MARKET CONDUCT REPORT ON EXAMINATION

OF

U.S. HEALTHCARE, INC.

AND

U.S. HEALTH INSURANCE COMPANY

AS OF

MARCH 30, 2000

DATE OF REPORT: **OCTOBER 16, 2000**

EXAMINER: **MARTIN A. SCHWARTZMAN**

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

October 16, 2000

Honorable Neil D. Levin
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 21308 and 21309 dated September 10th 1998, and annexed hereto, I have made an examination into the affairs of U.S. HealthCare, Inc. ("USHC-NY"), a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law and U.S. Health Insurance Company, ("USHIC-NY") an accident and health insurance company licensed under Article 42 of the New York Insurance Law. The following report, as respectfully submitted, deals with the findings concerning the manner in which USHC-NY and USHIC-NY conduct their business practices and fulfill their contractual obligations to policyholders and claimants.

Whenever the term "U.S. HealthCare" appears herein without qualification, it should be understood to refer to both USHC-NY and USHIC-NY. Wherever a distinction needs to be made, the terms "USHC-NY" and/or "USHIC-NY" shall be used respectively.

1. SCOPE OF EXAMINATION

A review of the manner in which U.S. HealthCare conducts its business practices and fulfills its contractual obligations to policyholders and claimants has been performed. This review covers the period January 1, 1998 to March 30, 2000. The primary purpose of this report is to assist U.S. HealthCare's management in addressing problems that are of such a critical nature that immediate corrective action is required. Accordingly, this report is confined to comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

2. MANAGEMENT

As part of the review of management, a detailed listing of all reports routinely distributed to senior management was requested. U.S. HealthCare provided a listing that included thirteen reports routinely distributed to senior management. It is significant to note that given all the claims processing and operational issues as denoted throughout this market conduct report on examination, only one of the thirteen reports routinely distributed to senior management includes information pertaining to claims processing activities. The report is entitled "Quality Management Report" and is an interdisciplinary review of certain service indicators that is prepared and presented to U.S. HealthCare's board of directors on a quarterly basis. Of the remaining twelve senior management reports, seven pertain to sales and underwriting issues, four relate to medical cost trends and one relates to Medicare.

While it is apparent that the focus of U.S. HealthCare's senior management reports are in the area of sales and marketing, not enough information pertaining to claims processing activities are being provided to senior management. Given that the principal function of U.S. HealthCare is to process health care claims, senior management should be provided with more detailed, accurate and timely information relative to claims processing activities so that appropriate business decisions can be made.

Circular Letter No. 9 (1999) dated May 25, 1999 "Adoption of Procedure Manuals" was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and Insurers Licensed to Write Health Insurance in New York State. The Circular Letter states in pertinent parts as follows:

> "…The directors of an insurer licensed to write health insurance and of a health maintenance organization (collectively referred to as "company") and, in the case of a controlled company, the parent company must, under long standing principles of corporate governance, confirm that the company is fulfilling all of its responsibilities…."
>
> "In order to fulfill its responsibility to oversee the claims adjudication process it is critical that the board adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations. One way for the board to ensure itself that such procedures are in place is to direct the officers responsible for claims adjudication to (i) issue, and up-date as necessary, a claims manual which sets forth the company's claims adjudication procedures; (ii) distribute the claims manual and necessary up-dates to all persons responsible for the supervision, processing and settlement of claims and obtain an acknowledgement of receipt; and (iii) provide the training necessary to ensure the claim manual's implementation including a formal educational program and periodic re-training. It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.
>
> The board is reminded that its responsibilities to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management, administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself.

> Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations. Examples of additional key areas include: implementation of the Managed Care Bill of Rights (e.g. information dissemination, accessing prompt quality care, grievance/appeal process); underwriting and rating; external appeals (effective 7/1/99); and the accurate and timely reporting of all financial statement schedules and exhibits. In this regard, the board should be aware that certain schedules are routinely reviewed by the media, provider community, the public and their elected representatives. These schedules include (Schedule references are to the HMDI and HMO Annual Statements):
>
> N.Y. Schedule G "Salaries and Compensation"
> N.Y. Schedule H "Aging Analysis of Claims Unpaid"
> N.Y. Schedule M "Grievances/Appeals"
>
> The previously recommended annual certification to the board regarding implementation of the adopted procedures and the board's need to oversee outside parties under contract with the company also extends to these additional areas."
>
> "It is requested that the Corporate Secretary acknowledge receipt of this Letter and confirm that it will be distributed to all board members and, if applicable, to the board members of the parent corporation prior to the respective board's next regularly scheduled meeting. Such distribution, receipt and any subsequent discussion should be recorded in the minutes of the respective board's meeting…"

U.S. HealthCare was requested to provide evidence that the aforementioned Circular Letter was distributed to all of its board members as well as the board members of the parent corporation and that the necessary written procedures were adopted in accordance with Circular Letter No. 9 (1999). In a response dated March 29, 2000, U.S. HealthCare stated that:

> On August 2, 1999 U.S. Health Insurance Company and U.S. Healthcare, Inc., d/b/a Aetna U.S. Healthcare, acknowledged receipt of Circular Letter No. 9 (1999), and advised that the circular letter would be distributed to all board members prior to the board's next regularly scheduled meeting (copies attached). The matter was on the agenda of the December 22, 1999 board meeting, and a resolution was scheduled for discussion and adoption. However, it was determined that some changes were needed to the resolution and the discussion and adoption of the resolution was postponed until the next meeting, scheduled for April 3, 2000.

While many of the findings contained throughout this report are characterized as violations of Law and Regulation, others are noted for U.S. HealthCare's failure to provide complete and thorough data on its operations. Given the findings and claims processing deficiencies as denoted throughout this Market Conduct Report on Examination, it is incumbent upon the board of directors of U.S. HealthCare as well as the board of directors of its parent corporation to immediately adopt the necessary written procedures in accordance with Circular Letter No. 9 (1999).

It is recommended that U. S. HealthCare distribute detailed, accurate and timely reports relative to its claims processing activities to senior management, its board of directors and the directors of the parent corporation on a regular basis so that management can be in a better position to make informed business decisions.

It is recommended that U.S. HealthCare's board of directors and its parent company's board of directors immediately adopts the necessary written procedures in accordance with Circular Letter No. 9 (1999).

3. CONDUCT OF EXAMINATION

§310(a)(2) of the New York Insurance Law states in part:

> "Any examiner authorized by the superintendent shall be given convenient access at all reasonable hours to the books, records, files, securities and other documents of such insurer or other person, including those of any affiliated or subsidiary companies thereof, which are relevant to the examination."

§310(a)(3) states further that:

> "The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so**."**

During the conduct of the examination, the officers and directors of U.S. HealthCare did not comply with §310 of the New York Insurance Law. There were numerous delays in responding to many of the examiners requests for data and information. Responses to examiner requests revealed that there was a lack of coordination in providing necessary information in that often such responses were incomplete and indicated that other sources within U.S. HealthCare would have to add to a response. There appeared to be little follow-up to ensure that such other elements within U.S. HealthCare actually provided the missing pieces of required information. In short, the examiner experienced various problems in trying to obtain the necessary information and data as well as explanations to the material that was supplied.

One particular example is the lack of facilitation provided the examiners with respect to the claims processing review. In April 1999, the examiners attempted to commence the claims processing review segment of the examination. Despite repeated requests, U.S. HealthCare did

not provide the appropriate personnel and data until October 1999. It should be noted that throughout this time, certain data was intermittently provided to the examiners, however, it could not be reconciled to the companies filed financial statements. Additionally, the data contained discrepancies and adequate explanations were not provided. As a result, the commencement of the claims review process was delayed for a number of months. Additionally, when claim files supporting the underlying data were selected for review, U.S. HealthCare did not provide them for over two months.

During the examination, the entire matter of U.S. HealthCare's inability to facilitate the examination was brought to the attention of senior management. Meetings were held at the Department with U.S. HealthCare's top management. The most recent meeting held at the Department to discuss U.S. HealthCare's operations including the lack of cooperation on this examination was on December 16, 1999. Present at that meeting, were Charles Sweeney, Regional HMO Head, James Brown, Regional General Counsel, Hartford, CT., Heriberto Barbot Jr., Regional General Counsel, New York, Mary Clarie Bonner, General Manager/Manhattan Office and James W. Reid, General Manager/Uniondale Office. The issues were outlined and the Department demanded that full cooperation and facilitation with the examination be effected forthwith. Despite senior management's assurances that facilitation of the examination would receive top priority, this did not occur. Accordingly, U.S. HealthCare's actions as set forth constitute a violation of the requirements of §310 of the New York Insurance Law.

It is strongly recommended that U.S. HealthCare's board of directors and its parent company's board of directors establish and implement a policy designed to ensure that U.S. HealthCare fully complies with the requirements of §310 of the New York Insurance Law.

4. SALES

Pursuant to Article 21 of the New York Insurance Law, U.S. HealthCare is authorized to use and utilizes independent insurance agents and brokers as its primary distribution system. In addition, U.S. HealthCare maintains a direct sales staff of account executives and group service representatives. U.S. HealthCare also employs a staff of telemarketing representatives who generate leads for the direct sales force and who sell directly to small group, individuals and government program customers.

A review of U.S. HealthCare's sales practices indicates violations of New York Insurance Law. In summary, U.S. HealthCare has violated:

- New York Insurance Law §2102(a)(1), §2114(a)(3) and §2116 by utilizing and paying commissions to unlicensed insurance agents, brokers and employees to solicit its products.

- New York Insurance Law §2112(a) since certificates of appointment for many of its

agents were not on file with the Department.

- New York Insurance Law §2112(d) in that it did not report terminated agents to the Department.

A. Use of and Commission Payments to Unlicensed Agents and Brokers

New York Insurance Law §2102(a)(1) prohibits any person, firm or corporation from acting as an insurance agent or broker without the requisite license. Said statute states:

> "No person, firm, association or corporation shall act as an insurance agent, insurance broker, reinsurance intermediary or insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

U.S. HealthCare utilized unlicensed insurance agents, brokers and employees to solicit its products. Additionally, with respect to U.S. HealthCare's employees that are utilized to solicit its products, New York Insurance Law §2101 defines the term "insurance agent" and denotes an exemption to the licensing of any regular salaried officer or employee of a licensed insurer under certain conditions. Specifically, New York Insurance Law §2101(a)(1) states in pertinent part that the term "insurance agent" shall not include any regular salaried officer or employee of a licensed insurer if:

> "...such officer or employee does not receive a commission or other compensation for his services which commission or other compensation is directly dependent upon the amount of business obtained;"

Accordingly, since U.S. HealthCare's employees are compensated in a manner that is directly dependent upon the volume of business produced, they are deemed to be insurance agents and are required to obtain the requisite license.

Additionally, New York Insurance Law §2114(a)(3) states:

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

New York Insurance Law §2116 states:

> "No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article."

As part of the examination review, U.S. HealthCare was requested to produce copies of licenses for a selection of fifty external insurance agents and fifty external insurance brokers. Of the fifty external insurance agents selected, eighteen or 36% of the agents were not licensed as of the date of the review. Of the fifty external insurance brokers selected, eighteen or 32% were not licensed as of the date of the review.

With respect to internal producers, it should be noted that U. S. HealthCare was unable

to provide licenses for all of its internal producers. In addition, serious record keeping deficiencies were noted with respect to the tracking of internal producers. U.S. HealthCare provided licenses for some employees who were not included on the internal producer listing. Additionally, it was noted that U.S. HealthCare no longer employed some internal producers whose names appeared on the listing that was provided.

In view of the foregoing, it appears that U.S. HealthCare violated New York Insurance Law §2102(a)(1); §2114(a)(3) and §2116 in that commissions were paid to unlicensed insurance agents and brokers.

B. **Failure to File Certificates of Appointment of Insurance Agents with the Department**

New York Insurance Law §2112(a) states:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

U.S. HealthCare violated New York Insurance Law §2112(a) in that certificates of appointment for many of its insurance agents were not on file with the Department as prescribed by statute. Of the fifty external insurance agents selected for review, U.S. HealthCare was unable to produce certificates of appointment for forty-seven or 94% of the number requested.

C. Failure to Report Terminated Insurance Agents to the Department

New York Insurance Law §2112(d) states in part:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall, upon termination of the certificate of appointment of any insurance agent licensed in this state, forthwith file with the superintendent a statement, in such form as the superintendent may prescribe, of the facts relative to such termination and the cause thereof…"

U.S. HealthCare did not maintain a listing of terminated producers. Furthermore, no evidence of notification to the Department of terminated producers could be provided. Accordingly, it appears that U.S. HealthCare violated New York Insurance Law §2112(d) in that it did not report all of its terminated insurance agents to the Department.

D. Maintenance of Supporting Documentation Relative to Commission Payments

U.S. HealthCare failed to maintain adequate supporting documentation of its commission payments to various external insurance agents and brokers. With respect to documentation of commissions relative to fifty external agents selected for review, U.S. HealthCare was unable to produce ten or 20% of the commission statements requested. With respect to documentation of commissions relative to fifty external brokers selected for review, U.S. HealthCare was unable to produce eight or 16% of the commission statements requested.

It is recommended that U.S. HealthCare ensure that its agents, brokers and employees maintain the requisite license in compliance with New York Insurance Law §2102(a)(1).

It is recommended that U.S. HealthCare comply with New York State Insurance Department licensing requirements as to all U.S. HealthCare's employees who earn a commission or fee based on sales and to comply with New York Insurance Law §2114(a)(3) and §2116 to ensure that commissions are only paid to licensed agents and brokers.

It is recommended that U.S. HealthCare comply with New York Insurance Law §2112(a) and file all certificates of appointment for its insurance agents with the Department as prescribed by statute and maintain evidence of such filings.

It is recommended that U.S. HealthCare comply with New York Insurance Law §2112(d) and report terminated insurance agents to the Department as prescribed by statute.

It is recommended that U.S. HealthCare implement the necessary internal control procedures in order to maintain adequate supporting documentation of its commission payments to various external insurance agents and brokers.

5. ADVERTISING

A review of U.S. HealthCare's advertising records was performed to ascertain compliance with 11 NYCRR 215 (Regulation No. 34), "Rules Governing Advertisements of Accident and Health Insurance."

Section 215.17 of New York Regulation No. 34 states in pertinent part:

> "Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies…"
>
> "…All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

Contrary to the above requirement, U.S. Healthcare failed to maintain the requisite advertising file. In addition, attempts were made to reconcile internal schedules of advertising expenses provided by U.S. HealthCare to filed financial statements in order to determine if all advertising expenses were accounted for. None of the schedules supplied by U.S. HealthCare could be reconciled to filed financial statements. Accordingly, the examiners were unable to verify that all of U.S. HealthCare's advertising material was provided for review.

It is recommended that U.S. HealthCare comply with 11 NYCRR 215 (Regulation No. 34) Section 215.17 to:

a) Maintain at its home or principal office a complete advertising file containing every printed, published or prepared advertisement of its polices.

b) Retain a complete advertising file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever

is the longer period of time.

6. WRITTEN DISCLOSURE OF INFORMATION

§4324 of the New York Insurance Law states in part that:

> "(a) Each health service, hospital service, or medical expense indemnity corporation subject to this article shall supply each subscriber, and upon request each prospective subscriber prior to enrollment, written disclosure information, which may be incorporated into the subscriber contract or certificate, containing at least the information set forth below…"

The statute goes on further to detail all of the various requirements.

As part of the examination review of U.S. HealthCare's compliance with §4324 of the New York Insurance Law, a disclosure information package was requested. In addition, three examiners participating on the U.S. HealthCare assignment requested that a disclosure packet be mailed to their homes via the company's toll free number (800) 435-8742.

All three examiners made a request for disclosure information relative to U.S. HealthCare's Individual Advantage Program on April 6, 1999. Follow-up requests were made on May 17, 1999 and May 18, 1999 respectively. On May 29, 1999, fifty-three days after the initial request, one examiner received the requested disclosure information. The other two examiners never received the disclosure information. It should be noted that when the examiners questioned U.S. HealthCare concerning the above, a response was provided dated October 4, 1999 that stated:

> "Aetna U.S. HealthCare Fulfillment Center has experienced a prolonged period of

disclosure items being backlogged. Included in these out of stock items are many of the materials sent out in the Pre-Enrollment kits."

With respect to the disclosure information supplied by U.S. HealthCare to the examiners for review as well as the disclosure information obtained through an anonymous inquiry the following deficiencies were noted:

ITEMS REQUIRED TO BE INCLUDED IN DISCLOSURE INFORMATION PACKAGE PURSUANT TO § 4324 NYIL	**INCLUDED IN PACKET SUPPLIED BY US HEALTHCARE**	**INCLUDED IN PACKET MAILED TO EXAMINER**
List of the names, businesses, addresses and official positions of the membership of the board of directors, officers, and members of the corporation.	Yes	**No**
Copy of the most recent annual certified financial statement of the corporation, including a balance sheet and summary of receipts and disbursements prepared by a Certified Public Accountant.	Yes	**No**
Information relating to consumer complaints compiled pursuant to §210 of the NYIL.	**Incomplete**	**Incomplete**
Procedures for protecting the confidentiality of medical records and other subscriber information.	Yes	**No**
Allow subscribers and prospective subscribers to inspect drug formularies used by the corporation and disclose whether individual drugs are included or excluded from coverage.	**No**	**No**
Provide a written description of the organizational arrangements and ongoing procedures of the corporations quality assurance program.	Yes	**No**

It is of concern that there was such a discrepancy between the disclosure information that was provided to an anonymous inquiry through the US Mail than that which was provided to the examiners as part of an on-site examination request.

It is recommended that U.S. HealthCare comply with the requirements of §4324 of the

New York Insurance Law and ensure that each subscriber, and upon request each prospective subscriber prior to enrollment, is provided with the required written disclosure information in a timely basis.

7. UNDERWRITING AND RATING

A review of U.S. HealthCare's underwriting and rating procedures was performed. A random sample of underwriting files were reviewed along with an Underwriting and Rating Exception report produced by U.S. HealthCare relative to seven hundred and twenty three groups that were offered rates considered to be exceptions. As a result, the following is noted:

- U.S. HealthCare issues a comprehensive health service product with an out-of-plan benefit, known as a point-of-service "POS" product. This product is written as two contracts, the HMO portion is issued by USHC-NY while the indemnity or out-of-plan portion is issued by USHIC-NY.

  U.S. HealthCare utilizes an experience rating methodology formula to set the rate for its POS product. U.S. HealthCare alleges that it will never offer an overall rate that is lower than what the community-rate would be for the HMO portion of the contract. Consequently, depending on the circumstances, the indemnity portion of the contract could theoretically be offered for no charge. USHC-NY must use an approved community rate for all HMO contracts and riders. The experience rating methodology

applied to USHIC-NY's portion of the contract should only be applied to that portion of the premium that represents the projected costs of providing the insured an out-of network benefit. Accordingly, U.S. HealthCare's practice of applying an experience rating methodology formula to the entire POS contract may entail subsidization from other community rated policyholders to make up for an inadequate rate, and therefore, may raise issues under the provisions of New York Insurance Law Section 4308 and Regulation 62 (11 NYCRR 52).

- Premium allocations between USHC-NY and USHIC-NY appear to be questionable. Currently, the premium allocation utilized by U.S. HealthCare is 71% to USHC-NY and 29% to USHIC-NY whereas the utilization allocation (the percentage of utilization that occurs in-network vs. out of network for the POS product in NY) is approximately 85% for USHC-NY and 15% for USHIC-NY. As a result, USHIC-NY reported a net income of $200,734,524 as of December 31, 1999, whereas USHC-NY reported a net income of $40,764,747 for the same period. Apparently, USHC-NY is not receiving its appropriate share of the premium.

- A review of USHIC-NY's experience-rating formula for large group accounts revealed that it is incomplete and many of the factors and/or assumptions are not defined. Moreover, with respect to the application of the experience–rating formula to determine

rates for U.S. HealthCare's POS product, it was noted that it was not adhered to in many cases. Furthermore, the use of any experience rating methodology is particularly troublesome in view of the U.S. HealthCare's acknowledgement that they do not have the capability to monitor the underwriting experience of individual groups. Specifically U.S. HealthCare informed the examiners that that they could not determine on which groups they are making an underwriting profit or incurring a loss. Underwriting gains and/or losses are reviewed as entire blocks of consolidated business.

- U.S. HealthCare was unable to fully demonstrate the rating process applied to any of five randomly selected underwriting files reviewed. From the information available at the time of the review, it appeared that the rating technique used by U.S. HealthCare was applied to what seemed to be incomplete and unverified data. Moreover, trend factors utilized were not documented nor did they appear to be applied consistently.

U.S. HealthCare's overall rating methodology with respect to the large group market appears to be discriminatory. The following are some examples that raises areas of concern:

1. "Oxford Power Play" discounts - In these cases discretionary and unjustified discounts were given to prospective accounts that were currently insured by Oxford Health Plan, Inc. U.S. HealthCare has acknowledged that, in some cases, a rate was offered to the account that was expected to produce an underwriting loss. This practice leads to "low-ball" rates, thus aggravating and prolonging financial losses to both U.S.

HealthCare and Oxford Health Plans, Inc.

2. "Full Profit, NY/NJ Profit, X% Profit, NY Profit" discounts - This rating technique is essentially the same as described in item 1 above, discretionary and unjustified discounts were unfairly given to prospective and/or renewal accounts.

3. "Field Manager –5%" discount - In this scenario, U.S. HealthCare Field Managers provided additional discounts to selected groups.

4. "Multi-Year Rate Guarantees" - Certain groups were offered multiple year rate guarantees. In these cases, the annual rate or percentage of increase was guaranteed not to exceed a specified amount regardless of claims experience.

It is recommended that U.S. HealthCare cease the practice of applying an experience rating methodology to the entire large group POS product until such time as it complies with the provisions of New York Insurance Law Section 4308, Regulation 62 (11 NYCRR 52) and Circular Letter No. 26 (2000).

It is recommended that U.S. HealthCare undertake a study to accurately determine the percentage of in-network vs. out-of-network utilization for its POS product in NY and adjust its premium allocation accordingly so that USHC-NY receives an appropriate share of the premium.

It is recommended that U.S. HealthCare cease offering its "Oxford Power Play" discounts", "Full Profit, NY/NJ Profit, X% Profit, NY Profit" discounts and its "Field Manager –5%" discount to selected groups.

It is recommended that U.S. HealthCare discontinue offering "Multi-Year Rate Guarantees" to selected groups.

It is recommended that U.S. HealthCare implement procedures whereby the underwriting experience of individual large groups in NY are monitored and reviewed.

8. CLAIMS

A. CLAIMS PROCESSING

A review of U.S. HealthCare's claims practices and procedures was performed. However, as of the date of this report, a second more detailed statistical review of claims processing procedures is scheduled to commence shortly. The findings of such review will be the subject of a supplementary report that will be issued in the near future. For purposes of this report, the following is noted:

- Instances were noted where subscribers who were referred to non-participating

providers by USHC-NY were incorrectly reimbursed at USHC-NY's participating provider rate fee. This generally caused the subscriber to be balance billed the difference. Only upon appeal and/or multiple resubmissions's of a claim would an adjustment be made.

Under certain circumstances, participating providers may refer a patient to a non-participating provider for specialist care. Since the non-participating visit is pre-certified by the participating provider, the subscriber should be indemnified against any liability beyond the contracted copayment. Accordingly, pursuant to USHC-NY's member handbook, when a subscriber is referred out of the network to a non-participating provider:

"the referral guarantees that, except for the applicable copayments, you will not have to pay the bill for covered benefits."

However, USHC-NY's claims payment policy (Policy # GEN90-00021-G) appears to be inconsistent with the terms of the member handbook. USHC-NY's claims payment policy is as follows:

"The following policy is to be followed when a non-participating provider submits a claim for payment:

1. When a rate has been negotiated with a provider, the first submission of a claim will be paid according to that rate.

2. If there was no negotiated rate, the first submission of a claim from a non-par provider is paid according to Ætna US Healthcare's Reasonable Equitable Fee (REF) schedule.

3. Out-of-network (non-referred) non-par balance billing for Point of Service plans is the responsibility of the member. No additional payment will be made.

The remainder of this policy applies to in-network (referred) claims only.

4. When the non-par provider submits a balance bill for additional payment (second submission of claim), payment will be based upon the following calculation:
   Calculate 80% of the original billed amount.
   Calculate two (2) times (X) the REF.
   Use the lesser of the two amounts and subtract the original pay amount.
   This amount will be paid to the provider as an additional payment.

5. If the balance amount for each payable procedure on a claim is less than $75.00, the balance for the procedure is paid in full.

6. If the balance is more than $15,000 pend SUPE. The supervisor will call either the Regional Medical Director or the Hospital Network Service Coordinator and request negotiation of a fee with the provider.

7. **If the claim is resubmitted for a second additional payment (third submission of claim where a payment was made on the second submission), the balance is paid in full."** Emphasis Added.

§4403 6(a) of the New York State Public Health Law states:

"6. (a) If a health maintenance organization determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the health maintenance organization shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network."

Additionally §2601(a)(4) of the New York State Insurance Law ("Unfair Claim Settlement Practices; Other Misconduct; Discrimination") states in part:

"§2601. Unfair claim settlement practices; penalties. (a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:…"

"…(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear,…"

USHC-NY's claims payment policy relative to reimbursement pertaining to claims submitted from non-participating providers appears to be in violation of §4403 6(a) of the New York State Public Health Law. Moreover, USHC-NY's practice of requiring subscribers to submit non-participating claims up to three times in order to obtain full

reimbursement appears to be in violation of §2601(a)(4) of the New York State Insurance Law.

It is recommended that USHC-NY comply with §4403 6(a) of the New York State Public Health Law, §2601(a)(4) of the New York State Insurance Law and its member handbook and provide full reimbursement beyond the contracted copayment to all subscribers who are properly referred to a non-participating provider.

B. PROMPT PAY

§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" 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:

> "(a) Except in a case where the obligation of an insurer to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or

> corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

§ 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 then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

Examination objectives 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 settlements within the timeframe 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, 1999 through September 30, 1999 and the calculated interest payable amount would have exceeded the two-dollar threshold were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest as required by statute.

The results of the review with respect to the claim data provided are as follows:

USHC-NY

TYPE OF CLAIM	NUMBER OF CLAIMS SELECTED *	NUMBER OF CLAIMS ELIGIBLE FOR INTEREST	NUMBER OF CASES INTEREST NOT PAID	ERROR RATIO
MEDICAL	100	93	93	100%
HOSPITAL	100	100	85	85%
TOTAL	**200**	**193**	**178**	**92%**

Note: * The number of claims that appeared to be eligible for interest from the overall population amounted to 12,214 and 6,798 for Medical and Hospital claims respectively. Thus, a statistical sample of 100 randomly selected claims for each category produced a sample with a confidence level of 95% and error rate of 7%. This is within accepted ranges for valid claims sampling techniques.

USHIC-NY

TYPE OF CLAIM	NUMBER OF CLAIMS SELECTED *	NUMBER OF CLAIMS ELIGIBLE FOR INTEREST	NUMBER OF CASES INTEREST NOT PAID	ERROR RATIO
MEDICAL	50	50	47	94%
HOSPITAL	50	50	43	86%
TOTAL	**100**	**100**	**90**	**90%**

Note: * The number of claims that appeared to be eligible for interest from the overall population amounted to 1,635 and 403 for Medical and Hospital claims respectively. Thus, a statistical sample of 50 randomly selected claims for each category produced a sample with a confidence level of 95% and an error rate of 5%. This is within accepted ranges for valid claims sampling techniques.

With respect to the above charts the following should be noted:

- A true indication of claims processing timeliness could not be ascertained in many instances. Therefore, some claims that could have been subject to interest payments may have been incorrectly excluded from the segregated population. This was due to the fact that in many cases the embossed date, which is put on a claim upon receipt in

the mailroom, did not show up on the imaged copy. Consequently, the examiners had to use the date the claim was entered into U.S. HealthCare's claims processing system as the starting point. The examiners noted one instance where it took up to thirty-two days from receipt of a claim in the mailroom for it to be entered into U.S. HealthCare's claims processing system.

- U.S. HealthCare encourages its providers to submit claims electronically, instead of through the US Mail. The process used to do this is referred to as Electronic Data Interface ("EDI"). U.S. HealthCare utilizes the services of Envoy Corporation, an Electronic Data Interchange Company. Envoy is the first step in the claims receipt process. Upon receipt of an EDI claim, Envoy verifies that all necessary information to process the claim is present before forwarding it on to U.S. HealthCare. Claims that are not complete are rejected and sent back to the sender. While providers are free to select any EDI intermediary, those intermediaries are then obligated to send the claims on to Envoy, U.S. HealthCare's EDI Company of choice.

  U.S. HealthCare does not consider the receipt date for prompt pay compliance to be the date the claim was received by Envoy. Consequently, U.S. HealthCare only counts the days it processes a claim after receipt of it from Envoy in determining compliance with NY Insurance Law §3224-a. This practice is contrary to NY Insurance Law §3224-a. HMOs and insurance companies are ultimately responsible for compliance with the prompt pay law, despite any contractual delegation of the claims payment

process. This includes not only compensation to the provider for the delay in paying the claim (interest) but also any sum to be paid to the Department as penalty for late payments

- Subsequent to the examination review and after discussion with management, U.S. HealthCare informed the examiners that they adjusted eighty-five claims identified in the above chart and paid the interest due. No documentation was provided to support this.

- With respect to twenty-five claims denoted in the above chart where U.S. HealthCare made interest payments, it is noted that in 14 instances, the interest amount was either underpaid or overpaid.

- U.S. HealthCare's processing procedures require that interest be calculated manually. When a claim has interest due, a claims processor must manually enter the information into a special calculator provided. Once calculated, interest due must be manually inputted into the claims processing system for payment. In view of the foregoing, it can be concluded that the manual process of calculating and inputting interest due into the claims processing system is not functioning effectively.

  Subsequent to the review of this item, U.S. HealthCare informed the examiners that an automated system for the payment of interest has been installed; however, such system was not reviewed by this examiner.

The above referenced claims were also reviewed to determine compliance with §3224-a(b) of the New York Insurance Law. As detailed above, this subsection requires that claims not paid within 30 days must have a communication sent out indicating what missing information is required to complete the processing of the claim.

Specifically, § 3224-a(b) states in part

> "b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or healthcare 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."

U.S. HealthCare was unable to demonstrate that any such correspondence was sent out on any of the claims reviewed.

Some of the reasons that may serve to rationalize the high error ratio are as follows:

- In certain cases, it was noted that an automatic system override was used to reverse out interest that was manually entered into the claims processing system. U.S. HealthCare was unable to explain why this occurred.

- U.S. HealthCare's claims processing system is designed such that a claims processing

examiner can ignore an interest warning message and continue to process the claim without paying any interest.

- U.S. HealthCare's claims processing system is designed such that there is a complex manual process in place that a claims processing examiner must go through to ultimately add interest on to the claim.

- Claims processors do not appear to be well trained in the application of §3224-a of the New York Insurance Law.

Circular Letter No. 6 (2000) dated January 27, 2000 was issued to remind insurers and HMO's of their responsibilities under §3224(a) of the New York Insurance Law and to further expand upon the Department's position on compliance with this statute. The Circular Letter states in relevant part:

> "The Prompt Pay Law, signed by Governor Pataki in September 1997, requires HMOs and Insurance companies to pay undisputed claims and bills within 45 days of receipt. Prompt pay violations undermine New York's health care system and greater attention by management and directors must be focused on eliminating such violations. Over the last two years, over $266,000 in fines have been paid by insurers and HMOs for violating the statute. Despite these actions, a large number of insurers and HMOs have repeatedly failed to comply with the law. This repeated failure requires that the Department take further action to ensure compliance. Therefore, the Department will be taking additional actions to enforce the prompt pay legislation. The following changes will be implemented:
>
> - Schedule H will be amended to include the total number of claims that are processed annually.
>
> - Letters will be issued pursuant to Section 308 of the New York Insurance Law requesting information regarding the number of claims processed during specific time periods.

- Tougher penalties will be sought for those companies that are determined to be recidivists. HMOs and insurers who have repeatedly failed to pay their claims on time will face fines of up to $5,000 per violation, as allowed by the statute.

  The officer in charge of claims should acknowledge in writing receipt of this Circular Letter no later than February 28, 2000…"

It is recommended that U.S. HealthCare implement the necessary procedures in order to ensure compliance with §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".

It is recommended that U.S. HealthCare consider the date a claim is received by Envoy, its electronic data interchange to be the receipt date with respect to compliance with §3224-a of the New York Insurance Law.

It is recommended that U.S. HealthCare perform a comprehensive review of all claims that were not processed within 45 days for the period 1998 through present and, submit a plan to the Department which addresses those claims where which interest is due pursuant to §3224-a of the New York Insurance Law.

It is recommended that U.S. HealthCare implement the necessary procedures to ensure compliance with §3224-a(b) of the New York Insurance Law and send out requisite notifications within 30 days where applicable.

It is recommended that U.S. HealthCare automate the interest paying process within its claims processing system.

It is recommended that U.S. HealthCare implement the necessary claims processing training in the application of §3224-a of the New York Insurance Law.

It is recommended that U.S. HealthCare's Quality Assurance Department establish procedures to periodically test New York claims for compliance with §3224-a of the New York Insurance Law.

C. SCHEDULE H ("AGING ANALYSIS OF UNPAID CLAIMS")

A review of U.S. HealthCare's Schedule H ("Aging Analysis of Unpaid Claims") as filed with the Department for the years 1997, 1998, and 1999 was performed. This review evidenced U.S. HealthCare's inability to adequately ascertain the aging of its unpaid claims.

To illustrate the problems, the following should be noted:

As of December 31, 1999, USHC-NY and USHI-NY filed the following data respectively with respect to Schedule H "Aging Analysis of Unpaid Claims":

USHC-NY December 31, 1999 Schedule H -Aging Analysis of Unpaid Claims -NY

Account	1-30 days	31-60 days	61-90 days	91-120 days	Over 120 days	Total
Claims Payable (reported)	$36,951,294	$911,706	$195,951	$35,438	$401,133	$38,495,522
IBNR						$247,831.349
Total						$286,326,871

USHIC-NY December 31, 1999 Schedule H -Aging Analysis of Unpaid Claims -NY

Account	1-30 days	31-60 days	61-90 days	91-120 days	Over 120 days	Total
Claims Payable (reported)	$124,516	$32,231	$6,108	$3,812	$26,120	$192,717
IBNR						$16,308,951
Total						$16,501,738

At first glance, it would appear that U.S. HealthCare does not have a significant problem with respect to the processing of its outstanding claims. However, it should be noted that contrary to information furnished to the Department in response to a 1999 inquiry, U.S. HealthCare only aged and reported unpaid claims that were in its accounts payable system. In other words, only claims that were fully adjudicated and forwarded to U.S. HealthCare's accounts payable system for payment were reflected in Schedule H. Claims received by U.S. HealthCare that were in various stages of the claims processing cycle prior to release to accounts payable were excluded.

To put this into context and to further illustrate the impact this schedule has on any

reader of U.S. HealthCare's financial statements, the following should be considered. At December 31, 1999, USHC-NY reported a little over $38 million dollars of aged reported claims. What USHC-NY failed to include was the portion of the $248 million of its unpaid claims classified as "Unreported Claims and Other Claims Reserves" that were actually received and were in various stages of the claims processing cycle, but not yet fully adjudicated or released to accounts payable for payment. USHC-NY could not provide an estimate for this segment of the unpaid claims. The underlying theory behind the Department's promulgation of Schedule H was to have Healthcare companies accurately report and age its reported claims so that a measure of claims processing efficiency could easily be obtained.

Accordingly, U.S. HealthCare's reporting treatment of Schedule H renders them useless. It should be noted that, effective with the March 31, 2000 quarterly statement, the format of Schedule H has been revised in order to require that the reserves for reported claims in the course of settlement be reported separately.

It is recommended that U.S. HealthCare take the necessary steps to enable it to complete its Schedule H ("Aging Analysis of Unpaid Claims") in accordance with the Department's instructions.

It is recommended that U.S. HealthCare submit corrected Schedules Hs to the Department forthwith.

D. EMERGENT CARE

§3216(i)(9) and §3221(k)(4)(A) of the New York State Insurance Law requires that health insurance contracts permit emergency room treatment using a prudent person standard.

§3216(i)(9) of the New York State Insurance Law "Individual accident and health insurance policy provisions" states in part:

> "(9) Every policy which provides coverage for inpatient hospital care shall also include coverage for services to treat an emergency condition in hospital facilities. An "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person`s bodily functions; (C)serious dysfunction of any bodily organ or part of such person; or (D)serious disfigurement of such person.."

§3221(k)(4)(A) of the New York Insurance Law "Group or blanket accident and health insurance policies; standard provisions" states in part:

> "(4) (A) Every group policy delivered or issued for delivery in this state which provides coverage for inpatient hospital care shall include coverage for services to treat an emergency condition provided in hospital facilities, except that this provision shall not apply to a policy which cover persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state. (B) In this paragraph, an "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person."

A sample of emergency room claims was examined to determine whether U.S.

HealthCare was in compliance with the prudent layperson standard of care. Accordingly, eleven files were selected for review from a listing of emergency room claims that were denied during the first two weeks of August 1999. One claim selected for review was a duplicate submission and another one was an office visit that was improperly coded as an emergency room denial. The following is noted with respect to the nine emergency room claims reviewed:

- All nine emergency room care claims reviewed were inappropriately denied on the initial claims processing adjudication. It should be noted that all of all of these claim submissions contained Current Procedural Terminology ("CPT") codes and International Classification of Disease - ICD-9-CM diagnostic codes that fell within acceptable parameters for emergency care as defined in U.S. HealthCare's medical payment policy. U.S. HealthCare was unable to provide any documentation to justify why these claims were initially denied. Additionally, it should be noted that four of them were eventually paid upon appeal while five still remain denied.

- When U.S. HealthCare denies an emergency room care charge, the denial code utilized is "D25" which indicates that the claim is being denied as "NON-EMERGENCY. BILL PATIENT. THIS CHARGE IS FOR A SERVICE WHICH DID NOT MEET OUR EMERGENCY BENEFIT PAYMENT CRITERIA. PLEASE BILL THE MEMBER." With respect to all nine emergency room care claim files reviewed, there was no documentation contained within U.S. HealthCare's claims processing system to explain why the "D25" denial code was used.
- In all cases, the "D25" denial code was inappropriately inputted into the system as a

manual override of an existing code. U.S. HealthCare was unable to explain why this occurred.

- In all cases, U.S. HealthCare's claims processing system reflected that a "D25" denial letter was sent out to the provider and/or subscriber. A denial letter explains in greater detail why the charge is being denied and advises the subscriber of his or her rights to file an appeal and/or where to submit additional documentation if the subscriber feels that emergency care was warranted. However, since U.S. HealthCare did not retain copies of the denial letters, there was no way to verify that they were actually sent out in these cases.

It is recommended that U.S. HealthCare comply with the prudent layperson person standard for emergency care as defined in §3216(i)(9) and §3221(k)(4)(A) of the New York State Insurance Law.

It is recommended that U.S. HealthCare review all emergency care claims that were submitted for the period 1998 through present and reprocess those claims that were inappropriately coded and therefore denied.

E. UTILIZATION REVIEW

§4902, §4903 and §4904 of the New York State Public Health Law sets forth the minimum utilization review program standards, requirements of utilization review determinations and appeals of adverse determinations by utilization review agents respectively.

All utilization reviews performed during the period under examination were administered by USHC-NY as part of an integrated benefits program. USHC-NY provided a log purporting to contain 2,926 utilization reviews for the period January 1, 1997 through October 31, 1998. However, upon review, it was noted the log contained files other than Utilization review files including files described by USHC-NY as "Targets and/or Retrospective Reviews". Accordingly, U.S. HealthCare was unable to provide the actual number of utilization review cases for the period under review.

Thirty-three utilization review files for the year 1998 were evaluated to determine compliance with §4902, §4903 and §4904 of the Public Health Law. The results are as follows:

§4903(4) of the New York State Public Health Law states:

> "4. 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."

It is noted that in seventeen of the thirty-three files reviewed (51%), USHC-NY failed to complete the utilization review within thirty days.

§4903(5) the New York State Public Health Law sets forth the requirements pertaining

to notices of adverse determinations and states:

> "5. 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."

USHC-NY failed to provide notice of adverse determinations on eight of the thirty-three files (44%). With respect to those files where notice of adverse determinations were issued, USHC-NY did not include a notice of the availability of the clinical review criteria relied upon to make the determination on twelve of the thirty-three files (36 %). Additionally, in one instance, USHC-NY's notice of adverse determination did not contain the clinical rational for the decision or instructions on how to initiate an appeal.

§4904(3) of the New York State Public Health Law sets forth the utilization review appeal process and states in part:

> "3. A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment 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."

USHC-NY failed to acknowledge an appeal in writing as required by statute in twenty

of the thirty-three files reviewed (63%). It should be noted that from notes contained within the various files, it appears that telephone contact may have been initiated in some cases to communicate the determination.

USHC-NY failed to resolve the utilization review appeal within sixty days of the receipt of all necessary information as required by statute in twenty of the thirty-three files reviewed (60%).

It is noted that two of the thirty-three utilization review appeals reviewed were wrongly denied. In these cases, USHC-NY denied these appeals for failure to submit it within 60 days of an adverse determination. However based upon the examiners review, both appeals were properly filed within 60 days of notice of an adverse decision (41 and 44 days respectively).

It is recommended that USHC-NY maintain complete and a separate logs for all Utilization Reviews and appeals.

It is recommended that USHC-NY comply with §4903(4) of the New York State Public Health Law and complete utilization reviews within thirty days of receipt.

It is recommended that USHC-NY comply with §4903(5) of the New York State

Public Health Law and provide notices of adverse determinations in accordance with said statute.

It is recommended that USHC-NY comply with §4904(3) of the New York State Public Health Law and resolve utilization review appeals within the specified timeframe.

F. EXPLANATION OF BENEFITS STATEMENTS

As part of the review of U.S. HealthCare's claims practices and procedures, an analysis of the Explanation of Benefits statements ("EOB") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and U.S. HealthCare. It should clearly communicate to the subscriber and/or provider that U.S. HealthCare has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers.

Overall, U.S. HealthCare's EOBs are easy to read and understand. However, the following is noted:

§3234(b)(7) of the New York State Insurance Law states in part:

> "(b) The explanation of benefit statement form must include at least the following:"
>
> "(7)…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 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".

Contrary to the above, U. S. HealthCare does not include the requisite information on its EOB's. Accordingly, subscribers and/or providers are not being properly informed of their appeal rights.

The review also revealed two areas where U.S. HealthCare might consider modifying its EOB to make them more user friendly an functional. These are as follows:

- It was noted that U.S. HealthCare does not include any fraud warning and/or notification on how to report healthcare fraud on its EOB's.

  Section 86.2 of 11NYCRR 86 (Regulation 95) was amended to include all health maintenance organizations and states as follows:

  > "§86.4 Warning statements.
  >
  > All applications provided to applicants for [non-automobile] commercial insurance and all claim forms for insurance, except personal automobile insurance, delivered to any person residing or located in this State (on and after February 2, 1994) in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:
  >
  > Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

  Notwithstanding that the above Regulation does not require the warning statement to be

placed on EOB's it would be prudent for U.S HealthCare to include such a warning as well as a toll free number to report fraud and/or abuse on its EOBs.

- It was noted that U.S. HealthCare does not include the date a claim was received on the EOB. This date is of particular importance to subscribers and/or providers given the enactment of §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"). Without disclosure of the receipt date, a subscriber and/or the provider cannot determine if any interest is due relative to a clean claim that took longer than 45 days to process.

It is recommended that U. S. HealthCare modify its EOB to comply with §3234 of the New York Insurance Law.

It is recommended that U. S. HealthCare include a fraud warning and disclose on the EOB a toll free number where subscribers can call in the event they suspect that a fraud has been committed.

It is recommended that U.S. HealthCare include the date a claim was received on the EOB so that a subscriber and/or the provider cannot determine if any interest is due relative to a claim that took longer than 45 days to process.

9. FRAUD PREVENTION AND DETECTION

A review was performed of the organization and structure of U.S. HealthCare's Fraud Division. U.S. HealthCare's compliance with New York Insurance Law §405 and Department Regulation 95 (11 NYCRR 86) with respect to the reporting of fraud cases to the Department was also reviewed. As a result, the following is noted:

- U.S. HealthCare has not sufficiently staffed its fraud division to provide assurance of its commitment to reduce fraud. As of August 31, 1999, U.S. HealthCare had seven-fraud investigators for its Eastern zone. These seven investigators perform work for all of U.S. HealthCare's companies throughout twenty-two states including New York. It is also noted that no investigator is specifically assigned to or located in the State of New York.

- Neither USHC-NY nor USHIC-NY was able to provide any verifiable statistics pertaining to the activities of its Special Investigation Unit. In other words, the examiners were not able to verify the amount of fraud dollars identified and/or recovered for the period under review. However, it is noted that in a report provided to the examiners entitled "Aetna US HealthCare Special Investigations Unit Quarterly Report Second Quarter 1999", an amount of $61,401 and $120,794 is reflected for "Systems Savings" as of the second quarter 1999 and year-to-date 1999 respectively. It is also noted that the aforementioned amounts relate to the entire Northeast area, which is comprised of twenty-two states.

  USHC-NY and USHIC-NY pay out over 1 billion dollars and 46 million dollars in

claim payments respectively on an annual basis. Both the General Accounting Office ("GAO") and the Health Insurance Association of America ("HIAA") estimate that approximately 10% of all medical claims are fraudulent. Accordingly, it appears that there is much more that U.S. HealthCare can do to combat health care fraud.

- U. S. HealthCare was unable to provide a listing of fraud cases pertaining specifically to either USHC-NY and/or USHIC-NY.

  In a memo dated October 18, 1999, U. S. HealthCare stated that:

  > "Aetna U. S HealthCare is a national company, and does not track cases in this manner. During an investigation, the investigator usually tracks exposure by product, (i.e., Traditional Choice, Managed Choice, HMO, etc)."

- U.S. HealthCare was unable to provide any documentation to support the operating budget for the Special Investigation Unit ("SIU") that is allocated to USHC-NY and USHIC-NY. In a memo dated October 18, 1999, U. S. HealthCare stated that:

  > "The Aetna U.S. HealthCare Special Investigation Unit Budget is not appropriated by state or specific company. Since Aetna U.S. HealthCare is a national company doing business in virtually every state, the units operating budget is administered on a national level. It would be difficult, if not impossible to accurately allocate specific dollar amounts by state, as investigative costs and related activities cannot be accurately estimated prior to occurrence."

It is also noted that U.S. HealthCare was unable to provide documentation pertaining to the actual SIU operating costs that were charged to USCH-NY and USHIC-NY. Given the

limited amount of Aetna US HealthCare's fraud investigation resources devoted to USHC-NY and USHIC-NY and, considering the lack of internal controls in place to monitor expenses related to the SIU unit, it is likely that USHC-NY and USHIC-NY may have unfairly incurred expenses that should have been charged to other entities within Aetna U.S. HealthCare.

- US HealthCare is in violation of New York Insurance Law §405 and Department Regulation 95 in that all cases of suspected fraud are not being reported to the Department as required.

  Part 86.5 of Regulation 95 states in part:

  > Any person licensed pursuant to the provisions of the Insurance Law who determines that an insurance transaction or purported insurance transaction appears to be fraudulent or suspect shall submit a report thereon to the Insurance Frauds Bureau. Reports shall be submitted the prescribed reporting form (IFB-1)..."

  Additionally, Circular Letter No. 3 dated February 10, 1997 reminded all insurers about the requirements to report suspected insurance fraud pursuant to New York Insurance Law §405(a). Emphasis was placed on an insurer's responsibility for reporting suspected frauds where there is an articulable factual basis for suspecting that an insurance fraud has been committed.

  Nevertheless, U.S. HealthCare reported only eight fraud cases to the Department between January 1, 1998 and August 5, 1999. This occurred even though the SIU initiated approximately one hundred and forty three fraud investigations during this time

pertaining to New York cases.

It is recommended that U. S. HealthCare adequately and appropriately staff its Special Investigation Unit so that frauds can be detected and investigated more effectively.

It is recommended that USCH-NY and USHIC-NY each maintain statistics pertaining to the activities of the Special Investigation Unit as it relates to their individual operations.

It is recommended that USHC-NY and USHIC-NY each maintain documentation relating to budgeted amounts and actual expenses incurred for U.S. HealthCare's Special Investigation Unit.

It is recommended that U.S. HealthCare comply with New York Insurance Law §405 and Department Regulation 95 so as to ensure that all cases of suspected fraud are reported to the Department as required.

10. GRIEVANCES, APPEALS AND COMPLAINTS

A review of grievances and appeals filed with USHC-NY for 1998 was performed to ascertain compliance with Article 4408-a of the New York State Public Health Law ("Grievance Procedure").

During 1998, USHC-NY recorded 1,788 grievances and 100 appeals. Ninety-four files were randomly selected for review. This resulted in the review of seventy-one grievances and twenty-three appeals. It is noted that sixty-three of the grievances reviewed pertained solely to a question of covered benefits, while the remaining eight concerned issues other than coverage of benefits.

§4408-a(4) of the New York State Public Health Law states in part:

> "4. Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:
>
> (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health;
>
> (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and
>
> (iii) forty-five days after the receipt of all necessary information in all other instances."

USHC-NY did not provide a written acknowledgement in six of the seventy-one grievances files reviewed (8.45%) as required by §4408-a(4) of the New York State Public Health Law.

There were seven instances where the grievance file provided by USHC-NY did not

contain documentation that written acknowledgement was provided to the insured within 15 business days of receipt of the grievance. However, USHC-NY provided the documentation subsequent to the examination.

USHC-NY failed to resolve grievances within thirty days on nineteen of sixty-three files (thirty percent) pertaining to questions of coverage as required by §4408-a (4)(ii) of the New York State Public Health Law.

USHC-NY failed to resolve grievances within forty-five days on one of eight files (12.5%) pertaining to issues other than questions of coverage as required by §4408-a (4)(iii) of the New York State Public Health Law.

§4408 (9) of the New York State Public Health Law states:

> "9. Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision."

USHC-NY failed to provide a written acknowledgement in twelve of the twenty-three appeals reviewed (52%) as required by §4408 (9) of the New York State Public Health Law.

§4408 (11) (i) and (ii) of the New York State Public Health Law states:

> "11. The organization shall seek to resolve all appeals in the most expeditious manner and

> shall make a determination and provide notice no more than: (i) two business days after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; and (ii) thirty business days after the receipt of all necessary information in all other instances."

USHC-NY failed to resolve appeals within thirty days after the receipt of all necessary information in eighteen of twenty-three files (78%) reviewed as required by §4408 (11) (ii) of the New York State Public Health Law.

USHC-NY failed to request all necessary information to resolve a grievance within 30 days on three of twenty-three files (13%) reviewed as required by §4408 (11) (ii) of the New York State Public Health Law.

It is recommended that USHC-NY provide a written acknowledgement for grievances filed as required by §4408-a(4) of the New York State Public Health Law.

It is recommended that USHC-NY resolve grievances within thirty days when the grievance pertains to questions of coverage as required by §4408-a (4)(ii) of the New York State Public Health Law.

It is recommended that USHC-NY resolve grievances within forty-five days for grievances pertaining to issues other than questions of coverage as required by §4408-a (4)(iii) of the New York State Public Health Law.

It is recommended that USHC-NY provide a written acknowledgement of all appeals

filed as required by §4408 (9) of the New York State Public Health Law.

It is recommended that USHC-NY resolve appeals within thirty days after the receipt of all necessary information as required by §4408 (11) (ii) of the New York State Public Health Law.

11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
	MANAGEMENT	
A.	It is recommended that U. S. HealthCare distribute detailed, accurate and timely reports relative to its claims processing activities to senior management, its board of directors and the directors of the parent corporation on a regular basis so that management can be in a better position to make informed business decisions.	2-5
B.	It is recommended that U.S. HealthCare's board of directors and its parent company's board of directors immediately adopts the necessary written procedures in accordance with Circular letter No. 9 (1999).	2-5
	CONDUCT OF EXAMINATION	
C.	It is strongly recommended that U.S. HealthCare's board of directors and its parent company's board of directors establish and implement a policy designed to ensure that U.S. HealthCare fully complies with the requirements of §310 of the New York Insurance Law.	6-8

| ITEM | | PAGE NO. |

SALES

D. It is recommended that U.S. HealthCare ensure that its agents, brokers and employees maintain the requisite license in compliance with New York Insurance Law §2102(a)(1). 8-13

E. It is recommended that U.S. HealthCare comply with NYSID licensing requirements as to all U.S. HealthCare's employees who earn a commission or fee based on sales and to comply with New York Insurance Law §2114(a)(3) and §2116 to ensure that commissions are only paid to licensed agents and brokers. 8-13

F. It is recommended that U.S. HealthCare comply with New York Insurance Law §2112(a) and file all certificates of appointment for its agents with the Department as prescribed by statute. 8-13

G. It is recommended that U.S. HealthCare comply with New York Insurance Law §2112(d) and report terminated agents to the Department as prescribed by statute. 8-13

H. It is recommended that U.S. HealthCare implement the necessary internal control procedures in order to maintain adequate supporting documentation of its commission payments to various external insurance agents and brokers. 8-13

ITEM		PAGE NO.
	ADVERTISING	
I.	It is recommended that U.S. HealthCare comply with 11 NYCRR 215 (Regulation No. 34) Section 215.17 to: a) Maintain at its home or principal office a complete advertising file containing every printed, published or prepared advertisement of its polices. b) Retain a complete advertising file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.	14-15
	WRITTEN DISCLOSURE OF INFORMATION	
J.	It is recommended that U.S. HealthCare comply with the requirements of §4324 of the New York Insurance Law and ensure that each subscriber, and upon request each prospective subscriber prior to enrollment, is provided with the required written disclosure information in a timely manner.	15-17
	UNDERWRITING AND RATING	
K.	It is recommended that U.S. HealthCare comply with the provisions of New York Insurance Law Section 4308 and Regulation 62 (11 NYCRR 52) and cease the practice of applying an experience rating methodology to the entire large group POS product until such	17-21

time as its large group POS experience-rating methodology complies with Circular Letter No. 26 (2000).

ITEM		PAGE NO.
L.	It is recommended that U.S. HealthCare undertake a study to accurately determine the percentage of in-network vs. out of network utilization for its POS product in NY and adjust the premium allocation accordingly so that USHC-NY receives an appropriate share of the premium.	18-24
M.	It is recommended that U.S. HealthCare cease offering its "Oxford Power Play" discounts", "Full Profit, NY/NJ Profit, X% Profit, NY Profit" discounts and its "Field Manager –5%" discount to selected groups.	18-24
N.	It is recommended that U.S. HealthCare discontinue offering "Multi-Year Rate Guarantees" to selected groups.	18-24
O.	It is recommended that U.S. HealthCare implement procedures whereby the underwriting experience of individual large groups in NY are monitored and reviewed.	18-24

ITEM		PAGE NO.
	CLAIMS	
P.	It is recommended that USHC-NY comply with §4403 6(a) of the New York State Public Health Law, §2601(a)(4) of the New York State Insurance Law and its member handbook and provide full reimbursement beyond the contracted copayment to all subscribers who are properly referred to a non-participating provider.	21-24
	PROMPT PAY	
Q.	It is recommended that U.S. HealthCare implement the necessary procedures in order to ensure compliance with §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".	24-32
R.	It is recommended that U.S. HealthCare consider the date a claim is received by Envoy, its electronic data interchange to be the receipt date with respect to compliance with §3224-a of the New York Insurance Law.	24-32

ITEM		PAGE NO.
S.	It is recommended that U.S. HealthCare perform a comprehensive review of all claims that were not processed within 45 days for the period 1998 through present and reprocess those claims where which interest is due pursuant to §3224-a of the New York Insurance Law. Said results should be forwarded to the Department for review.	24-32
T.	It is recommended that U.S. HealthCare implement the necessary procedures to ensure compliance with §3224-a(b) of the New York Insurance Law and send out requisite notifications within 30 days where applicable.	24-32
U.	It is recommended that U.S. HealthCare automate the interest paying process within its claims processing system.	24-32
V.	It is recommended that U.S. HealthCare implement the necessary claims processing training in the application of §3224-a of the New York Insurance Law.	24-32
W.	It is recommended that U.S. HealthCare's Quality Assurance Department establish procedures to periodically test New York claims for compliance with §3224-a of the New York Insurance Law.	24-32

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SCHEDULE H ("AGING ANALYSIS OF UNPAID CLAIMS")

X.	It is recommended that U.S. HealthCare take the necessary steps to enable it to complete its Schedule H ("Aging Analysis of Unpaid Claims") in accordance with the Department's instructions.	32-34
Y.	It is recommended that U.S. HealthCare submit corrected Schedules H's to the Department forthwith.	32-34

EMERGENT CARE

Z.	It is recommended that U.S. HealthCare comply with the prudent layperson person standard for emergency care as defined in §3216(i)(9) and §3221(k)(4)(A) of the New York State Insurance Law.	35-37
AA.	It is recommended that U.S. HealthCare review all emergency care claims that were submitted for the period 1998 through present and reprocess those claims that were inappropriately denied.	35-37

UTILIZATION REVIEW

BB.	It is recommended that USHC-NY maintain complete and a separate logs for all Utilization Reviews and appeals.	38-41

ITEM **PAGE NO.**

CC.	It is recommended that USHC-NY comply with §4903(4) of the New York State Public Health Law and complete utilization reviews within thirty days of receipt.	38-41
DD.	It is recommended that USHC-NY comply with §4903(5) of the New York State Public Health Law and provide notices of adverse determinations in accordance with said statute.	38-41
EE.	It is recommended that USHC-NY comply with §4904(3) of the New York State Public Health Law and resolve utilization review appeals within the specified timeframe.	38-41

EXPLANATION OF BENEFITS STATEMENTS

FF.	It is recommended that U. S. HealthCare modify its EOB to comply with §3234 of the New York Insurance Law.	41-43
GG.	It is recommended that U. S. HealthCare include a fraud warning and disclose on the EOB a toll free number where subscribers can call in the event they suspect that a fraud has been committed.	41-43
HH.	It is recommended that U.S. HealthCare include the date a claim was received on the EOB so that a subscriber and/or the provider cannot determine if any interest is due relative to a claim that took longer than 45 days to process.	41-43

ITEM		PAGE NO.
	FRAUD PREVENTION AND DETECTION	
II.	It is recommended that U. S. HealthCare adequately and appropriately staff its Special Investigation Unit so that frauds can be detected and investigated more effectively.	44-47
JJ.	It is recommended that USCH-NY and USHIC-NY each maintain statistics pertaining to the activities of the Special Investigation Unit as it relates to their individual operations.	44-47
KK.	It is recommended that USHC-NY and USHIC-NY each maintain documentation relating to budgeted amounts and actual expenses incurred for U.S. HealthCare's Special Investigation Unit.	44-47
LL.	It is recommended that U.S. HealthCare comply with New York Insurance Law §405 and Department Regulation 95 and ensure that all cases of suspected fraud are reported to the Department as required.	44-47
	GRIEVANCES, APPEALS AND COMPLAINTS	
MM.	It is recommended that USHC-NY provide a written acknowledgement for grievances filed as required by §4408-a(4) of the New York State Public Health Law.	48-51

ITEM		PAGE NO.
NN.	It is recommended that USHC-NY resolve grievances within thirty days when the grievance pertains to questions of coverage as required by §4408-a (4)(ii) of the New York State Public Health Law.	48-51
OO.	It is recommended that USHC-NY resolve grievances within forty-five days for grievances pertaining to issues other than questions of coverage as required by §4408-a (4)(iii) of the New York State Public Health Law.	48-51
PP.	It is recommended that USHC-NY provide a written acknowledgement of all appeals filed as required by §4408 (9) of the New York State Public Health Law.	48-51
QQ.	It is recommended that USHC-NY resolve appeals within thirty days after the receipt of all necessary information as required by §4408 (11) (ii) of the New York State Public Health Law.	48-51

Appointment No. 21308

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Martin Schwartzman

as a proper person to examine into the affairs of the

US HealthCare, Inc.

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

Company

with such other information as he shall deem requisite.

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

this 10th *day of* September *1998*

NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent

Appointment No. 21309

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Martin Schwartzman

as a proper person to examine into the affairs of the

US Health Insurance Company

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

Company

with such other information as he shall deem requisite.

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

this 10th *day of* September *1998*

NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent