

MARKET CONDUCT REPORT ON EXAMINATION

OF

EXCELLUS HEALTH PLAN, INC.

AS OF

OCTOBER 10, 2003

DATE OF REPORT

OCTOBER 31, 2003

EXAMINER

ROBERT W. MCLAUGHLIN, CFE, CIE

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STATE OF NEW YORK
INSURANCE DEPARTMENT
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NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

October 31, 2003

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the directions contained in Appointment Number 21853 dated March 11, 2002, annexed hereto, I have made an examination into the condition and affairs of Excellus Health Plan, Inc., a non-profit health service corporation licensed pursuant to Article 43 of the New York Insurance Law. The following report, as respectfully submitted, deals with the findings concerning the manner in which Excellus Health Plan, Inc. conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

Whenever the designations "Excellus" or "the Plan" appear herein without qualification, they should be understood to mean Excellus Health Plan, Inc.

1. SCOPE OF EXAMINATION

A review of how Excellus Health Plan, Inc. conducts its business practices and fulfills its contractual obligations to policyholders and claimants was conducted. The review covered the period from January 1, 2001 through October 10, 2003. The primary purpose of this report is to assist Excellus Health Plan, Inc.'s management in addressing problems that are of such a critical nature that immediate and corrective action is required. This report's comments chiefly involve matters that depart from New York laws, regulations and rules or those which are deemed to require an explanation or description from the Plan.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicate areas of weakness and/or directly impacted its compliance with the New York Insurance Law and the New York Public Health Law. The most significant findings of this examination include the following:

- Inability to provide reconciled claims data in a timely manner.
- Failure to report accurate claim counts and properly classify claim amounts in Schedule H of its filed financial statements.
- Failure to include all required appeal forfeiture language on its "Explanation of Benefits Statements" (EOBs) to members
- Failure to fully comply with the requirements of the Prompt Pay Law

In addition, this Report on Examination includes recommendations for enhanced oversight of executive compensation by the Board of Directors.

The examination findings are described in greater detail in the remainder of this report.

3. SALES

During the examination period, three employee sales consultants of Excellus Health Plan, Inc. received sales performance awards based on the percentage increase in business solicited during specified time frames. At the time such sales performance awards were paid, the three employees were not licensed as insurance agents pursuant to Section 2103(a) of the New York Insurance Law.

Section 4312(a)(1) of the New York Insurance Law states in part,

“Every corporation subject to the provisions of this article may employ solicitors or accept business from agents and brokers on a commission basis but all solicitors shall be paid on a salary basis only...”

Section 2101(a)(1)&(2) of the New York Insurance Law state,

“In this article, “insurance agent” means any authorized or acknowledged agent of an insurer, fraternal benefit society or health maintenance organization issued a certificate of authority pursuant to article forty-four of the public health law, and any sub-agent or other representative of such an agent, who acts as such in the solicitation of, negotiation for, or procurement or making of, an insurance, health maintenance organization or annuity contract, other than as a licensed insurance broker, except that such term shall not include:

(1)any regular salaried officer or employee of a licensed insurer, fraternal benefit society or health maintenance organization or of a licensed insurance agent, who does not solicit or accept from the public, outside of an office of such insurer, health maintenance organization or agent, applications or orders for any such contract, if such officer or employee does not receive a commission or other compensation for his services which commission or other compensation is directly dependent upon the amount of business done;

(2) any regular salaried officer or employee of any insurer or health maintenance organization, who devotes substantially all of his services to activities other than the solicitation of insurance business and health maintenance contracts from the insuring public, and who receives for the solicitation of such insurance and health maintenance organization contracts no commission or other compensation directly dependent upon the amount of business obtained.

Section 2114(a)(3) of the New York Insurance Law states:

“No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting or procuring in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article.”

It is recommended that the Plan, pursuant to Section 2114(a)(3) of the New York Insurance Law, refrain from paying any commissions or compensation directly dependent upon the amount of business obtained to any person that does not possess a valid agent’s or broker’s license.

4. UNDERWRITING AND RATING

A. Level Premium Agreements

Part 52.42(b)(3)(ii)(a) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(b)(3)(ii)(a)) allows an HMO to use a level premium rating methodology by use of an approved rider or remitting agent agreement.

Section 4308(a) of the New York Insurance Law states in part,

“No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a copy of the contract or certificate and of all applications, riders and endorsements for use in connection with the issuance or renewal thereof, to be formally approved by him as conforming to the applicable provisions of this article...”

A review of the Plan's level premium level premium rating program for its Rochester division revealed that the Plan did not maintain signed level premium agreements for all groups receiving level premium rates. The Plan could produce only eight (8) signed level premium agreements relative to twelve (12) sampled groups.

An examination of the level premium agreements for the Univera division sampled by the examiners indicated that only six (6) of twelve (12) level premium agreements were signed by the applicable group.

It is recommended that the Plan maintain signed copies of a Department approved rider or remitting agent agreement with all groups receiving level premium or guaranteed rates.

Part 52.42(b)(3)(ii)(a) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(b)(3)(ii)(a) states in part

“By use of an approved rider or remitting agent agreement an HMO may establish an estimated annual subscriber rate to accommodate employers who prefer a level monthly premium payment for the contract year. This rider may be applied to a group contract or group remittance arrangement where the group remitting agent agrees to accept liability for payments due to the HMO. Any difference between the approved subscriber rate and the estimated annual subscriber rate must be reconciled by use of

an advance premium deposit account (the accumulated surcharges). Settlement of the account must occur no later than twelve months after the end of the prior contract year or upon termination of the contract if earlier...”

The Plan did not provide evidence of New York Insurance Department approval for the level premium agreements used by the Plan at the time of the review for its Univera divisions.

A technical error was found in one of the sampled level premium agreements for the Rochester division.

It is recommended that the Plan, pursuant to Part 52.42(b)(3)(ii)(a) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(b)(3)(ii)(a)), obtain New York Insurance Department approval for its level premium agreements and amendments of previously approved agreements used by the Plan

B. Experience Rating

A sample taken of the Plan’s experience rated groups for the Rochester division indicated that experience rated group agreements were in place relative to such retrospective rating arrangements. However, the Plan could not provide evidence of New York Insurance Department approval for such agreements. Section 4308(b) of the New York Insurance Law and Part 52.40 of Department Regulation 62 (11 NYCRR 52.40) require such approval.

Section 4308(b) of the New York Insurance Law states in part,

“No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent’s approval thereof....”

Part 52.40 of Department Regulation 52 (11 NYCRR 52.40) states the following:

“(1) Contracts of master group insurance may be experience rated only in accordance with a formula or plan previously furnished to the department. Such formula or plan shall include a retention designed to provide for a contribution to surplus.

(2) Any such plan or formula of experience rating may include provision for a rate stabilization reserve provided that the terms under which the rate stabilization reserve is created are included in the master group contract or separate written agreement previously approved by the department and which upon termination of the group contract impose an obligation on the plan in respect to the application of the funds represented by such reserve.”

It is recommended that the Plan file, pursuant to Section 4308(b) of the New York Insurance Law and Department Regulation 62 (11 NYCRR 52.40), and obtain the Superintendent’s prior approval for its experience rating agreements.

C. Retroactive Terminations

During the examination period, the Plan failed to terminate for non-payment certain groups during the thirty (30) day grace period included in the Plan’s contracts. The Plan, in certain instances terminated such groups for non-payment beyond such grace period retroactive to the date of the last month payment was made.

It was the Plan’s policy, during the period under review, for all divisions, except the Rochester division, to pay claims during the period between the date of payment, the effective date of termination, and the date that the final termination letter is sent out. However, upon termination, the Plan then retroactively retracts or “takes back” such payment from the provider by means of netting such payments against current amounts owed such providers. In the Syracuse

and Utica/Watertown divisions, the practice was to retract such claims from subscribers as well. The Rochester division's policy was to deny any claims beyond the thirty (30) day grace period.

In such cases of retroactive termination beyond the contract grace period, it is the opinion of this Department's General Counsel that in circumstances where a subscriber or group defaults on the payment of premiums and the insurer voluntarily extends credit by extending the grace period, such insurer waives its rights to retroactively cancel the contract.

The Plan's contracts provide for a thirty (30) day grace period before terminations for non-payment of premium are effected.

Section 4235(k) of the New York Insurance Law states,

“Whenever an insurer elects to terminate any policy as described in this section, such insurer shall include in his notification of intent to terminate such policy reference to the policyholder's responsibilities under section two hundred seventeen of the labor law. Whenever any policy as described in this section terminates as a result of a default in payment of premiums, the insurer shall notify the policyholder that termination has occurred or will occur and shall include in his notification reference to the policyholder's responsibilities under section two hundred seventeen of the labor law.”

Section 4235(l) of the New York Insurance Law states,

“The superintendent shall promulgate rules and regulations concerning the method, manner and time for a policyholder to provide written notice of termination to the certificate holders as required by subdivision three of section two hundred seventeen of the labor law.”

In accordance with Section 4235(l) of the New York Insurance Law, the Superintendent of Insurance has promulgated Department Regulation 78 (11 NYCRR 55.2(a&b)) which state,

(a) An insurer who intends to terminate a group policy or contract of accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificate holders under a group policy shall give the policyholder at least 30 days' prior written notice of its intent to terminate coverage. The notice to the policyholder shall set forth in detail the policyholder's obligation under the Labor Law, section 217, and under this Part, to notify each certificate holder resident in New York State of the intended termination of the group policy..."

(b) In its notice of intent to terminate coverage, the insurer shall set forth in full the rights of the certificate holders under the terminating policy as to coverage for illness, accident and treatment occurring prior to and subsequent to the termination date, and such other rights of certificate holders as may exist under the contract or policy (e.g. conversion rights).''

At the time of the examination, the Plan was in the process of revising its procedures regarding retroactive terminations for non-payment. Such revised procedures provide for all terminations for non-payment to take place within thirty-five (35) days for direct pay subscribers with individual claims of \$50 or aggregate claims of \$100 retracted from the payee. For group contracts, the revised Plan policy is for cancellation dates to be established no later than 45 days beyond the premium due date. If cancellation occurs later than the contractual thirty (30) day grace period then no retractions may occur. At the time of the writing of this report, the above retroactive termination procedures had not been implemented in all divisions for all lines of business.

It is recommended that the Plan comply with the thirty (30) day grace period included in its contracts relative to cancellations for non-payment of premium. It is recommended that the Plan refrain from retracting or denying affected claims when the grace period is extended by the Plan beyond the thirty (30) day grace period included within its contracts.

It is further recommended that the Plan comply with the provisions of Section 4235(k)&(l) of the New York Insurance Law and Department Regulation 78 (11 NYCRR 55.2(a)) relative to the requirements of termination notices of group policies or contracts of accident, health or accident and health insurance.

D. Pre-Existing Conditions Clause

A review of policy forms, riders and group certificates indicated that the Plan issued the following group certificates which contained pre-existing condition wording which exceeded the six (6) month limitation prior to enrollment prescribed by Section 4318(b) of the New York Insurance Law.

Alternate 70-Day Group Certificate – C A70 CRT 384
 Wraparound Group Certificate – CS W CRT 384
 Major Medical Expense Group Certificate – CS MM CRT 782c
 Select Blue Surgical – Medical Group Certificate S SE CRT 782

Section 4318(b) of the New York Insurance Law states in part,

“No pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the enrollment date for the covered person and may only relate to a condition (whether physical or mental) regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date....”

It is recommended that the Plan include the appropriate pre-existing condition provisions wording, prescribed by Section 4318(b) of the New York Insurance Law, in all group certificates issued by the Plan.

5. CLAIMS

A. Claims Processing

The Plan, during the examination, provided the examiners with reconciled claims data relative to seven (7) of its systems for the year 2001. However, the Plan did not provide all requested reconciled system data in a timely manner. Throughout the delays relative to the TOPS, CAPSICPS FLRx and Univera – CNY claims systems data, certain data was intermittently provided to the examiners, however, such data was not initially reconciled to the Plan's filed financial statements. The inability of the Plan to provide reconciled data in a timely manner caused a delay in the conclusion of this examination.

A review of the Plan's Internal Audit section reports indicated that the Plan did not make any internal audits relative to the reconciliation of claims system support data. Such audits may have uncovered the data support problems which led to the delays in providing claims data to the examiners during the examination and, ultimately, to the length of this examination. It is noted that the Plan has indicated that it has recently hired a data system auditor.

It is recommended that, at a minimum, the Plan's internal audit section make periodic reviews and reconciliations of system data to the Plan's underlying books and records. The Plan agreed to develop an action plan to address this recommendation prior to the finalization of the report.

A review of Excellus Health Plan, Inc.'s claims practices and procedures was performed. This review was performed by using a statistical sampling methodology covering the scope period in order to evaluate the overall accuracy and compliance environment of the Plan's claims processing. In order to achieve the goals of this review, claim populations were segregated by system. Six (6) of the Plan's major claims data systems were selected for review as follows:

1. TOPS
2. TOPPS

3. CAPSICPS
4. MHS
5. Univera – WNY
6. Univera - CNY

These primary populations were then further divided into hospital and medical claims segments. Random samples were drawn from each of the segment groups. For purposes of this project, those medical costs characterized as Medicare, capitated, and SMC payments were excluded.

This statistical random sampling process 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 within the selected populations, individually or on a combined basis. For example, if ten (10) attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample. The following parameters were established to determine the sample size for the statistical sampling model:

a) Confidence Level

The rate was set at 95%, which infers that there is a 95% chance that the sample will yield an accurate result.

b) Tolerance Error

The rate was set at 5%. It was determined that a 5% error rate would be acceptable for this sample.

c) Expected Error

It was anticipated that a 2% error rate exists in the entire population subject to sampling, which was deemed acceptable for the model design.

d) Sample Size

The sample size for each of the populations described herein was comprised of one hundred sixty seven (167) randomly selected unique claims. A second random sample of fifty (50) items from each of the populations was also generated as “replacement items” in the event it was determined a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized. In total, two thousand four (2,004) claims for the scope period were selected for review. This reflects three hundred thirty four (334) claims for each of the six claims data systems reviewed.

e) Sample Unit

The term, “claim” can be defined in a myriad of ways. For purposes of these procedures, the Department defines a claim as the total number of items submitted with a single claim form, which is the basis of the Department’s statistical sample of claims or the sample unit.

To ensure the completeness of the claims population, the total dollars paid were accumulated and reconciled to the financial data reported by the Plan. To verify each service (item) that resulted in no payment, a reconciliation of transaction counts was performed.

The Plan’s internal performance measurement for claims accuracy is 97%.

ROCHESTER DIVISION

TOPS (Indemnity) and TOPPS (Managed Care) claims systems

The attribute review findings for both of the captioned claims systems indicated accuracy rates at or above the Plan’s internal accuracy rate of 97%.

SYRACUSE DIVISION

CAPS/ICPS claims system (Indemnity)

The attribute review findings for the captioned claims system indicated an accuracy rate above the Plan's internal accuracy rate of 97%.

MHS System (Managed Care & POS)

The attribute review findings for the captioned claims system indicated an upper level error rate of 4.7% for hospital claims and 3.8% for medical claims which exceeded the Plan's internal error rate of 3%.

UNIVERA HEALTHCARE DIVISION

The review of the Univera Healthcare Division claims systems included the claims history of the former Health Care Plan, Inc. d.b.a. Univera Healthcare - WNY and the former Univera Healthcare - CNY on the FACETS claims system. Inasmuch as the two aforementioned former health insurers merged with Excellus Health Plan, Inc. effective October 1, 2001, this review was confined to the fourth quarter of 2001.

For the Univera – WNY Facets claims system, the review indicated an upper error limit of 6.42% relative to hospital claims and an upper error limit of 4.71% relative to medical claims in excess of the Plan's internal error rate of 3%.

For the Univera – CNY Facets claims system, the review indicated an upper error limit of 6.42% relative to medical claims in excess of the Plan's internal error rate of 3%. The examination upper error limit for hospital claims was within the Plan's anticipated error rate.

B. Prompt Payment

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,” 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.”

“(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.”

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

In this regard, a statistical sample of claims paid during calendar year 2001 was selected for each system from a population of claims that were paid more than forty-five (45) days from receipt. The claims were reviewed for compliance with Section 3224-a of the New York Insurance Law. The results of the review were then projected for the total population of claim payments made during the period.

ROCHESTER DIVISION

In 2001, Excellus Health Plan, Inc. processed 3,887,322 paid claims on its TOPS and TOPPS claims systems. Of these claims, a combined population of 3,368 hospital claims was identified where the payment date was more than forty-five (45) days after the receipt date. A second combined population of 26,084 medical claims was identified where the payment date was more than forty-five (45) days after receipt date. A sample of 167 claims was drawn from each of the hospital and medical claim populations identified as more than forty-five (45) days after receipt date for both the TOPS and TOPPS systems.

TOPS Claims System

The following is a summary of the prompt pay review findings for the Rochester Division’s TOPS system (Indemnity lines of business) for Hospital and Medical claims:

Description	Hospital Paid claims over 45 days Section 3224-a(a)	Medical – Paid claims over 45 days Section 3224-a(a)
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Claim population	1,984	740
Sample size	167	167
Number of claims with errors	2	39
Calculated Error Rate	<u>1.20%</u>	<u>23.35%</u>
Upper Error limit	2.85%	29.77%
Lower Error limit	-0.45%	16.94%
Upper limit Claims in error	<u>56</u>	<u>220</u>
Lower limit Claims in error	<u>0</u>	<u>125</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Of the 39 Medical claims found to be in violation of Section 3224-a(a), 3 claims also violated Section 3224-a(c) because interest due of \$2 or more was not paid.

TOPPS Claims System

The following is a summary of the prompt pay review findings for the Rochester Division's TOPPS system (Managed care) for Hospital and Medical claims:

Description	Hospital Paid claims over 45 days Section 3224-a(a)	Medical – Paid claims over 45 days Section 3224-a(a)
Claim population	1,384	25,344
Sample size	167	167
Number of claims with errors	18*	34
Calculated Error Rate	<u>10.78%</u>	<u>20.36%</u>
Upper Error limit	15.48%	26.47%
Lower Error limit	6.08%	14.25%
Upper limit Claims in error	<u>214</u>	<u>6,708</u>
Lower limit Claims in error	<u>84</u>	<u>3,612</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples

were selected the rate of error would fall between these limits 95 times.)

Of the 34 Medical claims found to be in violation of Section 3224-a(a), 3 claims also violated Section 3224-a(c) because interest due of \$2 or more was not paid.

SYRACUSE DIVISION

Excellus Health Plan, Inc., relative to its CAPS/ICPS and MHS claims systems, processed 3,326,075 paid claims in 2001. Of these claims, a combined population of 42,036 hospital and medical claims were identified where the payment date was more than forty-five (45) days after the receipt date. A sample of 167 claims was drawn from the combined hospital and medical populations identified as more than forty-five (45) days after receipt date for both the CAPS/ICPS and MHS systems.

CAPS/ICPS System

The following is a summary of prompt pay review findings for the Syracuse Division CAPS/ICAPS system (Indemnity) for paid claims over 45 days and denied over 30 days. Hospital and Medical claims were combined for purposes of this review:

Description	Paid claims over 45 days Section 3224-a(a)	Denied over 30 days Section 3224-a(b)
Claim population	37,218	22,526
Sample size	167	167
Number of claims with errors	47	17
Calculated Error Rate	<u>28.14%</u>	<u>10.18%</u>
Upper Error limit	34.96%	14.77%
Lower Error limit	21.32%	5.59%
Upper limit Claims in error	<u>13,013</u>	<u>3,326</u>
Lower limit Claims in error	<u>7,936</u>	<u>1,260</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Of the 47 claims found to be in violation of Section 3224-a(a), 18 claims also violated Section 3224-a(c) because interest due of \$2 or more was not paid.

MHS System

The following is a summary of prompt pay review findings for the Syracuse Division's MHS System (Managed Care & POS) for paid claims over 45 days and denied over 30 days (Hospital and Medical has been combined):

Description	Paid claims over 45 days Section 3224-a(a)	Denied over 30 days Section 3224-a(b)
Claim population	4,718	3,242
Sample size	167	167
Number of claims with errors	76	19
Calculated Error Rate	<u>45.51%</u>	<u>11.38%</u>
Upper Error limit	53.06%	16.19%
Lower Error limit	37.96%	6.56%
Upper limit Claims in error	<u>2,503</u>	<u>525</u>
Lower limit Claims in error	<u>1,791</u>	<u>213</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Of the 76 Medical claims found to be in violation of Section 3224-a(a), 3 claims violated Section 3224-a(c) because interest due of \$2 or more was not paid.

UNIVERA HEALTHCARE DIVISION

Excellus Health Plan, Inc. processed 567,599 paid claims through its FACETS (WNY and CNY) claims systems in 2001. Of these claims, a combined population of 1,937 hospital and medical claims were identified where the payment date was more than forty-five (45) days after the receipt date. A sample of 167 claims was drawn from the Univera WNY FACETS combined population identified as more than forty-five (45) days after receipt date. A sample of 50 claims was drawn from the Univera CNY FACETS combined population identified as paid more than forty-five (45) days after receipt date.

Univera Healthcare - WNY FACETS System

The following is a summary of prompt pay review findings for the Univera Healthcare - WNY FACETS system (Managed Care) for claims paid over 45 days:

Description	Paid claims over 45 days Section 3224-a(a)
Claim population	1,604
Sample size	167
Number of claims with errors	63
Calculated Error Rate	<u>37.72%</u>
Upper Error limit	45.08%
Lower Error limit	30.37%
Upper limit Claims in error	<u>723</u>
Lower limit Claims in error	<u>487</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

No Section 3224-a(c) of the New York Insurance Law interest violations were noted in the examination review.

Univera Healthcare - CNY FACETS System

The following is a summary of prompt pay review findings for the Univera Healthcare - CNY FACETS system (Managed care) for claims paid over 45 days:

Description	Paid claims over 45 days Section 3224-a(a)
Claim population	333
Sample size	50
Number of claims with errors	33
Calculated Error Rate	<u>66.00%</u>
Upper Error limit	79.13%

Lower Error limit	52.87%
Upper limit Claims in error	<u>264</u>
Lower limit Claims in error	<u>176</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

No Section 3224-a(c) of the New York Insurance Law interest violations were noted in the examination review.

It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five (45) day receipt of claim period provided by such section of the New York Insurance Law where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

It is further recommended that the Plan comply with the requirements of Section 3224-a(c) of the New York Insurance Law and pay appropriate interest on all applicable claims paid over forty-five (45) days from date of receipt.

C. Schedule H

A review of the Plan's Schedule H submission as filed with the Department for the period ending December 31, 2001 was performed. As part of the examination procedures, appropriate reconciliations were performed from the filed Schedule H to the Plan's underlying books and records. Additionally claims samples were obtained by claims data system for selected areas of Schedule H.

It was noted that the Plan had difficulty in initially reconciling its paid claims data by system to its filed Schedule H. Certain paid claims data, primarily from the Plan's Univera division, had been omitted in the Plan's original Schedule H filing. As a result of the examination

request for a reconciliation by system of such data, the Plan made corrections to its reported paid amounts and subsequently refiled such Schedule H.

In addition, the refiled Schedule H included inconsistent claim count information. Service line counts were included in the Schedule H, Section 3, Claim Count section in error for certain claim systems. This inconsistency led to delays in the Plan's providing reconciled data relative to such data systems.

It is recommended that the Plan take the necessary steps to ensure that accurate paid claim amounts and claim counts are included in its future filed Schedules H.

D. Emergent Care

A review of twenty-five (25) grievance files revealed that ten (10) such files related to emergent care cases. It was noted that eight (8) of the ten (10) emergent care cases were reversed during the internal grievance reviews. Certain cases were noted as being originally denied for payment because of no prior approval or referral.

Section 4303(a)(2) of the New York Insurance Law states in part,

“(a) Every contract issued by a hospital service corporation or health service corporation which provides coverage for in-patient hospital care shall also provide coverage: ...

(2) For services to treat an emergency condition in hospital facilities. For the purpose of this provision, “emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person’s bodily functions; (C) serious

dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.”

It is noted that the Plan subsequently discontinued the prior approval and referral requirements for such emergent care cases in late 2000 and, in 2001, the Plan changed its procedures to provide for the payment of all such claims without review. The Plan identified all emergent care claims previously denied under referral and prior approval requirements and reprocessed them.

It is recommended that the Plan continue to comply with the requirements of Section 4303(a)(2) of the New York Insurance Law relative to the payment of emergent care claims.

E. Utilization Review

The following items apply to the Plan's participating providers only. Article 49 of the New York Insurance Law and Article 49 of the New York Public Health Law both set forth the minimum utilization review program requirements including standards for utilization review determinations and appeals of adverse determinations by utilization review agents. The aforementioned Articles establish the insured's/enrollee's right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an insured's/enrollee's health care provider shall have the right to request an external appeal.

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 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 is applicable to HMOs and contains similar language.

Further, Section 4904(a) of the New York Insurance and Section 4904.1 of the New York Public Health Law both state:

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

A review of claim denials indicated that many claims were denied retrospectively because the services rendered did not qualify as medically necessary. A retrospective claims utilization review of year 2001 files was conducted which revealed the following:

The Plan failed to send written notification of either the first adverse determination to participating providers in a number of retrospective claim utilization reviews.

It is recommended that the Plan send proper notices of first adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law, as applicable.

Both Section 4904(c) of the New York Insurance Law and Section 4904.3 of the New York Public Health Law state, in part:

“...The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal....”

Section 4904(c) of the New York Insurance Law further states, in part:

“...The notice of the appeal determination shall include:

(1) a notice of the insured’s right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health...”

Section 4904.3 of the New York Public Health Law, applicable to Health Maintenance Organizations, contains similar language.

In an undetermined number of appeals by participating providers, the Plan failed to send letters acknowledging receipt of an appeal of the first medical adverse determination to such participating providers.

It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law and Section 4904.3 of the New York Public Health Law and provide written acknowledgement of the filing of an appeal from its participating providers, within fifteen days of such filings.

Section 4910(b) of the New York Insurance Law and Section 4910.2 of the New York Public Health Law state, in part:

“An insured, the insured’s designee and, in connection with retrospective adverse determinations, an insured’s health care provider, shall have the right to request an external appeal...”

In addition, New York Department of Health Regulation, Part 98-2.9 (e)

(10 NYCRR98-2.9 (e)) states:

“Each notice of final adverse determination of expedited or standard utilization review appeal under section 4904 of the Public Health Law shall be in writing, dated and include the following:

- (1) a clear statement describing the basis and clinical rationale for the denial as applicable to the enrollee;*
- (2) a clear statement that the notice constitutes the final adverse determination;*
- (3) the health care plan’s contact person and his or her telephone number;*
- (4) the enrollee’s coverage type;*
- (5) the name and full address of the health care plan’s utilization review agent;*
- (6) the utilization review agent’s contact person and his or her telephone number;*
- (7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;*
- (8) a statement that the enrollee may be eligible for external appeal and the time frames for requesting an appeal; and*
- (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 days time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal.”*

The Plan did not include some retrospective utilization review appeals, made by its participating providers, in those cases where the participating provider's contracts with the Plan

contained dispute resolution language within Schedule M of its December 31, 2001 annual statement.

It is recommended that the Plan include all retrospective utilization review appeals, made by its participating providers, on Schedule M of its annual statements in future filings made to this Department.

6. EXPLANATION OF BENEFITS STATEMENTS

A review of the Explanation of Benefits (EOB) forms and denial letters issued by the Plan during the period under review indicated that such EOB forms and denial letters did not include all required wording required by Section 3234(b) of the New York Insurance Law.

Section 3234(b) of the New York Insurance Law states in part,

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

*“...a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate **and a notification that failure to comply with such requirements may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made**”.*

A review of the Plan’s EOBs produced by the Plan during the period under review indicated that the wording noted above in bold text was not included in the Plan’s EOBs sent to its subscribers. Although the required language was not included in the Plan's EOBs in 2001, the EOBs were subsequently modified to include the language. The Plan indicated that there were no denials of a member's appeal in 2001 because of lack of timeliness.

It is recommended that the Plan include all required wording prescribed by Section 3234(b) of the New York Insurance Law within its Explanation of Benefits statements and applicable denial letters sent to its subscribers.

7. FRAUD PREVENTION AND DETECTION

A review was performed of the organization and structure of the Plan's Special Investigation Unit (SIU). The Plan's compliance with Section 405 of the New York Insurance Law and Regulation 95 (11 NYCRR 86) with respect to the reporting of fraud cases to the Department was also reviewed. No problem areas were noted with regard to this review.

It was noted that the Plan's Rochester division's SIU employees were observed to be segregated from other Plan employees and contracted workers in the Rochester division while the examiners were on-site.

It was noted that the Plan's SIU employees were not completely segregated from other Plan employees and contracted workers in its Utica/Watertown division. Such segregation is necessary because of the privacy aspects of the SIU investigative process.

It is recommended that the Plan appropriately segregate its SIU employees from its other employees and contracted workers within all of its divisions.

Excellus SIU management advised the examiners that in each of the Plan's divisions, all new employees received fraud awareness training at the beginning of their employment. However, no formal or mandatory periodic refresher sessions on fraud awareness for its claims and underwriting unit employees as required by Part 86.6(a)(6) of New York Insurance Department Regulation 95 (11 NYCRR 86.6(a)(6)) appear to have been conducted during the

examination period. It is further noted that the Plan was unable to document the participation of its employees in the SIU training that was conducted during the examination.

It is recommended that the Plan develop an annual in-service training program for its claims and underwriting unit employees as required by Part 86.6(a)(6) of New York Insurance Department Regulation 95 (11 NYCRR 86.6(a)(6)).

8. HOME HEALTH CARE PROVIDERS

A review of the procedures and practices relative to the captioned providers revealed that the Plan had not submitted the sampled provider contracts for approval to the Commissioner of Health prior to use.

Part 98-1.8(b) of Department of Health Regulation (10 NYCRR 98-1.8(b)) states the following:

“...All new contracts with new types of health services providers, shall require prior approval and be submitted to the commissioner at least 30 days in advance of their anticipated execution.”

It is recommended that the Plan submit all active contracts with its providers, including Home Health Care provider agreements, to the Commissioner of Health for approval in compliance with Department of Health Regulation (10 NYCRR 98-1.8(b)).

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

The following is a summary of the comments and recommendations made in the body of this report:

<u>ITEM NO.</u>		<u>PAGE NO.</u>
A.	<u>Sales</u> It is recommended that the Plan, pursuant to Section 2114(a)(3) of the New York Insurance Law, refrain from paying any commissions or compensation directly dependent upon the amount of business obtained to any person that does not possess a valid agent's or broker's license.	4
B.	<u>Underwriting and rating</u> It is recommended that the Plan maintain signed copies of a Department approved rider or remitting agent agreement with all groups receiving level premium or guaranteed rates. It is recommended that the Plan, pursuant to Part 52.42(b)(3)(ii)(a) of New York Insurance Department Regulation 62 (11 NYCRR	5 6

52.42(b)(3)(ii)(a)), obtain New York Insurance Department approval for its level premium agreements and amendments of previously approved agreements used by the Plan

It is recommended that the Plan file, pursuant to Section 4308(b) of the New York Insurance Law and Department Regulation 62 (11 NYCRR 52.40), and obtain the Superintendent's prior approval for its experience rating agreements. 7

It is recommended that the Plan comply with the thirty (30) day grace period included in its contracts relative to cancellations for non-payment of premium. 9

It is recommended that the Plan refrain from retracting or denying affected claims when the grace period is extended by the Plan beyond the thirty (30) day grace period included within its contracts. 9

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It is further recommended that the Plan comply with the provisions of Section 4235(k) &(1) of the New York Insurance Law and New York Insurance Department Regulation 78 (11 NYCRR 55.2(a)) relative to the requirements of termination notices of group policies or contracts of accident, health or accident and health insurance. 10

It is recommended that the Plan include the appropriate pre-existing condition provisions wording, prescribed by Section 4318(b) of the New York Insurance Law, in all group certificates issued by the Plan. 10

C. **Claims**

It is recommended that, at a minimum, the Plan's internal audit section make periodic reviews and reconciliations of system data to the Plan's underlying books and records. 11

It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five (45) day receipt of claim period provided by such section of the New York Insurance Law where there is not an appropriate reason for delay 21

in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

It is further recommended that the Plan comply with the requirements of Section 3224-a(c) of the New York Insurance Law and pay appropriate interest on all applicable claims paid over forty-five (45) days from date of receipt. 21

It is recommended that the Plan take the necessary steps to ensure that accurate paid claim amounts and claim counts are included in its future filed Schedules H. 22

It is recommended that the Plan continue to comply with the requirements of Section 4303(a)(2) of the New York Insurance Law relative to the payment of emergent care claims. 23

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It is recommended that the Plan send proper notices of first adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law, as applicable. 25

It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law and Section 4904.3 of the New York Public Health Law and provide written acknowledgement of the filing of an appeal from its participating providers, within fifteen days of such filings. 26

It is recommended that the Plan include all retrospective utilization review appeals, made by its participating providers, on Schedule M of its annual statements in future filings made to this Department. 27

D. **Explanation of Benefits Statements** 28

It is recommended that the Plan include all required wording prescribed by Section 3234(b) of the New York Insurance Law within its Explanation of Benefits statements and applicable denial letters sent to its subscribers.

- E. **Fraud Prevention and Detection** 29
- It is recommended that the Plan appropriately segregate its SIU employees from its other employees and contracted workers within all of its divisions.
- It is recommended that the Plan develop an annual in-service training program for its claims and underwriting unit employees as required by Part 86.6(a)(6) of New York Insurance Department Regulation 95 (11 NYCRR 86.6(a)(6)). 29
- G. **Home Health Care Providers** 30
- It is recommended that the Plan submit all active contracts with its providers, including Home Health Care provider agreements, to the Commissioner of Health for approval in compliance with Department of Health Regulation (10 NYCRR 98-1.8(b)).

APPENDIX

CORPORATE GOVERNANCE

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1. SCOPE OF EXAMINATION

A review of Excellus Health Plan, Inc.'s corporate governance procedures was conducted during the examination. The review covered the period from January 1, 2001 through October 10, 2003. The primary purpose of this report is to assist Excellus Health Plan, Inc.'s management in addressing corporate governance issues that are of such a critical nature that immediate and corrective action is required. This report's comments chiefly involve matters that depart from New York laws, regulations and rules or those which are deemed to require an explanation or description from the Plan.

2. BOARD GOVERNANCE

A review of the minutes of meetings of the Excellus Health Plan, Inc. board of directors and committees indicated that there is a need for more enhanced board oversight of executive compensation.

In 2001, Article V, Section 5(b) of the Plan's by-laws stated in part,..."The compensation of the Chief Executive Officer of the Corporation is to be determined by the Board of Directors, and the compensation of all other officers of the Corporation is to be determined by the Chief Executive Officer."

It was noted that although reports were presented to the board relative to approval of the CEO's salary by the Committee on Directors/Executive Committee, much of the discussion was made in "Executive Session" with little or no minutes taken of actions taken by the Executive Committee or Board of Directors. Although the board may have been aware of the Executive Committee's approval of the CEO's salary and variable pay award, there were no amounts specifically approved by the board.

The review indicated little oversight or board approval of other executive compensation paid to the Plan's officers and key employees.

It is recommended that the board of directors formally ratify the actions of the executive committee's approval of the CEO's compensation. It is also recommended that the Plan's board of directors review and ratify, on at least an annual basis, the compensation paid to senior level officers. It is recommended that the minutes of the meetings of the board of directors and executive committee specifically reflect such actions.

3. OFFICER/EMPLOYEE BENEFIT PLANS

It was noted that the Plan, at the time of the examination had not submitted the rewritten version of its Excess Benefit and Compensation Limit Plan (SERP) and amendments to its defined pension plan and 401(k) plan to the New York Insurance Department for approval.

Section 4312(b) of the New York Insurance Law states, in part,

“No such corporation shall grant any pension to any officer, director or trustee thereof or to any member of his family after death, except that such corporation may, in pursuance of the terms of the retirement plan adopted by the board of directors of such corporation and approved by the superintendent, provide for any person who is a salaried officer or employee of such corporation, a pension payable at the time of his retirement by reason of age or disability...”

Subsequent to the examination review, the Plan submitted the rewritten version of its SERP agreement and the aforementioned amendments to its defined pension plan and its 401(k) plan to the Superintendent of Insurance for approval.

It is recommended that the Plan, in the future, comply with the requirements of Section 4312(b) of the New York Insurance Law and submit all unapproved retirement, 401(k) plans, SERP agreements and any amendments to such plans and agreements for approval to the Superintendent of Insurance prior to implementation.

4. EMPLOYMENT AGREEMENTS

It was noted that, at the time of the examination, the Plan maintained employment agreements with certain senior officers of Excellus Health Plan, Inc. which contained automatic day-to-day evergreen clauses in violation of Section 4312(b) of the New York Insurance Law.

Section 4312(b) of the New York Insurance Law states,

“No corporation subject to the provisions of this article shall hereafter enter into any agreement, directly or indirectly, with an officer, director or salaried employee of such corporation whereby it agrees that for any services rendered or to be rendered he shall receive any salary, compensation or emolument that will extend beyond a period of thirty-six months from the date of such agreement...”

Subsequent to meetings with New York Insurance Department senior management, the Plan replaced the existing agreements with four of its senior management officers with new agreements that were limited to a three-year term, with no automatic renewals or extensions. In addition, the Plan agreed to review its employment agreements with its other employees and to the extent that any of these agreements have evergreen or renewal provisions that could extend beyond three years, those employees will receive a notice indicating that their agreements are considered void.

It is recommended that the Plan bring all of its employment agreements with its officers and employees into compliance with the requirements of Section 4312(b) of the New York Insurance Law. The Plan has indicated that all recommended actions have been implemented.

5. SUMMARY OF COMMENTS AND RECOMMENDATIONS

The following is a summary of the comments and recommendations made in the body of this report:

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<p>A. <u>Board Governance</u></p> <p>It is recommended that the board of directors formally ratify the actions of the executive committee's approval of the CEO's compensation. 37</p> <p>It is also recommended that the Plan's board of directors review and ratify, on at least an annual basis, the compensation paid to senior level officers. 37</p> <p>It is recommended that the minutes of the meetings of the board of directors and executive committee specifically reflect such actions. 37</p>	<p>37</p> <p>37</p> <p>37</p>
<p>B. <u>Officer/Employee Benefit Plans</u></p> <p>It is recommended that the Plan, in the future, comply with the requirements of Section 4312(b) of the New York Insurance Law and submit all unapproved retirement, 401(k) plans, SERP agreements and any amendments to such plans and agreements for approval to the Superintendent of Insurance prior to implementation.</p>	<p>38</p>
<p>C. <u>Employment Agreements</u></p> <p>It is recommended that the Plan maintain all of its employment agreements with its officers and employees into compliance with the requirements of Section 4312(b) of the New York Insurance Law.</p>	<p>39</p>

Respectfully submitted,

Robert W. McLaughlin, CFE, CIE
Principal Insurance Examiner

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

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

Robert W. McLaughlin

Subscribed and sworn to before me

this _____ day of _____ 2004.

**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:

Robert McLaughlin

as a proper person to examine into the affairs of the

Excellus Health Plan, Inc.

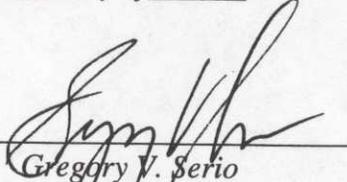
and to make a report to me in writing of the said

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 11th day of March 2002



Gregory V. Serio
Superintendent of Insurance

