

REPORT ON EXAMINATION

OF

HEALTHPLEX INSURANCE COMAPNY

AS OF

DECEMBER 31, 2017

DATE OF REPORT

MAY 14, 2019

EXAMINER

MANAAL AL MAMUN, AFE

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Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Acting Superintendent

May 14, 2019

Honorable Linda A. Lacewell
Acting Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31706, dated January 19, 2018, attached hereto, I have made an examination into the condition and affairs of Healthplex Insurance Company, an accident and health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2017. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Healthplex Insurance Company, located at 333 Earle Ovington Boulevard, Uniondale, New York.

Wherever the designations the “Company” or “HIC” appear herein, without qualification, they should be understood to indicate Healthplex Insurance Company.

Wherever the designations “Healthplex” or the “Parent” appear herein, without qualification, they should be understood to indicate Healthplex, Inc., HIC’s parent company.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2012. This examination was a combined (financial and market conduct) examination and covered the five-year period from January 1, 2013 through December 31, 2017. The financial component of the examination was conducted as a financial examination, as such term is defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2018 Edition* (the “Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2017 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner’s assessment of risk in the Company’s operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Company’s current financial condition, as well as identify prospective risks that may threaten the future solvency of HIC.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management’s compliance with the Department’s statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

Information concerning the Company's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Company's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing / Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The examination also evaluated the Company's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation / Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness / Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy / Quality
- Reserve Data
- Reserve Adequacy
- Related Party / Holding Company Considerations
- Capital Management

The Company was audited annually, for the years 2013 through 2017, by the accounting firm of Withum, Smith & Brown, PC ("WSB"). The Company received an unmodified opinion in each of those years. Certain audit work papers of Withum, Smith & Brown, PC were reviewed and relied upon in conjunction with this examination.

During the examination, a review was made of the Company's computer systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

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

The examiner reviewed the corrective actions taken by the Company with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item 6 of this report.

2. DESCRIPTION OF THE COMPANY

Healthplex Insurance Company was incorporated on June 12, 1998, as a for-profit accident and health insurer. The Company was licensed on October 1, 2001, pursuant to Article 42 of the New York Insurance Law to write insurance business as defined under Section 1113(a)(3)(i) and (ii) of the New York Insurance Law. The Company began writing business in March 2003.

Healthplex Insurance Company offers dental contracts to groups and individuals in the New York metropolitan area through fee-for-service plans. Effective January 1, 2014, the Company became a Qualified Health Plan ("QHP") to sell dental plans to individuals and shop businesses on the New York State of Health Marketplace (Exchange). Additionally, the Company received approval to operate as an accident and health insurer, limited to dental services, in the State of New Jersey on August 4, 2016. To date, the Company has not started its writing in New Jersey.

In early 2016, a recapitalization of the Company's common stock and paid-in capital was necessary to meet a certain statutory surplus requirement to transact business as a foreign insurer in the State of New Jersey. On May 21, 2016, the New York State Department of Financial Services approved the recapitalization of the Company's authorized capital by increasing the capital from \$300,000 to \$2,500,000, consisting of 500 shares of common stock with a par value of \$5,000 per share.

Sections 1505(a)(1) and (c) of the New York Insurance Law state:

“(a) Transactions within a holding company system to which a controlled insurer is a party shall subject to the following: (1) the terms shall be fair and equitable...

(c) The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year-end.”

By a letter dated August 3, 2017, Citibank issued a line of credit of \$9 million (the “LOC”) to Healthplex, Inc. (“Borrower”), Parent of Healthplex Insurance Company. Under the terms of the LOC, repayment of all loans, extensions of credit and financial accommodations together with interest and costs is guaranteed jointly and severally, by Healthplex of CT, Healthplex of NJ, Inc., Healthplex I.P.A., Inc., International Healthcare Services, Inc., Healthplex Insurance Company, and any subsidiary or affiliate of Borrower (collectively “Guarantors”) to be created or acquired. The LOC is secured by a first priority security interest in all assets and personal property of the Borrower and the Guarantors. Healthplex Insurance Company failed to obtain the Department's approval prior to entering into this LOC agreement as a Guarantor, in violation of Sections 1505(a)(1) and (c) of the New York Insurance Law. The Company also advised the Department that it had taken corrective action to revise the agreement with Citibank, as demonstrated by

Citibank's January 9, 2018 letter to Healthplex, Inc., terminating the revolving credit line for Healthplex, Inc. as of December 31, 2017.

It is recommended that the Company comply with the requirements of Sections 1505(a)(1) and (c) of the New York Insurance Law by ensuring that all intercompany transactions are fair and equitable and by obtaining the Department's approval prior to entering into an agreement with another company in its holding company system.

Section 4207(b)(1) of New York Insurance Law states:

"(b)(1) Except as provided in paragraph three hereof, no domestic stock accident and health insurance company shall declare or distribute any dividend on its capital stock, except out of earned surplus, as defined in subsection (a) of section four thousand one hundred five of this chapter. Notwithstanding the forgoing, the superintendent may permit a domestic stock accident and health insurance company to restate its earned surplus under a plan of quasi-reorganization in accordance with regulations as may be promulgated by the superintendent. No domestic stock accident and health insurance company shall declare or distribute any dividend to shareholders which, together with all such dividends declared or distributed by it during the next preceding twelve months, exceeds the lesser of ten percent of its surplus to policyholders, as shown by its last statement on file with the superintendent, or one hundred percent of adjusted net investment income for such period unless, upon prior application therefor, the superintendent approves a greater dividend payment based upon his finding that the insurer will retain sufficient surplus to support its obligations and writings. Within the meaning of this section, "adjusted net investment income" means net investment income for the twelve months immediately preceding the declaration or distribution of the current dividend increased by the excess, if any, of net investment income over dividends declared or distributed during the period commencing thirty-six months prior to the declaration or distribution of the current dividend and ending twelve months prior thereto; "surplus" means the amount of the insurer's admitted assets in excess of its capital and its liabilities and both "surplus" and "surplus to policyholders" shall include any voluntary reserves, or any part thereof, which are not required by law."

As of December 31, 2016, Healthplex Insurance Company distributed a \$200,000 dividend to Healthplex, Inc. without obtaining approval from the Department. The Department concluded that such dividend distribution therefore violated New York Insurance Law Section 4207(b)(1). The Department sent a letter to the Company on September 26, 2017, asking the Company to describe the corrective action(s) it would take to remedy this violation. The

Company's response, dated October 12, 2017, verified agreement with the Department's conclusion, and accordingly, Healthplex Inc. returned the \$200,000 distribution on October 12, 2017.

It is recommended that the Company comply with the requirements of Section 4207(b)(1) of the New York Insurance Law by obtaining the Department's approval prior to any dividend distribution.

A. Corporate Governance

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of no less than thirteen (13) and no more than twenty-one (21) directors. As of December 31, 2017, the directors consisted of thirteen (13) members as set forth below:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Stephen J. Cuchel Roslyn, NY	Chairman, Healthplex Insurance Company and Healthplex, Inc.
Karen Cuchel-Dubow Brooklyn, NY	Director, Healthplex Insurance Company
David Kane Oceanside, NY	Vice President, Healthplex Insurance Company and Healthplex, Inc.
George Kane Sarasota, FL	Treasurer, Healthplex Insurance Company and Healthplex, Inc.
Martha Kane Rockville Centre, NY	Director, Healthplex Insurance Company
Rebekah Kane Oyster Bay, NY	Director, Healthplex Insurance Company

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Jenna-Marie Mastandrea East Meadow, NY	Director, Healthplex Insurance Company
Alex Mikhailov Fisher Island, NY	Director, Healthplex Insurance Company
Philip J. Rizzuto Jr. N. Merrick, NY	Vice President – IT, Healthplex Insurance Company and Healthplex, Inc.
Christopher M. Schmidt Lattingtown, NY	President and Chief Executive Officer, Healthplex Insurance Company and Healthplex, Inc.
Pascale Schmidt Lattingtown, NY	Director, Healthplex Insurance Company
Valerie Vignola Bellmore, NY	Chief Financial Officer, Healthplex Insurance Company and Healthplex, Inc.
George Wang New York, NY	Attorney, Barton, LLP

According to its by-laws, HIC's Board is required to meet once a year for an annual meeting, may hold special meetings as desired and is to conduct quarterly meetings after said annual meeting. The Board of Directors of the Company met at least quarterly during the period January 1, 2013 through December 31, 2017. A review of the minutes of the Board of Directors' meetings indicated that the meetings were generally well attended, with all members attending at least one-half of the meetings they were eligible to attend.

The principal officers of HIC as of December 31, 2017, were as follows:

<u>Name</u>	<u>Title</u>
Christopher M. Schmidt	President and Chief Executive Officer
Valerie Vignola	Chief Financial Officer and Secretary
George Kane	Treasurer

B. Enterprise Risk Management (“ERM”)

Part 82.2(a) of New York Insurance Regulation 203 (11 NYCRR 82) states, in part:

“Pursuant to Insurance Law sections 1503(b)... an entity shall adopt a formal enterprise risk management function that identifies, assesses, monitors, and manages enterprise risk. Except as provided in subdivision (c) of this section, a domestic insurer that is not a member of a holding Plan system... also shall adopt such a formal enterprise risk management function. The enterprise risk management function shall be appropriate for the nature, scale, and complexity of the risk...”

In accordance with Insurance Regulation 203 (11 NYCRR 82) – “Enterprise Risk Management and Own Risk and Solvency Assessment,” the Company’s parent, Healthplex, Inc., was required to adopt a formal enterprise risk management function, effective December 31, 2014. However, neither Healthplex, Inc. nor the Company had a formal ERM function in place during the examination period to proactively identify and mitigate various business risks, including prospective business risks.

It is recommended that HIC in conjunction with Healthplex, Inc., comply with the requirements of Part 82.2(a) of Insurance Regulation 203 by adopting a formal enterprise risk management function.

C. Internal Audit Department (“IAD”)

The Company does not have an Internal Audit Department, however, the Internal Audit Department of its Parent, Healthplex Inc., provides oversight over all affiliated entities, including those of the Company.

D. Insurance Regulation 118 (11 NYCRR 89)

The Company’s parent, Healthplex, Inc., is a non-publicly traded company and therefore not subject to the Sarbanes-Oxley Act of 2002. However, the Parent and HIC are subject to the

provisions of Insurance Regulation 118. Insurance Regulation 118 (11 NYCRR 89) – “Audited Financial Statements” is based on the NAIC’s Model Audit Rule and became effective January 1, 2010.

Part 89.1(c) of Insurance Regulation 118 (11 NYCRR 89) states in part:

“Audit committee means a committee (or equivalent body) established by the board of directors of a company for the purpose of overseeing the accounting and financial reporting processes of a company or group of companies, and auditing of financial statements of the company or group of affected companies provided that...

(3) for a company that does not otherwise designate an audit committee, the company’s entire board of directors shall constitute the audit committee.”

Part 89.2(c) of the Insurance Regulation 118 (11 NYCRR 89) states:

“Every company required to file an annual audited financial report pursuant to this Part shall designate a group of individuals to constitute its audit committee.”

Healthplex Insurance Company has not formally designated the Company’s Board of Directors or a group of individuals to constitute its Audit Committee, as required by Insurance Regulation 118.

It is recommended that HIC comply with the requirements of Insurance Regulation 118 by formally designating the Company’s entire Board of Directors, or a group of individuals, to constitute its Audit Committee.

E. Territory and Plan of Operation

Healthplex Insurance Company is licensed pursuant to Article 42 of the New York Insurance Law and is authorized to write accident and health insurance as defined in paragraphs 3(i) and (ii) of Section 1113(a) of the New York Insurance Law. Healthplex Insurance Company is licensed to conduct business in New York and New Jersey, but only wrote business in New

York State. Based upon the line of business for which the Company is licensed, and pursuant to the requirements of Article 42 of the New York Insurance Law, the Company is required to maintain minimum capital and surplus of \$300,000.

The Company's direct premiums written and enrollment during the five-year examination period were as follows:

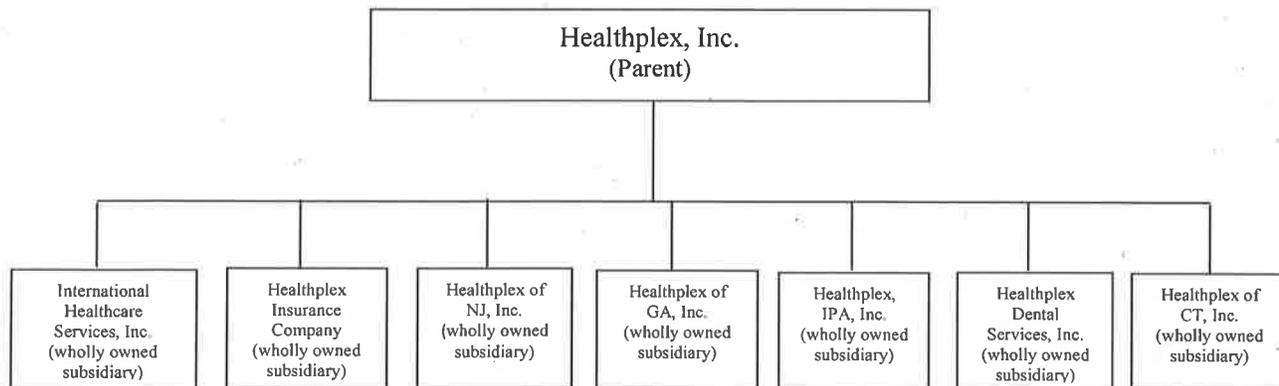
<u>Calendar Year</u>	<u>Direct Premiums Written</u>	<u>Enrollment</u>	<u>Premiums to Capital and Surplus</u>
2013	5,270,325	19,400	0.9
2014	7,857,803	46,966	1.3
2015	8,771,683	43,670	1.5
2016	8,110,836	46,212	1.4
2017	8,344,361	46,678	1.4

F. Reinsurance

The Company neither assumed nor ceded any business during the examination period.

G. Holding Company System

Below is a chart of the holding company system applicable to the Company and its related parties, as of the examination date:



Healthplex Insurance Company is a wholly-owned subsidiary of Healthplex, Inc., a privately held corporation. As a member of a holding company system, HIC is required to file registration statements pursuant to the requirements of Article 15 of the New York Insurance Law and Insurance Regulation 52 (11 NYCRR 80). The Company made all of its pertinent filings regarding the aforementioned statute and regulation during the examination period.

HIC does not have any employees and the business operations and affairs of the Company are effectuated by Healthplex, Inc. (the "Parent") pursuant to the terms of an amended Administrative Services Agreement. This amendment was approved by the Department on April 26, 2011, pursuant to Section 1505(d)(3) of the New York Insurance Law. The services covered by this agreement include, but are not limited to: marketing, management, claims processing, electronic data processing, consulting, and administrative services. The Company pays a service fee to Healthplex, Inc. for the various administrative services that the Parent performs on the Company's behalf.

The Company has a consolidated Tax Allocation Agreement with its Parent, with an effective date of March 29, 1999. This Agreement was found to be consistent with the guidelines contained in Circular Letter No. 33 (1979), and was approved by the Department on March 9, 1999, pursuant to Section 1505(d)(3) of the New York Insurance Law. Effective January 1, 2005, the Company elected to be treated as an S Corporation ("S-Corp"), however, in its December 31, 2017 tax memo, the Company's CPA noted that HIC and two of its affiliates (International Healthcare Services, Inc. and Healthplex Dental Services, Inc.) were ineligible for such S-Corp status because these entities function as insurance companies. Effective January 1, 2018, the Company elected to terminate its S-Corp filing and correctly began filing as a C-Corp. It should

be noted that the Company's CPA does not believe that this impacts the Company's tax position, because the taxes paid at the shareholder level would have offset the taxes due at the Company level.

H. Significant Operating Ratios

The Company's significant operating ratios, as of December 31, 2017, were as follows:

<u>Description</u>	<u>Ratio</u>
Net change in capital and surplus	30.1%
Liquid assets and receivables to current liabilities	972%
Premium and risk revenue to capital and surplus	1.4 to 1
Medical loss ratio	67.1%
Administrative expense ratio	18.8%
Combined loss ratio	86.0%

The above ratios, with the exception of the Administrative Expense Ratio, fell within the benchmark ranges set forth in the Fast Analysis Solvency Tools ("FAST")-scoring ratios of the National Association of Insurance Commissioners ("NAIC").

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

	<u>Amount</u>	<u>Percentage</u>
Claims	\$ 25,693,749	67.00%
Claims adjustment expenses	458,778	1.20%
General administrative expenses	7,534,257	19.80%
Net underwriting gain	<u>4,589,383</u>	<u>12.00%</u>
Net premiums earned	\$ <u>38,355,008</u>	<u>100.00%</u>

Note: There is a slight difference between the above net premiums earned amount and the total revenue of \$38,276,167 which is due to offsetting aggregate write-ins for other health care related revenues in the amount of \$(78,841).

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2017, as contained in the Company's 2017 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2017, filed annual statement.

Withum, Smith and Brown, PC ("WSB") was retained by the Company to audit the Company's combined statutory basis statements of financial position for the year ended December 31, 2017, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

WSB concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audit date. Balances reported in these audited financial statements were reconciled to the corresponding year's annual statement with no discrepancies noted.

A. Balance SheetAssets

Cash and short-term investments	\$ 6,465,012
Investment income due and accrued	556
Uncollected premiums	<u>45,125</u>
Total assets	\$ <u>6,510,693</u>

Liabilities

Claims unpaid	\$ 480,046
Unpaid claims adjustment expense	10,086
Premiums received in advance	105,161
Amount due to parent, subsidiaries and affiliates	<u>74,552</u>
Total liabilities	\$ <u>669,845</u>

Capital and surplus

Common capital stock	\$ 700,000
Unassigned surplus	<u>5,140,848</u>
Total capital and surplus	\$ <u>5,840,848</u>
Total liabilities and surplus	\$ <u>6,510,693</u>

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2017. The examiner is unaware of any potential exposure of the Company to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Change in Capital and Surplus

Capital and surplus increased by \$4,560,429 during the examination period, January 1, 2013 through December 31, 2017, detailed as follows:

<u>Revenue</u>			
Net premium income			\$ 38,355,008
Aggregate write-ins for other health care related revenues			<u>(78,841)</u>
Total revenues			\$ 38,276,167
<u>Expenses</u>			
Other professional services	\$ 25,693,749		
Total hospital and medical expense	\$ 25,693,749		
<u>Administrative expenses</u>			
Claim adjustment expenses	458,778		
General administrative expenses	<u>7,534,257</u>		
Total underwriting deductions			<u>33,686,784</u>
Net underwriting gain			\$ <u>4,589,383</u>
Net investment income earned	(11,709)		
Net realized capital gain (or loss)	<u>0</u>		
Net investment gains			<u>(11,709)</u>
Net income before federal income taxes			\$ 4,577,674
Federal income taxes incurred			<u>0</u>
Net income			\$ <u>4,577,674</u>
<u>Change in Capital and Surplus</u>			
Capital and surplus, per report on examination, as of December 31, 2012			\$ 1,280,419
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$ 4,577,674		
Change in non-admitted assets	<u> </u>	\$ <u>17,245</u>	
Net gain in capital and surplus			\$ <u>4,560,429</u>
Capital and surplus, per report on examination, as of December 31, 2017			\$ <u>5,840,848</u>

4. SUBSEQUENT EVENTS

The Department received an acquisition application on November 19, 2018, whereby a Florida Limited Liability Company is seeking to acquire 100% ownership of Healthplex, Inc. and its subsidiaries, including Healthplex Insurance Company. The acquisition application continues to be under review by the Department.

5. MARKET CONDUCT ACTIVITIES

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

- A. Prompt Pay Law
- B. Reporting of claims
- C. Explanation of benefits statements
- D. Utilization review
- E. Grievances
- F. Reporting of utilization review determinations and appeals
- G. Policy forms
- H. Underwriting and rating
- I. Patient Protection and Affordable Care Act (“PPACA”)
- J. Network adequacy

A. Standards For Prompt, Fair and Equitable Settlement of Claims For Health Care and Payments For Health Care Services (“Prompt Pay Law”)

Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” (“Prompt Pay Law”), requires all insurers to pay undisputed claims within 30 days of receipt of a claim

that is transmitted electronically or within 45 days of receipt for a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

A review of the Company's claims practices and procedures was performed by using a statistical sample covering claims adjudicated during the period January 1, 2017 through December 31, 2017, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 167 claims for review and reviewed the claims on a stop and go basis.

It should be noted that although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material findings were noted.

B. Reporting of Claims

A review of the "Health Insurance Claims Payable – Section 3" exhibit for Healthplex Insurance Company, as contained in its 2017 NY Supplement filing with the Department, found that the Company incorrectly reported the "total amount of claims paid other than capitated" on the respective filed exhibit. The Company included the "total amount paid to capitation" on the "total amount of claims paid other than capitated" line. In addition, the Company failed to report the total number of claims paid to capitation.

Healthplex Insurance Company acknowledged that the 2017 "Health Insurance Claims Payable – Section 3" exhibit in its filed NY Supplement was incorrectly reported.

It is recommended that Healthplex Insurance Company report correct data in its “Health Insurance Claims Payable – Section 3” exhibit, of its NY Supplement filings made with the Department.

C. Explanation of Benefits Statements

Sections 3234(b)(6) and (7) of the New York Insurance Law state:

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

(6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and

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

A review of the explanation of benefits statements (“EOB”) issued by Healthplex Insurance Company, for the examination period, revealed that notices did not include specific explanations for the denial, reduction, or other reason for not providing full reimbursement for the amount claimed. Additionally, it was noted that the EOB did not include the above language regarding the forfeiture of the consumer’s right to challenge a denial or rejection.

It is recommended that Healthplex Insurance Company ensure that all EOBs issued to its members include all of the information required by Sections 3234(b)(6) and (7) of the New York Insurance Law.

By means of extrapolation, the aforementioned number of violations regarding HIC’s issuance of deficient EOBs is summarized as follows:

2017 HIC – Summary of Violations of EOBs	
Total sample size	50
Total number of violations	27
Calculated violation rate	54%
Total population	130,270
Total EOB violations	70,346

D. Utilization Review

Section 4903(b) of the New York 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.”

It should be noted that for all five (5) prospective utilization review cases reviewed by the examiner, HIC failed to provide a determination for services requiring pre-authorization to the insured or insured’s designee and the insured’s health care provider by telephone within three business days of receipt of the necessary information, as required by Section 4903(b) of the New York Insurance Law.

It is recommended that HIC comply with the requirements of Section 4903(b) of the New York Insurance Law by providing the notice of determination for services requiring pre-authorization by telephone to all members and providers within the required timeframe.

Section 4904(c) of the New York Insurance Law states, in part:

“... The utilization review agent must provide written acknowledgement 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...”

Of the ten (10) appeal cases reviewed by the examiner, there were five (5) instances where HIC failed to provide written acknowledgement to the appealing party within fifteen (15) days.

Of the ten (10) appeal cases reviewed by the examiner, there were two (2) instances where HIC failed to notify the insured and the insured's designee in writing of the appeal determination within two (2) business days of the rendering of such determination.

It is recommended that HIC comply with the requirements of Section 4904(c) of the New York Insurance Law by sending acknowledgement letters within fifteen (15) days, and sending, in writing, the appeal determination to the insured, the insured's designee and, where appropriate, the insured's health care provider, within two (2) business days after rendering a determination.

45 C.F.R. Sections 147.136(b)(2)(ii)(E)(1) and (5) state the following, in part:

“(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning)...

(5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.”

Of the ten (10) appeal cases reviewed by the examiner, there were two (2) instances where HIC failed to include a notice of the availability, when requested, of the diagnosis code, treatment code and their corresponding meanings in the final adverse determination letters.

Of the ten (10) appeal cases reviewed by the examiner, there were two (2) instances where HIC failed to include, in its final adverse determination letters, a statement regarding the availability of any applicable office of health insurance consumer assistance ombudsman to assist enrollees with the appeal process.

It is recommended that HIC include all required information and statements, in compliance with 45 C.F.R. Sections 147.136(b)(2)(ii)(E)(1) and (5), in all its final adverse determination letters.

29 C.F.R Sections 2560.503-1(j)(3), (4)(i) and (5)(i) state the following, in part:

“(j) The plan administrator shall provide a claimant with written or electronic notification of a plan’s benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant...

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits...

(4) (i) A statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to obtain the information about such procedures...

(5) In the case of a group health plan -

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request...”

Of the ten (10) appeal cases reviewed by the examiner, there were two (2) instances where HIC failed to include in its final adverse determination letters, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant’s claim for benefits.

Of the ten (10) appeal cases reviewed by the examiner, there were two (2) instances where HIC failed to include a statement of the claimant’s right to bring an action under section 502(a) of the Act, in its final adverse determination letters.

Of the ten (10) appeal cases reviewed by the examiner, there were two (2) instances where HIC failed to include a statement that “an internal rule, guideline, protocol or other similar

criterion were relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request,” in its final adverse determination letters.

It is recommended that HIC include all the required statements, in compliance with 29 C.F.R Sections 2560.503-1(j)(3), (4)(i) and (5)(i), in all its final adverse determination letters.

Section 4914(b)(1) of the New York Insurance Law states, in part:

“... The insured’s health care provider shall have sixty days to initiate an external appeal after the insured or the insured’s health care provider, as applicable, receives notice from the health care plan, or such plan’s utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal...”

HIC violated Section 4914(b)(1) of the New York Insurance Law when it failed to include the provider external appeal rights in its initial adverse determination letters, for ten of the ten utilization cases that were reviewed by the examiner.

Of the ten (10) utilization review appeal cases reviewed by the examiner, there were five (5) instances where HIC included language in its final adverse determination letters about provider rights to an external appeal that indicated the providers have 45 days to submit an external appeal, or failed to include the provider external appeals rights in the final adverse determination letters, which did not comply with Section 4914(b)(1) of the New York Insurance Law.

It is recommended that HIC comply with the requirements of Section 4914(b)(1) of the New York Insurance Law by giving providers sixty (60) days to initiate an external appeal after the insured or the insured’s health care provider receives notice of a final adverse determination.

It is also recommended that HIC include the provider's external appeal rights in all its initial and final adverse determination letters.

The examiner extrapolated the following number of violations below, based on the abovementioned violations:

2017 HIC - Summary of Violations of Utilization Review & Appeals				
	Utilization Review ("UR")			Total violations
	Prospective	Concurrent	Retrospective	
Total sample size	5	0	5	
Total number of violations	5	0	5	
Total population	4,624	0	1,114	
Calculated violation rate	100%	0%	100%	
Total UR violations extrapolated	4,624	0	1,114	5,738
Utilization Review Appeals				
	Member	Provider	Total violations	
Total sample size	6	4		
Total number of violations	5	2		
Calculated violation rate	83.33%	50%		
Total population	110	8		
Total Appeals violations extrapolated	92	4	96	
Total violations - UR				5,738
Total violations - appeals				96

E. Grievances

Section 4802(g)(3) of the New York Insurance Law states:

“(g) The notice of a determination shall include:

(3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.”

Of the ten (10) grievance samples reviewed by the examiner, there were six (6) instances where HIC failed to include the procedures for the filing of an appeal of the grievance determination, including a form for the filing of such an appeal, in its grievance determination letters.

It is recommended that HIC include the procedures for filing an appeal, including a form for the filing of such an appeal, in its grievance determination letters, in compliance with Section 4802(g)(3) of the New York Insurance Law.

By means of extrapolation the aforementioned errors are summarized in the following table:

2017 HIC - Summary of Violations of Grievances	
Total sample size	10
Total number of violations	6
Calculated violation rate	60%
Total population	44
Total violations - grievances	26

F. Reporting of Utilization Review Determinations and Appeals

A review of the “Exhibit of Grievances and Utilization Review Appeals” for Healthplex Insurance Company, as contained in its 2017 NY Supplement filed with the Department, found that the Company did not report the total number of utilization review determinations and utilization review appeals in the respective filed exhibit.

It is recommended that Healthplex Insurance Company report correct data in its “Exhibit of Grievances and Utilization Review Appeals” exhibit within its NY Supplement filings, made with the Department.

G. Policy Forms

Sections 3201(a) and (b) of the New York Insurance Law state, in part:

“(a) In this article, “policy form” means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto...

(b) (1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law...”

During the review of HIC’s policy forms by the examiner, it was noted that HIC used riders for off-exchange indemnity products that were not approved by the Department for the years 2015 and 2016. Because the policy renewals were sent to members in January 2017, and subsequently, and because HIC obtained the approval from the Department in July 18, 2017, to use the riders, the Company did not use the approved riders for off-exchange indemnity products until January 2018.

It is recommended that HIC comply with Sections 3201(a) and (b)(1) of the New York Insurance Law by having all riders approved by the Department prior to use.

The chart below shows the total number of members that were affected by the Company’s issuance of unapproved off-exchange indemnity riders in the years 2015, 2016 and 2017:

HIC – Summary of Violations of Unapproved Off-exchange Indemnity Riders	
	Total members affected
2015	2,296
2016	2,309
2017	<u>3,509</u>
Total violations	<u>8,114</u>

H. Underwriting and Rating

Section 4235(h)(1) of the New York Insurance Law states in part:

“(h)(1) Each domestic insurer... doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of... group health... and health insurance, and of its rates of commissions, compensation or other fees or allowances...”

During the examiner's review of the Company's underwriting and rating procedures it was noted that HIC issued contracts for off-exchange indemnity products with premium rates that were not filed (nor approved) with the Department for the calendar years 2013 through 2017.

Over the entire examination period, HIC violated Section 4235(h)(1) of the New York Insurance Law by using factors that deviated from the rate manual filed with and approved by the Department for its experience rated groups. It should be noted that this action may have resulted in the Company overcharging its members.

It is recommended that HIC comply with Section 4235(h)(1) of the New York Insurance Law by using only those rating factors that have been filed with and approved by the Department.

A similar finding was cited in the previous two reports on examination.

It is also recommended that the Company make the appropriate restitution to those members that were overcharged.

A similar finding was cited in the previous two reports on examination.

The chart below shows the total number of members that were affected by the Company's use of unapproved premium rates for calendar years 2013 to 2017:

HIC – Summary of Violations of Experience Rating Premiums			
	Total members affected	Original premium amount	Corrected premium amount
2013	891	\$ 377,588	347,656
2014	3074	587,354	555,772
2015	911	336,677	326,864
2016	341	170,279	157,424
2017	894	333,702	308,490
Total violations	6,111		

I. Patient Protection and Affordable Care Act (“PPACA”)

Section 3221(l)(8)(E) of the New York Insurance Law and additional implementing regulations require non-grandfathered group health plans offering health insurance coverage in the group market to provide certain benefits and to prohibit the imposition of cost-sharing requirements for those benefits. These include the following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

- Evidenced-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices (“ACIP”) of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Similar references are included within New York Insurance Law Section 3216(i)(17)(E) for the individual market, while Section 2713 of the Public Health Service Act offers similar supporting guidance.

The examiner reviewed 1 element (children from birth to age 5 - fluoride supplementation and application) of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims from this element for co-pay, deductible and coinsurance costs attributed to the member.

Healthplex Insurance Company was unable to provide to the examiner, a preventive service claims payment policy containing instructions for providers filing preventive service claims. The Company did, however, provide a list of procedure codes addressing the element.

It is recommended that HIC provide its network providers with a claims payment policy detailing those preventive service procedures that require no cost-sharing, noting all CPT, diagnosis codes and/or modifiers that are required for the claim to be calculated so as to result in no cost-sharing to the member.

The examiner also performed compliance testing on a sample of HIC preventive service claims. For 2017, the examiner tested the entire population of 12 paid preventive service claims that included member cost-sharing. There were no preventive care claims that had been denied with cost sharing. The results for the paid claims represented the actual number of errors with no further calculation.

The testing resulted in a 75% error rate (totaling 9 claims in violation) for the paid claims.

It is recommended that HIC comply with New York Insurance Law Sections 3216(i)(17)(E) and 3221(l)(8)(E) and Section 2713 of the Public Health Service Act by not applying member cost-sharing to preventive care claims, when not applicable.

It is also recommended that HIC perform Quality Assurance testing of the effectiveness of its claim payment policies / procedures on paid claims for preventive services to ensure compliance with the abovementioned stated laws and regulations.

J. Network Adequacy

Section 3241 of the New York Insurance Law states, in part:

“(a) An insurer... that issues a health insurance policy or contract with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The superintendent shall review the network of health care providers for adequacy at the time of the superintendent's initial approval of a health insurance policy or contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract in conformance with the standards set forth in subdivision five of section four thousand four hundred three of the public health law. To the extent that the network has been determined by the commissioner of health to meet the standards set forth in subdivision five of section four thousand four hundred three of the public health law, such network shall be deemed adequate by the superintendent.”

It was determined that, during the examination period, HIC violated Section 3241(a) of the New York Insurance Law by failing to obtain DFS’ approval prior to using three provider networks, Healthplex Metro, Capital and Liberty, for its nonexchange dental plans.

The chart below shows the total number of members that were affected from calendar years 2013 to 2017, by the Company’s use of nonapproved provider networks:

HIC – Summary of violations of provider networks	
	Total members affected
2013	889
2014	3,065
2015	901
2016	337
2017	891
Total violations	6,083

It is recommended that Healthplex Insurance Company comply with Section 3241(a) of the New York Insurance Law by filing all the networks of providers with DFS prior to use.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2012, contained the following six (6) comments and recommendations (the page numbers included below refer to that prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Agents and Brokers</u>	
1. It is recommended that the Company comply with Section 2112(a) of the New York Insurance Law by filing all of its agents' certificates of appointment with the Department. <i>The Company has complied with this recommendation.</i>	13
<u>Complaints</u>	
2. It is recommended that all items required by Department Circular Letter No. 11 (1978) be included in the Company's complaint log. <i>The Company has complied with this recommendation.</i>	16
<u>Special Investigations Unit</u>	
3. It is recommended that the Company update and resubmit its fraud prevention and detection plan to the Department with accurate and up-to-date information regarding the personnel currently employed in its Special Investigations Unit. <i>The Company has complied with this recommendation.</i>	17
<u>Underwriting</u>	
4. It is recommended that the Company comply with the experience rated formula as filed and approved by this Department, pursuant to Section 4235(h)(1) of the New York Insurance Law. <i>The Company did not comply with this recommendation. A similar recommendation is contained in this report.</i>	18
5. It is also recommended that the Company adhere to the manual rates that are filed and approved by the Department. <i>The Company has complied with this recommendation.</i>	18
6. It is further recommended that the Company make the appropriate restitution to the insureds that were overcharged. <i>The Company did not comply with this recommendation. A similar recommendation is contained in this report.</i>	18

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Description of the Company</u>	
i. It is recommended that the Company comply with the requirements of Sections 1505(a)(1) and (c) of the New York Insurance Law by obtaining the Department's approval prior to entering into an agreement with another company in its holding company system.	6
ii. It is recommended that the Company comply with the requirements of Section 4207(b)(1) of the New York Insurance Law by obtaining the Department's approval prior to any dividend distribution.	7
B. <u>Enterprise Risk Management</u>	
It is recommended that HIC in conjunction with Healthplex, Inc., comply with the requirements of Part 82.2(a) of Insurance Regulation 203 by adopting a formal enterprise risk management function.	9
C. <u>Insurance Regulation 118 (11 NYCRR 89)</u>	
It is recommended that HIC comply with the requirements of Insurance Regulation 118 by formally designating the Company's entire Board of Directors, or a group of individuals, to constitute its Audit Committee.	10
D. <u>Reporting of Claims</u>	
It is recommended that Healthplex Insurance Company report correct data in its "Health Insurance Claims Payable – Section 3" exhibit, of its NY Supplement filings made with the Department.	19
E. <u>Explanation of Benefits Statements</u>	
It is recommended that Healthplex Insurance Company ensure that all EOBs issued to its members include all of the information required by Sections 3234(b)(6) and (7) of the New York Insurance Law.	19

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Utilization Review</u>	
i. It is recommended that HIC comply with the requirements of Section 4903(b) of the New York Insurance Law by providing the notice of determination for services requiring pre-authorization by telephone to all members and providers within the required timeframe.	20
ii. It is recommended that HIC comply with the requirements of Section 4904(c) of the New York Insurance Law by sending acknowledgement letters within fifteen (15) days, and sending, in writing, the appeal determination to the insured, the insured's designee and, where appropriate, the insured's health care provider, within two (2) business days after rendering a determination.	21
iii. It is recommended that HIC include all required information and statements, in compliance with 45 C.F.R. Sections 147.136(b)(2)(ii)(E)(1) and (5), in all its final adverse determination letters.	22
iv. It is recommended that HIC include all the required statements, in compliance with 29 C.F.R Sections 2560.503-1(j)(3), (4)(i) and (5)(i), in all its final adverse determination letters.	23
v. It is recommended that HIC comply with the requirements of Section 4914(b)(1) of the New York Insurance Law by giving providers sixty (60) days to initiate an external appeal after the insured or the insured's health care provider receives notice of a final adverse determination.	23
vi. It is also recommended that HIC include the provider's external appeal rights in all its initial and final adverse determination letters.	24
G. <u>Grievances</u>	
It is recommended that HIC include the procedures for filing an appeal, including a form for the filing of such an appeal, in its grievance determination letters, in compliance with Section 4802(g)(3) of the New York Insurance Law.	25

<u>ITEM</u>	<u>PAGE NO.</u>
H. <u>Reporting of Utilization Review Determinations and Appeals</u>	
It is recommended that Healthplex Insurance Company report correct data in its "Exhibit of Grievances and Utilization Review Appeals" exhibit within its NY Supplement filings, made with the Department.	25
I. <u>Policy Forms</u>	
It is recommended that HIC comply with Sections 3201(a) and (b)(1) of the New York Insurance Law by having all riders approved by the Department prior to use.	26
J. <u>Underwriting and Rating</u>	
i. It is recommended that HIC comply with Section 4235(h)(1) of the New York Insurance Law by using only those rating factors that have been filed with the Department.	27
A similar finding was cited in the previous two reports on examination.	
ii. It is also recommended that the Company make the appropriate restitution to those members that were overcharged.	27
A similar finding was cited in the previous two reports on examination.	
K. <u>Patient Protection and Affordable Care Act ("PPACA")</u>	
i. It is recommended that HIC provide its network providers with a claims payment policy detailing those preventive service procedures that require no cost-sharing, noting all CPT, diagnosis codes and/or modifiers that are required for the claim to be calculated so as to result in no cost-sharing to the member.	29
ii. It is recommended that HIC comply with New York Insurance Law Sections 3216(i)(17)(E) and 3221(l)(8)(E) and Section 2713 of the Public Health Service Act by not applying member cost-sharing to preventive care claims, when not applicable.	29

ITEM**PAGE NO.****Patient Protection and Affordable Care Act ("PPACA")**

- iii. It is also recommended that HIC perform Quality Assurance testing of the effectiveness of its claim payment policies / procedures on paid claims for preventive services to ensure compliance with the abovementioned stated laws and regulations. 29

- L. **Network Adequacy**
It is recommended that Healthplex Insurance Company comply with Section 3241(a) of the New York Insurance Law by filing all the networks of providers with DFS prior to use. 30

Respectfully submitted,

Manaal Al Mamun
Financial Services Examiner 2

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

MANAAL AL MAMUN, being duly sworn, deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

Manaal Al Mamun

Subscribed and sworn to before me

this _____ day of _____ 2019

APPOINTMENT NO. 31706

NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

I, MARIA T. VULLO, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Manaal Al Mamun

as a proper person to examine the affairs of

Healthplex Insurance Company

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

Company

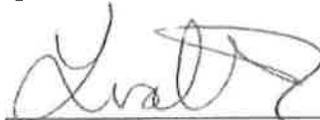
with such other information as she shall deem requisite.

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

this 19th day of January, 2018

MARIA T. VULLO
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

