REPORT ON EXAMINATION

OF

HORIZON HEALTHCARE OF NEW YORK, INC.

AS OF

JUNE 30, 2002

DATE OF REPORT **MAY 16, 2003**

EXAMINER **ARCELIO VEGA**

STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

May 16, 2003

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Number 21868, dated May 15th, 2002, and annexed hereto, I have made an examination into the condition and affairs of Horizon Healthcare of New York, Inc. a for-profit health maintenance organization licensed under the provisions of Article 44 of the New York Public Health Law, at its home office located at 1180 Avenue of the Americas, New York, New York 10036. The following report as respectfully submitted, deals with the findings concerning the manner in which Horizon Healthcare of New York, Inc. conducts its financial business transactions and fulfills its contractual obligations to policyholders and claimants.

Wherever the terms "Plan" or "HMO" appear herein, without qualification, they should be understood to refer to Horizon Healthcare of New York, Inc.

Wherever the term "HHICNY" appears herein, without qualification, it should be understood to refer to Horizon Healthcare Insurance Company of New York, a fifty percent owned subsidiary of the Plan. The other fifty percent is owned by Horizon Healthcare Holding Company, LLC ("HHHC")

Wherever the term “BCBSNJ” appears herein, without qualification, it should be understood to refer to Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, the ultimate parent company of the Plan, HHHC and HHICNY.

1. SCOPE OF EXAMINATION

This is the first examination of the Plan. The examination covers the period January 1, 1999 to June 30, 2002. Where deemed appropriate, transactions subsequent to this period were also reviewed.

The examination comprised a complete verification of assets and liabilities as of June 30, 2002, in accordance with Statutory Accounting Principles, as adopted by the Department, and a review of income and disbursements deemed necessary to accomplish such verification. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Company
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of Plan
Business in force
Claims experience
Reinsurance
Accounts and records
Financial statements
Treatment of policyholders and claimants

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

This examination was conducted in conjunction with an examination of HHICNY. In several instances there were similar findings for both entities. Those findings are referenced herein, further detail appears in the HHICNY report.

2. EXECUTIVE SUMMARY

The examination revealed some operational deficiencies that directly impacted the Plan's compliance with the New York Insurance Law and the New York Public Health Law. The most significant findings of this examination include the following:

- During the examination period, the HMO's board of directors minutes and other documentation inadequacies gave the appearance that the board lacked proper control over the Plan's activities;
- Violations of Part 98-1.10(b) of the Administrative Rules and Regulations of the Health Department relative to transactions with its ultimate parent, Horizon Blue Cross Blue Shield of New Jersey ("BCBSNJ");
- The Plan failed to maintain a distinct operating identity as required by Parts 98-1.10(a) (1)-(a)(3) and 98-1.11(a) of the Administrative Rules and Regulations of the New York State Department of Health;
- Explanation of benefits statement do not include proper appeals language in violation of Section 3234(b) of the NYIL;

3. DESCRIPTION OF PLAN

Horizon Healthcare of New York, Inc. was originally incorporated under New York State Law on February 4, 1998, as a for profit corporation licensed pursuant to Article 44 of the New York Public Health Law using the name Medigroup of New York, Inc. On July 22, 1998, the Certificate of Incorporation was amended to change the name of the corporation from Medigroup

of New York, Inc. to Horizon Healthcare of New York, Inc. According to the Certificate of Incorporation, the number of shares of common stock authorized "shall be one thousand having a par value of one dollar ($1.00) each". Ten shares of common stock are issued and outstanding and owned by Horizon Healthcare Plan Holding Company, Inc. ("HHPHC"), (formerly known as Medigroup Holding Plan, Inc.) which purchased the ten shares for $10. HHPHC is a wholly owned subsidiary of Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey ("BCBSNJ").

The Plan began doing business on December 31, 1999.

A. **Management**

Pursuant to the HMO's charter and amended by-laws, management of the HMO is vested and exercised by its Board of Directors who shall number not less than three nor more than 25. Pursuant to Part 98-1.11(f) of the Department of Health Administrative Rules and Regulations {10 NYCRR 98-1} at least one director and no less than twenty percent (20%) of all the directors shall be enrollees of the HMO.

At June 30, 2002, the Board of Directors consisted of the following three members:

Name and Residence	Principal Business Affiliation
William J. Marino Morris Plain, NJ	President and Chief Executive Officer Horizon Blue Cross Blue Shield of New Jersey
Christy W. Bell Chester, NJ	Senior Vice-President Horizon Blue Cross Blue Shield of New Jersey
Michael R. McGarvey, MD New York, NY	Retired

Enrollee: Michael McGarvey, MD

During the period under examination, the Board of Directors met twenty times.

The minutes of the board do not reflect discussions of the Plan's losses from operations or surplus contributions, including the initial paid-in surplus.

It is recommended that the Company's Board of Directors' underwriting and surplus discussions be documented.

The Board of Directors' minutes do not reflect that intercompany agreements were approved by the Plan's Board.

It is recommended that all agreements within the holding company system be approved by the Board of Directors prior to implementation.

A similar finding and recommendation is explained in detail in the HHICNY Report dated May 5, 2004.

Section 1411(a) of the New York Insurance Law states:

> "(a) No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting."

A review of the minutes of the board of directors' meetings disclosed that the minutes were silent regarding investments. The Plan has delegated this responsibility to its ultimate parent BCBSNJ.

It is recommended that the Plan's investments be approved by the board of directors or a committee thereof, in compliance with Section 1411(a) of the New York Insurance Law.

It is also recommended that the HMO's board of directors create and implement Plan specific policies and procedures that will enable it to approve the sales and purchases of its investments.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

The principal officers of the Plan as of June 30, 2002 were as follows:

Name	Title
Thomas G. Boyajy	President and Chief Operating Officer
Robert A. Marino	Chief Executive Officer
Robert E. Meehan	Vice-President
Christine L. Nelson	Deputy Secretary
William J. Frantel	Treasurer

B. **Territory and Plan of Operation**

The Plan commenced business on December 31, 1999, and writes business in the counties of New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, and Orange.

The HMO's first year of operation was 2001 with 231 members enrolled. The total membership at June 30, 2002 was 483 enrollees. The Plan's management contends that the popularity of HMO products is still in decline in New York due to regulatory requirements, the price competitiveness of other products and commission disincentives for brokers. Management continues to review the viability of continuing to offer HMO products in New York.

C. Reinsurance

At June 30, 2002, the Plan had a stop loss reinsurance program in effect with an authorized reinsurer for its HMO and POS business. The policy provided is a renewal policy covering the period of January 1, 2002 through December 31, 2002 that may only be terminated by either party giving 60 days notice. The reinsurance coverage in effect is as follows:

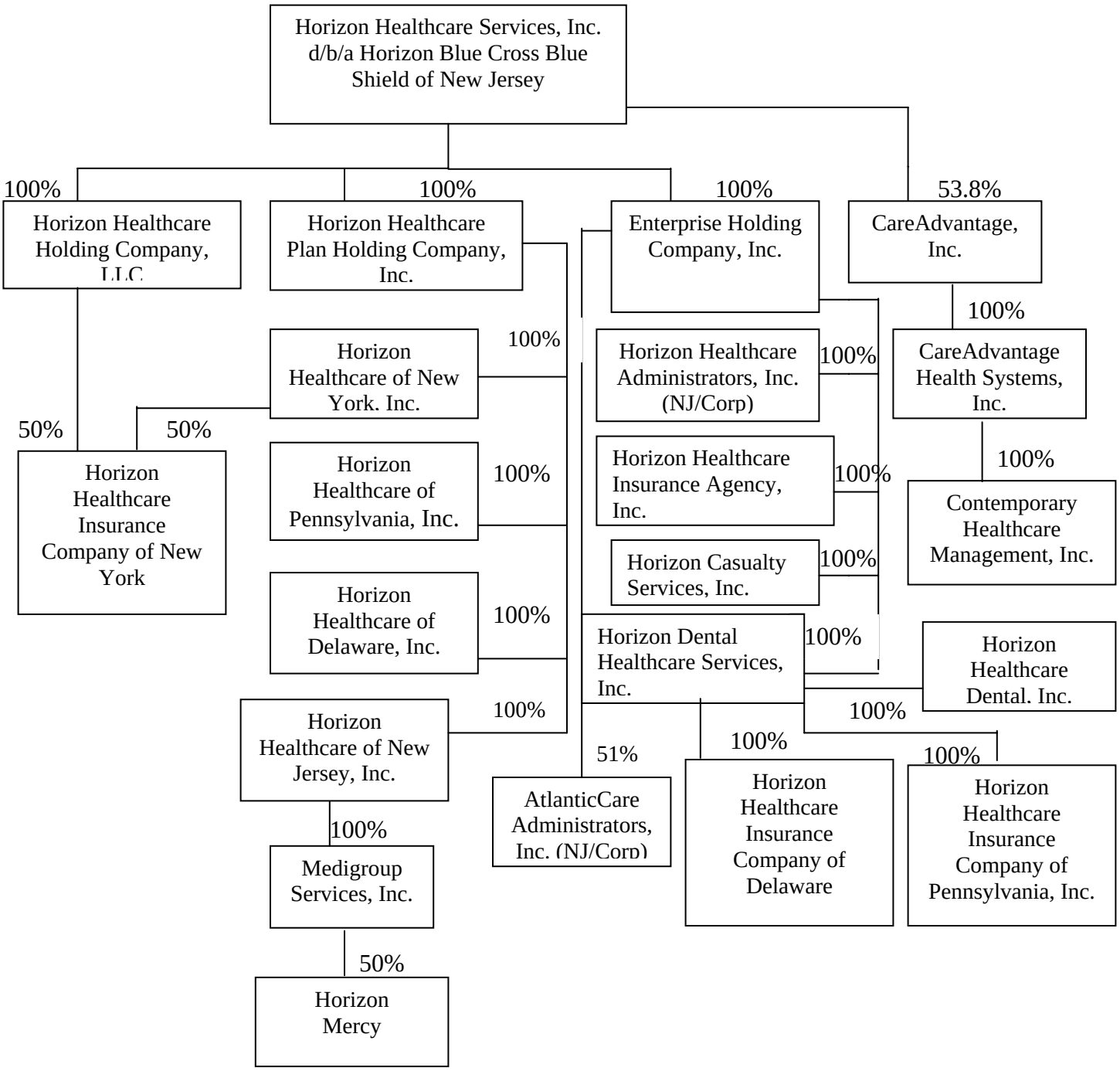
Benefit Plans Covered:	HMO and POS
Stop Loss Retention:	$200,000 per covered member per reinsurance period
Reinsurers Stop Loss Maximum Liability:	$1,800,000 per covered member per reinsurance period

The reinsurance agreement contains the standard clauses required by Section 1308(a) of the New York Insurance Law.

D. Holding Company System

The Plan is 100% owned by Horizon Healthcare Plan Holding Company, Inc. ("HHPHC") which is in turn owned by the ultimate parent BCBSNJ.

Schedule Y of the Plan's filed June 30, 2002 Quarterly Statement presents the Holding Company System as follows:


Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey
100%
Horizon Healthcare Holding Company, LLC
100%
Horizon Healthcare Plan Holding Company, Inc.
100%
Enterprise Holding Company, Inc.
53.8%
CareAdvantage, Inc.
100%
Horizon Healthcare of New York. Inc.
100%
Horizon Healthcare Administrators, Inc. (NJ/Corp)
100%
CareAdvantage Health Systems, Inc.
50%
50%
Horizon Healthcare Insurance Company of New York
100%
Horizon Healthcare of Pennsylvania, Inc.
100%
Horizon Healthcare Insurance Agency, Inc.
100%
Contemporary Healthcare Management, Inc.
100%
Horizon Healthcare of Delaware, Inc.
100%
Horizon Casualty Services, Inc.
100%
Horizon Dental Healthcare Services, Inc.
100%
Horizon Healthcare Dental. Inc.
100%
Horizon Healthcare of New Jersey, Inc.
100%
100%
51%
AtlanticCare Administrators, Inc. (NJ/Corp)
100%
Horizon Healthcare Insurance Company of Delaware
100%
Horizon Healthcare Insurance Company of Pennsylvania, Inc.
100%
Medigroup Services, Inc.
50%
Horizon Mercy

I. Horizon Healthcare Insurance Company of New York

The Plan owns 50% of the issued and outstanding stock of Horizon Healthcare Insurance Company of New York, a domestic accident and health company, with the remaining 50% held by Horizon Healthcare Holding Company, LLC, which in turn is a wholly-owned subsidiary of BCBSNJ.

HHICNY has experienced significant operating losses during the examination period and subsequent. According to its filed Annual and Quarterly Statements through June 2002, HHICNY has sustained net losses of $60,163,140 since it began writing business in 1999. Surplus contributions to HHICNY to cover the losses flow through HHPHC so as to reflect HHPHC's 50% ownership of the subsidiary from BCBSNJ. If the funds contributed are intended for HHICNY, BCNSNJ transfers the funds to HHICNY and the value of the Plan's investment in subsidiary increases by the amount contributed. HHNY's investment value of the subsidiary is reduced by 50% of net operating losses. A chart illustrating all contributions to the Plan and the Plan's contribution to HHICNY follows:

Date	Common Stocks	Paid-In Surplus Contributions To HMO	HMO's Contribution To HHICNY	50% of Net Operating Losses
Initial Sale of Stock (July 14, 1998)	$10	$5,149,990	$5,150,000	
1999		5,600,000	0	$1,847,483
2000		12,500,000	7,500,000	4,045,160
2001		15,000,000	15,000,000	14,459,905
2002*		16,050,000	16,050,000	9,729,021
Total through 06/30/02	$10	$54,299,990	$43,700,000	$30,081,569
Contribution in 10/24/02		8,950,000	8,950,000	
Total Contributions	$10	$63,249,990	$52,650,000	$30,081,569

*The 2002 Paid-In Surplus represents surplus reported or permitted to be recorded as of June 30, 2002.

Section 1408(a) of the New York Insurance Law states:

> "Any insurer which makes investments under the authority of subsection (c) of section one thousand four hundred three of this article and which meets the requirements of such subsection and section one thousand four hundred two of this article, may invest in, or otherwise acquire, the shares… of any other insurance companies, including for purposes of this section any corporation having a majority of its assets invested in one or more insurance companies, in an amount which, together with its present holdings and with any indirect or proportionate interest in insurance company shares held by it through any intermediate subsidiary, shall not exceed in value thirty-five percent of the surplus to policyholders of such acquiring insurer, or fifty percent of its surplus over and above its liabilities and capital, whichever is greater. No United States branch of an alien insurer shall be permitted to acquire or hold any shares of any alien insurance corporation."

For the period of January 1 through December 31, 2002, the Plan reduced its investment in HHICNY to reflect 50% of the net operating losses and changes in nonadmitted assets of the subsidiary. It also nonadmitted $17,978,307 of its investment in HHICNY's and maintained $380,873 as an admitted asset for December 31, 2002 as permitted by Section 1408(a), which allows it to have excess investments not to exceed 50% of its surplus.

As of June 30, 2002, the examiner performed an examination of the Plan's subsidiary. The examiner's findings increase HHICNY's surplus by a $2,471,242 decrease to general expenses payable. The Plan's share (50%) of the increase in surplus is $1,235,621 for June 30 and December 31, 2002.

It is recommended that the Plan comply with the requirements of Section 1408(a) of the New York Insurance Law.

II. Intercompany Agreements

a. Horizon Healthcare of New Jersey, Inc.

On January 1, 1998, the Plan entered into a management services agreement with Horizon Healthcare of New Jersey, Inc. ("HH-NJI"), where HH-NJI will perform certain administrative services as approved by the Board of Directors of the HMO on February 10, 1998. The services include provider network services, additional subscriber services, quality assurance/quality improvement and utilization management services and such other services or functions necessary for the Plan to properly operate a health maintenance organization. The agreement was approved by the Department.

The agreement states that on or about the 15th of each month HH-NJI will submit to HHICNY an invoice for administrative services provided during the preceding month. The HMO will pay HH-NJI for amounts charged within fifteen (15) days of its receipt of the related invoice. The terms of the agreement as applies to payments for services rendered in the previous months are not followed by the parties involved.

It is recommended that the Plan and HH-NJI follow the terms of the contract approved by the Department.

A similar finding and recommendation is explained in detail in the Horizon Healthcare Insurance Company of New York Report dated May 5, 2004.

> Part 98-1.10(c) of the Administrative Rules and Regulations of the New York State Department of Health states:

> "The commissioner's and superintendent's prior approval shall be required for the following transactions between a controlled HMO and any person in its holding company system: sales, purchases, exchanges, investments or rendering of services on a regular or systematic basis the aggregate of which involves 10 percent or more of the HMO's admitted assets at last year-end…"

The Plan charged HHICNY for management services that were provided without the benefit of a management agreement during years 1999, 2000 and 2001.

It is recommended that the Plan submit to the Department, for approval, all holding company service agreements prior to entering into transactions as required by Part 98-1.10(c) of the Administrative Rules and Regulations of the New York State Department of Health.

A similar finding and recommendation is explained in detail in the HHICNY Report dated May 5, 2004.

b. **Tax Allocation Agreement**

The guidelines in Circular Letter 33 (1979) state in part:

> "…Income taxes paid based on consolidated tax returns and intercorporate income tax allocations are transactions between related parties and as such the agreement must be fair and equitable and recognize the separate operating identity of the domestic insurer…"

Also, Items 1 and 5 in Circular Letter 33 (1979) state:

> "1. Every domestic insurer which is a party to a consolidated federal income tax filing must have a definitive written agreement, approved by its Board of Directors, governing its participation therein…"

> "5…All settlements shall be in cash or securities eligible as investments for such domestic insurer, at market value…"

Item 5 above is also reproduced in the Tax Allocation Agreement that was signed by all parties involved.

BCBSNJ and the Plan rely on journal entries to record benefits to the "Payable to parent, subsidiaries and affiliates" account, which has not been settled since the inception of the Plan.

It is recommended that the Plan settle its Federal income tax recoverable account in cash or securities eligible as investments as required by the Tax Allocation Agreement and Circular Letter 33 (1979).

It is also recommended that the Plan follow the terms of the Tax Allocation Agreement and settle the Federal income tax recoverable within the 30 day term specified in the agreement.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

c. **Investments**

BCBSNJ makes investments with the Plan's assets, but no formal investment agreement, between the two entities, delineating the Plan's investment policy was provided to the examiners.

A “Domestic Custody Agreement” from The Chase Manhattan Bank was provided to the examiners. The agreement does not specify that the Plan is a party to the agreement.

It is recommended that the Plan provide more detail in the management services agreement for portfolio management including investment guidelines.

III. Cash Accounts

The Plan decided it would not open any operating cash accounts. All premium received on behalf of the HMO is deposited into a checking account titled solely to BCBSNJ. BCBSNJ invests all monies received and pays all expenses for HHICNY. The Company maintains no checking account in its own name.

Wire transfers’ bank names and account numbers were altered after the transfers were authorized by the Plan.

It is recommended that the Plan take steps to strengthen and improve adherence to accounting procedures and controls concerning the issuance of wire transfers. It is also recommended that the Plan maintain a wire transfer log or other adequate documentation that will provide an audit trail allowing examiners to trace the flow of all wire transfers.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

IV. **Allocation of Expenses**

SSAP No. 70 paragraphs 7 and 8, as applies to apportionment of shared expenses between members of a group of entities, states:

> 7. "Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios.
>
> 8. Any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group."

It was determined that advertising invoices from the SAWTOOTH GROUP, which had a contract with BCBSNJ, but not with the Plan, were paid by the Plan.

It is recommended that the Plan record the proper amounts to its advertising expense. It is further recommended that the Plan report expenses that it (as opposed to its parent) has incurred.

BCBSNJ provides certain administrative services, including executive oversight, financial, legal, and human resources support that are allocated according to a defined formula. The examiners requested the formula, but the Plan was unable to provide it.

It is recommended that the Plan create a basis for the apportionment of those expenses requiring allocation in greater compliance with SSAP No. 70 paragraphs 7 and 8. It is also recommended that the Plan formalize the allocation of expenses with its parent and affiliates to comply with SSAP No. 70.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

V. Separate Legal and Operating Identity

Part 98-1.11(a) of the Administrative Rules and Regulations of the New York State Department of Health states:

> "The HMO function shall be clearly distinguished from any other functions through the maintenance of separate records, reports and accounts for the HMO function. Each line of business of an HMO shall be distinguished from any other line of business of that HMO. The records, reports and accounts of each HMO shall be maintained separately from those of other persons or HMO's in the holding company system. All records pertaining to the article 44 certified HMO shall be maintained in New York State."

Parts 98-1.10 (a)(1)-(a)(3) of the Administrative Rules and Regulations of the New York State Department of Health state:

> "Transactions within a holding company system to which a controlled HMO is a party shall be subject to the following guidelines:
> (1) the terms of the financial transaction shall be fair and equitable to the HMO at the time of the transaction;
> (2) charges or fees for services performed shall be reasonable; and
> (3) expenses incurred and payments received shall be allocated to the HMO on an equitable basis in conformity with customary accounting practices consistently applied."

The examiner concluded that based on the frequency, regularity and documentation of the above described transactions; the lack of formal written agreements; the lack of involvement by the Plan's Board of Directors and by the officers of the Plan in the control of assets; the lack of

identification of the Plan, and the lack of distinct record-keeping, gives the appearance that BCBSNJ, the HMO's ultimate Parent, ran the operations of the Plan as if it were a division of the Parent corporation, and failed to maintain the distinct operating identity of the Plan as required by Parts 98-1.10(a)(1)-(a)(3) and 98-1.11(a) of the Administrative Rules and Regulations of the New York State Department of Health.

It is recommended that the Plan be in compliance with Parts 98-1.11(a), and 98-1.10 (a)(1), (a)(2), and (a)(3) of the Administrative Rules and Regulations of the New York State Department of Health by taking steps to more clearly define the New York entity and by improving its compliance with Parts 98-1.11(a), and 98-1.10 (a)(1), (a)(2), and (a)(3).

4. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the assets, liabilities and net worth as determined by this examination as of June 30, 2002 as determined by this examination and as reported by the Plan. The statement is the same as the balance sheet filed by the HMO.

Assets	**Health Maintenance Organization**			**Examination**
Current Assets	Assets	Nonadmitted Assets	Net Admitted Assets	Net Admitted Asset
Cash ($0) and short-term investments ($1,477,741)	$1,477,741	$ 0	$1,477,741	$1,477,741
Accident and health premiums due and unpaid	108,695	16,504	92,191	92,191
Investment income due and accrued	3,511	0	3,511	3,511
Federal and foreign tax Recoverable-Parent	791,581	0	791,581	791581
State tax deposit	24,187	0	24,187	24,187
Total current assets	$2,405,715	$16,504	$2,389,211	$2,389211
Other Assets				
Bonds	$ 312,801	$ 0	$ 312,801	$ 312,801
Common stocks	12,697,830	11,800,749	897,081	897,081
Total other assets	$13,010,631	$11,800,749	$1,209,882	$1,209,882
Property and Equipment				
Furniture and equipment	$361,749	$361,749	$ 0	$ 0
Electronic data processing equipment and software	21,611	0	21,611	21,611
Total property and equipment	$383,360	$361,749	$ 21,611	$21,611
Total assets	$15,799,706	$12,179,002	$3,620,704	$3,620,704

Liabilities	HMO	Examination
Current Liabilities		
Claims unpaid	$399,000	$399,000
Unpaid claims adjustment expenses	15,960	15,960
Aggregate policy reserves	5,374	5,374
Premiums received in advance	30,100	30,100
General expenses due or accrued	194,500	194,500
Amounts due to parent, subsidiaries and affiliates	1,076,615	1,076,615
State income taxes payable	15,500	15,500
Other accrued expenses	89,493	89,493
Total liabilities	$1,826,542	$1,826,542
Capital and Surplus		
Common capital stock	$ 10	$ 10
Contingent reserve	100,000	100,000
Gross paid in and contributed surplus	54,299,990	54,299,990
Unassigned funds (surplus)	(52,605,838)	(52,605,838)
Total capital and surplus	1,794,162	1,794,162
Total liabilities and net worth (Deficit)	$3,620,704	$3,620,704

Note – The Internal Revenue Service has completed its audits of the consolidated tax returns filed on behalf of the Plan through tax year 1998. No final assessment has been issued. There are no other ongoing audits. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenue, Expenses, Capital and Surplus

Capital and Surplus Account

Reserves and unassigned funds increased $1,794,162 during the examination period, January 1, 1999 through June 30, 2002, detailed as follows:

Revenue

Premiums	$ 808,420	
Investments	420,376	
Total Revenue		$ 1,228,796

Expenses

Claims incurred net of reinsurance	$ 714,578	
Claims adjustment expenses incurred	417,304	
Administrative expenses incurred	11,730,220	
Total expenses		12,862,102
Gross operating income		($ 11,633,306)
Federal and foreign income taxes incurred		2,308,640
Net loss		($ 9,324,666)

Gains and Losses to Capital and Surplus

Capital and surplus at January 1, 1999		$ 0
	Gains (Losses) in Surplus	
Net loss	($ 9,324,666)	
Change in non-admitted asset	(12,179,002)	
Unrealized capital gains	(31,002,170)	
Capital paid-in	10	
Surplus adjustments paid-in	54,299,990	
Net increase in surplus fund		1,794,162
Surplus as regards policyholders per report on examination as of June 30, 2002		$ 1,794,162

5. MARKET CONDUCT ACTIVITIES

In the course of the examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

The general review was directed at practices of the Plan in the following major areas:

A. Explanation of Benefits Form
B. Advertising
C. Sales
D. Complaints
E. Grievances

Following are the examiners' findings:

A. Explanation of Benefits Form (EOBs)

NYIL §3234(b)(7) of the New York Insurance Law states in part:

> "(b) The explanation of benefit statement form must include at least the following:"
>
> "(7)… 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 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 HMO does not include the above requisite information on its EOBs. Subsequent to the period under examination, the Plan provided the examiners with an EOB with a date of service of November 8th, 2002. This EOB contained revised appeal language but still differed from the requirements of NYIL § 3234(b)(7).

It is recommended that the HMO modify its EOBs to comply with §3234(b)(7) of the New York Insurance Law.

The wording of the appeals language is confusing and compressed. The name of the Plan is difficult to identify as it appears in fine print above the larger easier to read holding company logo, “Horizon Healthcare”.

It is recommended that the Plan create its EOBs in a form that is easy to read and understand. It is also recommended that the Plan’s identity be substituted for the holding company logo.

None of the EOBs reviewed displayed the date the claim was received by HHICNY. This information is necessary so that the length of the processing cycle time can be determined.

It is recommended that the HMO display the date the claim was received by it on all EOBs so that the length of the processing cycle time is determined.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

B. **Advertising**

A review of the Plan’s advertising for the period under examination revealed the following:

The Plan failed to reference where the statistics for the pricing of the advertised service were obtained. The Plan's omission violated Section 215.9(c) of Department Regulation No. 34, which states:

" The source of any statistics used in an advertisement shall be identified in such advertisement."

It is recommended that the Plan be in compliance with Part 215.9(c) of Department Regulation No. 34 and identify the source of all statistics used in its advertisements.

Part 215.1 of Department Regulation 34 {11 NYCRR 215.1} requires truthful and adequate disclosure of all material and relevant information in the advertising of accident and health insurance.

- An advertisement directed to HHICNY's brokers includes the statement that HHICNY pays the "highest commissions in the marketplace".

- " As one of New York's fastest growing companies, our expanded provider network, value-added programs and focus on world class customer service make HHICNY Healthcare the Company of choice in the marketplace".

Material provided by the Company was inadequate to support the above. Therefore they did not comply with Part 215.1.

It is recommended that the Plan comply with Part 215.1 of Department Regulation 34.

A similar finding and recommendation is explained in greater detail in the HHICNY Report dated May 5, 2004.

Part 215.13(a) of Department Regulation 34 {11 NYCRR 215.13(a)} provides that the name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all its advertisements.

It was noted that in at least two instances the Plan did not identify itself in its advertisements. The logo of the ultimate parent was used which could cause confusion to a consumer as to who the actual insurer is.

It is recommended that the Plan disclose the name of the New York licensed insurer placing the advertisement as required by Part 215.13(a) of Department Regulation 34.

The Plan provided the examiners with one advertising contract that had expired in 2001 and a contract with THE SAWTOOTH GROUP, INC. that was not entered into by the Plan.

It is recommended that the Plan keep updated contracts that it holds with its advertising agencies. It is further recommended that the Plan obtain an amended agreement to include itself with the agencies under contract with its parent.

As disclosed under the caption of “Separate Legal and Operating Identity” in the “Holding Company” section of this Report, the Plan’s ultimate parent does not comply with

Parts 98-1.11(a) and 98-1.10(a)(1)-(a)(3) of the Administrative Rules and Regulations of the New York State Department of Health.

Good business practices dictate that there should be a separation of identities (i.e. books, records, accounting, property, and accounts). Review of the cancelled checks used to pay the advertising expenses, showed that both, HHICNY and the Plan, were listed at the top of the check, therefore it could not be determined which company was paying the expense.

It is again recommended that the Plan be in compliance with Parts 98-1.10 (a)(1), (a)(2), and (a)(3) of the Administrative Rules and Regulations of the New York State Department of Health. It is also recommended that the HMO maintain separate records from those of its ultimate parent, its subsidiary, and its affiliates to be in compliance with Part 98-1.11(a) of the Administrative Rules and Regulations of the New York State Department of Health.

The above cited deficiencies indicate that the HMO failed to maintain complete advertising files. Therefore they failed to comply with Part 215.17(a) of Department Regulation No. 34.

It is recommended that the Plan comply with Section 215.17(a) of Department Regulation No. 34 and maintain a complete file containing every printed, published or prepared advertisement for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

C. **Sales**

Pursuant to Article 21 of the New York Insurance Law, the Plan is authorized to utilize independent insurance agents and brokers in its primary distribution system. Only the general agents write business directly with the Plan, all other brokers and agents write business through the contracted general agents. All agents soliciting business for the Plan must be appointed by the Plan by submitting form AGT-1 to the Department. The names of all terminated agents must also be submitted to the Department using the same form. The Insurance Department has a record of seventy-six agents writing business with HHICNY, the Plan's affiliate, but no record of agents appointed by the Plan. The Plan provided the examiners with a list of 1,363 agents and brokers. The Department also identified ten terminated agents by HHICNY, none terminated by the Plan.

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

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

The Plan did not provide certificates of appointment for any agent, nor any Plan employee writing health business for the Plan. It appears that the agents that write business for the Plan are not appointed by the Plan with the Department.

It is recommended that the Plan be in compliance with Section 2112(a) of the New York Insurance Law and submit Form AGT-1 to the Department.

D. **Complaints**

When a subscriber submits a complaint to the Department, in most cases the individual company that provided the coverage is not identified. It has previously been noted in this report that the ultimate parent of the Plan does not properly identify its New York subsidiaries.

An electronic complaint log maintained by the Plan is missing four fields recommended by Circular Letter 11 (1978).

It is recommended that all fields mentioned in the guidelines of Circular Letter 11 (1978) be added to the Plan's electronic complaint Log.

Part 243.2(b)(6) of Department Regulation 152 {11 NYCRR 243.2(b)(6)} states that an insurer shall maintain:

> "A complaint record required to be maintained under Chapter IX of this Title for six calendar years after all elements of the complaint are resolved and the file is closed."

The Plan did not maintain a log of complaints received prior to 2002, either in written or verbal form.

It is recommended that the Plan keep a log of all complaints, including direct complaints to the Plan. It is also recommended that the Plan comply with Part 243.2(b)(6) of Department Regulation 152.

Similar findings and recommendations are explained in greater detail in the HHICNY Report dated May 5, 2004.

E. Grievances

The Plan provided the examiner with seven complete grievances filed during the examination period. Upon review of the grievance files, it could not be determined which grievances were for HHICNY and which ones were for the Plan.

It is recommended that the Plan take the immediate and necessary steps to modify its reporting system so those grievances applicable for each company, (HHICNY or the Plan), can be determined.

The examiner reviewed the Plan's filed Schedule M. Although two out of the seven grievances were filed with HHICNY or the Plan in 2001, no grievances were reported in the Plan's Schedule M for calendar year 2001.

It is recommended that the Plan revise its Schedule M filing procedures to properly reflect grievances received.

6. Summary of Comments and Recommendations

Appointment No. 21868

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY V. SERIO, *Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Arcelio Vega

as a proper person to examine into the affairs of the

Horizon Healthcare of New York, Inc.

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

Company

with such information as he shall deem requisite.

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

this 15th *day of* May 2002

Gregory V. Serio
Superintendent of Insurance