112(a) of the New York State Insurance Law and that commission payments are made only to those agents that have been appointed by Empire.

B. Brokers Agreements and Agents' Licensing

A review of Empire's brokers and licensing agreements was performed. As part of that review, an Empire's internal control report dated October 17, 2002 was reviewed. The report noted that approximately 2,300 brokerage agreements and agents' licenses for both New York and New Jersey have not been recovered since being destroyed on September 11, 2001. The report went on further and warned that without the agreements Empire would leave itself exposed to any legal dispute that arose with a broker. A recommendation in the report was made that given the time that has passed since September 11, 2001 that Empire aggressively pursue the recovery of broker agreements and licenses. The findings in Empire's internal report are consistent with those of the examination.

It is recommended that Empire aggressively pursue the recovery of any broker agreements and licenses that are missing.

C. Brokers Commission Payments

A sample of ten brokers was selected to review that commission payments made by the HMO were calculated and paid correctly and that commission payments did not exceed 4% of the premium received.

Regulation 62 11 NYCRR 52.42 (e) states:

> "Commissions or fees payable by health maintenance organizations to an insurance broker as authorized by 10 NYCRR Part 98. A health maintenance organization (HMO) issued a certificate of authority pursuant to article 44 of the Public Health Law, HMO operated as a line of business of a health service corporation licensed under article 43 of the Insurance Law and having a certificate of authority pursuant to article 44 of the Public Health Law, or HMO organized prior to the enactment of article 44 of the Public Health Law which has a license from the Superintendent of Insurance as a health service corporation pursuant to article 43 of the Insurance Law and a certificate of need as a health facility from the Commissioner of Health pursuant to article 28 of the Public Health Law, may, as authorized by 10 NYCRR Part 98, pay commissions or fees to a licensed insurance broker. Such authority to pay commissions or fees by a corporation, other than a corporation solely holding a certificate of authority from the Commissioner of Health, shall be restricted to its HMO operation only. No licensed insurance broker shall receive such commissions or fees from an HMO, unless the HMO has filed the actual rate to be paid and included the anticipated expenses for such payments to insurance brokers in its application to amend its community premium rates pursuant to the provisions of section 4308 of the Insurance Law. Such rate shall be incorporated into the HMO's premium rate manual. The actual rate per annum may not exceed four percent of the HMO's approved premium for the contract sold."

One of the ten brokers reviewed had received commission payments of 5% on premiums received in excess of $50,000. The HMO's own internal review found that it had paid commissions in excess of 4% on HMO products for premiums received in excess of $250,000 and less than $750,000 which resulted in overpayments of approximately $48,000 in broker commissions. The HMO's broker commission schedule shows a commission rate of 4.5% on group premiums in that range.

The HMO has agreed with the findings and stated that system corrections would be implemented to ensure that it would not pay premiums in excess of 4% of HMO products.

It is recommended that the HMO comply with Regulation 62 11 NYCRR 52.42(e) and ensure that broker commissions do not exceed the 4% limitation.

It was also noted that the HMO's Oracle Broker Commission database listed $493 million in premiums in its Premium Holding tables where commissions could be owed as of July 31, 2002. This amount was reduced to $49 million in September 2002 after a management review found that no commission was owed on $444 million of the premium. The reason for the buildup was due to delays in updating brokers' licenses and the timely loading of broker information.

The HMO stated that it would work to resolve issues with broker licensing delays and updating of broker information in order to clear transaction from the tables more efficiently.

5. DISCLOSURE OF INFORMATION

A review was performed of the HMO's compliance with the disclosure requirements of §4408 of the New York State Public Health Law. The enrollment packets for the HMO's Direct Pay contracts for HMO, HMO/POS, Healthy New York and Child Health Plus were reviewed.

§4408(1)(c)(v) of the New York State Public Health Law states:

> "Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information which may be incorporated into the member handbook or the subscriber contract or certificate containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following:"

...(c) "a description of utilization review policies and procedures used by the health maintenance organization, including:"

...(v) "the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;"

The HMO's HMO/POS handbook did not contain the appeal information required by §4408(1)(c)(v) of the New York State Public Health Law. The HMO stated that the language was inadvertently left out and that a revised handbook would be printed with the required information.

It is recommended that the HMO ensure that its handbooks contain all disclosure notices required by §4408(1)(c)(v) of the New York State Public Health Law.

6. GRIEVANCES AND APPEALS

A review of grievances and appeals filed with the HMO for the period under examination was performed to ascertain compliance with Article 4408-a of the New York State Public Health Law ("Grievance Procedure").

§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 acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. 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."

During the period January 1, 2002 through April 15, 2003, the HMO recorded 1,002 grievances and 185 appeals. Twenty files were randomly selected for review. This resulted in the review of twenty grievances and four appeals. It is noted that two of the grievances reviewed pertained solely to a question of covered benefits, while the remaining eighteen concerned issues other than coverage of benefits.

The HMO was unable to provide copies of the 15 day acknowledgement letters on seven of the twenty grievances files reviewed (35%) as required by §4408-a(4) of the New York State Public Health Law.

The HMO's system did not indicate an acknowledgement letter was sent on five of the twenty grievances files reviewed (25%) as required by §4408-a(4) of the New York State Public Health Law.

The HMO failed to resolve grievances within thirty days on both of the files reviewed pertaining to questions of coverage as required by §4408-a(4)(ii) of the New York State Public Health Law.

The HMO failed to resolve grievances within forty-five days on one of the eighteen files 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 noted that on two other files the grievance letter was not date stamped so the actual receipt date could not be determined.

It is recommended that the HMO provide a written acknowledgement within 15 business days for grievances filed as required by §4408-a(4) of the New York State Public Health Law.

It is recommended that the HMO resolve grievances within thirty days when the grievance pertains to questions of coverage as required by §4408-a(4)(ii) of the New York State Public Health Law.

It is recommended that the HMO resolve grievances within forty-five days for grievances pertaining to issues other than questions of coverage as required by §4408-a (4)(iii) of the New York State Public Health Law.

7. UTILIZATION REVIEW

§4902, §4903 and §4904 of the New York State Insurance Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews and appeals of adverse determinations by utilization review agents respectively for insurers licensed under Article 42 of the New York State Insurance Law. The Public Health Law contains the same requirements for HMO's licensed under Article 44 of the Public Health Law.

The Company provided a log containing 4,940 utilization reviews and a log containing 714 appeals of adverse utilization reviews for the period January 1, 2002 through April 15, 2003. Thirty utilization review files were selected for review. Seventeen of the files were prospective reviews, twelve were concurrent reviews and one was a retrospective review. The files were

evaluated to determine compliance with §4903 of the New York State Insurance Law. Additionally, twenty five utilization review appeals of adverse determinations were selected and reviewed to determine compliance with §4904 of the New York State Insurance Law.

The HMO provided a log containing 3,470 utilization reviews and a log containing 115 appeals of adverse utilization reviews for the period January 1, 2002 through April 15, 2003. Thirty utilization review files were selected for review. Twenty three of the files were prospective reviews and seven were concurrent reviews. The files were evaluated to determine compliance with §4903 of the New York State Public Health Law. Fifteen utilization review appeals of adverse determinations were selected and reviewed to determine compliance with §4904 of the New York State Public Health Law.

§4903(b) of the New York State Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

§4903(2) of the New York State Public Health Law contains the same provisions applicable to the HMO.

For the Company files that were reviewed, one of the seventeen prospective files reviewed failed to provide notice of determination within three business days by telephone and in writing to the insured/insured's designee and the provider as required by §4903(b) of the New York State Insurance Law.

For the HMO files that were reviewed, six of the twenty three prospective review files reviewed (26.09%) failed to provide notice of determinations within three business days by telephone and in writing to the insured/insured's designee and the provider as required by §4903(2) of the New York State Public Health Law.

It is recommended that the Company comply with §4903(b) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide notice of determination within three business days by telephone and in writing to the insured/insured's designee and the provider on prospective reviews.

§4904 (c) of the New York State Insurance Law states:

> "A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include:
> (1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and
> (2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.

§4904(3) of the New York State Public Health Law contains the same provisions applicable to the HMO.

The review found that on two of the twenty five appeals reviewed the Company failed to provide written acknowledgement of the filing of the appeal within 15 days as required by §4904 (c) of the New York State Insurance Law.

The review found that on five of the fifteen (33.33%) appeals reviewed the HMO failed to provide written acknowledgements of the filing of the appeal within 15 days as required by §4904(3) of the New York State Public Health Law. For three of the five appeals that were found not to be in compliance with the law, it is noted that an acknowledgement letter was sent but the date the letter was sent could not be determined from the file.

It is recommended that the Company comply with §4904(c) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide written acknowledgement within 15 days of receipt of an appeal of a utilization review determination.

On one of the fifteen appeals reviewed the HMO failed to complete the utilization review appeal determination within sixty days of the receipt of the necessary information to conduct the appeal as required by §4904(3) of the New York State Public Health Law.

It is recommended that the HMO comply with §4904(3) of the New York State Public Health Law and complete utilization review appeal determinations within sixty days of receipt of all required information.

On ten of the twenty-five (40%) appeal files reviewed the Company failed to provide the enrollee notice of the appeal determination within 2 business days of the rendering of such determination as required by §4904(c) of the New York State Insurance Law.

On eight of the fifteen (53.33%) appeal files reviewed the HMO failed to provide the enrollee notice of the appeal determination within 2 business days of the rendering of such determination as required by §4904(3) of the New York State Public Health Law.

