

MARKET CONDUCT REPORT ON EXAMINATION

OF

GROUP HEALTH INCORPORATED

AS OF

DECEMBER 31, 2008

DATE OF REPORT

AUGUST 10, 2012

EXAMINER

WAI WONG

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

August 10, 2012

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with instructions contained in Appointment Number 30344, dated August 12, 2009, and annexed hereto, I have made a market conduct examination into the affairs of Group Health Incorporated, a health service corporation licensed under the provisions of Article 43 of the New York Insurance Law, as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the home office of Group Health Incorporated, located at 55 Water Street, New York, New York.

Wherever the designations “the Plan” or “GHI” appear herein, without qualification, they should be understood to mean Group Health Incorporated.

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

Concurrent with this examination, an examination was conducted of the financial condition of Group Health Incorporated as of December 31, 2008. A separate report thereon has been submitted.

1. SCOPE OF THE EXAMINATION

The previous market conduct examination was conducted as of December 31, 2003. This examination covers the five-year period January 1, 2004 to December 31, 2008, and was performed to review the manner in which GHI conducts its business practices and fulfills its contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A review was also made to ascertain what actions were taken by the Plan with regard to comments and recommendations made in the prior report on examination.

2. DESCRIPTION OF THE PLAN

GHI is a non-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law. The Plan was originally incorporated as the Group Health Cooperative, Inc., and began operations on December 6, 1940. It was organized as a Consumer's Cooperative stock corporation under the provisions of Article VII of the Cooperative Corporation Law, for the purpose of furnishing medical expense indemnity insurance to its subscribers. On October 1, 1946, the name Group Health Insurance, Inc. was adopted and the Plan's operations became subject to the provisions of Article IX-C (re-codified as Article 43) of the New York Insurance Law. The change followed reincorporation as a membership corporation.

Effective December 7, 1971, the Charter of Group Health Insurance, Inc., was amended pursuant to the provisions of Section 803 of the Not-For-Profit Corporation Law, changing the name to Group Health Incorporated (“GHI”) and extending the powers of the corporation to include those of a health service corporation. On December 12, 1972, GHI merged with Group Health Dental Insurance, Inc., leaving GHI as the surviving corporation.

On June 1, 1999, GHI created a subsidiary, GHI HMO Select, Inc. (“the HMO”), a health maintenance organization licensed pursuant to Article 44 of the Public Health Law, concurrent with the purchase of the commercial business of WellCare of New York, a New York licensed health maintenance organization. GHI indirectly owns one hundred percent (100%) of the HMO, via GHI’s wholly-owned subsidiary, GHI Services LLC.

GHI filed a “Restated Certificate of Incorporation” with the Department in 2006, as part of GHI’s plan to pursue an affiliation with Health Insurance Plan of Greater New York (“HIP”).

On November 15, 2006, having received regulatory approval from the New York State Insurance Department, the Board of Directors of GHI and HIP Foundation, Inc., the parent corporation of Health Insurance Plan of Greater New York, made the Foundation the sole corporate member of both companies. Also, on this date, the name of the Foundation was changed to EmblemHealth, Inc. (“Emblem”). HIP and GHI named an equal number of directors to the Board of EmblemHealth, Inc.

On March 31, 2007, the New York State Legislature passed legislation as part of the New York State Budget that would allow for the conversion of HIP and GHI into a for-profit public company. Such legislation paves the way toward allowing Emblem to become a profit-making

company that can raise capital through the issuance of stock. At the outset, that stock would belong to the State. To date, such conversion has not been effectuated.

3. CLAIMS PROCESSING

A review of GHI's claims was performed to identify errors in GHI's claim processing system that were occurring on a systematic basis and/or any procedures that GHI had in place that were not in compliance with the Insurance law and related Regulations.

Claims were selected by the examiner from a listing of overturned grievance or appeal cases that were settled during 2008. From a listing of 15,612 in-network medical grievances, 2,694 out-of-network medical grievances, 2,724 hospital grievances and 1,793 dental grievances, samples of twenty-three, nineteen, twenty and ten grievances, respectively, were randomly selected for review. During the process of reviewing the above items, the following was noted:

- There were two instances where GHI incorrectly denied payment for rental of a Continuous Passive Motion Device ("CPM") on an in-network claim. In September 2006, GHI implemented a change of payments for CPM rental devices from payment on a daily basis to payment on a flat monthly rate. Thus, providers who billed for multiple day rentals were only paid as a one day rental during the month with the other days being denied. GHI corrected this error in June 2008 and returned to paying on a daily basis for CPM rentals (which CMS guidelines had indicated were payable on a daily basis).

A review was also performed of improperly denied ambulance claims submitted to GHI by the Fire Department of New York ("FDNY"). These claims had been improperly denied due to an improper edit check by GHI's vendor I-Health. Working with the Department's Consumer Services Bureau, GHI reprocessed all the improperly denied claims as a mass adjustment.

A listing of the reprocessed claims was provided by GHI to the Department. A sample of ten claims which were reprocessed but “Prompt Pay” interest had not been paid was reviewed to determine why the interest was not paid. Five of the claims were duplicate claims where interest had already been paid under another claim number. For the other five claims, GHI erroneously failed to pay interest. GHI could not pay interest on these claims because they were “non-par” claims and GHI’s claim system could not automatically calculate interest on non-par claims for mass adjustments. The claims were initially reprocessed without the interest calculation, however such calculation was done outside of the claim system and properly paid.

It is recommended that GHI establish procedures that automatically calculate interest on mass adjusted non-par claims.

4. TIMOTHY’S LAW CLAIMS PROCESSING

The Department’s Consumer Services Bureau found that GHI had failed to load the New York City Contract terms correctly in its claim system from July 1, 2007 to August 6, 2009. As a result, the cost sharing requirements of “Timothy’s Law” (Section 4303(g) of the NYIL; Chapter 748 of the Laws of 2006) was only being applied to biologically based illnesses and not all mental illnesses, as required. This error affected 26,752 GHI members.

Subsequent to the examination date, GHI reprocessed all the affected Timothy’s Law claims that did not involve deductibles by July 12, 2010 and those claims that involved deductibles by November 2, 2010. 96,053 claims were adjusted with a total payment of \$2,573,987.54, of which \$103,803.31 was interest paid.

5. PROMPT PAY LAW

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

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

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

Section 3224-a(c)(1) of the New York Insurance Law states in part:

“(c)(1) ...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.”

A sample of claims not adjudicated within 45 days of receipt by GHI was reviewed to determine whether such adjudication violated the timeframe requirement of Section 3224-a(a) of the New York Insurance Law and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. Accordingly, all claims that were not adjudicated within

45 days of receipt that were received during the period January 1, 2008 through December 31, 2008 were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

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

“In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim...”

A sample of claims denied after 30 days of receipt by GHI was reviewed by the examiner to determine whether the denial violated the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims that were denied after 30 days of receipt that were received during the period January 1, 2008 through December 31, 2008, were segregated. A statistical sample of this population was then selected to determine whether the claims were in violation of Section 3224-a(b) of the New York Insurance Law.

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

Summary of Violations of Section 3224-a(a) of the NYIL

	Medical Claims	Hospital Claims	Dental Claims
Total population	18,328,046	757,628	842,877
Population of claim transactions adjudicated after 45 days	126,859	17,362	9,239
Sample size	50	50	50
Number of transactions with violations	29	34	13
Calculated violation rate	58%	68%	26%

Summary of Violations of Section 3224-a(c) of the NYIL

	Medical Claims	Hospital Claims	Dental Claims
Total population	18,328,046	757,628	842,877
Population of claim transaction paid past 45 days that are eligible for interest	77,183	6,449	4,458
Sample size	50	50	50
Number of transactions with violations	7	6	3
Calculated violation rate	14%	12%	6%

Summary of Violations of Section 3224-a(b) of the NYIL

	Medical Claims	Hospital Claims	Dental Claims
Total population	18,328,046	757,628	842,877
Population of claim transactions denied past 30 days	11,369	819	2,873
Sample size	50	50	50
Number of transactions with violations	10	45	1
Calculated violation rate	20%	90%	2%

It should be noted that the number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated more than forty-five days after receipt; denied after thirty days of receipt; and those claims which incurred interest of two dollars or more based upon the examiner's calculations, that were received during the period January 1, 2008 through December 31, 2008. The aforementioned population of claims includes numerous transactions from the overall claims data received from GHI. The Department used its own methodology to select the claims included in the population.

The population of claims adjudicated after forty-five days from date of receipt for GHI consisted of 153,460 medical, hospital and dental claims out of 19,928,551 total medical, hospital and dental claims processed. The population of claims which incurred interest of two dollars or more consisted of 88,090 medical, hospital and dental claims out of 19,928,551 total medical and hospital claims processed. The population of claims that were denied over thirty days from date of receipt consisted of 15,061 medical, hospital and dental claims out of 19,928,551 total medical and hospital claims processed.

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

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

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

6. UNDERWRITING AND RATING

A. Healthy New York Rates

GHI provided the examiner with a listing of 1,113 Healthy New York policies that were issued or renewed during the period January 1, 2008 through December 31, 2008. A sample of fifteen files was selected for review. The files were reviewed to determine whether a recertification application was completed and signed, a rate increase notice was sent out at least 30 days prior to the effective date of the new rate and that the policyholder was billed with the correct new rates.

Section 4308(b) of the New York Insurance Law states in part:

“No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent’s approval thereof...”

GHI failed to charge the correct rate for one small group Healthy New York policy due to a processing error in loading the rates for the group. This resulted in an undercharge of \$426.48 for 2008. The group was subsequently charged the correct rate for 2009.

It is recommended that GHI ensures that correct rates are loaded for accurate billing and that GHI charges the correct rates to its policyholders in order to comply with Section 4308(b) of the New York Insurance Law.

B. Termination of Policy Beyond Grace Period

From a listing of 4,798 policies terminated during the period January 1, 2008 through December 31, 2008, a sample of 30 policies was reviewed. Of the 30 policies, 21 were terminated at the request of the subscriber or because there were no longer any active members in the group. Nine policies were terminated for non-payment.

Of the nine policies terminated for non-payment, three were terminated past the thirty day grace period, retroactive to the last date payment was made. All three policies were small group community rated policies. It was GHI's policy during the period under review, to pay claims during the grace period, however, upon termination, GHI attempted to recover payments made during the grace period using two vendors.

In cases of retroactive termination beyond the contract grace period, it is the opinion of the Department's General Counsel that in circumstances where a subscriber or group defaults on the payment of premiums and the insurer voluntarily extends credit by extending the grace period beyond a few business days to process the termination transaction, such insurer waives its rights to retroactively cancel the contract.

The Plan's contracts provide for a thirty (30) day grace period before termination for non-payment of premium.

Section 4235(k) of the New York Insurance Law states:

“Whenever an insurer elects to terminate any policy as described in this section, such insurer shall include in his notification of intent to terminate such policy reference to the policyholder’s responsibilities under section two hundred seventeen of the labor law. Whenever any policy as described in this section terminates as a result of a default in payment of premiums, the insurer shall notify the policyholder that termination has occurred or will occur and shall include in his notification reference to the policyholder’s responsibilities under section two hundred seventeen of the labor law.”

Section 4235(l) of the New York Insurance Law states:

“The superintendent shall promulgate rules and regulations concerning the method, manner and time for a policyholder to provide written notice of termination to the certificate holders as required by subdivision three of section two hundred seventeen of the labor law.”

Parts 55.2(a) and (b) of Department Regulation No. 78 (11 NYCRR 55.2(a) and (b))

states:

“(a) An insurer who intends to terminate a group policy or contract of accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificate holders under a group policy shall give the policyholder at least 30 days prior written notice of its intent to terminate coverage. The notice to the policyholder shall set forth in detail the policyholder’s obligation under the Labor Law, section 217, and under this Part, to notify each certificate holder resident in New York State of the intended termination of the group policy.

(b) In its notice of intent to terminate coverage, the insurer shall set forth in full the rights of the certificate holders under the terminating policy as to coverage for illness, accident and treatment occurring prior to and subsequent to the termination date, and such other rights of certificate holders as may exist under the contract or policy (e.g., conversion rights).”

It is recommended that GHI comply with the provisions of Sections 4235(k) and 4235(l) of the New York Insurance Law when terminating contracts for non-payment of premium.

It is recommended that GHI refrain from recovering claims from providers on affected claims when the grace period is extended by GHI for a significant period beyond the thirty (30)

day grace period permitting the group and the members to reasonably believe GHI has waived termination of coverage for non-payment.

It is further recommended that GHI comply with the provisions of Department Regulation No. 78 relative to the requirements of termination notices of group policies or contracts of accident and health insurance.

C. Healthy New York Applications – Small Group

From a population of 1,062 Healthy New York Small Group applications received from January 1, 2008 through December 31, 2008, a sample of seven applications was selected for review by the examiner.

Section 3201(b)(1) of the New York Insurance Law states in part:

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

The review found that three of the seven applications had outdated forms, which contained outdated premium rates. The rates on the form were lower than the actual rates charged to the insured.

It is recommended that GHI institutes procedures to ensure that the forms on its applications are up to date and contain the correct rates.

D. Healthy New York Applications – Direct Pay

From a population of 1,233 Healthy New York Direct Pay applications received from January 1, 2008 through December 31, 2008, a sample of five applications was selected for review by the examiner.

Section 243.2(b)(8) of Department Regulation No. 152 states:

“(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.”

GHI was unable to provide copies of the signature page and several sections of the application for one of the five applications reviewed.

It is recommended that GHI maintains documentation of its applications in compliance with the record retention timeframe prescribed by Section 243.2(b)(8) of Department Regulation No. 152.

7. PRODUCERS

A. Licensing

A review was performed of GHI’s agent terminations that occurred during the period January 1, 2004 through December 31, 2008. According to a file provided by GHI, the Plan terminated 1,358 agents during this period.

Section 2112(d) of the New York Insurance Law states:

“Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication.”

There were 373 instances where the Department’s Licensing Bureau did not have any record of an agent’s termination by GHI.

For 356 of the 373 agents listed as terminated, GHI explained that when an agent’s license has expired, GHI flags the agent as “terminated” in its Broker Master File System to stop commission payments from being generated and paid to an unlicensed agent. Once the agent who has been terminated on the Broker Master File system for an expired license provides proof of license renewal, the Broker Master file is updated with the agent’s current license information and the termination date is removed. GHI does not report these flagged agents as terminated agents to the Department, since GHI does not consider these terminations to be official.

It was noted that among these 356 “flagged” agents, 171 had a termination date of June 30, 2005, and 184 had a termination date of June 30, 2007. It appears that GHI flagged

these agents indefinitely as terminated agents in its system until the agent provided the renewal license. These terminations were never made official.

It is recommended that GHI file all termination notices with the Department, in compliance with the requirements of Section 2112(d) of the New York Insurance Law.

It is also recommended that GHI create a separate identifier in its system for agents whose terminations are not official, to distinguish them from agents who were officially terminated.

It is recommended that GHI keep its listing of appointed agents current, and terminated agents who fail to submit a copy of their renewed license for an extended period of time.

B. Commission Payments

From a listing of 290 payments made to agents in 2008, a sample of 16 payments was selected for review. One payment from each of the sixteen agents on the listing was reviewed.

There was one commission payment made in 2008 which was paid to an agent who had been terminated as of June 30, 2007. GHI was unable to explain why the payment was made. According to GHI, the payment which was issued on April 17, 2008, was not processed as part of the commission cycle.

GHI was unable to provide the check request so the reason for the check issuance could not be determined. GHI records indicate the check had not been cashed.

Department Regulation No. 152 (11 NYCRR 243) sets forth standards of retention of records by an insurer.

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243) 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.”

It is again recommended that GHI comply with Part 243.2(b)(8) of Department Regulation No. 152 by keeping its check request records for at least 6 years from creation.

8. COMPLAINTS

A listing of 1,290 complaints filed against GHI and closed in 2008 was received from the Department’s Consumer Services Bureau. A sample of twenty complaints was reviewed by the examiner.

Section 2404 of the New York Insurance Law states in part:

“The superintendent is empowered to examine and investigate into the affairs of any person in order to determine whether the person has violated or is violating section two thousand four hundred three of this article. In the event any person does not provide a good faith response to a request for information from the superintendent, within a time period specified by the superintendent of not less than fifteen business days, as part of an examination or investigation initiated by the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance, or health maintenance organization coverage,...

GHI failed to respond to the Department’s request for additional information within fifteen (15) business days on four (4) of the twenty (20) complaint files reviewed.

It is recommended that GHI respond to the Department within fifteen business days in order to comply with the requirements of Section 2404 of the New York Insurance Law.

9 GRIEVANCES

A listing of 20,158 grievances closed in 2008 was received by the examiner from GHI. A sample of fifteen (15) grievances was reviewed. The Plan's internal grievance policy and procedures and the sample files were reviewed to determine compliance with GHI's internal guidelines and contract provisions. GHI's grievance policy and procedures are, for the most part, similar to the Department of Health's requirements for health maintenance organizations.

The examiner found that for seven (7) of the fifteen (15) Grievance files, GHI failed to send an acknowledgement letter within fifteen (15) business days, as required by GHI's internal Grievance procedures.

It is recommended that GHI comply with its Grievance procedures and acknowledge all filed Grievances, in writing, within fifteen (15) business days.

10. UTILIZATION REVIEW AND APPEALS

Sections 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents respectively, for companies licensed under Article 43 of the New York Insurance Law.

For the period January 1, 2008 through December 31, 2008, GHI provided the examiner with utilization review and utilization review appeal logs for cases involving GHI and several of its delegated entities. GHI delegates to certain of its contracted providers, utilization review and

utilization review appeal responsibilities. These contracted providers include: CareCore, Palladium, Value Options and Express Scripts. Utilization review and utilization review appeal cases conducted by GHI and the above contracted providers were reviewed.

A. GHI

From a population of 30,494 prospective utilization review cases resolved during January 1, 2008 to December 31, 2008, twenty (20) utilization review files were reviewed.

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

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

Three (3) out of the twenty (20) cases reviewed were found to be in violation of Section 4903(3)(b) of New York Insurance Law; for failure to provide the determination within three (3) business days.

It should be noted that the three cases in question were considered “pre-determinations” under a contract covering New York City employees. Pre-determinations are cases where a pre-authorization is not required by GHI for a procedure, but an authorization request is still submitted to GHI by the provider. Since GHI considers these cases voluntary pre-authorizations the prospective utilization review time frames of Article 49 of the Insurance Law are not strictly observed.

It is the Department's position that even in cases where GHI does not require pre-authorizations, if a voluntary request for utilization review is submitted, GHI is required to abide by the prospective review time frames in Article 49 of the New York Insurance Law.

One (1) out of the twenty (20) cases reviewed was found to be in violation of Section 4903(b) of New York Insurance Law, when GHI failed to provide written notification to the enrollee or their representative of the determination.

It is recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide the determination notice within three (3) business days.

It is also recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination.

From a population of 34,744 concurrent utilization review cases resolved during January 1, 2008 to December 31, 2008, twenty (20) utilization review files were reviewed.

Section 4903(c) of the New York Insurance Law states:

"A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending."

Two (2) out of the twenty (20) cases reviewed were found to be in violation of Section 4903(c) of New York Insurance Law when GHI failed to provide written notification of the determination within one (1) business day.

It is recommended that GHI comply with Section 4903(c) of the New York Insurance Law and provide written notice of determination within one (1) business day.

B. CareCore

From a population of 256,274 prospective utilization review cases resolved during January 1, 2008 to December 31, 2008, twenty-five (25) utilization review files were reviewed.

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

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

Two (2) out of the twenty-five (25) cases reviewed were found to be in violation of Section 4903(b) of the New York Insurance Law when CareCore failed to provide verbal notification to the enrollee or their representative within the allotted timeframe.

It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination within the required timeframe.

C. Value Options

From a population of 33,839 prospective utilization review cases resolved during January 1, 2008 through December 31, 2008, fifteen (15) utilization review files were reviewed.

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

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

All fifteen (15) cases reviewed were found to be in violation of Section 4903(b) of the New York Insurance Law when Value Options failed to provide verbal notification to the enrollee or their representative and their health care provider of the determination within the allotted timeframe.

It is recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination.

From a population of 28,285 concurrent utilization review cases resolved during January 1, 2008 through December 31, 2008, fifteen (15) utilization review files were reviewed.

Section 4903(c) of the New York Insurance Law states, in part:

“A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee’s designee, which may be satisfied by notice to the enrollee’s health care provider, by telephone and in writing within one business day of receipt of the necessary information...”

Eleven (11) out of fifteen (15) cases reviewed were found to be in violation of Section 4903(3)(c) of New York Insurance Law when Value Options failed to provide verbal notification to the enrollee or their representative of the determination within the allotted timeframe.

It is recommended that GHI comply with the requirements of Section 4903(c) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination within the allotted timeframe.

10. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2003, contained twenty (20) comments and recommendations that pertained to market conduct items (page numbers refer to the prior Market Conduct report on examination):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
	<u>Claims Processing</u>	
1.	It is recommended that GHI take proactive steps to identify and correct errors that may be occurring on an ongoing basis and that GHI address the causes of the errors such as providing retraining to individuals who process claims. <i>GHI has complied with this recommendation.</i>	25
2.	It is recommended that GHI create procedures to ensure that claims are processed within the time frames mandated by Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law. <i>GHI has complied with this recommendation.</i>	29
3.	It is also recommended that the Plan implement the necessary procedures and training in order to ensure compliance with Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law. <i>GHI has complied with this recommendation.</i>	30
4.	It is also recommended that GHI comply with the requirements of Section 3224-a(c) of the New York Insurance Law by calculating interest due on all claims paid after 45 days of receipt, and paying any calculated interest amount that is equal to, or in excess of two dollars. <i>GHI has complied with this recommendation.</i>	30

ITEM NO.**PAGE NO.**Claims Processing (Cont'd)

5. It is recommended that GHI modify the denial explanation, on its EOB's, in cases where GHI is not the insurance carrier 30

GHI has complied with this recommendation

6. It is recommended that GHI monitor and track claims that were submitted as hospital claims, which were actually medical claims, in order to assure that these claims are subject to the same standards as regular medical or hospital claims. 31

GHI has complied with this recommendation.

Ambulance Claims

7. GHI agreed to use Ingenix data beginning November 1, 2004 for reimbursement of its ambulance claims. Additionally, GHI reached an agreement with the Department to re-price and adjust ambulance claims previously paid to non-participating providers during the period January 1, 2002 through November 30, 2004. 32

GHI has complied with this recommendation.

Record Retention

8. It is recommended that GHI comply with the requirements of Department Regulations No. 64 and No. 152 by retaining copies of all EOBs. 33

GHI has complied with this recommendation.

9. It is recommended that GHI act in accordance with the requirements of Department Regulations No. 64 and No. 152 by retaining all aspects of its claims so that the examiner can view the complete claim transaction. 33

GHI has complied with this recommendation.

ITEM NO.**PAGE NO.**Sales and Advertising

10. It is recommended that GHI comply with the requirements of Department Regulation No. 34 when using a membership figure in its advertisements. 35

GHI has complied with this recommendation.

11. It is recommended that GHI report the New York State mental health insured members in its NY5 Exhibits of its filed Annual Supplements. 35

GHI has complied with this recommendation.

Underwriting, Rating, Issuance of Policy Forms and Third Party Administrators

12. It is recommended that GHI send cancellation notices to policyholders in all situations in which the policy is terminated, including subscriber initiated cancellations, and that GHI assure that its cancellation notices comply with Section 4235(k) of the New York Insurance Law. 38

GHI has complied with this recommendation.

13. It is recommended that GHI comply with the requirements of Department Regulation No. 152 and assure all documents relating to cancellations, including the cancellation notice, are retained. 38

GHI has complied with this recommendation.

14. It is recommended that GHI communicate all policies to brokers/TPAs in a timely manner, and that GHI perform follow-up reviews or audits to assure that the broker/TPAs are adhering to GHI's policies and procedures. 39

GHI has complied with this recommendation.

ITEM NO.**PAGE NO.****Underwriting, Rating, Issuance of Policy Forms and Third Party Administrators**

15. It is recommended that GHI directly oversee the activities of its broker/TPA with regard to administration of small group policies and assure that the broker/TPA is performing the designated services in accordance with the New York Insurance Law and Regulation, and with GHI's policies and procedures. 39

GHI has complied with this recommendation.

16. It is recommended that GHI ensure that its TPA be audited by a CPA, on an annual basis and that GHI obtains a copy of the audit report and be made aware of any material findings. 39

GHI has complied with this recommendation.

Complaints

17. It is recommended that GHI comply with the time limit mandated by Section 2404 of the New York Insurance Law when responding to CSB inquiries. 40

GHI has not fully complied with this recommendation and it is repeated herein.

18. It is recommended that GHI provide the Department's CSB with correct and verifiable information when responding to complaints. 41

GHI has complied with this recommendation.

19. It is recommended that GHI apply prior creditable coverage to all eligible members. It is further recommended that GHI request additional information from the member when incomplete prior coverage information is provided on the enrollment form, rather than ignoring incomplete information. 42

GHI has complied with this recommendation.

ITEM NO.**PAGE NO.**Complaints (Cont'd.)

20. It is recommended that GHI comply with Section 4318 of the New York Insurance Law with respect to the crediting of prior creditable coverage. 43

GHI has complied with this recommendation.

12. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Claims Processing</u>	
It is recommended that GHI establish procedures that automatically calculate interest on non-par claims.	6
B. <u>Timothy's Law Claims Processing</u>	
Subsequent to the examination date, GHI reprocessed all the affected Timothy's Law claims that did not involve deductibles by July 12, 2010 and those claims that involved deductibles by November 2, 2010. 96,053 claims were adjusted with a total of payment of \$2,573,987.54, of which \$103,803.31 was interest paid.	6
C. <u>Prompt Pay Law</u>	
i. It is recommended that GHI take steps to ensure that the provisions of §3224-a(a) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with.	10
ii. It is recommended that GHI take steps to ensure that the provisions of §3224-a(b) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with.	10
iii. It is recommended that GHI take steps to ensure that the provisions of §3224-a(c) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with.	11
D. <u>Underwriting and Rating</u>	
i. It is recommended that GHI ensure correct rates are loaded for accurate billing and charge the correct rates to its policyholders in order to comply with Section 4308(b) of the New York Insurance Law.	12

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Underwriting and Rating (Cont'd.)</u>	
ii. It is recommended that GHI comply with the provisions of Sections 4235(k) and 4235(l) of the New York Insurance Law when terminating contracts for non-payment of premium.	13
iii. It is recommended that GHI refrain from recovering claims from providers on affected claims when the grace period is extended by GHI for a significant period beyond the thirty (30) day grace period permitting the group and the members to reasonably believe GHI has waived termination of coverage for non-payment.	13
iv. It is further recommended that GHI comply with the provisions of Department Regulation No. 78 relative to the requirements of termination notices of group policies or contracts of accident and health insurance.	14
v. It is recommended that GHI institute procedures to ensure that the forms on its applications are up to date and contain the correct rates.	14
vi. It is recommended that GHI maintains documentation of its applications to comply with the record retention requirements of Department Regulation No. 152.	15
E. <u>Producers</u>	
i. It is recommended that GHI file all termination notices with the Department when terminating agents in compliance with Section 2112(d) of the New York Insurance Law.	17
ii. It is also recommended that GHI create a separate identifier in its system for agents whose terminations are not official, to distinguish them from agents who were officially terminated.	17
iii. It is recommended that GHI keep its listing of appointed agents current, and terminated agents who fail to submit a copy of their renewed license for an extended period of time.	17
iv. It is again recommended that GHI comply with Part 243.2(b)(8) of Department Regulation No. 152 by keeping its check request records for at least 6 years from creation.	18

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Complaints</u>	
It is recommended that GHI respond to the Department within fifteen business days in order to comply with the requirements of Section 2404 of the New York Insurance Law.	18
G. <u>Grievances</u>	
It is recommended that GHI comply with its Grievance procedures and acknowledge all filed Grievances, in writing, within fifteen (15) business days.	19
H. <u>Utilization Review and Appeals</u>	
i. It is recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide the determination notice within three (3) business days.	21
ii. It is also recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination.	21
iii. It is recommended that GHI comply with Section 4903(c) of the New York Insurance Law and provide written notice of determination within one (1) business day.	22
iv. It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination within the required timeframe.	22
v. It is recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination.	23
vi. It is recommended that GHI comply with the requirements of Section 4903(c) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination within the allotted timeframe.	24

Appointment No. 30344

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, **Kermitt J. Brooks**, Acting Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Wai Wong

as a proper person to examine into the affairs of the

Group Health Incorporation

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

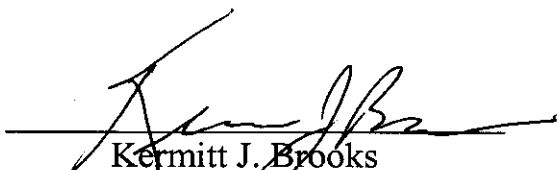
Company

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 12th day of August, 2009




Kermitt J. Brooks
Acting Superintendent of Insurance