MARKET CONDUCT REPORT ON EXAMINATION

OF

EXCELLUS HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2013

DATE OF REPORT	**AUGUST 22, 2016**
EXAMINER	**WAI WONG**

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Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

August 22, 2016

Honorable Maria T. Vullo
Superintendent of Department 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 Number 31056, dated November 25, 2013, attached hereto, I have made an examination into the affairs of Excellus Health Plan, Inc., a non-profit health service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2013, and submit the following report thereon.

The examination was conducted at the home office of Excellus Health Plan, Inc., located at 165 Court Street, Rochester, New York.

Wherever the designations the "Plan," "EHP," or "Excellus" appear herein, without qualification, they should be understood to indicate Excellus Health Plan, Inc., a wholly-owned subsidiary of Lifetime Healthcare, Inc.

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

An examination was performed to review the manner in which Excellus Health Plan, Inc. conducted its business practices and fulfilled its contractual obligations to policyholders and claimants. The previous market conduct examination of Excellus Health Plan, Inc. was conducted as of December 31, 2007. This examination covered the six-year period January 1, 2008 to December 31, 2013. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A review was also made to ascertain what actions were taken by the Plan with regard to comments and recommendations made in the prior market conduct report on examination.

A concurrent examination regarding the financial condition of Excellus Health Plan, Inc., was made as of December 31, 2013. A separate report thereon has been submitted.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicated areas of weakness and/or directly impacted the Plan's compliance with the New York Insurance Law, Insurance Regulations, New York Public Health Law, and the Code of Federal Regulations.

Significant findings relative to this examination include the following:

- The Plan did not comply with Section 3224-a of the New York Insurance Law ("Prompt Pay Law") relative to the payment of certain claims, payment of interest on such claims, and the denial of certain claims.
- The Plan did not comply with Section 4308(b) of the New York Insurance Law and Section 52.40(g)(1) of Insurance Regulation No. 62 (11 NYCRR 52.40(g)(1)) by not experience rating groups in compliance with the approved formula on file with the Department.
- The Plan's failure to send to the appealing party, written notice of acknowledgement of a utilization appeal was in violation of Section 4904(c) of the New York Insurance Law.

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

3. DESCRIPTION OF THE PLAN

Excellus Health Plan, Inc. is a domestic not-for-profit health service corporation organized and licensed pursuant to Article 43 of the New York Insurance Law. The Plan operates under two assumed (d/b/a) names for its Article 43 business, Excellus BlueCross BlueShield and Univera Healthcare. Excellus BlueCross BlueShield provides hospital, surgical-medical, major medical/comprehensive, dental and prescription drug coverages within the Rochester, New York and Central New York State regions. Univera Healthcare provides hospital, medical, dental and prescription drug coverages within an eight county area of western New York State.

The Plan also holds a Certificate of Authority under Article 44 of the New York Public Health Law to operate Excellus Health Plan, Inc. d/b/a Upstate HMO, Univera Healthcare HMO and Univera, as a separate line of business. The latter two d/b/a names pertain to the Plan's HMO operations within an eight county region of the western region of New York State.

At the examination date, Lifetime Healthcare, Inc. was the sole member of Excellus Health Plan, Inc. Excellus Inc. changed its name on January 23, 2004 to Lifetime Healthcare, Inc., d/b/a The Lifetime Healthcare Companies. Excellus Health Plan, Inc. is the surviving entity resulting from the mergers of the Blue Cross/Blue Shield Plans in the Rochester, Central New York, and Utica-Watertown regions and HMOs in Central and Western New York; including HMO-CNY and Univera Healthcare of Central and Western New York.

4. CLAIMS PROCESSING

A. Systemic Claim Denials

In order to evaluate the overall accuracy and compliance environment of Excellus' claims processing, a review was performed by using a statistical sampling methodology to select claims processed during the period January 1, 2013 through December 31, 2013. The examiner selected a sample of hospital and medical claims and reviewed the selected claims for any processing errors that were the result of systemic issues in Excellus claim processing system.

The claim population for Excellus was divided into medical and hospital claim segments and a random statistical sample was drawn from each segment. It should be noted for the purpose of this review that medical costs characterized as "Pharmacy," "Medicare/Medicaid," "Dental," "Capitated Payments," "Federal Employees Program," and "HCRA" bulk payments were excluded.

The initial sample size for each population was comprised of 167 randomly selected unique claim transactions. Additional random samples were generated for each group as "replacement items" in the event it was determined a particular claim transaction selected in the sample should be excluded. Accordingly, various replacement items were appropriately utilized. In total, 334 claims were selected for this review.

The examiner noted that under certain circumstances, a billing provider, e.g., a hospital, added new doctors who were coded as servicing providers on facility claims. The new doctors had to be credentialed before Excellus could pay claims where they were listed as the servicing provider. A system message that was in place to ensure claims did not process until the

credentialing information was updated did not always work as designed; instead of pending claims for review, some claims were denied, in error.

After the system was corrected, an analysis was undertaken by Excellus to identify impacted claims; 1,706 claims were adjusted, with interest paid where applicable, as required by Section 3224-(a)(c) of the NYIL.

B. Contraceptive Medical and Hospital Claims Processing

In order to evaluate the overall accuracy and compliance of Excellus processing of medical and hospital contraceptive claims with regard to the requirements of the Affordable Care Act effective January 1, 2014, a review was performed by using a statistical sampling methodology to select claims processed during the period January 1, 2014 through June 30, 2014. The examiner selected a sample of contraceptive claims from Excellus from both the hospital and medical claims population, and evaluated the selected claims, testing various attributes deemed necessary for successful claims processing activity.

The claim population was divided into "paid" and "denied" claim segments and a random statistical sample was drawn from each segment. There were a total of 17,234 total claims in the population, with 16,201 paid claims and 1,123 denied claims. There were 1,543 paid claims with cost sharing applied such as co-pays, co-insurance and deductibles. Separate samples were taken from the population of paid claims where cost sharing was applied and from the denied claims population.

The initial sample size for each population was comprised of 167 randomly selected unique claim transactions. In total, 334 claims were selected for this review.

There were five (5) claims where subscriber cost sharing was applied to the claim payment, in the review of one-hundred and sixty seven (167) medical and hospital contraceptive claims. In four (4) of the cases, Excellus had already reversed the subscriber cost share applied to the claims at the time of the review.

There were an additional thirty-six (36) claims where subscriber cost sharing was applied because the provider failed to identify the claim as a contraceptive claim. In these cases the medical / hospital procedure code billed for either a contraceptive service or a non-contraceptive service. If the claim was for a contraceptive service the provider was supposed to include a modifier, in their claim submission indicating the claim as such. Many providers failed to include this modifier resulting in an initial cost share charge applied to the subscriber. Excellus subsequently reversed these charges when they were informed the claim was a contraceptive claim.

Excellus was able to identify providers that did not bill using the modifier through inquiries from members and/or providers, or through subsequent system implementations. As Excellus was made aware of the issues, and after validating how the claims were being billed, Excellus undertook system corrections to allow the codes to be paid under the preventative services provisions. These system changes included updates to the logic used to assign a preventative type of service and combine procedure code/diagnosis/modifier logic tables. As part of the system corrections, Excellus reviewed denied claims to identify those that were processed incorrectly, and had those claims repaid, with interest, where applicable. This eliminated the need for members and/or providers to notify Excellus each time an issue arose.

It is recommended that Excellus take steps to ensure its providers are notified of and complying with any requirements to identify preventive claims under the Affordable Care Act including applying any required modifiers to claim submissions.

The examiner determined that fifteen (15) claim denials were issued in error from the review of denied medical and hospital contraceptive claims. The claims were for use of an out-of-network provider by subscribers who did not have an out-of-network benefit. The claims were denied in error because two provider networks, one that was in-network and one that was not in-network had merged. Excellus had not updated their records to reflect the change in status of the out-of network provider group to "in-network". All fifteen (15) of the claims had already been adjusted and paid at the time of the examiner's review, and the claims system had been updated with the revised network status.

Excellus adjusted 1,001 claims due to this issue. The provider files were updated in early April 2014, and all claim adjustments were completed by April 28, 2014.

It is recommended that Excellus put in place procedures to ensure that claims are not denied in error for being out-of-network.

C. Contraceptive Drug Claims Processing

In order to evaluate the overall accuracy of Excellus processing of contraceptive drug claims and its compliance with the requirements of the Affordable Care Act, effective January 1, 2014, a review was performed by the examiners using a statistical sampling methodology to select contraceptive drug claims processed during the period January 1, 2014 through June 30, 2014. The examiner selected a sample of paid and denied contraceptive drug claims, and evaluated the selected

claims, testing various attributes deemed necessary for successful claims processing activity.

The claim population was divided into "paid" and "denied" claim segments, and a random statistical sample was drawn from each segment. There was a total of 288,033 claims in the population, with 247,972 paid claims and 40,061 denied claims. There were 2,695 paid claims with cost sharing applied such as co-pays, co-insurance and deductibles. Separate samples were taken from the population of paid claims where cost sharing was applied and from the denied claims population.

The initial sample size for each population was comprised of 167 randomly selected unique claim transactions. Additional random samples were generated for each group as "replacement items" in the event it was determined a particular claim transaction selected in the sample should be excluded. Accordingly, various replacement items were appropriately utilized. In total, 334 claims were selected for this review.

The examiner noted during the review that for some claims, a co-pay charge was applied to the purchase of a generic drug or to the purchase of a brand drug which did not have a generic substitute, which was in violation of Excellus' internal processing rules.

It is recommended that Excellus put in place procedures to ensure that subscribers are charged cost sharing correctly.

From the review of denied contraceptive drug claims it was noted that certain claims had been denied because the drugs requested were non-formulary drugs and others were denied because the drug supply requested exceeded the 30-day limit specified under the subscriber's drug contract. The subscribers had received approval for the non-formulary drugs and the requested

drug supplies over 30 days. The claims reviewed had been adjusted and paid at the time of the review.

It is recommended that Excellus put in place procedures to ensure that contraceptive drug claims are paid correctly.

D. Claims Processing

In order to evaluate the overall accuracy and compliance of Excellus' processing of claims, a review was performed by using a statistical sampling methodology to select claims processed during the period July 1, 2014 through July 31, 2014. The examiner selected a sample of "paid" and "denied" claims and evaluated the selected claims, testing various attributes deemed necessary for successful claims processing activity.

The selected claims population was divided into paid and denied claim segments and a random statistical sample was drawn from each segment. There was a total of 32,458 claims in the population, with 31,365 paid claims and 1,093 denied claims. Separate samples were taken from the population of paid claims and denied claims population.

The initial sample size for each population was comprised of 167 randomly selected unique claim transactions. In total, 334 claims were selected for this review.

The following claim processing errors were noted.

The examiner determined that thirty-eight (38) claim processing errors were found with regard to the relevant claims from a review of 167 denied claims. The errors were the result of

various issues such as incorrect classification of the provider as out-of-network, denial for failure to have an authorization or referral to see the physician when one had been provided, incorrect Blue Card lab denials, denials for claims that were incorrectly deemed to be payable by Medicaid rather than Excellus for subscribers with dual coverage, one where the provider's fee schedule did not include all the codes he was allowed to bill, and one where the claim was denied because the lab was out-of–network, but should have been paid as an in-network claim because the physician who referred the claim to the lab was an in-network physician.

It is noted that twenty (22) of the thirty-eight (38) claims that were processed in error were related to the out-of-network lab issue.

Excellus' management had indicated that the Plan is working on the system correction for this issue. While the system corrections are being made, monthly reports are pulled to identify the out-of-network lab claims that had a participating referring physician so that adjustments can be made in advance of the system fix. MedLab and Millennium are two of the labs impacted; these providers are submitting reports to Excellus for adjustments. Since May of 2014, approximately 10,000 claims have been adjusted due to this network issue.

There were eighty-two (82) total claims adjusted for the provider whose fee schedule needed to be updated to include all the required billing codes.

It is recommended that Excellus put in place procedures to ensure that its claims are paid correctly.

5. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("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 30 days of receipt of a claim that is transmitted via the internet or electronic mail or 45 days of receipt of a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven 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 ("covered person") 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 thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

In addition, Section 3224-a(c)(1) of the New York Insurance Law states:

> "(c)(1) Except as provided in paragraph two of this subsection, 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, and 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 of receipt for claims transmitted via the internet or electronic mail, or 45 days of receipt for claims submitted by other means such as paper or a facsimile by Excellus was reviewed by the examiner to determine whether the 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 and appropriately paid pursuant to Section 3224-a(c)(1) of the NYIL. Accordingly, all claims that were not adjudicated within the respective 30 or 45 day time frames during the period January 1, 2013 through December 31, 2013, were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated and paid (when required).

The claim population for EHP was separated and further divided into medical and hospital claim segments. A random statistical sample was drawn from each segment.

The sample size for each population was comprised of 167 randomly selected claims. In total, 334 claims were selected for this review.

The following chart illustrates EHP's compliance with the Prompt Pay Law, as determined by this examination:

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

	Medical Claims	Hospital Claims
Total population of claims	16,474,958	3,964,044
Population of claims paid past 30/45 days	558,393	203,332
Sample size	167	167
Number of claims with violations	115	42
Calculated violation rate	**68.86%**	**25.15%**
Upper violation limit	75.89%	31.73%
Lower violation limit	61.84%	18.57%
Calculated claims in violation	**384,509**	**51,138**
Upper limit claims in violation	423,764	64,517
Lower limit claims in violation	345,310	37,759

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

Summary of Violations of Section 3224-a(c)(1) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	16,474,958	3,964,044
Population of claims paid past 30/45 days that are eligible for interest	514,038	184,581
Sample size	167	167
Number of transactions with violations	1	0
Calculated violation rate	**.60%**	**0.00%**
Upper violation limit	1.77%	0.00%
Lower violation limit	0.00%	0.00%
Calculated transactions in violation	**3,084**	**0**
Upper limit transactions in violation	9.098	0
Lower limit transactions in violation	0	0

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

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample (claims received during the period January 1, 2013 through December 21, 2013), which consisted of only those claims adjudicated over thirty days of receipt that were transmitted via the internet or electronic mail or forty-five days of receipt for claims submitted by other means such as paper or a facsimile and/or which should have incurred interest of two dollars or more based upon the examiner's calculations.

The population of claims adjudicated after thirty days for electronic submission or forty-five days for paper submission from the date of receipt for EHP consisted of 558,393 and 203,332 medical and hospital claims, respectively, out of 16,474,958 and 3,964,044 medical and hospital claims processed, respectively, during the period under review.

It is recommended that Excellus take steps to comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims.

It is also recommended that Excellus take steps to comply with the provisions of Section 3224-a(c) of the New York Insurance Law regarding the payment of interest on claims that were paid in violation of the aforementioned prompt payment standards.

A review was also performed as to the manner in which EHP handled the denial of claims and requested additional information needed to determine liability to pay a claim.

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

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven 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 or certified pursuant to article forty-three or forty-seven 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 denied more than 30 days after receipt by Excellus was reviewed to determine whether the denial/request for information exceeded the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims that were denied past 30 days after receipt during the period January 1, 2013 through December 31, 2013, were segregated. A statistical sample of this population was then selected to determine whether the claims were adjudicated within the parameters of the aforementioned statute.

The following chart illustrates EHP's compliance with Section 3224-a(b) of the New York Insurance Law, as determined by this examination:

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

	Medical Claims	Hospital Claims
Total population of claims	16,474,958	3,964,044
Population of claims adjudicated over 30 days	455,324	103,929
Sample size	167	167
Number of claims with violations	113	112
Calculated violation rate	**67.66%**	**67.07%**
Upper violation limit	74.76%	74.19%
Lower violation limit	60.57%	59.94%
Calculated claims in violation	**308,072**	**69,705**
Upper limit claims in violation	340,400	77,105
Lower limit claims in violation	275,790	62,295

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

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 that were denied more than thirty days from receipt.

The population of claims denied more than thirty days from the date of receipt for EHP consisted of 455,324 and 103,929 medical and hospital claims, respectively, out of 16,474,958 and 3,964,044 medical and hospital claims processed, respectively, during the period under review.

It is recommended that Excellus take steps to comply with the provisions of Section 3224-a(b) of the New York Insurance Law regarding the denial of claims.

6. EXPERIENCE RATING

In order to determine whether Excellus was following the requirements of its filed experience rating plan with regard to the rating of its large group experience rated polices, a review was performed of experience rated policies renewed during the period January 1, 2013 through December 31, 2013.

There were a total of 1,241 experience rated large groups renewed during the period under review. Of those 1,241 groups, only 446 groups had group specific renewal rates calculated using Excellus' experience rating plan. These groups had a base experience plan (BEP) of 100 contracts or more. The remaining 795 groups had renewal rates calculated by a block rating methodology where a single overall renewal percentage increase was calculated and applied to the entire block rated group using the experience of all insureds in the groups.

A sample of 167 policies with a Base Experience Period (BEP) Average Contract of 100 contracts or more was selected for review.

Part 52.40(g)(1) of Insurance Regulation No. 62 (11 NYCRR 52) states in part:

> "(g) The following rules shall apply to the adjustment of the rate of premium based on the experience of any contract of master group insurance as provided for under section 4305(a), (b) or (c) of the Insurance Law:
>
> (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."

The review of the sample files found that the initial base rate that is used as a starting point of the process of determining the group's renewal premium was adjusted downward on 133 out of

167 policies reviewed to arrive at the rate negotiated with the group based on parameters that were outside of the approved formula.

Based on this violation rate, it is estimated that 355 out of the total experienced rated population of 446 groups were not rated in compliance with the approved formula on file with the Department, with an upper limit of 382 claims in error and a lower limit of 328.

It is recommended that Excellus comply with Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Insurance Regulation No. 62 (11 NYCRR 52) by experience rating policies only in accordance with a formula or plan approved by the Department.

7. UTILIZATION REVIEW

Sections 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum utilization review program standards and requirements of utilization review determinations for prospective, concurrent and retrospective reviews and appeals of adverse determinations by utilization review agents. Comparable sections of Article 49 of the New York Public Health Law contain the same requirements for Excellus' line-of-business HMO policies. The findings detailed herein refer to the New York Insurance Law. However, unless otherwise noted, the violations are applicable to the comparable statutory citations of Article 49 of the New York Public Health Law (for the Excellus line of business HMO).

Excellus provided a listing of 3,734 utilization review appeal files closed from January 1, 2013 to December 31, 2013. From this listing 167 utilization review files were selected for review

by the examiner. The initial utilization review determinations for each of these files were also requested for review.

For the period January 1, 2013 to December 31, 2013 there were 306,485 prospective, concurrent or retrospective utilization review cases closed by Excellus or its third party administrators.

The files encompass utilization reviews and utilization review appeals performed by Excellus and its third party administrators Healthplex, CareCore National and Palladian Health.

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

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

There were four (4) instances where a utilization review determination which requires pre-authorization was not completed within three business days.

Based on the error rate from the review of the 167 cases sampled it is estimated, that on 7,341 out of a total population of 306,485 utilization review cases, a utilization review determination was not conducted within three business days for a case requiring pre-authorization, in violation of the above law, with an upper limit of 14,448 utilization review cases estimated as being in error and a lower limit of 234 cases in error.

It is recommended that Excellus and its third-party administrators comply with the requirements of Section 4903(b) of the New York Insurance Law.

Section 4903(c) of the New York Insurance Law states in part:

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

There was one instance (1) where a utilization review determination which requires continued or extended health care services was not completed within one business day.

Based on the error rate from the review of the 167 cases sampled it is estimated, that on 1,839 out of a total population of 306,485 utilization review cases, a utilization review determination which requires continued or extended health care services was not done within one business day, in violation of the above law, with an upper limit of 5,425 utilization review cases estimated as being in error and a lower limit of zero (0) cases in error.

It is recommended that Excellus and its third-party administrators comply with the requirements of Section 4903(c) of the New York Insurance Law.

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

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

There were twelve (12) instances, where a utilization review determination involving health care services which have been delivered was not completed within thirty days.

Based on the error rate from the review of the 167 cases sampled it is estimated that on a calculated basis, there were 22,023 out of the total population of 306,485 utilization review cases where a utilization review determination was not calculated within thirty days for cases where health care services have been delivered, in violation of the above law. The review estimate indicated an upper limit of 34,027 cases in error and a lower limit of 10,018 cases in error.

It is recommended that Excellus and its third-party administrators comply with the requirements of Section 4903(d) of the New York Insurance Law.

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

> "(e) Notice of an adverse determination made by a utilization review agent shall be in writing…"

There was one instance where a written notice of adverse determination was not sent to the insured.

Based on the error rate from the review of the 167 cases sampled it is estimated, that on 1,839 out of a total population of 306,485 utilization review cases, a written notice of adverse determination was not sent to the insured, in violation of the above law, with an upper limit of 5,425 utilization review cases were estimated as being in error and a lower limit of zero (0) cases in error.

It is recommended that Excellus and its third-party administrators comply with the requirements of Section 4903(e) of the New York Insurance Law.

Section 4904(c) of the New York Insurance Law states 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 appeal…"

There were thirty-five (35) instances where a written notice of acknowledgment of an appeal was not sent to the appealing party.

Based on a review of the 167 cases sampled it is estimated, on a calculated rate basis, there were 783 out of the total population of 3,734 utilization appeal review cases in which a written notice of acknowledgement of appeal was not sent to the appealing party within fifteen days of the filing of such appeal, in violation of the above law. The review estimated an upper limit of 1,013 cases in error and a lower limit of 552 cases in error.

It is recommended that Excellus and its third-party administrators comply with the requirements of Section 4904(c) of the New York Insurance Law.

The high number of cases noted above, where Excellus failed to send an acknowledgement letter of the filing of an appeal was due to a change in policy instituted in 2009. Participating hospitals were offered three levels of appeal related to level of care disputes involving inpatient reviews done on a retrospective basis. These appeals have no member liability and are filed by providers on their own behalf. The disputes involve payment at an "observation rate" versus a "full inpatient rate". The facility contracts offer two levels of appeal and dispute resolution process (DRA). Facilities also have an option to use the external appeal process under New York Insurance Law and Public Health Law Article 49 in lieu of a level 2 appeal and a DRA. In addition, appeal time frames are different from those included in Article 49. Excellus did not send

acknowledgement letters to members on these disputes in order to avoid confusion for the member and because they were not involved in the appeal.

In 2014, the Department's Consumer Assistance Unit advised Excellus that it should send acknowledgement letters to its members because the member always has the right to file an appeal, even though the member is not involved in the appeal and has no member liability. Excellus began sending acknowledgement letters to members in these cases beginning in November 2014.

8. GRIEVANCES AND APPEALS

Section 4802 of the New York Insurance Law sets forth the minimum requirements of grievance and appeals procedures for insurers which offer a managed care product. Excellus offers managed care products through a line of business HMO.

Excellus provided a listing of 2,980 grievances closed from January 1, 2013 to December 31, 2013. Of the 2,980 grievances, 129 went to a second level grievance appeal. An initial sample of 167 files was selected for review. Twelve (12) of the 167 files reviewed went to a second level grievance appeal. The following are the examiner's findings.

Section 4802(d) of the New York Insurance Law states in part:

> "(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance…"

In twenty-seven (27) out of 167 cases reviewed, Excellus failed to acknowledge receipt of the grievance within 15 business days of receipt of the grievance, in violation of Section 4802(d) of the New York Insurance Law.

Based on the error rate from the review of the 167 grievance cases sampled it is estimated that on 482 out of a total population of 2,980 grievance cases, a written acknowledgement letter was not sent within fifteen business days, in violation of the above law. The review indicated an estimate of an upper limit of 648 cases in error and a lower limit of 315 cases in error.

It is recommended that Excellus comply with the requirements of Section 4802(d) of the New York Insurance Law by acknowledging receipt of all grievances within 15 business days of receipt of the grievance.

Section 4802(d)(2) of the New York Insurance Law states in part:

> (d)"…All grievances shall be resolved in an expeditious manner, and in any event, no more than:
> (2)thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract…"

In nineteen (19) out of 167 cases reviewed, Excellus failed to resolve the grievance and issue a determination letter within 30 days of receipt of all necessary information, in violation of Section 4802(d)(2) of the New York Insurance Law.

Based on the error rate from the review of the 167 grievance cases sampled it is estimated that on 339 out of the total population of 2,980 grievance cases, Excellus failed to resolve the grievance and issue a determination letter within 30 days of receipt of all necessary information,

in violation of the above law. The review estimated an upper limit of 482 cases in error and a lower limit of 195 cases in error.

It is recommended that Excellus comply with the requirements of Section 4802(d)(2) of the New York Insurance Law by resolving all grievances and issuing determination letters within 30 days of receipt of all necessary information.

Section 4802(i) of the New York Insurance Law states in part:

> "(i) Within fifteen business days of receipt of the appeal, the insurer shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the insurer to respond to the appeal and what additional information, if any, must be provided in order for the insurer to render a decision."

In one (1) out of 167 cases reviewed, Excellus failed to acknowledge receipt of the appeal within 15 business days of receipt of the appeal, in violation of Section 4802(i) of the New York Insurance Law.

Based on the error rate from the review of the 167 grievance cases sampled it is estimated that on eighteen (18) out of the total population of 2,980 grievance cases, Excellus failed to acknowledge receipt of an grievance appeal within 15 business days of receipt of the appeal, in violation of the above law. The review estimated an upper limit of 53 cases in error.

It is recommended that Excellus comply with the requirements of Section 4802(i) of the New York Insurance Law by acknowledging receipt of all appeals within 15 business days of receipt of the appeal.

Section 4802(k)(2) of the New York Insurance Law states:

> "(k) The insurer shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:
> (2) thirty business days after the receipt of all necessary information in all other instances."

In one (1) out of 167 cases reviewed, Excellus failed to resolve the appeal and issue a determination letter within 30 days of receipt of all necessary information, in violation of Section 4802(k)(2) of the New York Insurance Law.

Based on the error rate from the review of the 167 grievance cases sampled it is estimated that on eighteen (18) out of the total population of 2,980 grievance cases, Excellus failed to resolve the appeal and issue a determination letter within 30 days of receipt of all necessary information, in violation of the above law. The review estimated an upper limit of 53 cases in error.

It is recommended that Excellus comply with the requirements of Section 4802(k)(2) of the New York Insurance Law by resolving all appeals and issuing determination letters within 30 days of receipt of all necessary information.

9. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

Excellus Health Plan, Inc.'s prior report on examination as of December 31, 2007, contained the following nineteen (19) comments and recommendations pertaining to market conduct items (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Facilitation of Examination	
1.	It is recommended that the Plan enhance its procedures to ensure it facilitates examination requests completely and in a timely manner. *The Plan has complied with this recommendation.*	5
	Underwriting and Rating	
2.	It is recommended that Excellus abide by its Large Group Experience Rated Formula filed with and approved by the Department. *The Plan has not complied with this recommendation. A similar recommendation is contained herein.*	6
	Claims	
3.	It is recommended that the Plan take steps to ensure that those claims requiring manual pricing are priced accurately. *The Plan has complied with this recommendation.*	7
4.	It is recommended that the Plan follow the procedures defined in its subscriber contracts by sending formal denials in the circumstance that additional information is not received after a request for such has been made. *The Plan has complied with this recommendation.*	8
5.	It is also recommended that the United States Department of Labor be requested to clarify the applicability to health insurers of United States Department of Labor Regulation No. 29 CFR (2560.503-1(f)(2)(iii)(B)), prior to the implementation of PPACA. *The Plan has complied with this recommendation.*	9

ITEM NO.		PAGE NO.
6.	It is recommended that Excellus comply with the requirements of Section 4303(a)(2) of the New York Insurance Law. *The Plan has complied with this recommendation.*	9
7.	It is recommended that Excellus send denial notices to the insured school systems, in those instances where claims have been denied as a result of the school system's failure to submit an accident report form as required under the policy. *The Plan has complied with this recommendation.*	10
	Explanation of Benefits Statements	
8.	It is recommended that Excellus comply with the requirements of Section 3234(a) of the New York Insurance Law and send explanation of benefits statements to members when those members have purchased pharmaceutical drugs and either co-insurance or a deductible is involved, or when an EOB is requested. *The Plan has complied with this recommendation.*	11
9.	It is recommended that Excellus issue Explanation of Benefit statements that contain all of the information that is required under Section 3234 of the New York Insurance Law and that such information is presented clearly and completely. *The Plan has complied with this recommendation.*	13
10.	While not directly required under New York statute, it is recommended that Excellus disclose the surcharge that is the responsibility of the subscriber on its Explanation of Benefit statements. *The Plan has complied with this recommendation.*	13
	Prompt Payment Law Compliance	
11.	It is recommended that the Plan improve its internal claim procedures to ensure compliance with Sections 3224-a (a), (b) and (c) of the New York Insurance Law. The prior report contained a similar recommendation. *The Plan has not fully complied with this recommendation. A similar recommendation is contained herein.*	17

ITEM NO. **PAGE NO.**

12. 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. The prior report contained a similar recommendation. 18

The Plan has complied with this recommendation.

13. Further, it is recommended that the Plan comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and maintain the adequate support documentation relative to the information reported within its filed Schedules H. 18

The Plan has complied with this recommendation.

Utilization Review

14. It is recommended that the Plan comply with all the requirements of Sections 4903(e)(1), 4903(e)(3) and 4904(b) of the New York Insurance Law and ensure that its members are provided with their full and appropriate rights under such laws. 21

The Plan has not fully complied with this recommendation. A similar recommendation is contained herein.

15. It is recommended that Excellus and other Blue Cross / Blue Shield plans which process Excellus' claims on Excellus' behalf, comply with the timeline requirements of Section 4904 of the New York Insurance Law relative to the appeal of adverse determinations. The Plan reported to the Department that this is now the practice of the Blue Cross and Blue Shield Association Plans. 22

The Plan has complied with this recommendation.

Disclosure of Information

16. It is recommended that the Plan amend its approved HMO Direct Blue Point of Service manual to eliminate misleading and/or inaccurate content. 24

The Plan has complied with this recommendation.

ITEM NO. **PAGE NO.**

Privacy

17. It is recommended that the Plan comply with the privacy provisions of Department Regulation No. 173 and ensure that it has signed Business Associate Agreements which contain such privacy provisions with all third parties with which Excellus shares Personal Health Information. 25

It is noted in the above cases, subsequent to the examination date, that the Plan included such privacy protections within the pertinent service agreements.

The Plan has complied with this recommendation.

Record Retention

18. It is recommended that Excellus comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and maintain images of the explanation of benefits statements sent to its members, as well as the information supporting filed annual and quarterly statement schedules. 26

The Plan has complied with this recommendation.

19. It is also recommended that the Plan comply with the requirements of Part 216.11 of Department Regulation 64 (11 NYCRR 216.11) by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction. 26

The Plan has complied with this recommendation.

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____/S/_____
Wai Wong
Principle Insurance Examiner

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

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

_____/S/_____
Wai Wong

Subscribed and sworn to before me
this _____ day of_____2015.

APPOINTMENT NO. **31056**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Wai Wong

as a proper person to examine the affairs of

Excellus Health Plan, Inc.

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

Plan

with such other information as he shall deem requisite.

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

this 25th day of September, 2013

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau