REPORT ON EXAMINATION

OF

GHI HMO SELECT, INC.

AS OF

DECEMBER 31, 2003

DATE OF REPORT **OCTOBER 28, 2005**

EXAMINER **KAIWEN K. GUO**

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

George E. Pataki
Governor

Howard Mills
Superintendent

October 28, 2005

Honorable Howard Mills
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 22138, dated January 30, 2004, annexed hereto, I have made an examination into the condition and affairs of GHI HMO Select, Inc. (D/B/A GHI HMO), a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law, as of December 31, 2003, and submit the following report thereon.

The examination was conducted at the Plan's home office, located at 789 Grant Ave, Lake Katrine, New York.

Wherever the terms "the Plan", "the HMO" or "GHI HMO" appear herein, without qualification, they should be understood to indicate GHI HMO Select, Inc. Wherever the terms "GHI" or "the Parent" appear herein, without qualification, they should be understood to indicate Group Health Incorporated, a health service corporation licensed under Article 43 of the New York Insurance Law, the ultimate Parent of the Plan.

1. SCOPE OF EXAMINATION

The Plan was formed on June 1, 1999. This examination covered the three year period from January 1, 2001 through December 31, 2003. 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 December 31, 2003 in accordance with Statutory Accounting Principles (SAP), as adopted by the Department. A review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners' Handbook of the National Association of Insurance Commissioners:

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

This report on examination contains the significant findings of the examination and 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.

2. DESCRIPTION OF PLAN

The Plan was formed on June 1, 1999 as a for-profit health maintenance organization (HMO) licensed pursuant to Article 44 of the Public Health Law.

Effective June 1, 1999, GHI HMO entered into an agreement with WellCare of New York, Inc., a New York HMO to purchase commercial (non-government) membership along with certain assets and assumed certain liabilities under the GHI-WellCare Asset Purchase Agreement (Purchase Agreement). Pursuant to the Purchase Agreement, GHI, the ultimate Parent company, paid $4,781,100 for 22,811 commercial members. Also, effective June 1, 1999, GHI made a capital contribution to GHI HMO in the amount of $3,218,900. The total amount contributed by GHI in conjunction with the purchase and capital contribution was $8,000,000.

The Plan is a wholly-owned subsidiary of GHI Services, LLC, which is a wholly-owned subsidiary of GHI. As of the examination date, GHI HMO's operations consisted of non-government commercial business, New York State Family Health Plus and Healthy New York. In 2004, it commenced selling Medicaid and Child Health Plus.

The Plan operates as both an Independent Practice Association ("IPA") and a Direct Contract Model Article 44 HMO. Under the IPA Model, arrangements are entered into with regional health care delivery networks directly, or IPAs, which in turn contract with providers to render health care services to the HMO's enrollees. Under the Direct Contract Model, agreements are entered into directly with individual primary care physicians or physician groups for the provision of health care services.

A. Management and Controls

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board of directors consisting of not less than three members. As of the examination date, the board of directors was comprised of the following twelve members:

Name and Residence	Principal Business Affiliation
Frank J. Branchini New York, NY	Group Health Incorporated, President
Yvonne Burgess-Reed Latham, NY	New York State United Teachers, Director, Human Resources
Howard Jones Suffern, NY	CUNY Professor, Retired
Donna Lynne New York, NY	Group Health Incorporated, Chief Operating Officer
Thomas Martinelli* Poughkeepsie, NY	Independent Consultant
Susan Mathews* Niskayuna, NY	Independent Consultant
George McDonald Brooklyn, NY	Allied Printing Trades, President (Labor leader)
David Mesches, MD New Paltz, NY	The Medical Center of New Paltz, Chief Executive Officer
John Nelson* Saratoga Spring, NY	Retired
Regis Obijiski** Kingston, NY	New Horizons, President
Daniel Rubino Bedford, NY	Wilkie, Farr, Gallagher, Attorney (Partner)
Bernard Schayes New York, NY	Physician

* Enrollee representative – Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(f)) requires that a minimum of twenty percent (20%) of the board of directors of an HMO be comprised of enrollee representatives. The Plan is in compliance with said Regulation.

** Regis Obijiski was elected to the board in November 2003, but did not attend his first meeting until 2004. He subsequently resigned from the board.

The minutes of all meetings of the board of directors and committees thereof held during the examination period were reviewed. All meetings were well attended.

The examination noted that Plan management regularly receives reports summarizing the operations of the Plan. Further, the board appears to be in compliance with the requirements of Circular Letter No. 9 (1999) – Adoption of Procedures Manuals.

The principal officers of the Plan as of December 31, 2003, were as follows:

Name	Title
Frank Joseph Branchini	President
William Mastro	Secretary
William Guerci	Treasurer
John Williamson Baackes	Executive Director

The Plan's by-laws requires that it hold an annual shareholder's meeting within five months of its fiscal year end, and allow for special meetings to be held as desired. It was noted by the examiner that the Plan did not hold the required annual meeting within this five month period for any year during the examination period. The Plan's Corporate Secretary indicated that the shareholder meeting was not formally held since the Plan is held under a holding company system, with similar management and directors as its ultimate Parent.

It is recommended that the annual shareholder's meeting be held within the required five month period, or that a quorum of the Plan's board prepare a written resolution agreeing to waive the meeting (the by-laws of the Plan would need to be

amended to explicitly allow for this waiver) or modify the by-laws to change the timeframe within which to hold the meeting.

The Plan has a Conflict of Interest policy in place for employees and members of its board of directors. The policy requires that employees and members of the board complete annually, a questionnaire regarding activities or interests that might impair or have the appearance of impairing independence of judgment.

It was noted during the examination that one board member, Thomas Martinelli, shared in the ownership of a publishing company, Suburban Publishing, Inc. ("Suburban"), which entered into an advertising contract with the Plan. As a condition of this contract, the Plan provided health insurance to Suburban in exchange for advertising. This arrangement was "inherited" from Wellcare of New York, Inc. when the Plan took over its business in June 1999. This matter is further detailed in Section G herein. Though Mr. Martinelli appeared to comply with the Plan's Conflict of Interest policy when he noted in his 2001 Conflict of Interest Questionnaire that GHI HMO bought advertising space in his publication, the full nature of the business relationship and resulting contractual arrangement was not detailed. It should be noted that the aforementioned arrangement, whereby the Plan provided health insurance to Suburban in exchange for advertising was not discussed with the Plan's board of directors.

It was noted that Mr. Martinelli did not complete a conflict of interest statement for 2002. The Plan reported that he terminated his relationship with Suburban in 2002, though he remained on the Plan's board and completed a conflict of interest statement for

2003. The Plan further stated that the arrangement with Suburban was terminated on June 30, 2004.

It is recommended that business transactions directly or indirectly involving board members and the Plan, particularly where a potential conflict of interest is noted on a filed questionnaire, should be discussed with and approved by the Plan's board or appropriate committee.

B. Territory and Plan of Operation

As of December 31, 2003, the Plan held a certificate of authority to operate in the following counties of New York State:

Albany	Greene	Queens	Ulster
Bronx	Kings	Rensselaer	Warren
Broome	Montgomery	Rockland	Washington
Columbia	New York	Saratoga	Westchester
Delaware	Orange	Schenectady	Nassau
Dutchess	Otsego	Schoharie	Richmond
Fulton	Putnam	Sullivan	Suffolk

As of the examination date, GHI HMO's operations consisted of non-government commercial business, New York State Family Health Plus and Healthy New York. In 2004, it commenced selling Medicaid and Child Health Plus. In addition to its standard HMO contracts, the Plan offers a Point of Service (POS) product whereby it covers the out-of-plan benefits. GHI HMO acted in compliance with the requirements of Section 4406 of the New York Public Health Law, in regard to the maximum amount of out-of-plan benefits it covered.

During the period January 1, 2001 through December 31, 2003, the HMO experienced a net increase in enrollment of 7,155 members. An analysis of the increase in enrollment is set forth below:

	2001	2002	2003
Enrollment at January 1	28,491	29,759	33,154
Net gain	1,268	3,395	2,492
Enrollment at December 31	29,759	33,154	35,646

C. Reinsurance

As of the examination date, the Plan had one reinsurance agreement, with Allianz Life Insurance Company of New York (Allianz), previously known as Preferred Life Insurance Company of New York. The Plan's previous coverage with Allianz, lapsed on November 30, 2002, and a new policy was placed effective December 1, 2002 through December 1, 2003. A new policy was executed with Allianz, effective December 1, 2003 through December 31, 2003. Subsequently, another agreement with Allianz was initiated, effective January 1, 2004 through December 31, 2004. All of the above reinsurance agreements cover Commercial HMO, Commercial Point of Service (in and out-of-network), and the Family Health Plus lines of business. The limits of coverage are as follows: 90% in excess of $100,000 per Member per Year for both HMO and POS members, subject to a $2,000,000 lifetime cap.

The examination review revealed that none of the reinsurance agreements noted above included the “Continuity of Benefits” and “Conversion Coverage” provisions as required by Department guidelines. Further, the “Out-of-Area Conversion Coverage” provision contained in the agreements was not in compliance with Department guidelines.

The Continuity of Benefits provision shall provide for the following:

> a. “Benefits would continue for any HMO member confined to an acute care hospital until discharge, and
>
> b. Benefits would continue for any HMO member until the end of the contract period for which premiums have been paid.”

The requisite Conversion Coverage provision shall include the following:

> “Upon the insolvency of the HMO as determined by a court of competent jurisdiction, this reinsurer must make available to all HMO members, for a period of 31 days, without evidence of insurability, an A&H conversion contract that is customarily issued at the then current rates by the assuming reinsurer."

The Out-of-Area Conversion Coverage provision shall include the following:

> "Also, in the event that an HMO member moves outside the service area of the HMO, the HMO member shall have the right, for a period of 31 days, without evidence of insurability to purchase a conversion A&H indemnity contract customarily issued by the assuming reinsurer at the then current rate."

The current contract allows for a period of 30 days.

It is recommended that the Plan amend its reinsurance agreement to include proper Continuity of Benefits and Conversion Coverage provisions.

It is further recommended that the Plan amend the Out-of-Area Conversion Coverage provision to allow for 31 days to purchase conversion contracts.

D. Holding Company System

The Plan is determined to be a controlled HMO under the definitions set forth in Part 98-1.2(l) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.2(l)). The Plan filed the holding company documents required by Part 98.1-16(e) of the Administrative Rules and Regulations of the Health Department during the examination period.

The Plan is a wholly-owned subsidiary of GHI Services, LLC, which in turn is a wholly-owned subsidiary of GHI.

The following is the organizational chart of the holding company system as of December 31, 2003:

During 2003, GHI made capital contributions to the Plan totaling $1.7 million. Since commencement of business, GHI has made accumulated capital contributions of $21,215,000. The Plan shows in its balance sheet an amount of $5,350,000 for surplus notes (Section 1307 Loans), which the Plan properly shows in a footnote in its annual statement.

The Plan is party to three agreements with members of its holding company system, detailed as follows:

(1) Management Services Agreement
(2) Administrative Services Agreement
(3) Tax Allocation Agreement

Further, GHI guarantees the Plan's payment obligations under four equipment lease agreements.

Management Services Agreement

The Plan has a Management Services Agreement with GHI, its ultimate Parent. The Agreement was effective June 9, 1999, and was in effect for the entire period under examination. According to the terms of the Management Services Agreement, GHI is to provide certain functions to the Plan. Such services include: Underwriting and Actuarial, Legal, Human Resources and Payroll, Internal Auditing, Anti-Fraud Program, Disaster Recovery, Medical Director, and other services as agreed to by the parties.

The Management Services Agreement does not appear to fully comply with the provisions set forth in Part 98-1.11(h)(4) of the Administrative Rules and Regulations of the Health Department as follows:

Part 98-1.11(h)(4) of the Administrative Rules and Regulations of the Health Department states in part:

> "(h) Management contracts shall be effective only with the prior written consent of the commissioner, and shall include the following:
>
> (4) a plan for assuring maintenance of the fiscal stability, the level of services provided and the quality of care rendered by the HMO during the management contract;"

The Management Services Agreement did not have a provision regarding such plan as required by Part 98-1.11(h)(4).

Part 98-1.11(h)(7) of the Administrative Rules and Regulations of the Health Department states in part the following:

> "(h) Management contracts shall be effective only with the prior written consent of the commissioner, and shall include the following:
>
> (7) specification of payment terms that are reasonable and do not jeopardize the financial security of the HMO."

The Management Services Agreement sets forth a provision for management fees in Exhibit A of the Agreement. This provision is not in full compliance with Part 98-1.11(h)(7) of the Administrative Rules and Regulations of the Health Department in that it does not specify a payment term as required by such Regulation.

Part 98-1.11(l) of the Administrative Rules and Regulations of the Health Department states in part that:

> "The term of a management contract shall be limited to five years and may be renewed only when authorized by the commissioner…"

In accordance with Part 98-1.11(l) of the Administrative Rules and Regulations of the Health Department, the Management Services Agreement expired in June 2004, however, the Plan continued to operate under the terms of this "expired" agreement. During the on-site review, the Plan indicated that due to a number of new programs, the Management Services Agreement was being revised.

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

Administrative Services Agreement

As of the examination date, the Plan also had an Administrative Services Agreement with GHI. The effective date of the Agreement is January 1, 2003 and the term of the Agreement is for one year. The Administrative Services Agreement requires that the Plan provide certain services for GHI's Medicare+Choice PPO product. These services include the administration for hospital claims payments, record-keeping services, enrollment, and calculation of benefits.

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

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

The examination determined that during 2003, the Plan billed GHI an aggregate amount of $6,732,731, which exceeded ten percent (10%) of the Plan's admitted assets, reported at last year-end. However, the Administrative Service Agreement was not submitted for approval to either the Department of Health or the Insurance Department.

It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10(c)) and submit its Administrative Services Agreement to the Commissioner of Health and the Superintendent of Insurance for review and approval.

Tax Allocation Agreement

The Plan entered into an Inter-company Tax Allocation Agreement that was effective the first day of June 1999. This Agreement stipulates that the ultimate Parent company (GHI) will compute and pay the consolidated Federal income tax liability for the group and will prepare and file the consolidated Federal income tax return for the group.

The Plan maintains that the Tax Allocation Agreement was submitted in 1999 as part of the expedited licensing process during the acquisition of Wellcare of New York, Inc. ("WCNY").

Although the Tax Allocation Agreement meets Department guidelines, it is recommended that the Agreement be formally re-submitted to this Department and the Department of Health for review, and that a formal approval be obtained from each Department.

E. Significant Operating Ratios

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

	Amounts	Ratios
Claims incurred	$198,040,256	89%
Claims adjustment expenses incurred	10,279,468	5%
General administrative expenses incurred	27,333,392	12%
Net underwriting loss	(11,927,096)	(6%)
Premiums earned	$223,726,020	100.0%

F. Investment Activities

The Plan maintains its cash in two overnight sweep accounts. Funds held to meet its escrow requirements are held in a Merrill Lynch Fund that is comprised solely of U.S. Treasury Bonds. Bonds totaling $9,246,194 are the Plan's largest balance sheet asset as of December 31, 2003, representing 41% of its total admitted assets. Cash and short-term investments account for $2,781,854, or 12% of total admitted assets.

Section 1404(a)(10)(B)(i) of New York Insurance Law states in part:

> "(B) Investments made by an insurer subject to the provisions of paragraph two of subsection (a) or subsection (b) of section one thousand four hundred three of this article shall not exceed the following limitations:
>
> (i) in any investment company qualifying under item (i) of subparagraph (A) hereof, ten percent of such insurer's admitted assets as shown by its last statement on file with the superintendent and the aggregate amount of investment in such qualifying investment companies shall not exceed twenty-five percent of such insurer's admitted assets as shown by its last statement on file with the superintendent…"

The examination revealed that the Plan had investments in the JP Morgan U.S. Government Money Market Fund in the amount of $3,066,667, which represented 15.09% of admitted assets as shown by the last statement on file (September 30, 2003) at the time of purchase.

Investments that do not qualify or are not permitted under Section 1404(a) are acceptable under Section 1404(b) of the Insurance Law (the "Leeway provision") to the extent such investments do not exceed five percent of the admitted assets as shown by the last statement on file. Section 1404(b) of the Insurance Law states in part:

> "(b) Investments which do not qualify or are not permitted under subsection (a) hereof, but excluding any investment prohibited by the provisions of paragraph six of subsection (a) of this section or by the provisions of paragraph one, two, three, four, six, eight, nine or ten of subsection (a) of section one thousand four hundred seven of this article, provided that:
>
> (1) the aggregate cost of such investments shall not exceed five percent of the admitted assets of the insurer as shown by its last statement on file with the superintendent…"

As of December 31, 2003, the amount of excess investment in the JP Morgan U.S. Government Money Market Fund was $18,644. Accordingly, the amount of Money

Market Investment the Plan could legally purchase under Sections 1404(a) and (b) of the New York Insurance Law was $3,048,023 ($3,066,667 less $18,644).

Section 1404 of the New York Insurance Law pertains to the purchase of securities. However, Section 1409(a) of the New York Insurance Law pertains to the maximum amount of such investment that is held as an admitted asset.

Section 1409(a) of New York Insurance Law states that:

> "(a) Except as more specifically provided in this chapter, no domestic insurer shall have more than ten percent of its admitted assets as shown by its last statement on file with the superintendent invested in, or loaned upon, the securities (including for this purpose certificates of deposit, partnership interests and other equity interests) of any one institution."

Accordingly, the maximum Money Market Investment that can be treated as an admitted asset per Section 1409(a) is $2,159,331. The additional $888,692 of the Money Market Fund Investment should be classified as a "non-admitted asset" as described in the following calculation:

Money Market Investment held as of 12/31/03	$3,066,667
Less: Section 1404(a) and (b) excess investment	(18,644)
Legal purchase of Money Market Investment	$**3,048,023**
Admitted Assets as of 12/31/2003	$22,481,998
Less: Accepted Money Market Investment	(3,048,023)
	$19,433,975
Divided by 90%:	0.90
Adjusted Admitted Assets as of 12/31/2003	$21,593,306
Multiplied by 10%	0.10
Maximum Money Market Investment per §1409(a)	$**2,159,331**
Money Market Investment	$3,048,023
Maximum Money Market Investment per §1409(a)	$2,159,331
Non admitted	**$888,692**

The $888,692 prospective non-admitted Money Market Investment could have resulted in an examination change in the Plan's financial statements impacting the Plan's net-worth as of December 31, 2003. However, subsequent to the examination date, the Plan provided documentation to the examiner showing that it closed its investment in the JP Morgan Money Market Fund, effective March 16, 2004. Based on the subsequent action, no change will be made to the Plan's financial statements contained herein.

It is recommended that the Plan comply with Sections 1404 and 1409(a) of the New York Insurance Law and not have investments in securities of any one institution in excess of ten percent of its admitted assets.

G. Accounts and Records

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

1. Section 12 of SSAP No. 84 states the following:

> "Income from pharmaceutical rebates of insured plans shall be reported as a reduction to claims expense on the summary of operations."

The examination revealed that while the Plan booked the pharmaceutical rebate as a healthcare receivable, it treated the account as revenue, rather than as a reduction to

claims expense. During 2003, the amount of pharmaceutical rebates recognized as revenue was $786,178.

Subsequent to the examination date (since the second quarter of 2004), the Plan has complied with the reporting requirements of Section 12 of SSAP No. 84.

2. As detailed in item 2A of this report, the Plan had an arrangement with Suburban Publishing, Inc. (Suburban) whereby the Plan provided a "credit" for healthcare premiums, and in turn the Plan received a "credit" towards advertising from Suburban for the same amount. This arrangement was “inherited” from Wellcare of New York, Inc. when the Plan took over its business in June 1999. In 2003, the Plan allowed a credit of approximately $42,000 for healthcare premiums, and in exchange, the Plan received credit towards advertising from Suburban for the same amount.

Suburban has a community rated group contract with the Plan and is "billed" in accordance with the Plan's regular group billing cycle. This activity is posted to the ledger via a debit to "Premiums Receivable" and credit to "Premium Revenue". Suburban's bills for advertisements are offset against amounts due from Suburban for the health insurance premium up to a fixed amount within a calendar year based on a budgeted projection. When an invoice is received from Suburban, the Plan “issues” an AP check payable to GHI HMO for the invoice dollar amount. This transaction is recorded to the ledger via a debit to advertising expense and credit to cash. The check is then entered into the cash receipts system as payment to the ledger via a debit to cash and credit to Premiums Receivable.

It appears that this "barter transaction" does not comply with Statutory Accounting Principles in that a bartered service is not recognized as an admitted asset under SSAP No. 4. In addition, bartered services are unavailable for payment of claims. Further, Section 4308(g) of the New York Insurance Law, which sets forth requirements for rate filings, implies that the approved rate should be in U.S. dollars, not bartered services.

The Plan stated that the arrangement with Suburban was terminated on June 30, 2004 and that no other similar arrangements have been entered into.

It is recommended that the Plan not enter into any barter or similar arrangements and that it comply with all applicable accounting principles and statutes when booking its premium accounts.

3. As of the examination date, the Plan recorded an asset, “Amount Due from Parent, Subsidiaries and Affiliates” in the amount of $762,165. The time frame of the settlement of the inter-company account set forth in the Administrative Services Agreement detailed in item D of this report calls for the settlement between GHI and GHI HMO to take place no later than 30 days from the date such amount becomes due. However, the Plan did not collect the balance owed it at December 31, 2003 from GHI until June 2004. By the time the money was collected, the receivable from GHI was allowed to accumulate to over $2 million (approximately 35% of the Plan’s net worth). According to Plan personnel, the normal time frame for settlement of this account with

GHI is every three to six months. This is contrary to the terms of the Administrative Services Agreement between the Plan and GHI.

It is recommended that the inter-company accounts be settled in a timely manner, in accordance with the terms set forth in the underlying agreement(s).

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2003. This is the same as the balance sheet filed by the Plan.

	Examination	Plan
Assets		
Current Assets:		
Bonds	$ 9,246,194	$ 9,246,194
Cash and short-term investments	2,781,854	2,781,854
Investment income due & accrued	135,199	135,199
Uncollected premiums	3,931,404	3,931,404
Reinsurance recoverable	341,271	341,271
Receivable from parent, affiliate	762,165	762,165
Health care receivable	338,040	338,040
Prepaid expenses	5,779	5,779
NYS Direct pay stop loss pool	546,907	546,907
Total current assets	18,088,813	18,088,813
Other Assets		
Goodwill	4,344,175	4,344,175
Security deposit & other	23,837	23,837
Total other assets	4,368,012	4,368,012
Property & Equipment		
EDP equipment	25,173	25,173
Total property & equipment	25,173	25,173
Total Assets	$22,481,998	$22,481,998

	Examination	Plan
Liabilities		
Claims unpaid	$13,307,595	$13,307,595
Unpaid claims adjustment expenses	559,812	559,812
Aggregate health policy reserves	117,694	117,694
Premiums received in advance	1,004,819	1,004,819
General expenses due and accrued	1,255,598	1,255,598
Amounts withheld or retained for the account of others	279,601	279,601
Total Liabilities	$16,525,119	$16,525,119
Net Worth		
Common capital stock	$ 10	$ 10
Gross paid in and contributed surplus	21,215,000	21,215,000
Surplus notes	5,350,000	5,350,000
NYS contingency reserve	2,739,501	2,739,501
NYS escrow deposit	3,013,499	3,013,499
Unassigned funds (surplus)	(26,361,131)	(26,361,131)
Total capital and surplus	5,956,879	5,956,879
Total liabilities, capital and surplus	$ 22,481,998	$ 22,481,998

Note 1: Pursuant to Section 1307 of the New York Insurance Law, no liability appears in the statement for loans in the amount of $5,350,000 of principal and $1,624,022 of interest accrued thereon. The principal and interest may be repaid only with the permission of the Superintendent of Insurance.

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

B. Statement of Revenue, Expenses and Net Worth

Reserves and unassigned funds increased by $2,223,406 during the examination period, January 1, 2001 through December 31, 2003, detailed as follows:

Revenue		
Premiums earned	$ 223,726,020	
Pharmacy rebate	1,555,439	
Net investment income	498,241	
Other income	29,674	
Total revenue		$ 225,809,374
Expenses		
Medical and hospital expenses		
Hospital/medical benefits	$ 133,867,969	
Outside referrals	14,029,276	
Emergency room, out-of-area	7,673,376	
Drug expense	35,651,482	
Other expense	7,881,884	
Less:		
Reinsurance expenses, net of recoveries	(1,063,731)	
Total Medical and hospital expenses	$ 198,040,256	
Plan Administration		
Claims adjustment expenses	10,279,468	
Administrative expenses	27,333,392	
Total expenses		235,653,116
Net loss before federal income taxes		(9,843,742)
Provision for Federal Income Tax		2,029,139
Net loss		$ (7,814,603)

Changes in Net Worth

	Gains in Net Worth	Losses in Net Worth	
Net worth per report on examination as of December 31, 2000			$ 3,733,473
Net income/(loss)		$ (7,814,603)	
Change in non-admitted assets		(815,186)	
Cumulative effect of change in accounting principle		(340,950)	
Change in Reserves and Unassigned Funds	13,574,000		
Changes in Contingency Reserve		(2,859,000)	
Change in Retained Earnings	479,145		
Net increase in net worth			2,223,406
Net worth per report on examination as of December 31, 2003			$ 5,956,879

4. CLAIMS PAYABLE

The examination liability of $13,307,595 is the same as that reported by the Plan in its filed Annual Statement as of December 31, 2003.

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 Plan's internal records and in its filed annual statements as verified during the examination.

5. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Plan 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 the Plan in the following major areas:

A. Claims processing
B. Prompt Pay
C. Explanation of benefits statements
D. Reimbursement of out-of-network claims (fee schedule)
E. Advertising

The following are the examiner's findings:

A. Claims Processing

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

The Plan receives its claims through both electronic submission and the U.S. Post Office. The Plan utilizes Web-MD as its electronic claims clearing house. Approximately 42% of medical claims were electronically submitted in 2003. However, all hospital claims were submitted through certified mail. For electronically submitted claims, the Plan counts the date the claims are received by the electronic clearinghouse as the date the claim was received. All claims received are assigned a 12 digit identification number. The first six digits indicate the date the claim was received. The seventh digit is a letter

which indicates whether the claim is received electronically ("T"), or through U.S. mail ("M"). The last five digits are the sequential claim number.

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

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

The term “claim” can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report: “claim” is defined by the Plan as a grouping of all line items (e.g. procedures or services) on any one claim form. It is possible, through the computer system used for this examination, to match or “roll-up” all procedures into one line, which is the basis of the Department’s statistical sample of claims or the sample unit. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data

reported by the Plan for the period January 1, 2003 through December 31, 2003, and included in its Annual Statement filed with the Department for calendar year 2003.

The examination review revealed that the overall claims processing financial accuracy level was 89.22% for Medical claims and 89.82% for Hospital claims. The overall claims processing procedural accuracy level is 85.03% for Medical claims and 87.43% for Hospital claims. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with the Plan's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such, it is counted both as a financial error and a procedural error. In summary, of the 167 Medical claims reviewed, 18 contained financial errors and there were 25 procedural errors; of the 167 Hospital claims reviewed, 17 contained financial errors and there were 21 procedural errors.

The following represents various errors noted by the examiners:

- Underpayment due to incorrect Revenue Code/Old Contract
- Applied incorrect co-pay
- Improper Denial
- Authorization issue
- Data entry errors
- (Under)/Over payment - Miscellaneous

It is recommended that the Plan take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider providing retraining to individuals who process claims.

The following tables summarize the claims processing errors:

Summary of Financial Accuracy

	Medical	**Hospital**
Claim Population	352,938	3,611
Sample Size	167	167
Claims with errors	18	17
Calculated Error Rate	**10.78%**	**10.18%**
Calculated Accuracy Rate	**89.22%**	**89.82%**
Upper Error Limit	15.48%	14.77%
Lower Error Limit	6.08%	5.59%
Calculated claims in error	**38,047**	**368**
Upper limit claims in errors	54,635	533
Lower limit in errors	21,459	202

Summary of Procedural Accuracy

	Medical	**Hospital**
Claims Population	352,938	3,611
Sample Size	167	167
Claims with Errors	25	21
Calculated Error Rate	**14.97%**	**12.57%**
Calculated Accuracy Rate	**85.03%**	**87.43%**
Upper Error Limit	20.39%	17.60%
Lower Error Limit	9.56%	7.55%
Calculated claims in error	**52,835**	**454**
Upper limit claims in errors	71,929	636
Lower limit claims in error	33,741	273

B. Prompt Pay

§3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

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

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

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> 1. that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> 2. to request all additional information needed to determine liability to pay the claim or make the health care payment."

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

> "(c) … any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim…When the amount of interest due on such a claim is less then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

In order to test the Plan's compliance with the above Prompt Pay Law, two statistical samples were drawn from the population of non-capitated claims that were not paid within 45 days of receipt during the period January 1, 2003 through December 31, 2003. The hospital sample consisted of 105 claims (this is the entire population of hospital claims paid after 45 days); and the medical sample consisted of 167 claims. The review disclosed compliance problems relative to Sections 3224-a(a), 3224-a(b), and 3224-a(c) of the New York Insurance Law, as summarized in the following tables:

New York Insurance Law Section 3224-a(a)

	Medical	**Hospital**
Over 45 days Population	6,611	105
Sample Size	167	105
Section 3224-a(a)* Violation	97	72
Calculated Error Rate	**58.08%**	**68.57%**
Calculated Accuracy Rate	**41.92%**	**31.43%**
Upper Error Limit	65.57%	77.45%
Lower Error Limit	50.60%	59.69%
Calculated claims in error	**3,840**	**72**
Upper limit claims in error	4,335	N/A
Lower limit claims in error	3,345	N/A

N/A – The projection of the error rate is not applicable, as the entire population of applicable claims was reviewed.

New York Insurance Law Section 3224-a(b)

	Medical	Hospital
Over 45 days Population	6,611	105
Sample Size	167	105
Section 3224-a(b) Violation	2	2
Calculated Error Rate	**1.20%**	**1.90%**
Calculated Accuracy Rate	**98.80%**	**98.10%**
Upper Error Limit	2.85%	4.52%
Lower Error Limit	0	0
Calculated claims in error	**79**	**2**
Upper limit claims in error	188	N/A
Lower limit claims in error	0	N/A

New York Insurance Law Section 3224-a(c)

	Medical**	Hospital***
Over 45 days Population	6,611	105
Sample Size	167	105
Section 3224-a(c)* Violation	52	51
Calculated Error Rate	**31.14%**	**48.57%**
Calculated Accuracy Rate	**68.86%**	**51.43%**
Upper Error Limit	38.16%	58.13%
Lower Error Limit	24.11%	39.01%
Calculated claims in error	**2,059**	**51**
Upper limit claims in error	2,523	N/A
Lower limit claims in error	1,594	N/A

* The violations of Section 3224-a(c) noted above directly relate to and should be considered a subset of the Section 3224-a(a) violations.

** Includes 34 claims affected by retroactive contract changes.

*** Includes 24 claims affected by retroactive contract changes.

N/A – The projection of the error rate is not applicable, as the entire population of applicable claims was reviewed.

The total number of Medical claims and Hospital claims adjudicated in 2003 were 352,938 and 3,611, respectively. The population of medical and hospital claims that took more than 45 days to pay in 2003 was 6,611 and 105, respectively.

It is recommended that the Plan create procedures to ensure that outstanding claims in its claims system be paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law.

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

It is also recommended that the Plan implement the necessary procedures to ensure compliance with §3224-a(b) of the New York Insurance Law and send out requisite notification within 30 days where applicable.

It is further recommended that the Plan comply with §3224-a(c) of the New York Insurance Law and calculate interest due on all claims paid after 45 days of receipt.

C. Explanation of Benefits Statements ("EOB")

As part of the review of the Plan's claims practices and procedures, an analysis of the EOB sent to subscribers and/or providers by the Plan was performed. An EOB is an important link between the subscriber, the provider, and the Plan. It should clearly communicate to the subscriber and/or provider that the Plan has processed a claim and

how that claim was processed. It should clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed to the provider. It should also serve as the documentation to recover any money from coordination of benefits with other carriers.

The samples selected for analyzing EOBs were the same Hospital claims sample and Medical claims sample used for the claims processing review noted in 5A above.

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

> "(a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits."

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

> "(c) Except on demand by the insured or subscriber, insurers, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer directly to the participating facility or provider."

The examination determined that the Plan did not send EOBs to subscribers for out-of-network claims, unless the denial of the claims resulted in the member's liability. This appears to be a violation of Section 3234(c) of the New York Insurance Law which requires that an EOB be sent for all out-of-network claims (whether such claim is fully paid or not).

It is recommended that the Plan comply with Section 3234(c) of the New York Insurance Law and send an EOB to its subscribers where the services are rendered by an out-of-network provider, regardless of whether the services are fully paid or not.

The examination also revealed that the Plan does not send EOBs to its members when claims submitted by its participating providers have been denied for administrative purposes, such as for late submission. Though in these cases the members are "held harmless" and are not responsible for payment, the Department's position is that because full reimbursement has not been made for these claims, EOBs should be provided to subscribers. This is to ensure that both parties involved are aware that the providers cannot attempt to collect any unpaid portion of the bill from the subscribers.

It is also recommended that the Plan comply with Section 3234(c) of the New York Insurance Law and send an EOB to the subscriber whenever a claim is denied or modified.

This matter regarding the issuance of EOBs was raised in the prior report on examination. At that time the Department and the Plan agreed that no action be taken on this matter pending issuance of industry-wide guidance. The Department issued Circular Letter No. 7 (2005) regarding Explanation of Benefits (EOB) Requirements on March 24, 2005. After reviewing this Circular Letter, GHI HMO established a task force to implement changes to its EOB statements.

D. Reimbursement of Out-of-Network Claims (Fee Schedule)

A rider to GHI HMO's contract with its enrollees regarding "Reimbursement for Out-of-Network Services or Benefits" states in part the following:

> "Reimbursement for out-of-network care is based upon GHI HMO's "Allowed Charge" for such care. The Allowed Charge is the amount GHI HMO will reimburse for covered services rendered by Non-Participating Providers. The Allowed Charge for covered services rendered by Non-Participating Providers is based upon a percentile of the *Health Insurance Association of America Prevailing Healthcare Charges System ("HIAA")* schedule in use by GHI HMO at the time your out-of-network claim is processed…"

The fee schedules utilized by the Plan are updated by HIAA (now known as Ingenix) twice a year to reflect updated charges; once to reflect primary updates and a subsequent one to reflect secondary changes. The Plan, however, only updates its systems once per year (primary update).

E. Advertising

The Plan utilized various media for advertisement. These media include print brochures, billboards, magazines, and radio programs. The examination review of the Plan's advertising binder revealed that in various advertisements, the name of the parent company, GHI, is used first and foremost in the ad; GHI HMO is mentioned secondary in the ad and/or in a footnote noting its relationship to GHI. Although there is no evidence that either company intended to mislead the public, this action appears to be in violation of Department Regulation 34, in light of the fact that it is clearly noted that the product being advertised is a "GHI HMO" product, but it is not clear that the product is actually offered by GHI HMO.

Section 13(a) of Department Regulation 34 (11 NYCRR 215.13) states:

> "The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all of its advertisements. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer."

It is recommended that the Plan comply with Section 13(a) of Department Regulation 34 (11 NYCRR 215.13) and clearly distinguish the identity of the company providing the health care coverage.

In addition, it is noted that there is no separate web-site under the GHI HMO name. Anyone searching either "ghihmo.com" or "ghi.com" will be directed to the same (GHI) web-site. Although this may not be intentional, this appears to be misleading to the public. If anyone wanted to specifically access GHI HMO's web-site by typing “ghihmo.com”, they will be directed to browse the various plans which are actually offered by GHI (there is no note distinguishing products offered by GHI HMO).

It is recommended that the Plan establish its own web-site or that there be a way to identify itself as a separate entity from its parent company in all advertising.

Subsequent to the examination date, the abovementioned web-site was amended to note that the site services GHI and GHI HMO Select, Inc.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The previous report on examination contained twenty-one comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
1.	Management and Controls	
	It is recommended that the Plan continue to comply with Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10 NYCRR Part 98-1.11(f)) and maintain the proper level of enrollee representatives on the board.	6
	The Plan has complied with this recommendation.	
2.	Holding Company System	
i.	It is recommended that, pursuant to Part 98-1.10(b) of the Administrative Rules and Regulations of the Health Department (10 NYCRR Part 98-1.10(b)), the Plan maintain its books, accounts and records so as to clearly and accurately disclose the nature and details of all transactions.	8
	The Plan has complied with this recommendation.	
ii.	It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR Part 98-1.10(c)) and submit its management / expense allocation agreement to the Superintendent of Insurance for review.	9
	Although a filed service agreement could not be located at the Department, GHI-HMO maintains that it submitted the service agreement as part of the expedited acquisition process and agrees to re-submit the agreement for the Superintendent's review.	
	A similar comment is contained herein.	
3.	Schedule H	
	It is recommended that the Plan account for its unpaid claims reported in Schedule H, "Aging Analysis of Claims Unpaid", as required by NYIL §308(a) using the instructions to that document.	10
	The Plan has complied with this recommendation.	

ITEM NO. **PAGE NO.**

ITEM NO.		PAGE NO.
ii.	It is recommended that the Plan reviews its denial codes in order to clarify the explanations used and to eliminate obsolete or misleading codes. The Plan has not complied with this recommendation. A similar recommendation is made in this report.	21
iii.	It is recommended the Plan comply with New York Insurance Law §3234(a)(6) and indicate clearly the cause of claims denied due to the treatment being experimental in nature. The Plan has complied with this recommendation.	21
9.	Emergency Room Treatment	
	It is recommended that the Plan reviews and overturns emergency room claims denied inappropriately due to a lack of authorization. Additionally, it is recommended that the Plan calculates and pays interest as applicable on those claims whose payment was delayed awaiting such authorization. The Plan has complied with this recommendation.	21
10.	Utilization Review	
i.	It is recommended that the Plan continue to comply with New York Public Health Law §4903(5)(b) and issue adverse determination letters to its providers that contain all of the required appeals language. The Plan has complied with this recommendation.	23
ii.	It is recommended that the Plan comply with Part 410.9(e)(9) of Department Regulation 166 (11 NYCRR 410.9(e)(9)) and include a bolded statement in the medical necessity denial letters it sends to its providers informing them that choosing a second internal appeal might cause the time to file an external appeal to expire. It is further recommended that such denials include an application for and description of the external review procedure. The Plan has complied with this recommendation.	23

ITEM NO. **PAGE NO.**

11. Usual, Customary and Reasonable

It is recommended that the Plan update its schedule of Usual and Customary charges in conformity with the changes made by HIAA in order to fulfill the obligations under its contract. 24

The Plan has complied with this recommendation through modification to its contracts.

12. Access Managed Care Plan

It is recommended that the Plan examine its contract with Access to determine whether Access is conforming to its own contract regarding electronic acceptance of claims and, if so, take appropriate action. 25

Subsequent to the examination, the Plan has indicated that it will terminate its relationship with Access, effective July 1, 2002.

The Plan has complied with this recommendation.

13. Fraud Prevention and Detection

It is recommended that the HMO evaluate its Fraud Prevention Plan to determine how it might be strengthened. 26

The Plan has complied with this recommendation.

14. Distribution Systems

i. It is recommended that the Plan complies with New York Insurance Law §2112(a) and file certificates of appointment for its internal sales staff. 27

Subsequent to the examination date, the Plan maintains it has submitted the change to the Department naming GHI-HMO as the organization appointing the agents.

The Plan has complied with this recommendation.

ITEM NO.		PAGE NO.
ii.	It is recommended that the Plan complies with New York Insurance Law §2112(d) and notifies the Department upon the termination of its filed certificates of appointment. Subsequent to the examination date, the Plan maintains it has forwarded the termination notice to the Department. The Plan has complied with this recommendation.	27
iii.	It is recommended that the Plan complies with New York Insurance Law §2114(a)(3) and only pay commissions to licensed agents. The Plan has complied with this recommendation.	28
iv.	It is recommended that the Plan change its commission policy to ensure it is in compliance with Part 52.42(e) of Department Regulation 62 (11 NYCRR Part 52.42(e)). The Plan has complied with this recommendation.	28

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
D.	Investment Activities	
	It is recommended that the Plan comply with Sections 1404 and 1409(a) of the New York Insurance Law and not have investments in securities of any one institution in excess of ten percent of its admitted assets.	18
E.	Accounts and Records	
i.	It is recommended that the Plan not enter into any barter or similar arrangements and that it comply with all applicable accounting principles and statutes when booking its premium accounts.	20
ii.	It is recommended that the inter-company accounts be settled in a timely manner, in accordance with the terms set forth in the underlying agreement(s).	21
F.	Claims Processing	
	It is recommended that the Plan take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider providing retraining to individuals who process claims.	28
G.	Prompt Pay	
i.	It is recommended that the Plan create procedures to ensure that outstanding claims in its claims system be paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law.	33
ii.	It is also recommended that the Plan implement the necessary procedures and training in order to ensure compliance with Section 3224-a(a) of the New York Insurance Law.	33
iii.	It is also recommended that the Plan implement the necessary procedures to ensure compliance within Section 3224-a(b) of the New York Insurance Law and send out requisite notification within 30 days where applicable.	33
iv.	It is further recommended that the Plan comply with Section 3224-a(c) of the New York Insurance Law and calculate interest due on all claims paid after 45 days of receipt.	33

Respectfully submitted,

Kaiwen Guo
Senior Insurance Examiner

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

KAIWEN GUO, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Kaiwen Guo

Subscribed and sworn to before me
This 19th day of October, 2005

Charles T. Lovejoy
Notary Public, State of New York
No. 31-4798952
Qualified in New York County
Commission Expires 1-28-06

Appointment No. *22138*

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Kaiwen Guo

as a proper person to examine into the affairs of the

GHI HMO SELECT, INC.

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

Company

with such information as he shall deem requisite.

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

this *30th* day of *January 2004*

Gregory V. Serio
Superintendent of Insurance