MARKET CONDUCT REPORT ON EXAMINATION

OF

HEALTH INSURANCE PLAN OF GREATER NEW YORK

AND

HIP INSURANCE COMPANY OF NEW YORK

AS OF DECEMBER 31, 2016

EXAMINER: **EDOUARD MEDINA**

DATE OF REPORT: **July 11, 2023**

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July 11, 2023

Honorable Adrienne A. Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with instructions contained in Appointment Numbers 31660 and 31661, dated August 17, 2017, annexed hereto, I have made an examination into the affairs of the Health Insurance Plan of Greater New York, a not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law, and its subsidiary, HIP Insurance Company of New York, an accident and health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2016, and submit the following report thereon.

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

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

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

Wherever the designation the "Companies" appears herein, without qualification, it should be understood to indicate Health Insurance Plan of Greater New York and HIP Insurance Company of New York, collectively.

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

Wherever the designations "GHI" appear herein, without qualification, it should be understood to indicate Group Health Incorporated, a subsidiary of HIP.

Wherever the designations the "Department" or "DFS" appear herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

Concurrently, examinations into the financial condition and affairs of HIP and HIPIC were performed. Separate financial reports on examination for HIP and HIPIC have respectively been submitted thereon.

1. SCOPE OF THE EXAMINATION

The previous market conduct examination was conducted as of December 31, 2011. This examination covers the five-year period January 1, 2012, through December 31, 2016, and was performed to review the manner in which the Companies conduct their business practices and fulfill their contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate.

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

A review was also made to ascertain what actions were taken by the Companies with regard to comments and recommendations made in the prior market conduct report on examination. The results of the examiners review are contained in Item 12 of this report.

2. DESCRIPTION OF THE COMPANIES

HIPNY is a New York State not-for-profit corporation operating under the provisions of Article 43 of the New York Insurance Law. The Plan also operates as a certified health maintenance organization ("HMO"), pursuant to the provisions of Article 44 of the New York Public Health Law. Since February 10, 2005, retroactive to January 1, 1998, HIPNY was exempt from federal income taxes under Section 501(a) of the Internal Revenue Code ("IRC"), as described in Section 501(c)(4) of the IRC. Prior to that date, HIPNY was exempt from federal income taxes per Section 501(c)(3) of the IRC. As a result of this change in tax status, HIPNY is required to pay federal unemployment taxes.

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

On November 15, 2006, having received regulatory approval from the Department, HIPIC's intermediate Parent, HIPNY, became an affiliate of GHI. As a result of this transaction EmblemHealth became the sole member and ultimate Parent of HIPNY, GHI and their subsidiaries. HIPNY and GHI named an equal number of Directors to the Board of EmblemHealth. In December 2010, HIPNY replaced EmblemHealth as the sole corporate member and Parent corporation of GHI.

On March 6, 2007, EmblemHealth Services Company, LLC ("EHS") was formed as a joint venture of HIPNY and GHI in order to integrate the operations of these two entities. On January 1, 2008, assets such as vendor agreements and employees were transferred to EHS. HIPNY, HIPIC, GHI, and GHI HMO Select, Inc. ("GHI HMO"), controlled by EmblemHealth then began receiving management and other services from EHS. Also on that date, with the approval of the Department, HIPNY and GHI entered into a written guarantee of all liabilities of EHS.

In March 2005, HIP, through its subsidiary HIP Holdings, acquired ConnectiCare, Inc. ("ConnectiCare"), which included ConnectiCare of Massachusetts, ConnectiCare of New York

and ConnectiCare Insurance Company. On January 26, 2011, ConnectiCare of New York was merged into GHI HMO, a subsidiary of GHI.

3. CLAIMS PROCESSING

A review of the Companies' claims practices and procedures for out-of-network claims submitted by the City of New York Group was performed. Claims paid during the period January 1, 2016, through December 31, 2016, were evaluated to determine the overall accuracy and compliance of the Companies' claims processing environment.

The claim populations for the Companies were divided into medical, hospital and pharmacy claim segments and a random statistical sample size of 75 claims processed for the City of New York Group was drawn from the two Companies for review. In addition, a risk assessment of the Companies' claims operation was performed to identify and analyze potential events that may negatively impact specific areas, including: insured eligibility, adherence to appropriate fee schedules, co-payments, and deductibles, treatment plan authorizations, proper denial of claims, and issuance of explanation of benefits statements ("EOBs").

Starting August 2016, the Companies' claims operations were transitioned to Cognizant Technical Services ("CTS"), a business process outsourcing vendor. In 2016, CTS used Q/CARE (HIP's legacy claim payment system) exclusively. CTS staff was processing Medicare, Medicaid, Essential Plan, and Individual Direct Pay claims using Q/CARE while Companies' remaining lines of business were being processed on CTS' internal claims system, Facets. Beginning in calendar year 2018, all of the Companies' claims are processed using Facets.

A. Claims Adjudication

Section 2601(a)(4) of the New York Insurance Law states, in part:

> "(a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:
> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear…"

In several instances, the Companies received claims on behalf of their third-party administrators. The Companies denied the claims and asked the member to resubmit those claims to the respective third-party administrator. For example, denial codes DHP and DR1 directed the member to resubmit claims to Healthplex Inc. and EviCore, respectively. The Companies were unable to provide documentation to show that they had provided any guidance to members on how to submit these third-party claims. This practice caused unnecessary delays in the processing of the claims.

It is recommended that the Companies comply with Section 2601(a)(4) of the New York Insurance Law by attempting in good faith to effectuate prompt, fair and equitable settlements of claims.

B. Explanation of Benefits Statements ("EOBs")

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

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

> "(b) The explanation of benefits form must include at least the following:
> (1) the name of the provider of service the admission or financial control number, if applicable;
> (2) the date of service;
> (3) an identification of the service for which the claim is made;
> (4) the provider's charge or rate;
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

The following was noted from the review of the EOBs issued by the Companies:

- The type of service is identified as "Medical Care" on the EOB, which does not identify the services a member has received.
- The EOB does not indicate how the Companies arrived at the paid amounts.
- The description HIP used for the following denial codes was determined to be vague: C24 – Review; DR2 – Claim denied: Not a privileged service; E67 – Possible COB; F60 – Other; F69 – All lines denied.
- GHI HMO Select, Inc. ("GHI HMO") merged with HIP in June 2013. However, GHI HMO was listed as one of entities in the footer of eight (8) EOB.

It is recommended that the Companies comply with Section 3234(b)(3) of the New York Insurance Law by identifying on the EOB the specific services provided to avoid possible confusion.

It is recommended that the Companies comply with Section 3234(b)(5) of the New York Insurance Law by identifying on the EOB the amount or percentage payable.

It is also recommended that the Companies comply with Section 3234(b)(6) of the New York Insurance Law by providing a specific explanation of any claim denial.

A similar comment was included in the prior report on examination.

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

A similar comment was included in the prior report on examination.

4. PROMPT PAY LAW

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within forty-five (45) days of receipt for paper claims and within thirty (30) days of receipt for electronically submitted claims. If such undisputed claims are not paid within forty-five/thirty (45/30) days of receipt, interest may be payable. Furthermore, the Section requires all insurers to deny all disputed portions of a claim or request additional information needed to determine liability to pay the claim within thirty (30) days of the receipt of the claim.

Sections 3224-a(a) (b) and (c) of the New York Insurance Law states, in part:

> "… (a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three 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 or organization or corporation 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.
> (b) In a case where the obligation of an insurer… to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
> (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. Upon receipt of the information requested… an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section."
> (c)(1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

For each of the Companies, all paid claims that were not adjudicated within forty-five (45) days of receipt for paper claims, thirty (30) days of receipt for electronic claims and thirty (30) days for all denials, during the period January 1, 2016, through December 31, 2016, were segregated. A statistical sample of one hundred sixty-seven (167) of these claims was reviewed by the examiner to determine whether payments were in violation of the timeframe requirements of Sections 3224-a(a) and (b) of the New York Insurance Law and whether interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law.

The following charts illustrate the Companies' compliance with the Prompt Pay Law as determined by this examination:

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

Total population of claims	13,368,670
Population of claims processed past 30/45 days	374,867
Sample size	167
Number of claims with violations	126
Calculated violation rate	**75.45%**
Upper violation limit	81.98%
Lower violation limit	68.92%
Calculated claims in violation	**282,837**
Upper limit claims in error	307,316
Lower limit claims in error	258,358

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

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

Total population of claims	30,690
Population of claims processed past 30/45 days	3,666
Sample size	167
Number of claims with violations	147
Calculated violation rate	**88.02%**
Upper violation limit	92.95%
Lower violation limit	83.10%
Calculated claims in violation	**3,227**
Upper limit claims in error	3,408
Lower limit claims in error	3,046

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

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample (claims received during the period January 1, 2016 through December 21, 2016), which consisted of only those claims adjudicated over thirty (30) days of receipt that were transmitted via the internet or electronic mail or forty-five (45) days of receipt for claims submitted by other means such as paper or a facsimile and/or which should have incurred interest of two dollars or more based upon the examiner's calculations. The population of claims adjudicated after thirty (30) days for electronic submission or forty-five (45) days for paper submission from the date of receipt for HIP and HIPIC consisted of 374,867 claims out of 13,368,670 claims processed, and 3,666 claims out of 30,690 claims processed, respectively, during the period under review.

It is recommended that the Companies comply with Sections 3224-a(a) and (b) of the New York Insurance Law by paying any undisputed portion of a claim to a policyholder or covered person or make a payment to a health care provider within thirty (30) days of receipt of a claim for services rendered that is transmitted via the internet or electronic mail or forty-five (45) days of receipt for a claim for services rendered that is submitted by other means, such as paper or facsimile, and, where applicable, notify the policyholder, covered person or health care provider in writing within thirty (30) calendar days of 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.

A similar comment was included in the prior report on examination.

5. PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Section 3221(l)(8)(E) of the New York Insurance Law and additional implementing regulations require non-grandfathered group health plans offering health insurance coverage in the group market to provide certain benefits but to prohibit the imposition of cost-sharing requirements for those benefits. These include the following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

- Evidenced-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Similar references are included within New York Insurance Law Sections 3216(i)(17)(E) for the individual market while Section 4303(j)(3) of the New York Insurance Law and Section 2713 of the Public Health Service Act offer similar supporting guidance.

