

MARKET CONDUCT REPORT ON EXAMINATION

OF

EMPIRE HEALTHCHOICE ASSURANCE, INC.

AND

EMPIRE HEALTHCHOICE HMO, INC.

AS OF

DECEMBER 31, 2014

DATE OF REPORT

JUNE 8, 2018

EXAMINER

VICTOR ESTRADA

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

June 8, 2018

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Numbers 31232 and 31234, dated October 9, 2014, attached hereto, I have made an examination into the affairs of Empire HealthChoice Assurance, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law and its wholly-owned subsidiary, Empire HealthChoice HMO, Inc., a for-profit health maintenance organization licensed under Article 44 of the New York Public Health Law, respectively, as of December 31, 2014, and submit the following report thereon.

The examination was conducted at the home office of Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc., located at One Liberty Plaza, New York, NY.

Wherever the designations “EHCA” or the “Company” appear herein, without qualification, they should be understood to indicate Empire HealthChoice Assurance, Inc.

Wherever the designations “EHC-HMO” or the “Plan” appear herein, without qualification, they should be understood to indicate Empire HealthChoice HMO, Inc.

Wherever the designations “Empire” or the “Companies” appear herein, without qualification, they should be understood to indicate EHCA and EHC-HMO, collectively.

Wherever the designation “WHC” appears herein, without qualification, it should be understood to indicate WellPoint Holding Corporation, the Parent of EHCA.

Wherever the designation “WellPoint” appears herein, without qualification, it should be understood to indicate WellPoint, Inc., the ultimate Parent of WHC. On December 2, 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc.

Wherever the designations the “Department” or the “DFS” appears herein, without qualification, they should be understood to indicate the New York State Department of Financial Services.

Concurrent examinations regarding the financial condition of EHCA and EHC- HMO were made as of December 31, 2013. Separate reports thereon have been submitted.

1. SCOPE OF THE EXAMINATION

The previous market conduct examination was conducted as of December 31, 2011. This examination covers the three-year period January 1, 2012 to December 31, 2014, and was performed to review the manner in which Empire 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 Companies with regard to comments and recommendations made in the prior market conduct report on examination.

2. DESCRIPTION OF THE COMPANIES

EHCA is a New York domiciled accident and health insurance company licensed under Article 42 of the New York Insurance Law (“NYIL”). EHCA is a wholly-owned subsidiary of WellPoint Holding Corporation (“WHC”), a wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. Effective November 7, 2002, Empire Blue Cross Blue Shield (“Empire BCBS”) converted from a NYIL Article 43 non-profit health service corporation to a NYIL Article 42 for-profit accident and health insurer. Simultaneously with the conversion, Empire BCBS merged with its then NYIL Article 42 subsidiary, Empire HealthChoice Assurance, Inc., with Empire BCBS being the surviving

corporation and taking the name of the subsidiary. EHCA wholly owns Empire HealthChoice HMO, Inc., a for-profit New York domiciled health maintenance organization (“HMO”) licensed under Article 44 of the New York State Public Health Law.

As a result of the conversion, a new entity, WellChoice Holdings of New York, Inc. was established. This new entity was owned by WellChoice, Inc. (“WellChoice”), a Delaware corporation and the ultimate parent of EHCA and EHC-HMO.

On September 27, 2005, representatives of WellPoint, Inc. (“WellPoint”), a publicly traded managed care for-profit company and WellChoice announced their intention to enter into a definitive merger agreement. Under the terms of the agreement, WellPoint agreed to acquire all of the outstanding shares of WellChoice. On December 28, 2005, WellPoint completed its acquisition of WellChoice when WellChoice merged with and into WellPoint Holding Corp., a direct and wholly-owned subsidiary of WellPoint, with WellPoint Holding Corp. as the surviving entity of the merger. After completion of the merger, the ultimate parent of EHCA was WellPoint. Effective December 2, 2014, WellPoint changed its corporate name to Anthem, Inc.

The Company continues to do business as Empire Blue Cross and Blue Shield in the State of New York and remains the Parent of Empire HealthChoice HMO, Inc.

Unless otherwise noted, the findings contained herein relate to both EHCA’s operations as a New York Insurance Law Article 42 insurer and EHC-HMO’s operations as a New York State Public Health Law Article 44 health maintenance organization.

3. CLAIMS PROCESSING

Section 4902(a) of the New York Insurance Law states the following in part:

“Each utilization review agent shall adhere to utilization review program standards consistent with the provisions of this title which shall, at a minimum, include...

(8) Establishment of a requirement that emergency services rendered to an insured shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.”

Section 4903 of the New York Insurance Law states in part:

“(a) Utilization review shall be conducted by:

(1) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;

(2) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and

(3) A clinical peer reviewer where the review involves an adverse determination...

(b) (1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured’s designee and the insured’s health care provider by telephone and in writing within three business days of receipt of the necessary information...

(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.

(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

(1) the reasons for the determination including the clinical rationale, if any;

(2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article;”

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

“(c) ...The utilization review agent shall notify the insured, the insured’s designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination...

(e) 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."

There are requirements within Article 44 of the New York State Public Health Law ("PHL") which apply similar Utilization Review standards to EHC-HMO as are required for EHCA. For ease of reading, this report will only reference the New York Insurance Law.

Section 3234 of the New York Insurance Law states in part:

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

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

(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."

Insurance Regulation No. 166 (11 NYCRR 410.9) states in part:

"(e) Each notice of a final adverse determination of an expedited or standard utilization review appeal under Section 4904 of the Insurance Law shall be in writing, dated and include the following...

(7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service...

(9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal."

The examiner reviewed three separate samples of denied claims for each of the two Empire companies. These samples consisted of the following:

- a. Hospital claims
- b. Emergency Room claims; and
- c. Claims deemed not medically necessary.

The samples were selected at random from sub-populations that were extracted from the listing of claims adjudicated by the Companies during 2014. These extracted claims were based on denial codes which appeared to warrant further review, to determine factually, what the companies were engaged in as a business practice, or whether these were systemic or random errors. In each case, only the hospital claim files were utilized and due to delays and miscommunications in obtaining the files from Empire, which included multiple ineligible claims, the examiner was not able to determine or extract all the potential populations for each category of claims. These delays are further detailed in Section 12 of this report. The limited populations from which the samples were selected consisted of the following:

<u>Company</u>	<u>Claim Type</u>	<u>Population</u>
EHCA	Hospital	437
	Emergency Room	2,953
	Not Medically Necessary	18,360
EHC-HMO	Hospital	53
	Emergency Room	980
	Not Medically Necessary	930

Of the 61 claims reviewed for EHCA, the Company acknowledged there were 17 claims where the claims were adjudicated incorrectly, while the examiner noted a higher total, with several of the claims containing multiple violations. These incorrect adjudications and the examiner's own testing, which are detailed below, revealed the following consolidated statutory violations within the samples tested:

<u>Statutory citation</u>	<u>Violation</u>	<u>Number of claims</u>
NYIL 4902(a)(8)	Emergency Room treatment denied as not pre-authorized	4
NYIL 4902(a)(8)	Emergency Room portion of the claim denied without consideration	11
NYIL 4903(b)	Failure to perform utilization review	1
NYIL 4903(d)	Late retroactive decision	3
NYIL 4903(e)	Failure to send an adverse determination letter	11
NYIL 3234(b)(5)	EOB contained an incorrect member liability	1
NYIL 3234(b)(6)	Unclear explanation on the EOB	3

The specific language for these laws is detailed above, though where discussion of the violations is warranted, the citations may also be found in the pertinent section of this report.

For EHC-HMO, the examiner reviewed 43 claims and the Plan acknowledged adjudication errors on four while the examiner noted a higher total, with several of the claims containing multiple violations. These incorrect adjudications and the examiner's testing, some of which are detailed below, revealed the following consolidated statutory violations:

<u>Statutory citation</u>	<u>Violation</u>	<u>Number of claims</u>
PHL 4902(1)(h)	Emergency Room treatment denied as not pre-authorized	1
PHL 4903(1)(h)	Emergency Room portion of the claim denied without consideration	7
PHL 4903(4)	Late retroactive decision	3
PHL 4903(5)	Failure to send an adverse determination letter	1
PHL 4904(3)	Failure to send an appeal determination letter	2
NYIL 3234(b)(5)	EOB contained an incorrect member liability	3
NYIL 3234(b)(6)	Unclear explanation on the EOB	15
NYIL 3234(b)(7)	EOB did not contain appeal rights	17

Insurance Regulation No.166 (11 NYCRR 410.9)	Incomplete Final Adverse Determination letter	1
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The specific language for these laws is detailed above, though where discussion of the violations is warranted, the citations may also be found in the pertinent section of this report.

As a result of this testing, the examiner noted the need for additional quality controls to be implemented and enforced within the Utilization Management Department. Additionally, the examiner noted the following:

According to the 2014 Empire BlueCross BlueShield Utilization Management Program Description:

“Empire staff evaluates the consistency of decision making by peer clinical reviewers and health professionals at least annually. Managers share evaluation results with UM associates. Empire analyzes results and provides educational interventions as needed. In addition, managers conduct annual performance evaluations to measure associates’ performance against established goals.”

While the Companies were able to provide evidence of performance reviews for the Utilization Management Department as a whole, they were not able to provide any evidence that annual evaluations or educational interventions were performed for the individual staff that handles claim management.

It is recommended that Empire institute additional quality control measures within its Utilization Review Department in order to eliminate errors and statutory violations.

Additionally, the following was noted:

A. Emergency Room claims

A review of a sample of Emergency Room (“ER”) claims that were denied for a lack of medical necessity found one claim in EHC-HMO’s ER sample and four claims in various

EHCA claim samples that were denied due to a lack of pre-authorization. There was also one claim within the EHCA sample that was denied due to emergent care not being a listed benefit. Both groups are violations of Section 4902(a)(8) of the New York Insurance Law. It is noted that Empire has indicated these denials were inadvertent.

