REPORT ON EXAMINATION

OF

GROUP HEALTH INCORPORATED

AS OF

DECEMBER 31, 2003

DATE OF REPORT: **MARCH 26, 2007**

EXAMINER: **KATHLEEN GROGAN**

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

Elliot Spitzer
Governor

Eric R. Dinallo
Acting Superintendent

March 26, 2007

Honorable Eric R. Dinallo
Acting Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in compliance with the instructions contained in Appointment Number 22137, dated January 30, 2004, attached hereto, I have made an examination into the condition and affairs of Group Health Incorporated, a not-for-profit health service corporation licensed pursuant to the provisions of Article 43 of the Insurance Law, as of December 31, 2003, and respectfully submit the following report thereon.

The examination was conducted at the home office of Group Health Incorporated, located at 441 Ninth Avenue, New York, New York.

Wherever the terms “the Plan” or “GHI” appear in this report without qualification, they should be understood to refer to Group Health Incorporated.

Wherever the term “the Department” appears in this report, it should be understood to refer to the State of New York Insurance Department.

1. SCOPE OF EXAMINATION

A previous examination was conducted as of December 31, 1999. This examination covers the four-year period January 1, 2000 through December 31, 2003. Where deemed appropriate, transactions occurring subsequent to this period were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2003 in accordance with Statutory Accounting Principles ("SAP"), as adopted by the Department; a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners' Handbook of the National Association of Insurance Commissioners:

History of the Plan
Management and control
Corporate records
Fidelity bond and other insurance
Territory and plan of operation
Market conduct activities
Growth of the Plan
Loss experience
Accounts and records
Financial statements

A review was also made to ascertain what action was taken by the Plan with regard to comments contained in the prior report on examination. This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulation or rules, or which are deemed to require explanation or description.

The Plan maintains a subsidiary, GHI HMO Select, Inc. ("the HMO"), a health maintenance organization licensed pursuant to Article 44 of the Public Health Law. A separate report on the examination of the HMO was conducted as of December 31, 2003.

2. DESCRIPTION OF PLAN

GHI is a non-profit health service corporation which was licensed under the provisions of Article 43 of the New York Insurance Law. The Plan was originally incorporated as the Group Health Cooperative, Inc., and began operations on December 6, 1940. It was organized as a Consumer's Cooperative stock corporation under the provisions of Article VII of the Cooperative Corporation Law, for the purpose of furnishing medical expense indemnity insurance to its subscribers. On October 1, 1946, the name Group Health Insurance, Inc. was adopted and the Plan's operations became subject to the provisions of Article IX-C (now recodified as Article 43) of the New York Insurance Law.

The change followed reincorporation as a membership corporation. Effective December 7, 1971, the Charter of Group Health Insurance, Inc. was amended pursuant to the provisions of Section 803 of the Not-for-Profit Corporation Law, changing the name to Group Health Incorporated (GHI) and extending the powers of the corporation to include those of a health service corporation. On December 12, 1972, GHI merged with Group Health Dental Insurance, Inc., leaving GHI as the surviving corporation.

On June 1, 1999, GHI created a subsidiary, GHI HMO Select, Inc. (the HMO"), a health maintenance organization licensed pursuant to Article 44 of the Public Health Law, concurrent

with the purchase of the commercial business of WellCare of New York, a New York licensed health maintenance organization. GHI indirectly owns one hundred percent (100%) of GHI HMO, via GHI's wholly-owned subsidiary, GHI Services LLC. This matter is discussed further under Item 2 B herein.

GHI filed a "Restated Certificate of Incorporation" with the Department in 2006, as part of GHI's plan to pursue an affiliation with Health Insurance Plan of Greater New York (HIP). GHI also adopted new by-laws as part of the pursuit of affiliation with (HIP). See Section 5, of this report "Subsequent Events" for further discussion of GHI's affiliation with HIP.

A. Management and Controls

As of December 31, 2003, the by-laws of the Plan, as amended, provided that the affairs of the Plan shall be managed by a board of directors consisting of not less than fifteen, nor more than twenty-one members. It was noted that subsequent to the examination date, GHI filed with the Department, amended by-laws, which were adopted by its Board on September 28, 2005. The amended by-laws reduced the minimum number of directors to thirteen from fifteen. As noted above, GHI filed new by-laws with the Department in 2006, however the new by-laws reflected no change in the number of directors, from the previously revised by-laws. As of December 31, 2003, the Board was comprised of the following fifteen members:

Name and Residence	Principal Business Affiliation
Provider Representatives	
Jerome S. Breslaw, M.D. New York, NY	Professional practice
Bernard Schayes, M.D. Roslyn, N Y	Professional practice
Employee Representative	
Frank J. Branchini New York, NY	President and Chief Executive Officer, Group Health Incorporated
Subscriber Representatives	
Daniel F. Donohue Clifton Park, NY	President, Civil Service Employees Association, Inc., Local 1000 AFSCME-AFL-CIO
Rosa M. Gil, D.S.W. Elmhurst, NY	University Dean for Health Sciences, City University of New York
Nicholas Mancuso Bronx, NY	Secretary/ Treasurer, International Brotherhood of Teamsters, Local 237, AFL-CIO
Arthur B. Pepper, Baldwin, NY	Director, United Federation of Teachers, Welfare Fund
Jay E. Russ, Esq. Lloyd Harbor, NY	Russ & Russ, P.C.
Roger Toussaint Brooklyn, NY	President, Transit Workers Union of America Local 100
Public Representatives	
Howard Berliner Brooklyn, NY	Professor, Milano Graduate School New School University
Ethelyn A. Chase New York, NY	Foundation Director
John Feerick, Esq. Mount Kisco, NY	Professor of Law, Fordham University

Name and Residence	Principal Business Affiliation
James F. Gill, Esq.* Rockville Centre, NY	Partner, Bryan Cave/Robinson Silverman
Daniel E. Rubino, Esq. Armonk, NY	Partner, Wilkie Farr Gallagher
E. Donald Shapiro, Esq. New York, NY	Former Dean, New York School of Law

* Chairman of the Board

Section 4301(k)(3) of the New York Insurance Law states:

> "No person who has served as a director of any corporation subject to this article for ten consecutive years shall thereafter be elected for an additional term of office as such until at least one year has elapsed since the expiration of his prior term of office. The preceding sentence shall not apply to a director of any corporation subject to this article who is an employee of the corporation and who also serves as an officer of the corporation. The superintendent, upon application by a corporation subject to the provisions of this article, may waive the ten year limit in this paragraph for a non-employee serving as chairman of its board of directors."

Section 4301(k)(3) of the New York Insurance Law limits the term of each director to ten years and provides that the director may be elected again after a year has elapsed. It was noted that GHI requested an exemption from the requirement of Section 4301(k)(3) for Mr. James Gill. In April 2005, the Department waived the requirement and granted a three-year extension for Mr. Gill.

Subsequent to the examination date, the following three GHI Board members reached their statutory ten-year maximum, and resigned from the Board: E. Donald Shapiro, Daniel F. Donohue and Arthur B. Pepper. Additionally, Nicholas Mancuso resigned as a director. The

following individuals joined the GHI Board subsequent to the examination: Harry Nespoli and Dennis Sullivan. In accordance with its newly amended by-laws, GHI's Board is comprised of thirteen directors.

A review of the minutes of the Board of Directors' meetings indicated that one Board member did not attend any of the meetings that he was eligible to attend. He resigned in June of 2003. One Board member attended less than 10% of the Board meetings held, and two other Board members attended less than 50% of the Board meetings held. The minutes of the Board meetings indicated that the above members absences were excused.

Section 4301(k)(4) of the New York Insurance Law states:

> "A director of a corporation subject to this article shall automatically forfeit his office if (i) he fails to attend at least one of the regular meetings of the board of directors held during any period of eighteen months or (ii) unless excused by the board of directors of which he is a member, which action shall be entered on the minutes of such board, it shall appear at the end of any calendar year that he failed to attend at least one-half of the regular meetings of such board held in such calendar year."

The following shows the percentages of meetings attended during the examination period for each board member who failed to attend 50% of the meetings held during that time:

Board Member	Percentage of meetings attended 1/1/2000 – 12/31/2003
Daniel F. Donohue	48%
Denis M. Hughes	0%
Sal T. Ingrassia	7%
Roger Toussaint	47%

Subsequent to the exam date, in 2004, Mr. Donohue did not attend any of the four board

meetings that were held. Additionally, Mr. Toussaint attended two of the four meetings. It should be noted that Mr. Ingrassia resigned from the Board in June 2001 and Mr. Hughes resigned from the Board in June 2003.

Members of the Board have a fiduciary responsibility to and must evince an ongoing interest in the affairs of the insurer. It is essential that Board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the Board. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.

Although Board members' absences were excused, it is recommended that Board members attend the majority of meetings that they are eligible to attend in order to evince their fiduciary responsibility.

Further, it is recommended that GHI's Board review its policy on excusing Board member absences.

The Plan's by-laws provide for an Executive Committee, an Audit Committees, and Special Committees on Nominations and Executive Remuneration. Additionally, regular Investment Committee meetings were held during the examination period. GHI's Audit Committee is comprised of outside directors. The Audit Committee meetings are attended by Mr. Branchini, the CEO and director, and other GHI officers. The Audit Committee minutes reflect that the Committee goes into Executive session with only the outside directors in attendance; however, no minutes from the Executive Session are retained. The Executive Session allows the Audit Committee members to freely discuss topics with the outside auditors,

internal auditors and compliance officer without management present. GHI states that the lack of minutes allows for open discussion.

The following were the Plan's officers as of December 31, 2003:

Name	Title
Frank J. Branchini	President and Chief Executive Officer
Donna Lynne	Executive Vice President and Chief Operation Officer
Jeffrey Chansler	Senior Vice President and General Counsel
William Guerci	Senior Vice President, Treasurer and Chief Financial Officer
Aran Ron, M.D.	Senior Vice President and Chief Medical Officer
William Mastro	Senior Vice President and Corporate Secretary

It was noted that Ms. Donna Lynne resigned effective April 2005 and Mr. William Guerci resigned effective July 2005.

As noted above, GHI filed with the Department, amended by-laws, which were adopted by its Board on September 28, 2005. The by-laws call for an annual meeting of the Board. The by-laws state further:

> *"Regular meetings of the Board shall be held at such times as may be fixed by the Board or pursuant to procedures established by the Board and special meetings of the Board may be held upon call of the President or Secretary or any three members of the Board."*

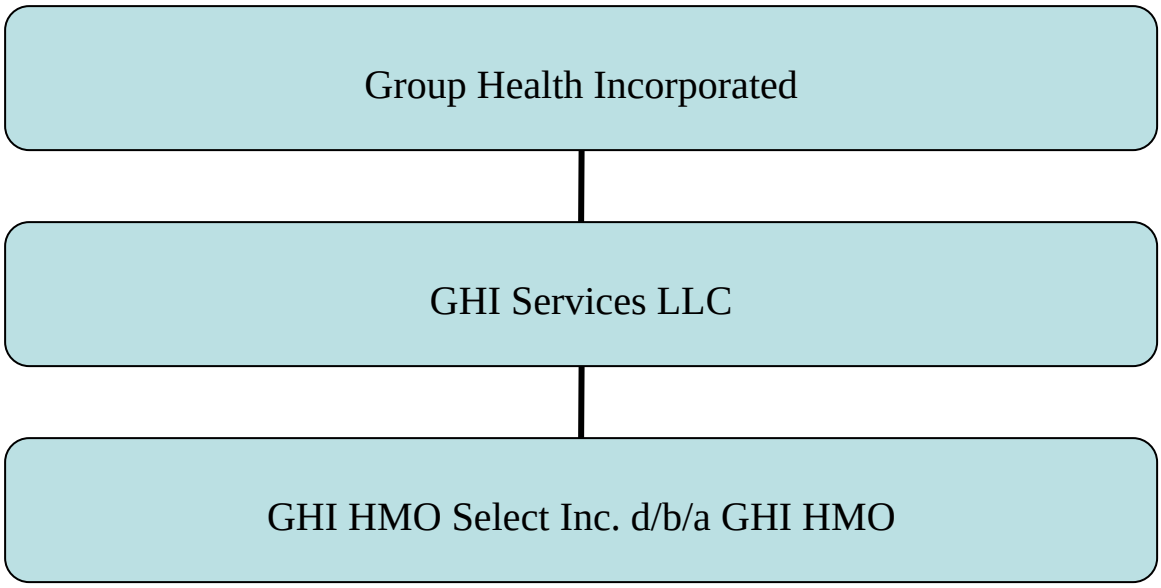
Although GHI's Board met in compliance with the requirements of its by-laws, there was a concern that unless there is a minimum occurrence requirement, the potential exists that the frequency of the meetings may not allow the Board to fulfill its fiduciary duty and provide adequate oversight of the Plan's operations. The Board should meet at least four (4) times per calendar year (preferably every quarter) to review the performance and activities of the Plan.

It is recommended that the Plan amend its by-laws to require its Board to meet a minimum of four times per calendar year.

As was noted above, GHI adopted new by-laws in 2006. These new by-laws call for regular meetings of the Board to be held four times per year.

B. Holding Company System

GHI is the direct parent of GHI Services LLC, who owns 100% of the outstanding shares of GHI HMO Select, Inc. d/b/a GHI HMO. Transactions under GHI's Parent/Subsidiary relationship are subject to Article 17 of the New York Insurance Law and thus the Plan must make the required filings under Department Regulation No. 115 (11 NYCRR 81-2.4) – "Subsidiaries of Life Insurance Companies, Retirement Systems and Article 43 Corporations". These relationships are detailed as follows:



GHI Services LLC was formed as a holding company for other subsidiaries. Currently, GHI HMO is the only subsidiary.

GHI HMO is a health maintenance organization "HMO" licensed pursuant to Article 44 of the Public Health Law. It was formed in 1999 when GHI purchased a block of commercial business from WellCare of New York "WellCare", an HMO operating in Kingston, New York. Effective June 1, 1999, GHI HMO purchased WellCare's commercial (non-government) membership, along with certain assets, and assumed certain liabilities under the GHI-WellCare Asset Purchase Agreement. GHI purchased the commercial business consisting of 22,811 members for $4,781,100. Also effective June 1, 1999, GHI made a capital contribution to GHI HMO in the amount of $3,218,900. The total amount disbursed by GHI in conjunction with the purchase and capital contribution was $8,000,000.

It was noted that subsequent to the examination date the organization chart has significantly

changed due to GHI's affiliation with HIP. The affiliation was also accompanied by a change in control. See Section 5, of this report "Subsequent Events" for further discussion of GHI's affiliation with HIP.

i. Capital Contributions and Loans

During the examination period, GHI invested $17,465,000 in its HMO subsidiary. GHI contributed capital to GHI HMO in the amount of $13,215,000 between October 30, 2000 and December 31, 2003 and GHI loaned GHI HMO $4,250,000 (nine separate loans) in the form of New York Insurance Law Section 1307 loans (surplus notes) during the period February 1, 2000 through June 29, 2000. All surplus notes were approved by the Department.

The balance of surplus notes due to GHI from GHI HMO was $5,350,000 as of December 31, 2003; which included a $1,100,000 surplus note from 1999. No payments on surplus notes have been received by GHI from GHI HMO, as of the date of this report, and all repayments are subject to the prior approval of the Superintendent pursuant to Section 1307(b) of the New York Insurance Law.

In 2004, GHI contributed an additional $2,700,000 to GHI HMO. Further, on August 1, 2005, GHI HMO purchased the enrollment of 8,818 members and certain other assets of ABC Health Plan, a Prepaid Health Services Plan operating in the Bronx and Manhattan. GHI contributed capital to the HMO in the amount of $4,200,000 to fund the purchase.