The examiner selected a sample of 50 pharmacy preventive service claims identified by the USPSTF for review. The examiner reviewed the claims for co-pay, deductible and coinsurance costs attributed to the member.

EmblemHealth updates its ACA eligible vaccine list as new vaccines are available in the market. In one case there was a delay in the implementation of the update which caused

cost-sharing to be applied in error. Further review by EmblemHealth found that a total of 226 claims had cost-sharing incorrectly applied.

In addition, Nexplanon, a rare birth control device, implanted subdermally, was added to EmblemHealth's exception list without an update to the system. This caused a total of 29 claims to have incorrectly cost-sharing applied.

It is recommended that HIP and HIPIC comply with Sections 3216(i)(17)(E) and 4303(j)(3) of the New York Insurance Law, and Section 2713 of the Public Health Service Act by not applying cost-sharing to pharmacy preventive care claims, when not applicable.

The examiner also performed compliance testing on a sample of 97 preventive and contraceptive claims. The review indicated that cost sharing was applied incorrectly on 69 claims.

It is recommended that HIP and HIPIC comply with Sections 3216(i)(17)(E) and 4303(j)(3) of the New York Insurance Law, and Section 2713 of the Public Health Service Act by not applying cost-sharing to preventive contraceptive claims, when not applicable.

Federal Regulation 29 C.F.R. Section 2590.715-2714(b) states:

> **"***In general.* With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict dependent coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person); residency with the participant or with any other person; whether the child lives, works, or resides in an HMOs service area or other network service area; marital status; student status; employment; eligibility for other coverage; or any combination of those factors. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may require coverage of certain children.)
> (2) *Construction.* A plan or issuer will not fail to satisfy the requirements of this section if the plan or issuer limits dependent child coverage to children under age 26 who are described in section 152(f)(1) of the Code. For an individual not

> described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for dependent child health coverage, such as a condition that the individual be a dependent for income tax purposes."

Section 4305 (c)(1)(A)(i) of the New York Insurance Law states the following:

> Group contracts…
> (c)(1)(A) Any such contract may provide that benefits will be furnished to a member of a covered group, for the member, the member's spouse, child or children, or other persons chiefly dependent upon the member for support and maintenance; provided that:
> (i) a contract of hospital, medical, surgical, or prescription drug expense insurance that provides coverage for children shall provide such coverage to a married or unmarried child until attainment of age twenty-six, without regard to financial dependence, residency with the member, student status, or employment, except a contract that is a grandfathered health plan may, for plan years beginning before January first, two thousand fourteen, exclude coverage of an adult child under age twenty-six who is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. For purposes of this item, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e); and

The Companies' member welcome kits for Exclusive Provider Organization ("EPO"), Point of Service ("POS"), HMO and Preferred Provider Organization ("PPO") lines of business contain the following language:

> "1. Under "PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER" *8. Dependent Children Covered to Age 26. …If your children are eligible for employer-sponsored coverage on their own, then they are not eligible for dependent coverage to age 26…"*

The above language is inconsistent with and therefore in violation of Federal Regulation 29 C.F.R. Section 2590.715-2714(b) and Section 4305(c)(1)(A)(i) of the New York Insurance Law.

It is recommended that the Companies comply with Section 4305(c)(1)(A)(i) of the New York Insurance Law by not denying or restricting dependent coverage for a child who has not attained age 26 based on the child's eligibility for other coverage.

6. UTILIZATION REVIEW AND APPEALS

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

During the examination period, utilization reviews ("UR") and appeals were processed by the Companies and their delegated third-party administrators, including Beacon Health Options, Inc., eviCore Healthcare, Healthplex Inc., OrthoNet LLC., Healthcare Partners, IPA, Montefiore Care Management Organization ("CMO"), Magellan Healthcare and Palladian Health.

From a log of 411,842 utilization reviews and 3,968 utilization review appeal cases closed in calendar year 2016, the examiner selected 167 utilization reviews and 167 utilization review appeal cases for review.

Section 4901(a) of the New York Insurance Law states:

> "Every utilization review agent shall biennially report to the superintendent of financial services, in a statement subscribed and affirmed as true under the

> penalties of perjury, the information required pursuant to subsection (b) of this section."

HIP and HIPIC did not file biennial reports during the examination period, in violation of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law.

It is recommended that the Companies comply with Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law by reporting biennially to the Superintendent their utilization review program as prescribed by these Sections.

Section 4903(b)(1) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify: (i) whether the services are considered in-network or out-of-network; (ii) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for but-of-network health care services."

An assessment of the prospective utilization review process indicated the following for both Companies:

- There were five (5) cases where HIP's prospective utilization review decisions were rendered late;
- There were two (2) cases where HIP's written notification of its prospective utilization review decision was issued late;

- There was one (1) case where HIP's verbal notice of its prospective utilization review decision was late;
- In twenty-five (25) HIP cases and three (3) HIPIC cases, the written and verbal notices of its prospective utilization review decisions were not sent or communicated.

It is recommended that the Companies comply with Section 4903(b) of the New York Insurance Law and Section 4903(2) of the New York Public Health Law by reaching the prospective review decision and communicating the decision within the timeframes prescribed by the Laws.

Section 4903(c)(1) of the New York Insurance Law states:

> "A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or requests for inpatient substance use disorder treatment, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance use disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date."

The examination of the concurrent utilization review indicated the following for both Companies:

- In twenty-six (26) HIP cases and three (3) HIPIC cases, the concurrent utilization review decisions were rendered late;
- In one (1) HIPIC case, the concurrent written utilization review decision notice was issued late;
- In one (1) HIP case, the concurrent verbal utilization review decision notice was provided late.

It is recommended that the Companies comply with Section 4903(c) of the New York Insurance Law and Section 4903(3) of the New York Public Health Law by reaching the concurrent review decision and communicating the decision within the time frames prescribed by these Sections.

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

> "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."

In six (6) cases, HIP failed to reach a retrospective review decision within the required timeframe of thirty (30) days.

It is recommended that the Companies comply with Section 4903(d) of the New York Insurance Law and Section 4903(4) of the New York Public Health Law by reaching a retrospective review decision within thirty (30) days of receipt of the necessary information.

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

> "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; or (3) potential court-ordered mental health and/or substance use disorder services pursuant to paragraph two of subsection (b) of section four thousand nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the insured's health care provider and the utilization review agent by provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of

> this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. Provided that the insured or the insured's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance use disorder treatment while a determination by the utilization review agent or external appeal agent is pending."

The examiner evaluated the utilization review appeal process, and the following was found for both Companies:

- In seventy-six (76) HIP cases and eleven (11) HIPIC cases, the Companies stated they will treat a utilization review appeal as urgent if they believe it is urgent. The Companies should indicate that they will use the guidelines of the New York Insurance Law and the New York Public Health Law to determine whether or not expedited appeals should be granted. Section 4904(b) of the New York Insurance Law and Section 4904(2) of the New York Public Health Law prescribe the conditions (such as an appeal of an adverse determination involving continued or extended health care services, an adverse determination in which the health care provider believes an immediate appeal is warranted, etc.) under which expedited appeals should be granted;
- In two (2) cases, HIP failed to reach the expedited appeal decision within the required timeframe of two (2) days.

It is recommended that the Companies comply with Section 4904(b) of the New York Insurance Law and Section 4904(2) of the New York Public Health Law by establishing an expedited appeal process for urgent appeals of an adverse determination which follows the guidelines prescribed by the captioned Sections.

It is recommended that the Companies comply with Section 4904(b) of the New York Insurance Law and Section 4904(2) of the New York Public Health Law by making expedited

appeal determinations within two (2) business days of receipt of necessary information to conduct such appeal.

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

> "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. The notice of the appeal determination shall include:
> (1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and
> (2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals."

Further review of the utilization review appeal process indicated the following for both Companies:

- In fourteen (14) cases, HIP's acknowledgement letters were late;
- In two (2) cases, HIPIC's acknowledgement letter was not sent;
- In one (1) case, HIPIC's appeal decision was rendered late,
- In seven (7) cases, HIP's written decision notices were issued late,
- In three (3) cases, HIP's written decision notices were not sent.

It is recommended that the Companies comply with Section 4904(c) of the New York Insurance Law and Section 4904(3) of the New York Public Health Law by providing written

acknowledgment of the filing of the appeals to the appealing party within fifteen (15) days of such filing.

It is recommended that the Companies comply with Section 4904(c) of the New York Insurance Law and Section 4904(3) of the New York Public Health Law by making a determination with regard to the utilization review appeal within sixty (60) days of the receipt of necessary information to conduct the appeal.

It is recommended that the Companies comply with Section 4904(c) of the New York Insurance Law and Section 4904(3) of the New York Public Health Law by notifying the insured, the insureds designee and, where appropriate, the insureds health care provider, in writing of the appeal determination within two (2) business days of the rendering of the appeal determination.

It is recommended that the Companies comply with Section 4904(c) of the New York Insurance Law and Section 4904(3) of the New York Public Health Law by notifying the insured, the insureds designee and, where appropriate, the insureds health care provider, in writing of the appeal determination.

Notice of initial adverse determinations must be issued in compliance with 42 U.S.C. §300gg-19; 45 C.F.R. §147.136; 29 C.F.R. §2560.503-1; 29 C.F.R. §2590.715-2719; New York Insurance Law §4903 and New York Public Health Law §4903. To ensure compliance with both New York State Law and Federal Law and regulations, initial adverse determination notices must include all of the following information:

- The notice must be written in a culturally and linguistically appropriate manner;
- Date of service;
- Name of health care provider who provided or will provide the service,
- The claim amount, if applicable;

- The reason for the determination, including clinical rationale, if any. The reason must include the denial code, if any, and its corresponding meaning. The clinical rationale should include an explanation of the scientific evidence or clinical judgment used, applying the terms of the plan to the enrollee's medical circumstances;
- Notice of the availability free of charge, upon request, of the clinical review criteria, internal rule, protocol or guideline relied upon to make such determination;
- Notice of the availability, upon request, of the diagnosis code and its corresponding meaning;
- Notice of the availability, upon request, of the treatment code and its corresponding meaning;
- Instructions on how to initiate standard and expedited appeals, including timeframes within which an appeal must be filed and decided;
- A statement that the appeal may be filed by phone or in writing, including address and phone number;
- Instructions on how to file an external appeal, including timeframes for filing an external appeal;
- Specification of what, if any, additional information must be provided to, or obtained by, the utilization review agent in order to render a decision on appeal;
- A statement of enrollee's right to bring a civil action under §502(a) of ERISA;
- A statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established under 42 U.S.C. §300gg-93 to assist enrollees with the appeal process.

Notice of final adverse determinations must be issued in compliance with 42 U.S.C. §300gg-19; 45 C.F.R. §147.136; 29 C.F.R. §2560.503-1; 29 C.F.R. §2590.715-2719; New York Insurance Law §4903; New York Public Health Law §4903; Part 98-2.9 of New York Codes, Rules, and Regulations (10 NYCRR 98) and Part 410.9 of Insurance Regulation No. 166 (11 NYCRR 410). To ensure compliance with both New York State Law and Federal Law and regulations, final adverse determination notices must include all of the following information:

- The notice must be written in a culturally and linguistically appropriate manner;
- Date of service;
- A description of the health care service, including the name of the health care provider, facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
- The claim amount, if applicable;
- A clear statement that the notice constitutes the final adverse determination;
- The insured's coverage type;
- The name and full address of the health plan's UR agent;
- The UR agent's contact person and telephone number;
- The health plan's contact person and telephone number;

- The reason for the determination, including clinical rationale, if any;
- The reason must include the denial code, if any, and its corresponding meaning. The clinical rationale should include an explanation of the scientific evidence or clinical judgment used, applying the terms of the plan to the enrollee's medical circumstances;
- Notice of the availability, upon request, of the diagnosis code and its corresponding meaning;
- Notice of the availability, upon request, of the treatment code and its corresponding meaning;
- Notice of the availability free of charge, upon request, reasonable access to, and copies of, all documents, records and other information relied upon to make such determination;
- Notice of the availability free of charge, upon request, of the clinical review criteria, internal rule, protocol or guideline relied upon to make such determination;
- For an out-of-network referral denial, the names of the in-network providers identified by the health plan that have the appropriate training and experience to meet the particular health care needs of the enrollee;
- If the appeal was expedited, a statement that the appealing party may further appeal through the standard appeal process or through an external appeal;
- Notice of the right to an external appeal and the time frames for requesting an external appeal;
- A copy of the standard description of the external appeal process, including a form and instructions for requesting an external appeal along with a description of the fee;
- Criteria for determining eligibility for a waiver of any fee based on financial hardship, and the process for requesting such waive;
- A statement describing any voluntary appeal procedures offered by the plan, if applicable, and a statement of the enrollee's right to bring a civil action under §502(a) of ERISA;
- For group health plans that offer two levels of internal appeal, a clear statement in bolded text that the timeframes for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, and that by choosing to request a second level internal appeal, the time to request an external appeal may expire;
- A statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established under 42 U.S.C. §300gg-93 to assist enrollees with the appeal process.

The examiner's review determined that HIP had thirty-three (33) initial adverse determination notices and fifty-two (52) final adverse determination notices and HIPIC had six (6) final adverse determination notices, that did not contain the above mentioned items.

It is recommended that HIP comply with 42 U.S.C. §300gg-19; 45 C.F.R. §147.136; 29 C.F.R. §2560.503-1; 29 C.F.R. §2590.715-2719; New York Insurance Law §4903 and New York

Public Health Law §4903by including in their initial adverse determination notices all the items required by these statutes.

It is recommended that the Companies comply with 42 U.S.C. §300gg-19; 45 C.F.R. §147.136; 29 C.F.R. §2560.503-1; 29 C.F.R. §2590.715-2719; New York Insurance Law §4903; New York Public Health Law §4903; Part 98-2.9 of New York Codes, Rules, and Regulations and Part 410.9 of Insurance Regulation No. 166 by including in their final adverse determination notices all the items required by these statutes.

7. AGENTS AND BROKERS

The examiner reviewed HIP's processes related to the appointment and termination of their agents and brokers during the period January 1, 2012, through December 31, 2016, to ensure compliance with Article 21 of the New York Insurance Law.

Sections 2112(a), (b) and (d) of the New York Insurance Law state:

> "(a) 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 or, in the case of a title insurance corporation, title insurance agents, to represent such insurer, fraternal benefit society or health maintenance organization.
> (b) To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within fifteen days from the date the agency contract is executed, or the first insurance application is submitted.
> (d) Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent, or title insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit

> society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication."

The examiners' review of the Companies' distribution system indicated that among the agents who transacted with the Companies during the years under examination, four (4) of them were not appointed and sixteen (16) were not terminated when their license expired, in violation of Section 2112(a), (b) and (d) of the New York Insurance Law.

It is recommended that the Companies comply with Section 2112(a) of the New York Insurance Law by filing with the Department a certificate of appointment when appointing insurance agents to represent the Companies.

It is recommended that the Companies comply with Section 2112(b) of the New York Insurance Law by filing with the Department a notice of appointment within fifteen (15) days from the date the first insurance application is submitted by any producer.

It is recommended that upon termination of a producer the Companies comply with Section 2112(d) of the New York Insurance Law by filing such termination with the Department within thirty (30) days.

8. RECORD RETENTION

Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243) states in part:

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

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

The examiner reviewed the Companies' policy declination and termination practices to ensure compliance with applicable law and regulations. HIP was unable to provide supporting documentation for four (4) declinations and three (3) termination records, in violation of Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243).

It is recommended that HIP comply with Part 243.2(b)(8) of Insurance Regulation No. 152 by keeping its records for six calendar years from their 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.

9. PREMIUM RATES

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

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof. The superintendent may refuse such approval if he finds that such premiums, or the premiums derived from the rating formula, are excessive, inadequate or unfairly discriminatory, provided, however, the superintendent may also consider the financial condition of such corporation in approving or disapproving any premium or rating formula. Any adjustments to an approved schedule of premiums or to the approved rating formula for non-community rated contracts shall also be subject to the approval of the superintendent provided, however, such adjustments shall not be subject to the requirements of subsection (c) of this section. Any premium or formula approved by the superintendent shall make provision for such increase as may be necessary to meet the requirements of a plan approved by the superintendent in the manner prescribed in section four thousand three hundred ten of this article for restoration of the statutory reserve fund required by such section. Notwithstanding any other provision of law, the superintendent, as part of the rate increase approval process, may defer, reduce or reject a rate increase if, in the judgment of the superintendent, the salary increases for senior level management executives employed at corporation's subject to the provisions of this article are excessive or unwarranted given the financial condition or overall performance of such corporation. The superintendent is authorized to

> promulgate rules and regulations which the superintendent deems necessary to carry out such deferral, reduction or rejection."

Section 3231(d)(1) of the New York Insurance Law states, in part:

> "Notwithstanding any other provision of this chapter to the contrary, no policy form subject to this section shall be issued or delivered, nor any insurance contract entered into, unless and until the insurer has filed with the superintendent a schedule of premiums, not to exceed twelve months in duration, to be paid under the policy forms and obtained the superintendent's approval thereof..."

A review of the large group HMO premium revenue indicated that the premium paid by the groups included a broker advisory fee of 4%. While the Plan bills the member for the full premium, the Plan will unbundle the premium received and book 96% of the premium billed / received as premium revenue while recording the remainder as a commission liability. This commission liability is later remitted to the broker as a commission.

The Plan had previously requested approval from the Department to reduce the broker's commission from 4% to 0% for this book of business which was approved by the Department. However, the Plan continues to charge the commission to the large groups as a broker advisory fee. For example, for every $100 premium received, the Plan only reported $96 as premium written and $4 is paid to the broker as a broker advisory fee.

It is recommended that the Plan comply with Sections 4308(b) and 3231(d) of the New York Insurance Law by using only premiums rates that were approved by the Department.

10. ADVERTISING

The examiner reviewed HIP's advertising documentation for the period January 1, 2012, through December 31, 2016, to ascertain compliance with the requirements of Sections 4224(c),

4226(a)(1), 4235(h)(3) and 4323(c) of the New York Insurance Law and Insurance Regulation No. 34 (11 NYCRR 215).

Section 4224(c) of the New York Insurance Law states:

> "Except as permitted by section three thousand two hundred thirty-nine of this chapter or subsection (f) of this section, no such life insurance company and no such savings and insurance bank and no officer, agent, solicitor or representative thereof and no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds, or other securities, or any dividends or profits accruing or to accrue thereon, or any valuable consideration or inducement whatever not specified in such policy or contract other than any valuable consideration, including but not limited to merchandise or periodical subscriptions, not exceeding twenty-five dollars in value; nor shall any person in this state knowingly receive as such inducement, any rebate of premium or policy fee or any special favor or advantage in the dividends or other benefits to accrue on any such policy or contract, or knowingly receive any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever which is not specified in such policy or contract."

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

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

The following Companies' advertisements materials were in violation of the above Sections of New York Insurance Law:

- Free iPads if labor unions attend EmblemHealth's meetings;
- Free lunch and free iPads if labor unions attend EmblemHealth's meetings to implement its new Shared Administrative Advantage Program;
- Baseball game tickets and a cocktail reception at City Field for brokers.

It is recommended that the Companies comply with Sections 4224(c) and 4323(c) of the New York Insurance Law by not offering, directly or indirectly, any inducement to any person as a condition to buy insurance.

Section 4226(a)(1) of the New York Insurance Law states:

> "(a) No insurer authorized to do in this state the business of life, or accident and health insurance, or to make annuity contracts shall:
> (1) issue or circulate, or cause or permit to be issued or circulated on its behalf, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts;"

The Companies advertised a gym discount as a benefit but failed to disclose that the benefit depends on visiting the gym a specified number of times (fifty (50) visits) within a six month timeframe

It is recommended that the Companies comply with Sections 4226(a)(1) and 4323(c) of the New York Insurance Law by not offering access to services which misrepresent the terms, benefits or advantages of any of its policies or contracts.

Section 4235(h)(3) of the New York Insurance Law states:

> "No insurer shall issue any policy of group accident, group health or group accident and health insurance the premium rate under which for the first policy year is less than that determined by the schedules of such insurer as then on file with the superintendent; nor shall it pay to the agent or agents or to a broker or brokers for the solicitation or sale of such policy or for any other purpose related to such policy any commission, compensation or other fees or allowances in excess of that determined on the basis of the schedules of such insurer as then on file with the superintendent; nor shall such insurer pay for services pertaining to the service or administration thereof to any individual, firm or corporation any fees, commissions or allowances in excess of that determined on the basis of the schedules of such insurer as then on file with the superintendent or for such services not rendered in behalf of such insurer; provided, however, that nothing contained herein shall apply to or affect the computation of dividends or experience rating credits."

The Companies' 2016 advertisements show the use of a large group Bonus Program, which did not receive the approval of the Department, in violation of Sections 4235(h)(3) and 4323(c) of the New York Insurance Law.

It is recommended that the Companies comply with Sections 4235(h)(3) and 4323(c) of the New York Insurance Law by not paying brokers fees in excess of those determined by the schedules on file with the Department.

Part 215.6(a)(2) of Insurance Regulation No. 34 (11 NYCRR 215) states:

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

The Companies' 2013 and 2014 advertisement materials stated, "*Preventive care is covered in full*", and "*An EmblemHealth labor insurance specialist will present the comprehensive claims analysis*", however, because the advertisements used the words "full" and "comprehensive" respectively, they violated Part 215.6(a)(2) of Insurance Regulation No. 34 (11 NYCRR 215).

It is recommended that the Companies comply with Part 215.6(a)(2) of Insurance Regulation No. 34 by not including prohibited phrases in their advertisements such as, "all", "full", and "complete".

Part 215.6(b)(1) of Insurance Regulation No. 34 (11 NYCRR 215) states:

> "When an advertisement refers to either a dollar amount, a period of time for which any benefit is payable, the cost of the policy, a specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions

> and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive."

The Companies' 2015 advertisements display specific dollar amounts for gym reimbursements but do not specify the exceptions, reductions, and limitations clause required by Part 215.6(b)(1) of Insurance Regulation No. 34.

It is recommended that the Companies comply with Part 215.6(b)(1) of Insurance Regulation No. 34 by disclosing the exceptions, reductions and limitations in all advertisements which refer to either a dollar amount, a period of time for which any benefit is payable, the cost of the policy, etc.

Part 215.8(b) of Insurance Regulation No. 34 (11 NYCRR 215) states:

> "If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid endorsement". This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation."

In 2015 the Companies used the endorsements of a New York radio station for their advertisements. However, the words "paid endorsement" were not included in the advertisement, in violation of Part 215.8(b) of Insurance Regulation No. 34 (11 NYCRR 215).

It is recommended that the Companies comply with Part 215.8(b) of Insurance Regulation No. 34 by disclosing the language "paid endorsement" in their advertisements if the person making the advertisement is compensated for such advertisement.

Part 215.9(c) of Insurance Regulation No. 34 states (11 NYCRR 215):

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

The Company was unable to provide the sources of the statistics used in the following advertisements:

- "More than 50,000 people in the United States will be infected with "HIV"."
- "The program seeks to address some of needs of unpaid caregivers, of whom there are more than 65.7 Million – a number that grows daily."
- "GHI and HIP were the first to provide affordable empire health care."

It is recommended that the Companies comply with Part 215.9(c) of Insurance Regulation No. 34 by ensuring that they have the source of any statistics they use in their advertisements.

Part 215.13(a) of the Insurance Regulation No. 34 (11 NYCRR 215) states:

> "The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all of its advertisements. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer."

It should be noted that one of the Companies' advertisements did not contain EmblemHealth's names and logo as required by Part 215.13(a) of the Insurance Regulation No. 34 (11 NYCRR 215).

It is recommended that the Companies comply with Part 215.13(a) of the Insurance Regulation No. 34 by identifying the names of the Companies clearly in their advertisements.

11. SUBSEQUENT EVENTS

As of August 24, 2020, Group Health Incorporated ("GHI") received approval from the Department of Financial Services to change its name to EmblemHealth, Plan, Inc. ("EHPI").

12. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT

The prior market conduct report contained thirty (30) comments and recommendations (page numbers refer to the prior market conduct report):

ITEM NO.		PAGE NO.
	Claims Processing	
1.	It was recommended that HIP suppress the generation of EOBs on their Medicaid Reclamation claims to avoid possible confusion to the recipients *The Plan has complied with this recommendation.*	8
2.	It was recommended that HIP modify their description of denial code DG2 to comply with the requirements of Section 3234(b)(6) of the New York Insurance Law. *The Plan has not complied with this recommendation. A similar comment is included in this report.*	8
3.	It was further recommended that HIP take actions to ensure the accuracy of the information reported on their EOBs. *The Plan has not complied with this recommendation. A similar comment is included in this report.*	8
	Prompt Pay Law	
4.	It was recommended that HIP take the necessary steps to ensure that it fully implement and comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims. *The Plan has not complied with this recommendation. A similar comment is included in this report.*	14

ITEM NO. **PAGE NO.**

Utilization Review and Appeals (Continued)

10. It was also recommended that HIPIC comply with the requirements of Section 4903(c) of the New York Insurance Law by ensuring written notices of the determination are provided to the insured, or the insured's designee and the insured's health care provider within one business day of receipt of the necessary information. 19

HIPIC has not complied with this recommendation. A similar comment is included in this report.

11. It was further recommended that HIPIC comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by maintaining all relevant UR documents for the required retention period. 19

The Company has complied with this recommendation.

12. It was recommended that HIPIC comply with the requirements of Sections 4903(b) and (c) of the New York Insurance Law. 20

The Company has not complied with this recommendation. A similar comment is included in this report.

13. It was further recommended that HIP comply with the requirements of Parts 243.2(a) and (b)(8) of Insurance Regulation No. 152 by maintaining all relevant UR documents for the required retention period. 20

The Plan has complied with this recommendation.

14. It was recommended that HIP and HCP comply with the requirements of Section 4903(3) of the NYPHL by maintaining written notification of its determination to the enrollee's health care provider within one (1) business day of receipt of all of the necessary information. 21

The Plan has not complied with this recommendation. A similar comment is included in this report.

ITEM NO.		PAGE NO.
	Utilization Review and Appeals (Continued)	
15.	It was recommended that HCP, acting on behalf of HIP, comply with the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152 by retaining the relevant information or data to accurately represent a record of communications between a person or entity and the insurer. *The Plan has complied with this recommendation.*	22
16.	It was recommended that HIP comply with the requirements of Section 4904(3) of the New York Public Health Law by making written notification of its determination to the appealing party within two business days of rendering its determination. *The Plan has not complied with this recommendation. A similar comment is included in this report.*	22
17.	It was recommended that HIPIC comply with the requirements of the Section 4904(c) of the New York Insurance Law by making a determination with regard to the appeal within sixty (60) days of the receipt of necessary information. *The Company has not complied with this recommendation. A similar comment is included in this report.*	24
18.	It was further recommended that HIPIC comply with the requirements of Section 4904(e) of New York Insurance Law and Bulletin No. 12 of its Utilization Management/Mental Health policy, No. EP.MM.CM.01, by reversing the adverse determinations of delayed appeals. *The Company has complied with this recommendation.*	24
19.	It was recommended that CareCore, acting on behalf of HIP, comply with the requirements of Section 4904(3) of the New York Public Health Law by issuing written acknowledgment of the filing of an appeal to the appealing party *The Plan has not complied with this recommendation.*	25

ITEM NO. **PAGE NO.**

Utilization Review and Appeals (Continued)

20. It was recommended that CMO, acting on behalf of HIP, comply with the requirements of Section 4904(3) of the New York Public Health Law by issuing timely written notice to the enrollee, the enrollee's designee, and the enrollee's health care provider within two (2) business days of rendering of its determination. 25

The Plan has not complied with this recommendation.

21. It was further recommended that CMO, acting on behalf of HIP, comply with the requirements of Part 243.3(a)(2) of Insurance Regulation No. 152 by retaining accurate records of its UR appeals. 26

The Plan has complied with this recommendation.

22. It was recommended that HIP include UR appeals handled by their delegated entities in Table 2 of Schedule M of the New York Supplement to the Health Blank for HIP and Part Two of the Exhibit of Grievances and Utilization Review Appeals of New York Supplement to the Health Blank for HIPIC respectively. 26

The Plan has complied with this recommendation.

Advertising

23. It was recommended that HIP comply with the requirements of Section 4323(c) of the New York Insurance Law and Parts 215.6(a)(1) and (2) of Insurance Regulation No. 34. 28

The Plan has not complied with this recommendation. A similar comment is included in this report.

24. It was recommended that HIP comply with the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 by discontinuing its advertisement of GHI HMO. 29

The Plan has complied with this recommendation.

ITEM NO. **PAGE NO.**

Agents and Brokers

25. It was recommended that HIP comply with the requirements of Sections 2112(b) and (d) of the New York Insurance Law by filing their appointments and terminations of their agents with the Department within the required timeframes. 30

The Plan has not complied with this recommendation. A similar comment is included in this report.

26. It was also recommended that HIP comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining copies of the termination notices for the required timeframe. 30

The Plan has complied with this recommendation.

27. It was further recommended that, as a good business practice, HIP develop written policies and establish procedures for appointing and terminating their external agents. 30

The Plan has complied with this recommendation.

28. It was also recommended that HIP comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining the agents' and brokers' agreements as well as the commission sharing agreements for the required time period. 31

The Plan has complied with this recommendation.

Grievance and Appeals

29. It was recommended that HIP's acknowledgement letters for administrative appeals contain the correct date. 32

The Plan has complied with this recommendation.

Underwriting and Rating

30. It was recommended that HIP comply with the requirements of Parts 362-2.5(a) and (b) of Insurance Regulation No. 171 by collecting the required recertification forms for all of its Healthy New York renewals. 33

The Plan has complied with this recommendation.

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

ITEM **PAGE NO.**

ITEM **PAGE NO.**

Respectfully submitted,

_____

Edouard Medina
Financial Services Manager 1

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

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

_____

Edouard Medina
Financial Services Manager 1

Subscribed and sworn to before me
this ____ day of _____ 2023.

APPOINTMENT NO. 31660

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, 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:*

Edouard Medina

as a proper person to examine the affairs of

Health Insurance Plan of Greater New York

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

Plan

with such other information as 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 17th day of August, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. 31661

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, 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:*

Edouard Medina

as a proper person to examine the affairs of

HIP Insurance Company of New York

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

Company

with such other information as 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 17th day of August, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau