

REPORT ON EXAMINATION

OF

TOUCHSTONE HEALTH HMO, INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT

DECEMBER 22, 2011

EXAMINER

KAIWEN K. GUO

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

December 22, 2011

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30348, dated September 21, 2009, attached hereto, I have made an examination into the condition and affairs of Touchstone Health HMO, Inc., a for-profit health maintenance organization (HMO) licensed under the provisions of Article 44 of the New York Public Health Law as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the home office of Touchstone Health HMO, Inc. located at 14 Wall Street, New York, New York.

Wherever the terms the "HMO" or "Touchstone" appear herein, without qualification, they should be understood to indicate Touchstone Health HMO, Inc.

Wherever the designation, the "Department" appears herein, without qualification, it should be understood to indicate the New York State Insurance Department (On October 3, 2011, the New York State Insurance Department merged with the New York State Banking Department to become the New York State Department of Financial Services).

This examination has determined the HMO to be insolvent in the amount of \$(14,111,264), and its contingent reserve fund of \$6,954,197, required by Parts 98-1.11(d) and(e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), to be impaired in the amount of \$(21,065,461) as of December 31, 2008.

As of September 30, 2011, subsequent to the examination date, the HMO reported itself solvent in the amount of \$1,608,135, however, its contingent reserve fund of \$16,682,521, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), remained impaired, in the amount of \$(15,074,386).

1. SCOPE OF THE EXAMINATION

This is the first examination that has been performed on the HMO. Touchstone Health HMO, Inc. began writing business in September of 2007. The examination covers the period from September 1, 2007 through December 31, 2008. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2008, in accordance with Statutory Accounting Principles (“SAP”), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by Touchstone’s independent certified public accountants.

A review or audit was also made of the following items as called for in the *Examiners Handbook of the National Association of Insurance Commissioners* (“NAIC”):

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

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

2. FACILITATION OF THE EXAMINATION

Section 310(a)(2) of the New York Insurance Law states in part:

“(2) Any examiner authorized by the superintendent shall be given convenient access at all reasonable hours to the books, records, files, securities and other documents of such insurer or other person...”

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

“(3) 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.”

During the examination, the examiner made various requests for supporting documentation needed to facilitate the examination. However, the HMO consistently failed to provide responses to the examiner’s requests in a timely manner; some of the documentation requested should have been readily available. In other instances, documents provided to the examiner were incomplete and/or without signatures, dates, or a combination of both.

It should be noted that throughout the examination, the examiner held regular status meetings with the HMO's management to address document requests and other issues pertaining to the facilitation of the examination. However, these meetings yielded only limited improvement in the timeliness of responses to subsequent requests.

It is recommended that the HMO improve its procedures for facilitating the examination process.

It is also recommended that the documentation provided be complete and that it also be provided in a timely manner.

3. DESCRIPTION OF THE HMO

Touchstone Health HMO, Inc. is a for-profit health maintenance organization ("HMO") incorporated under Section 402 of the New York Business Corporation Law. Its certificate of incorporation was executed on May 31, 2006 and filed with the Department of Health and the Department of State on September 28, 1995. It was issued a certificate of authority on June 21, 2007 pursuant to the provisions of Article 44 of the New York Public Health Law. Touchstone is a wholly-owned subsidiary of Touchstone Health Partnership, Inc., a holding company incorporated on April 17, 1995. Touchstone Health HMO, Inc. received an initial capital contribution from its Parent, Touchstone Health Partnership, Inc. ("Parent") of \$7,100,000 in September 2007 and began operations on September 1, 2007. Subsequently, the HMO received an additional capital contribution of \$5,600,000 on October 7, 2008. The HMO's home office was located at 14 Wall Street, New York, New York from September 1, 2007 through January 6, 2010. On January 7, 2010, the HMO's home office was relocated to 1 North Lexington Avenue, White Plains, New York.

The HMO's main source of operating capital during the examination period came from capital infusions from its shareholders through its Parent, Touchstone Health Partnership, Inc. Through December 31, 2008, the Parent had contributed \$12,700,000 to the HMO; including the \$7,100,000 initial capital contribution.

A. Management and Controls

Article III, Section 3.01 of the HMO's By-Laws provides that the number of directors which shall constitute the entire Board of Directors shall be set by the Board of Directors from time to time and shall initially be three (3). Directors shall be elected by plurality vote of the stockholders.

The members of the HMO's Board of Directors as of December 31, 2008 were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Stacey Blair-Greenfield Staten Island, NY	Director of Compliance, Touchstone Health HMO, Inc.
Michael Muchnicki New York, NY	President and Chief Executive Officer, Touchstone Health HMO, Inc.
David R. Pfaff, MD Staten Island, NY	Physician,
Peter Sabados * New York, NY	Enrollee,

*Enrollee representative per Part 98-1.11(g) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11(g)).

Part 98-1.11(g) of the Administrative Rules and Regulations of Department of Health (10

NYCRR 98-1.11(g) states in part:

“(g) Except in the case of an HMO operated by a corporation licensed under article 43 of the Insurance Law which also operates a Public Health Law article 44 line of business, no less than one third of the members of the governing authority of an MCO shall be composed of residents of New York State.

(1) Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO...”

The HMO complied with this requirement during the examination period.

A review of the minutes of the HMO’s Board of Directors’ meetings held during the examination period indicated that the Board held three meetings; one each in the second, third and fourth quarters of 2008, respectively. There was no evidence that a Board meeting was held during the fourth quarter of 2007 or in the first quarter of 2008.

The amendment to the HMO’s By-Laws, executed April 16, 2007, provides that the Board meet at least quarterly, during any calendar year. The amendment to the By-Laws states in part:

“...Whereas, the amendment to the By-Laws hereinafter set forth is being made by the Board of Directors to incorporate changes requested by the New York State Department of Health to indicate that the Board of Directors of the Company shall meet at least quarterly and provide requisite notice of such meeting to each enrollee or consumer representative and/or advisory council member as such terms are contemplated in 10 NYCRR 98-1.6(a).”

It is recommended that the HMO comply with the requirements of its By-Laws and have Board of Directors’ meetings at least once a quarter.

A review of the attendance records of the Board of Directors’ meetings held during the period under examination revealed that the meetings were generally well attended, with all directors attending at least one-half of the meetings they were eligible to attend.

Section 1411 of the New York Insurance Law states in part:

“No domestic insurer shall make any loan or investment...unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee’s minutes shall be recorded and a report submitted to the board of directors at its next meeting...”

It was noted by the examiner that, as of December 31, 2008, the HMO had short-term investments of \$10,049,574 in money market mutual funds, however, there was no documentation verifying that these investments were discussed, reviewed or approved by the HMO’s Board of Directors.

It is recommended that the HMO comply with the investment authorization approval requirements of Section 1411 of the New York Insurance Law.

The HMO indicated that decisions for investments were made by members of the HMO’s Board, as well as members of the Parent’s Board, however, these decisions were not formalized at the Board meetings, nor were they noted in the Board minutes.

It is recommended that the HMO formalize and document the discussion, and the approval of all of its investment decisions.

Additionally, the examiner reviewed the HMO’s Investment Policy. Section 5.0 of the Investment Policy states:

“The Investment Policy must be reviewed and affirmed by the Board of Directors annually, for the purpose of ensuring that it remains consistent with the company’s operating constraints and financial objectives, and that it reflects then prevailing market conditions.”

The examination revealed that the HMO's Investment Policy had not been reviewed and approved by the HMO's Board of Directors, presuming it was never approved for the period under examination.

It is recommended that the HMO comply with its Investment Policy by submitting its Investment Policy to the Board of Directors annually, for its review and approval.

The principal officers of the HMO as of December 31, 2008 were as follows:

<u>Name</u>	<u>Title</u>
Michael Muchnicki	Chief Executive Officer
Stacey Blair-Greenfield	Secretary
Daniel O'Brien	Chief Financial Officer

During the examination period, the HMO's management experienced a high rate of turnover. A review of the management records indicated that sixteen (16) individuals were listed as Senior Officers of the HMO during the examination period; twelve (12) of them left the HMO and were replaced. Those who left the HMO included: the Chief Executive Officer, Michael Muchnicki; the Controller, Chris Masi; and the Chief Financial Officer, Daniel O'Brien.

B. Circular Letter No. 9 (1999) - Adoption of Procedure Manuals

Circular Letter No. 9 (1999) – “Adoption of Procedure Manuals” dated May 25, 1999, was issued to Article 43 corporations, Public Health Law Article 44 health maintenance organizations and insurers licensed to write health insurance in New York State. The Circular Letter applies to Touchstone as a health maintenance organization.

Circular Letter No. 9 (1999) states in part:

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

The examination revealed that the aforementioned annual certifications were not obtained during the examination period.

It is recommended that the HMO’s Board comply with the requirements of Circular Letter No. 9 (1999) by obtaining the required certifications on an annual basis.

C. Territory and Plan of Operation

The New York State Department of Health issued a Certificate of Authority to Touchstone Health HMO, Inc., effective June 21, 2007, pursuant to Article 44 of the New York Public Health Law. The certificate authorized the HMO to offer Medicare products in the following ten (10) counties of New York State: Bronx, Broome, Chenango, Delaware, Kings, Onondaga, Orange, Queens, Richmond and Westchester. An amended Certificate of Authority was issued on November 13, 2008 to reflect the Health Department’s approval of the HMO’s expansion application to serve the Medicare population in the county of New York (Manhattan). The certificate contained the following conditions and limitations:

- Touchstone Health HMO, Inc. is limited to enrolling and offering only Medicare products in these counties.

- All aspects of operation in these Medicare only counties will be governed primarily by the Center for Medicare and Medicaid Services (“CMS”), and implementation is contingent upon securing a Medicare contract with the Federal government.

D. Enrollment

Medicare Advantage Plan was the only line of business of the HMO. During the examination period September 1, 2007 through December 31, 2008, the HMO experienced a net increase in enrollment of 1,599 members. An analysis of the enrollment is set forth below:

	<u>2007</u>	<u>2008</u>
Enrollment, January 1	N/A	9,677
Net gain	9,677	1,599
Enrollment at December 31	9,677	11,276

E. Reinsurance

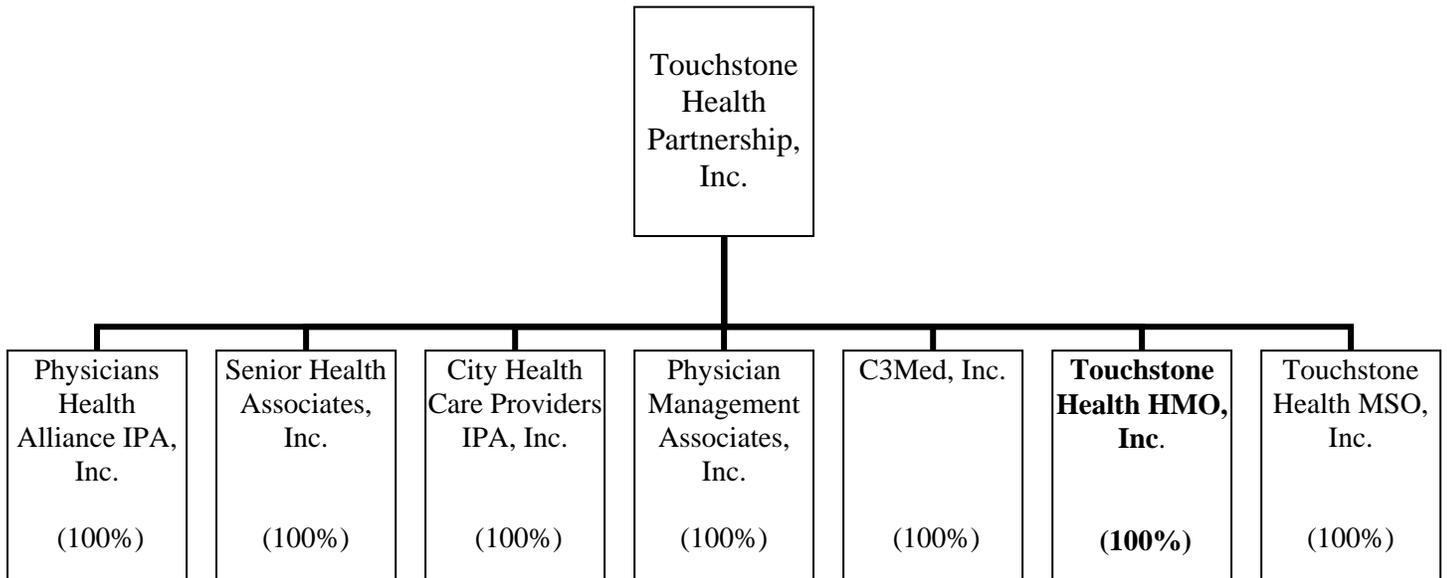
As of December 31, 2008, the HMO had an excess of loss reinsurance contract in effect with QBE Reinsurance Corporation, an authorized reinsurer. The contract’s effective date was July 1, 2008 to June 30, 2009. Prior to July 1, 2008, the HMO had an excess of loss reinsurance contract with Executive Risk Indemnity, Inc., an authorized reinsurer. Effective July 1, 2009, the HMO entered into an excess of loss reinsurance agreement with Star Line Group, an authorized reinsurer.

The reinsurance coverage in effect as of December 31, 2008 was as follows:

Covered member type:	Medicare
HMO’s deductible:	\$170,000 per member per agreement period
Coinsurance:	90%
Policy limit:	\$1,000,000 per member per agreement period

F. Holding Company System

The HMO is a wholly-owned subsidiary of Touchstone Health Partnership, Inc. The following chart depicts the HMO's holding company system as of December 31, 2008:



i. Holding Company Transactions

The HMO is a member of a holding company system. However, it was noted that the HMO answered “No” in the General Interrogatories page of its filed 2008 annual statement when asked whether the reporting entity is a member of an insurance holding company system.

It is recommended that the HMO accurately report all information in its filed annual statement.

Touchstone Health MSO, Inc.

Touchstone Health MSO, Inc. (“MSO”), a wholly-owned subsidiary of Touchstone Health Partnership, Inc., was incorporated on May 30, 2006, in the State of New York. Touchstone Health MSO, Inc. was incorporated at the same time as the HMO. MSO was formed to operate as the HMO’s management services organization and accordingly, performs administrative services for the HMO.

According to a service agreement between MSO and the HMO, MSO is to provide the HMO with services such as: medical management, claims processing, appeals, credentialing, re-credentialing, provider services, member services, information technology, financial and accounting, human resources and pharmacy management.

During 2008, the HMO booked transactions with Touchstone Health MSO, Inc. in the amount of \$52,902,316 (243% of the HMO’s admitted assets as of December 31, 2008). However, the HMO failed to provide the examiner with a written expense allocation methodology documenting how the expenses were allocated between the two entities. In response to the examiner’s inquiries, the HMO stated that, “*the entries that occur between entities are all straight forward and do not involve any allocation methodology.*” Additionally, there was no evidence that a service agreement was provided to nor approved by the New York Departments of Health and Insurance as required by Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10), which states in part:

“The commissioner’s and, except in the case of PHSP, HIV SNP or PCPCP, the superintendent’s prior approval shall be required for the following transactions between a controlled MCO and any person in its holding company system: sales, purchases, exchanges, loans, extensions of credit or investments the aggregate of which involves five percent or more of the MCO’s admitted assets at last year-end...”

It is recommended that the HMO comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the New York Department of Health by executing a formal written agreement with any entity within its holding company system and by submitting the agreement to the Commissioner of Health and the Superintendent of Insurance for their prior approval for any transaction with a member of its holding company system involving five percent or more of its admitted assets at last year-end.

ii. Tax Allocation Agreement

Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(c)) states in part:

“...Thirty days prior notice to the commissioner and... superintendent, is required before entering into the following transactions between a controlled MCO and any person in its holding company system: a reinsurance agreement or an agreement for rendering services on a regular or systematic basis... Such transactions may become effective unless the commissioner or the superintendent has disapproved the transaction within such period.”

Department Circular Letter No. 33 (1979) states in part:

“...Pursuant to the provisions of Section 27 of the Insurance Law every domestic insurer is directed to notify this Department within 60 days of this circular letter if it participates in a consolidated tax return and to submit a copy of its tax allocation agreement with such notification. Any domestic insurer which currently does not participate in a consolidated tax return shall file a copy of its tax allocation agreement with this Department within 30 days of electing to do so. Furthermore, notification to this Department should be given within 30 days of any amendment to or termination of a tax allocation agreement...”

