

ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU

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: AOD # 08 -098
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In the Matter of
HEALTH INSURANCE PLAN OF GREATER NEW YORK

**ASSURANCE OF DISCONTINUANCE
UNDER EXECUTIVE LAW § 63(15)**

As authorized by Article 22-A of the New York General Business Law and Section 63(12) of the New York Executive Law, Andrew M. Cuomo, Attorney General of the State of New York, caused an inquiry to be made into the business practices of Health Insurance Plan of Greater New York (“HIP”) relating to its administration of out-of-network benefits in New York State. HIP has agreed to the following provisions of this Assurance of Discontinuance (“Assurance”):

1. HIP is a New York State not-for-profit health service corporation holding a certificate of authority to operate a health maintenance organization under Article 44 of the New York Public Health Law, and authorized to operate as an indemnity insurer under Article 43 of the New York Insurance Law. Its principal offices are located at 55 Water Street, New York, New York 10041.

2. HIP, as used herein, includes all of its divisions, subsidiaries, and affiliates, to the extent that their operations affect consumers and enrollees in New York State. Moreover, the provisions of this Assurance are binding upon and enforceable against any subsequent owner or operator (whether by merger, transfer of control, contractual arrangements or other means) of HIP.

THE ATTORNEY GENERAL’S INVESTIGATION

3. The Office of the New York State Attorney General (OAG) received a complaint from a HIP member about out-of-network benefits and maximum visit limits, and thereafter the OAG conducted an investigation to examine whether HIP violated consumer protection and insurance laws.

4. The investigation focused primarily on HIP's own plan documents that it provides to its members, including the Certificate of Coverage and Schedule of Benefits. HIP's Certificate of Coverage directs members to refer to the Schedule of Benefits when determining their out-of-network benefits. The Schedule of Benefits, attached hereto as Exhibit A, identifies "variables" that apply to in-network and out-of-network benefits, including copayment, deductible, coinsurance and the maximum number of visits. As can be seen in Exhibit A, the Schedule has two columns – one for in-network variables/participating providers, and one for out-of-network variables/non-participating providers. In certain rows, including those that address mental health care and speech, occupational, cardiac, respiratory and physical therapy services, there is a maximum number of visits for which HIP will provide coverage. These maximum numbers of visits are listed in the in-network column; there are no maximum numbers of visits listed in the out-of-network column.

5. When administering members' out-of-network benefits, HIP applies a visit limit to the services that have a limit identified in the in-network column, despite the fact that no such limit is identified in the out-of-network column.

6. The OAG also reviewed complaints that HIP received about out-of-network benefits, which confirmed that some members did not understand that maximum visit limits applied to out-of-network services.

7. In one example, a member was being treated by an out-of-network mental health care provider. She paid the provider out-of-pocket \$100.00 for each visit, and then submitted the claims to HIP for reimbursement according to the Summary of Benefits, which stated that HIP would pay 50% after deductible and coinsurance. Despite the fact she had exceeded her deductible of \$250, HIP denied the claims on the basis that she had exceeded the maximum number of visits allowed. HIP later overturned its denial and reimbursed her 50% of her payments, \$1095.00, when it learned that a customer service representative told the member that no visit limit applied.

IT NOW APPEARING THAT HIP desires to settle and resolve the investigation, and improve its business practices;

THEREFORE, the OAG and HIP hereby enter into this Assurance in accordance with Executive Law § 63(15), and agree as follows:

I. PROSPECTIVE RELIEF

8. HIP will amend the Schedule of Benefits by 1) listing the maximum number of visits in both the in-network and out-of-network columns, or 2) adding a third column that precedes the other two columns, which will state that any limit on the number of visits applies to both out-of-network and in-network benefits.

9. HIP will also amend the out-of-network section of the Certificate of Coverage to disclose that visit limits apply to certain out-of-network benefits.

10. In addition, because of related confusion HIP members had concerning deductibles and visit limits, HIP will add the following language to the Certificate of Coverage: WHEN A MEMBER RECEIVES COVERED BENEFITS THAT ARE SUBJECT TO THE DEDUCTIBLE REQUIREMENT UNDER THIS POLICY, SUCH BENEFITS WILL REDUCE THE TOTAL NUMBER OF DAY AND/OR VISIT LIMITS AVAILABLE DURING THE CALENDAR YEAR. AS A RESULT, CLAIMS FOR WHICH NO AMOUNT WAS PAID WILL REDUCE THE TOTAL NUMBER OF DAY AND/OR VISIT LIMITS ALLOWED FOR COVERED BENEFITS.

II. CONSUMER CORRECTIVE ACTION

11. HIP will pay to those members who 1) received out-of-network services at any time from June 1, 2002 through the present; 2) submitted the claim(s) for those visit(s) to HIP for payment (or had them submitted); and 3) were required to make full payment because HIP denied coverage on the basis that the maximum number of visits had been exceeded ("Qualified Members").

12. Within forty-five (45) days from the Effective Date of this Assurance, HIP will send written notice to Qualified Members that will explain the procedures for them to submit documentation or certification of the Qualified Members' out-of-pocket expenses associated with their denied claim(s). The form and content of this notice shall follow the form and content of the letter attached to this Assurance as Exhibit B.

13. HIP will accept written responses from Qualified Members up to sixty (60) days from the date the Qualified Member are mailed HIP's written notice, allowing for an additional five (5) business days for delivery by first class mail.

14. For those Qualified Members who return the appropriate documentation or certification, HIP will issue a check to that reimburses the Qualified Member for all out-of-pocket expenses in an amount no greater than the amount charged by the health care provider, less any applicable coinsurance payments. HIP will send the check to the Qualified Member within thirty (30) days after receiving the Qualified Member's response. In the instances where HIP requires additional information or determines to investigate the information submitted, HIP will notify Qualified Members of such decision thirty (30) days after receiving the response (Preliminary Determination). HIP will conclude its investigation and make a final determination no more than sixty (60) days after the Preliminary Determination date is sent to the Qualified Member.

III. REPORT TO THE ATTORNEY GENERAL

15. Within eight months from the Effective Date of this Assurance, HIP shall report to the OAG on all payments made pursuant to this Assurance. The report shall include a list of the Qualified Members to whom restitution was paid, the restitution amount and date paid.

16. All correspondence, reports, and payment for costs sent to the OAG pursuant to this Assurance shall be mailed to:

Carol Hunt
Health Care Bureau
Office of the New York State Attorney General
120 Broadway, 25th Floor
New York, New York 10271

IV. COSTS

17. Within 60 days of the Effective Date of this Assurance, HIP shall pay a total of \$5,000 to the OAG for costs incurred during the investigation of this matter. All checks issued pursuant to this paragraph shall be made out to "State of New York Department of Law."

V. MISCELLANEOUS

18. All payments and correspondence related to this Assurance must reference AOD # 08-098.

19. Acceptance of this Assurance by the OAG is not to be deemed or construed as an approval by the OAG of any of HIP's actions, and HIP is not to make any representation to the contrary. In addition and as an example, this Assurance is not to be deemed or construed as an approval of HIP's calculation of usual and customary charges, and in no way affects future agreements HIP may reach with the OAG regarding out-of-network payments based on usual and customary charges.

20. Nothing in this Assurance in any way limits the OAG's ability to investigate or take other action with respect to any noncompliance at any time by HIP with respect to this Assurance, or HIP's noncompliance with any applicable law with respect to any other matters.

21. This Assurance does not in any way limit the OAG's right to obtain, by subpoena or any other means permitted by law, documents, testimony or other information to determine whether HIP has fully complied with this Assurance.

22. Nothing in this Assurance is to be construed as narrowing or limiting any rights of any person or entity under the law or any of HIP's obligations under the laws of New York State or the United States, or any applicable regulations thereunder.

23. HIP hereby accepts the terms and conditions of this Assurance and waives any right to challenge it in a proceeding under Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

24. HIP will not take any action or to make or permit to be made any public statement denying, directly or indirectly, any findings in this Assurance or creating the impression, or attempting to create the impression that this Assurance is without factual basis. Nothing in this paragraph affects HIP's: (a) testimonial obligations; or (b) right to take legal or factual positions in defense of litigation.

VI. EFFECT OF VIOLATION OF THIS ASSURANCE OF DISCONTINUANCE

25. In accordance with Executive Law § 63(15), in the event that this Assurance Discontinuance is violated, evidence of such violation is *prima facie* proof of a violation of § 349(a) of the General Business Law and § 63(12) of the Executive Law in any civil action or proceeding thereafter commenced by the OAG.

VII. EFFECTIVE DATE

26. This Assurance is effective upon the date of its last signature, and the document may be executed in counterparts, which shall be deemed an original for all purposes.

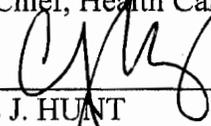
IN WITNESS THEREOF, the undersigned subscribe their names:

Dated: New York, New York

~~September~~ ~~July~~ 10, 2008

ANDREW M. CUOMO
Attorney General of the State of New York

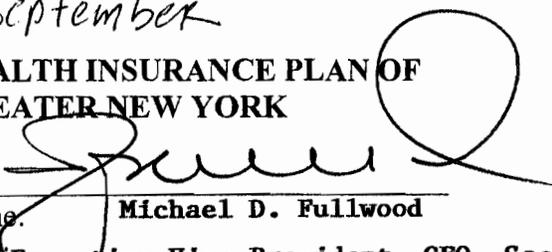
TIMOTHY A. CLUNE
Bureau Chief, Health Care Bureau

By: 
CAROL J. HUNT
Assistant Attorney General, Health Care Bureau

Dated: New York, New York
June 15, 2008

~~September~~

HEALTH INSURANCE PLAN OF GREATER NEW YORK

By: 
Name: **Michael D. Fullwood**
Title: **Executive Vice President, CFO, Secretary & General Counsel**
Address:

**55 Water Street
New York, NY 10041**