MARKET CONDUCT REPORT ON EXAMINATION
OF
EMPIRE HEALTHCHOICE ASSURANCE, INC.
AND
EMPIRE HEALTHCHOICE HMO, INC.
AS OF
DECEMBER 31, 2018

EXAMINER: **MANAAL AL MAMUN, AFE**

DATE OF REPORT: **MARCH 8, 2024**

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March 8, 2024

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

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31840 and 31841, both dated December 13, 2018, attached hereto, I have made an examination into the affairs of Empire HealthChoice Assurance, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law and its wholly-owned subsidiary, Empire HealthChoice HMO, Inc., a for-profit health maintenance organization ("HMO") licensed under Article 44 of the New York Public Health Law, respectively, as of December 31, 2018. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc., located at 9 Pine Street, New York, NY.

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

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

Wherever the designations “Empire” or the “Empire Companies” appear herein, without qualification, they should be understood to indicate both Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc., collectively.

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

Wherever the designation “Anthem” appears herein, without qualification, it should be understood to indicate Anthem, Inc., the ultimate Parent of WHC.

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

1. SCOPE OF THE EXAMINATION

The previous market conduct examination of EHCA and EHC HMO was conducted as of December 31, 2014. This examination covers a four-year period January 1, 2015 through December 31, 2018. This market conduct examination was performed to review the manner in which EHCA and EHC HMO conducted their business practices and fulfilled their contractual obligations to policyholder and claimants. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination 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 Empire Companies with regard to the comments and recommendations concerning market conduct issues contained in the prior report on examination, as of December 31, 2014. The results of the examiner's review are contained in item 14 of this report on examination.

Concurrent examinations regarding the financial condition of EHCA and EHC HMO were conducted by the Department as of December 31, 2019, and separate reports on examination were issued thereon.

2. DESCRIPTION OF THE COMPANIES

EHCA is a New York domiciled accident and health Insurance company licensed under Article 42 of the New York Insurance Law ('NYIL"). EHCA is a wholly-owned subsidiary of WHC, a wholly-owned subsidiary of Anthem, a publicly traded company. Effective November 7, 2002, Empire Blue Cross Blue Shield ("Empire BCBS") converted from a NYIL Article 43 non-profit health service corporation to a NYIL Article 42 for-profit accident and health insurer. Simultaneously with the conversion, Empire BCBS merged with its then NYIL Article 42 subsidiary, EHCA, with Empire BCBS being the surviving corporation and taking the name of the subsidiary. EHCA wholly owns EHC HMO.

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

On September 27, 2005, representatives of WellPoint, Inc. ("WellPoint"), a publicly traded managed care for-profit company and WellChoice announced their intention to enter into a definitive merger agreement. Under the terms of the agreement, WellPoint agreed to acquire all of the outstanding shares of WellChoice. On December 28, 2005, WellPoint completed its acquisition of WellChoice when WellChoice merged with and into WellPoint Holding Corp., a direct and wholly-owned subsidiary of WellPoint, with WellPoint Holding Corp. as the surviving entity of the merger. After completion of the merger, the ultimate parent of EHCA was WellPoint. Effective December 2, 2014, WellPoint changed its corporate name to Anthem, Inc. Subsequently on June 27, 2022, Anthem, Inc. changed its name to Elevance Health Inc.

The Company continues to do business as Empire Blue Cross and Blue Shield in the State of New York and remains the parent of EHC HMO.

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

3. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("PROMPT PAY LAW")

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within either 30 days of receipt of a claims that is transmitted via the internet or electronic mail or within 45 days of receipt for a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim…within 30 days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or 45 days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

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

> "(c)(1) …any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the

> amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

Section 3224-a(d)(2) of the New York Insurance Law states, in part:

> "(d) For the purposes of this section:
>
> (2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen or thirty-one of the mental hygiene law, a fiscal intermediary operating under section three hundred sixty-five of the social services law, a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical products, services or durable medical equipment, or a representative designated by such entity or person…"

A review of EHC HMO's compliance with Section 3224-a of the NYIL, was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material issues were noted by the examiner.

A statistical sample of claims not adjudicated within 30 days (for claims submitted via internet or electronic mail), or 45 days (for claims submitted by other means such as paper or facsimile) by EHCA was reviewed to determine whether claims were processed in compliance with the timeframe requirements of Sections 3224-a(a) and (b) of the NYIL, and if interest was required, whether it was paid pursuant to Section 3224-a(c) of the NYIL. Accordingly, all claims that were paid after 30 (electronic submission) and 45 days of receipt (manual submission) respectively during the period January 1, 2018 through December 31, 2018 were segregated.

Using ACL software, the examiner conducted an analysis of the medical, hospital, Medicare supplemental, vision, dental and pharmacy claims. It was determined that the number of

claims that EHCA processed in excess of the time frames prescribed in Section 3224-a of the NYIL exceeded the 2% threshold.

The examiner, therefore, conducted a review of claims (electronic claim submissions) processed by EHCA's Pharmacy Benefit Manager, Express Scripts, Inc. ("ESI") in order to determine the number of claims that were processed in violation of New York Insurance Law Sections 3224-a(a) and (c). During the review of the EHCA pharmacy claims submitted electronically, it was noted that 117,743 claims out of the total population of 1,460,802 pharmacy claims processed, during the period under review, were not paid within 30 days. Samples were drawn from EHCA's pharmacy claims consisting of 167 randomly selected unique claims to test compliance with Section 3224-a(a) of the NYIL for this review.

The following chart illustrates EHCA compliance with the Prompt Pay Law, as determined by this examination:

2018 EHCA ESI – Summary of Violations of NYIL Section 3224-a(a)	
	Pharmacy Claims
Total population	1,460,802
Population of claims paid after 30 days	117,743
Sample Size	167
Number of claims with violations	167
Calculated violation rate	100%
Total Prompt Pay claims in violation	**117,743**

Of the 117,743 claims found to be in violation of Section 3224-a(a) of the New York Insurance Law, 16,417 claims were also found to be in violation of Section 3224-a(c) of the New York Insurance Law.

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims paid more than 30 days from receipt, and were adjudicated during the period January 1, 2018 through December 31, 2018.

Additionally, when an explanation for the delay in pharmacy claims payment was requested, EHCA responded that most of the claims were filled at out-of-state pharmacies. EHCA further explained that prescriptions are written by a physician or other provider licensed to prescribe under Title Eight of New York Education Law, and are dispensed by a pharmacist. Since the pharmacists are not licensed in New York, these claims, according to EHCA, are not subject to New York Prompt Pay Law. However, the Law does not permit such an exception and so, the claims were deemed to be late under the sample testing detailed above. Section 3224-a(d) of the New York Insurance Law defines the "healthcare provider" as "a dispenser or provider of pharmaceutical products" irrespective of them having a New York license. The prior market conduct report on examination recommended that EHCA comply with Section 3224-a of the New York Insurance Law.

It is again recommended that EHCA comply with the requirements of Sections 3224-a(a), (c) and (d) of the New York Insurance Law and process all claims within the required timeframes, paying interest where appropriate.

4. FRAUD WARNING STATEMENTS

Part 86.4(a) of New York Insurance Regulation No. 95 (11 NYCRR 86.4) states, in part:

> "(a) Except with respect to automobile insurance, all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:

> "Any person who knowingly and with intend to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

A review of the Empire Companies' pharmacy claim form used during the examination period revealed that the form included a fraud warning statement that was not in compliance with the requirements of Part 86.4(a) of New York Insurance Regulation No. 95 (11 NYCRR 86.4).

It is recommended that the Empire Companies comply with the requirements of Part 86.4(a) of New York Insurance Regulation No. 95 by revising the fraud warning statement included in its pharmacy claim forms to specifically indicate the monetary fine for the filing of a fraudulent claim(s).

The chart below displays the total number of pharmacy claim forms used in calendar years 2015, 2016, 2017 and 2018.

Summary of Violations of Pharmacy Claim Form		
	EHCA	**EHC HMO**
2015	1,982	1,662
2016	1,492	2,409
2017	1,176	877
2018	9,198	327
Total violations	**13,848**	**5,275**

5. RISK-SHARING AGREEMENTS

Part 101.4(c) of Insurance Regulation No. 164 (11 NYCRR 101.4) states:

"An insurer who uses a capitation arrangement to transfer all or part of its financial risk to a health care provider must do so by a contract approved by the superintendent."

For calendar years 2017, 2018 and 2019, Empire failed to provide its risk-sharing agreement (effective January 1, 2017), and five (5) subsequent amendments for LIBERTY Dental Plan Corporation, to the Department for review and approval.

It should be noted that the LIBERTY Dental Plan Corporation agreement was hereby amended via the Sixth Amendment on October 4, 2019, to change the compensation arrangement for the Empire HMO business from pre-capitation to post capitation.

For calendar years 2016 and 2017, EHC HMO failed to provide its thirteenth amendment, effective January 1, 2016 and fourteenth amendment, effective January 1, 2017, for the American Specialty Health IPA of New York Inc. agreement to the Department for review and approval.

It is recommended that Empire Companies file all risk-sharing agreements and amendments thereto with the Department, in accordance with Part 101.4(c) of Insurance Regulation No. 164.

6. RECORD RETENTION

Parts 243.2(b)(7) and (8) of Insurance Regulation No. 152 (11 NYCRR 243.2) states:

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

(7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset ownership, and source documents, for six calendar years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer.

