

REPORT ON EXAMINATION

OF

HEALTHFIRST HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2015

DATE OF REPORT

MAY 29, 2019

EXAMINERS:

DAVID CRANDALL, CFE

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ARM, CLU, MBA

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of the examination	2
2.	Description of the Plan	4
	A. Corporate governance	6
	i. Enterprise Risk Management	8
	ii. Internal Audit Department	10
	B. Territory and plan of operation	12
	C. Contingent reserve	13
	D. Holding company system	13
	E. Reinsurance	17
	F. Significant operating ratios	18
3.	Financial statements	19
	A. Balance sheet	20
	B. Statement of revenue and expenses and capital and surplus	21
4.	Claims unpaid	22
5.	Market conduct activities	23
	A. Complaint handling	23
	B. Agents and brokers	24
	C. Underwriting and rating	24
	D. Claims processing	25
	E. Explanation of benefits statements	26
	F. Utilization review	27
6.	Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services (“Prompt Payment Law”)	28
7.	Facilitation of the examination	30
8.	Subsequent events	31
9.	Compliance with prior report on examination	33
10.	Summary of comments and recommendations	36



Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Superintendent

May 29, 2019

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

Madam:

Pursuant to the requirements of the New York Insurance Law and New York Public Health Law, and acting in accordance with the instructions contained in Appointment Number 31549, dated December 7, 2016, attached hereto, I have made an examination into the condition and affairs of Healthfirst Health Plan, Inc. a New York not-for-profit health maintenance organization authorized pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2015, and respectfully submit the following report thereon.

The examination was conducted at the home office of Healthfirst Health Plan, Inc., located at 100 Church Street, New York, NY.

Wherever the designations "HFHP" or the "HMO" or the "Plan" appear herein, without qualification, they should be understood to indicate Healthfirst Health Plan, Inc.

Wherever the designations "Healthfirst" or the "Parent" appear herein, without qualification, they should be understood to indicate Healthfirst, Inc., the ultimate parent of HFHP.

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, 2010. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period January 1, 2011 through December 31, 2015. The financial component of the examination was conducted as a “financial examination,” as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2016 Edition* (the “Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2015 were also reviewed.

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 examiners’ assessment of risk in the HMO’s operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiners planned and performed the examination to evaluate the HMO’s current financial condition, as well as to identify prospective risks that may threaten the future solvency of Healthfirst Health Plan, Inc.

The examiners 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 Plan's organizational structure, business approach, and control environment were utilized to develop the examination approach. The examination evaluated the Plan'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 Plan'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 Plan was audited annually, for the years 2011 through 2015, by the accounting firm of Ernst & Young LLP ("E&Y"). The Plan received an unqualified opinion in each of those years. Certain audit work papers of E&Y were reviewed and relied upon in conjunction with this examination.

During the years 2011 through 2015, the Plan's internal audit activities were managed on a co-sourcing basis with KPMG, LLP. A review was also made of the Plan's compliance with the provisions of Insurance Regulation 118 (11 NYCRR 89), "Audited Financial Statements." The examiners also reviewed the corrective actions taken by the Plan with respect to the recommendations contained in the prior report on examination. The results of the examiners' review are contained in Item 9 of this Report.

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.

2. DESCRIPTION OF THE PLAN

Healthfirst Health Plan, Inc. is a not-for-profit health maintenance organization incorporated under Section 402 of the New York Not-For-Profit Corporation Law and was issued a Certificate of Authority pursuant to the provisions of Article 44 of the New York Public Health Law. HFHP was originally incorporated on September 6, 1990, as Managed Health, Inc. ("MHI"), a not-for-profit health maintenance organization ("HMO") certified in the State of New York. MHI commenced business on October 19, 1990.

On August 1, 1998, Healthfirst, Inc., ("Healthfirst") a not-for-profit non-insurance entity, which was controlled in equal portions by each of the twenty-one hospitals that comprise its corporate members, was granted approval by the New York State Department of Health to acquire control of MHI. Healthfirst became the sole member of MHI on that date.

Upon approval by the New York State Department of Health ("DOH"), MHI changed its corporate name to Healthfirst Health Plan, Inc., effective November 12, 2015.

The examination was conducted at HFHP's home office located at 100 Church Street, New York, New York. At this location, the functions of administration, membership services, operations and all other services were performed.

HFHP contracts with various healthcare providers for the provision of certain medical services to its enrollees. A significant portion of those healthcare providers consist of hospitals which are corporate members of Healthfirst, Inc. ("Members") or their affiliates, together with physicians who are associated with the Members. There are also a significant number of independent hospitals, community physicians and independent practice associations, and ancillary providers, such as pharmacies, durable medical equipment suppliers, home health agencies and nursing homes that are unrelated to the Members and which also provide services to its enrollees.

HFHP compensates providers directly for claims for covered services and shares risk and "surpluses" with Members, and other contracted providers that are not Members, in accordance with the terms of a healthcare services agreement entered into with each Member or provider. Member hospital agreements provide for an allocation of premiums to the Members' hospital services pool based on a percentage of premium revenue received by HFHP under its agreements to service Medicare enrollees. These percentages of premiums primarily range from 85% to 90%. In all cases, providers submit claims for covered services and the claims are paid by HFHP in accordance with their respective agreements. Calculations and reconciliations regarding surpluses and deficits are completed quarterly.

The Plan's health care services agreements with Members, as a health care provider to enrollees, provide that certain payments due to each Member are retained by the Plan as additional capital contributions. Members may be entitled to have their retained payments repaid in the future,

without interest, upon the dissolution of the Plan or similar circumstances or with the approval of the Board of Directors, subject to any restrictions by the State Regulators.

HFHP, its members, and certain contracted providers, assume the risk for healthcare costs in the hospital services pool. To the extent that there is a deficit (estimated medical expense in excess of pool funding) in the hospital services pool of a Member or contracted provider, HFHP records a receivable from the Member or contracted provider.

These receivables are collected through reductions of future surpluses in the hospital services pool at the time the quarterly reconciliations are prepared. Management periodically evaluates the likelihood of collecting receivables from Members and contracted providers. The agreements with Members and contracted providers do not relieve HFHP of its obligation to pay claims to providers for healthcare services.

Certain contracted providers have elected not to take risk for certain product lines. For these providers, HFHP fully accepts the risk.

