

REPORT ON MARKET CONDUCT EXAMINATION

OF

GROUP HEALTH INCORPORATED

AS OF

DECEMBER 31, 2013

DATE OF REPORT

MARCH 9, 2018

EXAMINER

JO LO HSIA, ARM

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

March 9, 2018

Honorable Maria T. Vullo
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 No. 31209, dated November 6, 2014, annexed hereto, an examination has been made into the affairs of Group Health Incorporated, a not-for-profit health service corporation licensed pursuant to Article 43 of the New York Insurance Law, as of December 31, 2013, and the following report thereon is respectfully submitted.

The examination was conducted at the home office of Group Health Incorporated, located at 55 Water Street, New York, NY.

Wherever the designations the “Plan” or “GHI” appear herein, without qualification, they should be understood to indicate Group Health Incorporated.

Wherever the designation “HIPNY” appears herein, without qualification, it should be understood to indicate the Health Insurance Plan of Greater New York, the direct Parent of GHI.

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

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

Concurrently, an examination into the financial condition of GHI was performed. A separate financial report on examination for GHI has been submitted thereon.

1. SCOPE OF THE EXAMINATION

The Plan was previously examined as of December 31, 2008. This examination covers the five-year period January 1, 2009 to December 31, 2013, and was performed to review the manner in which Group Health Incorporated conducts its business practices and fulfills its contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate.

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

A review was also made to ascertain what actions were taken by GHI with regard to comments and recommendations made in the prior market conduct report on examination.

2. EXECUTIVE SUMMARY

The examination revealed several operational deficiencies that occurred during the examination period. The following are the significant findings included within this report on examination:

- GHI failed to disclose the source of the statistics used in one of its advertisement brochures, in violation of the requirements of Part 215.9(c) of Insurance Regulation No. 34 - *Advertisements of Accidents and Health Insurance*.
- GHI continued the listing of GHI HMO in its web-pages and in its advertisements subsequent to the merger of GHI HMO and HIPNY, in violation of the requirements of Parts 215(a) and 215.5(a) of Insurance Regulation No. 34.
- GHI failed to comply, in various instances, with the requirements of Section 4802 of the New York Insurance Law (“NYIL”) with regard to its handling of member grievances.

- GHI failed to comply with the requirements of Section 4324(a)(17) of the NYIL when it did not offer its members the option of receiving a full hard-copy provider directory, and for its inability to produce and send the full hard-copy provider directory to its current and prospective members upon request.
- GHI failed to comply with the requirements of Section 4308(b) when it used a Mail Order Factor Rate that was not filed with the Department and applied underwriting adjustments exceeding the limit allowed by the rate manual filed with the Department.
- GHI and its delegated utilization review agents were found, in various instances, to be in violation of the requirements of Article 49 of the NYIL, Federal Regulation 29 C.F.R. Part 2560, Federal Regulation 29 C.F.R. Part 2590, Federal Regulation 45 C.F.R Part 147 of the Health Insurance Reform Act of 2010 and Insurance Regulation No. 166.
- GHI failed to comply with the record retention requirement of Insurance Regulation No. 152 in various instances, including when it failed to retain copies of the Explanation of Benefits Statements (“EOBs”) for its members who elected to receive electronic EOBs instead of paper EOBs for the timeframe required by Part 243.2(b) of Insurance Regulation No. 152 - *Standards of Records Retention by Insurance Companies*.

The above findings, as well as others, are described in greater detail in the remainder of this Report.

3. DESCRIPTION OF THE PLAN

GHI is a New York State not-for-profit corporation operating under the provisions of Article 43 of the New York Insurance Law.

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

In December 2010, with the approval of the Department (then New York State Department of Insurance), HIPNY replaced EmblemHealth as the sole corporate member and direct Parent corporation of GHI. In 2013, EmblemHealth filed to restructure the ownership of EmblemHealth Services Company, LLC such that it is wholly-owned by HIPNY. The Department issued a non-objection letter on December 23, 2013, with regard to this transaction.

Pursuant to Section 4301(j) and Section 7317 of the New York Insurance Law (the “Conversion Legislation”), GHI and HIPNY filed a plan of conversion (the “Conversion Plan”) on April 16, 2007 seeking the approval of the Department’s (then Department of Insurance) Superintendent (the “Superintendent”) to convert from their not-for-profit status to for-profit status. The Conversion Plan was amended and refiled on December 31, 2007. Pursuant to the plan of conversion, GHI and HIPNY, both not-for-profit entities, would have become for-profit entities. Presently, GHI and HIPNY are not pursuing conversion.

4. CLAIMS PROCESSING

A review of GHI’s claims practices and procedures was performed covering claims paid during the period January 1, 2013 through December 31, 2013, in order to evaluate the overall accuracy and compliance environment of its claims processing. The claim populations for the companies were divided into medical, hospital, pharmacy, and dental claim segments. A random statistical sample was drawn from each segment to test for verification of compliance with certain specified areas, including: eligibility, payment adherence to appropriate fee schedules, co-payments, deductibles, treatment plan authorization, denial of claims and explanation of benefits statements (“EOBs”).

The examiner randomly selected and reviewed fifty (50) dental claims, seventy (70) pharmacy claims, sixty (60) hospital claims, and thirty (30) medical claims. The following represents areas of non-compliance and/or errors identified by the examiner during the abovementioned claims review:

- GHI failed to retain copies of members' EOBs for the required time period for two (2) dental claims, in violation of the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152.
- GHI overpaid one claim with coordination of benefits for which it was the secondary benefit provider.
- GHI failed to retain a copy of the EOBs for the required time period for twenty (20) hospital claims, in violation of the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152. For all twenty claims, the members enrolled in EDOC which means that they elected to receive electronic EOBs instead of paper EOBs. GHI only retained copies of these electronic EOBs for eighteen months after the claims were settled.
- GHI failed to issue an EOB for one hospital claim that was filed late.

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

“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.”

It is recommended that GHI retain copies of EOBs for the timeframe required by Part 243.2(b)(8) of Insurance Regulation No.152.

5. PROMPT PAY LAW

Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” (“Prompt Pay Law”), requires all insurers to pay undisputed claims within forty-five (45) days of receipt for paper claims

and within thirty (30) days of receipt for electronically submitted claims. If such undisputed claims are not paid within forty-five/thirty (45/30) days of receipt, interest may be payable.

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 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.”

Section 3224-a(c)(1) of the New York Insurance Law states in part:

“...Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim.”

All medical and hospital claims that were not adjudicated within forty-five (45) days of receipt for paper claims and within thirty (30) days of receipt for electronic claims, during the period January 1, 2013 through December 31, 2013, were segregated. A statistical sample of these claims was reviewed by the examiner to determine whether the payment was in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law, and, if applicable, whether interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law.

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

“...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...”

All denied medical and hospital claims that were not denied within thirty (30) days of receipt during the period January 1, 2013 through December 31, 2013, were segregated. A statistical sample of these claims was reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law.

It was determined that GHI was in substantial compliance with the foregoing statutory requirements.

6. ADVERTISING

Part 215.3(a) of Insurance Regulation No. 34 (11 NYCRR 215.3), *Advertisements of Accidents and Health Insurance*, states in part:

“(a) An advertisement for the purpose of this Part shall include:

(1) printed and published material, audio-visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays...”

Part 215.5(a) of Insurance Regulation No. 34 (11 NYCRR 215.5) states:

“(a) The format and content of an advertisement of an accident and health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the superintendent from the overall impression that the advertisement may be reasonably expected to create upon a person of average education and intelligence, unique to the particular type of audience to which the advertisement is directed, and whether it may be reasonably comprehended by the segment of the public to which it is directed.”

Part 215.9 of Insurance Regulation No. 34 (11 NYCRR 215.9) states in part:

“(a) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state...

(c) The source of any statistics used in an advertisement shall be identified in such advertisement.”

The examiner reviewed GHI’s documentation for advertisements made during the period January 1, 2009 through December 31, 2013, to ascertain compliance with the requirements of Insurance Regulation No. 34 (11 NYCRR 215) - *Advertisements of Accident and Health Insurance*.

Use of Statistics

In one of GHI’s advertisement brochures, GHI made the following statement:

“We’re expanding in the western New York region, over 90 percent of other plans’ doctors participating in our PPO network.”

GHI failed to disclose the source of the statistics used in the brochure, in violation of the requirements of Part 215.9(c) of Insurance Regulation No. 34. Furthermore, GHI was unable to produce documents to support the accuracy of the statement it made in the brochure, in violation of the requirements of Part 215.9(a) of Insurance Regulation No. 34.

It is recommended that GHI comply with the requirements of Parts 215.9(a) and (c) of Insurance Regulation No. 34 by disclosing the source of the statistics used in its advertisements, and by retaining support for the accuracy for all such statements made in its advertisements.

GHI HMO

On June 26, 2013, GHI HMO Select, Inc. (“GHI HMO”), a subsidiary of GHI, merged into HIPNY, with HIPNY being the surviving entity. It was noted that although GHI HMO no longer

existed as a corporate entity, GHI HMO was listed as a separate company underwriting EmblemHealth insurance products in the footer of one of GHI's advertisements published in October 2013. In addition, GHI HMO was listed as a separate entity underwriting EmblemHealth's insurance products in the footer of EmblemHealth's webpages in 2015 and 2016. It should be noted that such inaccuracies could potentially be misleading to those reviewing such advertisements and/or webpages.

GHI violated the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 (11 NYCRR 215.3 and 215.5) when it continued to list GHI HMO, as a separate entity, on its webpages and in its advertisements after the merger of GHI HMO and HIPNY.

It is recommended that GHI comply with the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 by discontinuing the listing of GHI HMO as a separate insurance entity in its advertisements and on its webpages.

7. GRIEVANCES AND APPEALS

Schedule M

The Department requires all Article 43 entities to report their grievances information in Part 2, Column 4 of Schedule M in the New York Supplement.

It was noted that the number of grievances GHI reported in its 2013 Schedule M was substantially greater than the actual grievances it processed during the year. GHI explained that the discrepancy was caused by service inquiries being incorrectly included in the Schedule M.

It is recommended that GHI exercise greater care in its filing of Schedule M to ensure the accuracy of the information being reported.

Member grievances

Section 4306-c(a) of the New York Insurance Law (“NYIL”) states:

“A corporation, including a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, that issues a comprehensive contract that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall establish and maintain a grievance procedure consistent with the requirements of section four thousand eight hundred two of this chapter.”

The examiner selected and reviewed a sample of thirty (30) grievance files from a log of one thousand nine hundred and eighty-six (1,986) grievance files closed by GHI in 2013 to determine GHI’s compliance with the requirements of Section 4802 of the New York Insurance Law and GHI’s written grievance and appeal procedures.

Section 4802(d) of the New York Insurance Law (“NYIL”) states in part:

“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...”

GHI did not comply with the requirements of Section 4802(d) of the NYIL in the following instances:

- GHI did not issue the acknowledgement letter for one (1) out of thirty (30) files selected.
- GHI did not issue the acknowledgement letter for eighteen (18) out of thirty (30) files selected. For these eighteen (18) files, the determination letters, which were being used as the acknowledgement letters, were issued within fifteen business days of the receipt of the grievance. However, the determination letters, when serving as acknowledgement letters, did not include the telephone number of the individual designated by GHI to respond to the grievance, as required by Section 4802(d) of the NYIL.

It is recommended that GHI comply with the requirements of Section 4802(d) of the New York Insurance Law by issuing an acknowledgement letter within fifteen business days of the

receipt of the grievance and by ensuring the acknowledgement letter contains all of the required information.

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

“The notice of a determination of the grievance shall be made in writing to the insured or to the insured’s designee...”

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

“The notice of a determination shall include:

- (1) the detailed reasons for the determination;
- (2) in cases where the determination has a clinical basis, the clinical rationale for the determination;
- (3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.”

GHI violated all of the requirements of Section 4802(f) of the New York Insurance Law, when it failed to issue a determination letter for three (3) out of the thirty (30) files sampled.

GHI violated the requirements of Section 4802(g)(3) of the NYIL when it failed to include the procedures for the appeal filing and a form for the filing of an appeal for eight (8) out of the thirty (30) files reviewed.

It is recommended that GHI comply with the requirements of Section 4802(f) of the New York Insurance Law by issuing the determination letter for all of its provider grievance files.

It is also recommended that GHI comply with the requirements of Section 4802(g)(2) of the New York Insurance Law by including its appeal procedures and form in all determination letters.

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

“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.”

GHI violated the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.2) when it failed to retain the correspondence for one (1) of thirty (30) files.

It is recommended that GHI comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by retaining its grievance records for the required timeframe.

Provider Grievances

To determine GHI's compliance with its own written grievance and appeal procedures, the examiner selected and reviewed a total of thirty (30) files from a log of sixty-seven thousand four hundred and two (67,402) participating provider grievance files closed by GHI in 2013.

Section B of GHI's and EmblemHealth's Policy No. EO.CS.GC.01, *Grievance and Complaint Response Process – Handling of Grievance and Complaints*, requires the following:

“All grievances and complaints require timely acknowledgement from handling departments. Areas responsible for responding to transferred grievances or complaints will acknowledge all written and e-mailed grievances or complaints within 15 calendar days...”

GHI failed to issue the acknowledgement letter required by Section B of its Policy No. EO.CS.GC.01 for twenty-three (23) out of the thirty (30) files reviewed.

It is recommended that GHI comply with its own Policy, by issuing an acknowledgement letter within 15 calendar days of receipt of the provider's grievance.

The Dispute Resolution section of the EmblemHealth Provider Manual states:

“EmblemHealth will acknowledge, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance will be reviewed and a written response will be issued for grievances with a final disposition of partial overturn or upheld, no later than 45 days after receipt. The determination included in the response will be final.”

For two (2) out of the thirty (30) files reviewed, GHI took more than forty-five (45) days to issue its determination letters exceeding the timeframe set forth in EmblemHealth's Provider Manual.

It is recommended that GHI comply with the terms of its Provider Manual, by issuing its determination letters in a timely manner.

8. COMPLAINT HANDLING

NYDFS Consumer Assistance Unit ("CAU") Complaints

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

"The superintendent is empowered to examine and investigate into the affairs of any person in order to determine whether the person has violated... section two thousand four hundred three of this article. 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... the superintendent is authorized... to levy a civil penalty against such person in an amount not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response, but in no event shall such penalty exceed ten thousand dollars..."

The examiner selected and reviewed a total of twenty-eight (28) files from a complaint log of four hundred and seventy-four (474) CAU complaints handled and closed by GHI in 2013 to determine GHI's compliance with the requirements of Section 2404 of the NYIL.

For one (1) out of the twenty-eight files reviewed, GHI violated the provisions of Section 2404 of the NYIL when it failed to provide a response within fifteen business days of the receipt of the Department's inquiry.

It is recommended that GHI comply with the requirements of Section 2404 of the New York Insurance Law by providing its responses to the Department's complaint inquiries within the required timeframe.

Member complaints

To determine GHI's compliance with its written grievance and appeal procedures, the examiner selected and reviewed a total of 24 files (five provider relations complaints, fifteen clinical complaints and four Special Investigation Unit complaints) from a complaint log of two hundred and seventy (270) member complaints closed by GHI in 2013.