Further, GHI guarantees the HMO's payment obligations under four equipment lease

agreements.

ii. Service Agreements

GHI maintained three service agreements with GHI HMO: a "Management Services Agreement" and two "Administrative Services Agreements." In addition, a tax allocation agreement was maintained with the HMO and GHI Services LLC. GHI entered into its Management Services Agreement, effective June 9, 1999, under which GHI provides the HMO with management services. GHI entered into two Administrative Services Agreements with the HMO, one effective January 1, 2002 "2002 agreement" and the other effective January 1, 2003 "2003 agreement". Under the 2002 agreement, GHI HMO provides administrative services to GHI for GHI's Family Health Plus PPO product (FHP). Under the 2003 agreement, GHI HMO provides administrative services for GHI's Medicare+ Choice PPO product "Medicare+ Choice." These agreements are discussed in more detail below.

In 2003, GHI paid the HMO a net amount of $4,094,533 for services rendered under the agreements and also for reimbursement of consolidated taxes paid by GHI.

The service agreements provide that settlements will occur on a monthly basis. It was noted that the December 31, 2003 balance of $762,165 was not settled until June of 2004 when the payable to the HMO had accumulated to over $2 million.

It is recommended that GHI settle its intercompany account balances on a monthly basis as called for in its service agreements.

GHI agreed to settle its intercompany charges on a monthly basis as called for in its service agreements.

The Management Services Agreement between the Plan and the HMO was effective June 9, 1999, and was in effect for the entire period under examination. According to the terms of the Management Services Agreement, GHI is to provide certain functions to the HMO, which include: underwriting and actuarial, legal, human resources and payroll, internal auditing, anti-fraud program, disaster recovery, medical director, and other services as agreed to by the parties.

A new Management Services Agreement between GHI and the HMO was submitted to the Insurance Department ("DOI"), and on June 3, 2005 DOI sent a "non-objection letter" to the Department of Health.

Under the Administrative Services Agreements, the HMO provides and administers GHI's FHP and Medicare+ Choice products for a fee which is detailed in each agreement. The services provided by the HMO include claim processing, record-keeping services, enrollment, and calculation of benefits.

The Plan entered into an Inter-company Tax Allocation Agreement that was effective June 1, 1999. This agreement stipulates that GHI will compute and pay the consolidated federal income tax liability for the group and will prepare and file the consolidated federal income tax return for the group. Tax benefit or liability is then charged back to the HMO.

It should be noted that the GHI HMO filed report on examination as of December 31,

2003 contained certain comments and recommendation in regard to some of the above-mentioned agreements.

C. Territory and Plan of Operation

The Plan is licensed as a non-profit health service corporation under Article 43 of the New York Insurance Law. The Plan markets its products as a Preferred Provider Organization (PPO). The majority of the Plan's products provide for both "in-network" and "out-of-network" benefits. Additionally, the Plan offers certain community rated products which provide for in-network benefits only.

All premiums are written in New York State and the Plan writes business in all counties of New York State. The following shows the premiums written and enrollment during the examination period:

Year	Direct Premium Written	Enrollment
2000	$1,632,998,255	1,622,748
2001	$1,733,760,314	1,649,589
2002	$2,038,930,930	1,712,932
2003	$2,172,545,783	1,644,778

In 2004, GHI reported premiums of $2,302,200,916 and enrollment of 1,642,311.

D. Reinsurance

The Plan was not a party to any assumed or ceded reinsurance agreements during the examination period.

E. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles or Annual Statement Instructions. A description of such items is as follows:

1. GHI misclassified certain liabilities in its filed Annual Statement as of December 31, 2003. These are detailed as follows:

- GHI included a $2,873,365 liability for HCRA Assessments in its "General Expenses Due and Accrued" account. The HCRA Assessments are essentially claims related items and thus should have been included in the "Claims Unpaid" liability.
- GHI included a $10,742,245 liability which represents advances for implementation and marketing fees from GHI's Pharmacy Benefits Manager ("PBM"), in the "General Expenses Due and Accrued" liability. This item should have been reported as an "Aggregate Write-in" liability item.
- GHI included $13,887,104 in its "Miscellaneous Accounts Payable" liability on line 2102 of its 2003 Annual Statement, representing pharmacy claims paid by GHI's PBM that needed to be reimbursed by GHI to the PBM. This amount should have been reported as part of its "Unpaid Claims" liability.

No changes were made to the financial statements to reflect the above items the changes recommended by the examiner because the misclassifications of the above noted items pertain to the classification of individual liabilities not to the total amount of liabilities reported in GHI's filed financial statements, thus there is no effect on surplus.

It is recommended that GHI report its claim reimbursements to third parties as a component of its Unpaid Claims liability in its filed financial statements.

It is recommended that GHI report advances from its PBM as an "Aggregate Write-in" liability item in its future financial statement filings.

2. Additionally, GHI included $287,154 of Miscellaneous income as an offset to paid expenses. The amount represents income from the leasing of GHI's provider panel. This amount should have been reported in GHI's Statement of Revenue and Expenses as "Risk Revenue" on line 5.

It is recommended that GHI report income from the leasing of its provider panel as Risk Revenue on the Statement of Revenue and Expenses. It was noted that GHI reported $0 as Risk Revenue in 2003. GHI reported Risk Revenue in the amount of $1,147,080 in its 2004 Annual Statement.

3. As described above under item 2Bii, "Service Agreements", GHI maintains several service agreements with its HMO subsidiary. Under the service agreements, GHI provides services performed by GHI employees. The fee for services performed by GHI employees is charged via an allocation of expenses which is reimbursed to GHI from the HMO. It was noted that GHI did not include all the amounts allocated and charged to its HMO in Schedule Y "Summary of Insurer's Transactions with Any Affiliates." Specifically, GHI did not report all salaries and fringe benefit charges incurred by GHI employees for the benefit of the HMO. Schedule Y shows $4,094,533 as allocated expenses but, an additional $814,102 should have been included in this amount.

It is recommended that GHI report all allocations to its subsidiary as intercompany

transactions in Schedule Y.

3. FINANCIAL STATEMENTS

The following shows the assets, liabilities, reserves and unassigned funds as determined by this examination as of December 31, 2003, and as reported by the Plan. The statement is the same as the balance sheet filed by the Plan.

A. Balance Sheet

Assets	Examination	Plan
Bonds	$244,690,374	$244,690,374
Common stocks	21,960,754	21,960,754
Real estate - properties occupied by the company	43,590,544	43,590,544
Cash	(57,344,819)	(57,344,819)
Short-term investments	12,034,449	12,034,449
Other invested assets	656,869	656,869
Receivable for securities	4,156,164	4,156,164
Subtotal, cash and invested assets	269,744,335	269,744,335
Investment income due and accrued	2,417,164	2,417,164
Uncollected premiums and agents' balances in the course of collection	198,690,031	198,690,031
Deferred premiums, agent's balances and installments booked but deferred and not yet due	7,185,324	7,185,324
Amounts receivable relating to uninsured plans	10,178,079	10,178,079
Current federal & foreign income tax recoverable and interest thereon	2,241,020	2,241,020
Net deferred tax asset	3,128,379	3,128,379
Electronic data processing equipment and software	102,117	102,117
Furniture and equipment, including health care delivery assets	161,103	161,103
Health care receivables	235,575	235,575
Funds held by New York City	102,083,000	102,083,000
Receivables from federal government, New York State and others	39,939,925	39,939,925
Section 1307 loan due from GHI HMO	5,350,000	5,350,000
Funds held on deposit with various insured	3,900,000	3,900,000
Leasehold improvements	59,438	59,438
Pension transition asset	6,084,982	6,084,982
Total net admitted assets	$651,500,472	$651,500,472

	Examination	Plan
Liabilities		
Claims unpaid	$286,375,388	$286,375,388
Unpaid claims adjustment expenses	15,417,697	15,417,697
Aggregate health policy reserves	38,273,587	38,273,587
Premiums received in advance	2,259,887	2,259,887
General expenses due or accrued	32,145,825	32,145,825
Amounts withheld or retained for the account of others	10,563,754	10,563,754
Amounts due to parents, subsidiaries and affiliates	762,165	762,165
Payable for securities	9,301,547	9,301,547
Liability for amounts held under uninsured Accident and health plans	4,558,750	4,558,750
Unclaimed disbursements	26,738,938	26,738,938
Miscellaneous accounts payable	18,879,504	18,879,504
Minimum pension liability	26,897,244	26,897,244
Total liabilities	472,174,286	472,174,286
Reserves and Unassigned Funds		
Surplus funds	204,638,668	204,638,668
Unassigned funds (surplus)	(25,312,482)	(25,312,482)
Total capital and surplus	179,326,186	179,326,186
Total liabilities, reserves and unassigned funds	$651,500,472	$651,500,472

Note 1: The Plan reported an impairment of its required Statutory Reserve Fund (SRF), required by Section 4310(d) of the New York Insurance Law, at December 31, 2003, in the amount of $25,312,482. The Plan filed a Restoration Plan of its SRF with the Department, pursuant to Section 4310(e)(1) of the New York Insurance Law. The invasion of the SRF and the Restoration Plan were approved by the Department.

Note 2: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2003. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Underwriting and Investment Exhibit

Reserves and unassigned funds increased by $16,561,041 during the four-year examination period, January 1, 2000 through December 31, 2003, detailed as follows:

Underwriting Income		
Net premium earned	$ 7,578,235,282	
Change in unearned premium reserves and reserve for rate credits	10,426,758	
Total revenues		$ 7,588,662,040
Deductions:		
Hospital/Medical benefits	(6,783,001,755)	
Claim adjustment expenses	(382,613,032)	
General administrative Expense	(406,974,055)	
Total underwriting deductions		(7,572,588,842)
Net underwriting gain		16,073,198
Investment Income		
Net investment income earned	56,718,570	
Net realized capital gains	12,504,019	
Net investment gain		69,222,589
Other Income/(Loss)		
Net gain or (loss) from agents or premium balances charged off	57,633	
Amount recovered	(358,569)	
Amount charged off	(621,709)	
Net other income (loss)		(922,645)
Net income before federal income taxes		84,373,142
Federal and foreign income taxes incurred		(9,653,297)
Net income		$ 74,719,845

Reserves and Unassigned Funds

	Gains in Surplus	Losses in Surplus	
Reserves and unassigned funds, per report on examination as of December 31, 1999			$ 162,765,145
Net income	$74,719,845		
Net unrealized capital gains/(loss)		$41,783,523	
Change in non-admitted assets	586,689		
Cumulative effect of changes in accounting principles	1,905,023		
Change in deferred income tax	785,298		
Aggregate write-ins for gains/losses to surplus		19,652,291	
Net increase in reserves and unassigned funds			16,561,041
Reserves and unassigned funds, per report on examination as of December 31, 2003			$ 179,326,186

4. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which GHI conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at the practices of the Plan in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Claims received as hospital and subsequently denied as ineligible
D. Ambulance claims
E. Record retention
F. Sales and advertising
G. Underwriting, rating and issuance of policy forms
H. Complaints
I. Third party administrators/Managing general agent

A. Claims Processing

The examination included a review of GHI's claims settlement practices and oversight of the claims adjudication process by GHI's management.

GHI receives its claims in both electronic and paper formats. Paper claims are received via the US Post Office, and GHI utilizes WebMD as its electronic claims clearinghouse for electronic claims. Approximately 67% of medical claims and 62% of hospital claims were electronically submitted in 2003. For electronically submitted claims, GHI counts the date the claims are received by the clearinghouse as the date the claim was received. All paper claims received are assigned a 15 digit identification number - the first seven digits indicate the year

and date the claim was received, the next five digits are the sequential claim number, and the last three digits are the claim's version number and debit/credit code. Electronic claims are assigned a 10 digit identification number - the first three characters are alpha characters, followed by a seven digit sequential identification number.

A review of GHI's claims practices and procedures was performed using a statistical sample covering claims adjudicated during the period of January 1, 2003 through December 31, 2003, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 167 medical claims, and a separate sample of 167 hospital claims for review.

The statistical random sampling process, which was performed using the computer software program ACL, was used to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes individually, or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be made for each item in the sample.

The term "claim" can be defined in a myriad of ways. For the purpose of this report, a "claim" is defined by GHI as a grouping of all line items (e.g., procedures or services) on any one claim form. It was possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims or the sample unit. The services detailed on one claim form represent one record in GHI's claims systems. To ensure the completeness of the claims

population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by the Plan for the period January 1, 2003 through December 31, 2003, and included in its 2003 Annual Statement filed with the Department.

The examination review revealed that the overall claims processing financial accuracy level was 95.81% for medical claims and 98.20% for hospital claims. The overall claims processing procedural accuracy level is 95.21% for medical claims and 98.20% for hospital claims. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with GHI's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such; it is counted both as a financial error and a procedural error. In summary, of the 167 medical claims reviewed, 7 contained financial errors and 8 contained procedural errors; of the 167 hospital claims reviewed, 3 contained financial errors and 3 contained procedural errors.

The following represents various errors noted by the examiners:

- Improper denial
- Applied incorrect co-pay
- Applied incorrect deductible
- Authorization issue
- Duplicate payment
- Incorrect payment amount

It is recommended that GHI take proactive steps to identify and correct errors that may be occurring on an ongoing basis and that GHI address the causes of the errors such as providing retraining to individuals who process claims.

The following tables summarize the claims processing errors:

Summary of Financial Accuracy

	Medical Claims	**Hospital Claims**
Claims Population	16,582,282	497,282
Sample size	167	167
Number of claims with errors	7	3
Calculated Error Rate	**4.19%**	**1.80%**
Calculated Accuracy Rate	**95.81%**	**98.20%**
Upper Error Limit	7.23%	3.81%
Lower Error Limit	1.15%	0.22%
Calculated claims in error	**694,798**	**8,951**
Upper limit claims in error	1,198,899	18,946
Lower limit claims in error	190,696	1,094

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

Summary of Procedural Accuracy

	Medical Claims	**Hospital Claims**
Claims Population	16,582,282	497,282
Sample size	167	167
Number of claims with errors	8	3
Calculated Error Rate	**4.79%**	**1.80%**
Calculated Accuracy Rate	**95.21%**	**98.20%**
Upper Error Limit	8.03%	3.81%
Lower Error Limit	1.55%	0.22%
Calculated claims in error	**794,291**	**8,951**
Upper limit claims in error	1,331,557	18,946
Lower limit claims in error	257,025	1,094

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

B. Prompt Pay Law

§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 days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

§3224-a(a) of the New York Insurance Law states:

> "(a) Except in a case where the obligation of an insurer… to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

§3224-a(b) of the New York Insurance Law states:

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> 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."

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

> "(c) … 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…When the amount of interest due on such a claim is less then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

In order to test GHI's compliance with the above Prompt Pay Law, one statistical sample was drawn from each population of medical and hospital claims that either were not paid within 45 days of receipt, or were not denied within 30 days of receipt during the period January 1, 2003 through December 31, 2003. Each sample consisted of 167 claims. The following charts illustrate Prompt Pay compliance as determined by this examination:

Summary of Prompt Pay Errors of Medical Claims

	§3224-a(a)	§3224-a(b)	§3224-a(c)
Total population	16,582,282	16,582,282	16,582,282
Eligible claims population	17,291	17,291	17,291
Sample size	167	167	167
Number of claims with errors	25	118	16
Calculated Error Rate	**14.97%**	**70.66%**	**9.58%**
Calculated Accuracy Rate	**85.03%**	**29.34%**	**90.42%**
Upper Error Limit	20.38%	77.56%	14.04%
Lower Error Limit	9.56%	63.75%	5.12%
Calculated claims in error	**2,588**	**12,218**	**1,656**
Upper limit claims in error	3,524	13,411	2,428
Lower limit claims in error	1,653	11,023	885

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

Summary of Prompt Pay Errors of Hospital Claims

	§3224-a(a)	§3224-a(b)	§3224-a(c)
Total population	497,282	497,282	497,282
Eligible claims population	11,597	11,597	11,597
Sample size	167	167	167
Number of claims with errors	72*	6	48
Calculated error rate	**43.11%**	**3.59%**	**28.74%**
Calculated Accuracy Rate	**56.89%**	**96.41%**	**71.26%**
Upper Error Limit	50.62%	6.42%	35.61%
Lower Error Limit	35.60%	0.77%	21.88%
Calculated claims in error	**4,999**	**146**	**3,333**
Upper limit claims in error	5,870	745	419
Lower limit claims in error	4,129	89	2,537

* Includes 55 claims affected by retroactive contract changes.

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

The total number of medical claims and hospital claims adjudicated in 2003 were 16,582,282 and 497,282, respectively. The population of medical and hospital claims that took more than 45 days to pay or more than 30 days to deny in 2003 were 17,291 and 11,597, respectively.

The examiner's review disclosed compliance problems relative to Sections 3224-a(a), 3224-a(b), and 3224-a(c) of the New York Insurance Law as summarized in the above tables.

It is recommended that GHI create procedures to ensure that claims are processed within the time frames mandated by Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law.

It is also recommended that the Plan implement the necessary procedures and training in order to ensure compliance with Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law.

It is also recommended that GHI comply with the requirements of Section 3224-a(c) of the New York Insurance Law by calculating interest due on all claims paid after 45 days of receipt, and paying any calculated interest amount that is equal to, or in excess of two dollars.

C. Claims Received as Hospital and Denied as Ineligible

Twenty-six claims from the original hospital sample, selected by the examiner for the claims adjudication review noted above, were removed as ineligible claims and were replaced. The examiners reviewed these twenty-six claims for accuracy and compliance. Of the twenty-six claims reviewed, two were denied because GHI was not the hospital carrier. However, the reason for the denial of these claims stated, "Primary carrier's statement was not enclosed." These denials should have clearly indicated that GHI was not the insurer.

It is recommended that GHI modify the denial explanation, on its EOBs, in cases where GHI is not the insurance carrier.

The remaining twenty-four claims were denied by GHI's hospital claims system because these were GHI medical claims rather than GHI hospital claims. GHI then forwarded these claims to its medical claims department. The examiner reviewed the twenty-four claims and the following was noted:

- 4 claims were paid in excess of the prompt pay time frame requirements
- 1 claim was paid twice
- 2 claims were never paid
- 1 claim was overpaid and did not show the correct dates of service

There is concern that these "misdirected" claims are not being adjudicated within the standards and guidelines that GHI generally applies to claims received.

It is recommended that GHI monitor and track claims that were submitted as hospital claims, which were actually medical claims, in order to assure that these claims are subject to the same standards as regular medical or hospital claims.

D. Ambulance Claims

Section 4303(a) of the New York Insurance Law states in part:

> "(1) Every contract issued by a hospital service corporation or health service corporation which provides major medical or similar comprehensive-type coverage shall include coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service issued a certificate to operate pursuant to section three thousand five of the public health law…
>
> (3) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be excessive or unreasonable."

GHI's reimbursement rates to providers of ambulance claims were based on data comprised of GHI's previously paid ambulance claims. Thus, GHI developed a reimbursement methodology using its own data, rather than industry data. It was noted that there is no

definition of "the usual and customary charge" ("UCR") in the New York Insurance Law.

As a result of a review of certain complaints regarding GHI's reimbursement of ambulance claims by the Department's Consumer Services Bureau, the Department determined that HIAA/Ingenix (industry) rates provided a better UCR rate than GHI's own data.

Consequently, GHI agreed to use Ingenix data beginning November 1, 2004 for reimbursement of its ambulance claims. Additionally, GHI reached an agreement with the Department to re-price and adjust ambulance claims previously paid to non-participating providers during the period January 1, 2002 through November 30, 2004. GHI adjusted the payment amount in only those cases where the Ingenix reimbursement amount was higher than the GHI reimbursement amount. GHI did not seek a refund in instances where its reimbursement exceeded the Ingenix amount.

E. Record Retention

Section 243.2(b)(4) of Department Regulation No. 152 states in part:

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

Further, Section 216.11 of Department Regulation No. 64 states in part:

> "…to enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating

> to the claim can be reconstructed by the Insurance Department examiners. Insurers shall make a notation in the file or retain a copy of all forms mailed to claimants."

GHI was unable to provide copies of the original or reproduce copies of original Explanation of Benefits Statements (EOBs) for any of the claims reviewed by the examiner in Section 4A "Claims processing" of this report. GHI provided the examiners with letters detailing the claims transaction. These letters were created from the historical claims settlement data.

It is recommended that GHI comply with the requirements of Department Regulations No. 64 and No. 152 by retaining copies of all EOBs. A similar recommendation was made in the prior report on examination.

Additionally, GHI's policy is to purge its medical claims eighteen (18) months after the settlement of the claim. Once the claim is purged, it can not be restored to GHI's medical claims system, but certain key elements of the claim are retained and were able to be provided to the examiners in hard copy. These key elements included: provider, date received, date of service, date paid, amount paid and other key elements of the claim. Although these key elements are reproduced on hard copy, certain aspects of how the claim was processed were lost. For example, comments or notes made by the claim processors are not available on the hard copy "purge."

It is recommended that GHI act in accordance with the requirements of Department Regulations No. 64 and No. 152 by retaining all aspects of its claims so that the examiner can view the complete claim transaction.

F. Sales and Advertising

The examination included a review of the Plan's advertising. The Plan utilized various media for advertisement. In three advertisements, GHI stated that it provides services to over 2.5 million individuals, with the following statements:

> "GHI currently provides services for more than 2.5 million individuals" and "GHI is the health plan of choice for over 2.5 million people across New York State."

Section 215.9(a) of Department Regulation No. 34 states:

> "An advertisement relating to the dollar amounts of claims paid, the number of person insured, or similar statistical information relating to any insured or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all the relevant facts."

GHI reported 1,644,778 members at December 31, 2003 in Exhibit NY5G of its filed 2003 "Supplement to Article 43 Corporations Annual Statement" ("Supplement"). The difference between the total membership figure used in GHI's advertising and the total membership figure reported in the 2003 Supplement was due to the following:

- GHI did not include approximately 1,060,000 members in its Supplement for which it insures only the mental health portion of one of New York State's medical plans. GHI intentionally did not include this membership because the membership pertained to only a portion of the medical plan. Therefore, the premium dollars relative to the members insured was very low and would have distorted certain ratios and other analytics.

- GHI included approximately 100,000 non-insured, administrative services only ("ASO") members in its three advertisements as noted above.

The statement “GHI is the health plan of choice for over 2.5 million people across New York State” is misleading in that 1,060,000 members (42%) are covered for mental health benefits only.

It is recommended that GHI comply with the requirements of Department Regulation No. 34 when using a membership figure in its advertisements.

It is recommended that GHI report the New York State mental health insured members in its NY5 Exhibits of its filed Annual Supplements.

G. Underwriting, Rating, Issuance of Policy Forms and Third Party Administrators

A review of GHI’s underwriting, rating and policy issuance practices and procedures was performed. Included in the review were new and renewal underwriting files, both issued and declined, cancellations and terminations.

As required by Section 4304 of the New York Insurance Law and Department Regulation No. 145, GHI’s commercial health insurance business is community rated for small groups and individuals. Small groups are defined as groups of between 2 and 50 employees or subscribers. Large groups are groups with over 50 employees or subscribers, and are experience-rated by GHI. A review of GHI’s experience-rated large groups was completed by the examiner and a separate report regarding the findings of this review was issued and is attached to this report as Appendix A. Additionally, GHI, in accordance with Department Regulation No. 145, issues

policies to sole proprietors, and considers these small groups for the purposes of rating.

GHI contracts with seven brokers to perform certain administrative services on small group policies written by them. These administrative services are primarily related to billing, enrollment, underwriting and related record keeping functions. GHI maintains contracts, which detail the services to be provided, with all seven brokers. Contracts with three of the brokers specify that these brokers will perform termination/cancellation services.

Part 55.2 of Department Regulation No. 78 states:

> "(a) An insurer who intends to terminate a group policy or contract of accident, or health, or accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificate holders under a group policy shall give the policyholder at least 30 days prior written notice of its intent to terminate coverage. The notice to the policyholder shall set forth in detail the policyholder's obligation under Labor Law, section 217, and under this Part, to notify each certificate holder resident in New York State of the intended termination of the group policy."

Further subsections (b) through (f) of Department Regulation No. 78 contain specific references with regard to the policyholder's duties with regard to notification of cancellation.

Section 4305(d)(1) of the New York Insurance Law states in part:

> "A group contract issued pursuant to this section shall contain a provision to the effect that in case of a termination of coverage under such contract of any member of the group because of (I) termination for any reason whatsoever of his employment or membership, if he has been covered under the group contract for at least three months, or (II) termination for any reason whatsoever of the group contract itself… he shall be entitled to have issued to him by the corporation, without evidence of insurability, upon application therefore and payment of the first premium made to the corporation within forty-five days after termination of the coverage, an individual direct payment contract,

> covering such member and his eligible dependents who were covered by the group contract…"

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

> "Whenever an insurer elects to terminate any policy as described in this section, such insurer shall include in his notification of intent to terminate such policy reference to the policyholder's responsibilities under section two hundred seventeen of the labor law. Whenever any policy as described in this section terminates as a result of a default in payment of premiums, the insurer shall notify the policyholder that termination has occurred or will occur and shall include in his notification reference to the policyholder's responsibilities under section two hundred seventeen of the labor law."

Part 243.2 of Department Regulation No. 152 states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this part. A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to section 243.3(a) of this Part. A policy record shall include:
>
> (i) the policy term, basis for rating, and return premium amounts, if any;
>
> (ii) the application, including any application form or enrollment form for coverage under any insurance contract or policy;
>
> (iii) the contract or policy forms issued including the declaration pages, endorsements, riders, and termination notices of the contract or policy. Binders shall be retained if a contract or policy was not issued; and
>
> (iv) other information necessary for reconstructing the solicitation, rating, and underwriting of the contract or policy.
>
> (2) An application where no policy or contract was issued for six calendar years or until after the filing of the report on examination in which the record was subject to review, whichever is longer."

A review of a sample of twenty-four (24) small group cancellations and terminations

revealed the following:

- Seven were subscriber initiated cancellations, and all seven were administered by one of GHI's brokers and this broker also acts as a third party administrator (TPA) for GHI. During the processing of the seven cancellations, none of the policyholders were provided with a cancellation notice as required by New York Insurance Law Section 4305(d)(1).

- Six were cancelled because the groups failed to requalify under GHI's underwriting guidelines. All six were administered by the GHI's TPA. These groups received a cancellation notice that did not comply with the provisions of Section 4235(k) of the New York Insurance Law and Department Regulation No. 78.

- The Plan could not produce a record of the cancellation for three of the 24; two of these -were administered by GHI's TPA.

- For three other groups, GHI could not produce a file on the group. All three were administered by GHI's TPA.

It is recommended that GHI send cancellation notices to policyholders in all situations in which the policy is terminated, including subscriber initiated cancellations, and that GHI assure that its cancellation notices comply with Section 4235(k) of the New York Insurance Law.

It is recommended that GHI comply with the requirements of Department Regulation No. 152 and assure all documents relating to cancellations, including the cancellation notice, are retained.

During the examination of complaints, errors were found in the enrollment of community rated subscribers, by TPAs, with respect to the crediting of prior health insurance coverage

towards pre-existing condition limitations. This resulted in improper claim denials and this matter is described under Section 4 H "Complaints", below.

As is evidenced by the errors found in the review of community rated underwriting and in the review of enrollment of those community rated subscribers, GHI should more actively oversee the activities of its TPA. During the examination period, GHI performed one audit of its largest TPA.

It is recommended that GHI communicate all policies to brokers/TPAs in a timely manner, and that GHI perform follow-up reviews or audits to assure that the broker/TPAs are adhering to GHI's policies and procedures.

It is recommended that GHI directly oversee the activities of its broker/TPA with regard to administration of small group policies and assure that the broker/TPA is performing the designated services in accordance with the New York Insurance Law and Regulation, and with GHI's policies and procedures.

The examiner requested a certified financial statement of GHI's largest TPA. GHI was unable to provide audited financial statements, because its TPA is not required to and does not contract with a Certified Public Accountant (CPA) to produce such statements.

It is recommended that GHI ensure that its TPA be audited by a CPA on annual basis, and that GHI obtain a copy of the audit report and be made aware of any material findings.

H. Complaints

Section 2404 of the New York Insurance Law states in part:

> "…In the event any person does not provide a good faith response to a request for information from the superintendent, within a time period specified by the superintendent of not less than fifteen business days, as part of an examination or investigation initiated by the superintendent pursuant to this section relating to accident insurance, health insurance accident and health insurance or health maintenance organization coverage, the superintendent is authorized, after notice and hearing to levy a civil penalty against such person in an amount not to exceed five hundred dollars per day…"

A review of a random sample of 20 complaints filed with the Department's Consumer Services Bureau ("CSB"), revealed that 5 of the 20 were not responded to by GHI within the 15 business day limit required by Section 2404 of the New York Insurance Law. It was noted that 4 of the 5 related to inquiries concerning pre-existing condition.

It is recommended that GHI comply with the time limit mandated by Section 2404 of the New York Insurance Law when responding to CSB inquiries.

The examiner then reviewed a sample of 24 complaints relating to GHI's denial of claims due to the application of the pre-existing condition exclusion. The review of complaints relating to pre-existing conditions revealed issues relating to GHI's handling of the application of prior creditable coverage toward the pre-existing condition and GHI's use of third party administrators "TPAs". Additionally, it was noted that discussions were held between the CSB and GHI regarding GHI's application of the pre-existing limitation and the application of prior creditable coverage in 2003.

In the course of the review of these complaints, the examiners observed that when GHI

responded to CSB's inquiries, information contained in GHI's claims processing system and data base systems were used to determine GHI's position. However, the system data was incorrect, resulting in erroneous information being provided to the Department in response to complaint inquiries.

It is recommended that GHI provide the Department's CSB with correct and verifiable information when responding to complaints.

The examiner's review of the sample of 24 complaints relating to claims denied due to the invoking of the pre-existing condition exclusion revealed the following:

1. GHI's policy was to ignore any incomplete prior coverage information that was provided on the enrollment form. This resulted in the member not receiving credit for prior coverage, which resulted in claim denials, pending requests to providers for pre-existing condition information, when requests should have gone to subscribers for prior coverage information.

2. In 4 of the 24 complaints sampled, the complete prior coverage information was provided, but the information was not entered into GHI's system by the TPAs who were contracted to perform enrollment services.

3. Of the 24 complaints sampled, seven were cases in which incomplete prior coverage was indicated on the enrollment form but the prior coverage information was not credited to the member in GHI's system, resulting in inappropriate claim denials. All seven complaints involved enrollments performed by broker/TPAs on behalf of GHI. Furthermore, all seven of these involved enrollments that occurred after the Department's CSB and GHI discussed these issues.

4. Enrollment forms used by one of GHI's groups did not ask for prior coverage information.

It is recommended that GHI apply prior creditable coverage to all eligible members. It is further recommended that GHI request additional information from the member when incomplete prior coverage information is provided on the enrollment form, rather than ignoring incomplete information.

Section 4318(b) of the New York Insurance Law states, in part:

> "Every individual health insurance contract and every group or blanket accident and health insurance contract issued or issued for delivery in this state which includes a pre-existing condition provision shall contain in substance the following provision or provisions which in the opinion of the superintendent are more favorable to individuals, members of the group and their eligible dependents:
>
> (b) No pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the enrollment date for the covered person and may only relate to a conditions (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date…No pre-existing condition provision shall exclude coverage in the case of:
>
> (1) an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage as defined in subsection (c) of this section;"

Although GHI's health insurance contracts contain the language required by Section 4318(b) of the New York Insurance Law, GHI did not act in compliance with the provisions of the above statute when it denied claims for pre-existing conditions without having credited the members with prior creditable coverage when such prior creditable coverage was indicated on the enrollment applications.

It is recommended that GHI comply with Section 4318 of the New York Insurance Law with respect to the crediting of prior creditable coverage.

5. SUBSEQUENT EVENTS

On September 28, 2005, with the approval of its Board of Directors, GHI announced plans to pursue an affiliation with Health Insurance Plan of Greater New York (HIP). HIP is a not-for-profit corporation licensed as a health insurer under Article 43 of the New York Insurance Law and as an HMO under Article 44 of the Public Health Law.

Subsequently on December 15, 2005, HIP Foundation, Inc. (The Foundation), pursuant to Section 1506 of New York Insurance Law and Department Regulation No. 52 (11 NYCRR 80), submitted an application for approval of the acquisition of control of GHI. The application proposed that GHI will admit The Foundation as the sole member of GHI. Further, The Foundation's board of directors will be reconstituted to include six members designated by GHI, to reflect equal representation from both GHI and HIP, and the Foundation would be renamed.

On November 15, 2006, GHI and HIP concluded their affiliation and The Foundation was renamed "EmblemHealth Inc." (EmblemHealth). EmblemHealth is now the parent of GHI and HIP and its Board is comprised of equal representation from the two organizations.

6. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

There are two prior reports on examination; a report on the financial condition of the Plan as of December 31, 1999 and a report on market conduct as of March 31, 2001. The prior report on examination, as of December 31, 1999 contained seven comments and recommendations. The current status of these matters is as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
1.	Two Board members failed to attend any Board meetings during an eighteen-month period, two other Board members failed to attend 50% of the Board meetings held each year. One other Board member attended no Board meetings from September 1999 (the first meeting since his appointment to the Board) through December 2000. The Plan complied with this recommendation although this report on examination notes that attendance of four Board members at Board meetings, during the period under review, was less than 50% ..	6
2.	It is recommended that the Plan comply with Section 4301(k)(4) of the Insurance Law and have the Directors forfeit their positions if they do not attend any Board meetings in an eighteen-month period. The Plan complied with this recommendation. Although attendance at Board meetings by four members still needed improvement, there was no Board member who did not attend any meeting within an eighteen-month period.	7
3.	It is recommended that the Board members realize their fiduciary responsibilities and evince an ongoing interest in the affairs of the insurer. It is further recommended that the Directors attend the Board of Directors meetings on a regular basis, minimally 50% of the Board meetings and if directors are unable to do so should resign or be replaced. The Plan did not comply with this recommendation. A similar recommendation is contained in this report on examination.	7

ITEM NO. **PAGE NO.**

4. The Plan could not provide the responses to the 1996 conflict of interest questionnaires. 11

   GHI demonstrated that copies of conflict of interest questionnaire responses were retained for all years under review.

5. It is recommended that the GHI Board members show their union roles and affiliations in their responses to conflict of interest questionnaires. 12

   The Plan complied with this recommendation.

6. It is recommended that the Plan administer conflict of interest questionnaires on an annual basis. The Plan has a fiduciary responsibility to its policyholders to ensure that its directors, officers and responsible employees do not use their official position to promote an interest that is in conflict with that of the Plan. 12

   The Plan complied with this recommendation.

7. It is recommended that the Plan report uncashed claims checks as a reduction to its asset rather than reporting it as a separate liability. 15

   The Plan complied with this recommendation.

The prior market conduct examination report, as of March 31, 2001, contained the following comments and recommendations. The current status of these matters is as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
1.	GHI maintained a practice of using income-based criteria in reviewing applications for coverage by groups of one/sole proprietors. Specifically, applicants earning less than $15,000 per year were required to meet additional standards in order to obtain coverage, and in some instances, were denied coverage when these additional standards were not met. In May 2000, GHI agreed to eliminate the income requirement for sole proprietors and to apply the same underwriting requirements to all sole proprietors regardless of income. The Plan complied with this recommendation.	2
2.	GHI did not submit, for approval, policy forms delineating the "deferred premium" payment arrangement to the Department. It is recommended that GHI file these arrangements with the Department. The Plan complied with this recommendation.	3
3.	GHI insures the employees of the City of New York under a large group contract. The certificates of coverage that are based upon this contract and issued to NYC employees who are GHI subscribers were submitted to and approved by the Department. However, the actual group master contract was not filed with the Department. It is recommended that GHI submit the group contract itself for approval as required by Section 4308(a). The Plan complied with this recommendation.	3
4.	The Plan delayed issuance to community rated contract holders of the external appeal rider for eight months. It is recommended that GHI distribute mandatory policy form changes in a more timely manner. The Plan complied with this recommendation.	4

ITEM NO.		PAGE NO.
5.	It is recommended that GHI comply with Regulation No. 34 by accurately reflecting its financial position and membership in its advertisements. The Plan did not comply with this recommendation. A similar comment is contained in this report.	5
6.	It is recommended that GHI retain the documentation to support changes in rates for covered medical procedures. The Plan complied with this recommendation.	7
7.	It is recommended that GHI pay claims denied for student dependent eligibility status when the student dependent certification is received, rather than requiring that the claim be resubmitted. The Plan states that it has complied with this recommendation.	8
8.	It is recommended that GHI link the original date received to all claims including resubmitted claims. The Plan complied with this recommendation.	8
9.	It is recommended that GHI assure that all claims, including those processed by third-party administrators, are processed in accordance with Section 3224-a(c). The Plan complied with this recommendation: claims processed by GHI's third party administrator were generally processed in accordance with Section 3224-a(c).	10
10.	It is recommended that GHI complete its Schedule H "Aging Analysis of Unpaid Claims" in accordance with the Department's instructions and account for those claims in which additional information was requested, rather than counting those claims as denied claims and creating new claims when the claim is resubmitted. The Plan has developed a method to estimate the number of claims denied for lack of adequate information where a resubmission is expected.	11

11. It is recommended that GHI include VO claims in Schedule H. 11

The Plan complied with this recommendation.

12. It is recommended that GHI modify its EOBs to include all requisite appeals disclosure language pursuant to Section 3234(b) of the New York Insurance Law. 13

The Plan complied with this recommendation.

13. It is recommended that GHI make the necessary programming changes to its claims processing systems so that duplicate EOBs can be reproduced. 14

The Plan is not in compliance with this recommendation.

14. It is recommended that GHI include all appealed cases in Schedule M and that GHI retain the documentation to support the appeals reported in its Schedule M. 15

The Plan complied with this recommendation.

15. It is recommended that GHI notify the insured or the insured's designee both in writing and by telephone of the determination of pre-authorization for health care services within three business days, in accordance with Section 4903(b) of the Insurance Law. 16

The Plan complied with this recommendation.

16. It is recommended that GHI assure that appeals of adverse determinations are handled in accordance with Section 4904(c) of the New York Insurance Law by requiring its third party administrator, VO, to acknowledge receipt of all appeals in writing. It is further recommended that GHI notify the insured or the insured's designee and where appropriate, the insured's health care provider in writing within the two business days' requirement of an adverse determination. 18

The Plan complied with this recommendation

ITEM NO. **PAGE NO.**

17. It is recommended that the Plan respond to inquiries about complaints from the Insurance Department's Consumer Services Bureau within the fifteen-business-day requirement specified by Section 2404 of the New York Insurance Law. 18

The Plan complied with this recommendation.

18. It is recommended that GHI adhere to Regulation Nos. 152 and 64 and to the guidelines of its record retention plan by either retaining paper copies or by establishing a system that allows for exact duplication of all EOBs. Additionally, it is recommended that GHI retain the date of receipt of precertified dental claims and the documentation supporting new reimbursement rates and the date the new reimbursement rates went into effect. 20

The Plan has not complied with this recommendation with regard to the retention of EOBs. The Plan states that it is in retaining the receipt date of precertified dental claims and the documentation to support rate changes..

19. It is recommended that GHI document and retain documentation supporting the medical information furnished by providers via telephone used for determination of utilization reviews. 20

The Plan complied with this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Management	
i.	Although Board members' absences were excused, it is recommended that Board members attend the majority of meetings that they are eligible to attend in order to evince their fiduciary responsibility.	8
ii.	It is recommended that GHI's Board review its policy on excusing Board member absences.	8
iii.	It is recommended that the Plan amend its by-laws to require its Board to meet a minimum of four times per calendar year.	10
B.	Holding Company System	
	It is recommended that GHI settle its intercompany account balances on a monthly basis as called for in its service agreements.	13
C.	Accounts and Records	
i.	It is recommended that GHI report its claim reimbursements to third parties as a component of its Unpaid Claims liability in its filed financial statements.	16
ii.	It is recommended that GHI report advances from its PBM as an "Aggregate Write-in" liability item in its future financial statement filings.	17
iii.	It is recommended that GHI report income from the leasing of its provider panel as Risk Revenue on the Statement of Revenue and Expenses. It was noted that GHI reported $0 as Risk Revenue in 2003. GHI reported Risk Revenue in the amount of $1,147,080 in its 2004 Annual Statement.	17
iv.	It is recommended that GHI report all allocations to its subsidiary as intercompany transactions in Schedule Y.	17

ITEM		PAGE NO.
D.	Claims Processing	
i.	It is recommended that GHI take proactive steps to identify and correct errors that may be occurring on an ongoing basis and that GHI address the causes of the errors such as providing retraining to individuals who process claims.	25
ii.	It is recommended that GHI create procedures to ensure that claims are processed within the time frames mandated by Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law.	29
iii.	It is also recommended that the Plan implement the necessary procedures and training in order to ensure compliance with Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law.	30
iv.	It is also recommended that GHI comply with the requirements of Section 3224-a(c) of the New York Insurance Law by calculating interest due on all claims paid after 45 days of receipt, and paying any calculated interest amount that is equal to, or in excess of two dollars.	30
v.	It is recommended that GHI modify the denial explanation, on its EOBs, in cases where GHI is not the insurance carrier	30
vi.	It is recommended that GHI monitor and track claims that were submitted as hospital claims, which were actually medical claims, in order to assure that these claims are subject to the same standards as regular medical or hospital claims.	31
E.	Ambulance Claims	
	GHI agreed to use Ingenix data beginning November 1, 2004 for reimbursement of its ambulance claims. Additionally, GHI reached an agreement with the Department to re-price and adjust ambulance claims previously paid to non-participating providers during the period January 1, 2002 through November 30, 2004.	32
F.	Record Retention	
i.	It is recommended that GHI comply with the requirements of Department Regulations No. 64 and No. 152 by retaining copies of all EOBs.	33

ITEM		PAGE NO.
ii.	It is recommended that GHI act in accordance with the requirements of Department Regulations No. 64 and No. 152 by retaining all aspects of its claims so that the examiner can view the complete claim transaction.	33
G.	Sales and Advertising	
i.	It is recommended that GHI comply with the requirements of Department Regulation No. 34 when using a membership figure in its advertisements.	35
ii.	It is recommended that GHI report the New York State mental health insured members in its NY5 Exhibits of its filed Annual Supplements.	35
H.	Underwriting, Rating, Issuance of Policy Forms and Third Party Administrators	
i.	It is recommended that GHI send cancellation notices to policyholders in all situations in which the policy is terminated, including subscriber initiated cancellations, and that GHI assure that its cancellation notices comply with Section 4235(k) of the New York Insurance Law.	38
ii.	It is recommended that GHI comply with the requirements of Department Regulation No. 152 and assure all documents relating to cancellations, including the cancellation notice, are retained.	38
iii.	It is recommended that GHI communicate all policies to brokers/TPAs in a timely manner, and that GHI perform follow-up reviews or audits to assure that the broker/TPAs are adhering to GHI's policies and procedures.	39
iv.	It is recommended that GHI directly oversee the activities of its broker/TPA with regard to administration of small group policies and assure that the broker/TPA is performing the designated services in accordance with the New York Insurance Law and Regulation, and with GHI's policies and procedures.	39
v.	It is recommended that GHI ensure that its TPA be audited by a CPA, on an annual basis and that GHI obtain a copy of the audit report and be made aware of any material findings.	39

ITEM **PAGE NO.**

I. Complaints

i. It is recommended that GHI comply with the time limit mandated by Section 2404 of the New York Insurance Law when responding to CSB inquiries. 40

ii. It is recommended that GHI provide the Department's CSB with correct and verifiable information when responding to complaints. 41

iii. It is recommended that GHI apply prior creditable coverage to all eligible members. It is further recommended that GHI request additional information from the member when incomplete prior coverage information is provided on the enrollment form, rather than ignoring incomplete information. 42

iv. It is recommended that GHI comply with Section 4318 of the New York Insurance Law with respect to the crediting of prior creditable coverage. 43

APPENDIX - A

SPECIAL MARKET CONDUCT REPORT

OF

GROUP HEALTH INCORPORATED

AS OF

SEPTEMBER 30, 2004

DATE OF REPORT	**MARCH 26, 2007**
EXAMINER	**KATHLEEN GROGAN**

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3.	Summary of comments and recommendations	5

1. SCOPE OF EXAMINATION

This special market conduct examination was conducted to review compliance with Section 4308(b) of the New York Insurance Law and Department Regulation No. 62 ({11 NYCRR 52} Minimum Standards for the Form, Content and Sale of Health Insurance...). The examination targeted GHI's rating practices for its large group experience rated business and entailed a review of the compensation for agents and brokers involved with the selling of these products. The examination covered the period January 1, 2003 to September 30, 2004, however, transactions prior to and subsequent to this period were reviewed where deemed appropriate.

2. UNDERWRITING AND RATING

A review of a sample of experience rated policies and commissions paid on experience rated groups was performed. As noted above, GHI experience rates large groups which are groups with over 50 employees or subscribers. Within the large group classification, there are small (51 – 200), medium (200 – 500) and large groups (over 500).

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".

GHI filed its experience rate formula with the Department and received approval on May 18, 1998. GHI was not able to demonstrate that the Board of Directors approved the formula.

It is recommended that GHI retain proof of the Board of Directors' approval of the experience rated formula.

Beginning July 2003, GHI uses experience only to develop rates for all experience rated groups. Prior to July 2003, GHI used manual rates and or a blending of manual rates and experience rates to develop rates for small and midsize groups because the claims experience data was not large enough to be deemed credible for developing rates.

A review of the underwriting and rating practices of fifteen groups, five small (51 – 200 members), five mid-size (201 – 500 members) and five large groups (over 500 members) rates was performed. The following was noted:

- GHI updated the rate formula but did not file the updates with the Department. Further,

GHI did not have a current copy of the experience rate formula which contained all updates. The underwriters used software to develop the rates but the values of certain factors used to develop the rates could not be documented and provided to the examiners.

- GHI's marketing department was allowed to make certain adjustments to rates. This practice was terminated in 2002.

- GHI deviated from the rate manual in that adjustments were applied to the rates in order to decrease or increase the rates charged to certain groups. The following are the deviations that were noted:

    - Two of five mid-size groups' rates were adjusted downward for competitive reasons.
    - All five small size groups' rates were adjusted. Three were adjusted downward for competitive reasons and two were adjusted upward. One was adjusted upward due to a relationship between GHI and the broker, the other was adjusted upward to compensate for the lack of credible experience.
    - One large group was adjusted downward when GHI reenrolled the group for competitive reasons and this group was then adjusted upward at renewal to compensate for delinquent payments by the group. One large group's rates were adjusted downward at renewal, while one other group's rates were adjusted upward.

It is recommended that GHI file the updates to its experience rate formula with the Department.

It is recommended that GHI refrain from using adjustments for competitive reasons.

It is recommended that GHI adhere to its filed experience rated formula.

It was noted that GHI filed a new experience rated formula with the Department in April 2006.

3. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
	Underwriting and rating	
i.	It is recommended that GHI retain proof of the Board of Directors' approval of the experience rated formula.	3
ii.	It is recommended that GHI file the updates to its experience rate formula with the Department.	4
iii.	It is recommended that GHI refrain from using adjustments for competitive reasons.	4
iv.	It is recommended that GHI adhere to its filed experience rated formula.	4

Appointment No. *22137*

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Kathleen Grogan

as a proper person to examine into the affairs of the

Group Health Inc.

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

Company

with such information as she shall deem requisite.

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

this *30th* day of *January 2004*

Gregory V. Serio
Superintendent of Insurance