It is recommended that EHCA comply with Section 4902(a)(8) of the New York Insurance Law by establishing procedures to ensure that emergency service claims for covered persons are only denied when it is determined that such services are not medically necessary.

The examiner's review also found four claims for EHCA and one claim for EHC-HMO where the hospital admitted the patient directly to the hospital from the Emergency Room for additional care. These claims were eventually denied in their entirety as being not medically necessary. When asked why the Emergency Room portion of the claims had been denied along with the hospital portion of the claims, Empire noted that consistent with the Explanation of Benefits issued on the claim, it was necessary for the hospital to resubmit the ER portion of the claim separately. This procedure was implemented as part of a Plan of Corrections made in response to an operational survey review of EHC-HMO conducted by the Department of Health in 2007. However, testing by the examiner showed that the procedure was not applied consistently to all Empire lines of business in that a sample of claims revealed that the agreed upon language was not consistently included on the EOBs.

As described earlier in this section of the report, Section 4902(a)(8) of the New York Insurance Law requires emergency services not be denied on retrospective review, so long as such services are medically necessary. Additionally, Section 3224-a(a) of the New York Insurance Law, detailed in Section 4 of this report, requires that insurers and HMOs pay whatever portion of a claim that can be paid when the claim is submitted.

Although it is recognized that Empire established new procedures for processing these claims, further review revealed inconsistencies in the implementation of the procedure. As a result, it is recommended that Empire comply with Section 4902(a)(8) of the New York Insurance Law by prospectively revising its claims process to consider the Emergency Room portion of a claim separately from the hospital portion of a claim when the two are submitted jointly.

Fourteen of the claims reviewed from EHC-HMO's Emergency Room claim sample were denied because of problems implementing a new claim adjudication system. The EOBs for these denied claims included the following explanation: "*The provider is not eligible for payment.*" This "explanation" is insufficient under Section 3234(b)(6) of the New York Insurance Law, as such explanation is inaccurate. It is noted that when the error with the new claim adjudication system was discovered, all claim payments were discontinued until such time as the error was fixed and the improperly denied claims were then re-adjudicated with appropriate interest.

A recommendation for exceptions related to Empire's failure to explain the cause for a claim denial may be found in Item 4 of this section of the report.

Generally, the review of the claims also revealed the following:

B. Utilization Review

Many of the post-treatment Adverse Determination letters that were reviewed contained an introduction to the letter stating, "*We have reviewed your request for the below services...*" Because these letters respond to a claim for treatment that already occurred, the use of the word "request" in this case may be misleading and confusing to the reader.

It is recommended, as a best practice, that Empire utilize an introduction to its post-service Adverse Determination letters that accurately reflects the fact that the treatment already occurred.

C. Explanation of Benefits Statements

The Explanation of Benefits Statements (“EOBs”) issued by Empire to its members do not indicate the actual amount paid to the provider. Instead, the EOBs indicate that the billed amount is what was paid, instead of the contracted rate Empire has agreed to with the providers. This omission is a violation of Section 3234(b)(5) of the New York Insurance Law, cited above.

It is noted that this practice was reviewed as part of Empire’s 2006 Market Conduct Examination by the Department. Empire accepted the 2006 finding and presented a corrective action plan to the DFS with several proposed solutions to resolve the issue, but no plan was ever implemented.

It is further noted that Empire has instituted a new IT system (WGS) that accurately populates the EOB’s allowed amount.

It is recommended that Empire comply with of Section 3234(b)(5) of the New York Insurance Law, and accurately report the amount payable under its policies or certificates after deductibles, co-payments, and any other reduction of the amount claimed on its Explanation of Benefits Statements.

Subsequent to the examination, Empire instituted a new processing system, WGS, that is programmed to report the amount payable accurately.

4. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES (“PROMPT PAY LAW”)

Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services,” requires all insurers to pay undisputed claims within either 30 days or 45 days of receipt, depending upon whether the claim was submitted electronically or on paper, respectively. Where a claim has been disputed, insurers are required to notify the sender of the dispute in order to seek clarification within thirty days of receipt of the claim.

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

“(a) Except in a case where the obligation of an insurer... licensed or certified pursuant to article forty-three or forty-seven 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 (“covered person”) 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... shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.”

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

“(b) In a case where the obligation of an insurer... licensed or certified pursuant to article forty-three or forty-seven 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... 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... 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:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment...”

To test Empire’s claims for compliance with the aforementioned laws, claim lines during the calendar year were “rolled up” so that each claim submitted was only represented a single time. Claims that then appeared to be violations of Subsections 3224-a (a) and (b) were extracted into separate populations for testing. From there, statistical samples were selected and those samples were tested to determine whether the delays were appropriate.

The sample size for each of the two populations described herein was comprised of randomly selected unique claims for each line of business. The results of the review with respect to the claim data provided are as follows:

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

	EHC-HMO	EHCA
Lines of business tested	2	5
Sample items tested	110	239
Number of claims with determined violations	55	22
Calculated error rate for the population	50%*	9.21%*
Population of potential violations	27,003	220,923
Total population of claims less 181,770 WGS claims	966,632	6,067,132
Extrapolated result	13,761*	37,925*
Extrapolated percentage of violations	1.42%*	.63%*

For EHC-HMO, these totals don’t include claims from the WGS claim system as this system was the subject of earlier testing, not part of this examination.

* The calculated error rates and extrapolated results cannot be directly calculated from the sample size and violation rate as they both represent weighted averages derived from different claim populations within the systems tested.

The Department notes that while the violation rate for EHC-HMO was high, the cause for the high rate was largely due to systematic issues within a new claim system that were

limited to a single quarter of the calendar year. When it became apparent that claims adjudicated on the new system were not being adjudicated correctly, Empire froze all claims on that system until the issues were resolved. Good business practice dictates that systems not be implemented until they have been fully and successfully tested.

It is recommended that Empire test all systems thoroughly to ensure they are working properly before they are loaded into production.

During this review, the examiner found several claims that had been paid late because new provider rates had been established but those new rates were not installed into the adjudication system on a timely basis. In analyzing this situation, the examiner reviewed Empire's Policy, "Rate Confirmation – Institutional/Professional," which states in part:

"Contract Manager (CM), CM Peer Reviewer, Provider Network Manager and Director: Responsible for completing the rate sheet creation process 30 calendar days prior to the rate sheet effective date."

While the policy does not specify how long the Companies have to install newly contracted rates into the adjudication system once the new rates have been approved, the intent of the policy is to ensure the new rates are in force in time for the effective date. Thus, it would seem that, where the new rates are not finalized prior to the implementation date, Empire's policy would be to ensure that the upgraded rates are paid for all claims received after the implementation date.

It is recommended that Empire comply with its own policy and ensure that the rate sheet creation process is completed at least 30 calendar days prior to the rate sheet effective date.

Additionally, during the review of pharmacy claims, several claims were found to have been paid late by Empire's Pharmacy Benefit Manager, Express Scripts, Inc. ("ESI"). These claims were payable to the independent mail order pharmacy, Accredo, which is owned by ESI. Empire expressed the opinion that, because the claims were paid late by ESI to ESI's own mail order pharmacy, the claims should not be counted as late under New York's Prompt Pay law. However, the law does not permit such an exception and so, the claims were deemed to be late under the sample testing detailed above.

It is recommended that Empire comply with Section 3224-a of the New York Insurance Law and pay claims timely, regardless of source.

A separate sample testing compliance with Section 3224-a(c) of the New York Insurance Law (interest due on late claim payments) was not selected. Instead, for the Plan only, the number of subsection (c) violations was determined using the Section 3224-a subsections (a) and (b) samples previously tested (as described earlier in this section of the report). The Plan's results are displayed in the chart below.

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

	Potential Violations	Preliminary Sample Size	# of Violations Prelim sample	Violation Rate	Overall Calculated Violations
Hospital	1,994	55	14	25%	508
Medical	22,975	55	4	7%	1,671
Total					2,179

* The overall calculated violations cannot be directly calculated from the potential violations and violations rates as they represent weighted averages derived from different claim populations within the systems tested.

It is recommended that the Plan comply with Section 3224-a(c) of the New York Insurance Law by implementing controls to ensure that claims paid late under the Prompt Pay Law are paid interest when such interest is due.

5. PREVENTIVE CARE

The United States Preventive Care Task Force (“USPCTF”) issues recommendations on medical treatments that are required to be offered to members by insurers with no cost sharing on the part of the member. The examiner submitted to Empire a population of Current Procedural Terminology (“CPT”) codes that are covered by these recommendations during calendar year 2015 and upon review, Empire noted that the codes for three such treatments were not properly programmed within the Companies’ systems. Two of the codes represent physical therapy to prevent falls in older adults. Empire indicated that these codes are also used generically for all physical therapy claims and as a result, there was no method to program the code into the adjudication system but that, while Empire researches such a methodology, they would routinely audit the claims system for such claims and reverse and

correct the claims as they occur. During testing, no actual claims were located that fit the parameters described above.

In order to test compliance with the programming of the adjudication system, the examiner selected a sample of claims that applied member cost sharing to Preventive Care treatments. Of the sixteen claims that appeared to be eligible for consideration, thirteen applied cost sharing because the provider had not coded the claim forms properly; the “Modifier 33” was not applied to the claim form. The other three claims ultimately did not fit the parameter of the USPCTF requirements. When asked how Empire communicates the “Modifier” requirement to its provider network, Empire submitted two documents available to providers that describe the Modifier’s function. The high number of Preventive Care claims that lacked the Modifier 33 and were adjudicated to include cost sharing indicate that the Companies need to take a more proactive approach and communicate directly with providers that fail to code such claims correctly in order to ensure that the USPCTF claims are properly adjudicated.

It is recommended that Empire perform outreach to its provider networks to educate them on the proper coding for claims containing treatments recommended by the United States Preventive Care Task Force.

6. UTILIZATION REVIEW

Sections 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum Utilization Review (“UR”) 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 insurers, such as EHCA, licensed

under Article 42 of the New York Insurance Law. Comparable sections of Article 49 of the New York State Public Health Law contain the same requirements for HMOs licensed under Article 44 of the Public Health Law, and thus would be applicable to EHC-HMO. For ease of reading, the findings detailed herein refer to the New York Insurance Law. However, unless otherwise noted, the violations are applicable to the comparable statutory citations of Article 49 of the New York State Public Health Law (for EHC-HMO).

In addition to the review of EHCA and EHC-HMO utilization review and utilization review appeal practices, a review was conducted of third-party administrators or affiliates who conduct these services for Empire, including American Imaging Management, Inc. (“AIM”), OrthoNet, LLC, (“OrthoNet”) and Anthem Utilization Management Services, Inc. (“AUMSI”), an Empire affiliate that performs utilization review services for both medical and behavioral health services.

From a log of 8,411 utilization review cases closed by AUMSI in calendar year 2014, three samples of ten cases each, from prospective, concurrent and retrospective UR cases were randomly selected and reviewed by the examiner. In addition, a limited number of cases were selected for review from the logs pertaining to reviews conducted by AIM and OrthoNet. No exceptions were noted.

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

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

AUMSI failed to notify the insured or the insured's designee and the insured's health care provider by telephone in one out of ten (10%) prospective cases reviewed, in violation of Section 4903(b) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(b) of the New York Insurance Law.

A similar recommendation was cited in the prior report on examination.

The examiner obtained a listing of 566 appeal cases for both EHC-HMO and EHCA. A sample of fifteen cases (five expedited appeals and ten standard appeals) was selected for review.

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

“A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this title; (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination...”

In one of five (20%) expedited files reviewed, AUMSI failed to comply with a request from the member for an expedited review of the member's case and instead treated the case as a standard appeal, in violation of Section 4904(b) of the New York Insurance Law.

It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(b) of the New York Insurance Law.

Section 4904(c) of the New York Insurance 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. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured’s designee and, where appropriate, the insured’s health care provider, in writing of the appeal determination within two business days of the rendering of such determination...”

AUMSI violated Section 4904(c) of the New York Insurance Law by failing to notify the insured, the insured’s designee and, where appropriate, the insured’s health care provider, in writing of the appeal determination within two business days of the rendering of such determination in one out of ten (10%) utilization appeal cases reviewed.

It is recommended that EHCA and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law.

7. MANAGEMENT SERVICES AGREEMENT

Part 98-1.11(k) of the Administrative Rules and Regulations of the New York State Department of Health (“Health Department”) (10 NYCRR 98-1.11(k)), which applies to EHC-HMO, states in part:

“A proposed management contract must be submitted to the department for its prior approval at least 90 days prior to the management contract’s proposed effective date. Management contracts shall be effective only with the prior written consent of the commissioner...”

During the examination period, Radiant Services, LLC, a registered UR Agent, provided post-service utilization management services on behalf of Empire HealthChoice

HMO, Inc. While EHC-HMO did obtain the required approval from the Department, the agreement was never officially executed.

It is recommended that EHC-HMO execute all management agreements prior to implementation.

8. GRIEVANCES AND APPEALS

Section 4408-a of the New York State Public Health Law sets forth the minimum requirements for grievance and appeal procedures for HMOs licensed under Article 44 of the Public Health Law, or EHC-HMO.

For non-managed care products sold by EHCA, the examiners selected a sample of twenty (20) grievances cases for review (9 cases for EHCA & 11 cases for EHC), to determine if the Company was following its written grievance and appeal procedures, Department statutes and Insurance regulations, as applicable. Of the twenty cases selected for review, four (4) were ASO files. The remaining sixteen (16) cases were reviewed for compliance.

Section 4408-a(4) of the New York State Public Health Law states in part:

“Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance...”

EHC-HMO violated Section 4408-a(4) of the Public Health Law in one out of eleven (9%) Level 1 cases selected for review, when it failed to provide acknowledgement letters.

Additionally, for three of the eleven (27%) cases provided, EHC-HMO failed to resolve the grievance within 15 business days of receipt, as required by said statute.

For one of the nine (11%) cases provided, EHCA failed to resolve the grievance within 15 business days of receipt, as required by said statute.

It is recommended that EHC-HMO comply with the provisions of Section 4408-a(4) of the New York Public Health Law by acknowledging receipt of all grievances within 15 business days of receipt of the grievance.