It is recommended that the Company comply with §4904(c) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide the enrollee notice of the appeal determination within 2 business days of the rendering of such determination.

On one of the seven concurrent review files reviewed, the HMO failed to provide a notice of determination within one business day of receipt of all necessary information as required by §4903(3) of the New York State Public Health Law.

It is recommended that the HMO comply with §4903(3) of the New York State Public Health Law and provide notice of determination within one business day of receipt of all necessary information on concurrent reviews

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8. CONTRACTS AND POLICY FORMS

A listing of contracts and forms used by the Company was reviewed to determine if all policy forms in use were approved by the New York State Insurance Department. Certain forms which had been filed by the Article 43 corporation Empire Blue Cross and Shield were still being used by the Company. It should be noted that due to the loss of the Company's offices at the World Trade Center on September 11, 2001, the Company no longer had copies of the Department's approvals of any policy form or contract approved prior to that date. The Company's contracts and forms in use were matched against what the Department's database reflected had listed as approved for the Company.

The review found that one policy form originally filed and approved for use by the Article 43 corporation, Empire Blue Cross and Blue Shield, had not been re-submitted for the Department's approval. for use by Empire when it converted to an Article 42 accident and health corporation in 2002.

The form continues to be used for members who were enrolled in the contract prior to Empire's conversion to an Article 42 accident and health insurer. Empire states the form has not been sold to any new subscribers since the conversion, and that it does not intend on marketing the contract to any new subscribers.

9. MANDATED BENEFITS

A review was performed of the HMO's Group HMO, Group Direct Connect HMO, Child Health Plus, Healthy New York and Empire Blue Cross and Blue Shield Direct Pay HMO contracts to determine if the contracts contained the benefits required by §4303 of the New York State Insurance Law.

§4303(z) of the New York State Insurance Law states in part:

> "No contract issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation shall exclude coverage of a health care service, as defined in paragraph two of subsection (e) of section four thousand nine hundred of this chapter, rendered or proposed to be rendered to an insured on the basis that such service is experimental or investigational, is rendered as part of a clinical trial as defined in subsection (b-2) of section forty-nine hundred of this chapter, or a prescribed pharmaceutical product referenced in subparagraph (B) of paragraph two of subsection (e) of section forty-nine hundred of this chapter provided that coverage of the patient costs of such service has been recommended for the insured by an external appeal agent upon an appeal conducted pursuant to subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter..."

Contrary to §4303(z) of the New York State Insurance Law, the HMO did not include the required language relative to experimental or investigational procedures in its group HMO contract.

It is recommended that the HMO comply with §4303(z) of the New York State Insurance Law and include the required language relative to experimental or investigational procedures in its group HMO contract.

10. FRAUD DEPARTMENT

The activities of Empire's Fraud Department fall within the purview of its General Counsel's Division. The Fraud Department is responsible for the detection and prevention of fraudulent activities by subscribers, providers, groups, employees and others for both Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc. The Department is comprised of the following units, "Fraud Investigation and Detection Unit," "Intelligence Unit," "Flagged Provider Unit," "Group Integrity Unit" and "Small Group Market Unit." The Fraud Department reports directly to the Vice President of Litigation within the General Counsel Division.

The Fraud Investigation and Detection Unit is responsible for investigating all allegations of fraud and abuse with respect to subscribers, providers and employees. The Intelligence Unit is responsible for the pro-active detection and development of cases of suspected fraud. This unit also reviews high dollar claims paid to subscribers. The Flagged Provider Unit reviews all payments to providers flagged by the Fraud Department prior to issuance of a check. The unit also reviews all cosmetic claims prior to their issuance. The Group Integrity Unit is responsible for performing audits of small groups to detect and prevent fraud and abuse by ensuring the group's validity, the eligibility of their membership and their overall adherence to corporate underwriting guidelines. The unit also performs background checks on all new employees to verify the accuracy of the information and credentials indicated on their applications and/or resumes. The Small Group Market Unit is responsible for the annual recertification of small groups.

With respect to staffing of the Empire companies' fraud prevention and detection programs, the table of organization revealed that the total number of personnel in the Fraud Department as of June 30, 2003, was 23, including support and clerical personnel. In the Fraud Investigation and Detection Unit, there were five employees.

As of the July 2004, the Fraud Department had six qualified insurance fraud investigators compared to thirteen investigators employed by the Fraud Department in 2000. To put this into context, the Empire companies had over 4.6 million members including Administrative Services Only members as of December 31, 2002 in its two subsidiaries Empire HealthChoice Assurance, Inc. and Empire HealthChoice, HMO, Inc. and only six fraud investigators, or one investigator for every 766,000 members. A comparison with other health insurers licensed to do business in NY shows a ratio of between 142,750 to 213,000 members per investigator.

The caseload of open cases per investigator at the Empire companies presently ranges from 100-120 cases. A review of other health insurers in the state indicates an average caseload of between 20 to 40 cases per investigator. The lowest caseload found in the review was 20 cases per investigator while the highest was 60 to 80 cases per investigator.

Based upon materials provided by the Empire companies, the number of cases reviewed by its Special Investigations Units (SIU) (i.e. the Flagged Provider Unit, Fraud Investigation and Detection Unit and Intelligence Unit) has declined from 5,160 cases in 2000 to 1,041 in 2002 and 718 for the first 10 months in 2003. The Empire companies attribute this decline to the fact that in past years, the SIU unit did non-fraud related work. Empire was not able to support this assertion.

Regulation 95, Section 86.6(a) states the following:

> (a) Every insurer writing private or commercial automobile insurance, workers' compensation insurance, or individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, which writes three thousand or more of such policies in any given year, and every entity licensed pursuant to article forty-four of the public health law, except those entities with an enrolled population of less than 60,000 persons in the aggregate and except those entities certified pursuant to sections 4403-a, 4403-c, 4403-d, 4403-f, and 4408-a of the public health law, shall develop and file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this State and those fraudulent insurance activities affecting policies issued or issued for delivery in this State. Notwithstanding the foregoing, insurers writing only reinsurance contracts shall not be required to comply with the provisions of this section.

Regulation 95, Section 86.6(b)(3) states the following:

> (b) The plan shall include the following provisions:
>
> (3) The rationale for the level of staffing and resources being provided for the Special Investigations Unit which may include, but is not limited to, the following objective criteria such as number of policies written and individuals insured in New York, number of claims received with respect to New York insureds on an annual basis, volume of suspected fraudulent New York claims currently being detected, other factors relating to the vulnerability of the insurer to fraud, and an assessment of optimal caseload which can be handled by an investigator on an annual basis.

Regulation 95, Section 86.6(b)(3) states that one of the criteria used to determine the adequacy of staffing in an SIU unit is to compare claims to investigators. The Empire companies generated 36.8 million claims in 2002 and had six investigators. A review of other insurers found a high of eleven investigators for 41.5 million claims and a low of three investigators for 4.6 million claims.

It is the contention of the Department that the Empire companies staffing level with a base of 4.6 million members, generating less than 1,000 fraud cases per year is inadequate. Clearly, an increase in the number of investigators would increase fraud detection and prevention.

In a letter dated January 12, 2004 by Charles Bardong, director of the Insurance Department's Insurance Fraud Bureau, addressed to Linda Tiano, Senior Vice President and General Counsel of the Empire companies, the Insurance Department rejected the Empire companies' fraud plan for its failure to justify its Fraud Department's staffing levels. The letter stated that in order for the Insurance Department to approve Empire's fraud plan, the number of investigators would have to be increased to its previous staffing levels of twelve to thirteen investigators as of 2000.

On February 9, 2004, the Insurance Department approved the Empire companies' fraud prevention plan under the condition that it increases its SIU staffing levels by four investigators to a total of eleven. As of the date of this report the Empire companies have 12 fraud Department Investigators, having reached the required staffing levels and received approval from the Insurance Department for its fraud plan.

A review was performed of 167 randomly selected suspected fraud cases from a listing of 6,480 cases provided by the Empire companies. The following are some of the findings:

- Ten of the claims reviewed were related to a special project undertaken by the Empire companies pertaining to Durable Medical Equipment (DME) and OxyContin. The Fraud Department began its review of hospital based DME services based on a fraud allegation received on the IC Fraud hotline that Stony Brook Hospital was overbilling Empire for DME supplies. The Fraud Department findings led Empire to open investigations on other hospitals that also over billed Empire. The OxyContin project was an investigation to determine if the drug was prescribed correctly. The Empire companies recouped $10,454,771 on its DME project for the years 1998 through 2001. These amounts were reported by the Empire companies as fraud related recoveries since the investigation arose out of a fraud tip and the Fraud Department's investigation of several hospitals

identified the over billing by the hospitals and the Fraud Department recovered the money. Though the investigation was initiated by a fraud tip there was no actual fraud involved in the overbilling and IFB-1 forms were never filed with the Department to indicate these cases involved fraud. The amounts recovered should therefore not have been reported as fraud savings.

- There were six cases where there was no sign off by the supervisor.

It is recommended that the Empire companies put in place procedures to ensure that all closed fraud cases are reviewed and signed off on by a supervisor promptly.

It is recommended that the Empire companies report only fraud related recoveries on its 409(g) filings with the Insurance Department.

11. CLAIMS PROCESSING

This review was performed by using a statistical sampling methodology covering claims processed during the period January 1, 2002 through December 31, 2002 in order to evaluate the overall accuracy and compliance environment of Empire's claims processing.

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

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

The examination review of the Company found a calculated financial error rate of 7.78% for Medical Claims and 1.20% for Hospital Claims and overall claims processing financial accuracy levels were 92.22% for Medical Claims and 98.80% for Hospital Claims. Procedural error rates were 8.38% for Medical Claims and 2.40% for Hospital Claims and overall claims processing procedural accuracy levels were 91.62% for Medical Claims and 97.60% for Hospital Claims.

The examination review of the HMO found a calculated financial error rate of 4.19% for Medical Claims and 4.79% for Hospital Claims and overall claims processing financial accuracy levels were 95.81% for Medical Claims and 95.21% for Hospital Claims. Procedural error rates were 5.39% for Medical Claims and 4.79% for Hospital Claims and overall claims processing procedural accuracy levels were 94.61% for Medical Claims and 95.21% for Hospital Claims.

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times claim transactions were processed in accordance with the Company's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy.

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

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

	Medical Transactions	Hospital Transactions
Population	1,599,920	1,598,817
Sample Size	167	167
Number of transactions with Errors	8	2
Calculated Error Rate	4.79%	1.20%
Upper Error limit	8.03%	2.85%
Lower Error limit	1.55%	0%
Calculated transactions in error	76,636	19,186
Upper limit transactions in error	128,474	45,566
Lower limit transactions in error	24,799	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.)

Summary of Procedural Accuracy of Empire HealthChoice Assurance, Inc.

	Medical Claim Processes	Hospital Claim Processes
Population	1,599,920	1,598,817
Sample Size	167	167
Number of transactions with Errors	14	4
Calculated Error Rate	8.38%	2.40%
Upper Error limit	12.59%	4.71%
Lower Error limit	4.18%	.08%
Calculated transactions in error	134,073	38,372
Upper limit transactions in error	201,430	75,304
Lower limit transactions in error	66,877	1,279

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.)

Summary of Financial Claims Accuracy of Empire HealthChoice HMO, Inc

	Medical Transactions	Hospital Transactions
Population	6,950,113	513,922
Sample Size	167	167
Number of transactions with Errors	7	8
Calculated Error Rate	4.19%	4.79%
Upper Error limit	7.23%	8.03%
Lower Error limit	1.15%	1.55%
Calculated transactions in error	291,210	24,617
Upper limit transactions in error	502,493	41,268
Lower limit transactions in error	79,926	7,966

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

Summary of Procedural Accuracy Empire HealthChoice HMO, Inc.

	Medical Claims	Hospital Claims
Population	6,950,113	513,922
Sample Size	167	167
Number of transactions with Errors	9	8
Calculated Error Rate	5.39%	4.79%
Upper Error limit	8.81%	8.03%
Lower Error limit	1.96%	1.55%
Calculated transactions in error	374,611	24,617
Upper limit transactions in error	612,305	41,268
Lower limit transactions in error	136,222	7,966

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

During the process of reviewing the claim transactions within the various claim adjudication samples, the following was noted:

- There were several instances found where Empire's manual system failed to reprocess claims in a timely manner in cases where the claim had previously been suspended for failure to submit a co-ordination of benefits form or a student questionnaire after the forms were subsequently received. Beginning in April 2003 the process of updating claims with this information has been automated from the manual process that was used prior to April 2003.

It is recommended that Empire adjudicate all suspended claims in a timely manner once it has received the requested documentation.

- For several claims, Empire did not request all the relevant documentation that Empire was aware that it needed to process the claim within thirty (30) days of receipt of the claim. Claims were observed where Empire required that both a co-ordination of benefit statement and a student questionnaire be submitted to process a claim. In these cases Empire initially issued an explanation of benefits statement denying a claim for failure to submit a co-ordination of benefit statement. When the subscriber submitted the co-ordination of benefit statement Empire would issue another explanation of benefits statement denying the claim for failure to submit the student questionnaire from.

It is recommended that Empire request all relevant documentation required to adjudicate a claim during its initial review.

12. COSMETIC DENIALS

As a result of a Consumer Services Bureau investigation concerning a complaint relative to the denial of a procedure deemed by Empire to be cosmetic, it was revealed that Empire was not conducting utilization reviews pursuant to Article 49 of the New York Insurance Law and Article 49 of the Public Health Law for certain claims submitted by healthcare providers wherein Empire presumed the procedure was cosmetic in nature and automatically denied the claims. Empire instituted this practice of automatic denials of these types of claims during 2001.

In 2003, the Department notified Empire that the practice of automatically denying certain procedures it deemed to be cosmetic, and not conducting utilization reviews, was violative of Article 49 of the New York Insurance Law and Article 49 of the Public Health Law. It has been the Department's long-standing position that those types of denials constituted a medical necessity denial, and not a contractual denial. Accordingly, Empire was instructed to conduct retroactive utilization reviews on all claims denied as cosmetic where utilization reviews were not previously performed. Empire responded by indicating that those denials were determined based solely upon the CPT-4 procedure codes and/or the ICD-9 diagnostic codes on the claims. Empire presumed that certain procedures were always cosmetic by their nature and unless otherwise supported by medical documentation, were automatically denied. The fact that independent panels of physicians, who are experts in the fields to which these claims pertained, concluded that such procedures were not always cosmetic refutes the Company's assertion.

Despite being advised of the Department's position, Empire continued the practice of automatic denials for many procedures that it deemed cosmetic.

Until otherwise permitted by the Superintendent, it is recommended that Empire cease the practice of issuing automatic denials for procedures deemed to be cosmetic unless utilization reviews are performed and the appropriate appeal rights are provided in accordance with Article 49 of the New York State Insurance Law and Public Health Law.

It is recommended that Empire request medical records and retroactively conduct utilization reviews for all of the procedures that were automatically denied as cosmetic for the period from July 1, 2003 through present and, as a result of such utilization review make all additional payments that are warranted based upon reversal of previously denied claims where applicable along with interest calculated pursuant to Section 3224-a(c) of the Insurance Law.

13. EVALUATION AND MANAGEMENT RE-CODING PROGRAM

Empire instituted a "re-coding" program in 2000 to correct what the Empire deemed were inappropriate billing practices by certain physicians. Based upon an analysis of Evaluation and Management Codes ("E&M") submitted to Empire, certain types of office visits were determined to be prone to over billing. Accordingly, Empire re-codes certain E&M codes resulting in a lower reimbursement levels as follows:

Evaluation and Management Code	Revised code:
92004	92002
92014	92012
99205	99204 or 99203
99204	99203
99215	99214 or 99213
99214	99213
Consultation code submitted	Revised code
99245	99244 or 99243
99244	99243

The following are the CPT descriptions of the codes:

92002	Opthalmological services new patient. - Intermediate
92004	Opthalmological services new patient. - Comprehensive
92012	Opthalmological services established patient. - Intermediate
92014	Opthalmological services established patient. - Comprehensive
99203	Office or outpatient visit for evaluation and management of new patient. Moderate severity.
99204	Office or outpatient visit for evaluation and management of new patient. Moderate to high severity. 45 minute evaluation.
99205	Office or outpatient visit for evaluation and management of new patient. Moderate to high severity. 60 minute evaluation.
99213	Office or outpatient visit for evaluation and management of established patient. Low to moderate severity.
99214	Office or outpatient visit for evaluation and management of established patient. Moderate to high severity. 25 minute evaluation.
99215	Office or outpatient visit for evaluation and management of established patient. Moderate to high severity. 40 minute evaluation.
99243	Office visit for consultations. Low to moderate severity.
99244	Office visit for consultations. Moderate to high severity. 60 minute consultation.
99245	Office visit for consultations. Moderate to high severity. 80 minute consultation.

On December 1, 2001 the re-coding program was narrowed in scope to involve 15% of Empire's providers who, based upon a review of prior medical records, and analysis of prior coding patterns, were determined by Empire to be submitting incorrectly coded claims. The list of Empire providers subject to E & M recoding is reviewed and adjusted quarterly. As of December 31, 2003 Empire had approximately 10,000 participating and 1,000 non-participating physicians who were subject to the automatic recoding process.

Section 4900(h)(3) of the New York State Insurance and Public Health Law provides that the review of the appropriateness of a particular coding is excluded from the definition of utilization review. However, the CPT code that a provider assigns represents, among other things, the level of care rendered to the patient. Under circumstances where the dispute involves the question of whether the level of care rendered was medically necessary, such disputes are subject to utilization review.

As describe above, the Empire currently recodes medical claims to a less complex level of care based upon the diagnosis reported, without first reviewing each patient's medical records to determine whether the level of care rendered to the patient was medically necessary. In recoding claims in this manner, the Empire is essentially stating that claims for services rendered

by the providers included a level of care that was not medically necessary based upon the diagnosis reported. In the case of non participating providers this deprives the members of their right to an objective and meaningful review under Article 49 when issues of medical necessity exist. Empire states that the recoding is done, based upon standards contained in the AMA CPT Coding Manual, to reflect instances where there is inadequate documentation to support the level of care indicated on the claim. However, Empire is not reviewing any documentation in these cases, Empire is not requesting any additional information from providers prior to the recoding, and Empire has not initiated fraud or abuse investigations in connection with each recoding.

