

MARKET CONDUCT REPORT ON EXAMINATION

OF

MVP HEALTH PLAN, INC.

MVP HEALTH INSURANCE COMPANY

MVP HEALTH SERVICES CORP.

PREFERRED ASSURANCE COMPANY, INC.

AS OF

DECEMBER 31, 2010

DATE OF REPORT

MAY 24, 2013

EXAMINER

JEFFREY USHER

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

May 24, 2013

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
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 Numbers 30732, 30734, 30736 and 30738, dated September 13, 2011, annexed hereto, I have made an examination into the affairs of MVP Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law; MVP Health Insurance Company, a for-profit accident and health stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law; MVP Health Services Corp., a not-for-profit health service corporation licensed pursuant to Article 43 of the New York Insurance Law; and Preferred Assurance Company, Inc. a not-for-profit health corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2010, and respectfully submit the following report thereon.

The examination was conducted at the home office of MVP Health Care, Inc., the ultimate parent company of the above mentioned four affiliated companies covered under this examination, located at 625 State Street, Schenectady, New York.

Wherever the designations “MVPHP” or the “HMO” appear herein, without qualification, they should be understood to indicate MVP Health Plan, Inc.

Wherever the designation “MVPHIC” appears herein, without qualification, it should be understood to indicate MVP Health Insurance Company.

Wherever the designation “MVPHSC” appears herein, without qualification, it should be understood to indicate MVP Health Services Corp.

Wherever the designation “PAC” appears herein, without qualification, it should be understood to indicate Preferred Assurance Company, Inc.

Wherever the designation “MVP” appears herein, without qualification, it should be understood to indicate MVP Health Care, Inc.

Wherever the designation the “MVP Companies” appears herein, without qualification, it should be understood to indicate MVP Health Plan, Inc., MVP Health Insurance Company, MVP Health Services Corp., and Preferred Assurance Company, Inc. collectively.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous market conduct examinations of the MVP Companies were conducted as a component of separate combined (financial and market conduct) examinations of MVPHP, MVPHIC, MVPHSC and PAC, as of December 31, 2007. This market conduct examination covers the three-year period from January 1, 2008 through December 31, 2010. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

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

A review was also made to ascertain what actions were taken by the MVP Companies with regard to the comments and recommendations (related to market conduct items) contained in the prior reports on examination.

Separate examinations of the financial condition of the MVP Companies were conducted, as of December 31, 2010. The resulting reports on examination were filed on June 25, 2012 for MVP Health Insurance Company and for MVP Health Plan, Inc., and on August 1, 2012 for MVP Health Services Corp. and for Preferred Assurance Company, Inc.

2. **EXECUTIVE SUMMARY**

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

- Relative to retrospective and concurrent utilization review, the MVP Companies failed to comply with Section 4903(e) of the New York Insurance Law and Section 4903(5) of the New York Public Health Law (MVPHP only) and issue a first determination letter to members and hospitals whenever the MVP Companies changed the payment of level of care for hospital services.
- MVPHP's instructions for an external appeal noted within its adverse determination letter indicated that a determination of the external appeal would be made within thirty (30) working days rather than within thirty (30) calendar days of the receipt of the request in violation of Section 4903(2)(b) of the New York Public Health Law.
- MVPHP failed to provide adverse determination letters in a timely manner to members as required, in violation of Section 4903(4) of the New York Public Health Law.

The examination findings are described in greater detail within this report.

3. DESCRIPTION OF THE COMPANIES

MVP Health Plan, Inc.

MVP Health Plan, Inc., an IPA model HMO, was incorporated on July 30, 1982, pursuant to Section 402 of the New York Not-For-Profit Corporation Law, for the purpose of operating as a health maintenance organization as such term is defined in Article 44 of the New York Public Health Law. MVPHP is a federally qualified HMO. The HMO incorporator was the board of directors of the Schenectady County Foundation for Medical Care, Inc., a not-for-profit physician association. Simultaneous with the incorporation of the HMO, pursuant to Section 402 of the Not-For-Profit Corporation Law, the incorporators formed Mohawk Valley Medical Associates, Inc., a not-for-profit independent practice association (IPA).

On March 8, 1982, , the HMO and Mohawk Valley Medical Associates, Inc. contracted, through an “IPA Service Agreement” to work together to provide for the administration of a comprehensive prepaid program of health care, and for the delivery of health services. Subsequently, the HMO made similar arrangements with other independent practice associations to achieve the same goal.

On May 1, 2009, MVPHP merged with Rochester Area Health Maintenance Organization, Inc. (“RAHMO”), a related party not-for-profit corporation operating as a federally qualified health maintenance organization. MVPHP, the surviving corporation, became the sole subsidiary of MVPHP Holding Company, Inc., which in turn is a wholly-owned subsidiary of MVP Health Care, Inc. (the ultimate parent). The

merger was approved by the Department on May 1, 2009. This merger was also approved by the Department of Health on May 16, 2009.

MVP Health Plan, Inc. is licensed as a health maintenance organization to deliver health care services in the states of New York and Vermont.

MVP Health Insurance Company

MVP Health Insurance Company was incorporated on April 24, 2000 as a for-profit accident and health insurer pursuant to Article 42 of the New York Insurance Law. MVPHIC was licensed in June 2001 to write the insurance business defined in Section 1113(a)(3) of the New York Insurance Law. MVPHIC began operations by delivering health care services in the State of New York in July 2001.

It received approval to operate as an accident and health insurer in the State of Vermont on May 1, 2002.

Prior to January 2006, MVPHIC was a wholly-owned subsidiary of MVPHIC Holding Corporation, which in turn, was a wholly-owned subsidiary of MVP Health Plan, Inc. (MVPHP), the ultimate parent company.

On January 6, 2006, MVPHP combined with Preferred Care, Inc. (PC). Under the terms of an agreement, MVPHP and PC reorganized their respective enterprises under a holding company structure, with MVP Health Care, Inc. established as the ultimate parent. The sole shareholder of the company became MVPRT Holdings, Inc.,

which is a wholly-owned subsidiary of MVPHIC Holding Corporation, which is a wholly-owned subsidiary of MVP Health Care, Inc. (the ultimate parent).

MVP Health Services Corp.

MVP Health Services Corp. was incorporated on October 8, 1992, under Section 402 of the Not-for-Profit Corporation Law and licensed pursuant to Article 43 of the New York Insurance Law as a not-for-profit health services corporation. Prior to January 2002, MVPHSC offered point-of-service (POS) health insurance products. At the examination date, MVPHSC provided only dental insurance to its subscribers.

MVPHSC is a Type D membership corporation as defined in Section 201 of the New York Not-for-Profit Corporation Law. Pursuant to its by-laws, MVPHSC has one corporate member, MVPRT Holdings, Inc., which is a wholly-owned subsidiary of MVPHIC Holding Corporation. MVPHIC Holding Corporation is a wholly-owned subsidiary of MVP Health Care, Inc.

Preferred Assurance Company, Inc.

Preferred Assurance Company, Inc. was incorporated on June 2, 1992, pursuant to Section 402 of the New York Not-For-Profit Corporation Law. PAC is licensed to write insurance business within New York State as a non-profit health corporation pursuant to the provisions of Article 43 of the New York Insurance Law. PAC commenced operations in New York State in 1993. Pursuant to Article I of its by-laws, the Plan has MVPRT Holdings, Inc. as its sole member.

On May 1, 2009, MVPHP merged with Rochester Area Health Maintenance Organization, Inc. (“RAHMO”), a related party not-for-profit corporation operating as a federally qualified HMO. MVPHP, the surviving corporation, became the sole subsidiary of MVPHP Holding Company, Inc., which is a wholly-owned subsidiary of MVP Health Care, Inc. (the ultimate parent). The merger was approved by the Department on May 1, 2009. The merger was also approved by the Department of Health on May 16, 2009.

MVPRT Holdings, Inc. (“MVPRT”), is a holding company for three New York State and two New Hampshire domiciled entities within the MVP Health Care, Inc. holding company system. MVPRT is a wholly-owned subsidiary of MVPHIC Holding Corporation. MVPHIC Holding Corporation is a wholly-owned subsidiary of MVP Health Care, Inc., the ultimate parent.

4. UTILIZATION REVIEW

The Level of Care Change (LOCC) process was reviewed by the examiner. The MVP Companies define LOCC as an inpatient acute care service that is changed to a lower level of care. The types of service that LOCC applies to are acute inpatient admissions, both medical and surgical, with a length of stay of two days or less. MVP Companies identified ninety-eight (98) LOCC cases in 2010 and one hundred forty (140) LOCC cases in 2011. MVP Companies did not issue a first adverse determination letter for those LOCC cases. Therefore, the MVP Companies were in

violation of Article 4903(e) of the New York Insurance Law and 4903(5) of the New York Public Health Law (MVPHP only).

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

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

- (1) the reasons for the determination including the clinical rationale, if any;
- (2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and
- (3) notice of the availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal.”

Section 4903(5) of the New York Public Health Law states:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

- (a) the reasons for the determination including the clinical rationale, if any;
- (b) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article; and
- (c) notice of the availability, upon request of the enrollee, or the enrollee's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal.”

It is recommended that the MVP Companies comply with Section 4903(e) of the New York Insurance Law and Section 4903(5) of the New York Public Health Law (MVPHP only) and issue a first adverse determination letter to affected members and hospitals whenever the MVP Companies change the level of care to a lower level of payment.

Also, during the review of retrospective utilization review cases, it was noted that in 10 of the cases sampled, MVPHP failed to provide adverse determination letters to the member in the time frame prescribed by Section 4903(4) of the New York Public Health Law which states:

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

It is recommended that MVPHP complies with Section 4903(4) of the New York Public Health Law and provide adverse determination letters within the required time frame.

In addition, MVPHP instructions for an external appeal on its adverse determination letter indicate that a determination of the external appeal will be made within thirty (30) workdays rather than within thirty (30) calendar days of the receipt of the request.

Section 4914(2)(b) of the New York Public Health Law states:

“The external agent shall make a determination with regard to the appeal within thirty days of receipt of the request, therefore, submitted in accordance with the commissioner’s instructions.”

It is recommended that MVPHP complies with Section 4914(2)(b) of the New York Public Health Law and revise its adverse determination letter to include the mandated time frame for allowed response to an external appeal.

5. PROMPT PAY LAW

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

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

“...(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim...within 30 days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or 45 days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.”

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

“...(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is

less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim.”

A statistical sample of claims not adjudicated within 30 days (for claims submitted via internet or electronic mail), or 45 days (for claims submitted by other means such as paper or facsimile) by the MVP Companies was reviewed to determine whether claims were processed in compliance with the timeframe requirements of Section 3224-a(a) of the New York Insurance Law (“NYIL”), and if interest was required, whether it was paid pursuant to Section 3224-a(c) of the NYIL. Accordingly, all claims that were paid after 30 (electronic submission) and 45 days of receipt (manual submission) respectively during the period January 1, 2010 through December 31, 2010 were segregated.

A “claim” is defined by the MVP Companies as the total number of items submitted on a single claim form to which the MVP Companies assigns a unique “claim number”.

A random statistical sample was drawn for each entity. It should be noted that for the purpose of this analysis, medical costs characterized by the MVP Companies as “Pharmacy”, “Medicare”, and “Capitated Payments”, were excluded from the examiner’s review.

Using ACL software the examiners conducted an analysis of the aforementioned claims. It was determined that the number of claims that MVPHP and PAC processed in excess of the time limitations prescribed in Section 3224-a exceeded the 2% threshold.

The examiner, therefore, conducted a review of claims processed by MVPHP and PAC in order to estimate the number of claims that were processed in violation of New York Insurance Law Sections 3224-a (a), (b) and (c). Samples were drawn from MVPHP and PAC, each consisting of 167 randomly selected unique claims. For MVPHP, four (4) samples were selected (2 to test compliance with 3224-a(a); 2 to test for compliance with 3224-a (b)) because the company used two (2) claims systems in 2010. For PAC, two (2) samples were selected. In total, 1,002 claims were selected for this review.

The following charts illustrate the MVPHP and PAC's compliance with the Prompt Pay Law, as determined by this examination:

MVPHP AMYSIS System - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	<u>Hospital and Medical Claims</u>
Total population	341,751
Population of claim transactions paid after 30 days and 45 days of receipt	8,066
Sample size	167
Number of claims with violations	53
Calculated violation rate	31.74%
Lower violation limit	24.68%
Upper violation limit	38.80%
Calculated claims in violation	2,560
Lower limit transactions in violation	1,990
Upper limit transactions in violation	3,129

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).

Of the 53 claims found to be in violation of Section 3224-a(a) of the New York Insurance Law, 17 claims were found to be also in violation of Section 3224-a(c) of the New York Insurance Law.

MVPHP FACETS System - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	<u>Hospital and Medical Claims</u>
Total population	1,300,733
Population of claim transactions paid after 30 days and 45 days of receipt	29,169
Sample size	167
Number of claims with violations	124
Calculated violation rate	74.25%
Lower violation limit	67.62%
Upper violation limit	80.88%
Calculated claims in violation	21,657
Lower limit transactions in violation	19,724
Upper limit transactions in violation	23,591

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).

Of the 124 claims found to be in violation of Section 3224-a(a) of the New York Insurance Law, 27 claims were found to be also in violation of Section 3224-a(c) of the New York Insurance Law.

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

	<u>Hospital and Medical Claims</u>
Total population	157,926
Population of claim transactions paid after 30 days and 45 days	5,371
Sample size	167
Number of claims with violations	71
Calculated violation rate	42.51%
Lower violation limit	35.02%
Upper violation limit	50.01%
Calculated claims in violation	2,283
Lower limit transactions in violation	1,881
Upper limit transactions in violation	2,686

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).

Of the 71 claims found to be in violation of Section 3224-a (a) of the New York Insurance Law, 18 claims were found to be also in violation of Section 3224-a(c) of the New York Insurance Law.

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims paid more than thirty days (electronic claim submissions) and forty-five days (manual claim submissions) from receipt, which were adjudicated during the period January 1, 2010 through December 31, 2010.

The population of claims paid over thirty days (electronic claim submissions) and over forty-five days (manual claim submissions) from receipt for MVPHP consisted of 37,235 medical and hospital claims combined, out of 1,642,484 medical and hospital claims processed, during the period under review by both Amysis and Facets systems.

The population of claims paid more than thirty days (electronic claim submissions) and over forty-five days (manual claim submissions) from receipt for PAC consisted of 5,371 medical and hospital claims combined, out of 157,926 medical and hospital claims processed, during the period under review.

It is recommended that MVPHP and PAC take steps to ensure full compliance with the provisions of Sections 3224-a(a) and (c) of the New York Insurance Law.

Similar recommendations were included within the prior MVPHP and PAC market conduct reports on examination.

A review was also performed as to determine whether MVPHP and PAC processed claims (denied/requested additional information) in the time frame prescribed by Section 3224-a(b) of the New York Insurance Law which states in part:

“... (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.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

A statistical sample of claims that were denied more than 30 calendar days after receipt by MVPHP and PAC was reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims that were denied after 30 calendar days of receipt during the

period January 1, 2010 through December 31, 2010, were segregated. A statistical sample of this population was then selected to determine compliance with the above mentioned statute.

The following charts illustrate MVPHP and PAC's compliance with Section 3224-a (b) of the New York Insurance Law, as determined by this examination:

MVPHP AMYSIS system - Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	<u>Hospital and Medical Claims</u>
Total population	61,860
Population of claims denied after 30 calendar days of receipt	8,173
Sample size	167
Number of claims with violations	83
Calculated violation rate	49.70%
Lower violation limit	42.12%
Upper violation limit	57.28%
Calculated claims in violation	4,061
Lower limit transactions in violation	3,442
Upper limit transactions in violation	4,682

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).

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

	<u>Hospital and Medical Claims</u>
Total population	177,641
Population of claims denied after 30 calendar days of receipt	11,468
Sample size	167
Number of claims with violations	124
Calculated violation rate	74.25%
Lower violation limit	67.62%

Upper violation limit	80.88%
Calculated claims in violation	8,514
Lower limit transactions in violation	7,755
Upper limit transactions in violation	9,276

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).

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

	<u>Hospital and Medical Claims</u>
Total population	18,868
Population of claims denied after 30 calendar days of receipt	2,699
Sample size	167
Number of claims with violations	91
Calculated violation rate	54.49%
Lower violation limit	46.94%
Upper violation limit	62.04%
Calculated claims in violation	1,470
Lower limit transactions in violation	1,267
Upper limit transactions in violation	1,675

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 that were denied more than thirty calendar days from receipt, which were processed during the period from January 1, 2010 through December 31, 2010.

The population of claims denied more than thirty calendar days from the date of receipt for MVPHP consisted of 19,641 medical and hospital claims combined, out of 239,501 medical and hospital claims processed, during the period January 1, 2010 to December 31, 2010 for the Amysis and Facets systems combined.

The population of claims denied more than thirty calendar days from the date of receipt for PAC consisted of 2,699 medical and hospital claims combined, from a total population of 18,868 medical and hospital claims processed during the period January 1, 2010 to December 31, 2010.

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

Similar recommendations were included within the prior MVPHP and PAC market conduct reports on examination.

6. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior reports on examination included twelve (12) market conduct related recommendations detailed as follows (page number refers to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Policy Benefits Forms</u>	
1. It is recommended that MVPHIC and MVPHP, in the future, file their policy benefits forms with the Department, in compliance with the requirements of Section 3201(b)(1) of the New York Insurance Law. Further, it is recommended that MVPHIC and MVPHP refrain from issuing any policy benefits forms that have not been approved by the Department.	9
<i>MVPHIC and MVPHP have complied with this recommendation.</i>	
<u>Agents and Brokers</u>	
2. It is recommended that the MVP Companies comply with the requirements of Sections 2112(a) and (d) of the New York Insurance Law and notify the Department of all appointments and terminations of its agents.	10
<i>The MVP Companies have complied with this recommendation.</i>	
<u>Termination of Coverage Notices</u>	
3. It is recommended that the MVP Companies revise their termination of coverage notices to include all of the information required by Part 55.2 of Department Regulation No. 78 relative to termination notices.	12
<i>The MVP Companies have complied with this recommendation.</i>	
<u>Record Retention</u>	
4. It is recommended that the MVP Companies maintain their policy applications in compliance with the requirements of Part 243(b)(2) of Department Regulation No. 152.	12
<i>The MVP Companies have complied with this recommendation.</i>	

ITEM NO.**PAGE NO.**Explanation of Benefits Notices – Pharmacy Claims

5. It is recommended that the MVP Companies ensure that all EOBs that are issued to its subscribers, including EOBs that are issued on behalf of MVP Companies to its subscribers by Medco Health Solutions, Inc., include all of the information required by Section 3234(b)(7) of the New York Insurance Law. 14

The MVP Companies have complied with this recommendation.

Prompt Pay Law

6. It is recommended that the MVP Companies take steps to ensure full compliance with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims. 18

The MVP Companies have not complied with this recommendation.

A similar recommendation is included within this report on examination.

7. It is recommended that the MVP Companies take steps to ensure full compliance with the provisions of Section 3224-a(c) of the New York Insurance Law regarding the payment of interest on claims paid in excess of 45 days of receipt.

The MVP Companies have not complied with this recommendation.

A similar recommendation is included within this report on examination.

8. It is recommended that the MVP Companies take steps to ensure full compliance with the provisions of Section 3224-a(b) of the New York Insurance Law regarding the denial of claims and requests for additional claim information. 20

The MVP Companies have not complied with this recommendation.

A similar recommendation is included within this report on examination.

ITEM NO.**PAGE NO.**Experience Rating

9. It is recommended that RAHMO comply with Section 4308(b) of the New York Insurance Law and file its experience rating formula with the New York State Insurance Department, and obtain the approval of the superintendent prior to implementing the rate (formula). 13

Due to the elimination of RAHMO in 2009, as noted on page 5 of this report, we did not confirm compliance.

10. It is recommended that Preferred Assurance Company, Inc. (“PAC”) complies with Part 52.40(g)(3) of Department Regulation No. 62, by including its own credible experience in the calculation of its rates, or obtains approval from the Department to continue its present practice. 14

PAC has complied with this recommendation by including its own credible experience.

Utilization Review

11. It is recommended that Preferred Assurance Company, Inc. (“PAC”) complies with the requirements of Sections 4903(e)(2) and 4904(a) of the New York Insurance Law and include instructions on how to initiate standard appeals and expedited appeals by the provider within its adverse determination letters sent to providers. 22

PAC has complied with this recommendation.

12. It is recommended the PAC comply with the requirements of Section 4901(a) of the New York Insurance Law and submit its utilization review programs to the New York State Insurance Department on a biennial basis. 23

PAC has complied with this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Utilization Review</u>	
i. It is recommended that the MVP Companies comply with Section 4903(e) of the New York Insurance Law and Section 4903(5) of the New York Public Health Law (MVPHP only) and issue a first adverse determination letter to affected members and hospitals whenever the MVP Companies change the level of care to a lower level of payment.	9
ii. It is recommended that MVPHP complies with Section 4903(4) of the New York Public Health Law and provide adverse determination letters within the required time frame.	10
iii. It is recommended that MVPHP complies with Section 4914(2)(b) of the New York Public Health Law and revise its adverse determination letter to include the mandated time frame for allowed response to an external appeal.	10
B. <u>Prompt Pay Law</u>	
i. It is recommended that MVPHP and PAC take steps to ensure full compliance with the provisions of Sections 3224-a(a) and (c) of the New York Insurance Law.	15
Similar recommendations were included within the prior MVPHP and PAC market conduct reports on examination.	
ii. It is recommended that MVPHP and PAC take steps to ensure full compliance with the provisions of Section 3224-a(b) of the New York Insurance Law.	19
Similar recommendations were included within the prior MVPHP and PAC market conduct reports on examination.	

Appointment No. 30732

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine into the affairs of the

MVP Health Plan, Inc.


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

HMO

with such other information as he 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 13th day of September, 2011



James J. Wrynn
Superintendent of Insurance



Appointment No. 30734

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine into the affairs of the

MVP Health Insurance Company

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

Company

with such other information as he 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 13th day of September, 2011



James J. Wrynn
Superintendent of Insurance



Appointment No. 30736

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine into the affairs of the

MVP Health Service Corporation

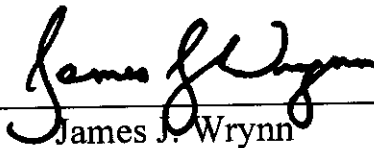
and to make a report to me in writing of the condition of the said

Company

with such other information as he 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 13th day of September, 2011



James J. Wrynn
Superintendent of Insurance



Appointment No. 30738

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine into the affairs of the

Preferred Assurance Company, Inc.

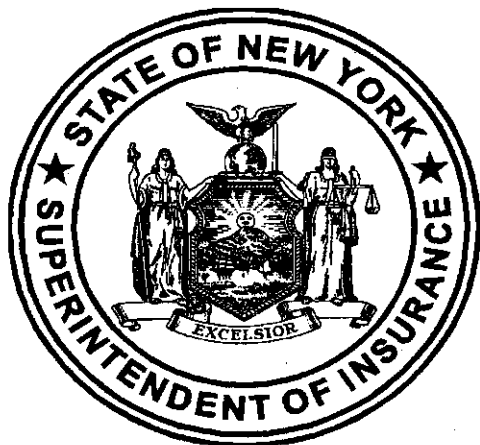
and to make a report to me in writing of the condition of the said


Company

with such other information as he 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 13th day of September, 2011




James J. Wrynn
Superintendent of Insurance