During the examination, the examiner obtained a copy of the HMO's 2007 consolidated federal income tax return filed in conjunction with its Parent, Touchstone Health Partnership, Inc and other members of its holding company system. Although the HMO did not owe any tax in 2007, the tax return showed that taxes would have been

allocated among entities within the holding company system if taxes were incurred. It should be noted that for the period under examination, the HMO failed to file a tax allocation agreement with this Department, thereby not complying with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(c)) as well as Department Circular Letter No. 33 (1979).

It is recommended that the HMO comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and file its tax allocation agreement with the Superintendent for approval.

It is also recommended that the HMO comply with the requirements of Department Circular Letter No. 33 (1979) by entering into a formal tax allocation agreement with its Parent, Touchstone Health Partnership, Inc., and other members of its holding company system by filing such tax allocation agreement with the Department.

G. Section 1307 Loan

As noted previously in Item 2 of this Report, the HMO's main source of capital was capital infusions from its Parent, Touchstone Health Partnership, Inc. At the commencement of business, the HMO obtained two (2) capital infusions in the form of Section 1307 loan agreements. These agreements called for an initial capital infusion of \$7,100,000, followed by a subsequent capital contribution of \$5,600,000. These capital infusions were made on September 1, 2007 and October 7, 2008, respectively.

Section 1307(d) of the New York Insurance Law states:

“No such insurance company or reciprocal insurer shall directly or indirectly make any agreement for any advance or borrowing pursuant to this section unless such agreement is in writing and shall have been approved by the superintendent as not unfair, misleading or contrary to law.”

The examination revealed that there was no evidence that the October 7, 2008 Section 1307 loan agreement of \$5,600,000 was filed with the Department.

It is recommended that the HMO comply with the requirements of Section 1307(d) of the New York Insurance Law by not directly, nor indirectly make any agreement for any borrowing pursuant to this Section unless such agreement has been submitted in writing to the Department and approved by the Superintendent.

Section 1307(c) of the New York Insurance Law states:

“Any sum so advanced or borrowed shall not be part of the legal liabilities of such insurer and shall not be a basis of any set-off but until repaid all statements published by such insurer or filed with the superintendent shall show, as a footnote, the amount then remaining unpaid.”

During the examination period, it was noted that the HMO’s financial statement failed to include a footnote regarding the two outstanding Section 1307 loans and their respective interest, as required by Section 1307(c) of the New York Insurance Law.

It is recommended that the HMO comply with the requirements of Section 1307(c) of the New York Insurance Law and include a footnote for all outstanding Section 1307 loans and their respective interest amounts in its filed annual statements.

As of December 31, 2008, the balance of the aforementioned two (2) Section 1307 loans was \$12,700,000. However, the HMO reported \$5,745,803 for Surplus Notes in its filed 2008 New York Data Requirements.

It is recommended that the HMO accurately report the amount of Surplus Notes in its filed New York Data Requirements.

H. Disaster Response and Business Continuity Plans

During the examination, the HMO provided the examiner with its Disaster Response Plan and Business Continuity Plan.

Insurance Department Circular Letter No. 2 (2008) states in part (Circular Letters with similar requirements are issued by the Department annually):

“...By June 1, 2008, each company must submit a Disaster Response Plan to the Insurance Department. Entities may provide their completed disaster response plans to the Insurance Department via the Insurance Department Portal Application or by hard copy...

...By June 1, 2008, the Disaster Response Questionnaire must be submitted to the Insurance Department via the Insurance Department Portal Application or in hard copy...

...By June 1, 2008, the Business Continuity Plan Questionnaire must be submitted to the Insurance Department via the Insurance Department Portal Application or in hard copy...”

The examination revealed that the HMO did not file its Disaster Response Plan, Disaster Response Questionnaire or its Business Continuity Plan Questionnaire during the examination period.

It is recommended that the HMO comply with the requirements of Circular Letter No. 2 (2008) and file its Disaster Response Plan, Disaster Response Questionnaire, and Business Continuity Plan Questionnaire on an annual basis with the Department.

I. Fraud Plan

Part 98-1.21(a) of the Administrative Rules and Regulation of the New York Health Department (10 NYRR 98-1.21(a)) states in part:

“Pursuant to Public Health Law section 4414, every MCO that participates in public or government sponsored programs with an enrolled population of 10,000 or more persons in the aggregate in any given year shall develop and file with the commissioner within 180 days of the effective date of these regulations a plan for the detection, investigation and prevention of fraudulent activities in this state and those fraudulent and abusive activities affecting policies or state or local department of social services contracts issued or issued for delivery in this state...”

The HMO had enrollment in excess of 10,000 members in 2008 (Item 2D of this Report). However the HMO did not implement a fraud plan as required by Part 98-1.21(a) of the Administrative Rules and Regulation of the New York Health Department (10 NYRR 98-1.2(a)).

It is recommended that the HMO comply with Part 98-1.21(a) of the Administrative Rules and Regulations of the Department of Health and implement a plan for the detection, investigation and prevention of fraudulent activities and file such plan with the commissioner of the Department of Health.

J. Abandoned Property Report

Pursuant to Section 1316 of New York Abandoned Property Law, an insurer is required to file an abandoned property report with the New York Office of the State Comptroller. In conjunction with the Abandoned Property Law, the State Office of Unclaimed Funds also publishes “*The Handbook for Reporters of Unclaimed Funds*” (“Handbook”). The Handbook provides detailed guidelines to insurers with regard to abandoned property filing. Such

guidelines also include instructions pertaining to filing requirements in cases where the insurer has no abandoned property to report.

The Handbook for Reporters of Unclaimed Funds states in part:

*“...If you do not have an account/item subject to reporting:
Complete a Verification and Checklist and indicate that there are no abandoned account/items by entering “None” in the Total field. This is known as a negative filing. We need to receive it by the close of business on April 1...”*

The examination revealed that the HMO did not have any abandoned property during the period under examination, however no filing, as required by the Handbook for Reporters of Unclaimed Funds, was made during the examination period.

It is recommended that the HMO comply with the abandoned property filing guidelines of The Handbook for Reporters of Unclaimed Funds and file the respective abandoned property report annually.

K. Record Retention Policy

Part 243.3(c) of Department Regulation No. 152 (11 NYCRR 243.3) states in part:

“(c) An insurer shall establish and maintain a records retention plan. The plan shall include a description of the types of records being retained, the method of retention, and the safeguards established to prevent alteration of the records...”

The examination review disclosed that the HMO does not maintain a record retention plan.

It is recommended that the HMO establish and implement a formal record retention plan in compliance with the requirements of Department Regulation No. 152.

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) states in part:

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

(8) any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review.”

The examiner obtained a listing of twenty-one brokers who provided services to the HMO during the examination period. The examiner made a request to the HMO to provide broker agreements for all brokers whose names appeared on the listing. It should be noted that the HMO was only able to locate documentation for eight brokers. For the remaining thirteen brokers' agreements, the HMO indicated that it was unable to locate these agreements because of “personnel turnover”. It appears that a former employee in charge of maintaining these agreements was no longer with the HMO, and management was unable to locate such agreements.

It is recommended that the HMO comply with the requirements of Department Regulation No. 152 and maintain all required records for a minimum of six calendar years from their creation.

In reviewing Utilization Review (pre-authorization) and Appeals, the examiner requested a listing of cases under these categories. However, the listing obtained was an incomplete listing. According to the HMO, because of high management turnover, the HMO was unable to locate all of the utilization review cases. It appears that the former employee responsible for keeping this information was no longer with the HMO, and the current management was unable to locate such documentation.

It is again recommended that the HMO comply with the requirements of Department Regulation No. 152 and maintain all required records for a minimum of six calendar years from their creation.

L. Custodial Agreement

The HMO reported in its December 31, 2008 annual statement, a short-term investment of \$10,049,574. The money in the account was invested in three money market mutual funds and the account was initially managed by Lehman Brothers, Inc, an investment company. The HMO provided the examiner with a custodial agreement between the HMO and Lehman Brothers, Inc. As a result of Lehman Brothers, Inc. filing for bankruptcy during 2008, Lehman Brothers' North America business was acquired by Barclays Wealth through acquisition. As a result of this transaction, the HMO's short-term investment account was transferred to Barclays Wealth. However, the HMO has yet to execute a formal custodial agreement with Barclays Wealth.

It is recommended that the HMO execute and implement a formal custodial agreement with Barclays Wealth.

Subsequent to the examination date, the HMO closed the Barclays Wealth account.

M. Conflict of Interest Policy

The examination included a review of how the HMO handles conflicts of interest. The HMO answered "Yes" to the general interrogatories in the annual statement that asked whether the HMO had an established procedure for annual disclosure to its Board of Directors of any material interest and affiliation on the part of any of its officers or directors. The HMO however,

does not have a conflict of interest policy; though the HMO included conflict of interest guidelines in its employee handbook. The guidelines state in part:

“Directors and associates must avoid situations where their personal interests could conflict or appear to conflict with the best interests of Touchstone. Before serving on the Board, all Directors must complete a state required conflict of interest and character reference form...”

The examination revealed that the HMO did not maintain signed conflict of interest forms for any individual for the years under examination. The HMO has a fiduciary responsibility to its enrolled members to ensure that its directors, officers and responsible employees do not use their official positions to promote an interest which is in conflict with that of the HMO.

It is recommended that, as a good business practice, all officers and directors of the HMO submit signed conflict of interest forms on an annual basis, and that the HMO establish a procedure for enforcing such policy.

N. Accounts and Records

During the course of the examination, it was noted that the HMO’s treatment of certain items was not in accordance with annual statement instructions and/or Department guidelines. A description of such items is as follows:

1. In Schedule H, Section 3 (“Claims and Interest Penalties Paid During the Year”) of the HMO’s 2008 filed New York Data Requirements, the claim count and Prompt Pay interest amounts were reported as 13,787 and \$0, respectively. However, the actual claims data provided by the HMO reflected a claim count and Prompt Pay interest of 1,512 and \$5,945.87, respectively.

It is recommended that the HMO accurately report its claim count and prompt payment interest amounts in Schedule H, Section 3 of its filed New York Data Requirements.

The “Footnotes” section for Schedule H of the 2008 New York Data Requirements provides detailed instructions for its completion. The instructions indicated that the total dollar value for claims paid during the year reported in Schedule H, Section 3 should agree with the combined value of columns 1 and 2 as shown in Schedule F, Section 3, line 9. The HMO reported \$8,236 as claims paid during 2008 in Schedule H, Section 3. However, the HMO reported a total of \$106,528,309 for columns 1 and 2 in Schedule F, Section 3, line 9.

It is recommended that the HMO accurately report the amounts of its claims paid during the year on Schedule H, Section 3 and on Schedule F, Section 3 of its filed New York Data Requirements.

In addition, the HMO did not completely fill out Schedule H, Section 3. The footnote section of Schedule H, Section 3 requires that information, such as the name of the contact person of the HMO, telephone number and the E-mail address be disclosed in the Schedule. The HMO did not disclose this information.

It is recommended that the HMO include all requisite information in Schedule H, Section 3 of its filed New York Data Requirements.

2. A review of the HMO’s Management Letter (“Letter”), which detailed certain control deficiencies of the HMO, prepared by the HMO’s independent certified public account, BDO Seidman, LLP was conducted. It was noted that the HMO did not maintain a segregation of duties for certain account payable functions, the same individual that prepared vendor listings

also received checks and had the authority to write checks for the HMO's expenses. A recommendation was made in the Letter that the HMO conduct independent reviews to detect errors and irregularities in the process.

It is recommended that the HMO incorporate the principle of "segregation of duties" into appropriate job functions, in order to ensure that the HMO's assets are safeguarded and its obligations and liabilities are properly authorized and recorded.

The Management Letter also noted that, when reviewing authorized signatures for the HMO's bank accounts, individuals were included who were either no longer employed by the HMO or were no longer involved in day-to-day management of the HMO.

It is recommended that the HMO revise all authorized signature lists to include only those individuals who possess signatory rights.

It is further recommended that this list be updated whenever a change of authorized signatories is made.

3. The Annual Statement Instructions of the National Association of Insurance Commissioners ("NAIC") for Schedule Y – *"Information Concerning Activities of Insurer Members of Holding Company Group"*, states in part:

"Part I – Organization Chart ...All insurers and reporting entity members of a holding company group shall prepare a common schedule for inclusion in each of the individual annual statements. If the company is required to file a registration statement under the provisions of the domiciliary state's Insurance Holding Company System Regulatory Act, then Schedule Y, Part 1, Organization Chart must be included in the annual statement...

Part II - Summary of Insurer's Transactions With Any Affiliates ...All insurers and reporting entity members of the holding company system shall prepare a common schedule for inclusion in each of the individual annual statements.

Include transactions between insurers and insurers and non-insurers within the holding company system..."

During the examination period, the HMO entered into various transactions with its Parent, as well as other entities within its holding company system. However, Schedule Y was not attached to its filed annual statements, as required by the NAIC Annual Statement Instructions.

It is recommended that the HMO file its annual statement in accordance with the NAIC Annual Statement Instructions, by completing and attaching Schedule Y to its filed annual statements.

4. In Schedule J, "Surplus Notes", of the HMO's 2008 filed New York Data Requirements, a footnote instruction incorrectly stated that the total amount should agree with page NY3, line 26. The amount of surplus notes should agree with page NY3, line 27 of the New York Data Requirements.

It is recommended that the HMO revises the footnote instruction that appears in Schedule J of its New York Data Requirements, so that it provides correct information.

5. As noted in Item 2 of this Report, during the examination period, the HMO received two capital infusions totaling \$12,700,000. On page NY3, line 27 of the HMO's 2008 New York Data Requirements, the HMO reported Surplus Notes in the amount of \$5,745,803. This amount did not agree with the amount reported as Surplus Notes (\$12,700,000), as shown on page 3, line 27 of the HMO's December 31, 2008 filed annual statement. As a result, Surplus Notes on the HMO's 2008 filed New York Data Requirements was understated by \$6,954,197.

It is recommended that the HMO accurately report the amount of Surplus Notes in its filed New York Data Requirements.

6. A review of the HMO's annual statement indicated that Schedule E, Part II, column 5, "Maturity Date" for short-term investments was incorrectly reported as "1/1/2008". Since the acquisition date was reported in column 3 as "12/31/2008". The correct maturity date should have been "1/1/2009".

It is recommended that the HMO accurately report all information in its filed annual statement.

7. A review of the 2008 New York Data Requirements - *New York Interrogatory* page, indicated that the HMO checked "No" for the question "*Did the HMO, directly or indirectly, pay any commission on the business transactions of the HMO?*". A schedule following the question also shows that "\$0" commissions were paid during 2008. However, commission data provided to the examiner by the HMO showed that during 2008, \$72,200 of commissions were paid to various brokers, and \$744,295 of commissions were paid to "in-house" licensed sales representatives. The total commission expenses shown in the commission data was \$816,495. However, the "Underwriting and Investment Exhibit" of the filed 2008 annual statement showed that \$1,255,763 was paid as commission expense during 2008.

It is recommended that the HMO accurately report commission expenses in its filed New York Data Requirements.

8. Section 101.4(c) of Department Regulation No. 164 (11 NYCRR 101.4(c)) states in part:

“An insurer who uses a capitation arrangement to transfer all or part of its financial risk to a health care provider must do so by means of a contract approved by the superintendent. Before granting such approval the insurer shall have demonstrated to the satisfaction of the superintendent the financial responsibility of the health care provider to render the services covered by the in-network capitation and compliance with the provisions of this Part. If so demonstrated, the insurer is relieved of the reporting requirements for carrying a liability on its own balance sheet for underlying unpaid claims and expenses related to in-network capitated payments made pursuant to the financial risk transfer agreement...”

During the examination period, the HMO entered into an arrangement with an Independent Practice Association (“IPA”), HealthPlex, Inc., for dental services. The arrangement requires the HMO to make payments to the IPA on a capitated basis. During 2008, \$1,509,693 was paid to HealthPlex, Inc. as capitation payments. The HMO provided the examiner with a contract to support the HealthPlex, Inc. capitation arrangement, however, the contract was between HealthPlex, Inc. and the HMO’s Parent, Touchstone Health Partnership, Inc. The examination revealed that the HMO did not formally execute a direct contract with HealthPlex, Inc.

It is recommended that the HMO comply with the requirements of Section 101.4(c) of Department Regulation No. 164 by implementing a contract for all applicable risk-sharing arrangements.

It is also recommended that the HMO comply with the requirements of Section 101.4(c) of Department Regulation No. 164 by filing all applicable risk sharing arrangements with the Department for approval.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with those reported by the HMO in its filed annual statement as of December 31, 2008:

<u>Assets</u>	<u>Examination</u>	<u>HMO</u>	<u>Net Worth Increase (Decrease)</u>
Cash, cash equivalents and short-term investments	\$ 11,234,271	\$ 20,043,542	(8,809,271)
Investment income due and accrued	3,150	3,150	
Amounts recoverable from reinsurer	321,416	321,416	
Health care and other amounts receivable	1,385,281	1,385,281	
Prepaid expenses	0	5,500	(5,500)
Total assets	\$ <u>12,944,118</u>	\$ <u>21,758,889</u>	\$ <u>(8,814,771)</u>
<u>Liabilities</u>			
Unpaid claims	\$ 25,827,047	\$ 21,002,632	\$(4,824,415)
Unpaid claims adjustment expenses	855,089	480,093	(374,995)
Aggregate health policy reserve	571,595	571,595	
Amounts withheld or retained for the accounts of Others	157,642	157,642	
Liability for amounts held under uninsured plans	(431,118)	(431,118)	
Payable to CMS	75,127	75,127	
Total liabilities	\$ <u>27,055,382</u>	\$ <u>21,855,971</u>	\$ <u>(5,199,410)</u>
<u>Capital and Surplus</u>			
Surplus notes	\$ 12,700,000	12,700,000	
NYS contingent reserve fund	6,954,197	0	(6,954,197)
Unassigned funds (surplus)	<u>(33,765,461)</u>	<u>(12,797,082)</u>	<u>(20,968,379)</u>
Total capital and surplus	<u>(14,111,264)</u>	<u>(97,082)</u>	<u>(14,014,182)</u>
Total liabilities, capital and surplus	\$ <u>12,944,118</u>	\$ <u>21,758,889</u>	

Note 1: This examination has determined the HMO to be insolvent in the amount of \$(14,111,264), and its contingent reserve fund of \$6,954,197, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), to be impaired in the amount of \$(21,065,461) as of December 31, 2008. As of September 30, 2011, subsequent to the examination date, the HMO reported itself solvent in the amount of \$1,608,135, however, its contingent reserve fund of \$16,682,521, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), remained impaired, in the amount of \$(15,074,386).

Note 2: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the HMO through tax year 2008. The examiner is unaware of any potential exposure of the HMO 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 decreased by \$14,111,264 during the sixteen-month examination period, September 1, 2007 through December 31, 2008, detailed as follows:

Revenue

Net premium income		\$ 158,242,812
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Hospital and medical expenses

Hospital/medical benefits	\$ 116,687,247	
Other professional services	7,457,041	
Emergency room and out-of-area	996,378	
Prescription drugs	16,595,008	
Net reinsurance recoveries	<u>(865,424)</u>	
Total medical and hospital expenses	\$ 140,870,250	

Administrative expenses

Claims adjustment expenses	15,903,933	
General administrative expenses	<u>27,332,539</u>	
Total underwriting expenses		<u>184,106,722</u>
Net underwriting loss		\$ (25,863,910)
Net investment income earned		<u>446,407</u>
Net loss		\$ <u>(25,417,503)</u>

Changes in Capital and Surplus

	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Capital and surplus as of January 1, 2007			\$ 0
Net loss		\$ 25,417,503	
Change in non-admitted assets		1,393,771	
Change in surplus notes	\$ 12,700,000		
Common stock	<u>10</u>	<u> </u>	
Net decrease in capital and surplus			\$ <u>(14,111,264)</u>
Capital and surplus, per report on examination, as of December 31, 2008			\$ <u>(14,111,264)</u>

4. UNPAID CLAIMS

The examination liability of \$25,827,047 for the captioned account is \$4,824,415 greater than the \$21,002,632 reported by the HMO in its filed annual statement as of December 31, 2008. The examination analysis of the unpaid claims liability was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements as verified during the examination. The examination unpaid claims reserve was based upon actual payments made subsequent to the examination date, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2008.

5. UNPAID CLAIMS ADJUSTMENT EXPENSES

The examination liability of \$855,089 for the captioned account is \$374,996 greater than the \$480,093 reported by the HMO in its filed annual statement as of December 31, 2008. The examination determined that the HMO's December 31, 2008, claims adjustment expenses of \$480,093 was inadequate by approximately 78.11% as compare to this Department's estimate.

6. CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS

The examination admitted assets of \$11,234,271 for the captioned account is \$8,809,271 less than the \$20,043,542 reported by the HMO in its filed annual statement as of December 31, 2008. The examination change is reflected by the following:

i. Section 1404(a)(10)(B)(i) of the New York Insurance Law states in part:

“...(B) Investment limitations. Investments made by an insurer...shall not exceed the following limitations:

(i) in any investment company qualifying under item (i) of subparagraph (A) hereof, ten percent of such insurer's admitted assets as shown by its last statement on file with the superintendent and the aggregate amount of investment in such qualifying investment companies shall not exceed twenty-five percent of such insurer's admitted assets as shown by its last statement on file with the superintendent...”

The examination revealed that the HMO had short-term investments totaling \$10,049,574 in three money market mutual funds invested with Barclay Wealth. Pursuant to Section 1404 of the New York Insurance Law, investments in money market mutual funds are subject to an investment limitation of 10% of admitted assets, and an aggregate limitation of 25% of admitted assets. The HMO's short-term investments were in excess of the aggregate limitation by \$4,609,852.

It is recommended that the HMO closely monitor its investment activity in order to maintain compliance with the applicable section of Article 14 of the New York Insurance Law.

ii. The examination also revealed that the HMO has a “Sweep Account” with Silicon Valley Bank (“SVB”). Money deposited in the sweep account is mainly used for claim payments. SVB’s headquarters is located in Santa Clara, California. However, SVB’s sweep account operation is from a branch office located in the Cayman Islands, which is beyond the jurisdiction of the United States government or any state government thereof. The “ACCOUNT DISCLOSURE” clause of the custodial agreement states:

“SVB Sweep Account are deposits of the Cayman Island branch of Silicon Valley Bank and are subject to the laws of the Cayman Island. These deposits are not domestics, are not insured by the FDIC and are not guaranteed in any way by the United States government or any government agency thereof. The obligations related to the SVB Sweep Account will be payable only at and by the Cayman Branch, subject to the laws (including any governmental actions, orders, decrees and/or regulations) and under the exclusive jurisdiction of the courts of the Cayman Island. The Bank of the Cayman Branch shall be excused from any failure to discharge its obligations hereunder that is a result of restrictions imposed on the transferability of funds, confiscations or expropriations, acts of war, civil disturbances, actions by any government or similar institutions, or any other reasons of force majeure or any other circumstances beyond its control. Neither the Bank’s head office nor any other office, branch, or affiliate of the Bank will be liable therefore...”

The Sweep Account was reported on the HMO’s filed annual statement as “cash equivalents”. As of December 31, 2008, the balance of such cash equivalents was \$4,199,419. The examination determined that cash in the Cayman Islands Sweep Account is not an admitted asset per the provisions of the New York Insurance Law.

It is recommended that the HMO withdraw the cash from the Cayman Islands Sweep Account and deposit the same in a bank or financial institution which is under the jurisdiction of the U.S. or State government.

Subsequent to the examination date, the HMO provided documentation indicating that the Cayman Island Sweep Account was closed in 2009.

7. NEW YORK STATE CONTINGENT RESERVE FUND

The examination amount for the Contingent Reserve Fund was \$6,954,197 greater than the \$0 amount reported by the HMO in its filed annual statement as of December 31, 2008.

On page 3, line 28 of its 2008 filed NAIC annual statement, the HMO reported "\$0" for the NYS Contingent Reserve Fund amount. This amount did not agree with the amount reported in page NY3, line 28.11 of the HMO's filed New York Data Requirements. The HMO reported \$6,954,197 for the NYS Contingent Reserve Fund on page NY3, line 28.11 of New York Data Requirements. The same should have been reported on page 3, line 2801 as the NYS Contingent Reserve Fund amount, as well as reported in page 3, line 28 of the filed annual statement as Aggregate write-ins for other than special surplus funds.

It is recommended that the HMO accurately report the amount of contingent reserve in its filed annual statement.

