

REPORT ON EXAMINATION

OF

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2004

DATE OF REPORT

APRIL 5, 2007

EXAMINER

BRUCE BOROFSKY, CPA, CFE

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of examination	2
2.	Executive summary	3
3.	Description of the HMO	4
	A. Management and controls	5
	B. Territory and plan of operation	8
	C. Reinsurance	9
	D. Holding company system	12
	E. Significant operating ratios	16
	F. Investment activities	16
	G. Provider/TPA arrangements	18
	H. Accounts and records	20
4.	Financial statements	25
	A. Balance sheet	25
	B. Statement of revenue and expenses	26
	C. Capital and surplus account	27
5.	Claims unpaid	27
6.	Market conduct	27
7.	Fraud prevention and detection	49
8.	Compliance with prior report on examination	50
9.	Summary of comments and recommendations	54
	Appendix A – Information systems review	62



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

Eliot Spitzer
Governor

Eric R. Dinallo
Acting Superintendent

Honorable Eric R. Dinallo
Acting Superintendent of Insurance
Albany, NY 12257

Date: April 5, 2007

Sir:

Pursuant to the provisions of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22345, dated March 11, 2005 attached hereto, I have made an examination into the condition and affairs of Capital District Physicians' Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health law. The following report, as of December 31, 2004, is respectfully submitted.

The examination was conducted at the HMO's home office located at 1223 Washington Avenue, Albany, New York.

A review was made of the HMO's information system and operations with the assistance of Ernst & Young, LLP. The results of such review are included in Appendix A of this report.

Wherever the designations "the HMO" or "CDPHP" appear herein without qualification, they should be understood to refer to Capital District Physicians' Health Plan, Inc.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 2000. This examination covers the four-year period from January 1, 2001 through December 31, 2004. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2004, in accordance with Statutory Accounting Principles, as adopted by the Department, a review of income and disbursements to the extent deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants. A review or audit was made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners (NAIC):

- History of the HMO
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Officers' and employees' welfare and pension plan
- Territory and plan of operation
- Growth of the HMO
- Accounts and records
- Loss experience
- Treatment of policyholders and claimants

A review was also made to ascertain what action was taken by the HMO with regard to comments and recommendations contained in the prior report on examination.

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

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that directly impacted the HMO's compliance with the New York Insurance Laws and New York Public Health Laws. Significant findings relative to this examination are as follows:

- The HMO made two loans to its subsidiary CDPHP-Universal Benefits, Inc. without the approval of the Superintendent as required by Section 1307(d) of the New York Insurance Law.
- The current examination revealed multiple violations relative to EOBs which included the following:
 - The HMO issued EOB forms to members and non-participating providers which did not include all of the requisite information required by Section 3234(b) of the New York Insurance Law.
 - The HMO failed to issue EOBs to members and non-participating providers for certain denial codes in violation of Section 3234(a) of the New York Insurance Law.
 - The HMO failed to issue EOBs relative to non-participating provider claims, member claims and claims submitted by participating providers in instances when the HMO's member was financially liable for payment of a portion of the claim in compliance with Department of Labor Regulation, Part 2560. The above instances occurred when a claim was denied when a request for missing information was made by the Plan and that information was never received.
- The HMO failed to issue a notice of first adverse determination relative to instances of concurrent utilization reviews in violation of Section 4903.3 of the New York Public Health Law.
- The HMO failed to comply with the requirements of Section 4903.5 of the New York Public Health Law regarding its notices of first adverse determination because of the wording in the notices concerning requests for additional information.

- It is the HMO's policy to resolve any dispute with participating providers according to the dispute resolution language in the participating provider contract. As a result, claims where there was no member liability, which were denied retrospectively, as not medically necessary did not have a notice of the first adverse determination issued to the participating provider in violation of Sections 4903.4, 4903.5 and 4904.1 of New York Public Health Law.
- The HMO did not comply with Sections 4903.5 and 4904.3 of the New York Public Health Law relative to wording included within its acknowledgement letters of an appeal of first adverse determination.
- In those cases where CDPHP had denied claims received from non-participating providers and members for missing medical information, the HMO violated Sections 4903.4 and 4903.5 of the New York State Public Health Law by failing to issue a notice of first adverse determination to its members/providers relative to a retrospective review of claims when such claims involved medical necessity.
- The HMO issued Individual Direct Pay and Healthy NY 2004 premium notices to subscribers which inaccurately stated that such proposed rate increases are approved by the Department in violation of Section 4308(g)(1) of the New York State Insurance Law.
- The HMO utilized an unlicensed claims adjuster to negotiate discounts for medical bills from non-participating providers in violation of Section 2108(a)(1) of the New York Insurance Law.

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

3. DESCRIPTION OF HMO

The HMO was formed as a membership corporation on February 27, 1984 under Section 402 of the Not-for-Profit Corporation Law, and incorporated within the State of New York on April 13, 1984. The members consist of physicians licensed by the State of New York. The HMO was licensed as a Health Maintenance Organization pursuant to Article 44 of the Public Health Law of the State of New York and obtained its certificate of authority to operate as an individual practice association (IPA) model HMO, effective April 30, 1984.

As of December 31, 2000, membership in the HMO was opened to physicians licensed by the State of New York who apply for membership and meet the criteria required by the HMO's by-laws and are accepted as member physicians.

The HMO is exempt from income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code.

A. Management and controls

The HMO is a physician-controlled corporation. The participating physicians, who are members in good standing of the corporation, constitute a majority of the corporation's board of directors.

Pursuant to the HMO's by-laws, management of the HMO is vested in a board of directors consisting of fifteen members. Eight of the fifteen directors shall be members of the corporation. The remaining seven directors shall not be members of the corporation. At least three such non-member directors shall be enrollees of the HMO.

As of the examination date, the board of directors was comprised of fifteen members. The composition of the board was in compliance with the HMO's by-laws and Part 98-1.11 (f) of the Administrative Rules and Regulations of the State of New York, Health Department (10 NYCRR 98).

The directors of the HMO as of December 31, 2004 were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
John D. Bennett, M. D. Menands, New York	Chairman of the Board of Directors, CDPHP Cardiologist, Albany Associates in Cardiology
James Michael Brennan Slingerlands, New York	President, Albany Truck Sales
Peter T. Burkart, M. D. Averill Park, New York	Hematologist, Capital District Hematology/Oncology
M. Bruce Cohen	Retired

Albany, New York

Gennaro A. Daniels, M. D.
Troy, New York

Surgeon,
Capital District Colon & Rectal Surgery Associates, PC

Robert H. Dropkin, M. D.
Albany, New York

Obstetrician,
Dropkin Costello, MD, OB/GYN, LLP

Name and Residence

Principal Business Affiliation

Daniel Frasca
Valatie, New York

Executive Director, Finance and Administration,
New York State United Teachers

Robert C. Griffin
Albany, New York

Principal,
Griffin Financial Group

Douglas P. Larsen, D. O.
Voorheesville, New York

Pediatrician

James C. Leyhane, M. D.
East Greenbush, New York

Internist,
Community Care Physicians, PC

Kelly A. Lovell
Saratoga Springs, New York

President,
Center for Economic Growth

William M Notis, M. D.
Delmar, New York

Gastroenterologist,
Albany Gastroenterology Consultants

Martha H. Pofit
Slingerlands, New York

Consultant

Stuart A. Rosenberg, M. D.
Albany, New York

Urologist,
Capital District Urologic Surgeons, LLP

Stephen C. Simmons
Albany, New York

President,
Simmons Computing Service, Inc.

A review of the minutes of the attendance records at the HMO's board of directors' meetings held during the period under examination revealed that the meetings were generally well attended.

Subsequent to the examination, directors Robert H. Dropkin, M.D. and Douglas P. Larsen, D.O. left the board and were replaced by Richard E. Lavigne and James E. Striker.

The principal officers of the HMO, as of December 31, 2004, were as follows:

<u>Name</u>	<u>Title</u>
John D. Bennett, M.D.	Chairman of the Board of Directors
William J Cromie, M.D.	President and Chief Executive Officer
Stephen R. Sloan, Esq.	Executive Vice-President and Chief Counsel
M. Bruce Cohen	Treasurer
Stephen C. Simmons	Secretary

New York Not-for-Profit Corporation Law, Article 5, Sections 515(a) and (b) state the following:

“a) A corporation shall not pay dividends or distribute any part of its income or profit to its members, directors, or officers.

(b) A corporation may pay compensation in a reasonable amount to members, directors, or officers for services rendered, and may make distributions of cash or property to members upon dissolution or final liquidation as permitted by this chapter.”

The HMO maintains a compensation program for its management that includes as one component, the profitability of the HMO. Although only a single component of compensation, the use of profitability in this manner is not consistent with the company’s status as a not-for-profit health plan.

It is recommended that the HMO revise its compensation program to eliminate profitability as a factor in the compensation package offered to its officers and employees.

B. Territory and plan of operation

The HMO's service area as stated in its Certificate of Authority, as revised May 25, 2001, includes the following counties in New York:

Albany	Essex	Montgomery	Schenectady
Broome	Fulton	Oneida	Schoharie
Chenango	Greene	Orange	Tioga
Columbia	Hamilton	Otsego	Ulster
Delaware	Herkimer	Rensselaer	Warren
Dutchess	Madison	Saratoga	Washington

The HMO also possesses a license from the State of Vermont, Department of Banking, Insurance and Securities, to transact insurance business as authorized by its charter. The HMO did not cover any members in Vermont as of the examination date.

The HMO provides a comprehensive prepaid health program by means of a network of participating physicians. Subscribers to the HMO select a participating physician who acts as the primary care physician. This physician refers subscribers to other participating HMO physicians when particular medical specialties are required. Except for services specifically excluded or limited in the HMO's contracts or riders, there is no limit to duration, frequency or type of health care provided as long as the care is directly provided or pre-authorized by the HMO medical director and/or the participating physician.

Inpatient hospital services are rendered as directed by HMO physicians. The HMO pays hospital charges through direct hospital billing. Out-of-area emergency care is provided for in the subscriber contracts.

The HMO's member enrollment as of December 31st for the years under examination was as follows:

	2001	2002	2003	2004
Members	302,412	318,751	320,627	297,186
% change	(4.4%)	+5.4%	+0.6%	(7.3%)

In addition to its commercial HMO coverage offered to employer groups and non-subsidized individuals, the HMO offers Medicare Advantage, Medicaid, Family Health Plus, Healthy New York and Child Health Plus. The enrollment that corresponds to these various lines of business during the exam period is as follows:

	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Commercial, HMO Only	242,838	246,248	238,388	213,260
Medicare	7,478	7,564	8,755	10,222
Medicaid	34,246	42,498	47,120	45,701
Family Health Plus	401	4,594	6,731	7,531
Child Health Plus	15,054	14,883	14,440	14,166
Healthy New York	429	1,703	4,278	6,306
Commercial POS	1,966	1,261	915	0

The HMO does business through the use of an internal sales force as well as through the utilization of independent agents and brokers.

Community rated premiums, as filed with the Superintendent of Insurance, are applicable to all enrollees.

C. Reinsurance

The HMO entered into two excess risk reinsurance agreements in order to limit its exposure to losses from catastrophic inpatient claims. At December 31, 2004, these reinsurance agreements were as follows:

- (i) Excess of loss reinsurance agreement with Carter Insurance Company, LTD (Carter), a 100% wholly owned subsidiary of the HMO. Carter, which is not licensed as a reinsurer in the State of New York, was organized for the purpose of providing reinsurance services for the HMO and began operations January 1, 2004. Carter reimburses the HMO for 85% of inpatient hospital services in excess of the following deductibles up to the following limits per member, per year relative to the lines of business listed below:

<u>Line of business</u>	<u>Deductible</u>	<u>Limit</u>
Commercial HMO	\$300,000	\$600,000
Child Health Plus	\$300,000	\$600,000
Family Health Plus	\$300,000	\$600,000
Healthy New York	\$300,000	\$600,000
Medicare	\$175,000	\$350,000
Medicaid	\$300,000	\$600,000

- (ii) A second layer excess of loss reinsurance agreement with Employers Reinsurance Corporation (ERC), an unrelated accredited reinsurance carrier. With certain exclusions and limitations, ERC reimburses the HMO for 85% of inpatient hospital services in excess of the following deductibles up to the following limits per member, per agreement period of one year and per lifetime relative to the lines of business listed below:

<u>Line of business</u>	<u>Deductible</u>	<u>Limit</u>
Commercial HMO	\$600,000	\$2,000,000
Child Health Plus	\$600,000	\$2,000,000
Family Health Plus	\$600,000	\$2,000,000
Healthy New York	\$600,000	\$2,000,000
Medicare	\$350,000	\$2,000,000
Medicaid	\$600,000	\$2,000,000

Both reinsurance agreements contain the insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

Statement of Statutory Accounting Principle No. 61, "Life, Deposit-type and Accident and Health Reinsurance", Paragraph 42 ("SSAP 61"), states, in part, the following:

"Credit for reinsurance with unauthorized companies shall be permitted if the ceding entity holds securities or cash of the assuming entity equal to the reserve credit taken. ...Other permissible arrangements include ..."clean" letters of credit."

The accounting rule also states:

“If the assuming entity is not licensed or is not an authorized reinsurer in the domiciliary state of the ceding entity or if the reinsurance does not meet required standards, the ceding entity must set up a net liability...”

At December 31, 2004, the HMO did not maintain an appropriate credit arrangement with its unauthorized reinsurer, as required by the accounting rule. As a result, the HMO was required to establish a liability equal to its \$1,042,980 balance of reinsurance recoverable, but did not do so.

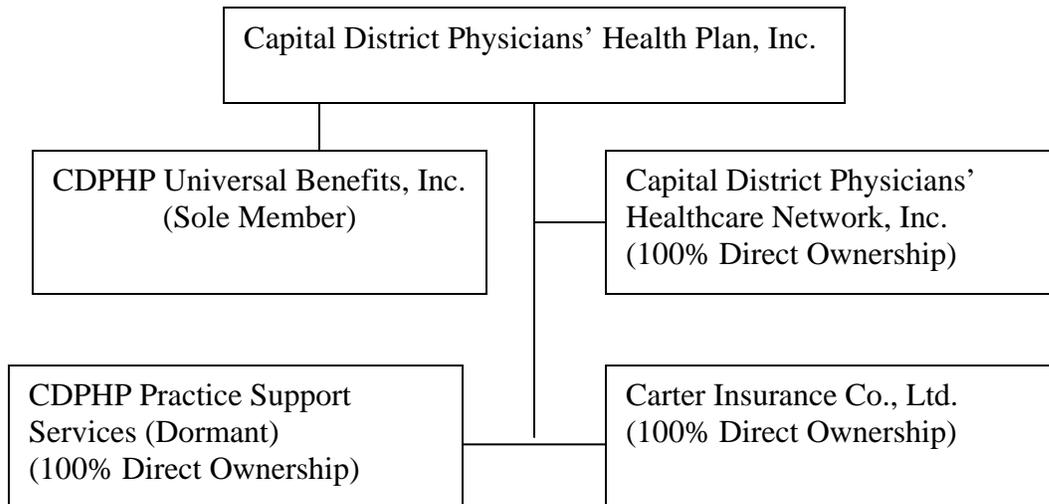
It is noted that in March 2005, the Plan complied with SSAP No. 61 Paragraph 42 through the initiation of a letter of credit.

Although no financial change was made relative to the HMO's reported reinsurance recoverable balance within this report on examination, it is recommended that, in future statements, the HMO report reinsurance recoverable balances as a non-admitted asset from an unauthorized reinsurer unless the HMO maintains appropriate credit in compliance with SSAP No. 61, Paragraph 42.

At the initiation of the examination period, the HMO owned a 50% share of Mason Insurance Company, Ltd. (Mason), an unauthorized captive offshore reinsurance company. While it maintained that ownership, the HMO's first level of reinsurance coverage was with its subsidiary. During the first quarter 2004, the HMO sold its interest in Mason and discontinued its reinsurance coverage with that entity.

D. Holding Company System

The following chart depicts the HMO and its relationship to its affiliates within the holding company system:



The HMO maintains administrative service agreements with its subsidiaries, CDPHP Universal Benefits, Inc. (UBI) and Capital District Physicians' Healthcare Network, Inc. (CDPHN), whereby various services are provided to the subsidiaries by the HMO. These services include, but are not limited to, financial, legal, internal operations, management information systems, marketing, consultation, utilization review services, claims administration, developing, revising, and refining new health care services products, systems, policies and overall administration.

As established by the administrative service agreements, premiums for the subsidiaries are collected by CDPHP and disbursed to the subsidiaries on a monthly basis. The agreements also establish the requirement that the HMO be reimbursed monthly for actual costs incurred. As of December 31, 2004, the HMO reported receivables from UBI and CDPHN in the amounts of \$206,794 and \$576,381 respectively.

CDPHP Universal Benefits, Inc (UBI)

UBI was incorporated on February 28, 1997 under Section 402 of the Not-for-Profit Corporation Law and was licensed on August 14, 1997 pursuant to the provisions of Article 43 of New York Insurance Law. UBI is an indemnity carrier offering the out-of-network portion of the Point of Service product for which CDPHP provides in-network benefits. UBI also offers stand-alone indemnity coverage such as PPO and EPO contracts.

New York State Insurance Law 1307(d) states the following:

“No ...insurance company ...shall directly or indirectly make any agreement for any advance or borrowing pursuant to this section unless such agreement is in writing and shall have been approved by the superintendent...”

UBI was capitalized by means of a \$1,250,000 loan from its parent and sole member, CDPHP. This transfer was half of a \$2,500,000 Section 1307 loan that had been approved by the Superintendent during 1997. The other half of the approved

amount was not transferred. Then, on May 1, 2004, \$1,250,000 was transferred from the Parent to UBI. While the HMO described this May 1, 2004 transfer as the second half of the originally approved amount, the Department's 1997 approval cannot be considered open-ended. When the HMO did not avail itself of the 1997 approval in full within a reasonable time thereafter, the approval for the un-remitted portion became null and void. As a result, the May 1, 2004 transfer is considered to have been made without the approval of the Superintendent and thus in violation of Article 1307(d) of the New York Insurance Law.

An additional transfer of \$1,500,000 was made on December 30, 2004. Though considered by the HMO to be a loan, this transfer was also not approved by the Superintendent and, as a result, it is also in violation of Article 1307(d) of the New York State Insurance Law.

It is recommended that the HMO comply with New York State Insurance Law 1307(d) and obtain Superintendent approval for the two loans it made to its subsidiary, UBI, during 2004. It is further recommended that the HMO desist from making further such loans until Superintendent approval has been obtained.

The HMO reported a surplus notes receivable in its December 31, 2004 annual statement in the amount of \$2,232,546. This value reflects the surplus value of the subsidiary as is appropriate under current statutory accounting guidelines.

On January 5, 2005, the board of directors of CDPHP approved a motion to provide its subsidiary, UBI, with an additional \$6,000,000 in Section 1307 loans. Of this amount, the Department approved \$4,500,000, which was distributed to UBI as follows:

<u>Date</u>	<u>Amount</u>
February 28, 2005	\$2,000,000
March 25, 2005	\$1,000,000
April 13, 2005	\$1,500,000

Capital District Physicians' Healthcare Network, Inc. (CDPHN)

CDPHN, a wholly owned subsidiary of CDPHP, was incorporated on June 14, 1991. CDPHN was organized for the purpose of providing managed care and administrative support services to self-insured employers.

The reported net equity for CDPHP in its CDPHN subsidiary as of December 31, 2004 was \$5,321,208. During the examination period, the value of the subsidiary increased by \$5,057,994, consisting of \$4,000,000 of Additional Paid in Capital contributed by CDPHP and an accumulated increase in equity due to net income of \$1,057,994.

CDPHP Practice Support Services (PSS)

PSS is a wholly owned subsidiary of CDPHP, incorporated on May 9, 1994. PSS was organized for the purpose of providing management support services to participating providers. PSS became dormant during 1997; therefore, it is not currently conducting business.

The total investment of the HMO in PSS was \$593,000 for the period of 1994-1997. The HMO did not report a carrying value for this subsidiary as of December 31, 2004.

Carter Insurance Company, LTD (Carter)

Carter, an unauthorized reinsurer, was incorporated November 2003 in Bermuda as a for-profit corporation and began operations on January 1, 2004. The HMO made a capital contribution of \$1,000,000 in this subsidiary during November 2003 and received in return 120,000 shares of stock, which represents 100% of common stock issued. At the examination date, Carter was valued at \$1,622,641 by the HMO which represented the net equity of Carter at such date.

As a member of a holding company system, the HMO is required to file Forms HC-1 and IR pursuant to Article 15 of the New York Insurance Law, New York

Insurance Regulation 115 (11 NYCRR 81-2.4), and Department of Health Regulation Part 98-1.10. All pertinent filings made during the examination period, regarding the aforementioned statute and regulation, were reviewed and no problem areas were encountered.

E. Significant operating ratios

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

	<u>Amount</u>	<u>Ratio</u>
Medical expenses	\$2,699,695,913	89.7%
Claim adjustment expenses	134,823,745	4.5%
Administrative expenses	134,016,695	4.4%
Net underwriting gain/(loss)	<u>41,812,317</u>	<u>1.4%</u>
Premiums earned	<u><u>3,010,348,670</u></u>	<u><u>100%</u></u>

F. Investment activities

During 2005, the HMO selected Wells, Canning & Associates (“Wells, Canning”) as its investment management consultant. The Letter of Intent between the two entities detailed that Wells, Canning would serve as the HMO’s new investment advisor, providing portfolio monitoring, performance review, asset manager evaluation, and peer and asset allocation analyses. In addition, the letter stated that Wells, Canning would maintain and update CDPHP’s portfolio and would conduct compliance reviews relative to existing guidelines and state statutes. Moreover, the selected advisor would be available, on an as needed basis, to provide analytical support for rating agency reviews and meetings, and to deliver other consultative services.

Although the HMO indicated, during August 2005, that the executed copy of the Letter of Intent between CDPHP and Wells, Canning was the final contract, it was not signed and thus, did not appear to be enforceable. As a result, the document was deemed not to be legally binding. After being informed of such, CDPHP did execute an enforceable contract.

A review was made of the HMO's contract with Wells, Canning by this Department's Capital Markets Bureau (CMB). As a result of this review, the following recommendations are made:

It is recommended that CDPHP's Office of General Counsel must review each contract with a financial adviser, consultant, broker, dealer, custodian, agent or auditor, or with any other financial intermediary or financial service provider concerning the formation, implementation, monitoring, management or review of any investment activity. Each contract must accurately state all material items and conditions of the contract, and state clearly the respective material duties and obligations of each party to that contract. CDPHP, its directors, officers, employees, or agents may execute any such contract only after CDPHP's General Counsel has approved such contract.

The Department will not deem to be a contract any letter of intent or functionally similar document that provides, in any form, that the parties intend to enter into a contract at some other date or by some other instrument.

These requirements are in addition to, and not in lieu of, any other requests or demands that the Department is otherwise authorized to make regarding CDPHP's contracts, books, or records. CDPHP's General Counsel will make and maintain a record of the review and approval of each contract by means of a review and approval log, email or similar physical, written, or electronic record.

This record must be available to New York Insurance Department examining personnel immediately upon request. CDPHP will deliver all contracts and records, or copies of such contracts and records to a New York Insurance Department examiner within the time established by such examiner after a New York Insurance Department request for those or similar items. In no event shall such established time for response or delivery be less than ten (10) business days. If the examiner has not established a time within which contracts, records, or copies thereof are to be delivered, all contracts,

records, or copies thereof must be delivered to an examiner no more than twenty (20) business days after the date on which the Department has requested those items. CDPHP must provide the Department's Capital Markets Bureau with the initial investment advisory reports produced by Wells, Canning in 2006 and/or the outline of services rendered in 2006.

It is recommended that the HMO require Wells, Canning to produce written reports detailing its review of CDPHP's investment managers periodically during the year.

It is recommended that, subsequent to changes implemented in the investment policy and associative benchmarks, that CDPHP provide these revisions in writing to CMB for its review.

It is recommended that any amended investment management agreements between CDPHP and its investment managers, BlackRock and Conning Asset Management, be furnished to CMB for its review.

The HMO maintains a custodial agreement with Key Trust Company. This agreement complies with all recommended controls and safeguards.

G. Provider/TPA arrangements

1. Provider withhold arrangements

Physicians contract individually with the HMO by means of participating agreements that authorize the HMO to withhold a portion of the contracted payment from any fees payable to the physician. The purpose of the withhold fees is to offset any possible operating deficits, to establish operating reserves, or to meet other financial needs of the HMO. Annually, the HMO determines using its sole discretion whether to distribute the amounts withheld or some portion of that amount to the participating providers. During the period under this examination, the amount that was withheld from the providers was thirteen percent (13%).

The Provider Contract establishes that the provider withhold will be calculated “from any fees payable” to the provider. When the HMO calculates the withhold amount, it does so by multiplying the withhold percentage by the total claim amount allowed, including those co-payments owed by the member. As an example, with a 13% withhold amount, a claim allowed amount of \$115 and a member's co-pay of \$15, the withhold amount would be \$14.95.

While the calculation of withhold from amounts not specifically owed by the HMO is not prohibited by the wording in the contract, it is also not specifically permitted. As a result of this practice, the HMO, for certain claims, withheld amounts that caused zero payments to the physician.

It is recommended that the HMO clarify within its provider contracts the methodology to be utilized in the calculation of withhold.

For each year during the examination period, the following withhold amounts were returned to the physicians:

<u>Year</u>	<u>Withhold</u>
2001	\$27,960,490.68
2002	\$32,125,449.37
2003	\$34,418,245.98
2004	\$33,639,025.34

These amounts are equal to 100% of the amounts withheld, with the exception of those amounts withheld for claims paid from previous years, as described earlier in this report.

2. Third party administrative agreements

The HMO maintains four third party administrative agreements with the following entities:

1. Labcorp: Labcorp provides laboratory services to the HMO's providers and is compensated on both a capitated basis and a fee-for-service basis, dependent on the location of the provider.
2. St. Peter's Addiction Recovery Center (SPARC): SPARC provides alcohol and substance abuse treatment services to HMO members on a capitated basis. SPARC also receives compensation for administrative services.
3. Value Options: This Independent Practice Association (IPA) provides psychological, psychiatric social services and other mental health services to HMO members on a capitated basis.
4. CaremarkPCS LP: This entity provides a network of pharmacies to the HMO for use by the HMO's members. CaremarkPCS is reimbursed for the cost of the drug dispensed on a prescription basis. CaremarkPCS also provides the HMO with rebates based on the contractual arrangement.

H. Accounts and records

The HMO utilizes a third party, Adminisource, a division of Medivante, Inc. to process claim checks. At the time of the examination, authorized check signatories were automatically affixed, regardless of the dollar level of the claim check. In other words, there was no level at which a human signature was required. Such a process may not be sufficient to protect against malfeasance.

It is recommended that the HMO's board of directors establish a dollar level at which claim checks must be personally signed by an authorized signatory.

It is noted that, subsequent to the examination date, the HMO instituted a policy to ensure that claim checks over a certain dollar amount are personally reviewed and signed by an authorized signatory.

The HMO does not allocate any expenses to investments in its Annual Statement Underwriting and Expense Exhibit, Part 3, Analysis of Expenses, other than those fees

paid specifically to investment consultants/managers/brokers/custodians. This is contrary to SSAP No. 70, Allocation of Expenses, which states the following:

“Investment expenses - Expenses incurred in the investing of funds and pursuit of investment income. Such expenses, include those specifically identifiable and allocated costs related to activities such as ... support personnel, postage and supplies, office overhead, management and executive duties and all other functions reasonable associated with the investment of funds.”

It is recommended that the HMO comply with SSAP No. 70 and properly allocate investment expenses within its Annual Statement, Underwriting and Expense Exhibit, Part 3, Analysis of Expenses.

In two cases, it was noted that the HMO netted certain assets and liabilities against one another in its reporting, when such balances should more appropriately have been recorded separately. These cases are as follows:

1.) Provider advances

The HMO netted provider advances against claims instead of reporting them separately. This is a violation of SSAP 84, Paragraph 18, which states:

“The receivable and payable shall be reported gross rather than netted on the balance sheet.”

2.) Accrued Retrospective Premium

The HMO netted accrued retrospective premium receivables against accrued retrospective premium liabilities. This is a violation of SSAP 64, which states the following:

“Assets and liabilities shall be offset and reported net only when a valid right of setoff exists...”

It is recommended that the HMO comply with the SSAP 84 and 64 and report assets and liabilities separately unless otherwise permitted.

Statement of Statutory Accounting Procedure 84, Paragraph 16 states, in part:

“... a loan or advance to a non-related party hospital shall be admitted up to the amount of claims incurred and payable to the hospital if all of the following conditions are met:...

b. The loan or advance is supported by a legally enforceable contract;”

The HMO was not in compliance with this accounting precept as it maintained, in one case, a provider advance without having had formal agreement in place.

It is recommended that the HMO comply with SSAP 84, Paragraph 16 and report as admitted assets only those provider advances for which it has formal agreements.

SSAP No. 54 Paragraph 18 states that a premium deficiency reserve occurs when the expected claim payments, claim adjustment expenses, and administration costs exceed the premiums for the remainder of the contract. When the HMO established its Premium Deficiency Reserve for the Family Health Plus line of business in the December 31, 2004 statement, it did so based upon a full twelve month period, yet the Family Health Plus contracts expire annually on September 30. Thus, the premium deficiency reserve should have been calculated based only upon the first nine months of the calendar year.

It is recommended that the HMO comply with SSAP No. 54, Paragraph 18 and establish premium deficiency reserves for the appropriate contractual term.

SSAP No. 54 Paragraph 6 describes advance premiums as premiums that have been received prior to or on the valuation date but which are due after the valuation date. These balances are reported in the financial statements as liabilities and are not considered premium income until due.

A review of this account revealed that some balances that were recorded as Advance Premiums as of December 31, 2004 were actually received as far back as calendar year 2000 and were for coverage periods that had already passed. Thus, these amounts should have been excluded from the calculation of the advance premium.

It is recommended that the HMO ensure that those sums recorded as advance premiums only represent premiums not yet due.

SSAP No. 6, Paragraph 9(a) states, in part:

“If an installment premium is over ninety days past due, the amount over ninety days past due plus all future installments that have been recorded on that policy shall be non-admitted.”

The amount reported by the HMO as uncollectible, or as a non-admitted asset in its December 31, 2004 annual statement was not determined in accordance with the SSAP No. 6, Paragraph 9(a) in that the HMO included in such amounts only the portion currently past due.

It is recommended that the HMO comply with SSAP 6, Paragraph 9(a) in calculating non-admitted assets.

The HMO reported on page 2 of its annual statements for all years during the examination period, premium receivables net of non-admitted amounts without showing the gross receivables. The annual statement instructions provide for the reporting of gross receivables, the non-admitted asset portion and the net admitted asset portion.

It is recommended that the HMO comply with the annual statement instructions and appropriately report its gross premium receivables and non-admitted asset premium receivable on the annual statement.

The HMO reported \$0 premiums outstanding over 90 days due, on its filed December 31, 2004 annual statement in Exhibit 3 - Accident and Health Premiums Due and Unpaid. The examination review revealed that certain premiums due were outstanding over six months. Therefore, the reporting on this exhibit was not an accurate representation of the HMO's aged premiums as of December 31, 2004.

It is recommended that the HMO report the proper aging of its premium receivable on its annual statement Exhibit 3-Accident and Health Premiums Due and Unpaid.

4. FINANCIAL STATEMENTSA. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination, as of December 31, 2004. This statement is the same as the balance sheet filed by the HMO.

<u>Assets</u>	<u>Assets</u>	Nonadmitted <u>Assets</u>	Net Admitted <u>Assets</u>
Bonds	\$130,429,950	\$	\$130,429,950
Stocks	11,338,399		11,338,399
Cash	63,233,833		63,233,833
Investment income due and accrued	1,841,228		1,841,228
Uncollected premiums	30,986,006		30,986,006
Deferred premiums	1,889,178		1,889,178
Amounts recoverable from reinsurers	1,042,980		1,042,980
Electronic data processing equipment	2,180,583	2,038,253	142,330
Furniture and equipment, including health care delivery assets (\$1,416,846)	1,416,846	1,416,846	-0-
Receivables from parent, subsidiaries and affiliates	783,175		783,175
Health care receivables	7,201,874		7,201,874
Surplus notes receivable	4,000,000	1,767,454	2,232,546
Goodwill	2,695,338		2,695,338
Other assets nonadmitted	4,378,763	4,378,763	
Total assets	<u>\$263,418,153</u>	<u>\$9,601,316</u>	<u>\$253,816,837</u>
<u>Liabilities:</u>	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims unpaid	\$104,378,436		\$104,378,436
Accrued medical incentive pool and bonus amounts	1,602,004		1,602,004
Unpaid claim adjustment reserves	2,003,808		2,003,808
Aggregate health policy reserves	1,643,633		1,643,633
Premiums received in advance	9,473,099		9,473,099
General expenses due or accrued	10,958,078		10,958,078
Total liabilities	\$130,059,058		\$130,059,058
Contingency reserves			\$ 43,536,833
Unassigned surplus			80,220,946
Total capital and surplus			<u>\$123,757,779</u>
Total liabilities, capital and surplus			<u>\$253,816,837</u>

Note:

The Internal Revenue Service did not audit the tax returns filed by the HMO since its inception. The examiner is unaware of any potential exposure of the HMO to any tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses:

Capital and surplus increased by \$59,638,900 during the four year period under examination, January 1, 2001 through December 31, 2004, detailed as follows:

Net premium income		\$ 3,010,348,670
Hospital and Medical:		
Hospital/medical benefits	\$ 1,467,191,273	
Other professional services	21,378,400	
Emergency room and out of area	65,978,343	
Prescription drugs	436,639,266	
Outpatient	374,416,956	
Lab and X-ray	200,432,925	
Regulatory charges	78,210,336	
Other write-ins	51,814,944	
Incentive pool, and withhold adjustments	11,643,304	
Subtotal	\$ 2,707,705,747	
Less:		
Net reinsurance recoveries	9,653,467	
Total hospital and medical	\$ 2,698,052,280	
Claims adjustment expense	134,823,745	
General administrative expenses	134,016,695	
Increase in reserves for A&H contracts	1,643,633	
Total underwriting deductions		\$ 2,968,536,353
Net underwriting gain/(loss)		\$ 41,812,317
Net investment income earned	\$ 22,441,413	
Net realized capital gains/(losses)	3,581,615	
Net investment income		26,023,028
Net income		\$ 67,835,345

C. Capital and surplus account

Capital and surplus as of December 31, 2000			\$64,118,879
	<u>Gains</u>	<u>Losses</u>	
Net Income	\$67,835,345	\$	
Unrealized capital gain/loss	1,404,872		
Change in nonadmitted assets		4,257,425	
Cumulative effect of changes in accounting practices	<u> </u>	<u>5,343,892</u>	
Net change in capital and surplus			<u>59,638,900</u>
Capital and surplus per examination as of December 31, 2004			<u><u>\$123,757,779</u></u>

5. CLAIMS UNPAID

The examination liability of \$104,378,436 is the same as the amount reported by the HMO as of December 31, 2004.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and utilized statistical information contained in the HMO's internal records and in its filed annual and quarterly statements, as well as additional information provided by the HMO.

6. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the HMO conducts its business and fulfills its contractual obligations to subscribers and claimants. The review was general in nature and was directed at practices of the HMO in the following major areas:

Claims processing
Prompt pay compliance
Explanation of benefit statements
Utilization review
Complaints and grievances
Underwriting and rating
Agents and brokers
Contract period – non-payment of premium
The use of Medcal as a third party claims payment negotiator
Advertising

A. Claim Processing

This review was performed by using a statistical sampling methodology covering the examination period in order to evaluate the overall accuracy and compliance environment of CDPHP's claims processing. In order to achieve the goals of this review, claims were divided into hospital and medical claims segments and a random statistical sample was drawn from each group. It should be noted that for the purpose of this examination, those medical costs characterized as Medicare were excluded.

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

The sample size for each of the populations described herein was comprised of 167 randomly selected claims. Additional random samples were also generated as "replacement items" when it was determined that particular claims within the sample should not be tested (i.e., Medicare claims that were inadvertently included). Accordingly, various replacement items were appropriately utilized. In total, 334 claims for the scope period were selected for review.

The term “claim” can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a “claim,” which is defined by the HMO as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It is possible, through the computer systems used for this examination, to match or “roll-up” all procedures on the original form into one line, which is the basis of the Department’s statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by CDPHP for the period January 1, 2004 through December 31, 2004.

It was further agreed upon that CDPHP was required to issue EOBs for all denied claims (wholly or partially denied) but in fact failed partially to do so.

The examination review revealed that overall claims processing accuracy rates were 94.61% for medical claims and 94.01% for hospital claims. Overall claims processing financial accuracy levels were 98.8% for medical claims and 97.6% for hospital claims.

However, if the EOB errors were not taken into consideration, the CDPHP's overall claims processing accuracy rates would have been 97.6% for medical claims and 97.0% for hospital claims. Also, overall claims processing financial accuracy rates would have been 98.8% for medical claims and 97.6% for hospital claims. This is consistent with CDPHP’s reported overall accuracy standard being at or above 98%.

Procedural accuracy is defined as the percentage of times a claim was processed in accordance with CDPHP’s claim processing guidelines and/or Department regulations. A claim determined by the HMO to be in error and corrected by the HMO at a later date would still be found to be an error for the purposes of this review. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. An error in processing accuracy may or may not affect the financial accuracy.

B. Prompt Pay Compliance

§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”) requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

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

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

“In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to ...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.”

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

“any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim.”

The examination included a statistical sample to determine whether or not interest was appropriately paid pursuant to § 3224-a(c) of the New York Insurance Law to those claimants not receiving payment within the timeframes required by §3224-a (a) of the New York Insurance Law. Accordingly, all claims that were not paid within 45 days during the period January 1, 2004 through December 31, 2004 were segregated. Further, claims from non-New York groups, non-New York providers, and Medicare claims were excluded from the population. 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, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:

	§ 3224-a(a)	§ 3224-a(b)	§ 3224-a(c)
Claim Population	69,223	25,184	21,137
Sample Size	167	167	167
Number of claims with errors	17	11	7
Calculated Error Rate	10.18%	6.59%	4.19%
Upper Error Limit	14.77%	10.35%	7.23%
Lower Error Limit	5.59%	2.82%	1.15%
Upper limit claims in error	10,224	2,606	1,528
Lower limit claims in error	3,869	710	243

Note: 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).

It is recommended that the HMO improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.

Prior to and during this examination period, CDPHP was found to be in violation of Section 3224-a of the New York Insurance Law for prompt pay violations cited by the Department's Consumer Services Bureau. The HMO executed stipulations resulting in fines covering the following periods:

4/1/98 - 9/30/98	\$4,200
10/1/98 - 2/1/99	\$1,100
2/2/99 - 4/26/99	\$1,100
4/27/99 - 7/31/99	\$1,900
8/1/99 - 12/31/00	\$47,200
1/1/01 - 12/31/02	\$200
1/1/03 - 9/30/04	\$1,000

C. Explanation of Benefit Statements

A detailed review of claims procedures was made during the previous examination that covered the period from January 1, 1996 to December 31, 2000. The prior Report on Examination findings included, among other violations, that CDPHP violated Section 3234(a) and (b) of the New York Insurance Law because it failed to send to its subscribers proper EOBs that include all of the requisite information required by the New York Insurance Law. Therefore, the subscribers were not properly informed of their appeal rights and how their claims were processed.

On August 7, 2003, CDPHP signed a stipulation with the New York State Insurance Department that required CDPHP to take actions to remedy the violation of Section 3234 (a) (b) of the New York Insurance Law.

Item 4 (c) of the stipulation stated the following:

“CDPHP and UBI shall begin issuing EOBs for all denied claims that comply with Section 3234(a) and (b).”

A follow up review during this examination of CDPHP actions to remedy the EOBs violations revealed multiple violations existed relative to EOBs for the years 2004 through present.

New York Insurance Law Section 3234(a) states in part:

“Every insurer, including health maintenance organizations ... is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy...”

New York Insurance Law Section 3234(c) creates an exception to the requirements for the issuance of an EOB established in New York Insurance Law Section 3234(a) as follows:

“[insurers] shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer’s program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid directly to the participating facility or provider.”

New York Insurance Law Section 3234(b) states,

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

- (1) the name of the provider of service the admission or financial control number, if applicable;
- (2) the date of service;
- (3) an identification of the service for which the claim is made;
- (4) the provider’s charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
- (7) 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.”

The review revealed the following:

1. Explanation of Benefits (EOB) statements issued to subscribers by CDPHP during the major portion of year 2004 for fully/partially paid claims to members and non-participating providers, failed to contain all the language required by Section 3234(b) of the New York Insurance Law (including the appeal language). Such EOBs, as presented to the examiners during the review, were issued in the form of payment vouchers/explanation of payment (EOP). Subscribers were neither properly informed of their appeal rights nor were they advised how their claims were processed. However, it should be noted that in the last quarter of 2004, CDPHP started to issue a proper form of EOB that contained all the language required by Section 3234(b) of the New York Insurance Law.

It is recommended that CDPHP issue EOB forms that contain all of the requisite information required by Section 3234(b) of the New York Insurance Law for claims involving payments to members and non-participating providers.

2. CDPHP's current procedures failed to include all situations that require CDPHP to issue EOBs. The following are three examples:

- a. CDPHP denied many participating provider's claims because of the providers' failure to submit original and/or adjusted claims in a timely manner in accordance with the time tables of their participating provider agreement with CDPHP.
- b. CDPHP denied many providers and member claims under Explanation-Codes that CDPHP considered as missing information, therefore, no EOBs are required, while in fact there was no missing information and claims were properly denied, yet no EOBs were issued.
- c. CDPHP failed to issue EOBs to subscribers when claims submitted by providers and members were fully or partially denied under medically unnecessary of the following Explanation-Codes:

CK Medically unnecessary days--don't bill member.

UI	Deny result of Utilization management decision.
UJ	Deny as result of Utilization management policy-don't bill member.
UK	Deny follow-up days-don't bill patient.
UM	Assistant surgeon not allowed-don't bill patient.
VB	Deny authorization request determined to be investigative/experimental.
ZH	Deny contract exclusion (Utilization management denial reason).
ZL	Deny for non-medical reasons (Used by Utilization Management).

The review of claims denied under the three examples mentioned above during the year 2004 yielded 47,592, 53,617 and 17,478 violations respectively of Section 3234(a) of the New York Insurance Law where no EOBs were issued to subscribers as required.

It is recommended that CDPHP issue EOBs in all situations that require CDPHP to issue an EOB in accordance with Circular Letter 7(2005). EOBs should include all of the requisite information required by Section 3234(b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

3. CDPHP's policy is to deny claims for missing information but does consider such claims not completely adjudicated until such missing information is received. Therefore, no EOBs are issued to subscribers in such cases.

EOP forms are used to request missing information from providers and members, however, the following categories and number of claims/lines of service received in 2004 were noted as not having been fully adjudicated as of the date of the examination review:

175 member claims
3,049 non-participating providers' claims

It is recommended that CDPHP issue an EOB for denied claims of non-participating providers and members relative to requests for missing information. and

change its policy by completing the adjudication process in a date certain in accordance with the requirement of Department of Labor, Part 2560 for non-participating providers/member claims .

4. EOBs issued by CDPHP for participating provider's claims show the allowed amount, contractual reductions from that amount such as deductibles, co-insurance, co-pays, and amount paid to the participating provider. However, such EOBs do not cross-balance because the provider withhold amount is not shown on the EOB. This could lead to member's confusion as to the cause for the missing amount.

It is recommended that CDPHP revise its EOB forms to show the amount payable to participating providers instead of amount paid to ensure that EOB forms issued to its subscribers cross balance from the allowed amount to payable amount.

5. CDPHP utilizes pre-established explanation of payment forms (EOPs) to pay, deny and also request missing information from providers and members. A review of CDPHP usage of EOP forms revealed the following:

- a. The explanation in certain instances did not sufficiently explain the cause for denial. Examples of such insufficient explanations included following:
 - The claims do not contain sufficient information to allow processing.
 - The information that has been provided appears to be incorrect or inaccurate.
- b. The EOPS reviewed, in certain cases, did not clearly indicate what information needs to be submitted in order to permit payment of the claim.
- c. Although providers are familiar with EOP forms, it is not appropriate to use the form for requesting missing information from members, because the form lacks sufficient and clear message of what missing information is needed to complete the claim adjudication process.
- d. The EOP forms frequently do not clearly indicate that there is no member liability for certain claims.

It is recommended that CDPHP review all of its explanation codes and ensure that the text utilized on the EOP and EOB forms for denials or requesting missing information clearly indicates the reason for denial and what information is missing. In addition, EOP forms should indicate the subscriber's additional claim payment liability, if any.

Also, it is recommended that CDPHP cease using EOP forms to request missing information from its members.

6. It was noted during the review that CDPHP, in certain instances, requested the member to provide proof of his/her payment to the providers before completing its adjudication of the claim.

It is recommended that CDPHP cease the practice of requesting its members provide a proof of payment during its adjudication of claims.

D. Utilization Review

Article 49 of the New York Public Health Law sets forth the minimum utilization review program requirements including standards for: registration of utilization review agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. The aforementioned Article establishes the 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 enrollee's health care provider shall have the right to request standard appeal and an external appeal.

An examination review was made of CDPHP's utilization review files and denied claims under medically unnecessary, experimental or investigational for year 2004. The review revealed the following:

1. Concurrent review:

Section 4903.3 of the New York Public Health Law states in part:

“A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee

undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date."

CDPHP did not comply with Section 4903.3 of the New York Public Health Law in that there were instances of concurrent reviews where CDPHP decided not to pay the provider for medical services to its members because such services were no longer medically necessary, but where CDPHP failed to issue a notice of first adverse determination to its members. CDPHP's policy is to issue denial letters of such coverage to the participating providers in accordance with the dispute resolution language of their contracts. Thereafter, the providers submitted claims are denied retrospectively under Explanation-code CK (Medically unnecessary days—don't bill member).

In addition, and as a consequence of its failure to issue a notice of its first adverse determination, the members did not receive their rights of the full due process of appeals of first adverse determination, notice of final adverse determination and notice of external review.

It is recommended that CDPHP comply with Section 4903.3 of the New York Public Health Law and issue a notice of the first adverse determination to its subscribers when CDPHP decides not to pay for medical services based on a concurrent review because medical services are no longer considered medically necessary.

2. Retrospective review:

Section 4903.4 of the New York Public Health 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."

Section 4903.5 of the New York Public Health Law states:

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

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

Section 4904.1 of the New York Public Health Law states:

“An enrollee, the enrollee’s designee and, in connection with retrospective adverse determinations, an enrollee’s health care provider, may appeal an adverse determination rendered by utilization review agent.”

Section 4904.3 of the New York Public Health 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 filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal....”

A review of retrospective claims utilization review conducted in 2004 revealed the following:

- a. CDPHP’s notification form of the first adverse determination was not in compliance with the requirement of Section 4903.5 of the New York Public Health Law because the notice stated that “...We will notify you within five (5) days from the date your appeal was received if we require additional information to decide your appeal...”, while Section 4903.5(c) requires CDPHP to “...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.”

The review indicated that 2,779 notices of the first adverse determination that were issued in 2004 violated Section 4903.5 of the New York Public Health Law.

It is recommended that CDPHP revise its notice of first adverse determination to its subscribers/providers, when claims are denied retrospectively for medical reasons, to fully comply with the requirement of Section 4903.5 of the New York Public Health Law.

- b. CDPHP's policy is to treat any dispute with its participating providers as a contractual issue to be resolved based on the dispute resolution language in their contracts. Therefore, an undetermined number of participating provider claims were denied retrospectively in 2004 because the services rendered did not qualify as medically necessary and no notice of the first adverse determination was issued to the member/participating provider as required by Section 4903.5 of the New York Public Health Law. However, notice of the first adverse determination was issued to the members only when such members were financially liable for additional payment.

CDPHP failed to issue a notice of first adverse determination to enrollees when claims submitted by providers and members were fully or partially denied as medically unnecessary under the following Explanation-Codes:

U4	Deny authorization request determined to be not medically necessary.
UI	Deny result of Utilization management decision.
UK	Deny follow-up days-don't bill patient.
UL	Visit not covered-surgery day.
UJ	Deny as result of Utilization management policy-don't bill member.

The review of claims denied under the explanation codes mentioned above during the year 2004 yielded 16,720 violations of Section 4903.5 of the New York Public Health Law.

It is recommended that CDPHP comply with Section 4903.5 of the New York Public Health Law and issue a notice of the first adverse determination letter to members and participating providers, when claims are denied retrospectively for medical reasons.

- c. CDPHP's practice with regard to its acknowledgement letter of an appeal of first adverse determination was noted to indicate to the members and providers that CDPHP would notify such member or provider within 5 days from the date of such appeal was received if any additional information was required to decide the appeal.

The review indicated that in 2004, 469 CDPHP acknowledgement letters of first adverse determination appeals by providers and members violated Sections 4903.5 and 4904.3 of the New York Public Health Law.

It is recommended that CDPHP comply with Sections 4903.5 and 4904.3 of the New York Public Health Law and cease the practice of requesting additional medical information in the acknowledgement letter of an appeal of medical adverse determination from its providers/members.

- d. CDPHP denied claims received from non-participating providers and members because missing medical information was needed to fully adjudicate these claims. CDPHP failed to issue notice of first adverse determination to members/providers of its retrospective review of claims involving medical necessity as required by Section 4903.4 of the New York Public Health Law. The New York Law does not provide an exception to the utilization review procedure because information to demonstrate medical necessity is not provided.

The Department of Labor (DOL) Regulation, Part 2560 requires HMOs to render a determination regardless of whether information is provided or not. Therefore, CDPHP must make a utilization review determination regardless of whether the necessary information is received.

The review of number of notices of first adverse determination that were not issued in 2004, yielded 8,382 violations of Sections 4903.4 and 4903.5 of the New York Insurance Public Health Law.

In addition, and as a consequence of its failure to issue a notice of the first adverse determination, the members did not receive their rights of the full due process of appeals of first adverse determination, notice of final adverse determination and notice of external review.

It is recommended that CDPHP issue a notice of first adverse determination to its members at date certain as required by Section 4903.4 of the New York Public Health Law and DOL Regulation, Part 2560 relative to retrospective reviews of non-participating provider/member submitted claims and also, claims of participating providers in those cases where the member is financially liable for additional payment, when missing medical necessity information is not received.

- e. CDPHP understated the number of appeals reported on Schedule M of its annual statement because it failed to include participating providers' appeals that were received in 2004 and treated them as contractual disputes.

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

E. Underwriting and Rating

The HMO violated New York State Insurance Law Section 4308(g)(1) for having inaccurately stated in its 2004 Direct Pay and Healthy New York premium notices to subscribers that proposed rate increases are approved by the Department. This violation is described in Circular Letter No. 13(2005), which states:

“Because rate filings made pursuant to Section 4308(g) (1) are deemed approved upon submission to the Department, it is inaccurate and misleading for an insurer or HMO to state or imply in its notices to subscribers, or in any other communication with subscribers, that a rate increase obtained pursuant to this provision has been approved by the Department. Such rate increases are filed with the Department and deemed approved by operation of law. Since the Department can neither approve nor disapprove rate increases under Section 4308(g) (1), it is inappropriate for an insurer or HMO to suggest otherwise in its communications with subscribers...”

It was further noted that the rate increase letters sent to members and groups during November 2005 for rates increases effective January 2006 also contained language in violation of Section 4308(g)(1) of the New York Insurance Law.

It is recommended that the HMO discontinue its practice of citing the need for New York Insurance Department approval for rate increases unless it cites specifically which portion of the rate or rate package is awaiting such approval.

In some cases, the notices also violate New York Insurance Law 4308(g)(2), which requires 30 days advance notice of premium increases. The violation is described in the previously cited Circular Letter No. 13 (2005), which states the following:

“A premium rate increase in accordance with Insurance Law 4308(g) may not be implemented unless each contract holder and subscriber receives an accurate and proper notice at least 30 days prior to the effective date of the premium rate increase. A notice that does not accurately state the revised premium or the exact percentage increase for the subscriber’s contract is defective. It is unacceptable to merely provide a range of increases or an average rate increase in such notice.”

This violation exists due to the fact that certain letters used to increase rates did not accurately state the revised premium or the exact percentage increase for the subscriber’s contract.

It is recommended that the HMO comply with Section 4308(g)(2) of the New York Insurance Law and state within its rate increase letters the specific rate or percentage increase that will be charged.

F. Agents and Brokers

New York State Insurance Law 2114(a) (3) states:

“No... health maintenance organization doing business in this state... shall pay any commission or other compensation to any person... for services in the... solicitation, negotiating or selling in this state of any... new health maintenance organization contract, except to a licensed accident and health insurance agent of such... health maintenance organization.”

During the review of the HMO's sales incentive plan, it was noted that commissions were paid to salaried employees who were not licensed to solicit health maintenance contracts. It was determined that in 2004, the HMO paid commissions to eight employees who did not possess a valid agent's license.

It is recommended that the HMO comply with New York Insurance Law Section 2114(a)(3) and only pay commissions to licensed agents of the HMO.

It is noted that the HMO has subsequently complied with this recommendation.

G. Contract Period – Non-payment of Premium

During the examination period, the HMO maintained a policy wherein they allowed groups to maintain coverage beyond the permitted grace period. In those cases where the groups did not pay overdue premiums, the HMO reversed the claims that had been paid, taking the funds back from the providers.

It is the position of the Department that when the HMO failed to cancel delinquent groups in a timely manner, it was in essence extending a credit to those groups for the premiums involved. In this sense, providers who accepted HMO members were acting in good faith that such coverage was in force. As a result, it is inappropriate for the HMO to pass the financial responsibility for those delinquencies onto the providers.

It is recommended that the HMO refrain from reversing claims for delinquent members when the HMO maintains the coverage beyond the grace period. It is further

recommended that the HMO repay providers for those claims it inappropriately reversed and pay prompt pay interest where due.

It is noted that the HMO subsequently discontinued this practice and on December 7, 2005, the HMO repaid the claims which had been reversed under its former policy.

H. Third Party claims negotiator

The HMO utilizes a third party, Medcal, Inc. (“Medcal”), to negotiate discounts with non-participating providers for medical bills from non-participating providers.

Medcal provides these discounts to CDPHP through two processes; its own independent network of hospitals and doctors, and negotiation with non-participating providers. In return, Medcal receives 20% of the monies that are saved by the HMO. Roughly 30% of the claims for which Medcal is compensated are discounts negotiated outside the Medcal network.

Medcal negotiates with non-participating providers through the use of a letter that makes an offer of a negotiated payment and promises, in return, to expedite the claim payment. According to Medcal, it establishes its negotiation rate “using “HIA data by cpt code and our IDB (Integrated Data Base) based on prior procedures by similar percentiles of medical fee schedules.” This method of establishing the value of claims establishes Medcal as a claim adjuster under Section 2108(a) of the New York Insurance Law Section which defines a claim adjuster as follows:

“Any person, firm, association or corporation who, or which, for money, commission or any other thing of value acts in the state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer....”

It is noted that Medcal does not have a New York license to adjust claims.

Section 2108(a)(1) of the New York Insurance Law states,

“Adjusters shall be licensed as independent adjusters or as public adjusters.”

It is recommended that the HMO take steps to ensure that its third party claim negotiator, Medcal, Inc., maintains a New York license to adjust claims in compliance with Section 2108(a)(1) of the New York Insurance Law if it is the intent of the HMO to continue to use the claims adjustment services of Medcal, Inc.

The text of the letter utilized by Medcal contains the following statement:

“We have been requested by the payor to negotiate with your office in order that we may reduce the out-of-network costs for the patient and expedite payment to your office.”

This statement is misleading for two reasons. First, a review of Medcal negotiated claims reveals that the vast majority of the claims only involved a co-payment on the part of the member. In this circumstance, the member’s costs are not being reduced. Second, prior to the negotiation, the HMO's liability is asserted because CDPHP has already been billed by the provider for the amount the provider charges for the services that were rendered to the CDPHP member. The negotiation is thus an attempt to reduce that liability.

It is recommended that the HMO preclude its third-party negotiator from using prompt payment of claims as justification for the negotiation of discounted rates. Additionally, the implication that a reduced liability will occur if a negotiated settlement is agreed upon should only be stated in the text of the letter in those cases where an actual savings will occur.

The letter also includes the following:

“With this in mind, we would propose a [contract type] payment of \$_____. In addition, late charges will not be billed.”

The statement regarding late charges is unclear as it does not specify what late charges are involved or who will charge them.

It is recommended that the negotiated agreement between the third party negotiator and the provider clearly indicate what charges may be billed and by whom.

Finally, much of the letter is ambiguous as to commitment. Examples are the words noted above “we *would propose* a [contract type] payment of...” and “...the patient *should not* be billed the difference...” (italics added). Additionally, the letter does not clearly indicate that a signature on the letter is an acceptance of the terms of the agreement.

It is recommended that the negotiated agreement between the third party negotiator and the provider clearly spell out the terms of the agreement and indicate the purpose that a signature on the letter serves.

To date, the HMO has not audited the performance of its third-party negotiators. As such, there is no certainty that the program is working according to the HMO’s understanding.

It is recommended that the HMO conduct an audit of its third party negotiator, Medcal.

Regarding the use of Medcal, the HMO does not maintain a copy of the signed agreements under which the extent of its liability is established. Such agreements serve to document the disposition of the HMO’s claims.

The HMO’s failure to obtain and retain the negotiated discount agreement is a violation of New York Regulation 152 (11 NYCRR 243.2 (b)), which states:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain...(4) A claim file for six calendar years after all elements of the claim

are resolved and the file is closed. ...A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.”

It is recommended that that the HMO comply with New York Regulation 152 (11 NYCRR 243.2(b)) and maintain a copy of its agreements with third party negotiator, Medcal, Inc.

I. Advertising

Section 4323(c) of the New York Insurance Law states in part:

“All health maintenance organization marketing materials must be sufficiently clear to avoid deception or the capacity or tendency to mislead ore deceive...”

Much of the HMO's advertising as well as the HMO's website failed to distinguish how available products are segregated by entity. In other words, various advertisements for the HMO discuss the lines of business that are available (HMO, PPO, EPO and ASO), but they do not clarify that those products are offered by different HMO subsidiaries. As a result, the advertising implies that all lines of business are written under the CDPHP corporate name.

It is recommended that the HMO comply with Section 4323(c) of the New York Insurance Law by ensuring that all media containing any information about the various products offered by the HMO or any of its subsidiaries clearly specify the product(s) each particular company is offering.

It is noted that the HMO has subsequently changed its website to bring it into compliance with the cited Insurance Law.

7. FRAUD PREVENTION AND DETECTION

A review was performed of the organization and structure of the HMO's special investigations unit (SIU), and its compliance with Article 4 of the New York Insurance Law, and New York Insurance Department Regulation 95 (11 NYCRR 86). The examination review indicated the HMO's compliance with Article 4 of the New York Insurance Law and New York Insurance Department Regulation No. 95 (11 NYCRR 86).

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. It is recommended that the HMO maintains minutes of its Nominating Committee meetings.</p> <p>The HMO has complied with this recommendation.</p>	6
<p>B. It is recommended that when a director is considered for re-election for more than three full, consecutive, three year terms, the minutes of the board of directors should describe the unusual circumstances that exist which make the additional service by a particular director in the best interest of the HMO.</p> <p>The HMO has complied with this recommendation.</p>	7
<p>C. It is recommended that CDPHP amend its reinsurance agreement with Mason Insurance Company, Ltd. to include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.</p> <p>The HMO has discontinued its reinsurance relationship with this entity. The HMO's new agreements do contain the prescribed wording.</p>	11
<p>D. It is recommended that the HMO submit its reinsurance agreements with Mason and Reliastar Life Insurance Company to the New York State, Departments of Health and Insurance for approval.</p> <p>The statutory requirement prescribing such approval has been discontinued.</p>	13
<p>E. It is recommended that the HMO formalize its business relationship with its affiliate CDPHN by entering into written administrative service agreement which specifies the services and the obligations of each entity to the other.</p> <p>The HMO has complied with this recommendation.</p>	15

<u>ITEM</u>	<u>PAGE NO.</u>
<p>F. It is recommended that the HMO complete permanent tagging of its equipment.</p> <p>The HMO has complied with this recommendation.</p>	18
<p>G. It is recommended that the HMO's internal control procedures over its assets located at some employees' homes should be improved by requiring employee's signatures, instead of a manager's signature for the custody of these assets. In addition, the HMO should conduct periodic inspections on a sample basis.</p> <p>The HMO has complied with this recommendation.</p>	18
<p>H. It is recommended that the HMO execute a proper custodian agreement with Key Bank National Association for the McDonald investment sweep account. The custodian agreement should include the prudent protective provisions as set forth in Department's guideline.</p> <p>The HMO has complied with this recommendation.</p>	19
<p>I. It is recommended that the HMO's custodian agreements should be updated for current authorized signatures.</p> <p>The HMO has complied with this recommendation.</p>	19
<p>J. It is recommended that the HMO should execute a new investment agreement with Smith Barney. The new agreement should not contain unacceptable terms such as the right to keep securities owned by CDPHP at Smith Barney.</p> <p>The HMO has complied with this recommendation.</p>	19
<p>K. The manner in which the Complete Benefit Connection program is administered appears to conflict with the provisions of Section 4224 (d)(1) of the New York Insurance Law which prohibits the interdependency of an insurance product with any good or service. The HMO limits the eligibility to select US Life products to those who are CDPHP subscribers or members.</p> <p>This comment is not longer applicable.</p>	27

<u>ITEM</u>	<u>PAGE NO.</u>	
L.	It is recommended that for schedule H purposes, the HMO should use an actual count of paid claims available from its claim system and estimates the remainder instead of using an estimate for all paid claims.	29
	The HMO has complied with this recommendation.	
M.	It is recommended that the HMO improve its internal claim procedures in order to ensure full compliance with Section 3224-a of the New York Insurance Law.	31
	The HMO has complied with this recommendation.	
N.	It is recommended that the HMO use the original date of receipt of the original claim number, for prompt pay purposes, unless the change in header information was due to the receipt of additional information requested from the provider/subscriber, and that the information requested was necessary to process the claim.	32
	The HMO has complied with this recommendation.	
O.	It is recommended that the HMO consistently follow its policy of recognizing the date of receipt of information, and not the date it was scanned into the claim system, or the date that a CSF or ISF is created for the starting date in determining compliance with Section 3224-a of the New York Insurance Law.	32
	The HMO has complied with this recommendation.	
P.	It is recommended that the HMO issue an EOB that includes all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law.	34
	The HMO has complied with this recommendation.	

ITEM

Q.

It is recommended that the HMO send proper notice of adverse determination to subscribers and/or providers, when claims are denied retrospectively for medical reasons as required by Section 4903(5) of the New York Public Health Law.

The HMO did not fully comply with this recommendation. A similar recommendation is included under item I of this report.

PAGE NO.

36

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management</u>	
i. It is recommended that the HMO revise its compensation program to eliminate profitability as a factor in the compensation package offered to its officers and employees.	7
B. <u>Reinsurance</u>	
i. It is recommended that, in future statements, the HMO report reinsurance recoverable balances as a non-admitted asset from an unauthorized reinsurer unless the HMO maintains appropriate credit in compliance with SSAP No. 61, Paragraph 42.	11
C. <u>Holding Company System</u>	
i. It is recommended that the HMO comply with New York State Insurance Law 1307(d) and obtain Superintendent approval for the two loans it made to its subsidiary, UBI, during 2004. It is further recommended that the HMO desist from making further such loans until Superintendent approval has been obtained.	14
D. <u>Investments</u>	
i. It is recommended that CDPHP's Office of General Counsel must review each contract with a financial adviser, consultant, broker, dealer, custodian, agent or auditor, or with any other financial intermediary or financial service provider concerning the formation, implementation, monitoring, management or review of any investment activity. Each contract must accurately state all material items and conditions of the contract and state clearly the respective material duties and obligations of each party to that contract. CDPHP, its directors, officers, employees, or agents may execute any such contract only after CDPHP's General Counsel has approved such contract.	17

ITEMPAGE NO.

- ii. The Department will not deem to be a contract any letter of intent or functionally similar document that provides, in any form, that the parties intend to enter into a contract at some other date or by some other instrument. 17
- iii. These requirements are in addition to, and not in lieu of, any other requests or demands that the Department is otherwise authorized to make regarding CDPHP's contracts, book, or records. CDPHP's General Counsel will make and maintain a record of the review and approval of each contract by means of a review and approval log, email, or similar physical, written, or electronic record.
- This record must be available to New York Insurance Department examining personnel immediately upon request. CDPHP will deliver all contracts and records, or copies of such contracts and records, to a New York Insurance Department examiner within the time established by such examiner after a New York Insurance Department request for those or similar items. In no event shall such established time for response or delivery be less than ten (10) business days. If the examiner has not established a time within which contracts, records, or copies thereof are to be delivered, all contracts, records, or copies thereof must be delivered to an examiner no more than twenty (20) business days after the date on which the Department has requested those items.
- iv. It is recommended that CDPHP must provide the Department's Capital Markets Bureau with the initial investment advisory reports produced by Wells, Canning in 2006 or an outline of services rendered in 2006. 18
- v. It is recommended that the HMO require Wells, Canning to produce written reports detailing its review of CDPHP's investment managers periodically during the year. 18
- vi. It is recommended that, subsequent to changes implemented in the investment policy and associative benchmarks, that CDPHP provide these revisions in writing to CMB for its review. 18

<u>ITEM</u>	<u>PAGE NO.</u>
vii. It is recommended that any amended investment management agreements between CDPHP and its investment managers, BlackRock and Conning Asset Management, be furnished to CMB for its review.	18
E. <u>Provider/TPA arrangements</u>	
i. It is recommended that the HMO clarify within its provider contracts the methodology to be utilized in the calculation of withhold.	19
F. <u>Accounts and records</u>	
i. It is recommended that the HMO's board of directors establish a dollar level at which claim checks must be personally signed by an authorized signatory.	20
It is noted that, subsequent to the examination date, the HMO instituted a policy to ensure that claim checks over a certain dollar amount are personally reviewed and signed by an authorized signatory.	
ii. It is recommended that the HMO comply with SSAP No. 70 and properly allocate investment expenses within its Annual Statement, Underwriting and Expense Exhibit, Part 3, Analysis of Expenses.	21
iii. It is recommended that the HMO comply with the SSAP 84 and 64 and report assets and liabilities separately unless otherwise permitted.	22
iv. It is recommended that the HMO comply with SSAP 84, Paragraph 16 and report as admitted assets only those provider advances for which it has formal agreements.	22

<u>ITEM</u>	<u>PAGE NO.</u>
v. It is recommended that the HMO comply with SSAP No. 54, Paragraph 18 and establish premium deficiency reserves for the appropriate contractual term.	22
vi. It is recommended that the HMO ensure that those sums recorded as advance premiums only represent premiums not yet due.	22
vii. It is recommended that the HMO comply with SSAP 6, Paragraph 9(a) in calculating non-admitted assets.	23
viii. It is recommended that the HMO comply with the annual statement instructions and appropriately report its gross premium receivables and non-admitted asset premium receivable on the annual statement.	24
ix. It is recommended that the HMO report the proper aging of its premium receivable on its annual statement Exhibit 3-Accident and Health Premiums Due and Unpaid.	24
G. <u>Claim processing</u>	
i. It is recommended that the HMO improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.	32
H. <u>Explanation of benefit statements</u>	
i. It is recommended that CDPHP issue EOB forms that contain all of the requisite information required by Section 3234(b) of the New York Insurance Law for claims involving payments to members and non-participating providers.	34

<u>ITEM</u>	<u>PAGE NO.</u>
ii. It is recommended that CDPHP issue EOBs in all situations that require CDPHP to issue an EOB in accordance with Circular Letter 7(2005). EOBs should include all of the requisite information required by Section 3234(b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.	35
iii. It is recommended that CDPHP issue an EOB for denied claims of non-participating providers and members relative to requests for missing information and change its policy by completing the adjudication process in a date certain in accordance with the requirement of Department of Labor, Part 2560 for non-participating providers/member claims.	35
iv. It is recommended that CDPHP revise its EOB forms to show the amount payable to participating providers instead of amount paid to ensure that EOB forms issued to its subscribers cross balance from the allowed amount to payable amount.	36
v. It is recommended that CDPHP review all of its explanation codes and ensure that the text utilized on the EOP and EOB forms for denials or requesting missing information clearly indicates the reason for denial and what information is missing. In addition, EOP forms should indicate the subscriber's additional claim payment liability, if any.	37
vi. It is recommended that CDPHP cease using EOP forms to request missing information from its members.	37
vii. It is recommended that CDPHP cease the practice of requesting its members provide a proof of payment during its adjudication of claims.	37

<u>ITEM</u>	<u>PAGE NO.</u>
I. <u>Utilization review</u>	
i. It is recommended that CDPHP comply with Section 4903.3 of the New York Public Health Law and issue a notice of the first adverse determination to its subscribers when CDPHP decides not to pay for medical services based on a concurrent review because medical services are no longer considered medically necessary.	38
ii. It is recommended that CDPHP revise its notice of first adverse determination to its subscribers/providers, when claims are denied retrospectively for medical reasons, to fully comply with the requirement of Section 4903.5 of the New York Public Health Law.	40
iii. It is recommended that CDPHP comply with Section 4903.5 of the New York Public Health Law and issue a notice of the first adverse determination letter to members and participating providers, when claims are denied retrospectively for medical reasons.	41
iv. It is recommended that CDPHP comply with Sections 4903.5 and 4904.3 of the New York Public Health Law and cease the practice of requesting additional medical information in the acknowledgement letter of an appeal of medical adverse determination from its providers/members.	41
v. It is recommended that CDPHP issue a notice of first adverse determination to its members at date certain as required by Section 4903.4 of the New York Public Health Law and DOL Regulation, Part 2560 relative to retrospective reviews of non-participating provider/member submitted claims and also, claims of participating providers in those cases where the member is financially liable for additional payment, when missing medical necessity information is not received.	42
vi. It is recommended that CDPHP include all retrospective utilization review appeals made by its participating providers on Schedule M of its annual statements in future filings to the New York Insurance Department.	42

<u>ITEM</u>	<u>PAGE NO.</u>
J. <u>Underwriting and rating</u>	
i. It is recommended that the HMO discontinue its practice of citing the need for New York Insurance Department approval for rate increases unless it cites specifically which portion of the rate or rate package is awaiting such approval.	43
ii. It is recommended that the HMO comply with Section 4308(g)(2) of the New York Insurance Law and state within its rate increase letters the specific rate or percentage increase that will be charged.	44
K. <u>Agents and brokers</u>	
i. It is recommended that the HMO comply with New York Insurance Law Section 2114(a)(3) and only pay commissions to licensed agents of the HMO.	44
It is noted that the HMO has subsequently complied with this recommendation.	
L. <u>Contract period – Non-payment of premiums</u>	
i. It is recommended that the HMO refrain from reversing claims for delinquent members when the HMO maintains the coverage beyond the grace period. It is further recommended that the HMO repay providers for those claims it inappropriately reversed and pay prompt pay interest where due.	45
It is noted that the HMO subsequently discontinued this practice and on December 7, 2005, the HMO repaid the claims which had been reversed under its former policy.	
M. <u>Third Party claim negotiator</u>	
i. It is recommended that the HMO take steps to ensure that its third party claim negotiator, Medcal, Inc., maintains a New York license to adjust claims in compliance with Section 2108(a)(1) of the New York Insurance Law if it is the intent of the HMO to continue to use the claims adjustment services of Medcal, Inc.	46

<u>ITEM</u>	<u>PAGE NO.</u>
ii. It is recommended that the HMO preclude its third-party negotiator from using prompt payment of claims as justification for the negotiation of discounted rates. Additionally, the implication that a reduced liability will occur if a negotiated settlement is agreed upon should only be stated in the text of the letter in those cases where an actual savings will occur.	46
iii. It is recommended that the negotiated agreement between the third party negotiator and the provider clearly indicate what charges may be billed and by whom.	47
iv. It is recommended that the negotiated agreement between the third party negotiator and the provider clearly spell out the terms of the agreement and indicate the purpose that signature on the letter serves.	47
v. It is recommended that the HMO conduct an audit of its third party negotiator, Medcal.	47
vi. It is recommended that that the HMO comply with New York Regulation 152 (11 NYCRR 243.2(b)) and maintain a copy of its agreements with third party negotiator, Medcal, Inc.	48
N. <u>Advertising</u>	
i. It is recommended that the HMO comply with Section 4323(c) of the New York Insurance Law by ensuring that all media containing any information about the various products offered by the HMO or any of its subsidiaries clearly specify the product(s) each particular company is offering.	48
<p>It is noted that the HMO has subsequently changed its website to bring it into compliance with the cited section of the Insurance Law.</p>	

APPENDIX A

INFORMATION SYSTEMS REVIEW

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope and objectives of the examination	63
2.	Computing environment	63
3.	Areas examined	65
4.	Summary of significant findings	67
A.	PaperFree – Change management	68
B.	PaperFree – Logical access controls	68
C.	LAN – Logical security controls	69
D.	Remote access	70
E.	AMISYS – Logical security controls	70
F.	LAN – Logical security controls (User recertification)	71
G.	LAN – Logical security controls (Password settings)	71
5.	Summary of comments and recommendations	73

1. SCOPE AND OBJECTIVES OF THE EXAMINATION

Information Technology (IT) at CDPHP is used to support the delivery of services and products, and to provide support for all management processes. The objective of this IT control evaluation is to assist the Examiner-In-Charge (EIC) in developing a risk-based strategy for setting the examination scope and objectives, and in identifying the appropriate procedures necessary to support the overall examination strategy. In order to accomplish this objective, the examiners reviewed the general controls regarding CDPHP's processing environment and reviewed certain controls over the applications that were determined to be financially significant.

Examination Limitations

The general controls as examined were identified through discussions with IT management and a review of control documentation. This is not an attest report in conjunction with American Institute of Certified Public Accountants standards. This report provides information about the condition of risks and internal controls at a single point in time. Future changes in environmental factors and actions by personnel may significantly and adversely impact these risks and controls in ways that this report did not and cannot anticipate.

2. COMPUTING ENVIRONMENT

Given the complexity of CDPHP's IT environment, the review was focused on financially significant applications and their technology platforms. Based on initial discussions with management, the examiners developed an understanding of CDPHP's business processes and of the systems that have the most significant impact on New York policyholders. The following applications were identified as financially significant:

- AMISYS – AMISYS is the core claims processing system used by CDPHP. It is a third-party software package developed by Amisys Synertech (“ASI”).

The AMISYS system automates health care payer transaction processing and consolidates administrative, financial, and member processes into a single system. ASI has modified the AMISYS application to make it HIPAA compliant. CDPHP maintains three AMISYS environments: development, staging (testing) and production. CDPHP is running version 11.01.06 of AMISYS on an HP 3000 platform.

- **MACESS** – MACESS is a third-party software package developed by Sungard. MACESS is CDPHP's core enterprise document workflow management system and is used to manage document imaging, workflow, archiving, and customer service support. Additionally, MACESS is designed to accept routine programs for extraction of information which opens the system to a variety of integration possibilities. CDPHP maintains 3 MACESS environments: development, staging (testing) and production. MACESS runs on a Netware 5.5 platform.
- **MULTIVIEW** – MULTIVIEW is a third-party software package developed by Multiview Incorporated, an independent supplier of full-featured financial applications. CDPHP uses the following five MULTIVIEW modules: Accounts Payable (A/P), Accounts Receivable (A/R), General Ledger (G/L), Purchase Order (P/O), and Fixed Assets. These modules are used to help manage finances and to assist in financial statement preparation. MULTIVIEW does not interface with the other core systems used by CDPHP. Instead, information is manually entered into the system by the Accounting Department. MULTIVIEW is supported by an Oracle database and runs on a Windows 2000 environment.
- **SYBASE PAPERFREE** – SYBASE Paperfree is a third-party Electronic Data Interface (EDI) server system. CDPHP uses SYBASE Paperfree to translate EDI data into formats required by AMISYS. It also has the capability to perform a variety of edit and validation checks on claims submitted via EDI.

Seventy percent of the claims submitted to CDPHP are processed by this system through the EDI gateway. Remaining claims are manually keyed into AMISYS or optically scanned (OCR) into MACESS. SYBASE Paperfree interfaces with AMISYS and runs on a Windows 2003 environment.

- ORACLE DATAWAREHOUSE – The ORACLE data warehouse is an internally developed database used by CDPHP. It interfaces with AMISYS and is used primarily as a management information tool. The data warehouse runs on an AIX 5.2 platform and uses Oracle version 9.2.06.

3. AREAS EXAMINED

The general controls reviewed during this examination are promulgated by the New York State Insurance Department (NYSID) and consist of 14 categories. These 14 categories can be further grouped into the following risk areas: management risks (associated with supporting IT management processes), transaction risks (associated with service or product delivery), or infrastructure risks (associated with the IT hardware and software supporting business processes). The general control categories, grouped by risk area, are described below:

Management Risks:

- Management Controls over the IT Department – Delivery of services and products and support for IT management processes.
- Organizational Controls over the IT Department – Adequacy of resources and separation of duties between application development and maintenance, computer operations, and data entry.
- Documentation Controls over Applications – Appropriate documentation exists for new applications and changes to existing systems.
- Contingency Planning Controls – The data center has a valid disaster recovery plan and the plan covers the critical applications identified by the Chief Examiner. The disaster recovery plan is tested and is integrated with an

overall business resumption plan. Also, critical data is backed up and that these backup files are stored in a secure manner.

- Personal Computers – Personal computers are utilized in an appropriate manner and do not expose the company to unnecessary financial risk.
- Service Agreements – Service agreements with outside vendors cover provisions for loss of data and processing ability that could affect output of financial data.

Transaction Risks:

- Processing Controls over Critical Applications - Data is transmitted completely and accurately, input edits are working as intended and detected errors are corrected.
- Converted Systems – Transactions processed on newly developed or converted systems do not work as intended and errors can occur.

Infrastructure Risks:

- Controls over Changes to Applications – Users and IT department personnel approve modifications before they are implemented into the production environment.
- Controls over System and Application Programming and Development – Application programming and development/ modifications are performed in a controlled manner and are adequately tested before they are moved into production.
- Operations Controls – Performance and problem resolution are monitored and the data center processes company information in a controlled manner. Also, the procedures for handling critical data and scheduling critical computer programs are monitored. Controls are in place to maintain an environmentally secure data center.
- Logical and Physical Security – Employees are granted access to *only* the information they need to perform their assigned job duties and computing

resources are adequately protected so that access is restricted to appropriate personnel.

- Local Area Networks (LANs) – Changes to the LAN are documented and implemented in a controlled manner and LAN access is granted for business purposes only.
- Wide Area Networks (WANs) – Changes to the WAN are documented and sensitive financial data transmitted on the WAN is adequately protected.

4. SUMMARY OF SIGNIFICANT FINDINGS

The audit testing that was performed resulted in the following findings and recommendations to company management. Certain areas that could impact the exam scope and increase substantive procedures were noted. These areas are described in further detail within the body of this report, but are summarized below:

- Exposures relating to Paperfree. The Paperfree application contains exposures in the areas of both logical security and change management. In the area of logical security, terminated employees are not removed from the Paperfree application in a timely manner. As a result, terminated employees had the ability to access the system after their termination date. In the area of change management, one individual possessed inappropriate access to Paperfree's production environment. Consequently, this individual had the ability to circumvent the company's change control process and modify processing. This could result in claim data being modified as it is being processed through the Paperfree application.
- End-user access has not been managed effectively. The process for managing access to both operating systems and financially significant applications is not effective. Management does not perform periodic recertifications of user access to operating systems or financially significant applications. As a result,

certain individuals possessed access to user rights that did not correlate to their job responsibilities. In addition, the privileged user ID for the HP 3000 was being shared among five (5) users reducing user accountability. Lastly, certain password settings do not comply with CDPHP's Password Policy.

These findings have been communicated to CDPHP and their responses are included within this report.

A. PaperFree – Change Management

Description and Risk

The Paperfree development, testing, and production environments are not properly segregated. One of CDPHP's developers has access to the production server, which is where production code resides.

The Paperfree system is used to translate claims information submitted through Electronic Data Interfaces (EDI) into a format that can be processed by AMISYS. As a result, changes could be made to the processing environment causing claim data to be modified without the appropriate approvals.

Recommendation:

It is recommended that Management review all individuals who have access to the PaperFree development, testing, and production environments. It is further recommended that all developer access to the production environment be removed immediately and a separate department assigned the responsibility of migrating code into production.

B. PaperFree – Logical Access Controls

Description and Risk

All IT personnel have access to the K: drive, which is where PaperFree code resides before it is migrated to the production environment. While developers do not have access to the system source code, they do have access to system configuration

settings. It was also noted that management does not use a version control tool to help manage changes to code.

The Paperfree system is used to translate claims information submitted through Electronic Data Interfaces (EDI) into a format that can be processed by AMISYS. As a result, changes could be made to the processing environment causing claim data to be modified without the appropriate approvals.

Recommendation:

It is recommended that Management review IT personnel access to the K: drive and limit the permissions to those developers working in the PaperFree environment. Additionally, it is recommended that Management implement a version control software tool to ensure that code is migrated correctly.

C. LAN – Logical Security Controls

Description and Risk

The Privileged user ID for the HP3000 Operating System is shared among 5 individuals.

Sharing passwords to administrator accounts increases the risk that unauthorized activities will not be detected and that individuals are not held personally accountable for their actions. It is important to note that the AMISYS application, CDPHP's core claims processing system, resides on the HP3000 system and that inappropriate access to this system through a generic account could cause processing errors/ problems.

Recommendation:

It is recommended that Management assign individual user IDs to all HP3000 administrators. It is further recommended that Management log access to the master ID and periodically review this log to ensure activities performed are appropriate and authorized. Finally, it is recommended that management require the master password to be changed periodically.

D. Remote Access

Description and Risk

Remote access to the company's internal network has been granted to non-company issued computers. While non-company issued computers are checked to ensure they have been equipped with appropriate virus control software, these computers are not part of the process used by CDPHP to update virus software for known threats. Employees could introduce a host of threats to the CDPHP network, if management does not actively manage software loaded to these non-company issued computers.

Recommendation:

It is recommended that Management discontinue the current policy of allowing virtual private network (VPN) access through non-company issued computers. It is further recommended that Management review and allow access only to users who require VPN access for their job function. Users who only require access to their CDPHP e-mail account should be issued a username and password to the company's web mail portal. The web mail portal does not need to be installed on CDPHP issued computers.

E. AMISYS – Logical Security Controls

Description and Risk

Two issues regarding the logical security controls around AMISYS were identified:

- Access privileges for terminated employees are not removed on a timely basis. As such, users may be able to access applications and network resources after their termination date; and,
- Access privileges for employees are not appropriately modified to reflect changes in job descriptions. If access is not modified to reflect changes in job descriptions, users may be given user rights that are not required for them to perform their job functions.

Recommendation

It is recommended that Management implement a process by which end-user access to the AMISYS system is removed from all terminated employees and from users that have been transferred within the company. If a user requires access to the AMISYS system as part of their new job function, a new user request should be created for that user. The system administrator should review the AMISYS access control listing periodically to ensure that user rights within AMISYS are appropriate.

F. LAN – Logical Security Controls (User Recertification)

Description and Risk

Management does not require application owners to recertify user access periodically to ensure that the rights given to individuals are still required for operating system platforms and financially significant applications.

Failure to recertify user accounts increases the risk of an individual retaining his/her old profile even though it no longer corresponds with the new job description.

Recommendation

It is recommended that Management conduct a quarterly/annual recertification of all LAN users including contractors, and verify that their access is appropriate for their given job responsibility.

G. LAN – Logical Security Controls (Password Settings)

Description and Risk

The AIX password settings do not comply with the CDPHP Password Policy regarding Minimum Length, complexity, Maximum age and Minimum age. Each setting currently has a value of zero, which means that none of these password controls are being used to help prevent unauthorized access to the AIX system. Easily guessable and poor password controls increases the risk of individuals gaining unauthorized access to information assets and network resources.

The ORACLE data warehouse, which is used as a management information tool, resides on the AIX system. As a result, users could exploit this vulnerability to gain unauthorized access to the data warehouse.

Recommendation

It is recommended that Management, at a minimum, enforce the following password settings on its AIX system: MinLength = 6, MaxAge = 60, MaxTry = 5, MinAge = 7, complexity set to alpha and numeric.

5. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM.	PAGE NO.
<p>A. PaperFree – Change management</p> <p>It is recommended that management review all individuals who have access to the PaperFree development, testing, and production environments. It is further recommended that all developer access to the production environment be removed immediately and a separate department assigned the responsibility of migrating code into production.</p>	<p>69</p>
<p>B. PaperFree – Logical access controls</p> <p>It is recommended that management review IT personnel access to the K: drive and limit the permissions to those developers working in the PaperFree environment. Additionally, it is recommended that Management implement a version control software tool to ensure that code is migrated correctly.</p>	<p>70</p>
<p>C. LAN – Logical security controls</p> <p>It is recommended that management assign individual user IDs to all HP3000 administrators. It is further recommended that management log access to the master ID and periodically review this log to ensure activities performed are appropriate and authorized. Finally, it is recommended that management require the master password to be changed periodically</p>	<p>70</p>
<p>D. Remote access</p> <p>It is recommended that management discontinue the current policy of allowing virtual private network (VPN) access through non-company issued computers. It is further recommended that management review and allow access only to users who require VPN access for their job function. Users who only require access to their CDPHP e-mail account should be issued a username and password to the company’s web mail portal. The web mail portal does not need to be installed on CDPHP issued computers.</p>	<p>71</p>

ITEM.		PAGE NO.
E.	AMISYS – Logical security controls	
	It is recommended that Management implement a process by which end-user access to the AMISYS system is removed from all terminated employees and from users that have transferred within the HMO. If a user requires access to the AMISYS system as part of their new job function, a new user request should be created for that user. The system administrator should review the AMISYS access control listing periodically to ensure that user rights within AMISYS are appropriate.	72
F.	LAN – Logical security controls (User recertification)	
	It is recommended that management conduct a quarterly/annual recertification of all LAN users including contractors, and verify that their access is appropriate for their given job responsibility.	72
G.	LAN – Logical security controls (Password settings)	
	It is recommended that management, at a minimum, enforce the following password settings on its AIX system: MinLength = 6, MaxAge = 60, MaxTry = 5, MinAge = 7, complexity set to alpha and numeric.	73

Appointment No. 22345

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Acting Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Capital District Physicians Health Plan

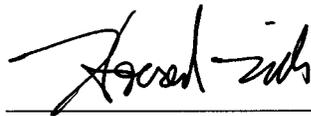
and to make a report to me in writing of the said

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 11 day of March 2005



Howard Mills
Acting Superintendent of Insurance

