

**REPORT ON EXAMINATION**

**OF**

**HEALTH NET OF NEW YORK, INC.**

**AS OF**

**SEPTEMBER 30, 2008**

**DATE OF REPORT**

**MAY 13, 2010**

**EXAMINER**

**JO LO HSIA**

## TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of examination	3
2.	Executive Summary	4
3.	Description of the HMO	5
	A. Management and controls	5
	B. Territory and plan of operation	7
	C. Reinsurance	8
	D. Holding company system	9
	E. Underwriting operating ratios	15
	F. Accounts and records	15
4.	Financial statements	21
	A. Balance sheet	21
	B. Statement of revenue, expenses and capital and surplus	23
5.	Health care and other amounts receivable	24
6.	Net deferred tax liability	25
7.	Amounts due to parent, subsidiaries and affiliates	25
8.	Unpaid claims	26
9.	Premium deficiency reserve	26
10.	Market conduct activities	28
	A. Prompt Pay Law	28
	B. Explanation of benefits statements	33
	C. Utilization review	35
	D. Grievances and appeals	37
	E. Retro-termination of policies	39
	F. Disclosure of information	40
	G. Agents and brokers	43
	H. Schedule H- Aging analysis of claims unpaid	43
	I. Department Circular Letter No. 9 (1999)	44
	J. Department Circular Letter No. 5 (2002)	45
	K. Out-of-network claims	45
	L. Record retention	47
	M. Passport contracts	47

**ITEM NO.****PAGE NO.**

11.	Subsequent events	48
12.	Compliance with prior reports on examination	49
13.	Summary of comments and recommendations	58



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

David A. Paterson  
Governor

James J. Wrynn  
Superintendent

May 13, 2010

Honorable James J. Wrynn  
Superintendent of Insurance  
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30209, dated September 25, 2008, annexed hereto, I have made an examination into the condition and affairs of Health Net of New York, Inc., a for-profit health maintenance organization (HMO) licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of September 30, 2008, and submit the following report thereon.

The examination was conducted at the administrative office of Health Net of New York, Inc., located at One Far Mill Crossing, Shelton, CT.

Whenever the designations, "HNNY" or "the HMO" appear herein, without qualification, they should be understood to indicate Health Net of New York, Inc.

Whenever the designation, "the Department" appears herein, without qualification, it should be understood to mean the New York State Insurance Department.

A concurrent examination of the Company's affiliate, Health Net Insurance of New York, Inc., was also conducted as of September 30, 2008. A separate report thereon has been submitted.

## 1. SCOPE OF EXAMINATION

Health Net of New York, Inc. was previously examined as of September 30, 2003. This examination covers the five-year period from October 1, 2003 to September 30, 2008. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of September 30, 2008, in accordance with Statutory Accounting Principles (SAP), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO'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* (NAIC):

- History of the HMO
- Management and controls
- Corporate records
- Territory and plan of operation
- Growth of the HMO
- Business in force
- Loss experience
- Accounts and records
- Financial statements
- Market conduct activities

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

A review was also made to ascertain what actions were taken by the HMO with regard to comments and recommendations contained in prior reports on examination.

## 2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies during the examination period. The most significant findings of this examination include the following:

- The HMO failed to comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department when it failed to obtain approval of the Commissioner of Health and the Superintendent of Insurance prior to implementing its administrative services agreements.
- The HMO failed to collect \$38.5M in pharmacy rebates from its affiliated pharmacy benefits manager, Health Net Pharmaceutical Services, Inc., during the examination period.
- The HMO failed to be charged the proper allocation of direct expenses incurred from an affiliate during the examination period.
- The HMO failed to charge adequate rates relative to its administrative services contracts.
- The HMO failed to comply with the requirements of Section 3224-a of the New York Insurance Law (Prompt Pay Law).
- The HMO violated Section 3234(b)(3) of the New York Insurance Law when it issued explanation of benefits statements (EOBs) which failed to identify the services for which the claim was made. Such issued EOBs also failed to include the appeal information required by Section 3234(b)(7) of the New York Insurance Law.
- The HMO violated Article 49 of the New York Public Health Law with regard to certain statutory requirements affecting utilization reviews and appeals.
- The HMO violated Section 4408-9(4) of the New York Public Health Law and its own policy and procedures with regard to the processing of certain grievances and appeals.
- The HMO retro-terminated certain policies in violation of its policy.
- The HMO improperly paid in-network facility claims involving non-participating physicians during the examination period.

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

### 3. DESCRIPTION OF THE HMO

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

The HMO'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. HNNY has no preferred capital stock issued or outstanding.

#### A. Management and Controls

The by-laws of the HMO provide that its affairs shall be managed by a board of directors consisting of not less than six (6), nor more than nine (9) members, who shall be elected at the annual meeting of the shareholder. The by-laws also provide that at least one-fifth of the directors shall be comprised of enrollees of the HMO, provided however, that no group covered by any group contract issued by the HMO shall be represented among such directors by more than one (1) such director. In addition, the by-laws provide that at least one-third 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 HMO, at the time of their election. Furthermore, at least one-third of the directors shall be elected from among nominees chosen by Health Net of the Northeast, Inc. (formerly known as PHS, Inc.), provided, however, that at least two (2) of such directors shall be physicians.

Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1) states that:

“no less than 20 percent of the members of the governing authority shall be enrollees of such MCO”

As of September 30, 2008, the HMO’s board of directors consisted of the following six (6) members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Julie L. Auster * Briarcliff Manor, NY	Director of Human Resources, Sarah Lawrence College
David B. Bernard, MD New York, NY	Professor, Albert Einstein College of Medicine
Martin L. Jenis Larchmont, NY	Broker, Self-employed
Paul S. Lambdin New Canaan, CT	Chairman of the Board, Health Net of New York, Inc.
Anju Sikka, MD New York, NY	President, Health Net of New York, Inc.
Adam R. Stracher, MD New York, NY	Physician, Weill Medical College of Cornell University

*\*Enrollee Representative per Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York Health Department.*

During the examination period, the examiner noted that only one (1) member of the HMO's board of directors was an eligible enrollee representative of the Plan. This constituted less than twenty (20) percent of the Plan's board members, thus the HMO was in violation of the requirements of its by-laws and Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)(1)).

It is recommended that the HMO comply with Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department and its own by-laws, by maintaining at least 20 percent of its board members with enrollees.

A similar recommendation was made in the prior report on examination.

As of September 30, 2008, the principal officers of the HMO were as follows:

<u>Name</u>	<u>Title</u>
Anju Sikka, MD	President
Peter E. Gladitsch	Treasurer
Joseph J. Kempf, Jr.	Secretary
Bret A. Morris	Vice President

On November 1, 2008, subsequent to the examination date, Scott Weiner replaced Peter Gladitsch as Treasurer of the HMO.

B. Territory and Plan of Operation

HNNY's service area includes the Bronx, Dutchess, Kings, Nassau, New York, Orange, Putman, Queens, Richmond, Rockland, Suffolk and Westchester counties of New York State.

The following schedule shows the HMO's direct premiums written and enrollment within the State of New York for the examination period:

<u>Period</u>	<u>Direct Premiums Written</u>	<u>Enrollment</u>
2003	\$ 642,073,193	217,991
2004	708,025,432	206,852
2005	719,413,846	188,589
2006	701,108,712	163,411
2007	618,683,293	130,508
9/30/08	353,706,902	102,536

Since 2004, the HMO has experienced a decline in membership. This can be attributed to competition from other HMOs and to other products offered by competitors and its affiliates, such as Point-of-Service (POS), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) and Indemnity Point-of-Service (IPOS).

Effective October 1, 2007, the HMO sold its Medicare Advantage (HMO) book of business to Touchstone Health Partnership, Inc. (Touchstone) for \$600,000. The sale transferred approximately 6,500 Medicare members in Kings, Queens, Bronx and Richmond counties from the HMO to Touchstone.

C. Reinsurance

The HMO did not maintain stop-loss insurance coverage as of September 30, 2008.

In 1995, the HMO and its affiliate Health Net Insurance of New York, Inc. (HNINY), were participants in marketing and reinsurance agreements with the Guardian Life Insurance Company of America (Guardian). Under the terms of the agreements, certain Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service

(POS), and Exclusive Provider Organization (EPO) products were jointly developed and sold to small groups within HNNY's and HNINY's service area. These products were distributed through the brokerage community in an integrated marketing effort, under the trade name "Healthcare Solutions".