8. PREPAID EXPENSES

The examination amount of \$0 for the captioned account is \$5,500 less than the amount reported as an admitted asset by the HMO on its filed annual statement as of December 31, 2008.

The HMO included prepaid expenses in the amount of \$5,500 in the Aggregate write-ins for other than invested assets account.

Statement of Statutory Accounting Principles No. 29 (SSAP No. 29) states in part:

“...Prepaid expense is an amount which has been paid in advance of receiving future economic benefits anticipated by the payment. Prepaid expenses generally meet the definition of assets in SSAP No. 4-Assets and Nonadmitted Assets (SSAP No. 4). Such expenditures also meet the criteria defining nonadmitted assets as specified in SSAP No. 4 and SSAP No. 87 – Capitalization Policy...Prepaid expenses shall be reported as nonadmitted assets and charged against unassigned funds (surplus). They shall be amortized against net income as the estimated economic benefit expires.”

It is recommended that the HMO report assets in accordance with the requirements of SSAP No. 29.

9. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO conducts its business 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 practices of the HMO in the following major areas:

- A. Claims processing
- B. Prompt Pay requirements
- C. Grievances and appeals
- D. Appointment of agents
- E. Fraud prevention and detection
- F. Advertising and Marketing
- G. Explanation of benefits statements
- H. Complaints

A. Claims Processing

For the examination period, the HMO utilized the services of an independent vendor, Affiliate Computer Services, Inc. (“ACS”) for processing its hospital and medical claims. ACS

receives its claims electronically and through the United States Post Office. Approximately 60% of the claims were received electronically, the rest were paper claims. ACS also provides the HMO with claims processing software.

A review of the HMO's claims practices and procedures was conducted by using a statistical sampling methodology covering claims processed during the period of January 1, 2008 through December 31, 2008, in order to evaluate the overall accuracy and compliance of the HMO's claims processing environment.

The statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be made for each claim in the sample. A combined sample of 100 medical and hospital claims was selected for review.

The term "claim" can be defined in a myriad of ways. For the purpose of this Report, a "claim" is defined as a grouping of all line items (e.g., procedures/services or service dates) on a single claim form. It was possible, through the computer system used, to match or "roll-up" all procedures on the original claim form into one item, which is the basis of the Department's statistical sample of claims, or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were totaled and reconciled to the paid claims data provided by the HMO, for the period of January 1, 2008 through December 31, 2008, and to the amount reported on its December 31,

2008 filed annual statement. The result of the reconciliation showed a material difference between the paid claims data in the lag table and the paid claims amount reported in the HMO's 2008 New York Data Requirements. The examiner requested the HMO to provide documentation to explain the discrepancy.

It is recommended that the HMO review the accuracy of the paid claims amount as reported in its filed 2008 New York Data Requirements.

It is again recommended that the HMO improve its procedures to facilitate the examination and provide requested documentation.

Subsequent to the examination date, the HMO provided documentation resolving the difference.

The examination review of the HMO's claim files found a calculated financial error rate of 3% and a calculated procedural error rate of 7%.

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times claim transactions were processed in accordance with the HMO's guidelines and/or Department requirements. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such, it is counted as both a financial error and a procedural error. In summary, of the 100 medical and hospital claims reviewed, 3 contained financial errors and 7 contained procedural errors.

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

Summary of Financial and Procedural Claims Accuracy

	<u>Procedural</u>	<u>Financial</u>
Claims population	330,107	330,107
Sample size	100	100
Number of claims with violations	7	5
Calculated violation rate	7%	5%
Upper violation limit	12%	9.27%
Lower violation limit	2%	N/A
Calculated claims in violation	23,107	16,505
Upper limit claims in violation	39,613	30,601
Lower limit claims in violation	6,602	2,410

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

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

- ❖ Of the five (5) claims financial errors, three of them were errors due to the incorrect rate being applied; two of them were errors due to the HMO paying the claims late and no interest was being paid on those claims.
- ❖ One of the 7 claims processing errors was the result of an improper denial. Another one of the 7 claims processing errors was the result of failure to authorize a medical procedure where such authorization was required.

It is recommended that the HMO initiate procedures to ensure that claims are paid based on the correct rate and that claims are adjudicated properly and in a timely manner.

B. Prompt Pay Requirements

The Center for Medicare and Medicaid Services (“CMS”) regulation requires that 95% of all Medicare only clean claims to non-participating providers be paid or denied within 30 days of receipt. All other claims must be paid or denied within 60 days. During 2008, a total of 330,107

Medicare claims (medical & hospital) were adjudicated. The HMO's population of clean claims paid to non-participating providers was 11,691. The examiner used this subset of data as the population for conducting a review for timely payment based on CMS' timely payment criteria. The result indicated that 6,734 claims were paid after 30 days of receipt. Approximately 58% of clean claims paid to non-participating providers were paid in excess 30 days.

It is recommended that the HMO takes steps to monitor and improve its timely payment of claims, in accordance with the timeframe mandated by CMS.

CMS also requires that a Managed Care Organization ("MCO"), which includes an HMO such as Touchstone Health HMO, Inc., pay interest on clean claims to non-participating providers that are not paid within 30 days. The interest payment requirement does not specify any minimum dollar threshold for interest to be paid. The examination disclosed that, during the examination period, the claims processing system was set up in a way in which it will only recognize and process interest payment only when the amount of such interest is over \$1. As a result of this procedure, interest payments due that were lower than \$1 were not paid.

It is recommended that the HMO revise its methodology for determining interest payment, so that all claims eligible for interest payment are paid regardless of the interest amount to be paid.

C. Complaints

New York Insurance Department Circular Letter No. 11 (1978) states in part:

"...As part of its complaint handling function, the company's consumer services department will maintain an ongoing central log to register and monitor all complaint activity. The log should be kept in a columnar form and list the following..."

As part of the examination, the examiner performed a comparison between the Department's Consumer Services Bureau's complaints listing and the HMO's complaints listing ("complaint log"). The examiner requested that the HMO provide a complete complaint log for the examination period. The HMO indicated that a complaint log for the examination period did not exist due to the high turnover of management. As such, the examiner was unable to verify the exact number of complaints the HMO received directly during the examination period. However, the Department Consumer Services Bureau received forty-eight (48) complaints for 2008.

It is recommended that the HMO establish and maintain a complaint log in compliance with the requirements of Department Circular Letter No. 11 (1978).

D. Explanation of Benefits Statements

Sections 3234(b)(6) and (7) of the New York Insurance Law states in part:

“(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 claims; 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.”

Section 40.2.2 of Chapter 13 of the Medicare and Managed Care Manual (“Manual”), published by CMS, states in part:

“Written Notification by Medicare Health Plan of Its Own Decision

If the Medicare health plan decides to deny, discontinue, or reduce services or payments, in whole or in part, and the enrollee believes that services should be covered, then it must give the enrollee a written notice of its determination. The Medicare health plan must provide notice using the most efficient manner of delivery to ensure the enrollee receives the notice in time to act...”

The Manual further requires that Medicare health plans use approved language in a form for both medical coverage denial and denial of payment. The instruction of the aforementioned form states in part:

“The MCO must provide a specific and detailed explanation why the medical services rendered or items already provided to the enrollee are not covered, with the description of any applicable Medicare coverage rule or any other applicable MC organization policy upon which the claim denial decision was based...”

As part of the review of the HMO’s claims practices and procedures, an analysis of the explanation of benefits statements (“EOB”) provided to members and/or providers by the HMO was performed.

An EOB is an important link between the member, the provider and the HMO. It should clearly communicate to the member and/or provider that the HMO has processed a claim and how that claim was processed. The sample selected for analyzing the EOBs was the same hospital and medical claims sample used for the claims processing review noted above. The examination review determined that when payment of a claim was denied, the EOB did not include the reason why the claim was not paid. Additionally, it was noted that the EOBs failed to include a description of the HMOs appeal process with regard to the time limit and proper steps taken in order to file a proper appeal.

It is recommended that the HMO revise its explanation of benefits statements to comply with the requirements of Sections 3234(b)(6) and (7) of the New York Insurance Law.

It is also recommended that the HMO revise its explanation of benefits statements to include the explanation for denials as required by CMS' Medicare and Managed Care Manual.

Subsequent the examination, the HMO reported that with the migration to the new claims platform in June 2009, it has been compliant with the text of denial messages, as well as appeal rights as approved by CMS. The HMO provided the examiner with a revised EOB indicating its compliance with said requirements.

E. Broker Commissions

Section 52.42(e) of Department Regulation No. 62 (11 NYCRR 52.42) states in part:

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

During the examination period, the HMO utilized the services of several brokers to solicit new enrollees. As noted previously in this Report, the HMO provided the examiner with certain

broker agreements. The examination review indicated that brokers earned commissions on both a referral and enrollment basis. The HMO paid \$500 and \$400 for each confirmed enrolled member by the broker, or each member referred by the broker, respectively. Under the agreement, commission is paid solely on the number of members the broker enrolls or refers to the HMO, subject to a maximum annual commission in the amount of \$250,000. The examination also revealed that several brokers received commission in excess of 4% of the premium they generated on their enrollment and referrals.

It is recommended that the HMO include in its broker agreement a provision which reflects the commission limitation mandated by Section 52.42(e) of Department Regulation No. 62.

It is also recommended that the HMO comply with Section 52.42(e) of Department Regulation No. 62 and limit its payment of commissions to brokers to no more than 4% of premiums.

F. The Center for Medicare and Medicaid Services' Audit

During the examination, the examiner reviewed the Compliance Audit Report conducted by the Center for Medicare and Medicaid Services ("CMS"). The audit was conducted in October 2008. The audit was performed on a sample basis and covered areas such as: enrollment, grievances, distribution of marketing materials, claims processing, prompt pay, utilization review, expedited review, appeals and quality improvement. The audit report identified various deficiencies of the HMO in meeting the CMS' compliance standards. The following findings were deemed significant:

- The HMO did not meet the CMS' compliance standard for voluntary disenrollment notices. In approximately one third (1/3) of the cases, the HMO did not send notices within the timeframe specified by CMS.
- The HMO failed to provide documentation demonstrating whether it was refunding premiums correctly to individuals who were involuntary disenrolled (moved out of service area).
- In approximately one third of the cases, the HMO failed to document the enrollment election receipt date.
- In 28 out of 30 cases, the HMO failed to provide enrollment notification notices to beneficiaries within CMS timeframes. The report also noted that the HMO had conducted an audit of this area prior to CMS audit and a correction action plan was already being implemented.
- A CMS compliance standard requires an HMO to conduct an annual working age survey. The HMO did not conduct such survey during the examination period.
- Over 30% of grievance cases were misclassified as other cases, as such, these cases were not processed through the appropriate mechanisms.
- CMS' regulations and Medicare Marketing Guidelines require that marketing materials be submitted for review and approval to CMS prior to its distribution. The HMO was found inappropriately using marketing materials that were not submitted to, reviewed or approved by CMS. In some cases, the HMO did not send the necessary correspondence to members, and in other cases, the correspondences were sent untimely.
- CMS' regulations require HMOs to provide reasonable reimbursement for services for which coverage has been denied by the HMO, but upon appeal found to be services the member was entitled to. The HMO did not meet said requirements because its policy and procedures were found to be incomplete and the HMO did not address reasonable reimbursement of coverage for services which had been denied but found to be services the member was entitled to upon appeal.
- Untimely payments of claims and incorrect interest payment amounts made to non-par providers.
- Denial notices did not specify the denial reason or inform the enrollee of his or her right for reconsideration. Additionally, the notices did not provide a description of the appeal process.
- CMS' regulations require an HMO to have an ongoing quality improvement ("QI") program which must be evaluated by a policy making body at least annually. There was no evidence that the HMO had its QI program evaluated annually.

- The HMO did not comply with Chapter 4, Section 80.2 of the Medicare Managed Care Manual in that it did not have policies or procedures to identify payers who are primary to Medicare, and therefore the amount payable and coordination of benefits could not be accurately determined.
- Upon review of grievance cases, it was determined that over 30% of cases were misclassified. The HMO did not correctly distinguish between organization determinations, reconsiderations and grievances. As a result, these determinations or requests were not processed through the appropriate mechanisms.

For each finding, the CMS made a recommendation that the HMO establish a Corrective Action Plan. In August, 2009, the Plan submitted its Corrective Action Plan to CMS for its approval. CMS has not yet completed its audit of the Corrective Action Plan.

G. Quality Management Program

During the examination, the HMO provided the examiner with a Quality Management Policy and a Quality Management Program Description. In the Quality Management Policy, the HMO used a generic number, 99/99/99, for the “Policy Issue Date”, “Revised Date”, and the “Date of Review”. The “Approval” section of the policy was left blank. Based on the document received, the examiner was unable to determine whether such policy was in effect and whether the policy was reviewed and approved.

The examination also revealed that a section in the Policy Management Program required the signatures of the Board of Directors, the Chair of the Quality Management and Improvement Committee and the Chief Executive Officer (“CEO”), however, no signatures were provided.

It is recommended that, as a good business practice, the HMO acquire and maintain required detailed information pertaining to all policies issued by the HMO.

It is also recommended that, as a good business practice, management of the HMO approve and sign all policies issued by the HMO.

10. SUBSEQUENT EVENTS

This examination has determined the HMO to be insolvent in the amount of \$(14,111,264), and its contingent reserve fund of \$6,954,197, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), to be impaired in the amount of \$(21,065,461) as of December 31, 2008.

As of September 30, 2011, subsequent to the examination date, the HMO reported itself solvent in the amount of \$1,608,135, however, its contingent reserve fund of \$16,682,521, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), remained impaired, in the amount of \$(15,074,386). Touchstone's turn to profitability was the result of the implementation of numerous business initiatives, including: a Global Medical Risk capitation agreement and an improved Medicare Part C risk adjustment.

Further, on December 31, 2009, the Parent, Touchstone Health Partnership, Inc., made a capital infusion of \$5,000,000. Two additional infusions, in the amount of \$16,873,772 and \$15,500,000, were made in the third and fourth quarter of 2010, respectively.

11. CONCLUSION

This examination has determined the HMO to be insolvent in the amount of \$(14,111,264), and its contingent reserve fund of \$6,954,197, required by Parts 98-1.11(d) and

(e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), to be impaired in the amount of \$(21,065,461) as of December 31, 2008. As of September 30, 2011, subsequent to the examination date, the HMO reported itself solvent in the amount of \$1,608,135, however, its contingent reserve fund of \$16,682,521, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), remained impaired, in the amount of \$(15,074,386).

11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. <u>Insolvency</u></p> <p>This examination has determined the HMO to be insolvent in the amount of \$(14,111,264), and its contingent reserve fund of \$6,954,197, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department, to be impaired in the amount of \$(21,065,461) as of December 31, 2008.</p> <p>As of September 30, 2011, subsequent to the examination date, the HMO reported itself solvent in the amount of \$1,608,135, however, its contingent reserve fund of \$16,682,521, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department, remained impaired, in the amount of \$(15,074,386).</p>	<p>1, 27, 44</p>
<p>B. <u>Facilitation of the examination</u></p> <p>i. It is recommended that the HMO improve its procedures for facilitating the examination process.</p> <p>ii. It is also recommended that the documentation provided be complete and that it also be provided in a timely manner.</p>	<p>4</p> <p>4</p>
<p>C. <u>Management and Controls</u></p> <p>i. It is recommended that the HMO comply with the requirements of its By-Laws and have Board of Directors' meetings at least once a quarter.</p> <p>ii. It is recommended that the HMO comply with the investment authorization approval requirements of Section 1411 of the New York Insurance Law.</p> <p>iii. It is recommended that the HMO formalize and document the discussion, and the approval of all of its investment decisions.</p> <p>iv. It is recommended that the HMO comply with its Investment Policy by submitting its Investment Policy to the Board of Directors annually, for its review and approval.</p>	<p>6</p> <p>7</p> <p>7</p> <p>8</p>
<p>D. <u>Circular Letter No. 9 (1999) - Adoption of Procedure Manuals</u></p> <p>It is recommended that the HMO's Board comply with the requirements of Circular Letter No. 9 (1999) by obtaining the required certifications on an annual basis.</p>	<p>9</p>

ITEM**PAGE NO.**

- E. Holding Company System
- i. It is recommended that the HMO accurately report all information in its filed annual statement. 11
 - ii. It is recommended that the HMO comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the New York Department of Health by executing a formal written agreement with any entity within its holding company system and by submitting the agreement to the Commissioner of Health and the Superintendent of Insurance for their prior approval for any transaction with a member of its holding company system involving five percent or more of its admitted assets at last year-end. 13
 - iii. It is recommended that the HMO comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and file its tax allocation agreement with the Superintendent for approval. 14
 - iv. It is also recommended that the HMO comply with the requirements of Department Circular Letter No. 33 (1979) by entering into a formal tax allocation agreement with its Parent, Touchstone Health Partnership, Inc., and other members of its holding company system, by filing such tax allocation agreement with the Department. 14
- F. Section 1307 Loan
- i. It is recommended that the HMO comply with the requirements of Section 1307(d) of the New York Insurance Law and by not directly, nor indirectly make any agreement for any borrowing pursuant to this Section unless such agreement has been submitted in writing to the Department and approved by the Superintendent. 15
 - ii. It is recommended that the HMO comply with the requirements of Section 1307(c) of the New York Insurance Law and include a footnote for all outstanding Section 1307 loans and their respective interest amounts in its filed annual statements. 15
 - iii. It is recommended that the HMO accurately report the amount of Surplus Notes in its filed New York Data Requirements. 16

ITEM**PAGE NO.**

- G. Disaster Response and Business Continuity Plan
- It is recommended that the HMO comply with the requirements of Circular Letter No. 2 (2008) and file its Disaster Response Plan, Disaster Response Questionnaire, and Business Continuity Plan Questionnaire on an annual basis with the Department. 16
- H. Fraud Plan
- It is recommended that the HMO comply with Part 98-1.21(a) of the Administrative Rules and Regulations of the Department of Health and implement a plan for the detection, investigation and prevention of fraudulent activities and file such plan with the commissioner of the Department of Health. 17
- I. Abandoned Property Report
- It is recommended that the HMO comply with the abandoned property filing guidelines of The Handbook for Reporters of Unclaimed Funds and file the respective abandoned property report annually. 18
- J. Record Retention Policy
- i. It is recommended that the HMO establish and implement a formal record retention plan in compliance with the requirements of Department Regulation No. 152. 18
 - ii. It is recommended that the HMO comply with the requirements of Department Regulation No. 152 and maintain all required records for a minimum of six calendar years from their creation. 19
 - iii. It is again recommended that the HMO comply with the requirements of Department Regulation No. 152 and maintain all required records for a minimum of six calendar years from their creation. 20
- K. Custodial Agreement
- It is recommended that the HMO execute and implement a formal custodial agreement with Barclays Wealth. 20
- Subsequent to the examination date, the HMO closed the Barclays Wealth account.

ITEM**PAGE NO.**

L.	<u>Conflict of Interest Policy</u>	21
	It is recommended that, as a good business practice, all officers and directors of the HMO submit signed conflict of interest forms on an annual basis, and that the HMO establish a procedure for enforcing such policy.	
M.	<u>Accounts and Records</u>	
i.	It is recommended that the HMO accurately report its claim count and prompt payment interest amounts in Schedule H, Section 3 of its filed New York Data Requirements.	22
ii.	It is recommended that the HMO accurately report the amounts of its claims paid during the year on Schedule H, Section 3 and on Schedule F, Section 3 of its filed New York Data Requirements.	22
iii.	It is recommended that the HMO include all requisite information in Schedule H, Section 3 of its filed New York Data Requirements.	22
iv.	It is recommended that the HMO incorporate the principle of “segregation of duties” into appropriate job functions in order to ensure that the HMO’s assets are safeguarded and its obligations and liabilities are properly authorized and recorded.	23
v.	It is recommended that the HMO revise all authorized signature lists to include only those individuals who possess signatory rights.	23
vi.	It is further recommended that this list be updated whenever a change of authorized signatories is made.	23
vii.	It is recommended that the HMO file its annual statement in accordance with the NAIC Annual Statement Instructions, by completing and attaching Schedule Y to its filed annual statements.	24
viii.	It is recommended that the HMO revises the footnote instruction that appears in Schedule J of its New York Data Requirements, so that it provides correct information.	24
ix.	It is recommended that the HMO accurately report the amount of Surplus Notes in its filed New York Data Requirements.	24
x.	It is recommended that the HMO accurately report all information in its filed annual statement.	25

ITEM**PAGE NO.****M. Accounts and Records (Cont'd)**

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|-------|--|----|
| xi. | It is recommended that the HMO accurately report commission expenses in its filed New York Data Requirements. | 25 |
| xii. | It is recommended that the HMO comply with the requirements of Section 101.4(c) of Department Regulation No. 164 by implementing a contract for all applicable risk-sharing arrangements. | 26 |
| xiii. | It is also recommended that the HMO comply with requirements of Section 101.4(c) of Department Regulation No. 164 by filing all applicable risk sharing arrangements with the Department for approval. | 26 |

N. Cash, Cash Equivalents and Short-Term Investments

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|-----|---|----|
| i. | It is recommended that the HMO closely monitor its investment activity in order to maintain compliance with the applicable section of Article 14 of the New York Insurance Law. | 31 |
| ii. | It is recommended that the HMO withdraw the cash from the Cayman Islands Sweep Account and deposit the same in a bank or financial institution which is under the jurisdiction of the U.S. or State government. | 31 |

Subsequent to the examination date, the HMO provided documentation indicating that the Cayman Island Sweep Account was closed in 2009.

O. New York State Contingent Reserve Fund

It is recommended that the HMO accurately report the amount of contingent reserve in its filed annual statement.	32
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P. Prepaid Expenses

It is recommended that the HMO report assets in accordance with the requirements of SSAP No. 29.	33
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Q. Claims Processing

- | | | |
|-----|--|----|
| i. | It is recommended that the HMO review the accuracy of the paid claims amount as reported in its filed 2008 New York Data Requirements. | 35 |
| ii. | It is again recommended that the HMO improve its procedures to facilitate the examination and provide requested documentation. | 35 |

Subsequent to the examination date, the HMO provided documentation resolving the difference.

ITEM**PAGE NO.**

- Q. Claims Processing (Cont'd)
- iii. It is recommended that the HMO initiate procedures to ensure that claims are paid based on the correct rate and that claims are adjudicated properly and in a timely manner. 36
- R. Prompt Pay Requirements
- i. It is recommended that the HMO takes steps to monitor and improve its timely payment of claims, in accordance with the timeframe mandated by CMS. 37
- ii. It is recommended that the HMO revise its methodology for determining interest payment, so that all claims eligible for interest payment are paid regardless of the interest amount to be paid. 37
- S. Complaints
- It is recommended that the HMO establish and maintain a complaint log in compliance with the requirements of Department Circular Letter No. 11 (1978). 38
- T. Explanation of Benefits Statement
- i. It is recommended that the HMO revise its explanation of benefits statements to comply with the requirements of Sections 3234(b)(6) and (7) of the New York Insurance Law. 40
- ii. It is also recommended that the HMO revise its explanation of benefits statements to include the explanation for denials as required by CMS' Medicare and Managed Care Manual. 40
- Subsequent to the examination, the HMO reported that with the migration to the new claims platform in June 2009, it has been compliant with the text of denial messages, as well as appeal rights as approved by CMS. The HMO provided the examiner with a revised EOB indicating its compliance with said requirements.
- U. Brokers Commissions
- i. It is recommended that the HMO include in its broker agreement a provision which reflects the commission limitation mandated by Section 52.42(e) of Department Regulation No. 62. 41

ITEM**PAGE NO.**

- U. Brokers Commissions (Cont'd)
- ii. It is also recommended that the HMO comply with Section 52.42(e) of Department Regulation No. 62 and limit its payment of commissions to brokers to no more than 4% of premiums. 41
- V. Quality Management Program
- i. It is recommended that, as a good business practice, the HMO acquire and maintain required detailed information pertaining to all policies issued by the HMO. 43
- ii. It is also recommended that, as a good business practice, management of the HMO approve and sign all policies issued by the HMO. 44

Appointment No. 30348

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Kaiwen Guo

as a proper person to examine into the affairs of the

Touchstone Health HMO, Inc.

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

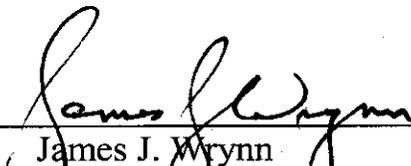
HMO

with such other information as he shall deem requisite.

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

this 21st day of September, 2009




James J. Wrynn
Superintendent of Insurance