It is also recommended that EHCA comply with its internal grievance procedures by acknowledging all grievances within 15 business days of receipt of the grievance.

Empire's grievance and appeal procedures for health plan members and providers in New York State, state in part:

“We will make a decision within the following time frames for 1st level grievances.

- *Pre-service (services have not yet been rendered). We will complete a pre-service review within fifteen (15) calendar days of receipt of the grievance.*
- *Post-service (services have already been rendered). We will complete our review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.”*

The time-frames were the same for level 2 grievances.

In one out of nine (11%) cases reviewed, EHCA failed to resolve the grievance within 30 days of receipt of all the necessary information, in contravention of EHCA's grievance procedures.

It is recommended that EHCA resolve all grievances within 30 days of receipt of all necessary information in compliance with its internal grievance procedures.

9. DISCLOSURE OF INFORMATION

Sections 3217-a of the New York Insurance Law, “Disclosure of Information”, and Section 4408 of the New York State Public Health Law relative to the HMO, which contain similar language, enumerate various rights and responsibilities that insurers/HMOs are required to communicate to all members.

Empire’s compliance with Sections 3217-a of the New York Insurance Law (EHCA) and Section 4408 of the New York State Public Health Law (EHC-HMO) was reviewed during the examination and it was noted that for each entity, the information being provided contained insufficient or incorrect information.

Section 3217-a(a)(17) of the New York Insurance Law states in part:

“(a) Each insurer subject to this article shall supply each insured, and upon written request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information, set forth below...

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer’s website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer’s network or a change in a physician’s hospital affiliation...”

Section 4408(1)(r) of the New York State Public Health Law states in part:

“(1) Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information which may be incorporated into the member handbook or the subscriber contract or certificate containing at least the information set forth below...

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance organization’s website and the health maintenance organization shall update the website within fifteen days of the addition or termination

of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation."

During the examination, the examiner randomly selected 25 providers from the Empire BCBS May 2015 HMO provider directory (hardcopy format) and the following was noted:

- 5 or 20% of the providers had incorrect contact information (phone, address) listed;
- 1 provider, although listed in the directory, was not accepting Empire BCBS;
- 1 provider was listed under the incorrect specialty;
- 2 providers were no longer accepting patients; and
- 2 providers listed were unreachable. (When the examiners attempted to call the provider's telephone number listed in the directory, they were placed on hold for 15 minutes or redirected to the Plan's website).

Additionally, the examiner randomly selected 25 providers from the Empire BCBS May 2015 Insurance Company provider directory (hard copy format), and the following was noted:

- 8 or 32% of the providers' contact (i.e., location information) information was incorrect;
- 8 or 32% listed an incorrect hospital affiliation, one of which was changed 5 years prior;
- 1 provider was listed with the incorrect specialty;
- 1 provider listed an incorrect service address; and
- 1 provider's listed telephone number was determined to be incorrect.

Although these exceptions are not violations of the New York Insurance Law and the Department understands that the Companies need to rely on providers to update their information, the directories contain vital information for members and so the Companies should strive for accuracy.

The Department recognizes that Empire has made significant efforts to increase the accuracy of its directories and recommends that the Companies institute regular and frequent audits of its directories to ensure such efforts are successful.

10. RECORD RETENTION

Parts 243.2 (a), (b)(1), (b)(4) and (b)(8) of Insurance Regulation No. 152 (11 NYCRR 243) state in part:

“(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 provision of this Part.

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

(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer...

A policy record shall include:

(i) the policy term, basis for rating and return premium amounts, if any;

(ii) the application, including any application form or enrollment form for coverage under any insurance contract or policy;

(iii) the contract or policy forms issued including the declaration pages, endorsements, riders and termination notices of the contract or policy. Binders shall be retained if a contract or policy was not issued; and

(iv) other information necessary for reconstructing the solicitation, rating and underwriting of the contract or policy...

(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received...

(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.”

During the examination, there were multiple occasions whereby Empire was unable to provide specific documentation to support their compliance with the New York Insurance Law, Insurance regulation and/or Empire policy. These include the following:

- During the reviewed sample grievance cases, it was noted that EHC-HMO failed to maintain documentation for one out of eleven sampled cases.
- During the review of underwriting and rating, Empire was unable to provide the examiners with a request for the filing of its New York City Hospital application and policy form. The said policy form was subsequently provided, to the satisfaction of the Department.
- During the review for compliance with Circular Letter No. 9 (1999) - Adoption of Procedure Manuals, for the year 2013, Empire was unable to provide the examiners with a signed certification from either the company's Director of Internal Audit or independent CPA that the responsible officers had implemented the procedures adopted by the board, and from the company's General Counsel, a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, were in accordance with applicable statutes, rules and regulations.

It is recommended that the Companies comply with Parts 243.2 (a) and (b) of Insurance Regulation No. 152 (11 NYCRR 243) and maintain all appropriate records for all areas of operations.

11. FACILITATION OF EXAMINATION

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

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

In order to conduct a thorough Market Conduct examination, one or more critical pieces of information that is required is the claims data. As a result, that data is requested early in the examination and the examiner is careful to describe specifically what is required in order to ensure understanding and minimize the chances that incorrect data is provided. Unfortunately, the claims data that was provided by the Companies initially included lines of

business that did not belong within the data, making analysis more difficult. Thereafter, it was discovered that the data was not complete in that it did not include certain fields that were needed to gain an understanding of how the claims were adjudicated.

Additionally, the Companies were very slow to respond to the examiner's requests, occasionally taking months for information to be provided.

It should be noted that such untimely response is a violation of Section 310(a)(3) of the New York Insurance Law.

It is recommended that the Companies comply with Section 310(a)(3) of the New York Insurance Law by ensuring that the information being provided to the examiner is accurate, complete and timely.

12. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior market conduct report on examination contained twenty-five (25) comments and recommendations detailed as follows (page numbers refer to the prior report on examination).

<u>ITEM NO.</u>		<u>PAGE NO.</u>
	<u>Claims Processing</u>	
1.	It is recommended that Empire establish procedures to avoid incorrect denials for lack of authorization when prior authorizations have been received to see providers. <i>The Companies have not complied with this recommendation. A similar recommendation is included in this report.</i>	8
2.	It is recommended that Empire remove the requirement from its HMO subscriber contract that specialist co-pays be applied to any provider including a general practitioner who is not identified by the subscriber as a primary care physician or back up primary care physician. <i>The Companies have complied with this recommendation.</i>	8
3.	It is also recommended that Empire clarify in its laboratory contracts that subscribers should not be balanced billed when referred by a provider to an out-of-network lab for outpatient services. <i>The Companies have complied with this recommendation.</i>	8
	It is further recommended that Empire ensure that subscribers are not balance billed when they use an out-of-network lab for outpatient services if they have been referred to such lab by the provider. <i>The Companies have complied with this recommendation</i>	9
5.	It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with. <i>The Companies have not complied with this recommendation. A similar recommendation is included in this report.</i>	15

ITEM NO.**PAGE NO.****Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Services (“Prompt Pay Law”)**

5. It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with. 15
- The Companies have not complied with this recommendation. A similar recommendation is included in this report.*
6. The Department also recommends that Empire take steps to ensure that the provisions of Section 3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with. 15
- The Companies have not complied with this recommendation. A similar recommendation is included in this report.*
7. It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(b) of the New York Insurance Law, regarding the prompt denial of claims/requests for information are fully implemented and complied with. 18
- The Companies have not complied with this recommendation. A similar recommendation is included in this report.*
8. It is recommended that Empire establish procedures to ensure that the proper date is used to identify claims for Prompt Pay Law compliance, including the calculation of interest owed on overdue claims. 20
- The Companies have not complied with this recommendation. A similar recommendation is included in this report.*

Underwriting

9. It is recommended that Empire comply with the requirements of Part 360.3 of Department Regulation No. 145 by removing the restriction on employer funding of cost sharing provisions from its small group underwriting guidelines. 21
- The Companies have complied with this recommendation.*

ITEM NO.**PAGE NO.****Reporting of Grievances and Utilization Review Appeal Data**

10. It is recommended that Empire report the correct data on its Exhibit of Grievances and Utilization appeals and Schedule M filings. 23

The Companies have complied with this recommendation.

Utilization Review

11. It is recommended that OrthoNet change the language on its adverse determination letters and make determinations within two business days of receiving the required information on expedited appeals to comply with the requirements of Section 4904(b) of the New York Insurance Law. 24

The Companies have complied with this recommendation.

12. The Department also recommends that Anthem Utilization Management Services, Inc. change the language on its adverse determination letters and make determinations within two business days of receiving the required information on expedited appeals to comply with the requirements of Section 4904(b) of the New York Insurance Law. 25

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

13. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(b) of the New York Insurance Law. 25

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

14. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(c) of the New York Insurance Law. 26

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

15. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(d) of the New York Insurance Law. 27

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

ITEM NO.**PAGE NO.****Utilization Review (Cont'd)**

16. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(b) of the New York Insurance Law. 27

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

17. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law. 28

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

18. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(c)(1) of the New York Insurance Law. 28

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

19. It is recommended that Empire provide OrthoNet with the date it receives all the required information for retrospective review cases and that OrthoNet uses that date as the initial date of receipt for the retrospective review to comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152. 29

The Companies have complied with this recommendation.

Grievances and Appeals

20. It is recommended that EHC-HMO comply with the requirements of Section 4408-a(4) of the Public Health Law and acknowledge receipt of all grievances within 15 business days of receipt of the grievance. 30

The Companies have not complied with this recommendation. A similar recommendation is included in this report

21. The Department also recommends that EHCA comply with its internal grievance requirements and acknowledge receipt of all grievances within 15 business days of receipt of the grievance. 31

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

22. It is recommended that EHC-HMO comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 and maintain documentation of all required grievance notices. 31

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

23. It is recommended that EHCA resolve all grievance cases within 45 days of receipt of all necessary information in compliance with its internal grievance procedures. 31

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

Department Complaints

24. It is recommended that Empire comply with the requirements of Section 2404 of the New York Insurance Law by responding to complaints within 15 business days. 32

The Companies have not complied with this recommendation. A similar recommendation is included in this report.

Special Investigations Unit

25. It is recommended that Empire report the correct number of fraud cases to the Department's Fraud Case Management System. 33

The Companies have complied with this recommendation.

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Claims Processing</u>	
i. It is recommended that Empire institute additional quality control measures within its Utilization Review Department in order to eliminate errors and statutory violations.	9
ii. It is recommended that EHCA comply with Section 4902(a)(8) of the New York Insurance Law by establishing procedures to ensure that emergency service claims for covered persons are only denied when it is determined that such services are not medically necessary.	10
iii. It is recommended that Empire comply with Section 4902(a)(8) of the New York Insurance Law by prospectively revising its claims process to consider the Emergency Room portion of a claim separately from the hospital portion of a claim when the two are submitted jointly.	11
iv. It is recommended, as a best practice, that Empire utilize an introduction to its post-service Adverse Determination letters that accurately reflects the fact that the treatment already occurred.	12
v. It is recommended that Empire comply with of Section 3234(b)(5) of the New York Insurance Law, and accurately report the amount payable under its policies or certificates after deductibles, co-payments, and any other reduction of the amount claimed on its Explanation of Benefits Statements.	12

<u>ITEM</u>	<u>PAGE NO.</u>
B. <u>Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Services (“Prompt Pay Law”)</u>	
i. It is recommended that Empire test all systems thoroughly to ensure they are working properly before they are loaded into production.	15
ii. It is recommended that Empire comply with its own policy and ensure that the rate sheet creation process is completed at least 30 calendar days prior to the rate sheet effective date.	15
iii. It is recommended that Empire comply with Section 3224-a of the New York Insurance Law and pay claims timely, regardless of source.	16
iv. It is recommended that the Plan comply with Section 3224-a(c) of the New York Insurance Law by implementing controls to ensure that claims paid late under the Prompt Pay Law are paid interest when such interest is due.	17
C. <u>Preventive Care</u>	
It is recommended that Empire perform outreach to its provider networks to educate them on the proper coding for claims containing treatments recommended by the United States Preventive Care Task Force.	18
D. <u>Utilization Review</u>	
i. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(b) of the New York Insurance Law. A similar recommendation was cited in the prior report on examination.	20
ii. It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(b) of the New York Insurance Law.	20
iii. It is recommended that EHCA and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law.	21
E. <u>Management Services Agreement</u>	
It is recommended that EHC-HMO execute all management agreements prior to implementation.	22

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Grievances and Appeals</u>	
i. It is recommended that EHC-HMO comply with the provisions of Section 4408-a(4) of the New York Public Health Law by acknowledging receipt of all grievances within 15 business days of receipt of the grievance.	23
ii. It is also recommended that EHCA comply with its internal grievance procedures by acknowledging all grievances within 15 business days of receipt of the grievance.	23
iii. It is recommended that EHCA resolve all grievances within 30 days of receipt of all necessary information in compliance with its internal grievance procedures.	23
G. <u>Disclosure of Information</u>	
The Department recognizes that Empire has made significant efforts to increase the accuracy of its directories and recommends that the Companies institute regular and frequent audits of its directories to ensure such efforts are successful.	26
H. <u>Record Retention</u>	
It is recommended that the Companies comply with Parts 243.2 (a) and (b) of Insurance Regulation No. 152 (11 NYCRR 243) and maintain all appropriate records for all areas of operations.	27
I. <u>Facilitation of Examination</u>	
It is recommended that the Companies comply with Section 310(a)(3) of the New York Insurance Law by ensuring that the information being provided to the examiner is accurate, complete and timely.	28

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:

Victor Estrada

as a proper person to examine the affairs of the

Empire HealthChoice Assurance, Inc.

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

Company

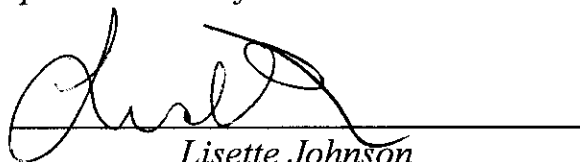
with such other information as he shall deem requisite.

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

this 9th day of October, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Lisette Johnson
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:

Victor Estrada

as a proper person to examine the affairs of the

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HMO

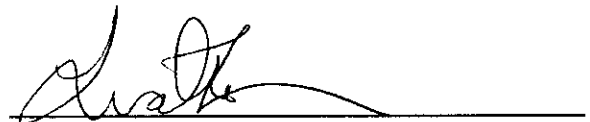
with such other information as he shall deem requisite.

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

this 9th day of October, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