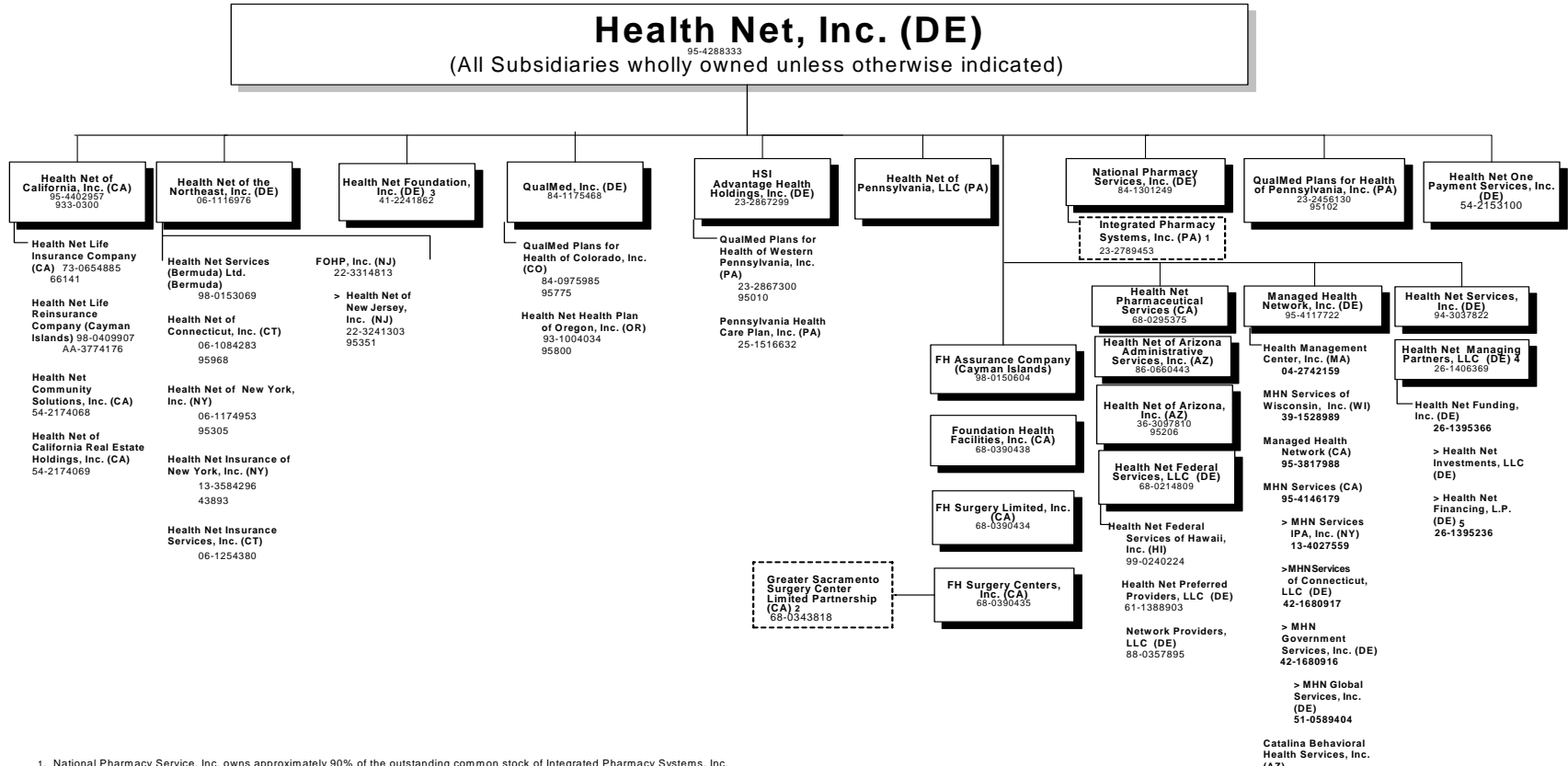
Under the terms of the agreements, the HMO wrote one hundred percent (100%) of the HMO business and in-network portion of the POS business and ceded fifty percent (50%) of such business to Guardian. Guardian wrote 100% of the out-of-network portion of the POS business and ceded fifty percent (50%) of the business to Physician Health Services (Bermuda), Ltd., now known as Health Net Services (Bermuda), Ltd., an affiliate of the HMO.

Effective June 1, 2007, the HMO and HNINY acquired Guardian's 50% interest in Healthcare Solutions for cash considerations.

D. Holding Company System

As of the examination date, the HMO is a wholly-owned subsidiary of Health Net of Northeast, Inc. (the Parent) which was formerly known as Physicians Health Services, Inc. The Parent is a wholly-owned subsidiary of Health Net, Inc., formerly known as Foundation Health Systems, Inc.

The following chart depicts the HMO's holding company system as of September 30, 2008:



1. National Pharmacy Service, Inc. owns approximately 90% of the outstanding common stock of Integrated Pharmacy Systems, Inc.
2. FH Surgery Centers, Inc. owns general and limited partnership units representing slightly over 50% of the total equity of Greater Sacramento Surgery Center Limited Partnership (which specific percentage fluctuates from time to time).
3. Health Net Foundation, Inc. is a nonprofit, nonstock corporation exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.
4. Health Net Managing Partners, LLC -75% common interest is owned by Health Net, Inc. and 25% common interest is held by Health Net One Payment Services, Inc.
5. Health Net Financing, L.P. - 100% general partnership interest is held by Health Net Funding, Inc., 100% of the Class A limited partnership interest is held by Lodgemore Holdings, Inc. and 100% of the Class B limited partnership interest is held by Health Net Investments, LLC.

During the examination period, the HMO operated under separate administrative services agreements with its immediate Parent company, Health Net of the Northeast, Inc. and Health Net, Inc., the HMO's ultimate parent.

Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(c)) states in part:

“The commissioner's and, except in the case of PHSP, HIV SNP or PCPCP, the superintendent's prior approval shall be required for the following transactions between a controlled MCO and any person in its holding company system: sales, purchases, exchanges, loans, extensions of credit or investments the aggregate of which involves five percent or more of the MCO's admitted assets at last year-end. Thirty days prior notice to the commissioner and, except in the case of a PHSP, HIV SNP or PCPCP, the superintendent, is required before entering into the following transactions between a controlled MCO and any person in its holding company system: a reinsurance agreement or an agreement for rendering services on a regular or systematic basis, other than medical or management services that require prior approval under this Subpart. Such transactions may become effective unless the commissioner or the superintendent has disapproved the transaction within such period.”

During the period, October 31, 2003 to January 31, 2004, the HMO utilized an agreement that was entered into with Health Net of the Northeast, Inc. (HNNE), its immediate parent, with an effective date of January 1, 2001. HNNY did not seek or obtain the prior approval of the Commissioner of Health and the Superintendent of Insurance for this agreement, as required by Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.1(c)).

During the period, February 1, 2004 to December 31, 2008, the HMO utilized a new administrative services agreement (the 2003 administrative services agreement) that it entered into with its Parent and Health Net, Inc. (HNI) with an effective date of February 1, 2004. This agreement was submitted to the Superintendent of Insurance for approval in December 2003. After several revisions were made to such agreement pursuant to recommendations made by the

Insurance Department, the agreement was approved by the Superintendent of Insurance on January 5, 2006. The HMO violated the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.1(c)) by failing to obtain the prior approval of the Commissioner of Health and the Superintendent of Insurance before implementing the agreement.

It should be noted that for all the years under the examination, the costs associated with such administrative services agreement exceeded five percent of the HMO's admitted assets at the prior year-end.

It is recommended that the HMO comply with the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and obtain the prior approval of the Commissioner of Health and the Superintendent of Insurance for all administrative services agreements that the HMO enters into with other members of its holding company system that involve five-percent or more of its prior year-end admitted assets. Thirty-day prior notice to the Commissioner and the Superintendent is required for services rendered on a regular or systematic basis that involve less than five-percent of its prior year-end admitted assets, before implementing such agreements.

During the examination period, the HMO received prescription drug claims administration, formulary management, and pharmaceutical rebate process services from Health Net Pharmaceutical Services, Inc. (HNPS), an affiliate, pursuant to an agreement entered into between HNPS (on behalf of the HMO and its other affiliates) and AdvancePCS Health, L.P. on September 2, 2003 (2003 pharmacy claims processing services agreement). This agreement did

not contain a provision regarding the ownership of the pharmaceutical rebates received from the drug manufacturers.

The HMO was not able to provide documentation indicating that the 2003 pharmacy claims processing services agreement was approved by the Commissioner of Health and the Superintendent of Insurance, thereby violating Part 98-1.10(c) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.10(c)).

The HMO subsequently filed with the Department of Health (DOH) a new pharmacy benefits management services agreement, with an effective date of January 1, 2005, between the HMO and HNPS. This agreement contained a provision requiring the return of the applicable pharmaceutical rebates from HNPS to HNNY. However, this agreement was not approved by the DOH and was later withdrawn by HNNY. This agreement was not filed with the New York Insurance Department.

Later during the examination period, HNNY had a new pharmacy benefit management services agreement between the HMO, HNPS and Caremark PCS Health, L.P. (formerly known as Advance PCS Health, L.P.) filed with the DOH. This agreement was approved by the DOH on January 22, 2009, with the effective date being the date of approval. This agreement was later approved by the Insurance Department on June 16, 2009. This agreement contained a provision requiring payment of pharmaceutical rebates to HNNY from HNPS.

It is recommended that the HMO comply with the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and obtain the prior approval of the Commissioner of Health and the Superintendent of Insurance for all pharmacy benefits management services agreements that the HMO enters into with other members of its holding



company system that involve five-percent or more of its prior year-end admitted assets. Thirty day prior notice to the Commissioner of Health and the Superintendent of Insurance is required for services rendered on a regular or systematic basis that involve less than five-percent of its prior year-end admitted assets, before implementing the agreements.

Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department states in part:

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

- (1) the terms of the financial transactions shall be fair and equitable to the MCO 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 MCO on an equitable basis in conformity with customary accounting practice consistently applied...”

It was noted that during the examination period, the HMO failed to collect approximately \$38.5 million in pharmacy rebates from its pharmacy benefit manger, Health Net Pharmaceutical Services, Inc. (HNPS) for prescription claims processed from 2002 to 2008. The examination established an asset in regard to this rebate amount. The details of this item are noted in item No. 5, “Health Care and Other Amounts Receivable”, of this report on examination.

It is recommended that the HMO comply with the provisions of Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(a)) by obtaining the pharmacy rebates from HNPS and by ensuring that the contractual terms regarding the financial transactions of its pharmacy benefits management services agreements are fair and equitable.

E. Underwriting Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the five-year period covered by this examination:

Claims	\$ 2,162,884,376	83.44%
Claims adjustment expenses	83,911,190	3.24%
Administrative expenses	315,886,289	12.19%
Net underwriting gain	<u>29,483,368</u>	<u>1.13%</u>
Premiums earned	\$ <u>2,592,165,223</u>	<u>100.00%</u>

F. Accounts and Records

During the course of the examination, it was noted that the HMO's treatment of certain items was not in accordance with statutory accounting principles or annual statement instructions. A description of such items is as follows:

1. The HMO maintains several custodial accounts with the Bank of New York and the Bank of America. A review of the custodial agreements revealed that the agreements lacked the following safeguards and controls as set forth by the New York Insurance Department and in the guidelines of the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners*:

“(1) If domiciliary state law, regulation or administrative action requires a strict standard of liability for custodians of insurance company securities than that set forth in Section 2.a., then such stricter standard shall apply. An example of a stricter standard that may be used is that the custodian is obligated to indemnify the insurance company for any loss of securities of the insurance company in the custodian's custody occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction;

(2) 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;

- (3) 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;
- (4) 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;
- (5) The custodian and its agents, upon reasonable request, shall be required to send all reports which they receive from a clearing corporation which the clearing corporation permits to be redistributed including reports prepared by the custodian's outside auditors, to the insurance company on their respective systems of internal control;
- (6) To the extent that certain information maintained by the custodian is relied upon by the insurance company in preparation of its annual statement and supporting schedules, the custodian agrees to maintain records sufficient to determine and verify such information;
- (7) The custodian shall provide, upon written request from a regulator or an authorized officer of the insurance company, the appropriate affidavits, with respect to the insurance company's securities held by the custodian; and
- (8) The custodian shall secure and maintain insurance protection in an adequate amount."

It is recommended that the HMO amend its custodial agreements with the Bank of New York and the Bank of America to include the requisite safeguards as set forth by the New York Insurance Department and as included within the guidelines of the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners*.

It is noted that the HMO amended its custodial agreements with the Bank of New York and with the Bank of America in March 2009 and April 2009, respectively, to include the requisite safeguards, in accordance with the guidelines of the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners*.

2. During the examination period, Health Net of the Northeast, Inc. (HNNE) and Health Net Inc. (HNI) provided administrative services to HNNY in accordance with the administrative service agreements made between HNNE, HNI and HNNY.

Pursuant to the terms of the agreements, all selling, general and administrative expenses, except broker and agent fees, compensation, taxes and regulatory assessments, incurred by HNNE and HNI on behalf of the Health Net affiliated insurance entities domiciled in Connecticut, New York, New Jersey, Bermuda, and Pennsylvania and those incurred by one additional affiliate on behalf of another affiliate are allocated based on a set of prescribed cost drivers. These expenses were accumulated in separate cost centers maintained by HNI and HNNE and were then allocated among each participating entity on a monthly basis.

It was noted that the expense allocation methodology HNNE and HNI used during the examination period failed to recognize the direct expenses on the individual invoice level. Direct expenses relating to only one or two entities in the region were included in cost centers, which were then allocated to all of the entities on a regional basis. The following are some of the examples of incorrect allocations of expenses that the examiner noted during the review of the HMO's expense allocation methodologies:

- Fees for out-of-network vendor negotiation services were included in cost center No. 36102, which were allocated based on weighted membership among all Health Net affiliates and subsidiaries in the tri-state area (New York, New, New Jersey and Connecticut), including the HMO, which only offered products with in-network benefits.
- Direct media marketing expenses for Health Net Insurance of Connecticut, Inc. were included within cost center 36108 for the purpose of allocation among all Health Net tri-state affiliates based on weighted membership.
- Direct sponsorship expenses and direct small group marketing expenses for the HMO and Health Net Insurance of New York, Inc. were included in cost centers 36074 and 36103, respectively, which were allocated among all of Health Net's affiliates in the tri-state area based on weighted membership.

Paragraph 9 of the Statements of Statutory Accounting Principles (SSAP) No. 70 of the NAIC Accounting Practices and Procedures Manual states in part:

“...Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.”

It is recommended that HNNY record direct expenses in accordance with Paragraph 9 of SSAP No. 70 of the NAIC Accounting Practices and Procedures Manual.

It is also recommended that expenses incurred be allocated to the HMO on an equitable basis, in accordance with Part 98-1.10(a)(3) of the Administrative Rules and Regulations of the New York Health Department.

The HMO reported that as result of its 2009 review, beginning in January 2010, cost center 36108 is being fully allocated to the Connecticut entity.

It is recommended that HNNE and HNNY continue to review and refine the allocation methodologies used to distribute expenses across cost centers.

3. Paragraph 12(b) of SSAP No. 47 of the NAIC Accounting Practices and Procedures Manual states in part:

“12. The statutory financial statements shall provide the following:

(b) Information with regard to the profitability to the administrator of all ASC plans and the uninsured portions of partially insured plans for which the reporting entity serves as an ASC administrator;

For the total and each category separately provided: (i) gross reimbursement for medical cost incurred, (ii) gross administrative fees accrued, (iii) other income or expense (including interest paid to or received from plans), (iv) gross expenses incurred (claims and administrative), and (v) total net gain or loss from operations...”

The HMO failed to disclose the required aforementioned financial information regarding the gross reimbursement for medical costs incurred for its ASO business in the “Notes to the Financial Statements” section of its filed annual statements during the examination period.

It is recommended that HNNY disclose all required financial information relative to its ASO business, including the gross reimbursement for medical costs incurred relative to its ASO business within the “Notes to the Financial Statements” section of its annual statement filings, in accordance with Paragraph 12(b) of SSAP No. 47 of the NAIC Accounting Practices and Procedures Manual.

A review of HNNY’s annual statements (Notes to the Financial Statements) for the years 2003 through 2008, revealed aggregate losses of approximately \$8.17M relative to its administrative services operations. The approximately \$8.17M cumulative loss is detailed in the following schedule:

<u>Year</u>	<u>ASO Net Gain/(Loss)</u>
2003	\$ 1,060,056
2004	(194,761)
2005	(466,073)
2006	(1,036,514)
2007	(3,214,815)
2008	<u>(4,318,201)</u>
Total	\$ <u>(8,170,308)</u>

It was noted that HNNY continued to charge its New York ASO clients inadequate premium rates, which resulted in five consecutive years of losses. The HMO indicated that retaining its ASO clients, even at a loss, was part of its Parent’s overall business strategy to maintain its competitive position in the ASO market.

The HMO's ASO losses were a continuing drain on its financial resources and could have resulted in higher rates for its insured policyholders. The HMO's officers and directors have a fiduciary responsibility to ensure that the rates charged to all lines of business, including the ASO line of business, are sufficient to cover all expenses.

It is recommended that HNNY charge adequate rates relative to its ASO business.

4. It was noted that as of the examination date, the HMO's book of business did not contain any large HMO employer groups. However, both the "*Statement of Revenue and Expenses by Line of Business*" and "*Schedule 1*" of its filed New York Data Requirements September 30, 2008 quarterly supplement mistakenly classified all non-Guardian small employer groups as large employer groups.

It is recommended that the HMO exercise due care to ensure that the information reported within its filed Data Requirements Statements is accurate. It is also recommended that the HMO properly segregate and report its large and small groups within its statements filed with this Department.

#### 4. FINANCIAL STATEMENTS

##### A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination, with that reported by the HMO as of September 30, 2008:

<u>Assets</u>	<u>Examination</u>				<u>HMO</u>	Surplus Increase (Decrease)
	Ledger Assets	Non-Ledger Assets	Non- Admitted Assets	Net Admitted Assets	Net Admitted Assets	
Bonds	\$ 86,793,179	\$ 0	\$ 0	\$86,793,179	\$ 86,793,179	\$ 0
Common stocks	16,710,822	0	0	16,710,822	16,710,822	0
Cash, cash equivalents and short-term investments	38,170,729	0	0	38,170,729	38,170,729	0
Receivables for securities	1,836,567	0	0	1,836,567	1,836,567	0
Premiums and considerations	8,421,241	0	1,206,290	7,214,951	7,214,951	0
Investment income due and accrued	1,034,549	0	0	1,034,549	1,034,549	0
Amounts receivable relating to uninsured plans	905,068	0	540,906	364,162	364,162	0
Net deferred tax assets	12,568,780	0	10,313,134	2,255,646	2,255,646	0
Electronic data processing equipment and software	72,488	0	0	72,488	72,488	0
Furniture and equipment	449,229	0	449,229	0	0	0
Receivables from parent, subsidiaries and affiliates	13,293	0	0	13,293	13,293	0
Health care and other amounts receivable	11,927,365	38,542,923	11,509,231	38,961,057	418,134	38,542,923
Aggregate write-ins for other than invested assets	<u>3,833,908</u>	<u>0</u>	<u>2,389,408</u>	<u>1,444,500</u>	<u>1,444,500</u>	<u>0</u>
Total assets	<u>\$ 182,737,218</u>	<u>\$ 38,542,923</u>	<u>\$ 26,408,198</u>	<u>\$ 194,871,943</u>	<u>\$ 156,329,020</u>	<u>\$ 38,542,923</u>



<u>Liabilities</u>	<u>Examination</u>	<u>HMO</u>	<u>Surplus Increase/ (Decrease)</u>
Claims unpaid	\$ 46,773,036	\$ 49,608,225	\$ 2,835,189
Unpaid claims adjustment expenses	622,733	622,733	0
Aggregate health policy reserve		459,576	(12,200,000)
Premium received in advance	8,322,676	8,322,676	0
General expenses due or accrued	3,382,150	3,382,150	0
Current federal and foreign income tax payable and interest thereon	5,988,940	5,988,940	0
Net deferred tax liability	7,288,812	0	(7,288,812)
Accounts withheld or retained for the account of others	84,894	84,894	0
Remittances due to parent, subsidiaries and affiliates	2,000,883	2,000,883	0
Amounts due to parent, subsidiaries and affiliates	15,280,878	8,302,731	(6,978,147)
Payable for securities	1,988,021	1,988,021	0
Liability for amounts held under uninsured plans	973,622	973,622	0
Aggregate write-ins for other liabilities	<u>6,912,945</u>	<u>6,912,945</u>	
Total liabilities	\$ <u>112,279,165</u>	\$ <u>88,647,396</u>	\$ <u>(23,631,769)</u>

#### Capital and Surplus

Common capital stock	\$ 14,500	\$ 14,500	
Gross paid-in and contributed surplus	126,448,655	126,448,655	0
Aggregate write-ins for other than special surplus	41,234,057	41,234,057	0
Unassigned funds	<u>(85,104,434)</u>	<u>(100,015,588)</u>	<u>14,911,154</u>
Total capital and surplus	<u>82,592,778</u>	<u>67,681,624</u>	<u>14,911,154</u>
Total liabilities, capital and surplus	\$ <u>194,871,943</u>	\$ <u>156,329,020</u>	

**Note:** The Internal Revenue Service completed its audits of the consolidated income tax returns filed on behalf of the HMO for tax years 2003 to 2005. All material adjustments, if any, made subsequent to the date of the audit and arising from said audits, are reflected in the financial statements included in this report. In addition, the IRS has completed its audit for tax years 2006 and 2007. Adjustments, arising from such IRS audit, were made to the 2007 consolidated tax return which resulted in a refund of \$696,290. No potential liabilities were reported. The examiner is unaware of any potential exposure of the HMO 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

Capital and surplus increased \$47,306,548 during the five-year examination period,

October 1, 2003 through September 30, 2008, detailed as follows:

Revenue

Net premium income	\$ 2,592,065,758	
Net investment income	27,833,011	
Change in unearned premium reserves	<u>99,465</u>	
Total revenue		\$ 2,619,998,234

Expenses

Medical and hospital	\$2,651,992,829	
Reinsurance expenses net of recoveries	(517,650,526)	
Claims adjustment expenses	83,911,190	
General administrative expenses	322,864,436	
Increase in reserves for life and accident and health contracts	(636,039)	
Aggregate write-ins for other income	<u>28,580,015</u>	
Total expenses		<u>2,569,061,905</u>
Net income before federal and foreign income taxes		50,936,329
Federal and foreign taxes incurred		<u>23,624,939</u>
Net income		\$ <u>27,311,390</u>

Change in Capital and surplus

	Gains in <u>Surplus</u>	Losses in <u>Surplus</u>	
Capital and surplus, per report on examination as of September 30, 2003			\$ 35,286,230
Net income	\$ 27,311,390		
Change in net deferred income tax	12,309,890		
Change in non-admitted assets		\$ 17,173,564	
Change in paid-in surplus	34,713,155		
Dividends to stockholders		9,600,000	
Aggregate write-ins for losses in surplus	<u>                    </u>	<u>254,323</u>	
Net increase in capital and surplus			<u>47,306,548</u>
Capital and surplus, per report on examination as of September 30, 2008			\$ <u>82,592,778</u>

## 5. HEALTH CARE AND OTHER AMOUNTS RECEIVABLE

The examination admitted asset of \$38,961,057 for this item is \$38,542,923 more than the \$418,134 reported by the HMO in its filed September 30, 2008 quarterly statements.

The aforementioned examination change reflected the total amount of pharmacy rebates due from HNPS resulting from the examination findings detailed below.

As was detailed in Section 3D of this report, Health Net Pharmaceutical Services, Inc. (HNPS) received approximately \$38.5 million in pharmaceutical rebates derived from HNNY claims from 2002 to 2008, while serving as the HMO's pharmacy benefit manager. The financial accounts affected by the pharmacy rebates, as reflected in this report, are as follows:

<u>Balance Sheet Account</u>	<u>Surplus Increase/ (Decrease)</u>
Pharmacy rebates receivable	\$38,543,923
Net deferred tax liability	(7,288,812)
Amounts due to affiliates	(6,978,147)
Net surplus increase	<u>\$24,266,959</u>

Further details regarding the above items are included within the "Holding Company System" section of this report. Details regarding the "Net Deferred Tax Liability" and "Amounts Due to Affiliates" balance sheet accounts are included within Sections 6 and 7 of this report, respectively.

It is recommended that the HMO consider reporting the amounts due relative to pharmacy rebates within the "Receivables From Parent, Subsidiaries and Affiliates" account of its filed quarterly and annual statements.

It is also recommended that the HMO comply with SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual and report such pharmacy rebates as a reduction to claims expenses in its filed quarterly and annual statements.

## **6. NET DEFERRED TAX LIABILITY**

The examination established a liability in the amount of \$7,288,812 for the HMO as of September 30, 2008, for the captioned account.

As noted in item 5, under the caption, "Health Care and Other Amounts Receivable" of this report, an additional non-ledger asset has been established within this report relative to overdue pharmacy rebates receivable from the HMO's affiliate, Health Net Pharmaceutical Services, Inc. for the period, January 1, 2002 through September 30, 2008. The aforementioned examination change of \$7,288,812 in deferred tax liability reflects the tax impact of the net \$38.5M of the pharmacy rebates receivable adjustment noted in item 5, of this report on examination.

## **7. AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES**

The examination liability of \$15,280,878 is \$6,978,147 more than the \$8,302,731 reported by the HMO in its filed September 30, 2008 quarterly statement.

As noted in item 5 above, under the caption, "Health Care and Other Amounts Receivable", an additional non-ledger asset has been established within this report relative to overdue pharmacy rebates amounts receivable from the HMO's affiliate, Health Net Pharmaceutical Services, Inc. (HNPS). In this regard, it was also noted that the HMO failed to

reimburse HNPS for the administrative expenses incurred on behalf of the HMO in an amount of \$6,978,147 during the period of 2002 to 2008 related to the receivable. As such, the aforementioned examination change of \$6,978,147 in “Amounts Due to Parent, Subsidiaries and Affiliates” was made accordingly.

## **8. UNPAID CLAIMS**

The examination liability of \$46,773,036 is \$2,835,189 less than the \$49,608,225 reported by the HMO in its filed September 30, 2008 quarterly statement.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO’s internal records and its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO’s experience in projecting the ultimate cost of claims incurred on or prior to September 30, 2008.

## **9. PREMIUM DEFICIENCY RESERVE**

The examination established a liability of \$12,200,000 for the HMO as of September 30, 2008, for the captioned account.

It was noted that the HMO’s Large Group Community-Rated HMO and Large Group Experience-rated POS lines of business were running at an underwriting loss of \$18.72 million at

December 31, 2007, and at an underwriting loss of \$18.68 million at September 30, 2008. As of September 30, 2008, the HMO did not establish a Premium Deficiency Reserve (PDR) for the imminent underwriting loss. As required by the Statements of Statutory Accounting Principles (SSAP) No. 54 of the NAIC Accounting Practices and Procedures Manual it was determined that the HMO establish the PDR for its large group line of business for the reason noted herein.

This reserve should be established in accordance with the provisions of paragraph 18 of the Statements of Statutory Accounting Principles (SSAP) No. 54 of the NAIC Accounting Practices and Procedures Manual, which states:

“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 reserve for the aforementioned specific lines of business, and not in the aggregate. As a result, losses by these lines of business were not offset by any applicable gains by other lines of business.

It is recommended that HNNY comply with the provisions of paragraph 18 of the Statements of Statutory Accounting Principles No. 54 of the NAIC Accounting Practices and Procedures Manual 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 all loss contracts, even if the contract period has not yet started.

## 10. MARKET CONDUCT ACTIVITIES

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

- A. Prompt Pay Law
- B. Explanation of benefits statements
- C. Utilization review
- D. Grievances and appeals
- E. Retro-termination of policies
- F. Disclosure of information
- G. Agents and brokers
- H. Schedule H- Aging Analysis of Unpaid Claims
- I. Department Circular Letter No. 9 (1999)
- J. Department Circular Letter No. 5 (2002)
- K. Out-of-network claims
- L. Record retention
- M. Passport contracts

### A. Prompt Pay Law

A review to test for compliance with the Prompt Pay Law was performed by using a statistical sampling methodology covering claims processed during the period January 1, 2008 to September 30, 2008.

The claim population for the HMO was divided into medical and hospital claim segments. A random statistical sample was drawn from each segment. It should be noted for the purpose of this analysis, that medical costs characterized as Pharmacy, Medicare, capitated payments, and HCRA bulk payments were excluded. In addition, claims for non New York providers were excluded.

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

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

“...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) of the New York Insurance Law states in part:

“...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 ...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.”

Two statistical samples (one for medical claims and one for hospital claims) of claims not adjudicated within 45 days of receipt by the HMO were reviewed to determine whether payments were in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. Accordingly, all claims that were not adjudicated within 45 days during the period January 1, 2008 through September 30, 2008, were segregated. A statistical sample of each population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:



**Summary of Violations of Section 3224-a(a) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population	1,844,460	6,041
Population of claim transactions adjudicated past 45 days	24,966	1,486
Sample size	167	167
Number of claims with violations	85	41
<b>Calculated violation rate</b>	<b>50.90%</b>	<b>24.55%</b>
Upper violation limit	58.48%	31.08%
Lower violation limit	43.32%	18.02%
<b>Calculated claims in violation</b>	<b>12,707</b>	<b>365</b>
Upper limit transactions in violation	14,600	462
Lower limit transactions in violation	10,814	268

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

**Summary of Violations of Section 3224-a(c) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population	1,844,460	6,041
Population of claim transactions adjudicated past 45 days	24,966	1,486
Sample size	167	167
Number of claims with violations	20	7
<b>Calculated violation rate</b>	<b>11.98%</b>	<b>4.19%</b>
Upper violation limit	16.90%	7.23%
Lower violation limit	7.05%	1.15%
<b>Calculated claims in violation</b>	<b>2,990</b>	<b>62</b>
Upper limit transactions in violation	4,219	107
Lower limit transactions in violation	1,761	17

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

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt and those claims adjudicated during the period January 1, 2008 through September 30, 2008, which incurred interest of two dollars or more based upon the examiner's calculations.

The population of claims adjudicated over forty-five days from date of receipt for the HMO consisted of 24,966 medical claims and 1,486 hospital claims, out of 1,844,460 medical claims and 6,041 hospital claims, respectively, processed.

It is recommended that HNNY take steps to ensure compliance with Sections 3224-a(a), and (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..., 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.”

Two statistical samples (one for medical claims and one for hospital claims) of claims not denied within 30 calendar days of receipt by the HMO were reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all denied claims that were not denied within 30 calendar days of receipt by the HMO during the period January 1, 2008 through September 30, 2008, were segregated. A statistical sample of each population was then selected to determine whether the claims were adjudicated in compliance with the requirements of Section 3224-a(b) of the New York Insurance Law.

The following chart illustrates Prompt Pay compliance as determined by this examination:

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

	Medical Claims	Hospital Claims
Total population	1,844,460	6,041
Population of claim transactions denied beyond 30 days	11,147	13
Sample size	167	13
Number of claims with violations	61	12
<b>Calculated violation rate</b>	<b>36.53%</b>	<b>92.31%</b>
Upper violation limit	43.83%	N/A*
Lower violation limit	29.22%	N/A*
<b>Calculated claims in violation</b>	<b>4,072</b>	<b>N/A*</b>
Upper limit transactions in violation	4,886	N/A*
Lower limit transactions in violation	3,258	N/A*

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

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims denied over thirty calendar days from receipt during the period January 1, 2008 through September 30, 2008.

The population of claims denied over thirty calendar days from date of receipt for the HMO consisted of 11,147 medical claims and 13 hospital claims out of 1,844,460 medical claims and 6,041 hospital claims processed, respectively.

It is recommended that HNNY take steps to ensure compliance with Section 3224-a(b) of the New York Insurance Law.

B. Explanation of Benefits Statements

As part of the review of HNNY's claims practices and procedures, an analysis of its Explanation of Benefits statements (EOBs) sent to subscribers was performed. An EOB is an important link between the subscriber and HNNY. It should clearly communicate to the subscriber that HNNY has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers.

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

“The explanation of benefits form must include at least the following:

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

The EOBs issued by HNNY during the examination period failed to properly identify the services for which the claim was made, in violation of Section 3234(b)(3) of the New York Insurance Law.

Furthermore, it was noted that when emergency room claims were paid at less than the billed amount, the HMO did not specifically communicate this action or identify the member's responsibility in its explanation of benefits statements, in violation of Section 3234(b)(6) of the New York Insurance Law.

Effective November 17, 2008, the HMO made changes to its EOBs to more clearly reflect the services performed.

Section 3234(b)(7) of the New York Insurance Law requires EOBs to include a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought, along with a notification that failure to comply with these requirements may lead to forfeiture of a consumer's right to challenge a claim denial. Prior to September 2006, the HMO's EOBs contained "forfeiture" wording, which appeared to mirror the requirements prescribed by Section 3234(b)(7) of the New York Insurance Law, however, the examiner questioned the specific wording contained in the EOB. Subsequent to September 2006, HNNY revised its EOBs; however, the new versions of its EOBs failed to contain the specific forfeiture wording prescribed by Section 3234(b)(7) of the New York Insurance Law.

The HMO reported that in August 2009, it reinserted wording, which it believed met the requirements of Section 3234(b)(7) of the New York Insurance Law.

It is recommended that HNNY issue EOBs that are in compliance with the requirements of Sections 3234(b)(3), (b)(6) and (b)(7) of the New York Insurance Law.

C. Utilization Review

(i) Prospective Utilization Review Procedures

Section 4903(2) of the New York Public Health 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 enrollee or enrollee’s designee and the enrollee’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

A total of forty-one prospective utilization review files, which were processed by either the HMO or its third party administrators, were selected and reviewed for compliance with Section 4903(2) of the New York Public Health Law.

For eight of the sampled utilization review files reviewed by the examiner, the HMO failed to provide a notice of determination in writing. In addition, for one of the sampled HNNY utilization files, the HMO failed to provide a notice of determination by telephone.

It is recommended that the HMO comply with the provisions of Section 4903(2) of the New York Public Health Law and provide notice of determinations by telephone and in writing within three business days of receipt of the necessary information for all utilization review determinations requiring pre-authorization.

(ii) Concurrent Review

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

“A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission and shall provide notice of such determination to the enrollee or the enrollee’s designee, which may be satisfied by notice to the enrollee’s health care provider, by telephone and in writing within one business day of receipt of the necessary information except...”

A review of the HMO's utilization review policy indicated that HNNY allows an additional three days to provide written notification for verbal notification, in addition to the three days provided for such notice as required by Section 4903(3) of the New York Public Health Law.

It is recommended that HNNY comply with Section 4903(3) of the New York Public Health Law by updating its policy on concurrent utilization review to provide that the utilization review determination by phone and in writing be performed within one business day of the receipt of the necessary information.

(iii) Retrospective Appeals

Section 4904(1) of the New York Public Health Law states:

“An enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider, may appeal an adverse determination rendered by a utilization review agent.”

A review of the HMO's appeals policy indicated that HNNY requires the member's consent in order for the provider to proceed with the appeal process in regard to adverse determinations on retrospective reviews. However, Section 4904(1) of the New York Public Health Law allows the provider to appeal adverse determinations without the member's consent for retrospective utilization reviews.

It is recommended that HNNY update its policy on retrospective appeals so that it is in compliance with Section 4904(1) of the New York Public Health Law and allow the enrollee's health care provider to appeal without the member's consent.

D. Grievances and Appeals

(i) Provider Grievances

The HMO's Administrative and Clinical Appeals Process and Administrative Appeal (Grievance) process for New York providers indicates the following:

“Health Net shall issue a final determination letter within 60 days of receipt of all of the information necessary to reach a determination.”

A total of 20 provider grievance files were selected and reviewed by the examiner to review compliance of the HMO's grievance policy and procedures. For five files, the HMO did not issue the final determination letter within 60 days of the receipt of the grievance as required by its own policy.

It is recommended that HNNY comply with its grievance policy by issuing the final determination letter in a timely manner (within 60 days), in compliance with its policy.

(ii) Member Appeals

A total of twenty member appeal files were selected by the examiner to review compliance with Section 4408-a of the New York Public Health Law and the HMO's policy and procedures.

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

“Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgement of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.”



Section B(2) of Part I, Internal Grievance Process, of the HMO's *New York Commercial Grievance Review Policy & Procedure: AG-01*, states in part:

“Health Net will issue an acknowledgement letter within fifteen (15) business days of the receipt of a grievance...”

For five appeal files reviewed by the examiner, the HMO failed to provide the written acknowledgement of the grievance within fifteen business days of receipt, in violation of its own policy and Section 4408-a(9) of the New York Public Health Law.

It is recommended that HNNY comply with Section 4408-a(9) of the New York Public Health Law and its appeal policy by providing a determination of coverage within thirty days after the receipt of all necessary information.

Section 4408-a(11) of the New York Public Health Law states, in part:

“(11) The organization shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than...  
(ii) thirty business days after the receipt of all necessary information in all other instances.”

Section B(6) of Part I, Internal Grievance Process, of the HMO's *New York Commercial Grievance Review Policy & Procedure: AG-01*, states in part:

“Health Net will issue its determination as follows:  
Post-service claims: Within 30 calendar days from receipt of the grievance.”

For two appeal files reviewed by the examiner, the HMO failed to provide a determination of coverage within thirty calendar days after the receipt of all necessary information, in violation of its appeal policy as well as Section 4408-a(11) of the New York Public Health Law.

It is recommended that HNNY comply with Section 4408-a(11) of the New York Public Health Law and its appeal policy by resolving all appeals in an expeditious manner (30 days).

E. Retro-termination of Policies

As noted previously in this report, effective June 1, 2007, HNNY and its affiliate, Health Net Insurance of New York, Inc. (HNINY), terminated their joint venture, Healthcare Solutions, with the Guardian Life Insurance Company of America (Guardian), by purchasing Guardian's 50% interest in Healthcare Solutions. As result, premium payments for Healthcare Solutions products erroneously mailed to Guardian were to be forwarded to the HMO or its affiliate, HNINY. It is the HMO's policy to terminate insurance policies when premiums are not received within the grace period, which is 30 days after their due date.

A review of policyholder cancellations relative to the former Healthcare Solutions group members indicated that HNNY failed to promptly cancel the Guardian Healthcare Solutions policies when premiums were not received within the 30-day grace period, in accordance with its own policy and procedures. Instead, policies were "retro-terminated" up to 45 days or more, back to the last day for which premiums were paid in full. The members were harmed by this since the HMO also stopped paying claims incurred during the retro-period.

The abovementioned action resulted in complaints being received by the Department's Consumer Services Bureau (CSB). Further inquiry by the CSB indicated that a total of 386 groups were not promptly terminated in accordance with the HMO's own policy. This issue has been remediated by the HMO, following CSB's recommendations. Claims affected by the improper retro-terminations were subsequently paid.

In addition, a review of policyholder terminations for five direct pay and twenty-seven Healthy NY contracts indicated that the HMO failed to promptly terminate one direct pay policy and one Healthy NY policy when the premium was not received within the 30-day grace period. Both policies were retro-terminated 48 or more days, back to the last day for which premiums were paid in full.

It is recommended that HNNY promptly terminate policies when premiums are not received within the allowed grace period. It is also recommended that the HMO review and pay all appropriate claims between the period the premium was paid and the date the policy was terminated.

F. Disclosure of Information

Section 4324(a)(3) of the New York Insurance Law states in part:

- “...a description of utilization review policies and procedures, used by the corporation, including:
- (A) the circumstances under which utilization review will be undertaken;
  - (B) the toll-free telephone number of the utilization review agent;
  - (C) the time frames under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;
  - (D) the right to reconsideration;
  - (E) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;
  - (F) the right to designate a representative;
  - (G) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;
  - (H) a notice of the right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this chapter of the external appeal process established pursuant to title two of article forty- nine of this chapter and the time frames for such appeals; and
  - (I) further appeal rights, if any...;”

A review of HNNY's Evidences of Coverage sent to members of its group policies indicated that the HMO failed to comply with Section 4324(a)(3)(D) of the New York Insurance Law when its disclosure of information failed to include the member's right to reconsideration, in its description of its utilization review policy and procedures.

It is recommended that HNNY amend its disclosure of information to comply with Section 4324(a)(3)(D) of the New York Insurance Law by including the right to reconsideration, under the description of its utilization review policy and procedures.

A review of HNNY's direct pay contracts indicated that the HMO did not disclose the determination time frames for prospective, retrospective, and concurrent utilization review cases.

It is recommended that HNNY amend its disclosure of information to comply with Section 4324(a)(3)(C) of the New York Insurance Law.

Section 4324(a)(7) of the New York Insurance Law states:

“(7) a description of the grievance procedures to be used to resolve disputes between the corporation and a subscriber, including: the right to file a grievance regarding any dispute between the corporation and a subscriber; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which subscribers may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;”

Section 4324(b) of the New York Insurance Law states:

“Each health service, hospital service, or medical expense indemnity corporation subject to this article, upon request of a subscriber or prospective subscriber shall:

- (1) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, and members of the corporation;
- (2) provide a copy of the most recent annual certified financial statement of the corporation, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;
- (3) provide a copy of the most recent individual, direct pay subscriber contracts;
- (4) provide information relating to consumer complaints compiled pursuant to section two hundred ten of this chapter;
- (5) provide the procedures for protecting the confidentiality of medical records and other subscriber information;
- (6) where applicable, to allow subscribers and prospective subscribers to inspect drug formularies used by such corporation; and provided further, that the corporation shall also disclose whether individual drugs are included or excluded from coverage to a subscriber or prospective subscriber who requests this information;
- (7) provide a written description of the organizational arrangements and ongoing procedures of the corporation’s quality assurance program, if any;
- (8) provide a description of the procedures followed by the corporation in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
- (9) provide individual health practitioner affiliations with participating hospitals, if any;
- (10) upon written request, provide specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the corporation might consider in its utilization review and the corporation may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the corporation, the subscriber or prospective subscriber shall only use the information for the purposes of assisting the subscriber or prospective subscriber in evaluating the covered services provided by the organization;
- (11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the corporation for participation in the corporation’s network for a managed care product; and
- (12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act.”

A review of the HNNY’s direct pay POS contract indicated that the HMO did not disclose its utilization review policies and procedures, grievance procedures, or information that can be provided upon the request of the insured, or prospective insured, in accordance with Sections 4324(a)(3), 4324(a)(7) and 4324(b) of the New York Insurance Law.

It is recommended that HNNY amend its disclosure of information to effect compliance with Sections 4324(a)(3), 4324(a)(7), and 4324(b) of the New York Insurance Law.

G. Agents and Brokers

Section 4312(a)(1) of the New York State Insurance Law states:

“Every corporation subject to the provisions of this article may employ solicitors or accept business from agents and brokers on a commission basis, but all solicitors shall be paid on a salary basis only. It is expressly provided such solicitors are exempt from obtaining a license. Commissions shall be included in the corporation's rate manual and rate filings and commissions payable by health maintenance organizations organized under this article or health maintenance organizations operating as a line of business of corporations organized under this article shall continue to be subject to existing regulations governing commissions payable by health maintenance organizations.”

During the examination period, HNNY failed to include its commission schedule into its rate manual for small group and Healthy NY contracts filed with the Department in accordance with Section 4312(a)(1) of the New York Insurance Law.

It is recommended that HNNY comply with Section 4312(a)(1) of the New York Insurance Law by including its commission schedules into the rate manual for its small group and Healthy NY contracts filed with this Department.

H. Schedule H – Aging Analysis of Claims Unpaid

Department Circular Letter No. 12 (2000) states that Prompt Pay violations incurred by the insurer's third party administrators (TPAs) and its independent practice administrators (IPAs) are the direct responsibility of the HMO and should be recorded as such in all filings and reports to this Department, regardless of who actually pays the interest or processes the claim.

A review of the HMO's and its TPAs' and IPAs' (Health Net Pharmaceutical Services, Inc., OrthoNet, Inc., Managed Health Network Services IPA, Inc., Landmark Healthcare IPA of NY, Inc. and CareCore National, LLC.) prompt pay claims data for 2007 and the reconciliation to Schedule H – Aging analysis of claims unpaid, indicated that the following prompt pay violations were not reported in Schedule H during the examination period:

- Total number of late claims and the total amount of interest paid for institutional claims.
- Total number of late claims and the total amount of interest paid for the claims processed and paid by Health Net's TPAs and IPAs.

It is recommended that HNNY exercise due care to ensure that the information reported in its Schedule H is complete and accurate. It is also recommended that the HMO include accurate prompt pay results for its TPA claims in its filed Schedule H, as required by Department Circular Letter No. 12 (2000).

I. Department Circular Letter No. 9 (1999)

Department Circular Letter No. 9 (1999), dated May 25, 1999, "Adoption of Procedure Manuals", was issued to Article 43 corporations, Public Health Law Article 44 HMOs and Insurers licensed to write health insurance in New York State. It requires:

"...It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations..."

The HMO failed to obtain such certifications during the examination period.

It is recommended that HNNY comply with Department Circular Letter No. 9 (1999) by obtaining the required annual certifications.

J. Department Circular Letter No. 5 (2002)

Department Circular Letter No. 5 (2002) states in part:

“...It is imperative that the information posted on the Department’s Website accurately reflect the premium rate charged or quoted by each insurer or HMO. The rate pages on the Website are revised monthly and each insurer and HMO marketing any of the above products should institute procedures to check that the monthly rates posted on the Department’s Website are identical to the rates used by the insurer or HMO when billing or quoting...”

It was noted that the HMO did not have any procedures in place to check the accuracy of the monthly rates posted on the Department’s website, as required by Circular Letter No. 5 (2002).

It is recommended that HNNY comply with Department Circular Letter No. 5 (2002) by implementing a procedure to check the accuracy of the monthly rates posted on the Department’s Website.

K. Out-of-Network Claims

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

“No insurer doing business in this state shall engage in unfair claim settlement practices.”

In 2007, the Office of the New York Attorney General (OAG) received consumer complaints against HNINY, HNNY, and HNNE (collectively Health Net) regarding its practice of covering in-network facilities and providers under the out-of network benefits when a point-



of-service member was admitted by an out-of-network provider. These members were therefore responsible for higher coinsurance and deductible payments.

Health Net indicated that the claims were adjudicated in accordance with the following provision in the Evidence of Coverage (EOC), the member contract:

“IMPORTANT NOTICE: Except in an Emergency or a second medical opinion for cancer, all Covered Services outlined in this EOC must be provided and arranged by an Advantage Platinum Physician or Advantage Platinum Specialty Provider or with Prior Authorization by us.”

The OAG initiated an investigation and concluded that Health Net’s EOC for its point-of-service products, failed to adequately disclose Health Net’s practice of covering an in-network facility under the out-of-network benefits, when the member is admitted to that facility by an out-of-network provider. As such, Health Net’s EOCs for its point-of-service product have a capacity to mislead consumers. The OAG found that Health Net was in violation of Section 63(12) of the New York Executive Law, Section 349(a) of the New York General Business Law, and Section 2601(a) of the New York Insurance Law.

It is recommended that the HMO comply with the requirements of Section 2601(a) of the New York Insurance Law by revising its claims processing policy and discontinuing its practice of covering in-network facilities under the out-of-network benefits when the service is arranged by an out-of-network provider.

It is noted that Health Net executed an Assurance of Discontinuance with the New York AG on June 4, 2009, in which it agreed to revise its policy and perform a claims remediation.

Health Net completed its remediation on all affected claims in September 2009.

L. Record Retention

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

“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. 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.”

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2(b)(8)) requires the maintenance of record for six calendar years or until after the filing of a report on examination, whichever is longer. The following violations of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2(b)(8)) by the HMO were noted by the examiner:

- The HMO was not able to provide a copy of the grievance resolution letter for one member’s grievance file.
- The HMO indicated that the letters were sent, however, it failed to document that determination letters were sent to the members and/or providers within one business day of receipt of the necessary information for concurrent utilization review files reviewed by the examiner.

It is recommended that HNNY maintain records in accordance with Part 243.2(b)(8) of Department Regulation No. 152.

M. Passport Contracts

It was noted in the previous market conduct examination report that the HMO’s passport contract requires that members obtain a referral to see any specialist other than an obstetrician or a gynecologist. This requirement was not enforced during calendar year 2001. On July 1 of that year, the HMO issued a directive to its claim adjudicators indicating that the requirement had been removed. This requirement, however, is still contained within the Health Net contract.

Health Net has an obligation to fully enforce its contract requirements or submit revisions to its member contracts for approval by the Department.

The previous market conduct report recommended that HNNY eliminate unenforced contract provisions from its member contracts.

It was noted that the HMO did not withdraw the unenforced contract provisions from its filing with this Department. It was also noted that the HMO had stopped selling group referral plans since 2007. Currently there are only 917 members enrolled in the NY Passport Direct Pay and Individual Plan.

It is recommended that HNNY withdraw unenforced contract provisions from its filings with this Department.

## **11. SUBSEQUENT EVENTS**

On July 20, 2009, Health Net, Inc. and UnitedHealth Group Incorporated entered into a Stock Purchase agreement to acquire the licensed subsidiaries of Health Net of the Northeast, Inc., which include HNNY.

This acquisition agreement was approved by the New York Insurance Department on December 11, 2009. Such agreement was approved previously by the Connecticut and New Jersey Insurance Departments.

## 12. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

There were twenty-seven (27) comments and recommendations from the prior market conduct report on examination as of December 31, 2001. They are repeated herein as follows (page numbers refer to the prior report):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<p>1. It is recommended that Health Net obtain the certifications suggested by Circular Letter No. 9 (1999) and obtain annual certifications (i) from either the Plan's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the Plan's general counsel a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with the applicable statutes, rules and regulations.</p> <p><i>The HMO has not complied with this recommendation. A similar recommendation is contained in this report.</i></p>	5
<p>2. It is recommended that the Plan prepare "report cards" for the New York entities outlining the timing and accuracy of claim processing.</p> <p><i>The HMO has complied with this recommendation.</i></p>	6
<p>3. It is recommended that paper claims inappropriately sent to Health Net instead of to the third party administrator ACS, be aged from the original received date instead of from the date the claim is received by ACS.</p> <p><i>The HMO has complied with this recommendation.</i></p>	7
<p>4. It is recommended that Health Net take steps to ensure it is in compliance with all aspects of new York Insurance Law Section 3224-a.</p> <p><i>The HMO has not complied with this recommendation. A similar recommendation is contained in this report.</i></p>	10

<b><u>ITEM NO.</u></b>		<b><u>PAGE NO.</u></b>
5.	It is recommended that the Plan calculate and pay the appropriate amount of interest only when it is due.  <i>The HMO has complied with this recommendation.</i>	11
6.	It is recommended that Health Net adjudicate all institutional claims on a line by line basis, paying or requesting additional information, as appropriate.  <i>The HMO has complied with this recommendation.</i>	16
7.	It is recommended that Health Net re-open all claims from members with Point of Service coverage that were denied for a lack of authorization and reconsider those claims using the member's out-of-network benefit. Further, where such claims are eligible for interest under New York's Prompt Pay law, such interest should be paid.  <i>The HMO has complied with this recommendation.</i>	16
8.	It is recommended that Health Net re-open all claims from clinics within participating hospitals and re-adjudicate those claims without any restrictions on the place of service.  <i>The HMO has complied with this recommendation.</i>	17
9.	It is recommended that Health Net retroactively pay all institutional claims that were denied for untimely filing during the period prior to its uniform enforcement of those rules.  <i>The HMO has not complied with this recommendation.</i>	18
10.	It is recommended that Health Net uniformly apply its policy regarding the timeliness of claim submitted by non-institutional providers.  <i>The HMO has complied with this recommendation.</i>	19

<u>ITEM NO.</u>		<u>PAGE NO.</u>
11.	It is recommended that Health Net adjudicate identical claims filed multiple times in the order of their receipt. In the event that an initial filing lacks sufficient information to process a claim, and a secondary submission is received prior to the adjudication of the original, then the original submission should be denied with an explanation indicating that that submission was incomplete, and referencing the claim that was paid.  <i>The HMO has complied with this recommendation.</i>	19
12.	It is recommended that Health Net eliminate unenforced contract provisions from its member contracts.  <i>The HMO has not complied with this recommendation. A similar recommendation is contained in this report.</i>	19
13.	It is recommended that Health Net reprocess claims denied as a result of delays in updating a provider's file.  <i>The HMO has complied with this recommendation.</i>	19
14.	It is recommended that Health Net re-adjudicate all claims found to be errors within the Department's adjudication sampling. Additionally, the Plan should pay interest on such claims when it is due.  <i>The HMO has complied with this recommendation.</i>	20
15.	It is recommended that Health Net have its Internal Auditors conduct a claims audit for the New York entities to ensure that policies and procedures are being properly applied.  <i>The HMO has complied with this recommendation.</i>	20
16.	It is recommended that the Plan re-open all claims with emergency room denials and offer subscriber appeals.  <i>The HMO has complied with this recommendation.</i>	21

<u>ITEM NO.</u>		<u>PAGE NO.</u>
17.	It is recommended that Health Net send a revision to its members clarifying member rights under New York Insurance Law.  <i>The HMO has complied with this recommendation.</i>	22
18.	It is recommended that Health Net ensure that the benefit screens on its claim system reflect the appropriate requirements for each level of care.  <i>The HMO has complied with this recommendation.</i>	22
19.	It is recommended that Health Net update its database on a regular basis to ensure that the most current data is utilized in establishing Usual, Customary and Reasonable reimbursement amounts.  <i>The HMO has complied with this recommendation.</i>	24
20.	It is recommended that all claims that were paid utilizing an outdated database for the period 1998 through the present be reprocessed utilizing the current charge that were in effect when the services were rendered.  <i>The HMO has complied with this recommendation.</i>	24
21.	It is recommended that Health Net comply with NY Insurance Law Section 3234(a) and send EOBs to its insureds or subscribers when claims from participating providers have been denied for administrative purposes such as “late filing”, “treatment not authorized”, and “missing CPT code”.  <i>The HMO has not complied with this recommendation.</i>	25
22.	It is recommended that Health Net comply with NY Insurance Law Section 3234(b)(3) and include an identification of the service for which the claim is made.  <i>The HMO has not complied with this recommendation. A similar recommendation is contained in this report.</i>	25

**ITEM NO.****PAGE NO.**

23. It is recommended that Health Net comply with NY Insurance Law Section 3234(b)(7) and include on its EOBs a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal or a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification is made. 26

*The HMO has partially complied with this recommendation. However, a similar recommendation is contained in this report.*

24. It is recommended that Health Net comply with the appropriate laws and include appeals language in all of its initial retroactive denials for medical necessity. 27

*The HMO has complied with this recommendation.*

25. It is recommended that Health Net comply with New York law and include the appropriate appeals language in all adverse determination notices sent to providers. 27

*The HMO has complied with this recommendation.*

26. It is recommended that Health Net establish a record retention policy in compliance with Part 243.2(b) of Department Regulation 152 (11NYCRR243), and maintain all records for a minimum of six years. 28

*The HMO has complied with this recommendation.*

27. It is recommended that the Company comply with Circular Letter No. 5 (2002) and ensure that the rates posted on the Department website are accurate. 29

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



There were twenty (20) comments and recommendations from the prior report as of September 30, 2003. They are repeated herein as follows (page numbers refer to prior report):

<b><u>ITEM NO.</u></b>	<b><u>PAGE NO.</u></b>
<p>1. 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 meeting consistently should resign or be replaced.</p> <p><i>The HMO has complied with this recommendation.</i></p>	5
<p>2. 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.</p> <p><i>The HMO has complied with this recommendation.</i></p>	5
<p>3. 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.</p> <p><i>The HMO has not complied with this recommendation. A similar recommendation is contained in this report.</i></p>	6
<p>4. It is recommended that the Plan comply with the provisions of Part 98-1.10(c) (10 NYCRR 98-1.10(c)) and Part 98-1.11(b) (10 NYCRR 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.</p> <p><i>The HMO has complied with this recommendation.</i></p>	12
<p>5. 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.</p> <p><i>The HMO has complied with this recommendation.</i></p>	12

**ITEM NO.****PAGE NO.**

6. 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 (10 NYCRR 98-1.10(c)). A similar recommendation was made in the prior report on examination. 12

*The HMO has complied with this recommendation.*

7. 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 practice consistently applied. 18

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

8. It is also recommended the Plan comply with the provision 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

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

9. 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

*The HMO has complied with this recommendation.*

10. It is also recommended the board of directors adhere to its fiduciary responsibility by properly overseeing and handling any conflicts disclosed. 21

*The HMO has complied with this recommendation.*

**ITEM NO.****PAGE NO.**

- |     |  |       |
|-----|--|-------|
| 11. | 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    |
|     | <i>The HMO has complied with this recommendation.</i>  |       |
| 12. | 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 Examiner's Handbook of the <i>National Association of Insurance Commissioners</i> .   | 22-23 |
|     | <i>The HMO has not complied with this recommendation. A similar recommendation is contained in this report.</i>  |       |
| 13. | 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    |
|     | <i>The HMO has complied with this recommendation</i>   |       |
| 14. | 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    |
|     | <i>The HMO has complied with this recommendation.</i>  |       |
| 15. | 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    |
|     | <i>The HMO has complied with this recommendation.</i>  |       |
| 16. | 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 to submit such plan to the Superintendent for approval.   | 26    |
|     | <i>The HMO has complied with this recommendation.</i>  |       |

<u>ITEM NO.</u>		<u>PAGE NO.</u>
17.	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>The HMO has not complied with this recommendation.</i>	
18.	It is recommended that the Plan comply with the terms and conditions of the fraud plan approval letter dated September 16, 2004.	38
	<i>The HMO has complied with this recommendation.</i>	
19.	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
	<i>The HMO has complied with this recommendation.</i>	
20.	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.	39
	<i>The HMO has complied with this recommendation.</i>	

### 13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. <u>Management and Controls</u></p> <p>It is recommended that the HMO comply with Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department and its own by-laws, by maintaining at least 20 percent of its board members with enrollees.</p> <p>A similar recommendation was made in the prior report on examination.</p>	<p>7</p>
<p>B. <u>Holding Company System</u></p> <p>i. It is recommended that the HMO comply with the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and obtain the prior approval of the Commissioner of Health and the Superintendent of Insurance for all administrative services agreements that the HMO enters into with other members of its holding company system that involve five-percent or more of its prior year-end admitted assets. Thirty-day prior notice to the Commissioner and the Superintendent is required for services rendered on a regular or systematic basis that involve less than five-percent of its prior year-end admitted assets, before implementing such agreements.</p> <p>ii. It is recommended that the HMO comply with the provisions of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and obtain the prior approval of the Commissioner of Health and the Superintendent of Insurance for all pharmacy benefits management services agreements that the HMO enters into with other members of its holding company system that involve five-percent or more of its prior year-end admitted assets. Thirty-day prior notice to the Commissioner of Health and the Superintendent of Insurance is required for services rendered on a regular or systematic basis that involve less than five-percent of its prior year-end admitted assets, before implementing the agreements.</p>	<p>12</p> <p>13-14</p>

<u>ITEM</u>	<u>PAGE NO.</u>
iii. It is recommended that the HMO comply with the provisions of Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(a)) by obtaining the pharmacy rebates from HNPS and by ensuring that the contractual terms regarding the financial transactions of its pharmacy benefits management services agreements are fair and equitable.	14
C. <u>Accounts and Records</u>	
i. It is recommended that the HMO amend its custodial agreements with the Bank of New York and the Bank of America to include the requisite safeguards as set forth by the New York Insurance Department and as included within the guidelines of the <i>Financial Condition Examiners Handbook of the National Association of Insurance Commissioners</i> .	16
ii. It is recommended that HNNY record direct expenses in accordance with Paragraph 9 of SSAP No. 70 of the NAIC Accounting Practices and Procedures Manual.	18
iii. It is also recommended that expenses incurred be allocated to the HMO on an equitable basis, in accordance with Part 98-1.10(a)(3) of the Administrative Rules and Regulations of the New York Health Department.	18
iv. It is recommended that HNNE and HNNY continue to review and refine the allocation methodologies used to distribute expenses across cost centers.	18
v. It is recommended that HNNY disclose all required financial information relative to its ASO business, including the gross reimbursement for medical costs incurred relative to its ASO business within the “Notes to the Financial Statements” section of its annual statement filings, in accordance with Paragraph 12(b) of SSAP No. 47 of the NAIC Accounting Practices and Procedures Manual.	19
vi. It is recommended that HNNY charge adequate rates relative to its ASO business.	20

<u>ITEM</u>	<u>PAGE NO.</u>
vii. It is recommended that the Plan exercise due care to ensure that the information reported within its filed Data Requirements Statements is accurate. It is also recommended that the HMO properly segregate and report its large and small groups within its statements filed with this Department.	20
D. <u>Health Care and Other Amounts Receivable</u>	
i. It is recommended that the HMO consider reporting the amounts due relative to pharmacy rebates within the “Receivables From Parent, Subsidiaries and Affiliates” account of its filed quarterly and annual statements.	24
ii. It is also recommended that the HMO comply with SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual and report such pharmacy rebates as a reduction to claims expenses in its filed quarterly and annual statements.	25
E. <u>Premium Deficiency Reserve</u>	
It is recommended that HNNY comply with the provisions of paragraph 18 of the Statements of Statutory Accounting Principles No. 54 of the NAIC Accounting Practices and Procedures Manual 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 all loss contracts, even if the contract period has not yet started.	27
F. <u>Prompt Pay Law</u>	
i. It is recommended that HNNY take steps to ensure compliance with Sections 3224-a(a), and (c) of the New York Insurance Law.	31
ii. It is recommended that HNNY take steps to ensure compliance with Sections 3224-a(b) of the New York Insurance Law.	32
G. <u>Explanation of Benefits Statements</u>	
It is recommended that HNNY issue EOBs that are in compliance with the requirements of Sections 3234(b)(3), (b)(6) and (b)(7) of the New York Insurance Law.	34

<u>ITEM</u>	<u>PAGE NO.</u>
H. <u>Utilization Review</u>	
i. It is recommended that the HMO comply with the provisions of Section 4903(2) of the New York Public Health Law and provide notice of determinations by telephone and in writing within three business days of receipt of necessary information for all utilization review determinations requiring pre-authorization.	35
ii. It is recommended that HNNY comply with Section 4903(3) of the New York Public Health Law by updating its policy on concurrent utilization review to provide that the utilization review determination by phone and in writing be performed within one business day of the receipt of the necessary information.	36
iii. It is recommended that HNNY update its policy on retrospective appeals so that it is in compliance with Section 4904(1) of the New York Public Health Law and allow the enrollee's health care provider to appeal without the member's consent.	36
I. <u>Grievances and Appeals</u>	
i. It is recommended that HNNY comply with its grievance policy by issuing the final determination letter in a timely manner (within 60 days), in compliance with its policy.	37
ii. It is recommended that HNNY comply with Section 4408-a(9) of the New York Public Health Law and its appeal policy by providing a determination of coverage within thirty days after the receipt of all necessary information.	38
iii. It is recommended that HNNY comply with Section 4408-a(11) of the New York Public Health Law and its appeal policy by resolving all appeals in an expeditious manner (30 days).	39
J. <u>Retro-termination of Policies</u>	
It is recommended that HNNY promptly terminate policies when premiums are not received within the allowed grace period. It is also recommended that the HMO review and pay all appropriate claims between the period the premium was paid and the date the policy was terminated.	40



<u>ITEM</u>	<u>PAGE NO.</u>
K. <u>Disclosure of Information</u>	
i.    It is recommended that HNNY amend its disclosure of information to comply with Section 4324(a)(3)(D) of the New York Insurance Law by including the right to reconsideration, under the description of its utilization review policy and procedures.	41
ii.   It is recommended that HNNY amend its disclosure of information to comply with Sections 4324(a)(3)(C) of the New York Insurance Law.	41
iii.  It is recommended that HNNY amend its disclosure of information to effect compliance with Sections 4324(a)(3), 4324(a)(7), and 4324(b) of the New York Insurance Law.	43
L. <u>Agents and Brokers</u>	
It is recommended that HNNY comply with Section 4312(a)(1) of the New York Insurance Law by including its commission schedules into the rate manual for its small group and Healthy NY contracts filed with this Department.	43
M. <u>Schedule H – Aging Analysis of Claims Unpaid</u>	
It is recommended that HNNY exercise due care to ensure that the information reported in its Schedule H is complete and accurate. It is also recommended that the HMO include accurate Prompt Pay results for its TPA claims in its filed Schedule H, as required by Department Circular Letter No. 12 (2000).	44
N. <u>Department Circular Letter No. 9 (1999)</u>	
It is recommended that HNNY comply with Department Circular Letter No. 9 (1999) by obtaining the required annual certifications.	45
O. <u>Department Circular Letter No. 5 (2002)</u>	
It is recommended that HNNY comply with Department Circular Letter No. 5 (2002) by implementing a procedure to check the accuracy of the monthly rates posted on the Department’s Website.	45

<b><u>ITEM</u></b>		<b><u>PAGE NO.</u></b>
P.	<u>Out of Network Claims</u>	
	It is recommended that the HMO comply with the requirements of Section 2601(a) of the New York Insurance Law by revising its claim processing policy and discontinuing its practice of covering in-network facilities under the out-of-network benefits when the service is arranged by an out-of-network provider.	46
Q.	<u>Record Retention</u>	
	It is recommended that HNNY maintain records in accordance with Part 243.2(b)(8) of Department Regulation No. 152.	47
R.	<u>Passport Contracts</u>	
	It is recommended that HNNY withdraw unenforced contract provisions from its filings with this Department.	48

Appointment No. 30209

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, **Eric R. Dinallo**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Jo-Lo Hsia**

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 condition of the said

**Plan**

with such information as she shall deem requisite.

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

this 25<sup>th</sup> day of September, 2008



Eric R. Dinallo  
Superintendent of Insurance