Consequently, Empire's decision to recode a claim for E & M services submitted by a non-participating provider to a less complex level of care based upon the diagnosis reported is a medical necessity determination that must be processed through the utilization review and external appeal procedures of Article 49 New York State Insurance and Public Health Law.

It is recommended that Empire cease the practice of recoding claims for E & M services submitted by a non-participating provider to a less complex level of care based upon the diagnosis reported unless utilization reviews are performed and the appropriate appeal rights are provided in accordance with Article 49 of the New York State Insurance and Public Health Law.

It is recommended that Empire request medical records and retroactively conduct utilization reviews for each of the claims for E & M services that were submitted by non-participating providers and recoded by Empire to a less complex level of care based upon the diagnosis reported, during the period from July 1, 2003 through present, and as a result of such utilization review make all additional payments to either the provider or subscriber, as appropriate, that are warranted based upon reversal of previously denied claims.

14. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH SERVICES.

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

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

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

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

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

A statistical sample of claims not adjudicated within 45 days of submission to the Company was reviewed to determine whether the payment was in violation of the timeframe requirements of §3224-a(a) of the New York State Insurance Law and if interest was appropriately paid pursuant to §3224-a(c) of the New York State Insurance Law. Accordingly, all claims that were not adjudicated within 45 days during the period January 1, 2002 through December 31, 2002 were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:

Empire HealthChoice Assurance, Inc - Summary of Violations of Section 3224-a(a)

	Medical Claim Processes	Hospital Claim Processes
Total Population	1,599,920	1,598,817
Population of claim transactions adjudicated past 45 days.	43,381	115,836
Sample Size	167	167
Number of transactions with Errors	11	9
Calculated Error Rate	6.59%	5.39%
Upper Error limit	10.35%	8.81%
Lower Error limit	2.82%	1.96%
Calculated transactions in error	2,859	6,244
Upper limit transactions in error	4,490	10,205
Lower limit transactions in error	1,223	2,270

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.)

Empire HealthChoice Assurance, Inc - Summary of Violations of Section 3224-a(c)

	Medical Claim Processes	Hospital Claim Processes
Total Population	1,599,920	1,598,817
Population of claim transaction paid past 45 days that are eligible for interest	18,182	79,007
Sample Size	167	167
Number of transactions with Errors	26	14
Calculated Error Rate	15.57%	8.38%
Upper Error limit	21.07%	12.59%
Lower Error limit	10.07%	4.18%
Calculated transactions in error	2,831	6,621
Upper limit transactions in error	3,831	9,947
Lower limit transactions in error	1,831	3,302

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.)

Empire HealthChoice HMO, Inc. - Summary of Violations of Section 3224-a(a)

	Medical Claims Processes	Hospital Claims Processes
Total Population	6,950,113	513,922
Population of claim transactions adjudicated over 45 days.	223,327	37,934
Sample Size	167	167
Number of transactions with Errors	5	23
Calculated Error Rate	2.99%	13.77%
Upper Error limit	5.58%	19.00%
Lower Error limit	.41%	8.55%
Calculated transactions in error	6,677	5,224
Upper limit transactions in error	12,462	7,207
Lower limit transactions in error	916	3,243

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.)

Empire HealthChoice HMO, Inc. - Summary of Violations of Section 3224-a(c)

	Medical Claims Processes	Hospital Claims Processes
Total Population	6,950,113	513,922
Population of claim transaction paid over 45 days that are eligible for interest	90,973	26,130
Sample Size	167	167
Number of transactions with Errors	49	10
Calculated Error Rate	29.34%	5.99%
Upper Error limit	36.25%	9.59%
Lower Error limit	22.44%	2.39%
Calculated transactions in error	26,691	1,565
Upper limit transactions in error	32,978	2,506
Lower limit transactions in error	20,414	625

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 adjudicated over forty-five days from receipt and those claims which incurred interest of two dollars or more based upon the examinations calculations during the period January 1, 2002 through December 31, 2002.

The population of claims adjudicated over forty-five days from date of receipt for the Company consisted of 159,217 medical and hospital claims out of 3,198,737 total medical and hospital claims processed or 4.98% of the claims processed during the period under review. The population of claims which incurred interest of two dollars or more consisted of 97,189 medical and hospital claims out of 3,198,737 total medical and hospital claims processed or 3.04% of the claims processed during the period under review.

The population of claims paid over forty-five days from date of receipt for the HMO consisted of 261,261 medical and hospital claims out of 7,464,035 total medical and hospital claims processed or 3.50% of the claims processed during the period under review. The population of claims which incurred interest of two dollars or more consisted of 117,103 medical and hospital claims out of 7,464,035 total medical and hospital claims processed or 1.57% of the claims processed during the period under review.

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

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

15. EXPLANATION OF BENEFITS STATEMENTS

As part of the review of Empire's claims practices and procedures, an analysis of its Explanation of Benefits statements ("EOBs") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and Empire. It should clearly communicate to the subscriber and/or provider that Empire has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, 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 insurance carriers.

In addition to the items listed above, Empire also uses Explanation of Benefits statements as a notice of denial on claims and to request additional documentation on claims suspended for lack of documentation or other reasons. Empire therefore issues Explanation of Benefits statements on virtually all of their claims both medical and hospital. The Explanation of Benefits statements issued for medical and hospital claims were reviewed as part of the claims processing review herein under Item 11.

§3234-(b)(5) of the New York State Insurance Law states in part that:

(b) The explanation of benefits form must include at least the following:
(5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;

The review found that Empire's Explanation of Benefits statements issued to subscribers on hospital claims does not always show the correct amount paid on the claim. The subject statements show Empire paying the amount charged by the provider minus applicable deductible, co-insurance, co-pay and uncovered charges rather than the contracted or negotiated amount actually paid to the hospital. This constitutes a violation of §3234-(b)(5) of the New York Insurance Law.

It is recommended that Empire accurately report the amount it reimburses hospitals on its Explanation of Benefits statement issued to subscribers.

16. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT

The prior Market Conduct Report contained sixty three comments and recommendations. In a stipulation dated February 29, 1996 Empire Blue Cross and Blue Shield agreed to retain for the next three years the services of an independent auditing firm for the purpose of conducting three annual compliance audits and advising the Board of Directors, in writing, whether Empire had fully complied during the audit period with all of the recommendations contained in the filed Market Conduct Report on Examination as of June 30, 1995, including the remedial action cited in the stipulation.

The independent auditors issued three reports detailing actions Empire took to comply with the recommendation made in the prior Market Conduct Report. The reports indicated that Empire had satisfactorily complied with all the recommendations. A follow-up review by the Department determined that all recommendations have been complied with.

17. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Utilization Review

M. It is recommended that the Company comply with §4904(c) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide the enrollee notice of the appeal determination within 2 business days of the rendering of such determination. 16

N. It is recommended that the HMO comply with §4903(3) of the New York State Public Health Law and provide notice of determination within one business day of receipt of all necessary information on concurrent reviews. 16

Contracts and Policy Forms

O. The review found that one policy form originally filed and approved for the Article 43 corporation Empire Blue Cross and Blue Shield had not been approved by the Department for use by Empire when it converted to an Article 42 accident and health corporation in 2002. 17

Empire states the form has not been sold to any new subscribers since it converted to an Article 42 accident and health insurer and it does not intend on marketing the contract to any new subscribers.

Mandated Benefits

P. It is recommended that the HMO comply with §4303(z) of the New York State Insurance Law and include the required language relative to experimental or investigational procedures in its group HMO contract. 18

ITEM **PAGE NO.**

Fraud Department

ITEM **PAGE NO.**

Empire's Evaluation and Management Re-Coding Program

W. It is recommended that Empire cease the practice of recoding claims for E & M services submitted by a non-participating provider to a less complex level of care based upon the diagnosis reported unless utilization reviews are performed and the appropriate appeal rights are provided in accordance with Article 49 of the New York State Insurance and Public Health Law. 31

Empire's Evaluation and Management Re-Coding Program

X. It is recommended that Empire request medical records and retroactively conduct utilization reviews for all of the E & M services that were submitted by non-participating providers and recoded by Empire to a less complex level of care based upon the diagnosis reported, for the period from July 1, 2003 through present, and as a result of such utilization review, make all additional payments to either the provider or subscriber that are warranted based upon reversal of previously denied claims 31

Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services

Y. It is recommended that Empire take steps to ensure that the provisions of §3224-a(a) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. 35

Z. It is recommended that Empire take steps to ensure that the provisions of §3224-a(c) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. 36

Explanation of Benefits Statements

AA. It is recommended that Empire accurately report the amount it reimburses hospitals on its Explanation of Benefits statement issued to subscribers. 37

Appointment No. *21986*

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:

Wai Wong

as a proper person to examine into the affairs of the

Empire HealthChoice Assurance, Inc..

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

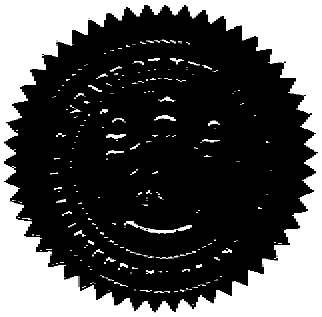
Company

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 *17th* day of *January* *2003*

Gregory V. Serio
Superintendent of Insurance



Appointment No. *21985*

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:

Wai Wong

as a proper person to examine into the affairs of the

Empire HealthChoice HMO, Inc..

and to make a report to me in writing of the 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 *17th* day of *January 2003*

Gregory V. Serio
Superintendent of Insurance