

MARKET CONDUCT REPORT ON EXAMINATION

OF THE

HEALTH INSURANCE PLAN OF GREATER NEW YORK

AND

HIP INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 2011

DATE OF REPORT

JANUARY 11, 2016

EXAMINER

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor
Superintendent

Shirin Emami
Acting

January 11, 2016

Honorable Shirin Emami
Acting Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with instructions contained in Appointment Numbers 30867 and 30869, dated July 31, 2012, annexed hereto, I have made an examination into the affairs of the Health Insurance Plan of Greater New York, a not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law, and its subsidiary, the HIP Insurance Company of New York, an accident and health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2011, and submit the following report thereon.

The examination was conducted at the home office of the Health Insurance Plan of Greater New York and HIP Insurance Company of New York, located at 55 Water Street, New York, NY.

Wherever the designations the “Plan” or “HIPNY” appear herein, without qualification, they should be understood to indicate the Health Insurance Plan of Greater New York.

Wherever the designations the “Company” or “HIPIC” appear herein, without qualification, they should be understood to indicate the HIP Insurance Company of New York.

Wherever the designations “HIP” or “Companies” appear herein, without qualification, they should be understood to indicate the Health Insurance Plan of Greater New York and the HIP Insurance Company of New York, collectively.

Wherever the designation “EmblemHealth” appears herein, without qualification, it should be understood to indicate EmblemHealth, Inc., the ultimate parent of the HIP Companies.

Wherever the designation “GHI” appears herein, without qualification, it should be understood to indicate Group Health Incorporated, an affiliate of the HIP companies.

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

Concurrently, an examination into the financial condition and affairs of HIPNY and HIPIC was performed. Separate financial reports on examination for HIPNY and HIPIC have respectively been submitted thereon.

1. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies during the examination period. The most significant findings of this examination include the following:

- HIP failed to comply with the requirements of Section 3224-a(a), (b), and (c) of the New York Insurance Law (“Prompt Pay Law”), in certain identified instances.
- HIP failed to provide a specific explanation for its Denial Code DR2 on their Explanation of Benefits Statements, in violation of the requirement of Section 3234(b)(1) of the New York Insurance Law.
- HIPNY, HIPIC, and their TPAs – Montefiore Care Management, HealthCare Partners, and CareCore, failed to comply with requirements of various Sections of Article 49 of the New York Insurance Law and/or Article 49 of the New York Public Health Law, in certain identified instances.
- HIP failed to comply with the requirements of Parts 215.6(a)(1) and (2) of Insurance Regulation No. 34 for one (1) universal small group advertisement and two (2) direct pay advertisements.
- HIP failed to notify the Department of the appointments and terminations of some of their agents and brokers, in violation of the requirements of Section 2112(d) of the New York Insurance Law.

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

2. **SCOPE OF THE EXAMINATION**

The previous market conduct examination was conducted as of December 31, 2006. This examination covers the five-year period January 1, 2007 to December 31, 2011, and was performed to review the manner in which the Health Insurance Plan of Greater New York and the HIP Insurance Company of New York conduct their business practices and fulfill their contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate.

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 explanation or description.

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

3. **DESCRIPTION OF THE COMPANIES**

HIPNY is a New York State not-for-profit corporation operating under the provisions of Article 43 of the New York Insurance Law. The Plan also operates as a certified health maintenance organization (“HMO”), pursuant to the provisions of Article 44 of the New York Public Health Law. Since February 10, 2005, retroactive to January 1, 1998, HIPNY was exempt from federal income taxes under Section 501(a) of the Internal Revenue Code (“IRC”), as described in Section 501(c)(4) of the IRC. Prior to that date, HIPNY was exempt from federal income taxes

per Section 501(c)(3) of the IRC. As a result of this change in tax status, HIPNY is required to pay federal unemployment taxes.

HIPIC was incorporated under the laws of the State of New York as a for-profit health insurance company on September 7, 1994. On January 12, 1995, HIPIC issued 30,000 shares of \$10 par value per share common stock to its immediate Parent, HIP Holdings, Inc., for a consideration of \$5,000,000, bringing its authorized capital to \$300,000 and contributed capital to \$4,700,000. On June 5, 1995, the Department granted HIPIC a license to operate as an accident and health insurance company, as defined in paragraphs 3(i) and (ii) of Section 1113(a) of the New York Insurance Law. HIPIC commenced its operations on September 7, 1994.

On November 15, 2006, having received regulatory approval from the Department, HIPNY agreed to an affiliation with Group Health Incorporated, a not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law. As a result of this transaction, EmblemHealth, Inc. became the sole member and Parent corporation of HIPNY, GHI and their respective subsidiaries. HIPNY and GHI named an equal number of directors to the EmblemHealth Board.

On March 6, 2007, EmblemHealth Services Company, LLC (“EHS”) was formed by a joint venture of HIPNY and GHI, in order to integrate operations of these two entities. On January 1, 2008, items such as vendor agreements and employees were transferred to EHS. HIPNY and GHI receive management and other services from EHS. Also on that date, with the approval of the Department, HIPNY and GHI entered into a written guarantee of the liabilities of EHS.

In December 2010, HIPNY replaced EmblemHealth as the sole corporate member and Parent corporation of GHI. In 2013, EmblemHealth filed and was approved by the Department to restructure the ownership of EHS such that it is wholly owned by the Health Insurance Plan of Greater New York.

In April 2007, a change in the New York Insurance Law was enacted to permit not-for-profit insurers such as HIPNY and GHI to convert to for-profit status. On April 16, 2007, EmblemHealth submitted an application to the Department, to convert HIPNY and GHI to for-profit status. The application was approved by the Boards of Directors of HIPNY and GHI.

The Conversion Plan was amended and refiled on December 31, 2007. On January 29th and 31st of 2008, the Superintendent held public hearings on the Conversion in New York City, NY and Albany, NY, respectively. Pursuant to the plan of Conversion, HIPNY and GHI, currently not-for-profit entities would become for-profit entities. However, given the lack of activity on the Conversion, it appears unlikely that it will occur.

4. CLAIMS PROCESSING

A review of HIPNY's and HIPIC's claims practices and procedures was performed covering claims paid during the period of January 1, 2011 through December 31, 2011, in order to evaluate the overall accuracy and compliance environment of their claims processing. The claim populations for the Companies were divided into medical and hospital claim segments. A random statistical sample was drawn from each segment for each of the above HIP companies, except for the items detailed further below within this paragraph, to test for verification of compliance with certain specified areas, including: eligibility, payment adherence to appropriate fee schedules, co-payments,

deductibles, treatment plan authorization, denied claims and explanation of benefits statements (“EOBs”). It should be noted for the purpose of this analysis, those medical costs characterized as Pharmacy, Medicare/Medicaid, Dental, and Capitated payments, were excluded from this review.

The sample size for each population was comprised of 167 randomly selected claim transactions. In total, 668 claims were selected for this review (167 hospital claims and 167 medical claims for each of the HIP companies). The review was conducted on a stop-and-go basis. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by each of the HIP entities for the period January 1, 2011 through December 31, 2011. The following was noted during the claims review:

A. Explanation of Benefits Statements

Explanation of Benefits Statements (“EOBs”) are an integral part of the link between the subscriber/contract-holder and their insurer, providing vital information as to how a claim was processed. Section 3234(b) of the New York Insurance Law sets forth, minimum standards for content of an EOB.

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

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

- (1) the name of the provider of service the admission or financial control number, if applicable;
- (2) the date of service;
- (3) an identification of the service for which the claim is made;
- (4) the provider’s charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount

claimed; and

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

The following was noted during the claims review pertaining to HIP's EOBs:

- HIP listed, without any annotation, the New York State of Department of Health (“NYSDOH”) as the provider of services on their EOBs for Medicaid Reclamation claims submitted by NYSDOH.
- The description HIP had for their denial code DR2 – CLAIM DENIED: NOT A PRIVILEGED SERVICE on their EOBs was determined to be too vague.
- HIP incorrectly identified a number of their in-network claims as out-of-network by stating that these were claims filed by non-participating providers on their EOBs. It should be noted that the claims themselves were processed correctly as in-network claims.

It is recommended that HIP suppress the generation of EOBs on their Medicaid Reclamation claims to avoid possible confusion to the recipients.

It is recommended that HIP modify their description of denial code DR2 to comply with the requirements of Section 3234(b)(6) of the New York Insurance Law.

It is further recommended that HIP take actions to ensure the accuracy of the information reported on their EOBs.

5. PROMPT PAY LAW

Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” (“Prompt Pay Law”), requires all insurers to pay undisputed claims within forty-five (45) days of receipt for paper claims

and within thirty (30) days of receipt for electronically submitted claims. If such undisputed claims are not paid within forty-five/thirty (45/30) days of receipt, interest may be payable.

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

“...(a) Except in 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:

“...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.”

For each of the HIP companies, all claims that were not adjudicated within forty-five (45) days of receipt for paper claims and within thirty (30) days for receipt of electronic claims, during the period January 1, 2011 through December 31, 2011, were segregated. A statistical sample of these claims was reviewed by the examiner to determine whether payments were in violation of the timeframe requirements 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.

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...”

For each of the HIP companies, all denied claims that were not denied within thirty (30) days of receipt during the period January 1, 2011 through December 31, 2011, were segregated. A statistical sample of these claims was reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law.

The following charts illustrate HIP’s compliance with the Prompt Pay Law as determined by this examination:

HIPNY - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

| | Medical Claims | Hospital Claims |
|----------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|
| Total population | 3,111,449 | 475,787 |
| Population of claim transactions adjudicated after 45 days of receipt of paper claims or after 30 days of receipt of electronic claims | 172,501 | 16,985 |
| Sample size | 167 | 167 |
| Number of transactions with violations | 166 | 145 |
| Calculated violation rate | 99.4% | 86.83% |
| Upper violation limit | 100% | 91.96% |
| Lower violation limit | 98.23% | 81.70% |
| Calculated transactions in violation | 171,468 | 14,747 |
| Upper limit transactions in violation | 172,501 | 15,619 |
| Lower limit transactions in violation | 169,450 | 13,876 |

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

HIPNY - Summary of Violations of Section 3224-a(c) of the New York Insurance Law

| | Medical Claims | Hospital Claims |
|----------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|
| Total population | 3,111,449 | 475,787 |
| Population of claim transactions adjudicated after 45 days of receipt of paper claims or after 30 days of receipt of electronic claims | 172,501 | 16,985 |
| Sample size | 167 | 167 |
| Number of transactions with violations | 37 | 7 |
| Calculated violation rate | 22.16% | 4.19% |
| Upper violation limit | 28.45% | 7.23% |
| Lower violation limit | 15.86% | 1.15% |
| Calculated transactions in violation | 38,219 | 712 |
| Upper limit transactions in violation | 49,084 | 1,228 |
| Lower limit transactions in violation | 27,353 | 196 |

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

HIPNY - Summary of Violations of Section 3224-a(b) of the New York Insurance Law

| | Medical Claims | Hospital Claims |
|--------------------------------------------------------------------------------|----------------|-----------------|
| Total population | 3,111,449 | 475,787 |
| Population of claim transactions denied after 30 days of receipt of the claims | 13,591 | 2,479 |
| Sample size | 167 | 167 |
| Number of transactions with violations | 51 | 160 |
| Calculated violation rate | 30.54% | 95.81% |
| Upper violation limit | 37.52% | 98.85% |
| Lower violation limit | 23.55% | 92.77% |
| Calculated transactions in violation | 4,151 | 2,375 |
| Upper limit transactions in violation | 5,100 | 2,450 |
| Lower limit transactions in violation | 3,201 | 2,300 |

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

HIPIC - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

| | Medical Claims | Hospital Claims |
|----------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|
| Total population | 378,596 | 59,132 |
| Population of claim transactions adjudicated after 45 days of receipt of paper claims or after 30 days of receipt of electronic claims | 14,532 | 1,447 |
| Sample size | 167 | 167 |
| Number of transactions with violations | 146 | 137 |
| Calculated violation rate | 87.43% | 82.04% |
| Upper violation limit | 92.45% | 87.86% |
| Lower violation limit | 82.40% | 76.21% |
| Calculated transactions in violation | 12,705 | 1,187 |
| Upper limit transactions in violation | 13,435 | 1,271 |
| Lower limit transactions in violation | 11,974 | 1,103 |

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

HIPIC - Summary of Violations of Section 3224-a(c) of the New York Insurance Law

| | Medical Claims | Hospital Claims |
|----------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|
| Total population | 378,596 | 59,132 |
| Population of claim transactions adjudicated after 45 days of receipt of paper claims or after 30 days of receipt of electronic claims | 14,532 | 1,447 |
| Sample size | 167 | 167 |
| Number of transactions with violations | 1 | 15 |
| Calculated violation rate | n/a | 8.98% |
| Upper violation limit | 1.77% | 13.32% |
| Lower violation limit | n/a% | 4.65% |
| Calculated transactions in violation | 87 | 130 |
| Upper limit transactions in violation | 257 | 193 |
| Lower limit transactions in violation | n/a | 67 |

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

HIPIC - Summary of Violations of Section 3224-a(b) of the New York Insurance Law

| | Medical Claims | Hospital Claims |
|--------------------------------------------------------------------------------|----------------|-----------------|
| Total population | 378,596 | 59,132 |
| Population of claim transactions denied after 30 days of receipt of the claims | 1,356 | 642 |
| Sample size | 167 | 167 |
| Number of transactions with violations | 32 | 134 |
| Calculated violation rate | 19.16% | 80.24% |
| Upper violation limit | 25.13% | 86.28% |
| Lower violation limit | 13.19% | 74.20% |
| Calculated transactions in violation | 260 | 515 |
| Upper limit transactions in violation | 341 | 554 |
| Lower limit transactions in violation | 179 | 476 |

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

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated more than forty-five (45) days (paper claims) or thirty (30) days (electronic claims) after receipt, or denied more than thirty (30) days from date of receipt, and where applicable, those claims which incurred interest of two dollars or more, based upon the examiner's review of claims adjudicated during the period January 1, 2011 through December 31, 2011.

The population of claims adjudicated more than forty-five (45) days (paper claims)/thirty (30) days (electronic claims) after date of receipt for HIPNY consisted of 189,486 medical and hospital claims combined out of 3,587,236 total medical and hospital claims extracted for review for 2011. The population of claims that were denied more than thirty (30) calendar days after date of receipt for HIPNY consisted of 16,070 medical and hospital claims out of 3,587,236 total medical and hospital claims extracted for review for 2011.

The population of claims adjudicated more than forty-five (45) days (paper claims)/thirty (30) days (electronic claims) after date of receipt for HIPIC consisted of 15,979 medical and hospital claims combined out of 437,728 total medical and hospital claims extracted for review for 2011. The population of claims that were denied more than thirty (30) calendar days after date of receipt for HIPIC consisted of 1,998 medical and hospital claims out of 437,728 total medical and hospital claims extracted for review for 2011.

It is recommended that HIP take the necessary steps to ensure that it fully implement and comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims.

It is also recommended that HIP take steps to ensure that it fully implement and comply with the provisions of Section 3224-a(b) of the New York Insurance Law regarding the payment of interest for claims not adjudicated within the timeframes mandated by Section 3224-a(a) of the New York Insurance Law.

It is further recommended that HIP take the necessary steps to ensure that it fully implement and comply with the provisions of Section 3224-a(c) of the New York Insurance Law regarding the payment of interest.

6. UTILIZATION REVIEW AND APPEALS

Sections 4902, 4903 and 4904 of the New York Public Health Law set forth the minimum utilization review program standards and requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents respectively, for HMOs licensed under Article 44 of the New York Public Health Law. Thus, these statutes apply to HIPNY, an Article 43 insurer with a line of business HMO. Comparable sections of Article 49 of the New York Insurance Law contain the same requirements for insurers licensed under Article 42 of the New York Insurance Law, and apply to HIPIC.

During the examination period, utilization reviews (“UR”) and appeals were processed by HIP and their delegated third-party administrators (“TPA”) including CareCore, Healthcare Partners, Montefiore Care Management (“CMO”), and Palladian.

A. Utilization Reviews

i. HIPNY – UR Approvals

From a log of 31,409 utilization review approvals closed by HIPNY in calendar year 2011, twenty-five (25) UR approval cases were randomly selected and reviewed by the examiner. Five (5) of the twenty-five (25) cases were prospective reviews, and the remaining twenty (20) cases were concurrent reviews.

Section 4903(2) of the New York Public Health Law (“NYPHL”) 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 enrollee or enrollee’s designee and the enrollee’s health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee’s health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties.”

Section 4903(3) of the New York Public Health Law states in part:

“A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee 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 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...”

Part 243.2(a) of Insurance Regulation No. 152 (Part 11 NCRR 243.2) states:

“(a) In addition to any other requirement contained in Insurance Law section 325, any other section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part.”

Part 243.2(b)(8) of Insurance Regulation No. 152 (Part 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.”

For two (2) of the five (5) prospective UR cases reviewed by the examiner, HIPNY was found to be in violation of the requirements of Section 4903(2) of the NYPHL, as follows:

- For one (1) case, HIPNY failed to make a determination within the required timeframe.
- For one (1) case, HIPNY failed to provide telephonic notice of the determination to the enrollee and the enrollee’s health care provider.

For eleven (11) of twenty (20) concurrent UR cases reviewed by the examiner, HIPNY was found to be in violation of the requirements of Section 4903(3) of the NYPHL and Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152, as follows:

- For two (2) cases, HIPNY failed to provide verbal notification of the determinations to the enrollees and the providers.
- For five (5) cases, HIPNY failed to retain documents proving that the written notifications of the determination were made to both the enrollee’s health care provider and the enrollees.
- For four (4) cases, HIPNY failed to make determinations within the required timeframe.

It is recommended that HIPNY comply with the requirements of Sections 4903(2) and (3) of the New York Public Health Law.

It is recommended that HIPNY comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by retaining all relevant UR documents for the required retention period.

ii. HIPIC - UR Denials

From a log of 566 UR denials closed by HIPIC in calendar year 2011, twenty-nine (29) UR cases were randomly selected and reviewed by the examiner. Three (3) of the twenty-nine (29) cases were prospective reviews, eight (8) of the twenty-nine (29) cases were concurrent, and the remaining eighteen (18) cases were retrospective reviews.

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

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

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 ...shall provide notice of such determination to the insured or the insured’s designee ...by telephone and in writing within one business day of receipt of the necessary information...”

For one (1) of the three (3) prospective UR cases, HIPIC was found to be in violation of the requirements of Section 4903(b) of the New York Insurance Law when it failed to make timely verbal and written notices of the determination to the insured, or the insured’s designee and the insured’s health care provider, within the required timeframe.

For one (1) of the eight (8) concurrent UR cases, HIPIC was found to be in violation of the requirements of Section 4903(c) of the New York Insurance Law and Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 when it failed to provide documentation that written notification of the determination to the provider and the insured was actually made.

It is recommended that HIPIC comply with the requirements of Section 4903(b) of the New York Insurance Law by ensuring that both verbal and written notices of the determination are provided to the insured, or the insured's designee and the insured's health care provider within three business days of receipt of the necessary information.

It is also recommended that HIPIC comply with the requirements of Section 4903(c) of the New York Insurance Law by ensuring written notices of the determination are provided to the insured, or the insured's designee and the insured's health care provider within one business day of receipt of the necessary information.

It is further recommended that HIPIC comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by maintaining all relevant UR documents for the required retention period.

iii. HIPIC - UR Approvals

From a log of 3,537 UR approved cases closed by HIPIC during calendar year 2011, twenty-six (26) UR cases were randomly selected and reviewed by the examiner. Four (4) of the twenty-six (26) cases were prospective reviews, and the remaining twenty-two (22) cases were concurrent reviews.

For two (2) of the four (4) prospective UR cases, HIPIC was found to be in violation of the requirements of Section 4903(b) of the New York Insurance Law and Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152, as follows:

- For one (1) case, HIPIC failed to provide proof of verbal and written notification to both the insured and the insured's health care provider.
- For one (1) case, HIPIC failed to provide proof of written notification to both the insured and the insured's health care provider. In addition, HIPIC failed to provide verbal notification to the insured's health care provider and the insured in a timely manner.

For seven (7) of the twenty-two (22) concurrent UR cases, HIPIC was found to be in violation of the requirements of Section 4903(c) of the New York Insurance Law and Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152, as follows (some cases had multiple reasons):

- In four (4) cases, HIPIC failed to provide proof of the written notification to the insured's health care provider and the insured.
- In four (4) cases, HIPIC failed to provide proof of the verbal notification of the determination to the insured's health care provider and the insured.
- In one (1) case, HIPIC failed to timely provide the written notification to the insured's health care provider within the required timeframe.
- In one (1) case, HIPIC failed to timely request for additional information within the required timeframe.

It is recommended that HIPIC comply with the requirements of Sections 4903(b) and (c) of the New York Insurance Law.

It is further recommended that HIPNY comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by maintaining all relevant UR documents for the required retention period.

iv. HealthCare Partners - UR Denials

From a log of 1,339 UR approvals closed by HealthCare Partners ("HCP"), a third-party administrator, acting on behalf of HIPNY, during calendar year 2011, ten (10) UR cases were

randomly selected and reviewed by the examiner. Three (3) of the ten (10) cases were prospective reviews, six (6) of the ten (10) cases were concurrent reviews, and the remaining (1) case was a retrospective review.

For one (1) of the six (6) concurrent cases, HCP was found to be in violation of the requirements of Section 4903(3) of the New York Public Health Law for failing to provide timely written notification of the determination to the enrollee's health care provider within the required timeframe.

It is recommended that HIPNY and HCP comply with the requirements of Section 4903(3) of the NYPHL by maintaining written notification of its determination to the enrollee's health care provider within one (1) business day of receipt of all of the necessary information.

v. HealthCare Partners UR approvals

From a log of 51,495 UR approvals closed by HCP during 2011, ten (10) HCP UR cases were randomly selected and reviewed by the examiner. Nine (9) of the ten (10) cases were prospective reviews, and the remaining (1) case was a concurrent review.

It was noted that for six (6) of the nine (9) prospective cases, copies of the notification letters provided by HCP didn't contain the dates the notifications were issued. HCP maintained that the letters provided were reproduction letters and that the original letters were dated, however, their system was not designed to put the original issuing dates on the reproductions of letters.

It is recommended that HCP, acting on behalf of HIPNY, comply with the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152 by retaining the relevant information or data to accurately represent a record of communications between a person or entity and the insurer.

B. Utilization Review Appeals

i. HIPNY

From a log of 2,631 UR appeals closed by HIPNY during calendar year 2011, thirty (30) cases were randomly selected and reviewed by the examiner.

Section 4904(3) of the New York Public Health Law states in part:

“A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone...The utilization review agent shall notify the enrollee, the enrollee’s designee and, where appropriate, the enrollee’s provider, in writing of the appeal determination within two business days of rendering such determination...”

For one (1) of the thirty (30) cases, HIPNY was found to be in violation of the requirements of Section 4904(3) of New York Public Health Law when it failed to make timely written notification of its determination to the appealing party within the required timeframe.

It is recommended that HIPNY comply with the requirements of Section 4904(3) of the New York Public Health Law by making written notification of its determination to the appealing party within two business days of rendering its determination.

ii. HIPIC

From a log of 221 UR appeals closed by HIPIC in calendar year 2011, twenty-seven (27) UR cases were randomly selected and reviewed by the examiner.

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

“...The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal...”

Section 4904(e) of the New York Insurance Law states:

“Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent’s adverse determination.”

Bulletin No. 12 of EmblemHealth’s policy No. EP.MM.CM.01, *Utilization Management/Mental Health*, states:

“If a determination is not made within the applicable time periods, it shall be deemed to be a reversal of the adverse determination.”

For two (2) of the twenty-seven (27) cases reviewed by the examiner, HIPIC was found to be in violation of the requirements of Section 4904(c) of the New York Insurance Law when it failed to make determinations within the required timeframe. It should be noted that in both cases, the determinations were made six months after the receipt of appeals, and no additional information was requested.

Upon further inquiry, it was found that the delays in the two (2) aforementioned UR appeal cases were caused by a problem in HIP’s legacy tracking system, prior to the implementation of

their new system in May 2011. HIPIC upheld the adverse determinations for both of these two appeals.

It is recommended that HIPIC comply with the requirements of the Section 4904(c) of the New York Insurance Law by making a determination with regard to the appeal within sixty days of the receipt of necessary information

It is further recommended that HIPIC comply with the requirements of Section 4904(e) of New York Insurance Law and Bulletin No. 12 of its Utilization Management/Mental Health policy, No. EP.MM.CM.01, by reversing the adverse determinations of delayed appeals.

iii. CareCore

Section 4904(3) of the New York Public Health Law states in part:

“A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone...The utilization review agent shall notify the enrollee, the enrollee’s designee and, where appropriate, the enrollee’s provider, in writing of the appeal determination within two business days of rendering such determination...”

From a log of 195 UR appeals (97 radiology and 98 cardiology appeals) closed by CareCore, acting on behalf of HIPNY, in calendar year 2011, twenty (20) UR cases were randomly selected and reviewed by the examiner.

For five (5) of the twenty (20) appeals cases reviewed by the examiner, CareCore, acting on behalf of HIPNY, was found to be in violation of the requirements of Section 4904(3) of the New York Public Health Law when it failed to provide an acknowledgement letter to the appealing party.

It is recommended that CareCore, acting on behalf of HIPNY, comply with the requirements of Section 4904(3) of the New York Public Health Law by issuing written acknowledgment of the filing of an appeal to the appealing party.

iv. Montefiore Care Management

From a log of 70 UR appeals closed by Montefiore Care Management (“CMO”), acting on behalf of HIPNY during calendar year 2011, ten (10) UR cases were randomly selected and reviewed by the examiner.

For one (1) of the ten (10) cases, CMO was found to be in violation of the requirements of Section 4904(3) of the New York Public Health Law, when it failed to timely issue written notification of the determination to the enrollee, the enrollee’s designee, and the enrollee’s health care provider within the required timeframe.

In addition, for one (1) of the ten (10) cases, CMO was found to be in violation of the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152, when it retained the wrong determination date in its system.

It is recommended that CMO, acting on behalf of HIPNY, comply with the requirements of Section 4904(3) of the New York Public Health Law by issuing timely written notice to the enrollee, the enrollee’s designee, and the enrollee’s health care provider within two business days of rendering of its determination.

It is further recommended that CMO, acting on behalf of HIPNY, comply with the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152 by retaining accurate records of its UR appeals.

C. Schedule M

The Department requires that all insurers report their UR appeals information either in Table 2 of Schedule M of the New York Data Requirements for New York Insurance Law (“NYIL”) Article 43 entities such as HIPNY, or in Part Two of the Exhibit of Grievances and Utilization Review Appeals of the New York Data Requirements for NYIL Article 42 entities such as HIPIC.

It was noted that during the examination period the information HIP reported on their Schedule M or Exhibit of Grievances and Utilization Review Appeals did not include the UR appeals handled by HIP’s delegated entities.

It is recommended that HIP include UR appeals handled by their delegated entities in Table 2 of Schedule M of the New York Data Requirements for HIPNY and Part Two of the Exhibit of Grievances and Utilization Review Appeals of the New York Data Requirements for HIPIC respectively.

7. ADVERTISING

Section 4323(c) of the New York Insurance Law states:

“All health maintenance organization marketing materials must be sufficiently clear to avoid deception or the capacity or tendency to mislead or deceive and may not disparage competitors.”

Part 215.6(a)(1) of Insurance Regulation No. 34 (11 NYCRR 215.6) states:

“No advertisement shall omit information or use words, phrases, statements or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.”

Part 215.6(a)(2) of Insurance Regulation No. 34 (11 NYCRR 215.6) states:

“No advertisement shall contain or use words or phrases such as, “all”, “full”, “complete”, “comprehensive”, “unlimited”, “up to”, “as high as”, “this policy will help pay your hospital and surgical bills”, “this policy will help fill some of the gaps that Medicare and your present insurance leave out”, “this policy will help to replace your income” (when used to express loss of time benefits), or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.”

The examiner reviewed HIP’s advertising documentation for the period January 1, 2007 through December 31, 2011, to ascertain compliance with the requirements of Section 4323(c) of the New York Insurance Law and Insurance Regulation No. 34 (11 NYCRR 215), “*Rules Governing Advertisements of Accident and Health Insurance*”.

A. Telemarketing Scripts

The scripts for two (2) of HIP’s HMO/POS Direct Pay telemarketing programs and one (1) HIP’s universal small group telemarketing program were found to be in violation of the requirements of Section 4323(c) of the New York Insurance Law and Parts 215.6(a)(1) and (2) of Insurance Regulation No. 34 (11 NYCRR 215.6) because they described benefits to the customers as “comprehensive.” A similar finding was made in the prior examination report.

It is recommended that HIP comply with the requirements of Section 4323(c) of the New York Insurance Law and Parts 215.6(a)(1) and (2) of Insurance Regulation No. 34.

B. GHI HMO

On June 26, 2013, GHI HMO Select, Inc. (“GHI HMO”), a subsidiary of GHI, merged into HIPNY, with HIPNY being the surviving entity. It was noted that although GHI HMO no longer existed as a corporate entity, HIPNY continued to list GHI HMO as one of EmblemHealth’s companies on several of its webpages.

Part 215.3(a) of Insurance Regulation No. 34 (11 NYCRR 215.3) states in part:

“(a) An advertisement for the purpose of this Part shall include:
(1) printed and published material, audio-visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays...”

Part 215.5(a) of Insurance Regulation No. 34 (11 NYCRR 215.5) states:

“(a) The format and content of an advertisement of an accident and health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the superintendent from the overall impression that the advertisement may be reasonably expected to create upon a person of average education and intelligence, unique to the particular type of audience to which the advertisement is directed, and whether it may be reasonably comprehended by the segment of the public to which it is directed.”

HIPNY violated the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 (11 NYCRR 215.3 and 215.5) when it continued to list GHI HMO on its webpages after their merger.

It is recommended that HIPNY comply with the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 by discontinuing its advertisement of GHI HMO.

8. AGENTS AND BROKERS

The examiner reviewed HIP's processes related to the appointment and termination of their agents and brokers during the period January 1, 2007 through December 31, 2011. As of the examination date, HIP had a total of one thousand one hundred and twenty eight (1,128) active agents and brokers. HIP terminated three hundred and eighty-two (382) agents and brokers during the examination period, none of which were "for cause". A sample of forty-six (46) terminations was reviewed by the examiner.

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

"To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted."

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

"Every insurer ...doing business in this state shall, upon termination of the certificate of appointment ...of any insurance agent licensed in this state, or upon termination for cause ...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..."

HIP was found to be in violation of the requirements of Section 2112(d) of the New York Insurance Law, as follows:

- HIP failed to retain copies of the notices of termination for five (5) of the forty-six (46) terminations for the required time period.
- HIP failed to provide documentation of its filing of the notices of terminations with the Department for twenty-six (26) of the forty-six (46) terminations.
- HIP failed to file notices of termination with the Department within the required timeframe for four (4) of the forty-six (46) terminations.

- For one (1) of the forty-six (46) terminations, there a discrepancy of 393 days between HIP's termination date and the termination date on the Department's records.

For the same twenty-six (26) terminations noted in the second bullet point above, HIP was also found to be in violation of the requirements of Section 2112(b) of the New York Insurance Law for failing to provide the documentation of its filing of the appointments of these agents.

It should also be noted that HIP does not have a written policy or established procedures for appointing and/or terminating their external agents.

It is recommended that HIP comply with the requirements of Sections 2112(b) and (d) of the New York Insurance Law by filing the appointments and terminations of their agents with the Department within the required timeframes.

It is also recommended that HIP comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining copies of the termination notices for the required timeframe.

It is further recommended that, as a good business practice, HIP develop written policies and establish procedures for appointing and terminating their external agents.

Part 243.2(b)(8) of Insurance Regulation No. 152 (Part 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.”

HIPNY and HIPIC reported \$23.2 million and \$2.3 million, respectively, of commission expenses for calendar year 2011. A sample of fifteen (15) commission payments was reviewed.

HIP was found to be in violation of the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152, as follows:

- HIP failed to provide to the examiner, a copy of their agreements with the agent or broker for three (3) of the fifteen (15) sampled commission payments.
- HIP failed to provide the agreements related to the commission sharing for three (3) of the fifteen (15) sampled commission payments.

It is recommended that HIP comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining the agents' and brokers' agreements, as well as the commission sharing agreements, for the required time period.

9. GRIEVANCES AND APPEALS

HIP offers two levels of administrative appeals to its members for issues such as claim disputes, network coverage, contract benefits, etc. Samples were reviewed by the examiner to determine HIP's compliance with their policies and established procedures with regard to their handling of grievances.

For the first level administrative appeals, the examiner reviewed a sample of twenty-eight (28) cases selected from a log totaling six hundred and seventy six (676) first level cases closed by HIPNY in calendar year 2011, and a sample of twenty-six (26) cases selected from a log totaling one hundred and sixty-two (162) first level cases closed by HIPIC in calendar year 2011.

For two (2) of the twenty-eight (28) HIPNY first level administrative appeals, it was noted that the acknowledgment letters were issued timely but were incorrectly dated.

For the second level administrative appeals, the examiner reviewed a sample of fourteen (14) cases selected from a log totaling twenty-seven (27) second level cases closed by HIPNY in calendar year 2011, and thirteen (13) HIPIC cases, which constituted the entire listing of the second level administrative appeals closed by HIPIC in calendar year 2011.

For two (2) of the thirteen (13) HPIC second level administrative appeals, it was noted that the acknowledgement letters were issued timely but were incorrectly dated.

It is recommended that HIP's acknowledgement letters for administrative appeals contain the correct date.

10. UNDERWRITING AND RATING

HIPNY provided a listing of 1,899 renewed Healthy New York policies for calendar year 2011. A sample of twenty (20) renewals, ten (10) individual policies and ten (10) group policies, was reviewed by the examiner to verify HIPNY's compliance with Insurance Regulation No. 171 (11 NYCRR 362-2.5).

Parts 62-2.5(a) and (b) of Insurance Regulation No. 171 state:

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

(b) Health maintenance organizations and participating insurers shall annually collect certifications of continued eligibility for the Healthy New York Program and shall be responsible for examination of such certifications to verify that small employers and individuals participating in the program continue to meet eligibility requirements and continue to comply with the terms of the program. Health maintenance organizations and participating insurers shall determine whether the small employer and individual participants continue to meet the requirements for participation in the Healthy New York Program and shall provide written notice of such determination within two weeks of receipt of the annual recertification.”

For six (6) of the ten (10) Healthy NY group renewals, HIPNY failed to obtain the recertification documents from the employers, in violation of the requirements of Parts 362-2.5(a) and (b) of Insurance Regulation No. 171 (Part 11 NYCRR 362-2.5).

It is recommended that HIPNY comply with the requirements of Parts 362-2.5(a) and (b) of Insurance Regulation No. 171 by collecting the required recertification forms for all of its Healthy New York renewals.

It should be noted that a similar finding was made in the prior examination of HIPNY.

11. SUBSEQUENT EVENT

EmblemHealth subcontracts administration of its GHI and HIP members' behavioral health benefits to ValueOptions, Inc., a third-party behavioral health administrator. ValueOptions, Inc., on behalf of EmblemHealth performed utilization review for all inpatient, partial hospitalization and intensive outpatient behavioral health claims, and certain outpatient visits. On January 1, 2012, ValueOptions, Inc. began managing HIP's member behavioral health benefits.

In 2014, the Office of the NY Attorney General conducted a review into EmblemHealth's coverage of behavioral health and substance abuse disorder benefits administered by ValueOptions. The Attorney General found that EmblemHealth's behavioral health coverage was not "on par" with medical/surgical coverage and that EmblemHealth applied more rigorous and frequent utilization review for behavioral health benefits than for medical/surgical benefits.

In July of 2014, EmblemHealth reached a settlement with the Office of the Attorney General regarding EmblemHealth's administration of mental health and substance abuse benefits.

As part of the settlement, EmblemHealth had to offer independent utilization reviews, by a third-party, of mental health benefit claims, submitted during a certain period, which had been denied for lack of medical necessity or due to lack of coverage for residential treatment for behavioral health services and for which the member subsequently incurred out-of-pocket costs for such treatment. In addition, EmblemHealth had to pay a \$1.2 million penalty to the Office of the Attorney General.

12. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT

The prior market conduct report contained thirty-eight (38) comments and recommendations (page numbers refer to the prior market conduct report):

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| | <u>Claims Processing</u> | |
| 1. | It is recommended that HIP comply with the requirements of Section 3234(b)(4) of the New York Insurance Law by including the provider's charge on all EOBs. <i>HIP have complied with this recommendation.</i> | 7 |
| 2. | It is recommended that HIP include the above required notification on its EOBs, in compliance with the requirements of Section 3234(b)(7) of the New York Insurance Law regarding a failure to appeal may result in loss of certain rights. <i>HIP have complied with this recommendation.</i> | 7 |
| 3. | It is recommended that HIP create separate EOCs for denials where there was no prior approval for a procedure and for denials where no referral was received from a primary care physician ("PCP"). <i>HIP have complied with this recommendation.</i> | 9 |
| 4. | It is recommended that HIPIC pay all out-of-network claims in accordance with the member contract and generally accepted medical coding and billing standards. <i>HIP have complied with this recommendation.</i> | 10 |
| 5. | It is recommended that HIP retain all records for the period required by Section 243.2(b)(8) of Department Regulation No. 152. <i>HIP have complied with this recommendation with regard to record retention of their grievance and appeal files. However, a similar recommendation appears in this report relative to record retention of certain other HIP functions.</i> | 10 |

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| 6. | It is recommended that HIP take steps to correct system errors that resulted in incorrect co-pay amounts being charged to subscribers. <i>HIP have complied with this recommendation.</i> | 11 |
| 7. | It is recommended that HIP conduct their PEC investigations at the time of enrollment, so that ensuing claims may be processed appropriately and in a timely manner. <i>HIP have complied with this recommendation.</i> | 11 |
| 8. | It is recommended that HIPIC take steps to correct system errors that result in incorrect co-insurance or deductible amounts charged to insureds for outpatient facility claims. <i>HIPIC has complied with this recommendation.</i> | 12 |
| | <u>Prompt Pay Law</u> | |
| 9. | It is recommended that HIP 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. <i>HIP have not complied with this recommendation. A similar recommendation appears in this report.</i> | 19 |
| 10. | It is also recommended that HIP take steps to ensure that the provisions of §3224-a(b) of the New York Insurance Law, regarding the prompt adjudication of claims, are fully implemented and complied with. <i>HIP have not complied with this recommendation. A similar recommendation appears in this report.</i> | 19 |
| 11. | It is further recommended that HIP take steps to ensure that the provisions of §3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with. <i>HIP have not complied with this recommendation. A similar recommendation appears in this report.</i> | 19 |

ITEM NO.**PAGE NO.**Underwriting and Rating

12. It is recommended that HIPNY notify the Department of the updated addresses for its Healthy New York applications. 20
HIPNY has complied with this recommendation.
13. It is recommended that HIPNY collect all recertification forms for all of its Healthy New York renewals, in compliance with the requirements of Section 362-2.5(a), (b) and (c) of Department Regulation No. 171. 21
HIPNY has not complied with this recommendation. A similar recommendation appears in this report.
14. It is recommended that HIPNY comply with the provisions of Section 55.2(a) of Department Regulation No. 78 and send all reminder notices at least 30 days prior to the end of the grace period. 22
HIPNY has complied with this recommendation.
15. It is again recommended that HIPNY comply with the requirements of Section 243.2(b)(8) of Department Regulation No. 152 and maintain all required records for at least six years. 23
HIPNY has not complied with this recommendation. A similar recommendation appears in this report.

Utilization Review and Appeals

16. It is recommended that HIPNY comply with Section 4903(3) of the New York Public Health Law and provide the written notice of determination within the required timeframe. 24
HIPNY has not complied with this recommendation. A similar recommendation appears in this report.
17. It is recommended that HIPNY and CareCore comply with the requirements of Section 4903(2) of the New York Public Health Law and provide notices of determination within three business days by telephone and in writing to the enrollee/enrollee's designee and the provider in regard to prospective reviews. 25
HIPNY and CareCore have complied with this recommendation.

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| 18. | It is recommended that HIPNY and Healthcare Partners provide a determination notice by telephone and in writing to the enrollee or enrollee's designee and the enrollee's health care provider within three business days of receipt of the necessary information, in compliance with Section 4903(2) of the New York Public Health Law. <i>HIPNY and Healthcare Partners have complied with this recommendation.</i> | 26 |
| 19. | It is recommended that HIPNY and CMO provide all verbal and written notices to the enrollee or his/her provider in order to comply with Section 4903(2) of the New York Public Health Law. <i>HIPNY and CMO have complied with this recommendation.</i> | 27 |
| 20. | It is recommended that HIPNY and CMO comply with Section 4903(3) of the New York Public Health Law and provide all notices of determination within one business day. <i>HIPNY and CMO have complied with this recommendation.</i> | 27 |
| 21. | It is recommended that HIPNY and CMO provide all notices of adverse determination where required, in compliance with the requirements of Section 4903(5)(b) of the New York Public Health Law. <i>HIPNY and CMO have complied with this recommendation.</i> | 28 |
| 22. | It is recommended that HIPNY/CMO comply with the provisions of Section 243.2(b)(8) of Department Regulation No. 152 and maintain all required records for at least six calendar years. <i>HIPNY and CMO have complied with this recommendation.</i> | 28 |
| 23. | It is recommended that HIPNY/CMO comply with the requirements of Section 243.3 (a)(2) of Department Regulation No. 152, by documenting all non-paper communications, transactions or events. <i>HIPNY and CMO have complied with this recommendation.</i> | 29 |

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| 24. | It is recommended that HIPNY ensure that its delegated entities comply with the requirements of Department Regulation No. 152. <i>HIPNY has not complied with this recommendation. Similar recommendations appear in this report.</i> | 29 |
| 25. | It is recommended that HIPNY comply with the requirements of Section 4904(3)(b) of the New York Public Health Law, by providing external appeal rights on all determination notices. <i>HIPNY has complied with this recommendation.</i> | 30 |
| 26. | It is recommended that HIPNY comply with the requirements of Section 4904(4) of the New York Public Health Law and require that a utilization review appeal be reviewed by a clinical peer reviewer, other than the clinical peer reviewer who rendered the initial adverse determination. <i>HIPNY has complied with this recommendation.</i> | 31 |
| 27. | It is recommended that HIPNY revise the applicable letter template to ensure consistency in the timeframes. <i>HIPNY has complied with this recommendation.</i> | 32 |
| 28. | It is recommended that HIPNY put in place procedures to ensure that the clinical peer reviewer date his/her sign-off on the appeal review sheet. <i>HIPNY has complied with this recommendation.</i> | 32 |
| | <u>Advertising</u> | |
| 29. | It is recommended that all advertisements comply with Section 215.6(a)(2) of Department Regulation No. 34 and discontinue use of the phrase “comprehensive”. <i>HIP have not complied with this recommendation. A similar recommendation appears in this report.</i> | 33 |
| 30. | It is recommended that HIP’s advertisements include a “valid through date” marked on them, in order to ensure that the references are timely and unambiguous and in compliance with Section 215.6(a)(1) of Department Regulation No. 34. <i>HIP have complied with this recommendation.</i> | 34 |

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| 31. | It is recommended that, where restrictions apply, the advertisement include language stating that: “limitations, and exclusions may apply on some services” and “ask for a summary of benefits for details”, in order to comply with the requirements of Section 215.6(a)(1) of Department Regulation No. 34. <i>HIP have complied with this recommendation.</i> | 34 |
| 32. | It is recommended that advertisements specify the source of the statistics/ratings, as well as the date of the accreditation in order to comply with the requirements of Section 215.6(a)(1) of Department Regulation No. 34. <i>HIP have complied with this recommendation.</i> | 34 |
| 33. | It is also recommended that HIPNY discontinue the use of the “Excellent” NCQA rating in its direct mail and print magazine advertisements, unless it is supported by the source <i>HIPNY has complied with this recommendation.</i> | 35 |
| | <u>Producer Licensing</u> | |
| 34. | It is recommended that when applicable HIPNY file all termination notices with the Department, in compliance with the requirements of Section 2112(d) of the New York Insurance Law. <i>HIPNY has not complied with this recommendation. A similar recommendation appears in this report.</i> | 36 |
| 35. | It is also recommended that HIPNY keep records of its terminated agents and the termination notices, in accordance with the provisions of Section 243.2(b)(8) of Department Regulation No. 152, as quoted above. <i>HIPNY has not complied with this recommendation. A similar recommendation appears in this report.</i> | 36 |
| | <u>Grievance and Appeals</u> | |
| 36. | It is recommended that HIPIC send out all required acknowledgement letters in response to a grievance filing within fifteen days as required by its grievance procedures. <i>HIPIC has complied with this recommendation.</i> | 36 |

ITEM NO.**PAGE NO.****Special Investigations Unit**

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|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 37. | It is recommended that HIPNY's fraud plan be updated on a more timely basis to reflect actual staffing. <i>HIPNY has complied with this recommendation.</i> | 37 |
| 38. | It is recommended that policies and procedures be updated to define the accounting of savings from SIU activities. <i>HIPGNY has complied with this recommendation.</i> | 37 |

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

| <u>ITEM</u> | <u>PAGE NO.</u> |
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| A. <u>Claims Processing</u> | |
| i. It is recommended that HIP suppress the generation of EOBs on their Medicaid Reclamation claims to avoid possible confusion to the recipients | 8 |
| ii. It is recommended that HIP modify their description of denial code DG2 to comply with the requirements of Section 3234(b)(6) of the New York Insurance Law. | 8 |
| iii. It is further recommended that HIP take actions to ensure the accuracy of the information reported on their EOBs. | 8 |
| B. <u>Prompt Pay Law</u> | |
| i. It is recommended that HIP take the necessary steps to ensure that it fully implement and comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims. | 14 |
| ii. It is also recommended that HIP take the necessary steps to ensure that it fully implement and comply with the provisions of Section 3224-a(b) of the New York Insurance Law regarding the payment of interest for claims not adjudicated within the timeframes mandated by Section 3224-a(a) of the New York Insurance Law. | 15 |
| iii. It is further recommended that HIP take the necessary steps to ensure that it fully implement and comply with the provisions of Section 3224-a(c) of the New York Insurance Law regarding the payment of interest. | 15 |
| C. <u>Utilization Review and Appeals</u> | |
| i. It is recommended that HIPNY comply with the requirements of Sections 4903(2) and (3) of the New York Public Health Law. | 17 |
| ii. It is recommended that HIPNY comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by retaining all relevant UR documents for the required retention period. | 17 |

ITEM**PAGE NO.**Utilization Review and Appeals (cont'd)

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|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| iii. | It is recommended that HIPIC comply with the requirements of Section 4903(b) of the New York Insurance Law by ensuring that both verbal and written notices of the determination are provided to the insured, or the insured's designee and the insured's health care provider within three business days of receipt of the necessary information. | 19 |
| iv. | It is also recommended that HIPIC comply with the requirements of Section 4903(c) of the New York Insurance Law by ensuring written notices of the determination are provided to the insured, or the insured's designee and the insured's health care provider within one business day of receipt of the necessary information. | 19 |
| v. | It is further recommended that HIPIC comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by maintaining all relevant UR documents for the required retention period. | 19 |
| vi. | It is recommended that HIPIC comply with the requirements of Sections 4903(b) and (c) of the New York Insurance Law. | 20 |
| vii. | It is further recommended that HIPNY comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by maintaining all relevant UR documents for the required retention period. | 20 |
| viii. | It is recommended that HIPNY and HCP comply with the requirements of Section 4903(3) of the NYPHL by maintaining written notification of its determination to the enrollee's health care provider within one (1) business day of receipt of all of the necessary information. | 21 |
| ix. | It is recommended that HCP, acting on behalf of HIPNY, comply with the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152 by retaining the relevant information or data to accurately represent a record of communications between a person or entity and the insurer. | 22 |
| x. | It is recommended that HIPNY comply with the requirements of Section 4904(3) of the New York Public Health Law by making written notification of its determination to the appealing party within two business days of rendering its determination. | 22 |

ITEM**PAGE NO.**Utilization Review and Appeals (cont'd)

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| xi. | It is recommended that HIPIC comply with the requirements of the Section 4904(c) of the New York Insurance Law by making a determination with regard to the appeal within sixty days of the receipt of necessary information. | 24 |
| xii. | It is further recommended that HIPIC comply with the requirements of Section 4904(e) of New York Insurance Law and Bulletin No. 12 of its Utilization Management/Mental Health policy, No. EP.MM.CM.01, by reversing the adverse determinations of delayed appeals. | 24 |
| xiii. | It is recommended that CareCore, acting on behalf of HIPNY, comply with the requirements of Section 4904(3) of the New York Public Health Law by issuing written acknowledgment of the filing of an appeal to the appealing party. | 25 |
| xiv. | It is recommended that CMO, acting on behalf of HIPNY, comply with the requirements of Section 4904(3) of the New York Public Health Law by issuing timely written notice to the enrollee, the enrollee's designee, and the enrollee's health care provider within two business days of rendering of its determination. | 25 |
| xv. | It is further recommended that CMO, acting on behalf of HIPNY, comply with the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152 by retaining accurate records of its UR appeals. | 26 |
| xvi. | It is recommended that HIP include UR appeals handled by their delegated entities in Table 2 of Schedule M of the New York Data Requirements for HIPNY and Part Two of the Exhibit of Grievances and Utilization Review Appeals of the New York Data Requirements for HIPIC respectively. | 26 |

D. Advertising

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|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| i. | It is recommended that HIP comply with the requirements of Section 4323(c) of the New York Insurance Law and Parts 215.6(a)(1) and (2) of Insurance Regulation No. 34. | 28 |
| ii. | It is recommended that HIPNY comply with the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 by discontinuing its advertisement of GHI HMO. | 29 |

ITEM**PAGE NO.**

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| E. | <u>Agents and Brokers</u> | |
| | i. It is recommended that HIP comply with the requirements of Sections 2112(b) and (d) of the New York Insurance Law by filing their appointments and terminations of their agents with the Department within the required timeframes. | 30 |
| | ii. It is also recommended that HIP comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining copies of the termination notices for the required timeframe. | 30 |
| | iii. It is further recommended that, as a good business practice, HIP develop written policies and establish procedures for appointing and terminating their external agents. | 30 |
| | iv. It is also recommended that HIP comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining the agents' and brokers' agreements as well as the commission sharing agreements for the required time period. | 31 |
| F. | <u>Grievances and Appeals</u> | |
| | It is recommended that HIP's acknowledgement letters for administrative appeals contain the correct date. | 32 |
| G. | <u>Underwriting and Rating</u> | |
| | It is recommended that HIPNY comply with the requirements of Parts 362-2.5(a) and (b) of Insurance Regulation No. 171 by collecting the required recertification forms for all of its Healthy New York renewals. | 33 |

Respectfully submitted,


Jo Lo Hsia
Principal Insurance Examiner

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

Jo Lo Hsia, being duly sworn, deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.


Jo Lo Hsia

Subscribed and sworn to before me
this 4th day of FEBRUARY, 2016.



Charles T. Lovejoy
Notary Public, State of New York
No. 01LO4798952
Qualified in New York County
Commission Expires 1-26-18

NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

JoLo Hsia

as a proper person to examine the affairs of the

HIP Insurance Company of New York

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

Company

with such other information as she shall deem requisite.

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

this 31st day of July, 2012

*BENJAMIN M. LAWSKY
Superintendent of Financial Services*

By:

Stephen J. Wiest

*Stephen J. Wiest
Deputy Bureau Chief
Health Bureau*



NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

JoLo Hsia

as a proper person to examine the affairs of the

Health Insurance Plan of Greater New York

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

Plan

with such other information as she shall deem requisite.

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

this 31st day of July, 2012

*BENJAMIN M. LAWSKY
Superintendent of Financial Services*

By:

Stephen J. Wiest

*Stephen J. Wiest
Deputy Bureau Chief
Health Bureau*