> (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 record retention periods for the Empire Companies' business functions *Actuarial* (ACT-1020 Customer Operational Results – Retention 5 years) and *Information Technology* (ISY-1000 Disaster Recovery Plans – Retention Active plus 3 years), was less than the required six (6) calendar years.

In one prospective review case, EHCA's third-party administrator ("TPA"), American Imaging Management, Inc. ("AIM"), failed to retain the approval and adverse determination letters, that are subject to audit for a period of six (6) calendar years, in violation of Part 243.2(b)(8) of Insurance Regulation No. 152.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Part 243.2(b)(7) and (8) of Insurance Regulation No. 152 by retaining copies of all approval and determination letters for the required timeframe.

7. COMPLAINTS

Part 216.4 of Insurance Regulation No. 64 (11 NYCRR 216.4) states, in part:

> "(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing...
>
> (b) An appropriate reply shall be made within 15 business days on all other pertinent communications…"

Of eighty-six (86) sampled complaints, there were two (2) instances where EHCA did not acknowledge receipt of the member's complaint. Of twenty (20) sampled complaints, there were two (2) instances where EHC HMO did not acknowledge receipt of the member's complaint. Of

eighty-six (86) sampled complaints, there were three (3) instances where EHCA did not respond to the member's complaint within fifteen (15) business days. Of twenty (20) sampled complaints, there were two (2) instances where EHC HMO did not respond to the member's complaint within fifteen (15) business days.

It is recommended that EHCA and EHC HMO comply with Part 216.4 of Insurance Regulation No. 64 by acknowledging and responding to member complaints within the required time frame.

By means of extrapolation, the aforementioned errors are summarized in the following table. Please note that any claim with one or more violation within the same section of the Law or regulation was reflected as a single violation on the chart:

2018 EHCA & EHC HMO Complaints - Summary of Violations NY Insurance Regulation violations		
	Total EHCA	**Total EHC HMO**
Total Reviewed	86	20
Regulation No. 64 (11 NYCRR 216.4)	3	2
Total Population	170	22
Total Violations	**6**	**2**

8. GRIEVANCES

Section 4802(b)(2)(iii) of the New York Insurance Law states:

> "(2) The notice to an insured describing the grievance process shall explain:
>
> (iii) the right of an insured to designate a representative to file a grievance on behalf of the insured.

Sections 4802(d)(1), and (d)(3) of the New York Insurance Law state, in part:

"(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:

(1) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health…

(3) forty-five days after the receipt of all necessary information in all other instances."

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

"(4) Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:

(i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health…"

The prior market conduct report on examination recommended that EHC HMO comply with Section 4408-a(4) of the New York Public Health Law.

Section 4802(f) of the New York Insurance Law states:

"(f) The notice of a determination of the grievance shall be made in writing to the insured or to the insured's designee. In the case of a determination made in conformance with subparagraph (1) of subsection (d) of this section, notice shall be made by telephone directly to the insured with written notice to follow within three business days."

Section 4408-a(6) of the New York Public Health Law states:

"(6) The notice of a determination of the grievance shall be made in writing to the enrollee or to the enrollee's designee. In the case of a determination made in conformance with subparagraph (i) of subdivision four of this section, notice shall be made by telephone directly to the enrollee with written notice to follow within three business days."

Section 4802(g)(3) of the New York Insurance Law states:

"(g) The notice of a determination shall include:

(3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal."

The examiner selected a sample of seventy (70) grievances for EHCA and fifty (50) grievances for EHC HMO, covering the year 2018, (totaling 120) for review. Based on the examiner's review, the Empire Companies appeared to be in violation of one or more of the aforementioned listed sections of the New York Insurance Law and Public Health Law. The examiner's review of the grievance cases determined the following number of violations:

2018 EHCA Grievances - Summary of Violations NY Insurance Laws violations	
	Total
Total Samples Reviewed	70
NYIL 4802	19
Total Population	1,932
Total Violations	**524**
2018 EHC HMO Grievances - Summary of Violations NY Public Health Laws violations	
	Total
Total Samples Reviewed	50
NYPHL 4408-a	4
Total Population	481
Total Violations	**39**

It is recommended that EHCA comply with Section 4802(b)(2)(iii) of the New York Insurance Law by ensuring that all notices to insureds explain the insured's right to designate a representative to file a grievance on behalf of the insured describing the grievance process.

It is recommended that EHCA and again recommended that EHC HMO comply with Section 4802(d) of the New York Insurance Law and Section 4408-a(4) of the New York Public Health Law by providing the written acknowledgment letter to the member within fifteen business days after receipt of the grievance.

It is also recommended that EHCA and EHC HMO comply with Section 4802(d)(1) and (3) of the New York Insurance Law and Section 4408-a(4)(i) of the New York Public Health Law by resolving expedited grievances within forty-eight hours and non-expedited grievances within forty-five days after receipt of all necessary information.

It is recommended that EHCA and EHC HMO comply with Section 4802(f) of the New York Insurance Law and Section 4408-a(6) of the New York Public Health Law by providing all notices of expedited grievance resolutions by telephone to the member within forty-eight hours after receipt of all necessary information.

It is recommended that EHCA comply with Section 4802(g)(3) of the New York Insurance Law by including the procedures for the filing of an appeal of the determination in all notices of grievance determinations.

For the appeal cases, the examiner selected 26 cases for EHCA and the entire population of 4 appeal cases for EHC HMO, covering 2018, (totaling 30 cases) for review. The review revealed that the Empire Companies appeared to be in violation of one or more sections of the New York Insurance Law and Public Health Law listed below.

Section 4802(i) of the New York Insurance Law states:

> "(i) Within fifteen business days of receipt of the appeal, the insurer shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the insurer to respond to the appeal and what additional information, if any, must be provided in order for the insurer to render a decision."

Section 4408-a(9) of the New York Public Health Law states:

> "(9) Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and

> what additional information, if any, must be provided in order for the organization to render a decision."

Section 4802(k)(2) of the New York Insurance Law states:

> "(k) The insurer shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:
>
> (2) thirty business days after the receipt of all necessary information in all other instances."

The examiner's review of the grievance appeal cases determined the following number of violations:

2018 EHCA Grievance Appeals - Summary of Violations NY Insurance Laws violations	
	Total
Total Samples Reviewed	26
NYIL 4802	4
Total Population	104
Total Violations	**16**
2018 EHC HMO Grievance Appeals - Summary of Violations NY Public Health Laws violations	
	Total
Total Samples Reviewed	4
NYPHL 4408-a	1
Total Population	4
Total Violations	**1**

It is recommended that EHCA and EHC HMO comply with Section 4802(i) of the New York Insurance Law and Section 4408-a(9) of the New York Public Health Law by providing the written acknowledgment letter to the member within fifteen business days after receipt of the appeal.

It is recommended that EHCA comply with Section 4802(k)(2) of the New York Insurance Law by providing the notice of appeal determination to the member within thirty business days after receipt of all necessary information.

9. UTILIZATION REVIEW AND APPEALS

During the examination period, the Empire Companies had the following TPAs: Express Scripts, Inc. ("ESI"), American Specialty Health Group, Inc. ("ASH"), OrthoNet LLC ("OrthoNet"), Women's Integrated Network, Inc. ("WIN"), American Imaging Management, Inc. ("AIM") and Anthem Utilization Management Services, Inc. ("AUMSI"), an Empire affiliate that performs utilization review services for both medical and behavioral health services ("BH"). They are assigned as utilization review agents to conduct and provide utilization review services. The examiner reviewed Utilization Review and Appeal cases for the year 2018 for the Empire Companies and their TPAs.

For the Utilization Review cases, the examiner selected 2 samples: 90 cases for EHCA and 44 cases for EHC HMO, covering 2018, (totaling 134) for review. The cases selected included retrospective, concurrent and prospective cases from the Empire Companies, as well as the TPAs mentioned above. Based on the examiner's review, the Empire Companies and TPAs appeared to be in violation of the below listed sections of the New York Insurance Law.

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

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

The prior market conduct report on examination recommended that the Empire Companies comply with Section 4903(b) of the New York Insurance Law.

Section 4903(2) of the New York Public Health Law states:

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

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

"(1) 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..."

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

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

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

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

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

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

"In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the insured's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one business day of receipt of the request and shall be conducted by the insured's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, the utilization review agent shall provide notice as required pursuant

to subsection (e) of this section. Nothing in this section shall preclude the insured from initiating an appeal from an adverse determination."

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

"A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone…"

The prior market conduct report on examination recommended that EHCA comply with Section 4904(c) of the New York Insurance Law.

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

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

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

29 C.F.R. § 2560.503-1(f)(2)(i) states the following, in part:

"In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible… The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information … The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information."

Empire's policy and procedures (Section XX(B)(2) of the 2017050166 filing) states, in part:

"With respect to urgent Preauthorization requests… If We need additional information, we will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or

> Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period."

Empire's policy and procedures (Section XX(C)(1) of the 2017100145 filing) states:

> "Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period."

45 C.F.R. § 147.136(b)(2)(ii)(E)(1) states the following:

> "(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning)."

The examiner's review of the Utilization Review cases determined the following number of violations:

2018 EHCA – AUMSI, ESI, ASH, OrthoNet, BH, WIN and AIM Utilization Review - Summary of Violations								
	AUMSI	**ESI**	**ASH**	**OrthoNet**	**BH**	**WIN**	**AIM**	**Total**
Prospective Cases								
Total Samples Reviewed	10	14	4	8	3	4	12	55
NY Insurance Law violations								
NYIL 4903	4	6	0	0	1	1	1	
45 CFR 147.136(b)(2)(ii)(E)(1)	0	7	0	0	2	0	0	
29 CFR 2560.503-1(f)(2)(i)	0	0	0	0	0	1	0	
Regulation No. 152 (11 NYCRR 243.2)	0	0	0	0	0	0	1	
Total Population	724	3,696	1,079	2,084	35	328	5,075	
Total Violations	290	3,432	0	0	35	82	846	**4,685**
Concurrent Cases								
Total Samples Reviewed	2	0	0	8	10	0	0	20
NY Insurance Law violations								
NYIL 4903	1	0	0	1	7	0	0	
45 CFR 147.136(b)(2)(ii)(E)(1)	0	0	0	0	2	0	0	
Total Population	619	0	0	2,187	77	0	0	
Total Violations	310	0	0	273	54	0	0	**637**

Retrospective Cases								
Total Samples Reviewed	0	0	3	0	1	3	8	15
NY Insurance Law violations								
NYIL 4903	0	0	0	0	0	2	2	
NYIL 4904	0	0	0	0	0	2	0	
45 CFR 147.136(b)(2)(ii)(E)(1)	0	0	0	0	0	2	0	
Total Population	0	0	281	0	1	6	329	
Total Violations	0	0	0	0	0	4	82	**86**
Grand total Violations	600	3,432	0	273	89	86	928	**5,408**

2018 EHC HMO - AUMSI, ESI, ASH, OrthoNet, BH, WIN and AIM Utilization Review - Summary of Violations								
	AUMSI	**ESI**	**ASH**	**OrthoNet**	**BH**	**WIN**	**AIM**	**Total**
Prospective Cases								
Total Samples Reviewed	5	7	4	4	2	2	6	30
NY Public Health Law violations								
NYPHL 4903	2	4	0	0	1	0	2	
45 CFR 147.136(b)(2)(ii)(E)(1)	0	2	0	0	0	0	0	
Total Population	25	285	95	222	2	3	419	
Total Violations	10	244	0	0	1	0	140	**395**
Concurrent Cases								
Total Samples Reviewed	2	0	0	4	2	0	0	8
NY Public Health Law violations								
NYPHL 4903	1	0	0	2	0	0	0	
45 CFR 147.136(b)(2)(ii)(E)(1)	0	0	0	0	1	0	0	
Total Population	67	0	0	262	2	0	0	
Total Violations	34	0	0	131	1	0	0	**166**
Retrospective Cases								
Total Samples Reviewed	0	0	3	0	0	0	3	6
NY Public Health Law violations								
45 CFR 147.136(b)(2)(ii)(E)(1)	0	0	0	0	0	0	2	
Total Population	0	0	33	0	0	0	13	
Total Violations	0	0	0	0	0	0	9	**9**
Grand total Violations	44	244	0	131	2	0	149	**570**

Note: The amounts listed in the above exhibits represent a summary of the Empire Companies and TPA's of which there were separate error rates and total populations for prospective, concurrent and retrospective cases for each company and each TPA. All totals by year, Company and TPA cases for that company were summarized and totaled for the above exhibits.

It is again recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(b)(1) of the New York Insurance Law and Section 4903(2)(a) of the New York Public Health Law by making a utilization review determination involving health care services which require pre-authorization and providing all notices of determination by telephone and in writing to the member and the provider within three (3) business days of receipt of the necessary information.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(c)(1) of the New York Insurance Law and Section 4903(3)(a) of the New York Public Health Law by making a determination involving continued or extended health care services and providing all notices of determination by telephone and in writing to the member and/or the provider within one (1) business day of receipt of the necessary information.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(e)(2) of the New York Insurance Law by including instructions on how to initiate expedited and standard appeals, and external appeals in all initial adverse determination letters.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(f) of the New York Insurance Law by providing the notice of adverse determination upon reconsideration to the member and the provider.

It is again recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law by including a statement that the appeal may be filed in writing or by telephone in all their initial adverse determination letters.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by retaining copies of all determination letters that are subject to an audit for the required timeframe.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of 29 C.F.R. § 2560.503-1(f)(2)(i) by providing the notice of the determination for all pre-service claims involving urgent care to the member and the provider within the required timeframe.

It is further recommended that the Empire Companies, its affiliates and third-party administrators adhere to its policies and procedures regarding urgent preauthorization requests.

It is recommended that the Empire Companies, its affiliates and third-party administrators request additional information, when needed within one business day of the initial receipt of the concurrent request according to its policies and procedures.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of 45 C.F.R. §147.136(b)(2)(ii)(E)(1) by including information sufficient to identify the claim involved.

For the Appeal cases the examiner selected 3 samples. 76 cases were selected for EHCA for 2018, 50 cases were selected for EHC HMO for 2018, and 19 cases were selected for OrthoNet totaling 145 cases for review in total. The cases selected included member and provider cases from the Empire Companies' affiliate, AUMSI and OrthoNet. The review revealed that the Empire Companies and their TPA appeared to be in violation of one or more of the below New York Insurance Laws, Public Health Laws, Regulations and Federal Laws.

Section 4904(c)(2) of the New York Insurance Law states, in part:

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

information to conduct the appeal. 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:

(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..."

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

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

(b) 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..."

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

"Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination."

Parts 410.9(e)(3) and (6) of Insurance Regulation No. 166 (11 NYCRR 410.9) state, in part:

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

(3) the health care plan's contact person and his or her telephone number…

(6) the utilization review agent's contact person and his or her telephone number…"

Parts 98-2.9(e)(2), (3) and (6) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-2.9) state, in part:

> "Each notice of a final adverse determination of an expedited or standard utilization review appeal under section 4904 of the Public Health Law shall be in writing, dated and include the following:
>
> (2) a clear statement that the notice constitutes the final adverse determination…
>
> (3) the health care plan's contact person and his or her telephone number…
>
> (6) the utilization review agent's contact person and his or her telephone number…"

Part 410.9(h)(1) of Insurance Regulation No. 166 (11 NYCRR 410.9) states, in part:

> "(h) Health care plans shall facilitate the prompt completion of external appeal requests, including but not limited to, the following:
>
> (1) Health care plans shall provide the insured with a copy of the standard description of the external appeal process as developed jointly by the superintendent and commissioner, including a form and instructions for requesting an external appeal along with a description of the fee, if any, charged to insureds for an external appeal, criteria for determining eligibility for a waiver of such fees based on financial hardship, and the process for requesting a waiver of such fees based on financial hardship…"

Part 98-2.9(h)(1) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-2.9) states, in part:

> "Health care plans shall facilitate the prompt completion of external appeal requests, including but not limited to, the following:
>
> (1) Health care plans shall provide the enrollee with 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, if any, charged to enrollees for an external appeal, criteria for determining eligibility for a waiver of such fees based on financial hardship, and the process for requesting a waiver of such fees based on financial hardship…"

The review of the Utilization Review Appeal cases resulted in the following number of violations:

2018 EHCA - AUMSI and OrthoNet Utilization Review Appeal - Summary of Violations Utilization Review Member Appeal Cases			
	AUMSI	**OrthoNet**	**Total**
Total Samples Reviewed	18	3	21
New York Insurance Law violations			
NYIL 4904	8	0	
Regulation No. 166 (11 NYCRR 410.9)	3	3	
Total Population	1,833	7	
Total Violations	917	7	**924**
2018 EHCA - AUMSI and OrthoNet Utilization Review Appeal - Summary of Violations Utilization Review Provider Appeal Cases			
	AUMSI	**OrthoNet**	**Total**
Total Samples Reviewed	58	13	71
New York Insurance Law & Federal Regulations violations			
NYIL 4904	47	5	
Regulation No. 166 (11 NYCRR 410.9)	2	10	
Total Population	4,365	47	
Total Violations	3,537	40	**3,577**
2018 EHC HMO – AUMSI and OrthoNet Utilization Review Appeal - Summary of Violations Utilization Review Member Appeal Cases			
	AUMSI	**OrthoNet**	**Total**
Total Samples Reviewed	11	1	12
New York Public Health Law violations			
NYPHL 4904	4	0	
NYDOH Part 98 (10 NYCRR 98-2.9)	1	1	
Total Population	115	1	
Total Violations	42	1	**43**
2018 EHC HMO – AUMSI and OrthoNet Utilization Review Appeal - Summary of Violations Utilization Review Provider Appeal Cases			
	AUMSI	**OrthoNet**	**Total**
Total Samples Reviewed	39	2	41
New York Public Health Law, Regulations & Federal Regulations violations			
NYPHL 4904	30	0	
NYDOH Part 98 (10 NYCRR 98-2.9)	4	2	
Total Population	537	5	
Total Violations	413	5	**418**

Note: The amounts listed in the above exhibits represent a summary of the Empire Companies and TPA's of which there were separate error rates and total populations for utilization review appeal cases for each company and each TPA. All totals by year, Company and TPA cases for that company were summarized and totaled for the above exhibits.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Sections 4904(c)(2) of the New York Insurance Law and Sections

4904(3)(b) of the New York Public Health Law, respectively, by sending acknowledgement letters within fifteen (15) days, by sending appeal determinations within two (2) business days after rendering a determination, and including the timeframes to request an external appeal in all final adverse determination letters.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4904(d) of the New York Insurance Law by ensuring that its peer reviewers are individuals other than the clinical peer reviewers who rendered the initial adverse determination.

It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Parts 410.9(e)(3) and (6) of Insurance Regulation 166 and Parts 98-2.9(e)(2), (3) and (6) of the Administrative Rules and Regulations of the New York Department of Health (10 NYCRR 98-2.9) by including a clear statement that the appeal determination constitutes the final adverse determination and by including the contact persons and telephone numbers for both the health care plan and the utilization review agent in all the final adverse determination letters.

It is also recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Part 410.9(h)(1) of Insurance Regulation 166 and Part 98-2.9(h)(1) of the Administrative Rules and Regulations of the New York Department of Health (10 NYCRR 98-2.9) by including 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 waiver, with all the final adverse determination letters.

10. REPORTING OF GRIEVANCES AND UTILIZATION REVIEW APPEALS

Insurance Circular Letter No. 5 (1999) states, in part:

> "… Section 210(b)(1) of the New York State Insurance Law mandates that HMOs and insurers report to the Insurance Department the number of grievances filed pursuant to 4408-a of the Public Health Law (as added by Chapter 705 of the Laws of 1996) or Section 4802 of the Insurance Law, and the number of such grievances where a determination was reversed in whole or in part compared to the number of determinations that were upheld. Section 210(b)(2) of the Insurance Law also requires HMOs and insurers to report the number of appeals to UR determinations which were filed pursuant to Article 49 of the Public Health Law or Article 49 of the Insurance Law and the number of adverse determinations which were reversed versus the number upheld. HMOs and insurers must include grievance and UR appeal information in the annual statements they are required to file with the Insurance Department …"

A review of the "Exhibit of Grievances and Utilization Review Appeals" for EHCA, and "N.Y. Schedule M" for EHC HMO as contained in their 2018 (NY Supplement/Data Requirements) filings with the Department, revealed that both companies incorrectly reported the total number of grievances and utilization review appeals on their respective filed exhibit and/or schedule.

The Empire Companies were unable to reconcile the grievances and utilization review appeals totals listed in the Supplement/Data requirements to the grievance and utilization review appeals data files given to the examiner for review.

Additionally, a review of the "Exhibit of Grievances and Utilization Review Appeals" for EHCA as contained in its 2018 (NY Supplement) filing with the Department, revealed that EHCA did not report the total number of utilization review determinations on its respective filed exhibit.

It is recommended that the Empire Companies comply with Insurance Circular Letter No. 5 (1999) and report correct data on the Exhibit of Grievances and Utilization Review Appeals and Schedule M within their NY Supplement/Data requirements' filings with the Department.

11. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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 2713 of the Public Health Service Act offer similar supporting guidance.

The examiner reviewed 75 elements of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims for EHCA and EHC HMO with regard to the aforementioned 75 elements for co-pay, deductible and coinsurance costs attributed to the member.

The examiner received separate data files by source system from Empire. Samples were selected per source system. The examiner extracted from the data files all preventive service claims with cost sharing.

The examiner also performed compliance testing on samples of EHCA and EHC HMO preventive service claims. For 2018, the examiner tested the entire population of the preventive service claims that included member cost sharing. The testing resulted in 897 claim instances, respectively, in which EHCA applied cost sharing to preventive service claims in error or the claims were denied in error, in violation of the abovementioned sections of state and federal laws.

The following chart shows the source system by company, total population and total claims in violation:

2018 EHCA – Summary of Violations of Preventive service claims	
System Type	WGS
Total population	37,477
Total Violations	**897**

It is recommended that EHCA comply with New York Insurance Law Sections 3216(i)(17)(E) and 3221(l)(8)(E) and Section 2713 of the Public Health Service Act by not applying member cost-sharing to Preventive Care claims, when not applicable.

12. MARKETING AND SALES

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

> "(c) 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."

A review of the Empire Companies' advertising materials, that included e-mails, internet postings, and mail packages, for the year 2017, revealed that the companies offered unlawful rebates or inducements, such as, offering the public a free Amazon Echo device, exceeding twenty-five dollars in value, as an incentive for scheduling a meeting to discuss their product offerings, in violation of Section 4224(c) of the New York Insurance Law.

It is recommended that the Empire Companies comply with the requirements of Section 4224(c) of the New York Insurance Law and refrain from offering unlawful inducements exceeding twenty-five dollars in value.

13. PRODUCER LICENSING

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

> "(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."

EHC HMO failed to file certificates of appointment with the Department for eight (8) agents within fifteen days from the date the agency contract was executed or the first insurance application was submitted, in violation of Sections 2112(a) and (b) of the New York Insurance Law.

It is recommended that EHC HMO comply with the requirements of Sections 2112(a) and (b) of the New York Insurance Law by filing a certificate of appointment with the Department within fifteen days from the date the contract is executed or the first insurance application is submitted, in order to appoint insurance agent to represent the Companies.

14. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2014, contained the following twenty (20) comments and recommendations (page numbers below refer to the prior report on examination):

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

ITEM NO.		PAGE NO.
6.	It is recommended that Empire test all systems thoroughly to ensure they are working properly before they are loaded into production. *The Companies have complied with this recommendation.*	15
7.	It is recommended that Empire comply with its own policy and ensure that the rate sheet creation process is completed at least 30 calendar days prior to the rate sheet effective date. *The Companies have complied with this recommendation*.	15
8.	It is recommended that Empire comply with Section 3224-a of the New York Insurance Law and pay claims timely, regardless of source. *The Plan has complied with this recommendation; EHCA did not comply with this recommendation*. *A similar comment is included in this report for EHCA.*	16
9.	It is recommended that the Plan comply with Section 3224-a(c) of the New York Insurance Law by implementing controls to ensure that claims paid late under the Prompt Pay Law are paid interest when such interest is due. *The Plan has complied with this recommendation.*	17
10.	It is recommended that Empire perform outreach to its provider networks to educate them on the proper coding for claims containing treatments recommended by the United States Preventive Care Task Force. *The Companies have complied with this recommendation.*	18
11.	It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4903(b) of the New York Insurance Law. *The Empire Companies did not comply with this recommendation. A similar comment is included in this report.*	20
12.	It is recommended that Empire, its affiliates and third-party administrators comply with the requirements of Section 4904(b) of the New York Insurance Law. *The Companies have complied with this recommendation.*	20

ITEM NO.		PAGE NO.
13.	It is recommended that EHCA and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law. *The Company did not comply with this recommendation. A similar comment is included in this report.*	21
14.	It is recommended that EHC-HMO execute all management agreements prior to implementation. *The Plan has complied with this recommendation.*	22
15.	It is recommended that EHC-HMO comply with the provisions of Section 4408-a(4) of the New York Public Health Law by acknowledging receipt of all grievances within 15 business days of receipt of the grievance. *The Plan did not comply with this recommendation. A similar comment is included in this report.*	23
16.	It is also recommended that EHCA comply with its internal grievance procedures by acknowledging all grievances within 15 business days of receipt of the grievance. *The Company did not comply with this recommendation. A similar comment is included in this report.*	23
17.	It is recommended that EHCA resolve all grievances within 30 days of receipt of all necessary information in compliance with its internal grievance procedures. *The Company did not comply with this recommendation. A similar comment is included in this report.*	23
18.	The Department recognizes that Empire has made significant efforts to increase the accuracy of its directories and recommends that the Companies institute regular and frequent audits of its directories to ensure such efforts are successful. *The Companies have complied with this recommendation.*	26
19.	It is recommended that the Companies comply with Parts 243.2 (a) and (b) of Insurance Regulation No. 152 (11 NYCRR 243) and maintain all appropriate records for all areas of operations. *The Companies have complied with this recommendation.*	27

ITEM NO.		PAGE NO.
20.	It is recommended that the Companies comply with Section 310(a)(3) of the New York Insurance Law by ensuring that the information being provided to the examiner is accurate, complete and timely. *The Companies have complied with this recommendation.*	28

15. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

ITEM **PAGE NO.**

G. Utilization Review and Appeals (cont'd)

which require pre-authorization and providing all notices of determination by telephone and in writing to the member and the provider within three (3) business days of receipt of the necessary information.

ii. It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(c)(1) of the New York Insurance Law and Section 4903(3)(a) of the New York Public Health Law by making a determination involving continued or extended health care services and providing all notices of determination by telephone and in writing to the member and/or the provider within one (1) business day of receipt of the necessary information. 22

iii. It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(e)(2) of the New York Insurance Law by including instructions on how to initiate expedited and standard appeals, and external appeals in all initial adverse determination letters. 22

iv. It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4903(f) of the New York Insurance Law by providing the notice of adverse determination upon reconsideration to the member and the provider. 22

v. It is again recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law by including a statement that the appeal may be filed in writing or by telephone in all their initial adverse determination letters. 22

vi. It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by retaining copies of all determination letters that are subject to an audit for the required timeframe. 22

vii. It is recommended that the Empire Companies, its affiliates and third-party administrators comply with the requirements of 29 C.F.R. § 2560.503-1(f)(2)(i) by providing the notice of the determination for all pre-service claims involving urgent care to the member and the provider within the required timeframe. 23

ITEM **PAGE NO.**

Respectfully submitted,

Manaal Al Mamun
Financial Services Examiner 3

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

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

Manaal Al Mamun

Subscribed and sworn to before me

this _____ day of _____ 2024

APPOINTMENT NO. **31840**

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:*

Manaal Al Mamun

as a proper person to examine the affairs of the

Empire HealthChoice Assurance, Inc.

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

Company

with such other information as she shall deem requisite.

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

this 13th day of December, 2018

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. 31841

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:*

Manaal Al Mamun

as a proper person to examine the affairs of the

Empire HealthChoice HMO, Inc.

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

HMO

with such other information as she shall deem requisite.

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

this 13th day of December, 2018

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau