

REPORT ON EXAMINATION

OF

HEALTH NET OF NEW YORK, INC.

AS OF

SEPTEMBER 30, 2003

DATE OF REPORT:

JANUARY 30, 2007

EXAMINER:

PEARSON GRIFFITH

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

Eliot Spitzer
Governor

Eric R. Dinallo
Acting Superintendent

January 30, 2007

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

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with directions contained in Appointment Number 22105 dated November 6th 2003, and annexed hereto, I have made an examination into the condition and affairs of Health Net of New York, Inc. (HNNY), a for-profit independent practice association model health maintenance organization (HMO) licensed pursuant to the provisions of Article 44 of the Public Health Law. During the examination, the Company's statutory home office was located at 399 Knollwood Road, White Plains, New York 10603. However, the HMO notified the Department on July 14, 2006 that such office was relocated to 150 East 42nd Street, New York, New York 10017. The primary location of the Company's books and records is 21650 Oxnard Street, Woodland Hills, California 91367. This examination was conducted at the Company's administrative office located at One Far Mill Crossing, Shelton, Connecticut 06484. The following report thereon as respectfully submitted deals with the findings concerning the manner in which HNNY conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

Whenever the terms "Health Net," "HNNY," "Plan," "Company" or "HMO" appear herein without qualification, they should be understood to refer to Health Net of New York, Inc.

1. SCOPE OF EXAMINATION

The Plan was previously examined as of December 31, 1998. This examination covers the period from January 1, 1999 through September 30, 2003. Where deemed appropriate, transactions subsequent to the examination date were reviewed.

The examination comprised a complete verification of assets and liabilities as of September 30, 2003, in accordance with generally accepted accounting principles (GAAP). The examination included a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

- History of the Plan
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of the Plan
- Accounts and records
- Market conduct activities

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

2. **DESCRIPTION OF THE PLAN**

The Plan was incorporated under New York State Law on April 22, 1986 under the name of Physicians Health Services of New York, Inc., as a for-profit health maintenance organization (“HMO”) to provide comprehensive health care services on a prepaid basis, and to establish a health care delivery system. It was originally granted a Certificate of Authority to operate as an Individual Practice Association (IPA) Model HMO under Article 44 of the New York State Public Health Law on June 30, 1987, and began operations on that date. The Plan was granted a revised Certificate of Authority, effective October 17, 2001, to change the name to Health Net of New York, Inc.

On October 21, 1987, the HMO attained federal qualification under Title XIII of the Public Health Service Act.

Health Net’s authorized capital consists of 2,000,000 shares of \$0.01 par value common stock, of which 1,450,000 shares are issued and outstanding. The Plan has no preferred capital stock issued or outstanding.

A. **Management and controls**

The by-laws of the Plan provide that its affairs shall be managed by a board of directors consisting of not less than six (6) or more than nine (9) members, with each member to be elected for a term of three (3) years. The by-laws also provide that at least one fifth (1/5) of the directors shall be comprised of enrollees of the Plan, provided however, that no group covered

by any group contract issued by the Plan shall be represented among such directors by more than one (1) such director. In addition, the by-laws provide that at least one third (1/3) of the directors shall be physicians elected from among nominees chosen by the individual practice associations, which are parties to agreements to provide services to enrollees of the Plan, at the time of their election. Furthermore, at least one third (1/3) of the directors shall be elected from among nominees chosen by Health Net, Inc., provided, however, that at least two (2) of such directors shall be physicians.

As of September 30, 2003, the board of directors consisted of the following seven members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Julie Auster * Briarcliff Manor, NY	Director of Human Resources Sarah Lawrence College
Scott Breidbart, MD Mount Kisco, NY	Medical Director Health Net Northeast, Inc.
Mark Jarrett, MD Staten Island, NY	Physician
Martin Jenis * Larchmont, NY	Agent/Broker Martin L. Jenis & Associates
Michael Perskin, MD New York, NY	Physician NYU/Concorde Medical Group
Anju Sikka, MD North Brunswick, NJ	Senior Medical Director Health Net Northeast, Inc.
Adam Stracher, MD New York, NY	Physician Cornell Medical Associates

* - *Enrollee Representative*

The board of directors of Health Net of New York met eighteen (18) times during the

period covered by this examination. A review of the minutes of the board of directors' meetings and committees thereof indicated that four (4) directors attended less than fifty percent (50%) of the meetings they were eligible to attend. The Company replaced three (3) of those directors who voluntarily resigned from the board. Additionally, board member Mark Jarrett, MD, attended or participated in only seven (7) of the eighteen (18) board meetings he was eligible to attend.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the insurer. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Individuals, who fail to attend at least one-half of the board's regular meetings, unless appropriately excused, do not fulfill such criteria. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.

It is recommended that board members who are unable or unwilling to attend at least one-half (1/2) of the regular board meetings should resign or be replaced. A similar recommendation was made in the prior report on examination.

During the period December 17, 2001 through June 16, 2003, the examiners noted that only one (1) member of the Plan's board of directors was an eligible enrollee representative of the Plan.

The provisions of Part 98-1.11(f) of the Health Department's Administrative Rules and

Regulations Department (10 NYCRR 98-1) require that:

“...Within one year of the HMO receiving a certificate of authority, no less than 20 percent of the members of the governing authority shall be enrollees of the HMO. Employees of the HMO or providers of health services may not serve as enrollee representatives.”

It is imperative that the Plan seek to fill vacancies of its enrollee members of the board of directors in a timely manner in order to be in compliance with its by-laws and Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1). The presence of enrollee representatives is critical to the establishment and oversight of the Plan’s policies, management and overall operations. The Plan, in its actions taken or proposed as regards the prior report on examination represented that it *“...will act expeditiously to replace such representatives as they resign their positions.”*

It is recommended that the Plan comply with the provisions of Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department, and its own by-laws, by seeking to fill vacancies of its enrollee members of the board of directors in a timely manner. A similar recommendation was made in the prior report on examination.

The principal officers of the Plan as of September 30, 2003 were as follows:

<u>Name</u>	<u>Title</u>
Anju Sikka, MD	President
Joseph Kempf, Jr.	Secretary
Pennell Hamilton	Treasurer

B. Territory and Plan of Operation

Health Net's service area includes Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester Counties.

C. Provider Agreements

During the period covered by this examination, the Plan's network was comprised of hospitals, primary care physicians, specialists and other professionals who were members of certain contracted independent practice associations (IPAs), physician hospital organizations (PHOs), individual physicians, and other medical professionals. Physicians and specialists under contract provide a defined range of health care services, including primary and specialty care throughout Westchester, Rockland, Putnam, Dutchess and Orange Counties, as well as the New York City and Long Island area. The Plan's agreements with providers include discounted fee-for-service agreements as well as capitated group agreements, in which the contracting group assumes a significant amount of the risk of over utilization. The benefits offered under the Plan's traditional products include all primary care and most specialty care, subject to various co-payments. The Plan maintains capitated reimbursement agreements for the provision of mental health, home care, laboratory and chiropractic services.

D. Capitation Agreements

The Plan's contracts with IPAs and PHOs consist of discounted fee-for-service agreements, as well as capitation agreements. Monthly capitation amounts are owed to the IPAs or PHOs based upon either a contractual percentage of the premium related to members that elect

a primary care physician from that IPA or PHO, or a contractual per member per month amount. The capitation agreements are designed to cover not only the professional medical services (including ancillary tests and services) rendered by the physicians and other providers associated with that IPA or PHO, but the agreements also include payments for certain other services rendered to the enrollee by providers who are not members of the IPA or PHO. Services covered by the capitation agreements include, among other things, virtually all physician claims (whether inpatient or outpatient, including authorized out-of-plan care) and care rendered by other professionals such as physical therapists and psychologists. The capitation agreements, in effect, shift all or a portion of the risk of over utilization, depending upon the IPA or PHO and type of care (physician or hospital), to the IPA or PHO. Agreements that shift only a portion of the risk to the IPA or PHO require the Plan to establish an estimated medical expense target. If the actual medical expenses incurred by the members of the IPA or PHO are less than the estimated medical expense target, the IPA or PHO will receive an additional payment equal to an agreed upon percentage of the difference between the estimated medical expense target and actual expenses. If actual medical expenses incurred by the participating providers of the IPA or PHO exceed the estimated medical expense target, the IPA or PHO will owe the Plan an agreed upon percentage of the excess of the actual expenses over the estimated targeted expenses.

E. Hospital Agreements

The Plan generally negotiates contracts with hospitals that include compensation at a daily rate, without regard to the scope of services actually provided. Other methods of compensation with hospitals include charge-based discounts, which are negotiated discounts from the hospital's billed charges. There are also agreements involving all-inclusive case rates.

In the case of non-participating hospitals, the Plan pays either hospital-billed charges or negotiated discounted charges. Additionally, some hospital contracts include per case, all-inclusive payment arrangements for select procedures such as maternity care.

The control of the use of hospital and other medical services by a member is largely the responsibility of the member's primary care physician. The Plan requires pre-admission notification of non-emergency hospital admissions and stays, pre-certification of selected inpatient and outpatient procedures, and retrospective review of ambulatory health services. The Plan also maintains nurse coordinators who are assigned to certain participating hospitals to conduct concurrent reviews of hospital admissions.

The Plan maintains either fully contracted affiliations or letters of understanding with hospitals in its network. In case of an emergency where care is provided out of the service area, or in a non-participating hospital, Health Net reimburses the subscriber or the provider for a reasonable cost, as determined by contract.

F. Enrollment

The Plan offers its products to small groups and individuals on a community-rated basis. Coverage is offered to large groups on an experience rated basis. The small group market is marketed through the Plan's alliance with Guardian Life Insurance Company. Group enrollment is available to employer groups with two or more employees. There is no minimum percentage of employees who must choose Health Net of New York.

Health Net of New York coverage can be obtained during specific group transfer or enrollment periods for existing group subscribers. However, new groups or individuals may request enrollment at any time subject to a mutually agreed specific period allowed for employees in such groups to choose the Plan as their health insurer. Direct pay conversion is available to subscribers who terminate their group coverage.

The net result of enrollment activity for the years under examination is as follows:

	<u>12/31/1999</u>	<u>12/31/2000</u>	<u>12/31/2001</u>	<u>12/31/2002</u>	<u>09/30/2003</u>
Total enrollment	231,236	217,146	213,318	199,412	216,203
Current year member months	2,594,946	2,528,478	2,576,511	2,384,791	1,864,645

G. Holding Company System

The Plan is a wholly owned subsidiary of Health Net of the Northeast, Inc. (formerly known as Physicians Health Services, Inc.,) which is itself a wholly owned subsidiary of Health Net, Inc. (formerly known as Foundation Health Systems, Inc.) The Plan filed all holding Company documents pursuant to the provisions of Part 98-1.16(e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1). A review of the Plan's affairs within the holding company system for the years covered by this examination indicated the following violations of Part 98 of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1):

The Plan received periodic capital contributions from its Parent company amounting to \$47,000,000 during 2000 and 2001 detailed as follows:

<u>Statement Date</u>	<u>Amount Received</u>
March 2000	\$ 3,000,000
June 2000	2,000,000
December 2000	4,000,000
March 2001	15,000,000
June 2001	8,000,000
September 2001	5,000,000
December 2001	<u>10,000,000</u>
	<u>\$ 47,000,000</u>

In addition, during 1999 and 2000 Health Net's capital and surplus reported in its filed annual and quarterly statements indicated impairments of its required contingency reserves.

It appears that the capital contributions were applied to gross paid-in and contributed surplus to correct these impairments. A review of the minutes of the board of directors' meetings held during 2000 and 2001 noted that none of the capital contributions was acknowledged therein.

The capital contributions detailed above were in violation of the provisions of Part 98-1.10(c) (10 NYCRR 98-1) and Part 98-1.11(b) (10 NYCRR 98-1) of the Administrative Rules and Regulations of the Health Department, inasmuch as the aggregate capital contributions exceeded ten percent (10%) of the HMO's admitted assets at last year end. Part 98-1.10(c) states:

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

In addition, Part 98-1.11(b) states:

“No funds the aggregate of which involves 10 percent of the HMO's admitted assets at last year-end shall be transferred or loaned from the HMO line of business to any other line of business, function or contractor of the HMO, or within a holding company system, without the prior approval of the superintendent and commissioner; and notice shall be required for transfers or loans involving five percent or more of the HMO's admitted assets at last year-end. Repayment of any such approved loans shall be made in accordance with schedules approved by the superintendent and commissioner.”

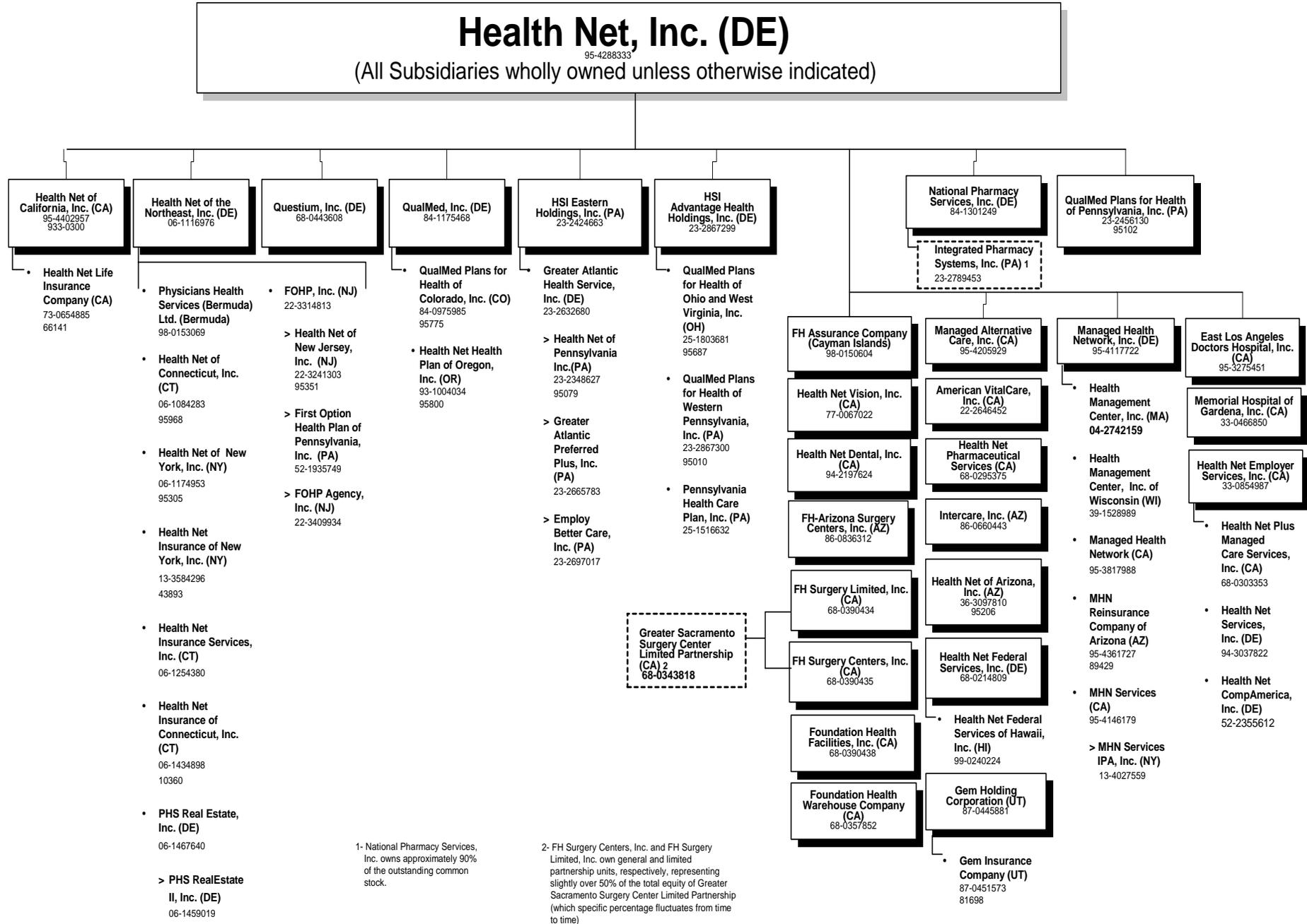
When this violation was brought to management's attention, the Company stated that Health Net, Inc., the ultimate parent, was committed to providing financial support to the Plan in the event of impairment or insolvency. However, there was no document or recorded action by the Plan's board of directors that formalized such commitment.

It is recommended that the Plan comply with the provisions of Part 98-1.10(c) (10 NYCRR 98-1) and Part 98-1.11(b) (10 NYCRR 98-1) of the Administrative Rules and Regulations of the Health Department as regards the aggregate capital contributions which exceeded ten percent of the HMO's admitted assets at last year end. A similar recommendation was made in the prior report on examination.

It is also recommended that the minutes of the meetings of the Plan's board of directors formally acknowledge and document capital contributions made by Health Net, Inc., its ultimate parent. A similar recommendation was made in the prior report on examination.

It is further recommended that the commitment to provide financial support to the Plan in the event of impairment or insolvency be formalized in writing and submitted to the Departments of Health and Insurance, for review and approval pursuant to Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1). A similar recommendation was made in the prior report on examination.

The following is a chart of the HMO's holding company system as of September 30, 2003:



1- National Pharmacy Services, Inc. owns approximately 90% of the outstanding common stock.

2- FH Surgery Centers, Inc. and FH Surgery Limited, Inc. own general and limited partnership units, respectively, representing slightly over 50% of the total equity of Greater Sacramento Surgery Center Limited Partnership (which specific percentage fluctuates from time to time)

H. Administrative Service Agreement

During the period under examination, the Plan operated under three different Administrative Service Agreements, only one of which was approved by the Department. During the period January 1, 1999 to December 31 2000, the Plan utilized an agreement with an effective date of January 1, 1996 referred to as “the 1996 Agreement.” An examination review of this agreement indicated that it was approved by the Insurance Department on February 5, 1996.

During the period January 1, 2001 to December 31, 2002, the Plan utilized an agreement that was entered into with Health Net of the Northeast, Inc. (HNNE), its immediate parent, effective January 1, 2001. Health Net did not seek or obtain the prior approval of the Department for this agreement.

Since January 1, 2003 to present, the Plan has been operating under a second agreement that was entered into with HNNE. This agreement was submitted to the Department in December 2003.

The Department’s initial review of the Administrative Service Agreement as submitted in December 2003 indicated that the proposed method of allocating selling, general and administrative expenses was not fair and equitable to the Plan in accordance with the provisions of Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1). The agreement that was submitted originally and put into use by the Plan, employed a set of “*cost drivers*” as the basis for allocating actual costs that were accumulated in

separate cost centers maintained by Health Net, Inc., (the Ultimate Parent), and each region or business unit (Health Net of the Northeast, Inc.). The corporate cost centers consisted of all corporate expenses, information technology, organizational effectiveness, facilities, finance, health plan operations, pharmacy, facilities distribution services, and business consolidation. The corporate overhead was then allocated to each region or business unit on a pro rata basis to be further allocated to each legal entity. Health Net of the Northeast, Inc. maintained approximately 150 such cost centers.

The “*cost drivers*” utilized by Health Net included premium revenue, claims volume, health care costs and membership. The proposed cost allocation method also provided for the weighting of these “*drivers*” by splitting cost centers and/or by applying a unique combination of factors arrayed by entity, segment, product, funding, and State, if necessary. Part 98-1.10(a) Administrative Rules and Regulations of the Health Department states:

“Transactions within a holding company system to which a controlled HMO is a party shall be subject to the following guidelines:

- (1) the terms of the financial transaction shall be fair and equitable to the HMO at the time of the transaction;*
- (2) charges or fees for services performed shall be reasonable; and*
- (3) expenses incurred and payments received shall be allocated to the HMO on an equitable basis in conformity with customary accounting practices consistently applied.”*

The Plan was notified of the Department’s concerns that the allocation methodology set forth in the Administrative Service Agreement did not comply with the provisions of Part 98-1.10(a) Administrative Rules and Regulations of the Health Department and that the use of premium revenue, claims volume, and health care costs as the bases for allocating expenses was not fair and equitable to the Plan. In addition, the Department stated that the provisions of the

agreement should explicitly delineate the services that Health Net, Inc. and Health Net of the Northeast would provide each New York Company. The Department further stated that the agreement should indicate that each company will directly reimburse Health Net, Inc. and HNNE for services provided.

Over the course of the twenty (20) months since the agreement was first submitted to the Department, the Plan provided several modifications and clarifications of its terms and conditions. As of the date of this report, the agreement has not been approved by the Department.

Notwithstanding the fact that the Plan submitted the Administrative Service Agreement in December 2003, it has continued to employ this agreement in violation of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1) which states:

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

It was noted that except for 2000, the rendering of administrative services in the aggregate exceeded the ten (10%) percent threshold of the Plan's admitted assets at the prior year-ends as detailed in the table shown below:

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>9/30/2003</u>
Administrative Expenses	\$ 32,239,214	\$ 820,126	\$ 24,259,316	\$ 45,994,750	\$ 57,651,408
Admitted Assets	135,096,033	186,359,219	125,221,906	122,043,494	174,924,520
10% of Admitted Assets	13,509,603	18,635,922	12,522,191	12,204,349	17,492,452

It is recommended that Health Net comply with the provisions of Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department by ensuring that the terms of the financial transactions of its Administrative Service Agreement are fair and equitable at the time of the transactions, charges or fees for services performed are reasonable, and expenses incurred and payments received are allocated on an equitable basis in conformity with customary accounting practices consistently applied.

It is also recommended that the Plan comply with the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department by seeking and obtaining the Commissioner's and Superintendent's prior approval for the Administrative Service Agreement entered into with Health Net of the Northeast, Inc.

I. Reinsurance

The Plan did not have a reinsurance agreement to provide excess of loss coverage for the period under examination. The Plan stated that based on its historical data, Health Net of New York, Inc. had sufficient resources to absorb any catastrophic loss. The Plan, however, does have a quota share reinsurance agreement with Guardian Life Insurance Company (“Guardian”) wherein the products involved are jointly developed managed care and indemnity products. These products are marketed under the trade name “Healthcare Solutions.” This item is discussed further in this section under the caption, “Guardian Reinsurance Agreement.”

Although the Insurance Department does not require the Plan to maintain reinsurance coverage, the Department views reinsurance as an additional layer of protection for the Plan’s

members against impairment or insolvency. Such contracts are approved during the initial certification of an HMO pursuant to Part 98-1.5(b)(7) of the Administrative Rules and Regulations of the Health Department (10 NYCRR98-1) and contain required provisions relative to insolvency protection and continuation of coverage.

Furthermore, Part 98-1.8(b) requires the prior approval of the Superintendent and the Commissioner for changes in risk sharing with insurers (i.e. reinsurance contracts). This matter was also commented on in the prior report on examination. The Plan in its response thereon stated that *“it will take this recommendation into consideration for any further changes to the reinsurance contracts.”*

Guardian Reinsurance Agreement

In 1995, the Plan entered into a quota share reinsurance agreement with Guardian Life Insurance Company (“Guardian.”) The products involved are jointly developed managed care and indemnity products, which are marketed under the trade name “Healthcare Solutions.” The products were distributed through the brokerage community utilizing a joint marketing arrangement with Guardian. The Plan wrote one hundred percent (100%) of the In-Network HMO and POS business, and under the terms of the quota share reinsurance agreement ceded fifty percent (50%) to Guardian. Profits and losses, after provisions for related expenses, as defined in the agreement, were equally shared. As part of the arrangement, Health Net recovers from Guardian a specified portion of the administrative expenses related to “Healthcare Solutions” activity. In addition, the direct costs for marketing the “Healthcare Solutions” products were equally shared.

The joint marketing arrangements with Guardian are for an unlimited term, but can be terminated by either party with or without cause, subject to potentially significant payments upon termination without cause, by the party electing to terminate; and in the event of certain cause terminations, by the party breaching an agreement.

The out-of-network portion of the Healthcare Solutions POS product was written by Guardian and ceded fifty percent (50%) to Physicians Health Services (Bermuda), Ltd., now known as Health Net Services (Bermuda), Ltd., an affiliate of the Plan. Health Net does not participate in the out-of-network business.

J. Conflict of Interest Policy

The Plan includes conflict of interest guidelines in its employment manuals. The Company answered “yes” to the general interrogatories in the annual statement that asked whether the Plan has an established procedure for annual disclosure to its board of directors of any material interest and affiliation on the part of any of its officers and directors. However, the Plan did not maintain signed conflict of interest statements from any individual for the years of the examination. The Plan has a fiduciary responsibility to its policyholders to ensure that its directors, officers and responsible employees do not use their official positions to promote an interest which is in conflict with that of the Plan.

It is recommended that all officers and directors submit signed conflict of interest statements during each calendar year and that the Plan establish a procedure for enforcing such policy.

It is also recommended the board of directors adhere to its fiduciary responsibility by properly overseeing and handling any conflicts disclosed.

K. Accounts and Records

Investments

A review of the Plan's investment transactions and the minutes of meetings of its board of directors indicated that there was no supporting evidentiary material to indicate that actions taken by the Plan's management were authorized or approved by the board of directors. In addition, the Plan answered "yes" to General Interrogatories in all its filed Annual Statements for the period under examination as to whether the Plan's purchase and sale of all investments are passed upon by either its board of directors or a subordinate committee thereof. It was noted that the Plan in its response to the comments and recommendations of the prior report on examination indicated that it has "*formally adopted Health Net, Inc.'s (formerly known as Foundation Health System, Inc.) investment policy.*" Section 1411(a) of the New York Insurance Law states in part:

"No domestic insurer shall make any loan or investment... unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting."

When this matter was brought to management's attention, the examiners were informed that investments were approved in accordance with the ultimate parent's (Health Net Inc.) guidelines by its Investment Oversight Committee every quarter. Notwithstanding that the Plan's investments are reviewed and approved by the ultimate parent, it is incumbent on the Company's board of directors to comply with the provisions of Section 1411(a) of the New York Insurance Law.

It is recommended that the board of directors authorize and approve the Company's investment transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law and that documentation supporting their actions be appended to the minutes of their meetings. A similar recommendation was made in the prior report on examination.

Custodial agreements

The Company maintains several custodial accounts with Fleet Bank. A review of the custodian agreements revealed that the agreements lacked certain safeguards and controls as set forth in the Department's Rules, and in the guidelines of the Financial Condition Examiners Handbook of the *National Association of Insurance Commissioners*. The rules and guidelines state in part:

- *That the national bank, state bank, or trust company, as custodian is obligated to indemnify the insurance company for any insurance company's loss of securities in the custodian's custody, except that, unless domiciliary state law, regulation or administrative action otherwise require a stricter standard the bank or trust company shall not be so obligated to the extent that such loss was caused by other than the negligence or dishonesty of the custodian;...*
- *That in the event of a loss of the securities for which the custodian is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced;...*
- *That if the custodial agreement has been terminated or if 100 percent of the account assets in any one custody account have been withdrawn, the custodian shall provide written notification, within three business days of termination or withdrawal, to the insurer's domiciliary commissioner;...*
- *That during regular business hours, and upon reasonable notice, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, its records relating to securities, if the custodian is given written instructions to that effect from an authorized officer of the insurance company;...*

It is recommended that the Plan amend its custodian agreements with Fleet Bank to include the requisite safeguards and controls as set forth in the Department's Rules, and in the

guidelines of the Financial Condition Examiners Handbook of the *National Association of Insurance Commissioners*.

L. Abandoned Property Law

Section 1316 of the New York Abandoned Property Law requires that certain unclaimed insurance proceeds which are unclaimed for three (3) years be reported to the Office of the State Comptroller of the State of New York by April 1 of each year. Such reports comprise all abandoned property held by the Company at the close of business on January 1, of each year.

Section 1315 of the New York Abandoned Property Law requires that certain unclaimed vendor payments, outstanding checks and escrow amounts, or gift certificates which are unclaimed for more than five (5) years be reported to the Office of the State Comptroller of the State of New York by March 10 of each year. Such reports comprise all abandoned property held by the Company at the close of business on December 31, each year.

The Company is also required pursuant to Section 1316 of the Abandoned Property Law to annually publish a list of names and last known addresses of persons appearing to be entitled to abandoned property and to file proof of such publication with the Office of the State Comptroller.

An examination review of the Plan's filed Abandoned Property Reports indicated that certain claim payments were incorrectly classified as unclaimed property pursuant to Section 1315 of the Abandoned Property Law. Such payments should have been properly reported as

unclaimed property pursuant to Section 1316 of the Abandoned Property Law. When this matter was brought to Management's attention, the examiners were informed by Management that Section 1316 of the Abandoned Property Law was not applicable to the HMO. It appears that Health Net did not properly segregate unclaimed claim payments and miscellaneous unclaimed property to comply with the provisions of Sections 1315 and 1316 of the New York Abandoned Property Law respectively. The Department determined that unclaimed claim payments pertaining to HMOs come within the purview of Section 1316 of the Abandoned Property Law because they were payments made on, or because of a policy of insurance.

It should be noted that the Company was also unable to provide the Reports of Abandoned Property for the Years Ended December 31, 1999 and December 31, 2000. Furthermore, the Company failed to provide documentation that it annually published a list of names and last known addresses of persons appearing to be entitled to abandoned cash amounts or provide proof that an affidavit of such publication was filed with the Office of the State Comptroller.

It is recommended that the Plan properly segregate unclaimed claim payments and miscellaneous unclaimed property to comply with the provisions of Sections 1316 and 1315 of the New York Abandoned Property Law respectively.

It is also recommended that the Plan file the required annual Reports of Abandoned Property with the Office of the State Comptroller to comply with the provisions of Sections 1315 and 1316 of the New York Abandoned Property Law.

It is further recommended that the Plan annually publish a list of names and last known addresses of persons appearing to be entitled to abandoned property and to file proof of such publication with the Office of the State Comptroller.

M. Location of Books and Records

During the period under examination, a review of the Plan's operations by the Department revealed that certain books of account were removed from its principal offices in the State of New York during 1999 through October 2002 without the Commissioner's or Superintendent's prior approval.

The provisions of Part 98-1.11(a) of the Health Department's Administrative Rules and Regulations Department (10 NYCRR 98-1) states in part:

"...All records pertaining to the article 44 certified HMO shall be maintained in New York State."

Health Net in its response to a request from the Department for an itemization of the books of accounts that are kept and maintained at the pertinent locations of White Plains, New York; Shelton, Connecticut; and Woodland Hills, California stated that commencing in 2004 workpapers supporting the statutory financial statements for calendar years 1999 through 2003 for the Plan were moved to Woodland Hills, California. Health Net stated that prior to 2004 these workpapers were retained in Shelton, Connecticut. The Plan also stated that copies of its financial statements are kept in White Plains, New York; Shelton, Connecticut; and Woodland Hills, California. The Plan further stated that GAAP accounting functions were transferred to Woodland Hills, California in October 2002.

The Company indicated that the “keeping and maintenance of books of accounts has been kept outside New York since 1999 (in Shelton, Connecticut) with suitable records retained in White Plains, New York with the Department’s knowledge.” The Company also indicated that it “remains committed to providing any and all personnel and materials to the Department at its Shelton, Connecticut offices for purposes of financial audits, as it has in past years.”

Notwithstanding the fact that the Department may have had knowledge of the Company’s transfer of its books of account in 1999 from White Plains, New York to Shelton, Connecticut, Health Net has neither sought nor received approval to such transfer from the Superintendent. In addition, an examination review of the minutes indicated that Health Net’s board of directors had not adopted a plan to maintain suitable records at its principal office in New York. Furthermore, Health Net has not responded to a Department request for “a detailed plan of how Health Net’s books and records that are located in Woodland Hills, California can be readily made available to Department employees engaged in field examinations of Health Net at either its White Plains, New York or Shelton, Connecticut office.”

It is recommended that the Health Net’s board of directors adopt a plan to maintain suitable records at its principal office in New York and submit such plan to the Superintendent for approval.

3. **FINANCIAL STATEMENTS**

A. Balance Sheet

The following compares the assets, liabilities and surplus as determined by this examination with those reported by the Plan in its September 30, 2003 filed quarterly statement:

Assets	<u>Plan</u>	<u>Examination</u>	<u>Surplus Increase (Decrease)</u>
Bonds	\$ 82,632,331	\$ 82,632,331	
Stocks Preferred Stocks	2,000,000	2,000,000	
Cash and Short-term investments	40,089,044	40,089,044	
Investment income due and accrued	559,671	559,671	
Uncollected premiums and agents balances in course of collection	11,937,466	11,937,466	
Amounts recoverable from reinsurers	85,516	85,516	
Other amounts receivable under reinsurance Contracts	6,220,145	6,220,145	
Net Deferred tax asset	258,889	258,889	
Electronic data processing equipment and Software	16,077	16,077	
Receivable from parent, subsidiaries and Affiliates	7,133,467	7,133,467	
	<hr/>		
Totals	\$ 150,932,606	\$ 150,932,606	\$ 0

<u>Liabilities</u>	<u>Plan</u>	<u>Examination</u>	<u>Surplus Increase (Decrease)</u>
Claims unpaid	\$ 50,015,602	\$ 54,315,602	\$ (4,300,000)
Aggregate health policy reserves	0	9,900,000	(9,900,000)
Unpaid claims adjustment expenses	683,094	683,094	
Premiums received in advance	2,519,043	2,519,043	
General expenses, due or accrued	7,700,738	7,700,738	
Current federal and foreign income tax payable and interest thereon	8,605,265	8,605,265	
Amounts withheld or retained for the account of others	9,185,078	9,185,078	
Remittances and items not allocated	258,625	258,625	
Amounts due to parent, subsidiaries and affiliates	20,087,900	20,087,900	
Payable for securities	1,000,000	1,000,000	
Liability for amounts held under uninsured accident and health plans	13,836	13,836	
Payable to providers	1,260,016	1,260,016	
Other liabilities	117,179	117,179	
Total Liabilities	\$ 101,446,376	\$ 115,646,376	\$ (14,200,000)
<u>Capital and Surplus</u>			
Common capital stock	14,500	14,500	
Gross paid in and contributed surplus	91,735,500	91,735,500	
Contingency reserve	20,807,854	20,807,854	
Unassigned Funds Surplus/(Deficit)	(63,071,624)	(77,271,624)	(14,200,000)
Total Capital and Surplus	49,486,230	35,286,230	(14,200,000)
 Total Liabilities, Capital and Surplus	 \$ 150,932,606	 \$ 150,932,606	

Note: The Internal Revenue Service completed its audits of the consolidated income tax returns filed on behalf of the Plan for tax years 1999 to 2001. In addition, the Internal Revenue Service has not commenced any audits of the consolidated income tax returns filed on behalf of the Plan for tax years 2002 and 2003, as of the examination date. All material adjustments, if any, made subsequent to the date of the examination and arising from said audits, are reflected in the financial statements included in this report. The examiner is unaware of any potential exposure of the Plan to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Surplus and capital increased \$18,745,502 during the examination period, encompassing January 1, 1999 to September 30, 2003, detailed as follows:

Revenue

Net premiums income	\$ 1,962,287,262	
Net investment income	27,832,374	
Other revenues	<u>(918,336)</u>	
Total revenues		\$ 1,989,201,300

Expenses

Medical and hospital	\$ 2,045,341,233	
Reinsurance expenses net of recoveries	(250,544,729)	
Administrative	<u>221,899,736</u>	
Total expenses		<u>\$ 2,016,696,240</u>
Net income before federal and foreign income taxes		(27,494,940)
Federal and foreign income taxes incurred		<u>(7,328,202)</u>
Net loss		<u>\$ (20,166,738)</u>

Capital and surplus

	<u>Gains in Surplus</u>	<u>Loss in Surplus</u>	
Capital and surplus, per report on examination as of December 31, 1998			\$ 16,540,728
Net loss		\$ 20,166,738	
Change in net deferred income tax		1,611,402	
Change in non-admitted assets		6,543,765	
Change in paid in surplus	47,000,000		
Cumulative effect of changes in accounting Principles	2,052,942		
Adjustment for prior year taxes		2,275,242	
Annual statement error	289,707		
	<u>\$ 49,342,649</u>	<u>\$ 30,597,147</u>	
Net increase in capital and surplus			<u>18,745,502</u>
Capital and surplus, per report on examination as of September 30, 2003			<u>\$ 35,286,230</u>

4 CLAIMS PAYABLE

The examination liability of \$54,315,602 is \$4,300,000 more than the \$50,015,602 reported by the HMO in its filed September 30, 2003 quarterly statement. A Department actuarial analysis of claims payable was performed in accordance with generally accepted actuarial principles and practices.

The Department's claim reserves were determined based on statistical data relevant to claims experience for medical care benefits accumulated over an extended period of time as provided by the Plan. The Department's actuaries employed an actuarial methodology referred to as the "*Paid Loss Developmental Method*" that is commonly used by actuaries in the derivation of claim reserves for medical care services. It determined completion factors from past claims experience on months with complete data and applied such completion factors to incomplete paid claims on months of incurred claims with less than complete data. The completion factors represented estimates of the percentages of incurred claims paid after periods of one month, two months and beyond.

The Department's actuarial review indicated that, for calendar years 2003 and 2004, there were significant problems with the data reported in the Plan's filed Data Requirements, as illustrated on the following page by a comparison of the information on Loss ratios in the Data Requirements, with information in the Annual loss ratio reports required by Section 4308(h) of the New York Insurance Law.

Loss Ratios	NY Data Requirements 2003	NYIL Section 4308(h) Report 2003	NY Data Requirements 2004	NYIL Section 4308(h) Report 2004
Large Groups	92.00%	85.13%	98.07%	92.83%
Small Groups	78.97%	77.57%	78.50%	80.82%
Direct Pay Plans	35.88%	86.91%	37.44%	80.00%
Healthy NY Plans	131.38%	79.31%	99.61%	96.83%
Medicare Plans	94.66%	94.66%	96.52%	96.52%
Grand Total	85.54%	83.22%	88.89%	87.96%

The bolded percentages in the above table highlight the significant differences in loss ratios reported in the NY Data Requirements and the annual loss ratio reports pursuant to Section 4308(h) of the NYIL.

The Department's actuarial review also noted additional problems with Health Net's Data Requirements, since it omitted all data pertaining to the Stop Loss amounts for both Direct Pay and Healthy New York lines of business and for Department Regulation 146 pools. The Plan has historically left these lines blank.

5. PREMIUM DEFICIENCY RESERVE

The examination liability for premium deficiency reserves of \$9,900,000 is \$9,900,000 more than the \$0 reported by the Plan in its filed September 30, 2003 quarterly statement.

The table below details the Department's allocation of the premium deficiency reserves by applicable line of business:

<u>Line of business</u>	<u>Amount</u>
Medicare	\$ 1,200,000
Large Group	<u>8,700,000</u>
Total	\$ <u>9,900,000</u>

This reserve was established in accordance with the provisions of paragraph 18 of the Statements of Statutory Accounting Principles (SSAP) No. 54 of the *National Association of Insurance Commissioners*, which states that:

“When the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.”

Accordingly, it should be noted that the Department calculated the premium deficiency by line of business, and not in the aggregate. As a result, losses by line of business were not offset by any applicable gains by line of business. The Department previously notified the Company that it may not consider the portion of a contract for which a separate entity is at risk, in order to determine the necessity of a premium deficiency reserve.

It is recommended that the Plan comply with the provisions of paragraph 18 of the Statements of Statutory Accounting Principles No. 54 of the *National Association of Insurance Commissioners* by establishing the requisite liability for each line of business where a premium deficiency is indicated. In addition, such deficiencies should not be offset by anticipated profits in other lines of business and such liabilities should be accrued for any loss contracts, even if the contract period has not yet started.

6. MARKET CONDUCT

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

- A. Claims processing
- B. Agents and brokers
- C. Frauds prevention

A. Claims processing

A review of the Plan's claims practices and procedures was performed by using a statistical sampling methodology covering claims adjudicated during the period January 1, 1999 to September 30, 2003, in order to evaluate the overall financial accuracy and compliance environment of Health Net's claims processing. In addition, the Examiners placed emphasis on the accuracy and completeness of the Plan's paid loss development schedules. In order to achieve the goals of this review, the Plan's claims were segregated into separate hospital (institutional) and medical claims segments. A random statistical sample one hundred sixty seven (167) claims was drawn from each of these segments.

This statistical random sampling process was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a

combined basis. For example, if ten (10) attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each item in the sample.

To ensure the completeness of the claims population being tested, the total dollars paid were reconciled to the financial data reported by Health Net. To verify each service that resulted in no payment, a reconciliation of transaction counts was also performed.

The examiners applied certain procedures to test the accuracy and validity of the Plan's paid claims as it related to service dates, received dates, lines of business, paid dates, and paid amounts. The examiners also formatted the Plan's paid claims data into matrices aligned by date of service month and date of payment month. Although the examiners' total paid claims from the matrices agreed with the Plan's total paid claims on its "lag" reports, the individual claims cells derived on the examiners' matrices did not match the Plan's individual claims cells from the "lag" reports. When the Plan was asked to explain the differences, management informed the examiners that such differences resulted from Health Net adopting month-end general ledger closing dates that were different from calendar month-ends. The Company also informed the examiners that its adopted month-end general ledger closing dates were applied consistently from year to year.

The following list summarizes the findings of the examination review of hospital (institutional) claims:

- ◆ There were two (2) claims noted where the date of service shown in the claims system did not match the applicable UB92 claim form.

- ◆ There were four (4) claims noted where there was an error in the admission date that was used as the primary the date of service. However, the statement period and the itemized dates of service shown in the claims system matched the applicable UB92 claim form.

- ◆ There was one (1) in-network claim that was improperly denied as not having a prior authorization.

- ◆ There was one (1) claim that was paid more than forty-five (45) days from the date of receipt. The Plan stated that at the time the claim was adjudicated, the provider was in a negative payment status. Bulk payments were made to this provider upon the correction of this condition. However, the Plan did compute and pay interest in accordance with the provisions of Section 3224-a (a) of the New York Insurance Law.

Section 3224-a (a) states:

“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.”

In addition, there was one (1) claim noted during the review of medical claims that was paid more than forty-five (45) days from the date of receipt. However, the Plan did compute and pay interest in accordance with the provisions of Section 3224-a (a) of the New York Insurance

Law. In addition, the Plan informed the examiners that the member had dual Health Net coverage and was insured as a dependent under both the mother's (secondary) and father's (primary) policies.

B. Agents and Brokers

Pursuant to Article 21 of the New York Insurance Law, Health Net utilizes independent insurance agents and brokers as its primary distribution system. The Plan maintains a direct sales staff of account executives and group service representatives. A review of agents and brokers licensing information revealed that the Plan was generally in compliance with the licensing provisions of Article 21 of the New York Insurance Law. The examiners traced a sample of Health Net's appointed agents and brokers to information on file with the Department and found no exceptions. Section 2112(d) of the New York Insurance Law states in part:

“Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication.”

The examiners traced a sample of terminated agents and brokers to statements on file with the Department. It was determined that the Department had not been notified of the termination of some agents and brokers in a timely manner. The Plan indicated that these

exceptions were due to an oversight. The requisite termination statements were subsequently filed with the Department.

C. Frauds Prevention and detection

A review was conducted of the organization and structure of Health Net's Fraud Division. The Plan's compliance with New York Insurance Law Sections 405 and 409, and Department Regulation 95 with respect to the reporting of fraud cases to the Department was also reviewed. The examiners noted that the Plan implemented a new fraud prevention plan that was not filed with the Department. Section 409(a) of New York Insurance Law states in part:

"Every insurer writing private or commercial automobile insurance, workers' compensation insurance, or individual, group or blanket accident and health insurance policies issued or issued for delivery in this state annually,....., file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state."

When this matter was brought to management's attention, the Plan submitted a revised fraud prevention plan in July 2004. The Department approved the revised plan on September 16, 2004 subject to the following conditions:

1. The Plan confirms with the Department's Frauds Bureau that two additional investigators were hired to work exclusively on New York fraud cases.
2. The Plan confirms with the Department's Frauds Bureau that fraud detection and prevention training for all underwriting and claims staff was completed by February 15, 2005, and that such training would continue on a periodic basis.
3. The Plan resubmit the Annual Fraud Report that reflected New York only information.

During the period January 1, 1999 to September 30, 2003, the Plan had not sufficiently staffed its fraud division to provide assurance of its commitment to reduce fraud. The Plan's frauds unit consisted of three (3) Investigators, three (3) Investigative Analysts, one (1) Administrative Assistant, and a Vice President. The fraud investigators perform work for all Health Net of Northeast companies in New York, New Jersey, and Connecticut. None of these investigators was specifically assigned to New York only cases. It was noted that there were several cases with assigned case numbers that were yet to be investigated, where the actual complaint dated back many months and years. The Plan also failed to include the Department's fraud-case log number in the case files and to provide the basis of allocation of expenses for fraud investigation to the Insurance Department during the period under examination. Furthermore, the Plan failed to provide documents to the Department's Frauds Bureau, such as fraud detection procedures, fraud case logs, and fraud case files for the years covered under this examination. Section 409(b)(1) of the New York Insurance Law states in part:

“The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigations unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims functions of an insurer, and shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent. An insurer shall include in such plan staffing levels and allocations of resources in such full-time special investigations unit as may be necessary and appropriate for the proper implementation of the plan and approval of such plan pursuant to subsection (d) of this section.”

In addition, Section 405(a) of the New York Insurance Law, states in pertinent part:

“Any person licensed pursuant to the provisions of this chapter, and any person engaged in the business of insurance in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent insurance transaction is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require...”

It is recommended that the Plan comply with the terms and conditions of the fraud plan approval letter dated September 16, 2004.

It is also recommended that the Plan add appropriate staff to its fraud investigation unit so that fraud can be investigated and prevented more effectively in accordance with the provisions of Section 409(b)(1) of the New York Insurance Law.

It is further recommended that the Plan comply with the provisions of Section 405(a) of the New York Insurance Law as regards suspected fraudulent transactions by submitting to the Insurance Department Frauds Bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transactions and the parties involved as the superintendent may require.

7. **COMPLIANCE WITH PRIOR REPORT ON EXAMINATION**

The prior report on examination as of December 31, 1998 contained forty four (44) comments and recommendations as follows (page numbers refer to the prior report):

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management</u>	
i. It is recommended that board members who are unable to attend meetings consistently should resign or be replaced.	5
<i>The Plan has complied with this recommendation.</i>	
ii. It is recommended that the Plan comply with the requirements of Part 98.11(f) of the Administrative Rules and Regulations of the Health Department, and its own by-laws, by having the requisite number of Plan enrollees on its board.	5
<i>The Plan has complied with this recommendation.</i>	
iii. It is recommended that the Board of Directors, or a formal committee thereof, insure sufficient involvement relative to the Plan's investments, and approve all investments made by the Plan in a timely manner, in accordance with Section 1411 (a) of the New York Insurance Law.	6
<i>The Plan has complied with this recommendation.</i>	
iv. It is recommended that the Board of Directors be fully apprised of the Plan's financial position on a regular basis by management. The Board should be informed of substantial transfers between the Plan and its affiliates. Further more, the Board should be informed of capital infusions received from its Parent company as well as the situations that necessitated the transfers.	6
<i>The Plan has complied with this recommendation.</i>	
B. <u>Holding Company</u>	
i. It is recommended that the Plan adhere to the following guidelines regarding its filed financial statements and cash infusion from FHS: Only those contributions actually received by the annual or quarterly reporting date may be included as increases to capital for that reporting date. Contributions not received by the statement's reporting date, but for which FHS has formally committed to by a board of directors resolution made prior to the reporting date may be reflected as an account receivable (and therefore an increase to net worth) in the filed statement for that reporting date.	12
<i>The Plan has complied with this recommendation.</i>	

<u>ITEM</u>		<u>PAGE NO.</u>
ii.	It is further recommended that if FHS wishes to provide regular contributions via an ongoing commitment, that such commitment be formalized in writing and submitted to the Departments of Health and Insurance, for review and approval pursuant to Part 98.10 (c) of the Administrative Rules and Regulations of the Health Department {10NYCRR 98.10 (c)}.	12
	<i>The Plan has complied with this recommendation.</i>	
iii.	It is recommended that the Plan comply with the requirements of Part 98.10 (c) of the Administrative Rules and Regulations of the Health Department {10NYCRR 98.11 (c)}.	13
	<i>The Plan has not complied with this recommendation. A similar recommendation is contained in this report.</i>	
iv.	The manner in which the Plan transfers cash within its holding company structure makes it difficult to determine whether the Plan is in compliance with its minimum net worth/contingency reserve requirements as set forth in Parts 98.11(d) & (e) of the Administrative Rules and Regulations of the Health Department {10NYCRR 98.11(d) & (e)}.	14
	<i>The Plan has complied with this recommendation.</i>	
v.	It is recommended that transactions meeting the definitions detailed in by Part 98.10 of the Administrative Rules and Regulations of the Health Department {10NYCRR 98.10}, within a holding company system be specified under an agreement, and that this agreement(s) be filed with the Departments of Insurance and Health.	15
	<i>The Plan submitted an Administrative Service Agreement to the Department in December 2003. As of the date of this report, the Agreement had not been approved by the Department.</i>	
vi.	It is recommended that the Plan settle balances within the holding company system pursuant to Part 98.10 (a) of the Administrative Rules and Regulations of the Health Department.	15
	<i>The Plan has complied with this recommendation.</i>	
vii.	It is recommended that an agreement detailing all transactions covered by the statute between the Plan and PHS Ins. be formalized and filed for approval with the Departments of Health and Insurance pursuant to Part 98.10 (c) of the Administrative Rules and Regulations of the Health Department.	15
	<i>The Plan submitted an Administrative Service Agreement to the Department in December 2003. As of the date of this report, the Agreement had not been approved by the Department.</i>	

ITEM

PAGE NO.

C. Administrative Service Agreement

- i. It is recommended that the Plan and its Parent maintain detailed cost information and the allocation basis for all charges used in developing the fees schedule set forth in the administrative services agreement and that it maintain reconciliations that document any differences between the scheduled fees and actual charges. 18

The Plan submitted an Administrative Service Agreement to the Department in December 2003. As of the date of this report, the Agreement had not been approved by the Department.

- ii. It is recommended that the Plan and its Parent company maintain detailed cost information so it can be verified whether the fees paid under the Agreement exceed the actual costs incurred by the Parent. 19

The Plan submitted an Administrative Service Agreement to the Department in December 2003. As of the date of this report, the Agreement had not been approved by the Department.

- iii. It is recommended that the Plan document transactions in a manner that facilitates clear and accurate reporting and which will permit this Department to verify the correctness of the fees charged and the parties' adherence to the terms of the Agreement as required by Parts 98.10(a)(1), (a)(2) and (b) of the Administrative Rules and Regulations of the Health Department. 19

The Plan has complied with this recommendation.

- iv. It is recommended that the Plan be provided with a monthly bill detailing the services and the corresponding charges by its Parent as required in its filed Agreement. 19

The Plan submitted an Administrative Service Agreement to the Department in December 2003. As of the date of this report, the Agreement had not been approved by the Department.

- v. It is recommended that the amounts due under the Agreement be settled in full, and in accordance with the terms of the Agreement and all applicable statutes. 20

The Plan has complied with this recommendation.

ITEM

PAGE NO.

D. Reinsurance

- i. It is recommended that the Plan comply with the provisions of Part 98.8(b) of the Department of Health Rules and Regulations by submitting changes to its reinsurance contracts, including cancellation thereof, to the Superintendent for prior approval. 20

The Plan has complied with this recommendation.

- ii. It is recommended that a list of administrative services performed on behalf of Guardian and PHS Bermuda by the Plan be included in the reinsurance agreement with Guardian. Appropriate expense allocation method for the services involved should be specified under the reinsurance contract. 22

The Plan has complied with this recommendation.

- iii. It is recommended that the administrative service, which involves an affiliate, should be filed for approval with the Department pursuant to Part 98.10 of the Administrative Rules and Regulations of the Health Department. 22

The Plan submitted an Administrative Service Agreement to the Department in December 2003. As of the date of this report, the Agreement had not been approved by the Department.

E. Conduct of Examination

- i. During the course of the examination, the examiners encountered numerous delays in obtaining supporting documentation. It is recommended that the Plan make every effort to facilitate such examinations in accordance with Section 310(a)(3) of the New York Insurance Law. 22/23

The Plan has complied with this recommendation.

F. Conflict of Interest

- i. It is recommended that all officers and directors submit signed conflict of interest statements during each calendar year and that the Plan establish a procedure for enforcing such a policy. 24

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

<u>ITEM</u>		<u>PAGE NO.</u>
ii.	It is further recommended that the Board of Directors adheres to its fiduciary responsibility by properly overseeing and handling any conflicts disclosed.	24
	<i>The Plan has not complied with this recommendation. A similar recommendation is contained in this report.</i>	
G. <u>Accounts and Records</u>		
i.	It is recommended that the Plan submit completed reports timely pursuant to Part 98.16 of the Administrative Rules and Regulations of the Health Department.	24
	<i>The Plan has complied with this recommendation.</i>	
ii.	It is recommended that the Plan should maintain, at minimum, copies of the Plan's annual statements, and other pertinent financial and corporate records in its statutory home office, pursuant to Part 98.11 (a) of the Administrative Rules and Regulations of the Health Department.	25
	<i>The Plan has not complied with this recommendation. A similar recommendation is contained in this report.</i>	
iii.	It is recommended that the Plan classify its restricted assets properly pursuant to the requirements of Parts 98.11 (d) & (e) of the Administrative Rules and Regulations of the Health Department.	26
	<i>The Plan has complied with this recommendation.</i>	
iv.	It is further recommended that the Plan reconcile its cash account on a timely basis.	26
	<i>The Plan has complied with this recommendation.</i>	
v.	It is recommended as regards pended claims aging, that the Plan's claims department develop a method that accumulates data pertaining to PHS-NY separately, as required by Part 98.11(a).	27
	<i>The Plan has complied with this recommendation.</i>	
vi.	It is recommended that the Plan's Schedule H for the annual and quarterly statements be completed and filed pursuant to Circular Letter No. 9 (1999).	27
	<i>The Plan has complied with this recommendation.</i>	

<u>ITEM</u>		<u>PAGE NO.</u>
vii.	It is recommended that the Plan maintain a listing that identifies components of medical claims expense paid data maintained within and outside the claims system, in order that a reconciliation with the annual statement could be readily prepared for future examinations.	28
	<i>The Plan has complied with this recommendation.</i>	
H. <u>Contingency Reserve</u>		
i.	It is recommended that the Plan follow the contingency reserve procedures outlined in Part 98.11 (d) & (e) of the Administrative Rules and Regulations of the Health Department.	33
	<i>The Plan has complied with this recommendation.</i>	
ii.	It is recommended that the Plan maintain its minimum net worth/contingency reserve requirements at all times.	33
	<i>The Plan has complied with this recommendation.</i>	
I. <u>Underwriting</u>		
i.	It is recommended that the composite rate used with regards to the NY Nurses Association and the experience rating formula utilized be filed with the Department pursuant to Section 4308 (c) of the New York Insurance Law.	35
	<i>The Plan has complied with this recommendation.</i>	
ii.	It is again recommended that the Plan comply with New York Regulation 62, Part 52.42 by accounting for any shortage/overage resulting from the difference between the approved rate and the guaranteed rate.	35
	<i>The Plan has complied with this recommendation.</i>	

ITEM

PAGE NO.

J. Review of Compliance with Prompt Pay Law

- i. The examiner's review was hampered by the Plan in the following manner: 37

Twice, the Plan failed to reconcile claims data provided to the examiners to its 1998 annual statement.

Several key components were missing from the first data extract and erroneous data was included in the second extract.

The Plan, in its second set of extracts provided to the examiners, omitted a required and requested field, the "clean claim date" column, which was included with the first extract. Several inquiries were made regarding this omission, but the Plan provided no reasonable explanation.

During the course of the examination, claims were identified where the date of payment was greater than forty-five (45) days from the date of receipt. After preliminary discussions with the Plan, additional information was requested for 2,722 of these claims. The Plan did not provide the requested information.

Health Net responded thus: "*The Plan continues to believe that the information was not supplied based on an understanding with the Department.*"

- ii The Department will conduct a more detailed review of claims adjudication in general, and compliance with Section 3224-a ("Prompt Pay Law") specifically. 38

The Department subsequently performed a Market Conduct Examination of Health Net of New York, Inc. as of December 31, 2001. That report revealed that the Plan failed to comply with the provisions of Section 3224-a(b) of the New York Insurance Law wherein it failed to deny or request additional information from an insured within thirty days. Specifically, the Examiners determined in that report that HNNY failed to deny or request additional information from an insured within thirty days on 112,714 of the 1,805,130 eligible claims (6.24 %.)

The Examiners in that report also determined that the Plan paid interest on adjudicated claims to providers, some of whom operated outside of New York, when none was due or the claims were denied. Those Examiners reported that 487 such claims included payments for interest amounting to \$3,176.15.

That report on examination recommended that the Company calculate and pay the appropriate amount of interest only when it is due.

ITEM

PAGE NO.

K. Agents and Brokers

- i. It is recommended that the Plan refrain from paying commission above the prescribed maximum limits pursuant to New York Regulation Part 52.42(e). 38

The Plan has complied with this recommendation.

- ii. It is recommended that the Plan ensure that all certificates of appointment for all its agents are on file with the Department pursuant to New York Insurance Law Section 2112(a) and it is further recommended that the Plan report all terminated agents to the Department pursuant to the requirements of the New York Insurance Law Section 2112(d). 39

The Plan has complied with this recommendation.

- iii. It is recommended that with regards to all of the Plan's employees who earn a commission or fee based on sales to comply with New York Insurance Law Sections 2114(a)(3) and 2116 to ensure that commissions are only paid to licensed agents and brokers. 40

The Plan has complied with this recommendation.

- iv. The Plan's employees which are compensated in a manner that is directly dependent upon the volume of business produced, are deemed to be insurance agents and are required to obtain the requisite license pursuant to New York Insurance Law Section 2102 (a) (1). 40

It is recommended that the Plan comply with the New York Insurance Law licensing requirements pursuant to New York Insurance Law Section 2102(a)(1).

The Plan has complied with this recommendation.

- v. It is recommended that the Plan's agent compensation plan be amended so as to insure the Plan's compliance with Department's statutes. 41

The Plan has complied with this recommendation.

- vi. It is recommended that the Plan amend its compensation plan to its sales agents and refrain from offering incentives to its agents for selling other products unapproved for PHS-NY. 41

The Plan has complied with this recommendation.

ITEM

PAGE NO.

L. Fraud Prevention

- i. The Plan's fraud division staffing appears inadequate. In view of the small percentage of fraud dollars identified, It is recommended that appropriate staff be added to the Plan's fraud investigation unit so that fraud can be investigated and prevented more effectively. 42/43

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

- ii. The Plan is in apparent violation of Sections 405 and 409 of the New York Insurance Law for failure to maintain and present documents such as frauds detection procedures, frauds case log, and frauds case files for the years covered under this examination. 43

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

M. Advertising

- i. It is recommended that advertising files are maintained in uniform and chronological order and available for review as required by New York Regulation 34. 44

The Plan has complied with this recommendation.

8. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management</u>	
i. Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the insurer. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Individuals, who fail to attend at least one-half of the board's regular meetings, unless appropriately excused, do not fulfill such criteria. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.	5
ii. It is recommended that board members who are unable or unwilling to attend at least one-half (1/2) of the regular board meetings should resign or be replaced. A similar recommendation was made in the prior report on examination.	5
iii. It is recommended that the Plan comply with the provisions of Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department, and its own by-laws, by seeking to fill vacancies of its enrollee members of the board of directors in a timely manner. A similar recommendation was made in the prior report on examination.	6
B. <u>Holding Company System</u>	
i. It is recommended that the Plan comply with the provisions of Part 98-1.10(c) [10NYCRR 98-1.10(c)] and Part 98-1.11(b) [10NYCRR 98-1.11(b)] of the Administrative Rules and Regulations of the Health Department as regards the aggregate capital contributions which exceeded ten percent of the HMO's admitted assets at last year end. A similar recommendation was made in the prior report on examination.	12
ii. It is also recommended that the minutes of the meetings of the Plan's board of directors formally acknowledge and document capital contributions made by Health Net, Inc., its ultimate parent. A similar recommendation was made in the prior report on examination.	12

<u>ITEM</u>	<u>PAGE NO.</u>
iii. It is also recommended that the commitment to provide financial support to the Plan in the event of impairment or insolvency be formalized in writing and submitted to the Departments of Health and Insurance, for review and approval pursuant to Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department [10NYCRR 98-1.10(c)]. A similar recommendation was made in the prior report on examination.	12
<u>C. Administrative Services Agreement</u>	
i. It is recommended that Health Net comply with the provisions of Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department by ensuring that the terms of the financial transactions of its Administrative Services Agreement are fair and equitable at the time of the transactions, charges or fees for services performed are reasonable, and expenses incurred and payments received are allocated on an equitable basis in conformity with customary accounting practices consistently applied.	18
ii. It is also recommended that the Plan comply with the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department by seeking and obtaining the Commissioner's and Superintendent's prior approval for the Administrative Services Agreement entered into with Health Net of the Northeast, Inc.	18
<u>D. Conflict of Interest Statements</u>	
i. It is recommended that all officers and directors submit signed conflict of interest statements during each calendar year and that the Plan establish a procedure for enforcing such policy.	20
ii. It is also recommended the board of directors adhere to its fiduciary responsibility by properly overseeing and handling any conflicts disclosed.	21
<u>E. Accounts and Records</u>	
i. It is recommended that the board of directors authorize and approve the Company's investment transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law and that documentation supporting their actions be appended to the minutes of their meetings. A similar recommendation was made in the prior report on examination.	22
ii. It is recommended that the Plan amend its custodian agreements with Fleet Bank to include the requisite safeguards and controls as set forth in the Department's Rules, and in the guidelines of the Financial Condition Examiners Handbook of the <i>National Association of Insurance Commissioners</i> .	22-23

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Abandoned Property</u>	
i. It is recommended that the Plan properly segregate unclaimed claim payments and miscellaneous unclaimed property to comply with the provisions of Sections 1316 and 1315 of the New York Abandoned Property Law respectively.	24
ii. It is also recommended that the Plan file all annual Reports of Abandoned Property with the Office of the State Comptroller to comply with the provisions of Sections 1315 and 1316 of the New York Abandoned Property Law.	24
iii. It is further recommended that the Plan annually publish a list of names and last known addresses of persons appearing to be entitled to abandoned property and to file proof of such publication with the Office of the State Comptroller.	25
G. <u>Location of books and records</u>	
i. It is recommended that the Health Net's board of directors adopt a plan to maintain suitable records at its principal office in New York and submit such plan to the Superintendent for approval.	26
H. <u>Premium Deficiency Reserve</u>	
Q. It is recommended that the Plan comply with the provisions of paragraph 18 of the Statements of Statutory Accounting Principles No. 54 of the <i>National Association of Insurance Commissioners</i> by establishing the requisite liability for each line of business where a premium deficiency is indicated. In addition, such deficiencies should not be offset by anticipated profits in other lines of business and such liabilities should be accrued for any loss contracts, even if the contract period has not yet started.	32
I. <u>Frauds prevention and detection</u>	
i. It is recommended that the Plan comply with the terms and conditions of the fraud plan approval letter dated September 16, 2004.	38
ii. It is also recommended that the Plan add appropriate staff to its fraud investigation unit so that fraud can be investigated and prevented more effectively in accordance with the provisions of Section 409(b)(1) of the New York Insurance Law.	38-39

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- iii. It is further recommended that the Plan comply with the provisions of Section 405(a) of the New York Insurance Law as regards suspected fraudulent transactions by submitting to the insurance frauds Insurance Department Frauds Bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transactions and the parties involved as the superintendent may require.

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Appointment No. 22105

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

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

Pearson Griffith

as a proper person to examine into the affairs of the

Health Net of New York, Inc.

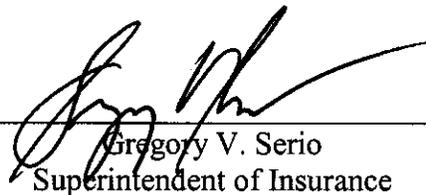
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 6th day of November, 2003



Gregory V. Serio
Superintendent of Insurance