EmblemHealth's Process No. EO.OP.GA.COM.11 (effective date July 1, 2013) - *Commercial PPO Complaints Process*, states in part:

"An acknowledgement letter is sent to the member within 5 business days of receipt of the complaint but no later than 15 calendar days from receipt of the complaint..."

For one (1) out of the twenty-four (24) instances reviewed, GHI failed to timely send an acknowledgement letter within 15 calendar days of receipt of the complaint, in violation of the requirements of its Process No. EO.OP.GA.COM.11.

It is recommended that GHI comply with the requirements of its internal Process No. EO.OP.GA.COM.11 by sending acknowledgement letters within the required timeframe.

Section B, bullet point No. 1, of EmblemHealth's Process No. EO.CS.GC.01 (effective August 2, 2012) - *Handling of Grievance and Complaints*, states in part:

"All grievances and complaints require timely acknowledgement from handling departments. Areas responsible for responding to transferred grievances or complaints will acknowledge all written and e-mailed grievances or complaints within 15 calendar days..."

For two (2) out of the twenty-four (24) instances reviewed, GHI failed to issue an acknowledgement letter as required by its Process No. EO.CS.GC.01.

Section A, bulletin point 3(c) of EmblemHealth’s Process No. EO.CS.GC.01 (effective August 2, 2012) - *Handling of Grievance and Complaints*, states in part:

“Provider Relations reviews the information that is sent to them from service via the Quality Complaint Intake (QCI) form. Upon completion of their review Provider Relations documents their findings on the QCI form and returns the case to service within the timeframes below:

For Standard Complaints and Complaint-Appeals – within 30 days of receipt of the complaint or complaint-appeal so that service can send the final determination letter to the member within 45 days of receipt of all necessary information for complaints...”

For two (2) out of the twenty-eight (28) instances reviewed GHI failed to issue determination letters as required by its Process No. EO.CS.GC.01.

It is recommended that GHI comply with the requirements of its internal Process No. EO.CS.GC.01 by issuing acknowledgement letters and determination letters for all of its complaints within fifteen calendar days.

9. DECLINATIONS – HEALTHY NEW YORK APPLICATIONS

During 2013, GHI declined forty-three (43) Healthy New York applications, two hundred and three (203) small group applications, and four hundred and five (405) large group request-for-quotations (“RFQs”).

The examiner selected and reviewed a sample of five (5) Healthy New York declinations, ten (10) small group declinations, and twenty (20) large group RFQs to verify GHI’s compliance with its underwriting guidelines.

Part 243.2(b) 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...

(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...

(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.”

GHI violated Parts 243.2(b)(2) and (8) of Insurance Regulation No. 152 by failing to retain copies of the following:

- The declination letter for seventeen (17) out of the twenty (20) large group applications.
- The written notice of denial for the five (5) Healthy New York applications. For two (2) of these five (5) applications, GHI was unable to locate any of the underwriting files.

It is recommended that GHI comply with the requirements of Part 243.2(b)(2) of Insurance Regulation No. 152 by ensuring that its underwriting files, including declination letters and written notices of denials, are retained for the required timeframe(s).

10. DISCLOSURE OF INFORMATION

Section 4324(a)(17) of the New York Insurance Law states in part:

“(a) Each health service, hospital service, or medical expense indemnity corporation subject to this article shall supply each subscriber, and upon request each prospective subscriber prior to enrollment, written disclosure information, which may be incorporated into the subscriber contract or certificate, containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following...

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities...”

GHI discontinued issuing a bonded hard-copy provider directory (a full listing of all participating providers in the network) for its medical and hospital lines of business in 2012. GHI maintains its entire listing of participating providers for all group and individual members on its website. In addition, its current and prospective members can request GHI’s customer service to print and mail a hard copy of the provider directory tailored to the member’s specific criteria, such as provider specialty, location, and name of the provider.

The examiner met with GHI's Lead Customer Service Representative ("LCSR") to discuss GHI's provider directory process. Upon speaking with the LCSR, it was determined that when a member requested a provider directory, the full hard-copy provider directory was not offered as an option. Furthermore, the examiner requested a hard-copy of GHI's full provider directory to determine GHI's ability to produce a full provider listing. It should be noted that GHI was unable to produce a full hard-copy provider directory.

It is recommended that GHI comply with the requirements of Section 4324(a)(17) of the New York Insurance Law by offering its members the option of receiving a full hard-copy provider directory and by producing and sending the full hard-copy provider directory to its current and prospective members, upon request.

11. UNDERWRITING AND RATING

From a log of five hundred and eight (508) large group experience-rated renewed and new policies, the examiner randomly selected and reviewed five (5) policies to determine GHI's compliance with the requirements of Section 4308(b) of the New York Insurance Law.

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

"(b) 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 violated the provisions of Section 4308(b) of the NYIL in the instances noted below:

- GHI updated its Mail Order Factor Rate on page 4.04a of its rate manual, but failed to file the updated page with the Department for approval. GHI applied the updated Mail Order Factor Rate, to four (4) of the rate files the examiner reviewed.
- As per GHI's filed rate manual, GHI limits its maximum underwriting adjustments to be -9% (decrease) to + 11% (increase). For the four (4) files

the examiner reviewed, GHI's applied underwriting adjustments exceeding the -9% limit (decrease).

- In addition to the adjustment factors allowed by its filed rate manual, it was determined that GHI applied additional rate concessions outside of its rate manual for three (3) files reviewed by the examiner.

In addition to the foregoing violations, it was also noted that, as evidenced in the five files the examiner reviewed, GHI's underwriting files were not documented in a sufficiently clear manner that showed the rate development leading up to the final rate.

It is recommended that GHI comply with the requirements of Section 4308(b) of the New York Insurance Law by ensuring that all policies that are experience rated are developed in accordance with its filed rate manual/formula.

It is also recommended that GHI ensure that its underwriting files are documented in a clear manner showing its rate development leading up to the final rate.

12. AGENTS AND BROKERS

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.”

The examiner reviewed GHI's agents and brokers appointment and termination processes. Additionally, a listing of GHI's agents and brokers for the examination period, January 1, 2009 through December 31, 2013 was also reviewed. As of the examination date, GHI had a total of four thousand three hundred and ninety-eight (4,398) active agents and brokers. GHI terminated two thousand six hundred and fifty-five (2,655) agents and brokers during the examination period.

Upon review, it was noted that fifty (50) of GHI's reported active agents and brokers and forty-three (43) of its reported terminated agents and brokers were not shown to be reported to the Department. Upon request, GHI was unable to provide documentation of these agents' appointments and/ or terminations with the Department.

It is recommended that GHI comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by ensuring that documentation of NYDFS filing of its agent appointments is retained for the required timeframe.

GHI reported \$46.8 million of commission expense in its filed 2013 annual statement. The examiner selected a sample and reviewed fourteen (14) commission payments to ensure the commission payments were made in accordance with the relevant agreement between GHI and the producer, and in accordance with the commission rates filed with the Department.

One of the items selected was the commission and fees withheld by Conference Associates, Inc. ("CAI") for the month of February 2013. CAI is GHI's master general agent which directly marketed and sold small group and sole proprietor products of EmblemHealth, including those of GHI and HIPNY. On a monthly basis CAI invoices small groups and sole proprietors and submits the collected premiums, less applicable commissions ("self-deducted commissions"), by wire transfer to GHI. For 2013, CAI withheld approximately \$7.9 million in commissions and fees from GHI.

The supporting documentation provided by GHI for CAI showed that the commission and fees CAI withheld from GHI ("the withheld amounts") were in the range of 5.05% to 13.80% of the billed premium amounts at the subscriber level. GHI was unable to further itemize the withheld amounts between the commissions and fees. Furthermore, GHI was unable to illustrate that the

calculation of the commissions and fees withheld by CAI was in accordance with the relevant agreement GHI had with CAI, and that the agreement was in accordance with the commission rates filed with the Department.

It is recommended that GHI maintain sufficient details and documentation to support the accuracy of its commission payments.

GHI's Internal Audit Department raised similar concerns in its report with regard to its audit of CAI in 2011. The report revealed GHI's lack of effective controls over contract administration, communication and monitoring of commission rates granted to billing administrators or master general agents. The following control deficiency and recommendation around self-deducted commissions were noted in the Internal Audit Department's report:

"The administration agreement between GHI and CAI stipulates that CAI will receive GHI's Standard MGA commission rate. Applying the current filed commission rate as criteria, commission discrepancies were noted between -0.25% and 1.75% involving all GHI products except SBA Plans. For CompreHealth HMO (HIP product), CAI appears to withhold 8.75% rather than the 7% approved rate..."

Internal audit recommends that the Sales Department's standard procedures be strengthened to include execution and maintenance of an administration agreement governing relationships with billing administrators or MGA's. All changes to commission payable should be made in compliance with the relevant administration agreement and filed commission rates, authorized by a sales executive and communicated in writing to the billing administrator or MGA."

The following was noted in GHI's management action plan with regard to the aforementioned control deficiency around self-deducted commissions:

"...Director of Billing stated that commission rates are based on year and product and are calculated at the subscriber level. The payment files provided monthly to Billing by CAI does not have this level of detail. Consequently, Billing is not able to verify commission on every group and member. Billing will, however, select a random sample of 20 subscribers each month and based on when they were enrolled and the product they are in, will calculate what the commission should be and compare it to what CAI deducted. If there is a difference, Billing will forward to Account Management for resolution with CAI."

In 2013, GHI's internal audit closed the issue citing the following:

“As part of the reconciliation process, Billing selects a random sample of 20+ subscribers from the payment file which shows the gross premium, commissions deducted and net premium paid. A column is added that calculates the commission percentage withheld and the file is sent to Sales for review against the contracted commission rates... SVP Underwriting & Account Management accepted the risk associated with forgoing the review of commissions, noting that Account Management had considered setting up a Financial Group for reviewing commissions but the idea was canceled due to budgetary constraints...”

It is recommended that GHI follow the foregoing internal control recommendation to strengthen its controls over self-deducted commissions.

It is also recommended that GHI strengthen its oversight over its management of its general agents.

It is further recommended that GHI recoup from CAI the full amount of all overpayments.

13. UTILIZATION REVIEWS AND APPEALS

42 USC § 300gg-19, US DOL 29 C.F.R. Part 2560, US DOL 29 CFR Part 2590, US HHS 45 CFR Part 147 and Article 49 of the New York Insurance Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents, respectively, for companies licensed under Article 43 of the New York Insurance Law.

The examiner was provided with utilization review and utilization review appeal logs for cases involving GHI and several of its delegated entities for the period, January 1, 2013 through December 31, 2013. GHI delegates certain of its utilization review and utilization review appeal responsibilities to third-party Utilization Review (“UR”) agents that include CareCore, Palladian, Value Options and Express Scripts.

Utilization review and utilization review appeal cases conducted by GHI and its third-party UR agents were randomly selected and reviewed by the examiner.

A. GHI

From a population of 75,243 utilization reviews (9,058 concurrent, 55,979 prospective, and 10,206 retrospective) conducted by GHI, during January 1, 2013 through December 31, 2013, thirty (30) UR cases were randomly selected and reviewed by the examiner. Among these thirty (30) cases, twenty-six (26) were prospective reviews, one (1) was a concurrent review, and three (3) were retrospective reviews. The examiner determined that two (2) of the prospective reviews should have been classified as concurrent reviews. After the reclassification, the composition of the sample was twenty-four (24) prospective, three (3) concurrent, and three (3) retrospective utilization review cases.

It is recommended that GHI properly classify its utilization reviews.

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

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

For sixteen (16) out of the twenty-four (24) prospective review cases, reviewed by the examiner, GHI was found to be in violation of the requirements of Section 4903(b) of the New York Insurance Law as follows:

- For eleven (11) cases, GHI failed to provide telephonic notification to the member due to failure to maintain member telephone numbers.
- For two (2) cases, GHI failed to provide the telephonic and written notifications to the provider in a timely manner, failed to provide the written notification to the

member in a timely manner, and failed to provide the telephonic notification to the member.

- For two (2) cases, GHI failed to provide the telephonic notification to the member and failed to provide the written notification to both the member and the provider.
- For one (1) case, GHI failed to provide both the telephonic and the written notifications to the provider and the member in a timely manner.

It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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.

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

“A utilization review agent shall make a determination involving continued or extended health care services... 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... Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.”

For two (2) out of the three (3) concurrent review cases, GHI was found to be in violation of the requirements of Section 4903(c) of the NYIL when it failed to provide the telephonic and written notifications to the provider within one business day of receipt of the necessary information.

It is recommended that GHI comply with the requirements of Section 4903(c) of the New York Insurance Law by providing the required telephonic and written notifications within one business day of receipt of the necessary information.

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

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

For one (1) out of the three (3) retrospective review cases, GHI was found to be in violation of the requirements of Section 4903(d) of the NYIL when it failed to make a utilization review determination within thirty days of receipt of the necessary information. GHI was unable to explain the delay.

It is recommended that GHI comply with the requirements of Section 4903(d) of the New York Insurance Law by making a determination within thirty days of receipt of the necessary information for all of its retrospective reviews.

Federal Regulation 45 C.F.R. 147.136(b)(2)(ii)(E) of the Health Insurance Reform Act of 2010 states in part:

“(E) *Notice*. A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner... The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E)...

(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).” (**emphasis added**)

Among the three (3) retrospective cases reviewed, one (1) was an initial adverse determination and two (2) were approvals. For the one (1) Initial Adverse Determination (“IAD”), GHI was found to be in violation of the requirements of 45 C.F.R. 147.136(b)(2)(ii)(E)(1) of the Health Insurance Reform Act of 2010 when it failed to include the claim amount on the IAD.

It is recommended that GHI comply with the requirements of Federal Regulation 45 C.F.R. 147.136(b)(2)(ii)(E)(1) of the Health Insurance Reform Act of 2010 by ensuring the claim amount is included in the Initial Adverse Determination letters, when applicable.

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.”

GHI was found to be in violation of the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243) when it failed to retain the initial UR request letter or fax for the required timeframe for three (3) of the thirty (30) UR cases.

It is recommended that GHI comply with the requirements of Part 243.2(b) of Insurance Regulation No. 152 by retaining copies of the initial UR request letters or faxes for the required timeframe.

It was noted that the insert contained within GHI’s Initial Adverse Determination letter which was used by certain of its utilization review delegates, violated requirements of Section 4904(b) of the New York Insurance Law, which states in part:

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

Federal Regulation 29 C.F.R. 2560.503-1(m)(1) states:

“(1) (i) A ‘claim involving urgent care’ is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a “claim involving urgent care” within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” within the meaning of paragraph (m)(1)(i) of this section shall be treated as a “claim involving urgent care” for purposes of this section.”

The insert to the Initial Adverse Determination letters stated, regarding the classification of the appeal:

“If we do not agree that your appeal relates to urgent care, we will treat it as a standard appeal.”

GHI utilization review delegates CareCore, Value Options, and Palladian were found to have used the GHI Initial Adverse Determination Letter insert that contained this language.

Both the New York Insurance Law Section 4904(b) and 29 C.F.R. 2560.503-1(m)(1) require the UR agent to treat an appeal as expedited or urgent if the member’s physician determines it to be expedited or urgent. Section 4904(b) of the New York Insurance Law requires the UR agent to expedite appeals involving continued or extended health care services. The UR agent’s ability to change the appeal type from expedited/urgent to standard is limited by Federal Regulation 29 C.F.R. 2560.503-(1)(m)(1)(ii).

It was determined that GHI’s statement in the insert of the IAD letters, used by CareCore, Value Options and Palladian, is an incomplete description of the requirements of Section 4904(b) of the New York Insurance Law and contrary to the requirements of Federal Regulation 29 C.F.R. 2560.503-(1)(m)(1), and could cause confusion to the recipients of the IADs.

It is recommended that GHI revise the statement in the insert of the IAD letters used by CareCore, Value Options and Palladian, with regard to the classification of the appeal, to provide

a complete and clear description of the requirements of Section 4904(b) of the New York Insurance Law and Federal Regulation 29 C.F.R. 2560.503-(1)(m)(1).

From a population of 75,243 UR appeals conducted by GHI during January 1, 2013 through December 31, 2013, thirty (30) UR appeal cases were randomly selected and reviewed by the examiner.

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.”

For three (3) of the thirty (30) appeal cases, GHI was found to be in violation of the requirements of Section 4904(d) of the NYIL, as follows:

- For two (2) appeals, the peer reviewer was the same individual who rendered the initial adverse determination.
- For one (1) appeal, the individual who conducted the review was not a clinical peer reviewer.

It is recommended that GHI comply with the requirements of Section 4904(d) of the New York Insurance Law by ensuring that all appeals are conducted by clinical peer reviewers who did not perform the initial utilization review on said appeal.

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

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

For fifteen (15) out of the thirty (30) appeal cases, GHI was found to be in violation of the requirements of Section 4904(c) of the NYIL, as follows:

- For one (1) case, GHI failed to make a timely determination within sixty days of receipt of the necessary information.

- For fourteen (14) cases, GHI failed to provide written acknowledgment of the filing of an appeal within fifteen days of receipt of such filing.

It is recommended that GHI comply with the requirements of Section 4904(c) of the New York Insurance Law by providing written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and by making a determination with regard to the appeal within sixty days of receipt of the necessary information.

Part 410.9(e) of Insurance Regulation No. 166 (11 NYCRR 410.9(e)), *External Appeals of Adverse Determinations of Health Care Plans*, states in part:

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

- (3) the health care plan’s contact person and his or her telephone number...
- (5) the name and full address of the health care plan’s utilization review agent;
- (6) the utilization review agent’s contact person and his or her telephone number...
- (9) ...a clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal.”

Federal Regulation 29 C.F.R. 2560.503-1(j) states in part:

“(j) **Manner and content of notification of benefit determination on review.** The plan administrator shall provide a claimant with written or electronic notification of a plan’s benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant...

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant’s right to bring action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits...

(iii) The following statement: “*You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.*”

For sixteen (16) Final Adverse Determination (“FAD”) letters reviewed by the examiner, GHI was found to be in violation of the requirements of Part 410.9(e) of Insurance Regulation No. 166 when it failed to include the following information in its FAD letters:

- GHI’s contact person and telephone number;
- A clear statement **written in bolded text** that the timeframe for requesting an external appeal begins upon receipt of the FAD of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal. (It should be noted that the FADs did contain the statement, however, the statement was **not** written in bold text).

It was also noted that the GHI’s Final Adverse Determination Letters issued by certain of its utilization review delegates failed to include the following required information in violation of the requirements of Part 410.9(e) of Insurance Regulation No. 166 (11 NYCRR 410.9(e)) and Federal Regulation 29 C.F.R. 2560.503-1(j):

- In seven (7) of the FADs in the sample of cases reviewed by the examiner, CareCore failed to include:
 - the name and full address of the health plan’s UR agent;
 - GHI’s contact person and telephone number;
 - a statement of the enrollee’s right to bring a civil action under §502(a) of ERISA; and
 - a provision that reads, *“You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office or your State insurance regulatory agency.”*
- In seven (7) of the FADs in the sample of cases reviewed by the examiner, Palladian failed to include:
 - GHI’s contact person and telephone number and
 - a clear statement **written in bolded text** that the timeframe for requesting an external appeal begins upon the receipt of the FAD of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time

may expire for the insured to request an external appeal. (It should be noted that the FADs did contain the statement, however, it was not written in bolded text.)

- For twenty-seven (27) of the FADs reviewed by the examiner, Value Options failed to include:
 - GHI's contact person and telephone number;
 - Value Options' contact person and telephone number; and (c) a clear statement **written in bolded text** that the timeframe for requesting an external appeal begins upon the receipt of the FAD of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal. (It should be noted that the FADs did contain the statement, however, it was not written in bolded text.)

It is recommended that GHI comply with the requirements of Part 410.9(e) of Insurance Regulation No. 166 and Federal Regulation 29 C.F.R. 2560.503-1(j) by including all of the required information in its Final Adverse Determination letters and those used by its utilization review delegates.

It was also noted that GHI failed to remove the reference of GHI HMO Select, Inc. ("GHI HMO") from the footer of its FAD letters issued after June 29, 2013, as evidenced by eleven (11) FAD letters in the sample.

It is recommended that GHI remove the reference of GHI HMO Select, Inc. from the footer of its FAD letters.

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

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

From a population of 5,530 prescription drug prospective utilization reviews, conducted by GHI during January 1, 2013 through December 31, 2013, thirty (30) cases were randomly selected and reviewed by the examiner.

It was noted that GHI did not have the telephonic notification process implemented in 2013 for its internal pharmacy UR program. For all of the thirty (30) cases in the sample, GHI was found to be in violation of the requirements of Section 4903(b) of the NYIL when it failed to provide the telephonic notification to the members of its UR determinations.

It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law by providing telephonic notification of the determination to the insured or the insured's designee and the insured's health care provider for all of its prospective reviews.

B. CareCore

From a population of 189,934 utilization review cases conducted by CareCore ("CCN"), a third-party administrator acting on behalf of GHI, during January 1, 2013 through December 31, 2013, thirty (30) cases were randomly selected and reviewed by the examiner. All thirty (30) cases were prospective reviews.

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

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

For all of the thirty (30) cases, CareCore was found to be in violation of the requirements of Section 4903(b) of the NYIL, as follows:

- For seventeen (17) cases, CCN failed to provide telephonic notification to the member.
- For one (1) case, CCN failed to provide the telephonic notification to the provider.
- For eleven (11) cases, CCN failed to provide the telephonic notification to both the member and the provider.
- For one (1) case, CCN failed to provide the telephonic and written notifications of the modified determination resulting from the reconsideration process.

It is recommended that GHI/CareCore comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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.

From a population of 329 UR appeal cases conducted by CareCore during January 1, 2013 through December 31, 2013, twenty-eight (28) appeal cases were randomly selected and reviewed by the examiner. Among the twenty-eight (28) appeal cases, seven (7) were final adverse determinations and twenty-one (21) were overturned.

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.”

For six (6) out of the total twenty-eight (28) appeals, reviewed by the examiner, CareCore was found to be in violation of the requirements of Section 4904(d) of the NYIL when it failed to have a clinical peer reviewer conduct the appeals.

It is recommended that GHI/CareCore comply with the requirements of Section 4904(d) of the New York Insurance Law by ensuring all of its UR appeals are conducted by clinical peer reviewers.

C. Palladian

From a population of 8,732 utilization review cases conducted by Palladian, a third-party administrator acting on behalf of GHI, during January 1, 2013 through December 31, 2013, thirty (30) cases were randomly selected and reviewed by the examiner. Of the thirty (30) cases, there were seven (7) prospective reviews and twenty-three (23) concurrent reviews. The examiner determined that three (3) prospective reviews in the sample should be classified as concurrent reviews. After the reclassification, the sample consisted of four (4) prospective reviews and twenty-six (26) concurrent reviews.

It is recommended that GHI/Palladian properly classify their utilization reviews.

For three (3) out of the twenty-six (26) concurrent cases, Palladian was found to be in violation of the requirements of Section 4903(c) of the NYIL, as follows:

- For one (1) case, Palladian failed to make the determination within one business day of receipt of the necessary information.
- For two (2) cases, Palladian failed to make the telephonic notification to the member within one business day of receipt of the necessary information.

It is recommended that GHI/Palladian comply with the requirements of Section 4903(c) of the New York Insurance Law by making their UR determinations in a timely manner, and by providing telephonic notification to the member within one business day of receipt of the necessary information.

Federal Regulation 29 C.F.R. 2560.503-1(f)(2)(iii)(A) states in part:

“...if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information...”

For six (6) out of the thirty (30) cases, reviewed by the examiner, Palladian requested additional information during its review. It was Palladian's policy to issue the initial adverse determination 15 days following the 45 days allowed for submittal of the additional information (referred to as "the sixty days pend period"). Palladian was found to be in violation of the requirements of Federal Regulation 29 C.F.R. 2560.503-1(f)(2)(iii)(A), as follows:

- For five (5) cases, Palladian failed to offer forty-five (45) days to the claimant to provide the specified additional information.
- For one (1) case, Palladian issued its Initial Adverse Determination before the end of the sixty (60) day pend period.

It is recommended that GHI/Palladian comply with the requirements of Federal Regulation 29 C.F.R. 2560.503-1(f)(2)(iii)(A) by providing 45 days for the claimant to submit additional information.

From a population of sixteen (16) UR appeal cases resolved by Palladian during the period January 1, 2013 through December 31, 2013, ten (10) cases were randomly selected and reviewed by the examiner. Among these ten (10) cases, seven (7) were final adverse determinations and three (3) were overturned.

D. Value Options

From a population of 16,392 utilization review cases resolved by Value Options ("VO"), a third-party administrator acting on behalf of GHI, for the period January 1, 2013 through December 31, 2013, thirty (30) cases were randomly selected and reviewed by the examiner. Of the thirty (30) cases, there were eight (8) prospective reviews, twenty-one (21) concurrent reviews and one (1) retrospective review. Upon further review, two (2) prospective reviews were

reclassified as concurrent reviews. After the reclassification, the sample consisted of six (6) prospective reviews, twenty-three (23) concurrent reviews and one (1) retrospective review.

It is recommended that GHI/VO properly classify their utilization reviews.

For five (5) out of the six (6) prospective UR cases, Value Options was found to be in violation of the requirements of Section 4903(b) of the New York Insurance Law, as follows:

- For one (1) case, VO failed to make the telephonic notification to the insured or insured's designee.
- For four (4) cases, VO failed to make the written notification to the provider.

It is recommended that GHI/VO comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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.

For the twenty-three (23) concurrent UR cases reviewed, nineteen (19) were approvals and four (4) were initial adverse determinations. For the nineteen (19) approvals reviewed, Value Options was found to be in violation of the requirements of Section 4903(c) of the New York Insurance Law, as follows:

- For eight (8) cases, VO failed to make the written determination to the provider and failed to include the "next review date" in its notification letters.
- For two (2) cases, VO failed to make the telephonic notification to the provider and failed to include the "next review date" in its notification letters.
- For one (1) case, VO failed to make the written notification to the provider.
- For one (1) case, VO failed to make the telephonic notification to the provider.
- For seven (7) cases, VO failed to include the "next review date" in its notification letters.

For one (1) out of the twenty-three (23) concurrent UR cases, Value Options was found to be in violation of the requirements of Part 243.2(b) of Insurance Regulation No. 152 (11 NYCRR 243.2) when it failed to retain a copy of the provider's initial UR request.

It is recommended that GHI/VO comply with the requirements of Section 4903(c) of the New York Insurance Law by providing both written and telephonic notifications to the insured's health care provider within one business day of receipt of the necessary information for all concurrent reviews and also by including the next review date.

It is also recommended that GHI/VO comply with the requirement of Part 243.2(b) of Insurance Regulation No. 152 by retaining copies of the provider's initial UR request for the required timeframe.

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

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

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...”

For the one (1) retrospective case reviewed by the examiner, VO was found to be in violation of the requirements of Sections 4903(d) and 4903(e) of the New York Insurance Law when it failed to make a determination and issue a written determination letter for all requested dates of services.

It is recommended that GHI/VO comply with the requirements of Sections 4903(d) and 4903(e) of the New York Insurance Law by ensuring that determination for all requested dates of services is made and a written notice of such determination is issued.

From a population of 1,639 UR appeals cases conducted by Value Options during period January 1, 2013 through December 31, 2013, twenty-nine (29) randomly selected UR appeal files were reviewed by the examiner. Among these twenty-nine (29) cases, two (2) were overturned, two (2) were modified final adverse determinations, and twenty-five (25) were Final Adverse Determinations.

It was noted that VO failed to remove the reference of GHI HMO Select, Inc. (GHI HMO) from the footer of its FADs issued after June 26, 2013, as evidenced by twelve (12) FADs in the sample.

It is recommended that GHI/VO remove the reference of GHI HMO Select, Inc. from the footer of VO's Final Adverse Determination letters.

E. Express Scripts

From a population of five thousand eight hundred and thirteen (5,813) prospective UR cases that consisted of 5,055 approvals and 758 Initial Adverse Determinations, conducted by Express Scripts, Inc. ("ESI") for GHI's contract with New York City during the period January 1, 2013 through December 31, 2013, thirty (30) cases were randomly selected and reviewed by the examiner. Among these thirty (30) cases, two (2) were Initial Adverse Determinations and the other twenty-eight (28) were approvals.

For two (2) out of the thirty (30) cases, ESI was found to be in violation of the requirements of Section 4903(b) of the New York Insurance Law for the reasons noted below:

- For one (1) case, ESI failed to make the verbal notification to both the provider and the member.
- For one (1) case, ESI made the verbal notification on the fourth business day of receipt of the necessary information exceeding the three business days required time frame.

It is recommended that GHI/ESI comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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 for their prospective URs.

Federal Regulation 45 C.F.R. 147.136(b)(2)(ii)(E) of the Health Insurance Reform Act of 2010 states in part:

“(E) *Notice.* A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 C.F.R. 2560.503-1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E)...

(5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.”

ESI failed to include in its Initial Adverse Determination the statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established to assist enrollees with the appeal process as required by 45 C.F.R. 147.136(b)(2)(ii)(E)(5) of the Health Insurance Reform Act of 2010, as evidenced in the two (2) Initial Adverse Determinations reviewed by the examiner.

It is recommended that GHI/ESI comply with the requirements of Federal Regulation 45 C.F.R. 147.136(b)(2)(ii)(E)(5) by ensuring that all of its Initial Adverse Determination letters contain the required statements.

14. SUBSEQUENT EVENTS

EmblemHealth subcontracts administration of its GHI and HIP members' behavioral health benefits to Value Options, Inc., (currently Beacon Health Options) a third-party behavioral health

administrator. Value Options, Inc., on behalf of EmblemHealth, performed utilization review for all inpatient, partial hospitalization and intensive outpatient behavioral health claims and certain outpatient visits.

In 2014, the Office of the NY Attorney General conducted an investigation into EmblemHealth's coverage of behavioral health and substance abuse disorder benefits administered by Value Options, Inc. The Attorney General ("AG") found that EmblemHealth's behavioral health coverage was not "on par" with medical/surgical coverage and that EmblemHealth applied more rigorous and frequent utilization review for behavioral health benefits than for medical/surgical benefits.

In July of 2014, EmblemHealth reached a settlement with the Office of the Attorney General regarding EmblemHealth's administration of its mental health and substance abuse benefits. EmblemHealth, as part of the settlement, offered independent utilization reviews, by a third-party, of mental health benefit claims submitted during a certain period that had been denied for lack of medical necessity or due to lack of coverage for residential treatment for behavioral health services, and for which the member subsequently incurred out-of-pocket costs for such treatment. In addition, EmblemHealth was required to pay a civil penalty of \$1.2 million to the Office of the Attorney General.

During the years of 2013 and 2014, the Office of the NY Attorney General also investigated GHI on the following issues:

- GHI's failure to adequately disclosure out-of-network reimbursement to members of its Comprehensive Benefit Plans.
- GHI's compliance with the Young Adult Option coverage notification requirement of Section 4305(1)(2)(G) of the New York Insurance Law for the period 2010 through 2014.

- GHI's improper application of member cost-sharing for 255 out-of-network anesthesia claims performed in connection with an in-network preventive colonoscopy procedure for the period 2012 through 2014.

GHI settled the three aforementioned issues with the Office of the NY Attorney General in 2014. With exception of the settlement on the Young Adult Option, GHI did not admit nor deny the respective AG's findings.

15. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

There were twenty-three (23) comments and recommendations from the prior Market Conduct report on examination as of December 31, 2008. They are repeated herein as follows (page numbers refer to the prior report):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
	<u>Claims Processing</u>	
1.	It is recommended that GHI establish procedures that automatically calculate interest on non-par claims. <i>GHI has complied with this recommendation.</i>	6
	<u>Timothy's Law Claims Processing</u>	
2.	Subsequent to the examination date, GHI reprocessed all the affected Timothy's Law claims that did not involve deductibles by July 12, 2010 and those claims that involved deductibles by November 2, 2010. 96,053 claims were adjusted with a total of payment of \$2,573,987.54, of which \$103,803.31 was interest paid. <i>GHI has complied with this recommendation.</i>	6
	<u>Prompt Pay Law</u>	
3.	It is recommended that GHI take steps to ensure that the provisions of §3224-a(a) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. <i>GHI has substantially complied with this recommendation.</i>	10
4.	It is recommended that GHI take steps to ensure that the provisions of §3224-a(b) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. <i>GHI has substantially complied with this recommendation.</i>	10
5.	It is recommended that GHI take steps to ensure that the provisions of §3224-a(c) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. <i>GHI has substantially complied with this recommendation.</i>	11

ITEM NO.**PAGE NO.**Underwriting and Rating

- | | | |
|-----|--|----|
| 6. | It is recommended that GHI ensure correct rates are loaded for accurate billing and charge the correct rates to its policyholders in order to comply with Section 4308(b) of the New York Insurance Law. | 12 |
| | <i>GHI has complied with this recommendation.</i> | |
| 7. | It is recommended that GHI comply with the provisions of Sections 4235(k) and 4235(l) of the New York Insurance Law when terminating contracts for non-payment of premium. | 13 |
| | <i>GHI has complied with this recommendation.</i> | |
| 8. | It is recommended that GHI refrain from recovering claims from providers on affected claims when the grace period is extended by GHI beyond the thirty (30) day grace period. | 13 |
| | <i>GHI has complied with this recommendation.</i> | |
| 9. | It is further recommended that GHI comply with the provisions of Department Regulation No. 78 relative to the requirements of termination notices of group policies or contracts of accident and health insurance. | 14 |
| | <i>GHI has complied with this recommendation.</i> | |
| 10. | It is recommended that GHI institute procedures to ensure that the forms on its applications are up to date and contain the correct rates. | 14 |
| | <i>GHI has complied with this recommendation.</i> | |
| 11. | It is recommended that GHI maintains documentation of its applications to comply with the record retention requirements of Department Regulation No. 152. | 15 |
| | <i>GHI has complied with this recommendation.</i> | |

Producers

- | | | |
|-----|---|----|
| 12. | It is recommended that GHI file all termination notices with the Department when terminating agents in compliance with Section 2112(d) of the New York Insurance Law. | 17 |
| | <i>GHI has complied with this recommendation.</i> | |

ITEM NO.**PAGE NO.**Producers (Cont'd.)

13. It is also recommended that GHI create a separate identifier in its system for agents whose terminations are not official, to distinguish them from agents who were officially terminated. 17

GHI does not comply with this recommendation. It indicated that creating a separate identifier in its system has little return on investment.

14. It is recommended that GHI keep its listing of appointed agents current, and terminated agents who fail to submit a copy of their renewed license for an extended period of time. 17

GHI has complied with this recommendation.

15. It is again recommended that GHI comply with Part 243.2(b)(8) of Department Regulation No. 152 by keeping its check request records for at least 6 years from creation. 18

GHI has complied with this recommendation.

Complaints

16. It is recommended that GHI respond to the Department within fifteen business days in order to comply with the requirements of Section 2404 of the New York Insurance Law. 19

GHI has not complied with this recommendation. A similar recommendation is made in this report.

17. Grievances 19

It is recommended that GHI comply with its Grievance procedures and acknowledge all filed Grievances, in writing within, fifteen (15) business days.

GHI has complied with this recommendation.

Utilization Reviews and Appeals

18. It is recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide the determination notice within three (3) business days. 21

GHI has complied with this recommendation.

ITEM NO.**PAGE NO.**Utilization Reviews and Appeals (Cont'd.)

- | | | |
|-----|---|----|
| 19. | It is also recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination. | 21 |
| | <i>GHI has not complied with this recommendation. A similar recommendation is made in this report.</i> | |
| 20. | It is recommended that GHI comply with Section 4903(c) of the New York Insurance Law and provide written notice of determination notice within one (1) business day. | 22 |
| | <i>GHI has not complied with this recommendation. A similar recommendation is made in this report.</i> | |
| 21. | It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination within the required timeframe. | 23 |
| | <i>This recommendation was pertaining to CareCore, GHI's delegated utilization review agent. CareCore, acting on behalf of GHI, has not fully complied with this recommendation. A similar recommendation is made in this report.</i> | |
| 22. | It is recommended that GHI comply with Section 4903(b) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination. | 23 |
| | <i>This recommendation was pertaining to Value Options, GHI's delegated utilization review agent. This recommendation has not been fully complied with. A similar recommendation is made in this report.</i> | |
| 23. | It is recommended that GHI comply with the requirements of Section 4903(c) of the New York Insurance Law and provide verbal notification to the enrollee or their representative and their health care provider of the determination within the allotted timeframe. | 24 |
| | <i>This recommendation was pertaining to Value Options, GHI's delegated utilization review agent. This recommendation has not been fully complied with. A similar recommendation is made in this report.</i> | |

16. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Claims Processing</u>	
It is recommended that GHI retain copies of EOBs for the timeframe required by Part 243.2(b)(8) of Insurance Regulation No. 152.	6
B. <u>Advertising</u>	
i. It is recommended that GHI comply with the requirements of Parts 215.9(a) and (c) of Insurance Regulation No. 34 by disclosing the source of the statistics used in its advertisements and by retaining support for the accuracy for all such statements made in its advertisements.	9
ii. It is recommended that GHI comply with the requirements of Parts 215.3(a) and 215.5(a) of Insurance Regulation No. 34 by discontinuing the listing of GHI HMO as a separate insurance entity in its advertisements and on its webpages.	10
C. <u>Grievances and Appeals</u>	
i. It is recommended that GHI exercise greater care in its filing of Schedule M to ensure the accuracy of the information being reported.	10
ii. It is recommended that GHI comply with the requirements of Section 4802(d) of the New York Insurance Law by issuing an acknowledgement letter within fifteen business days of the receipt of the grievance and by ensuring the acknowledgement letter contains all of the required information.	11
iii. It is recommended that GHI comply with the requirements of Section 4802(f) of the New York Insurance Law by issuing the determination letter for all of its provider grievance files.	12
iv. It is also recommended that GHI comply with the requirements of Section 4802(g)(2) of the New York Insurance Law by including its appeal procedures and form in all determination letters.	12
v. It is recommended that GHI comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by retaining its grievance records for the required timeframe.	13
vi. It is recommended that GHI comply with its own Policy, by issuing an acknowledgement letter within 15 calendar days of receipt of the provider's grievance.	13

<u>ITEM</u>	<u>PAGE NO.</u>
<u>Grievances and Appeals (Cont'd.)</u>	
vii. It is recommended that GHI comply with the terms of its Provider Manual, by issuing its determination letters in a timely manner.	14
D. <u>Complaint Handling</u>	
i. It is recommended that GHI comply with the requirements of Section 2404 of the New York Insurance Law by providing its responses to the Department's complaint inquiries within the required timeframe.	14
ii. It is recommended that GHI comply with the requirements of its internal Process No. EO.OP.GA.COM.11 by sending acknowledgement letters within the required timeframe.	15
iii. It is recommended that GHI comply with the requirements of its internal Process No. EO.CS.GC.01 by issuing acknowledgement letters and determination letters for all of its complaints within fifteen calendar days.	16
E. <u>Declinations – Healthy New York Applications</u>	
It is recommended that GHI comply with the requirements of Part 243.2(b)(2) of Insurance Regulation No. 152 by ensuring that its underwriting files, including declination letters and written notices of denials, are retained for the required timeframe(s).	17
F. <u>Disclosure of Information</u>	
It is recommended that GHI comply with the requirements of Section 4324(a)(17) of the New York Insurance Law by offering its members the option of receiving a full hard-copy provider directory and by producing and sending the full hard-copy provider directory to its current and prospective members, upon request.	18
G. <u>Underwriting and Rating</u>	
i. It is recommended that GHI comply with the requirements of Section 4308(b) of the New York Insurance Law by ensuring that all policies that are experience rated are developed in accordance with its filed rate manual/formula.	19
ii. It is also recommended that GHI ensure that its underwriting files are documented in a clear manner showing its rate development leading up to the final rate.	19

<u>ITEM</u>	<u>PAGE NO.</u>
H.	
<u>Agents and Brokers</u>	
i.	20
It is also recommended that GHI comply with the requirements of Part 243.2(b)(8) of Insurance Regulation No. 152 by ensuring that documentation of NYDFS filing of its agent appointments is retained for the required timeframe.	
ii.	21
It is recommended GHI maintain sufficient details and documentation to support the accuracy of its commission payments.	
iii.	22
It is recommended that GHI follow the foregoing internal control recommendation to strengthen its controls over self-deducted commissions.	
iv.	22
It is also recommended that GHI strengthen its oversight over its management of its general agents.	
v.	22
It is further recommended that GHI recoup from CAI the full amount of all overpayments.	
I.	
<u>Utilization Reviews and Appeals</u>	
i.	23
It is recommended that GHI properly classify its utilization reviews.	
ii.	24
It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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.	
iii.	24
It is recommended GHI comply with the requirements of Section 4903(c) of the New York Insurance Law by providing the required telephonic and written notifications within one business day of receipt of the necessary information.	
iv.	25
It is recommended that GHI comply with the requirements of Section 4903(d) of the New York Insurance Law by making a determination within thirty days of receipt of the necessary information for all of its retrospective reviews.	
v.	25
It is recommended that GHI comply with the requirements of Federal Regulation 45 C.F.R. 147.136(b)(2)(ii)(E)(1) of the Health Insurance Reform Act of 2010 by ensuring the claim amount is included in the Initial Adverse Determinations letters, when applicable.	

ITEM**PAGE NO.**Utilization Reviews and Appeals (Cont'd)

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| vi. | It is recommended that GHI comply with the requirements of Part 243.2(b) of Insurance Regulation No. 152 by retaining copies of the initial UR request letters or faxes for the required timeframe. | 26 |
| vii. | It is recommended that GHI revise the statement in the insert of the IAD letters used by CareCore, Value Options and Palladian, with regard to the classification of the appeal, to provide a complete and clear description of the requirements of Section 4904(b) of the New York Insurance Law and Federal 29 C.F.R. 2560.503-(1)(m)(1). | 27 |
| viii. | It is recommended that GHI comply with the requirements of Section 4904(d) of the New York Insurance Law by ensuring that all appeals are conducted by clinical peer reviewers who did not perform the initial utilization review on said appeal. | 28 |
| ix. | It is recommended that GHI comply with the requirements of Section 4904(c) of the New York Insurance Law by providing written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and by making a determination with regard to the appeal within sixty days of receipt of the necessary information. | 29 |
| x. | It is recommended that GHI comply with the requirements of Part 410.9(e) of Insurance Regulation No. 166 and Federal Regulation 29 C.F.R. 2560.503-1(j) by including all of the required information in its Final Adverse Determination letters and those used by its utilization review delegates. | 31 |
| xi. | It is recommended that GHI remove the reference of GHI HMO Select, Inc. from the footer of its FAD letters. | 31 |
| xii. | It is recommended that GHI comply with the requirements of Section 4903(b) of the New York Insurance Law by providing telephonic notification of the determination to the insured or the insured's designee and the insured's health care provider for all of its prospective reviews. | 32 |
| xiii. | It is recommended that GHI/CareCore comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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. | 33 |

ITEM**PAGE NO.**Utilization Reviews and Appeals (Cont'd)

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|--------|---|----|
| xiv. | It is recommended that GHI/CareCore comply with the requirements of Section 4904(d) of the New York Insurance Law by ensuring all of its UR appeals are conducted by clinical peer reviewers. | 33 |
| xv. | It is recommended that GHI/Palladian properly classify their utilization reviews. | 34 |
| xvi. | It is recommended that GHI/Palladian comply with the requirements of Section 4903(c) of the New York Insurance Law by making their UR determinations in a timely manner, and by providing telephonic notification to the member within one business day of receipt of the necessary information. | 34 |
| xvii. | It is recommended that GHI/Palladian comply with the requirements of Federal Regulation 29 C.F.R. 2560.503-1(f)(2)(iii)(A) by providing 45 days for the claimant to submit additional information. | 35 |
| xviii. | It is recommended that GHI/VO properly classify their utilization reviews. | 36 |
| xix. | It is recommended that GHI/VO comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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. | 36 |
| xx. | It is recommended that GHI/VO comply with the requirements of Section 4903(c) of the New York Insurance Law by providing both written and telephonic notifications to the insured's health care provider within one business day of receipt of the necessary information for all concurrent reviews and also by including the next review date. | 37 |
| xxi. | It is also recommended that GHI/VO comply with the requirement of Part 243.2(b) of Insurance Regulation No. 152 by retaining copies of the provider's initial UR request for the required timeframe. | 37 |
| xxii. | It is recommended that GHI/VO comply with the requirements of Section 4903(d) and 4903(e) of the New York Insurance Law by ensuring that determination for all requested dates of services is made and a written notice of such determination is issued. | 37 |
| xxiii. | It is recommended that GHI/VO remove the reference of GHI HMO Select, Inc. from the footer of VO's Final Adverse Determination letters. | 38 |

ITEM**PAGE NO.**Utilization Reviews and Appeals (Cont'd)

- xxiv. It is recommended that GHI/ESI comply with the requirements of Section 4903(b) of the New York Insurance Law by providing 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 for their prospective URs. 39
- xxv. It is recommended that GHI/ESI comply with the requirements of Federal Regulation 45 C.F.R. 147.136(b)(2)(ii)(E)(5) by ensuring that all of its Initial Adverse Determination letters contain the required statements. 39

NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

I, **BENJAMIN M. LAWSKY**, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

JoLo Hsia

as a proper person to examine the affairs of

Group Health Incorporated

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

Plan

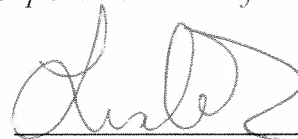
with such other information as she shall deem requisite.

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

this 6th day of November, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