A. Corporate Governance

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board of directors consisting of five (5) individuals, at least twenty percent (20%) of whom shall be comprised of individuals ("enrollee-representatives") who are enrolled in the prepaid health care program operated by the Plan, and at least one-third (33%) of whom shall be persons who reside in New York State. A majority of the HFHP Directors shall be persons nominated to serve on the board by the board of directors of its parent, Healthfirst, Inc.

As of December 31, 2015, the members of the board of directors of HFHP and their principal business affiliations were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Elizabeth St. Clair ** New York, NY	Senior Vice-President, General Counsel, Healthfirst, Inc.
Richard Murcott* Glen Cove, NY	Retired, Community Representative
Stephen Rosenthal Teaneck, NJ	President, Contract Management, Montefiore Medical Center
Eric Scalettar New York, NY	Director, Maimonides Medical Center
Jay Schechtman Scarsdale, NY	Senior Vice-President, Chief Medical Officer, Healthfirst, Inc.

*Enrollee representative – Part 98-1.11(g) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)), requires that a minimum of twenty percent (20%) of the board of directors of a health maintenance organization be comprised of enrollee representatives. The Plan was in compliance with said Regulation, as of December 31, 2015.

** Elizabeth St. Clair resigned in July 2016. She was succeeded by Linda Tiano, Chief Legal Officer and General Counsel, Healthfirst.

The following were the principal officers of HFHP as of December 31, 2015:

<u>Name</u>	<u>Title</u>
Patricia Wang	Chief Executive Officer
Elizabeth St. Clair	Secretary
Craig Barattin	Treasurer

The corporate records of Healthfirst Health Plan, Inc. and Healthfirst, Inc. lacked sufficient documentation with regard to the election of board members and the appointment of Audit, Risk and Compliance Committee (“ARCC”) members. The by-laws of HFHP, as amended May 5, 2011, state that its Directors shall be elected to serve on the Board for a term of one year, by the Board of Directors of Healthfirst. The Healthfirst corporate minutes did not adequately document the annual election of HFHP Directors.

Furthermore, certain Healthfirst Board Committees charged with the governance and oversight of HFHP, such as the ARCC, lacked appropriate detail in their corporate records, sufficient to ascertain the Directors appointed to serve on the ARCC.

It is recommended that the Healthfirst entities maintain detailed corporate records that reflect the election of Directors and appointment of Committee members, per the Plan's by-laws.

Section 312 of New York Insurance Law states in part:

“(a) The superintendent shall forward to every insurer or other person examined a copy of the report on examination as filed for public inspection, together with any recommendations or statements relating thereto which he may deem proper.

(b) A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report...”

It should be noted that HFHP failed to comply with Section 312 of the New York Insurance Law when it did not have the members of its Board of Directors sign an acknowledgment that they received and read the prior report on examination.

It is recommended that HFHP comply with Section 312 of the New York Insurance Law by obtaining its Board of Directors' signatures acknowledging that they received and read the examination report, and by retaining the acknowledgements in its corporate records.

i. Enterprise Risk Management

One aspect of an entity's corporate governance is its Enterprise Risk Management (“ERM”). The way an entity identifies, monitors, evaluates and responds to risks can be very important to the ongoing solvency of an entity.

Insurance Circular Letter No. 14 (2011) states in part:

“...The Department views ERM as a key component of the risk-focused surveillance process, and expects every insurer to adopt a formal ERM function that identifies, measures, aggregates, and manages risk exposures within predetermined tolerance levels, across all activities of the enterprise of which the insurer is part, or at the company level when the insurer is a standalone entity...”

In 2015, the Plan began to establish components of a formal ERM process. However, as of the examination date, the Plan failed to comply with the requirements of Circular Letter No. 14 (2011) since it had not developed nor adopted a complete and formal ERM function.

ERM was established at the Plan’s Parent level to govern risks that impact the various legal entities of which HFHP is a member. Healthfirst utilizes integrated risk assessments involving multiple levels of management to identify and prioritize significant risks based on impact, likelihood and speed of onset. Each of the key risks are assigned to senior leaders of management. However, defined risk appetites and tolerances have not been determined. Furthermore, risk mitigation strategies for the significant risks were not clearly defined and key performance indicators and metrics to monitor the risks were not in place at year end 2015, evidencing the lack of a formal ERM framework. Additionally, Healthfirst lacks an established means of reporting and communicating the mitigation status of the top tier risks.

Healthfirst acknowledged that its ERM function was not fully developed. A risk officer (“RO”) who reports to the CFO is charged with the responsibility of completing the formal framework. The RO is currently working with business unit leaders and senior management to implement an effective and sustainable risk management program.

It should be noted that the Plan’s Parent filed its initial ERM report with the Department as of April 30, 2017.

It is recommended that the Plan comply with Insurance Circular Letter No. 14 (2011) by furthering its efforts to develop and adopt a robust ERM function.

ii. Internal Audit Department

Healthfirst's board of directors and its Audit and Compliance Committee provide governance and oversight over related entities' activities, including HFHP. The Audit and Compliance Committee was established to provide assistance to the board with matters related to the financial reporting process and the Plan's compliance program. Unless otherwise noted below, references to Healthfirst are also applicable to HFHP.

Corporate Governance and Model Audit Rule ("MAR"), Insurance Regulation No. 118 (11 NYCRR 89), processes for the Plan are provided by HFI, the Parent of the Plan. HFI has established a co-sourced internal audit department that works with a third party (KPMG, LLP) to perform internal audit functions. Exhibit M (*Understanding the Corporate Governance Structure*) of Handbook was utilized by the examiners as guidance for assessing HFHP's Corporate Governance. The examiners determined that the Plan's corporate governance structure was satisfactory, set an appropriate "tone at the top," supported a proactive approach to operational risk management, and contributed to an effective system of internal controls.

Healthfirst's MAR controls are applied to all its subsidiaries and affiliates, which include the Plan. As part of its Insurance Regulation 118 analysis, risks from various operations were identified and segregated by operational cycles and entity level controls.

Part 89.12 of Insurance Regulation 118 (11 NYCRR 89.12) states in part:

“...In order to be considered independent for purposes of this section, a member of the audit committee may not... be an affiliated person of the company or any subsidiary thereof...

(g) The proportion of independent audit committee members for a company shall meet or exceed the following minimum criteria...

(3) If a company's prior calendar year direct written and assumed premiums are more than \$500,000,000, 75 percent or more of the members of the audit committee shall be independent.”

As per Part 89.12(g)(3) of Insurance Regulation 118, if a company's prior calendar year direct written and assumed premiums were greater than \$500 million, 75% or more of the Audit Committee members shall be independent. In 2015, HFHP had direct written premiums of \$2 billion, however, less than 75% of its Audit Committee members were deemed independent. It should be noted that the directors that comprised Healthfirst's Audit Committee were also Member hospital executives who had direct ownership interest in an affiliated company, HFMS.

It is recommended that the Plan comply with the requirements of Insurance Regulation 118 when appointing its Audit Committee members.

As per the Institute of Internal Auditors (“IIA”), the Internal Audit Department reporting structure independence is weakened by not having a direct reporting relationship to the Audit Committee. Additionally, the integrated audit plan did not include sufficient depth of coverage (i.e., there were no information technology or Treasury audits in last 3 years). As such, the annual budget established for the co-sourced audit function with KPMG may not be adequate for the size and complexity of the organization, particularly as it continues to grow. The risk universe used by the Internal Audit Department to prepare the audit plan places partial reliance on MAR activities in certain areas instead of conducting scheduled audits covering both financial and operational areas.

It is recommended that HFHP's management consider establishing a direct reporting relationship between its Internal Audit Department and its Audit Committee to assure transparency with regards to independence and objectivity matters, as defined by the IIA.

Additionally, the integrated audit plan should be made more comprehensive to include greater levels of operational functions to assure full coverage of key areas.

B. Territory and Plan of Operation

HFHP (formerly MHI) was granted a certificate of authority pursuant to the provisions of Article 44 of the New York Public Health Law to serve the commercial population in the five boroughs of New York City ("NYC") and the counties of Nassau and Suffolk.

HFHP was approved to sell only Medicare products in Westchester County. Furthermore, contingent upon the execution of a Medicaid Advantage contract, then MHI, was approved by the New York State Department of Health, effective January 1, 2010, to serve the dual eligible population, (i.e., seniors and persons with disabilities who are covered by both Medicaid and Medicare) through its Medicaid Advantage program in the Bronx, Brooklyn, Nassau, New York, Queens, Richmond, and Westchester counties.

As of December 31, 2015, HFHP's total enrollment of 129,778 enrollees consisted of 17 Healthy New York members, 4,920 Medicaid Advantage Plus ("MAP") and Fully Integrated Duals Advantage ("FIDA") members, and 124,841 Medicare Advantage members including 412 members not electing Part D coverage.

The following table displays HFHP's net admitted assets, capital and surplus, net premium income, and net income (rounded to nearest thousand) during the period under examination:

	<u>Net Admitted Assets</u>	<u>Capital and Surplus</u>	<u>Net Premium Income</u>	<u>Net Income</u>
2011	\$ 451,300	\$ 184,917	\$ 1,391,459	\$ 22,861
2012	\$ 502,904	\$ 207,447	\$ 1,472,363	\$ 16,666
2013	\$ 476,335	\$ 195,116	\$ 1,613,417	\$ (10,177)
2014	\$ 548,699	\$ 206,864	\$ 1,775,941	\$ (32,316)
2015	\$ 614,266	\$ 241,534	\$ 2,022,471	\$ 5,784

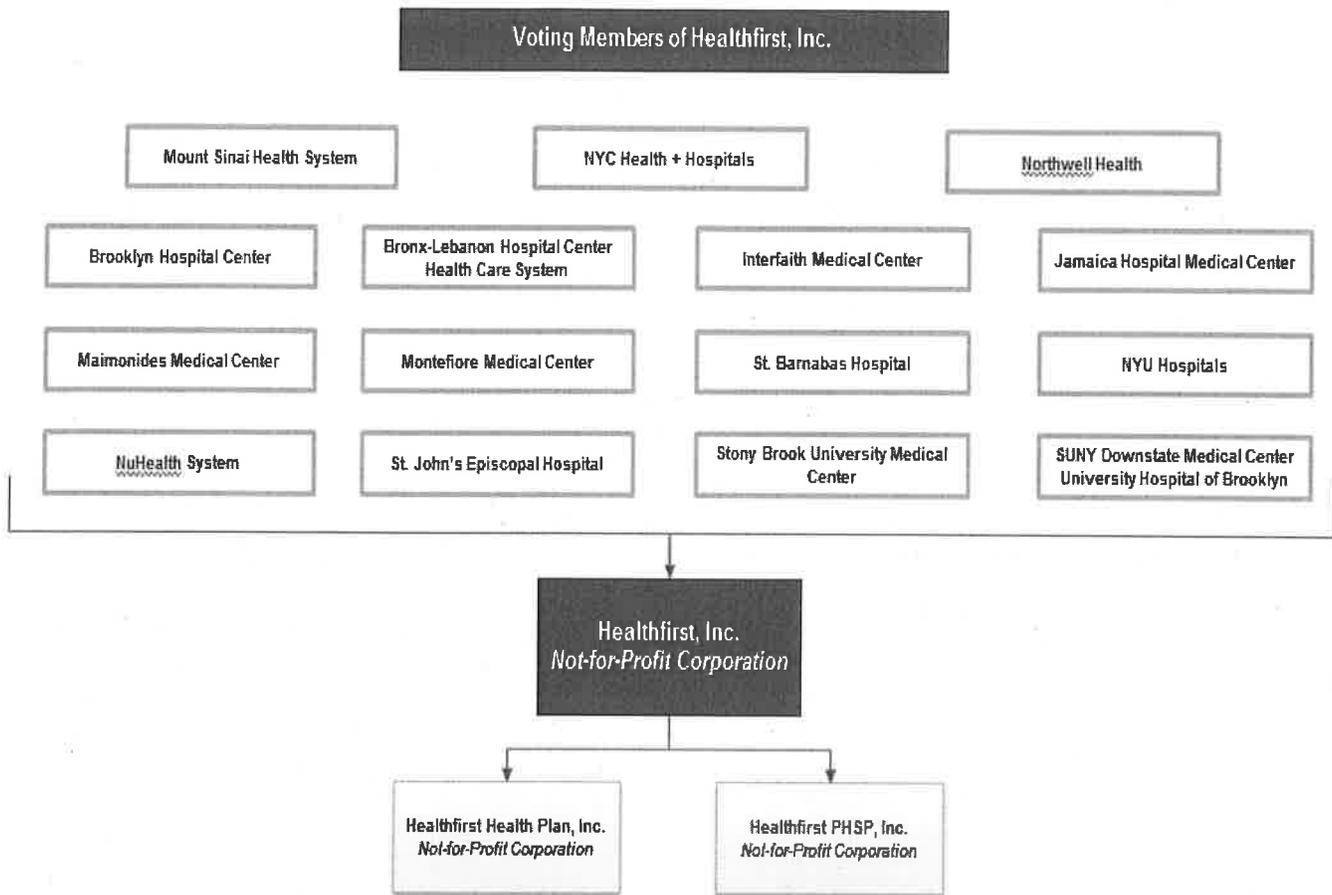
C. Contingent Reserves

As of December 31, 2015, the Plan's Contingent Reserve was \$228,409,568. Parts 98-1.11(e) and (f) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11(e) and (f)), require the Plan to maintain a Contingent Reserve and an escrow account with a custodian, for which a deed of trust has been approved by the Superintendent of Financial Services (formerly the New York State Department of Insurance). The Plan was in compliance with said Regulation as of December 31, 2015.

D. Holding Company System

During the period under examination, Healthfirst submitted all holding company filings pursuant to the applicable provisions of Part 98-1 of the Administrative Rules and Regulations of the Department of Health (10 NYCRR Sections 98-1.1 and 98-1.16). For purposes of its holding company filings, Healthfirst does not treat the Plan and HF Management Services, LLC as part of the same holding company system.

The following chart depicts the Plan's organizational structure as of December 31, 2015:



The following is a description of the Plan's affiliations as of December 31, 2015:

Healthfirst Health Plan, Inc.

Healthfirst Health Plan, Inc., is a not-for-profit membership corporation incorporated in the State of New York. Pursuant to HFHP's by-laws, Healthfirst, also a not-for-profit corporation, has the right to appoint the HFHP board of directors. Also, per its by-laws, Healthfirst has 18 member hospitals, which each have the right to appoint one director to Healthfirst's board of directors and 1 member health care system, NYC Health + Hospitals, which has the right to appoint five directors to Healthfirst's board of directors. Healthfirst's by-laws are in the process of being updated.

Healthfirst PHSP, Inc.

Healthfirst PHSP, Inc. (“HFPHSP”) is a not-for-profit corporation that was incorporated on August 24, 1994, by Healthfirst (its sole corporate member) as a licensed, prepaid health services plan that provides comprehensive prepaid health care coverage to Medicaid, Child Health Plus and Family Health Plus recipients. HFPHSP received a Certificate of Authority from the New York State Department of Health (“DOH”) to operate in the City of New York, and Nassau and Suffolk Counties, effective August 30, 1994. HFPHSP holds contracts with DOH to provide coverage to Medicaid, Family Health Plus and Child Health Plus beneficiaries.

HF Management Services, LLC

HF Management Services, LLC (“HFMS”) was formed under the provisions of Section 203 of the New York Limited Liability Company Law on April 15, 1999. As of December 31, 2015, HFMS was comprised of the following 19 member hospitals:

<u>Hospital System</u>	<u>Member</u>	<u>Percent Ownership</u>
Northwell Health	Long Island Jewish Medical Center	6.84 %
Northwell Health	North Shore University Hospital	1.11 %
Northwell Health	Staten Island University Hospital	3.10 %
NYC Health and Hospitals	NYC Health + Hospitals	7.43 %
Mt. Sinai Health System	Beth Israel Medical Center	3.32 %
Mt. Sinai Health System	Mount Sinai Medical Center	5.17 %
Mt. Sinai Health System	St. Luke’s- Roosevelt Hospital Center	2.67 %
	Bronx - Lebanon Hospital Center	11.12 %
	Episcopal Health Services, Inc.	4.17 %
	Interfaith	2.66 %
	Jamaica Hospital Medical Center	10.09 %
	Maimonides Medical Center	3.86 %
	Montefiore Medical Center	11.21 %
	NYU Hospitals Center	1.06 %
	St. Barnabas Hospital	4.80 %
	Stony Brook University Hospital	3.23 %

	SUNY Downstate	5.12 %
	The Brooklyn Hospital Center	7.05 %
	The NuHealth System	5.99 %
		<u>100.00%</u>

HFHP's Management Services Agreement (the "Agreement") with HFMS requires HFMS to provide certain management and administrative services, including: marketing and enrollment services, provider recruitment and provider relations services, accounting and financial services support, claims processing, financial reporting, maintenance of utilization and quality review programs and all data processing.

HF Administrative Services, Inc.

HF Administrative Services, Inc. ("HFAI") is a New York for-profit business corporation whose sole shareholder is HFMS. HFAI's provides certain administrative and management services to third-party customers outside of the holding company system.

i. Control of the Plan

The Department reviewed the relationships among Healthfirst, HFHP, and HFMS, the applicable provisions of Part 98-1 of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.10), the borrowed money transaction described below, and materials submitted by the Plan, and based on this assessment, the Department questioned whether Healthfirst, HFHP, and HFMS are part of the same holding company system. The Department solicited the opinion of the New York Department of Health, which is the agency that issues the holding company regulations applicable to HFHP. The Department of Health advised the Department that it does not believe HFHP and HFMS are part of the same holding company system.

Nonetheless, the examiners noted that among the 19 hospital representatives on Healthfirst's board, 17 representatives sit simultaneously on the board of HFMS. For this reason, the Department desired to monitor the financial relationship between the two entities as if an affiliation exists. Accordingly, the Department requested that within five (5) days of execution, HFHP provide the Department with copies of any executed agreements involving transactions where pre-notice for affiliated entities would be required under Parts 98-1.10 and 98-1.11 of the Administrative Rules and Regulations of the New York Department of Health (10 NYCRR 98-1.10, 98-1.11), as well as other sections of Part 98-1 and Article 44 of the New York Public Health Law. The Plan has agreed to comply with this request.

ii. Borrowed Money

In its 2015 filed Annual Statement, under the caption "Borrowed Money," HFHP indicated that on January 27, 2009, it received an advance payment of \$11,258,931 from HFMS for contracted hospitals accrued Additional Medical Compensation ("AMC"), as defined in an HFMS Board of Managers' resolution, in return for an interest bearing note payable by HFHP to HFMS. The note payable bears interest at prime plus 1%, which was 4.5% at December 31, 2015. Additionally, as of December 31, 2015, accrued interest thereon was \$3,841,970 for a total of \$15,100,901 in borrowings.

E. Reinsurance

The StarLine Group provides reinsurance through its affiliated company, United States Fire Insurance Company, which is licensed in New York State. Only \$1.9 million of \$2 billion (0.1%) in premium income is ceded under this policy.

The reinsurance agreement contained all the required standard clauses, including the insolvency clause, as required by Section 1308(a)(2)(A) of the New York Insurance Law.

Reinsurance is also provided to health care providers by the Centers for Medicare and Medicaid Services (“CMS”) through the risk sharing provisions of Medicare.

F. Significant Operating Ratios

The following ratios have been computed as of December 31, 2015, based upon the results of this examination:

<u>Description</u>	<u>Ratio</u>
Net change in capital and surplus	16.8%
Liquid assets and receivables to current liabilities	172.8%
Premium and risk revenue to capital and surplus	8.4 to 1
Medical loss ratio	86.0%
Administrative expense ratio	13.9%
Combined loss ratio	99.9%

The above ratios, with the exception of the Liquid Assets and Receivables to Current Liabilities Ratio and the Medical Loss Ratio, fell within the benchmark ranges set forth in the Fast Analysis Solvency Tools (“FAST”) scoring ratios of the NAIC.

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

	<u>Amounts</u>	<u>Ratios</u>
Total hospital and medical expenses	\$ 7,156,588,428	86.4%
Claim adjustment expenses	125,592,139	1.5%
Cost containment expenses	62,245,793	0.8%
General administrative expenses	940,497,411	11.4%
Net underwriting gain / (loss)	<u>(9,272,160)</u>	<u>(0.1)%</u>
Net premium income	\$ <u>8,275,651,611</u>	<u>100.00%</u>

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2015, as contained in the Plan's 2015 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiners' review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2015 filed annual statement.

Independent Accountants

The firm Ernst & Young LLP ("E&Y") was retained by HFHP to audit the Plan's combined statutory basis statements of financial position as of December 31st of each year in the examination period and the related statutory basis statements of operations, surplus, and cash flows for the year then ended.

E&Y concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the HMO at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements. No discrepancies were noted.

A. Balance Sheet

Assets

Bonds	\$ 277,042,779
Cash and short-term investments	96,268,677
Investment income due and accrued	1,146,520
Uncollected premiums and agents' balances in the course of collection	68,902,892
Amounts recoverable from reinsurers	478,811
Amounts receivable relating to uninsured plans	66,722,796
Health care and other amounts receivable	103,650,187
Miscellaneous receivables	<u>52,929</u>
Total assets	\$ <u>614,265,591</u>

Liabilities

Claims unpaid	\$ 334,321,059
Unpaid claims adjustment expenses	1,672,423
General expenses due or accrued	2,018,872
Borrowed money and interest	15,100,901
Amounts due to parent, subsidiaries and affiliates	5,483,760
Aggregate write-ins for other liabilities:	
Due to HF Management	7,573,800
Due to third-party payers	3,920,675
Unclaimed vendor payable	<u>2,639,673</u>
Total liabilities	\$ <u>372,731,163</u>

Surplus

Aggregate write-ins for other than special surplus	424,802,329
Unassigned funds (surplus)	<u>(183,267,901)</u>
Total surplus	\$ <u>241,534,428</u>
Total liabilities and surplus	\$ <u>614,265,591</u>

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2015. The Plan is a not-for-profit HMO which falls under IRC 501(C)(4), which exempts the Plan from federal income tax. The examiners are unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus increased \$81,445,338 during the five-year examination period, January 1, 2011 through December 31, 2015, detailed as follows:

Revenue

Net premium income	\$ 8,275,635,372	
Change in unearned premium reserves	<u>16,239</u>	
Total revenue		\$ 8,275,651,611

Hospital and Medical Expenses

Hospital and medical benefits	\$ 4,314,002,842
Other professional services	113,922,208
Emergency room and out-of-area	68,050,839
Prescription drugs	630,046,886
Other medical expenses	1,213,797,215
Risk pool balance adjustment	479,124,487
True-up adjustment	342,104,689
Net reinsurance recoveries	<u>(4,460,738)</u>
Total hospital and medical benefits	\$ 7,156,588,428

Administrative expenses

Claims adjustment expenses	187,837,932	
General administrative expenses	<u>940,497,411</u>	
Total administrative expenses	\$ 1,128,335,343	
Total underwriting deductions		\$ <u>8,284,923,771</u>
Net underwriting loss		\$ (9,272,160)
Net investment income earned	13,258,585	
Net realized capital gains	<u>4,967,945</u>	
Net investment gains		18,226,530

Other income

Interest expense on additional medical compensation	(2,889,033)	
Service fee for assignment of receivable	<u>(3,247,538)</u>	
Total other income expense		<u>(6,136,571)</u>
Net income		\$ <u>2,817,799</u>

Change in Surplus

Surplus, per report on examination, as of December 31, 2010			\$ 160,089,090
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$ 2,817,799		
Change in non-admitted assets		30,143,548	
Surplus adjustments, paid-in	<u>108,771,087</u>	<u> </u>	
Net increase in surplus			<u>81,445,338</u>
Surplus, per report on examination, as of December 31, 2015			<u>\$ 241,534,428</u>

4. CLAIMS UNPAID

The examination liability of \$334,321,059 is the same as the amount reported by the Plan as of the examination date.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and filed annual statements as verified during the examination.

The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2015.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducted its business practices and fulfilled 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 Plan in the following major areas:

- A. Complaint handling
- B. Agents and brokers
- C. Underwriting and rating
- D. Claims processing
- E. Explanation of benefits statements
- F. Utilization review

A. Complaint Handling

Part 216.4 of Insurance Regulation 64 (11 NYCRR 216.4) states in part:

“(c) Every insurer shall establish an internal department specifically designated to investigate and resolve complaints filed with the Department of Financial Services and to take action necessitated as a result of its complaint investigation findings... Responsibility for such department is to be vested in a corporate officer who is also to be entrusted with the duty of executing the Department of Financial Services’ directives...

(d) Every insurer, upon receipt of any inquiry from the Department of Financial Services respecting a claim, shall, within 10 business days, furnish the department with the available information requested respecting the claim.”

A population of seven (7) member complaints that were received by the Plan directly or via the Department were selected and reviewed. It was noted that one (1) of the selected complaints was not responded to in a timely manner. It took approximately 37 business days for the Plan to provide a response to the Department regarding said complaint.

It is recommended that the Plan comply with the provisions of Insurance Regulation 64 by ensuring that all complaint responses to the Department are provided in a timely manner.

B. Agents and Brokers

During the period under examination, HFHP contracted with licensed agents and brokers to sell its various health insurance products. HFHP also utilized salaried employees in its internal sales department to generate business and enroll members in its Medicare and commercial products.

The examiners selected a sample of ten (10) of the Plan's enrollment files for review. The examiners reviewed the new business applications and determined that the applications were submitted to HFHP by members and no agents or brokers were involved in these transactions, therefore, no commission payments were made to any entity or individual.

No exceptions were noted.

C. Underwriting and Rating

Insurance Regulation 171 (11 NYCRR 362) - *The Healthy New York Program and the Direct Payment Stop Loss Relief Program* - states in part:

“(a) Health maintenance organizations and participating insurers shall, at least 90 days prior to the annual renewal date, provide any forms necessary for recertification.

(b) Health maintenance organizations and participating insurers shall annually collect certifications of continued eligibility for the Healthy New York Program and shall be responsible for examination of such certifications to verify that small employers and individuals participating in the program continue to meet eligibility requirements and continue to comply with the terms of the program...”

The Plan has a very limited book of commercial business, with only one (1) direct pay subscriber as of December 31, 2015. The Plan also had four hundred two (402) Healthy New York subscribers.

The examiners utilized ACL to select a sample of ten (10) enrollment files to ensure that the Plan was adhering to Federal and New York Laws regarding the guaranteed issuance of coverage without discriminating for pre-existing conditions. The examiners also reviewed the enrollment files for compliance with Insurance Regulation 171 (11 NYCRR 362), which requires annual recertification forms to be sent to members 90 days prior to the end of the policy term. The examiners identified 9 of 10 (90%) enrollment files where HFHP did not send an annual recertification to members, as required by Insurance Regulation 171 (11 NYCRR 362).

It is recommended that the Plan create and implement procedures to ensure that all annual recertifications for each policy are processed in accordance with the requirements of Insurance Regulation 171.

D. Claims Processing

A review of HFHP's claims practices and procedures was performed by using a sample of claims adjudicated during the period January 1, 2015 through December 31, 2015, in order to evaluate the overall accuracy and compliance environment of its claims processing. The claims population for the Plan was divided into hospital and medical claims. A random sample was drawn to test for compliance with certain specified attributes, including: eligibility, copays, deductibles, denials of claims and explanation of benefits statements ("EOBs").

The examiners utilized ACL to select a sample of 20 claims, comprised equally of randomly selected hospital and medical claims, from the Plan's "Commercial" and Healthy New York claims populations.

The term “claim” can be defined in a myriad of ways. A “claim” as defined by the Plan, is a grouping of all line items (i.e., procedures or services) on any one claim form as entered into its claims processing system. It was possible, through the computer program used for this examination, to match or “roll-up” all procedures on the claim form into one item. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by the Plan for the period January 1, 2015 through December 31, 2015.

It should be noted that multiple claims data requests were made to the Plan’s management before the correct data file was eventually provided to the examiners for the claims processing review. Such issues caused delays and a vast amount of lost time. This matter is further addressed in Item 7 of this Report.

E. Explanation of Benefits Statements

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

“(a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits.”

Explanation of Benefits Statements (“EOBs”) are an integral part of the link between the subscriber/contract-holder and their insurer, providing vital information as to how a claim was processed.

Upon conducting the claims review of the Plan, it was noted that the Plan ceased providing EOBs to its Healthy New York members for the period February 1, 2014 through October 31,

2017. Upon inquiry, the Plan's management informed the examiners that due to a change made within its computer system the provision of EOBs for the Healthy New York line of business had mistakenly and unknowingly ceased. It was determined that a total of 8,722 claims were impacted during this period.

It is recommended that the Plan comply with the provisions of Section 3234(a) of the New York Insurance Law by providing EOBs to all of its members when such EOBs are required.

F. Utilization Review

Article 49 of the New York Public Health Law sets forth the minimum utilization review program standards and requirements for an HMO licensed under Article 44 of the New York Public Health Law.

A review of HFHP's utilization review ("UR") practices and procedures was performed. The review was conducted to ensure that UR transactions were processed in a timely manner, in accordance with statutory timeframes, providers and members were advised of UR decisions in a timely manner and that determination notices sent to providers and members contained required New York disclosures.

The examiners utilized ACL to select a sample of five (5) utilization review cases from the Plan's "Commercial" and Healthy New York utilization review populations, for the period January 1, 2015 – December 31, 2015.

No exceptions were noted.

6. **STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("PROMPT PAYMENT 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 Payment Law"), requires all insurers to pay undisputed claims within forty-five (45) days of receipt for paper claims and within thirty (30) days of receipt for electronically submitted claims. If such undisputed claims are not paid within forty-five/ thirty (45/30) days of receipt, interest may be payable.

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

"...(a) Except in 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."

Section 3224-a(c) of the New York Insurance Law states in part:

"... 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 than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

The examiners identified five (5) hospital and two (2) medical claims that were not paid within the timeframes mandated by Section 3224-a of the New York Insurance Law. It was determined that interest, when required, was not paid on said claims.

It is recommended that the Plan comply with Section 3224-a of the New York Insurance Law by paying all undisputed claims in a timely manner.

It is also recommended that the Plan comply with Section 3224-a(c) of the New York Insurance Law by paying all applicable interest, in excess of two dollars, on those claims that were not paid timely.

Additionally, it is recommended that the Plan enhance its claims inventory reporting process to identify claims that may not have been adjudicated within the aforementioned prescribed timeframes.

Finally, it is recommended that the Plan create a weekly audit process to ensure that claims are paid timely.

During the prior market conduct examination, two hundred and ten (210) claims were identified as not being correctly adjudicated due to the Plan's use of an incorrect fee schedule. As such, the Plan was directed to re-adjudicate those affected claims that were processed between July 2, 2010 and July 25, 2010, with dates of service between January 1, 2010 and July 25, 2010. Additionally, the Plan was to include interest payments, where applicable.

The examiners reviewed the Plan's compliance with the prior examination's recommendation. It should be noted that although the Plan re-adjudicated the affected claims, it failed to correctly calculate the interest that was to be paid on some of these claims.

It is recommended that the Plan exercise care when calculating interest that is to be paid to its respective members for violations of Section 3224-a of the New York Insurance Law.

It is also recommended that the Plan review and recalculate the interest due on the abovementioned two hundred and ten (210) claims and make the correct payment of interest due, where applicable.

7. FACILITATION OF THE EXAMINATION

Section 310(a)(3) of the New York Insurance Law states:

“The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so.”

Various market conduct and financial documentation requests were made by the examiners to the Plan’s management. It should be noted that there were numerous instances where the Plan’s management failed to provide the examiners with the requested documentation in a timely manner. Failure to provide the documentation in a timely manner led to numerous delays, causing the examination process to take much longer than planned.

It should be further noted that some of the information provided by the Plan was redacted, making it very difficult for the examiners to obtain vital information from these documents.

It is recommended that the Plan comply with the requirements of Section 310(a)(3) of the New York Insurance Law by providing all requested documentation in a timely manner.

It is also recommended that all documents provided to the examiners be provided in an unredacted form, so that the examiners can review all of the information needed to conduct the examination.

8. SUBSEQUENT EVENTS

On September 30, 2016, the Department licensed Healthfirst Insurance Company, Inc. (“HFIC”) to transact the business of accident and health insurance pursuant to Section 1113(a)(3)(i) of the New York Insurance Law. HFHP and Healthfirst PHSP, Inc. (“PHSP”), another subsidiary of Healthfirst, each own 50% of HFIC’s outstanding common stock.

Insurance Regulation 164 – *Standards for Financial Risk Transfer Between Insurers and Health Care Providers* - (11 NYCRR 101.10) states:

“A financial risk transfer agreement whereby the health care provider receives projected in-network capitation from an individual insurer, during any consecutive twelve month period, of no more than \$250,000, shall be exempt from the provisions of this Part. A financial risk transfer agreement whereby the health care provider receives projected in-network capitation from an individual insurer, during any consecutive twelve month period, of more than \$250,000 but less than \$1,000,000, shall only be exempt from the following provisions of this Part:

(a) The need for the superintendent’s approval of the financial risk transfer agreement, including the need to demonstrate to the superintendent the financial responsibility of the health care provider, as set forth in section 101.4(c) of this Part; and

(b) The provisions of section 101.9(a)(3) of this Part as respects the requirements for the filing of the health care provider’s financial statement and the CPA opinion thereon with the superintendent.”

It should be noted that during calendar year 2017, capitation payments made to two of the Plan’s providers, Alpha Health Care IPA and Montefiore Behavioral Care IPA, in the amount of \$3,212,644 and \$1,793,384, respectively, exceeded the \$1,000,000 threshold. On August 2, 2016, the Montefiore Behavioral Care IPA agreement was approved by the Department, however, the Plan failed to submit its agreement with Alpha Health Care IPA to the Department for approval.

During the examination period, capitation payments made by the Plan to Alpha Health Care IPA (“AHC”) were consistently below the \$1,000,000 threshold, however in calendar year 2017, its capitation payments substantially exceeded the threshold, thereby requiring the Plan to

not only obtain the Department's approval of the financial risk transfer agreement but also requiring the Plan to demonstrate, to the Department, AHC's financial responsibility. Upon the Department's inquiry, management of the Plan stated that its reason for failing to submit its financial risk transfer agreement with AHC to the Department for approval and its failure to demonstrate the financial responsibility of AHC to the Department, was due to the fact that AHC's capitated payments were not prospectively identified as potentially exceeding the regulatory threshold during the Plan's annual review of its capitation payments.

It is recommended that the Plan implement a more frequent monitoring process to ensure compliance with the requirements of Insurance Regulation 164.

It is also recommended that the Plan comply with the requirements of Insurance Regulation 164 by obtaining the Superintendent's approval, where applicable.

Finally, it is recommended that the Plan comply with the requirements of Insurance Regulation 164 by making the requisite filings, in a timely manner with the Superintendent, of all documentation demonstrating the risk bearing entity's financial responsibility.

9. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2010, contained 16 recommendations, as follows (page number refers to the prior report):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
	<u>Corporate Governance</u>	
1.	It is recommended that HFHP comply with the provisions of Section 3.07(a) of its by-laws and convene the requisite number of meetings of its board of directors during each year. <i>The HMO has complied with this recommendation.</i>	9
2.	Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decision may be reached by the board. Board members who fail to attend at least one-half of the board's regular meetings, unless appropriately excused, do not fulfill such criteria. <i>The HMO has complied with this recommendation.</i>	9
3.	It is recommended that board members who are unable or unwilling to attend board meetings consistently resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be an assessment of their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan. <i>The HMO has complied with this recommendation.</i>	9
4.	It is recommended that the board of directors comply with New York Insurance Law 1411(a) by authorizing and approving the Plan's investment transactions, and that documentation supporting the board's actions in this regard be appended to the minutes of its meetings. <i>The HMO has complied with this recommendation</i>	10
5.	It is also recommended that the Plan respond accurately to Question 15 of the "General Interrogatories" of the Plan's filed Annual Statements. <i>The HMO has complied with this recommendation.</i>	10

ITEM NO.

PAGE NO.

Holding Company System

6. Accordingly, the Department has requested that within five days of execution, MHI provide the Department with copies of any executed agreements involving transactions where pre-notice for affiliated entities would be required under Parts 98-1.10 and 98-1.11 of the Administrative Rules and Regulations of the New York State Department of Health Regulation (10 NYCRR 98-1.10, 98-1.11), as well as other sections of Part 98-1 and Public Health Law Article 44, effective upon the filing of this report. MHI has agreed with this request. 17

The HMO has not fully complied with this recommendation. A similar recommendation is contained herein.

7. It is recommended that HFHP include a clause in its management agreement that describes a methodology for cost allocation that is in accordance with the provisions of Section 98-1.10 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.) 20

The HMO has complied with this recommendation.

8. It is recommended that the Plan adopts best practices in its application of IT controls in order to ensure that the supporting documentation of controls are consistently implemented to mitigate all IT risks. 24

The HMO has complied with this recommendation.

9. It is recommended that the Plan ensure adequate expertise and support is provided to the Department during examinations and that all Departmental requests are fully responded to in a timely manner. 24

The HMO has not complied with this recommendation.

Underwriting and Rating

10. It is recommended that the Plan ensure that the posted rates on its website are the same as those approved by the Department and in agreement with those on the New York State Healthy New York website. 31

The HFHP website has a link to the Department's website in which rates are located. As such, this matter has been addressed.

ITEM NO.

PAGE NO.

Claims Processing

11. It is recommended that the Plan implement the proper fee schedule within the time frame required by the Plan's provider contracts. 32

The examination was limited in scope and this item was not reviewed.

12. It is recommended that the Plan re-adjudicate affected claims processed between July 2, 2010 and July 25, 2010 for dates of service between January 1, 2010 and July 25, 2010, and make additional payments, including prompt pay interest, if required, in accordance with the provisions of Section 3224-a of the New York Insurance Law. 33

HFHP has not complied with this recommendation. A similar recommendation is contained herein.

13. It is recommended that the Plan review the claims system logic to ensure adequate criteria is used to establish whether an auto-adjudicated denied claim is the duplicate of a previously submitted claim. 33

The HMO has complied with this recommendation.

14. It is also recommended that the Plan enhance its duplicate claims review process to identify any claims that may have been denied incorrectly and correct any claims denied in error; including complying with the provisions of Section 3224-a of the New York Insurance Law. 33

The HMO has complied with this recommendation.

15. In the event that management identifies claims denied in error, it is recommended that the Plan devote sufficient resources to minimize such errors in the future. 33

The HMO has complied with this recommendation.

Utilization Review

16. It is recommended that the Plan comply with the provisions of Section 4903(2) of the New York Public Health Law by providing notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of the receipt of necessary information. 34

The HMO has complied with this recommendation.

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Corporate Governance</u>	
i. It is recommended that the Healthfirst entities maintain detailed corporate records that reflect the election of Directors and appointment of Committee members, per the Plan's by-laws.	8
ii. It is recommended that HFHP comply with Section 312 of the New York Insurance Law by obtaining its Board of Directors' signatures acknowledging that they received and read the examination report, and by retaining the acknowledgements in its corporate records.	8
B. <u>Enterprise Risk Management</u>	
It is recommended that the Plan comply with Insurance Circular Letter No. 14 (2011) by furthering its efforts to develop and adopt a robust ERM function.	10
C. <u>Internal Audit Department</u>	
i. It is recommended that the Plan comply with the requirements of Insurance Regulation 118 when appointing its Audit Committee members.	11
ii. It is recommended that HFHP's management consider establishing a direct reporting relationship between its Internal Audit Department and its Audit Committee to assure transparency with regards to independence and objectivity matters, as defined by the IIA.	12
iii. Additionally, the integrated audit plan should be made more comprehensive to include greater levels of operational functions to assure full coverage of key areas.	12
D. <u>Complaint Handling</u>	
It is recommended that the Plan comply with the provisions of Insurance Regulation 64 by ensuring that all complaint responses to the Department are provided in a timely manner.	23
E. <u>Underwriting and Rating</u>	
It is recommended that the Plan create and implement procedures to ensure that all annual recertifications for each policy are processed in accordance with the requirements of Insurance Regulation 171.	25

ITEM

PAGE NO.

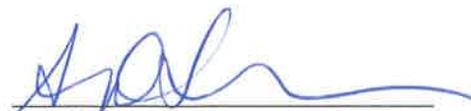
F.	<u>Explanation of Benefits Statements</u>	
	It is recommended that the Plan comply with the provisions of Section 3234(a) of the New York Insurance Law by providing EOBs to all of its members when such EOBs are required.	27
G.	<u>Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Healthcare Services (“Prompt Payment Law”)</u>	
i.	It is recommended that the Plan comply with Section 3224-a of the New York Insurance Law by paying all undisputed claims in a timely manner.	29
ii.	It is also recommended that the Plan comply with Section 3224-a(c) of the New York Insurance Law by paying all applicable interest, in excess of two dollars, on those claims that were not paid timely.	29
iii.	Additionally, it is recommended that the Plan enhance its claims inventory reporting process to identify claims that may not have been adjudicated within the aforementioned prescribed timeframes.	29
iv.	Finally, it is recommended that the Plan create a weekly audit process to ensure that claims are paid timely.	29
v.	It is recommended that the Plan exercise care when calculating interest that is to be paid to its respective members for violations of Section 3224-a of the New York Insurance Law.	30
vi.	It is also recommended that the Plan review and recalculate the interest due on the above-mentioned two hundred and ten (210) claims and make the correct payment of interest due, where applicable.	30
H.	<u>Facilitation of the Examination</u>	
i.	It is recommended that the Plan comply with the requirements of Section 310(a)(3) of the New York Insurance Law by providing all requested documentation in a timely manner.	30
ii.	It is also recommended that all documents provided to the examiners be provided in an unredacted form, so that the examiners can review all of the information needed to conduct the examination.	30

ITEM

PAGE NO.

- I. Subsequent Events
- i. It is recommended that the Plan implement a more frequent monitoring process to ensure compliance with the requirements of Insurance Regulation 164. 32
 - ii. It is also recommended that the Plan comply with the requirements of Insurance Regulation 164 by obtaining the Superintendent's approval, where applicable. 32
 - ii. Finally, it is recommended that the Plan comply with the requirements of Insurance Regulation 164 by making the requisite filings, in a timely manner with the Superintendent, of all documentation demonstrating the risk bearing entity's financial responsibility. 32

Respectfully submitted,


Sylvia D. Lawson, AINS, ARM, CLU, ~~AZE~~, MBA
Principal Insurance Examiner

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

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


Sylvia D. Lawson, AINS, ARM, CLU, ~~AZE~~, MBA .

Subscribed and sworn to before me
this _____ day of _____

Subscribed and sworn to before me

this _____ day of _____ 2019.

APPOINTMENT NO. 31549

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:

Risk & Regulatory Consulting, LLC

as a proper person to examine the affairs of

Healthfirst Health Plan, Inc.

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

HMO

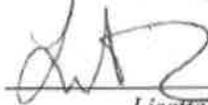
with such other information as they shall deem requisite.

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

this 7th day of December, 2016

MARIA T. VULLO
Superintendent of Financial
Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

