

MARKET CONDUCT REPORT ON EXAMINATION

OF

MDNY HEALTHCARE, INC.

AS OF

SEPTEMBER 30, 2001

DATE OF REPORT:

JUNE 25, 2002

EXAMINER:

PEARSON A. GRIFFITH

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of examination	2
2.	Description of Plan	2
3.	Executive Summary	3
4.	Management Reporting and Procedures	4
5.	Sales	7
	A. Agents and brokers	7
	B. Appointment of agents	9
	C. Termination of agents	10
	D. Commissions	10
6.	Underwriting and rating	13
7.	Claims	15
	A. Claims processing	15
	B. Prompt pay	21
	C. Utilization Review	27
	D. Explanation of benefits statements	29
8.	Summary of comments and recommendations	32



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NEW YORK, NEW YORK 10004

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Gregory V. Serio
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June 25, 2002

Honorable Gregory V. Serio
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Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Number 21768 dated August 23rd 2001, and annexed hereto, I have made an examination into the affairs of MDNY HealthCare, Inc. ("MDNY"), a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law. This examination was conducted at the administrative office of the Plan located at One Huntington Quadrangle, Melville, New York 11747. The following report, as respectfully submitted, deals with the findings concerning the manner in which MDNY conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

Whenever the term "MDNY", "the Plan", the "HMO", or "the Company" appears herein without qualification, it should be understood to refer to MDNY HealthCare, Inc.

1. SCOPE OF EXAMINATION

A review of the manner in which MDNY Healthcare conducts its business practices and fulfills its contractual obligations to policyholders and claimants has been performed. This review covers the period January 1, 2000 to September 30, 2001. An examination into the financial condition of MDNY was previously conducted as of June 30, 2000. The primary purpose of this report is to assist MDNY 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. DESCRIPTION OF PLAN

The Plan was incorporated in New York on June 21, 1995 under the name of MDLI Healthcare, Inc. The Company filed a Certificate of Amendment to its Certificate of Incorporation with the Department of State on October 12, 1995, thereby changing the name of the Company to MDNY Healthcare, Inc.

The Plan was originally licensed to operate a health maintenance organization under the provisions of Article 44 of the New York State Public Health Law in the Counties of Nassau and Suffolk and was granted a conditional the Certificate of Authority, effective November 1, 1995. The Plan commenced operations on January 1, 1996.

On October 12, 1995, the Plan's Certificate of Incorporation was amended to change the name of the Corporation to MDNY Healthcare, Inc.

In November 1996, the Company received approval from the Health Care Financing Administration (HCFA) to enroll Medicare eligible members under a "Medicare Risk" contract, effective February 1, 1997.

On September 14, 1998, the Company received approval from the State of New York Department of Health to expand its service area to include Erie and Niagara Counties, effective January 1, 1999.

The Plan was granted a request to withdraw its marketing and enrollment services from Erie and Niagara Counties effective April 1, 2000.

In October 2000, MDNY was granted approval by HCFA to terminate its enrollment of Medicare eligible members effective January 1, 2001.

3. EXECUTIVE SUMMARY

The results of this examination indicate a number of weaknesses in the HMO's management and control structure that directly impact the HMO's compliance with the Insurance Law and Department regulations as they pertain to market conduct practices. Particularly, testing for procedural and financial accuracy as well as compliance with "Prompt Pay"

requirements revealed a variety of errors and compliance issues that indicate underlying systemic problems. The deficiencies in controls and procedures are identified in this report. The most significant of the weaknesses included the following:

- ◆ Inadequate reporting to upper management and the Board of Directors
- ◆ Failure to maintain written procedures – Department Circular Letter No. 9 (1999)
- ◆ Improper practices regarding use of Agents and Brokers
- ◆ Failure to obtain prior contract form approval
- ◆ Inadequate notice of “File and Use” rate adjustments
- ◆ Systematic claims processing failures and errors in initial receipt and adjudication of claims
- ◆ Improper claim denials
- ◆ Failure to resolve Utilization Review appeals in a timely manner
- ◆ Failure to send proper EOBs for denied claims

These, and other findings, are described in greater detail in the remainder of this report. Action already taken by management in response to the findings is also described herein as applicable.

4. MANAGEMENT REPORTING AND PROCEDURES

As part of the review of management, a detailed listing of all reports routinely distributed to the board of directors and senior management was requested. In addition, the examiners reviewed the minutes of board of directors meetings held during the period under examination. The examiners determined that minutes of the board of directors meetings held during the period under examination did not contain adequate documentation to demonstrate that the board of

directors was kept apprised of procedural and operational deficiencies as denoted throughout this market conduct report. In addition, there appeared to be no substantive discussion at meetings of the board of directors of matters affecting MDNY's operations.

When this condition was brought to management's attention, MDNY began providing members of the board of directors with more detailed reports of the Plan's operational activities. In a follow up of the earlier review of minutes of the board of directors, the examiners requested and obtained the minutes of the two meetings held to date in 2002.

MDNY provided a listing that included eight reports that are distributed to the board of directors and senior management on a quarterly basis. It is noted that given all the claims processing and operational issues denoted throughout this market conduct report on examination, only one of the reports distributed to management and the board of directors included information pertaining to claims processing activities. This report provided details of claims processing service indicators but did not address issues such as late claim payments, processing errors, or financial errors.

Circular Letter No. 9 (1999) dated May 25, 1999 "Adoption of Procedure Manuals" was issued to Health Maintenance Organizations licensed pursuant to Article 44 of the New York Public Health Law 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") ...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.”

This Circular Letter also points out the board of directors responsibility for overseeing the activities of the Plan’s Management with respect to its handling of the claims adjudication process. In addition, the Circular Letter reminds the board that such responsibility 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. Furthermore, the Circular Letter highlights other key areas where the adoption of written procedures would enable the board to assure itself that the Plan’s operations are being conducted in accordance with applicable statutes, rules and regulations.

The Plan was requested to provide documentation that the aforementioned Circular Letter was distributed to all members of its board of directors and that the requisite written procedures were adopted in accordance with Circular Letter No. 9 (1999). MDNY was unable to provide documentation that such Circular Letter was distributed to the board or that it had adopted the

requisite written procedures. Given the findings and deficiencies noted throughout this Report on Examination, it is imperative that senior management and the board of directors immediately adopt written procedures in accordance with Circular Letter No. 9 (1999).

It is recommended that MDNY's board of directors immediately adopt the necessary written procedures in accordance with Circular Letter No. 9 (1999).

5. SALES

A. Agents and Brokers

MDNY Healthcare, Inc utilizes independent insurance agents and brokers as its primary distribution system. In addition, MDNY employs a direct sales staff of account executives and group service representatives who solicit business for the company.

A review of MDNY's sales practices indicates that it has violated the provisions of Article 21 of New York Insurance Law. MDNY violated New York Insurance Law Sections 2102(a)(1), 2114(a)(3) and 2116 by utilizing and paying commissions to unlicensed employees, insurance agents, and brokers solicit its products.

§2102 (a)(1) of the New York Insurance Law states that,

“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.”

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

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

In addition, §2116 of the New York Insurance Law 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.”

The examiners selected a sample of twenty-five individuals who were paid commissions during the period under examination. The Company was unable to provide certificates of appointment for any of these individuals or evidence that sixteen of the individuals were licensed agents or brokers. Of the remaining nine individuals, two were not licensed to sell health insurance.

Additionally, with respect to MDNY’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. In particular, 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”

Since MDNY’s employees are remunerated 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.

It is recommended that MDNY ensure that its agents, brokers and employees obtain and maintain the requisite license to solicit health insurance in compliance with the provisions of §2102(a)(1) of the New York Insurance Law.

It is also recommended that MDNY comply with the licensing requirements of the New York State Insurance Department with respect to its employees who earn commissions or fees based on sales, and to comply with the provisions of §2114(a)(3) and §2116 of the New York Insurance Law to ensure that commissions are paid only to licensed agents and brokers.

B. Appointment of Agents

§2112(a) of the New York Insurance Law 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.”

The HMO was unable to provide certificates of appointment for any individuals and entities soliciting business as agents on its behalf, nor did MDNY otherwise maintain evidence in its files supporting appointment of such agents

It is recommended that MDNY comply with the provisions of §2112(a) of the New York Insurance Law by submitting certificates of appointment for all insurance agents to the Department as prescribed by statute and by maintaining evidence of such filings.

C. Termination of Agents

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

“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...”

A review of MDNY’s terminated producer files indicates that no of the termination notices were filed with the Department.

It is recommended that MDNY comply with the provisions of §2112(d) of the New York Insurance Law by reporting terminated insurance agents to the Department as prescribed by statute.

D. Commissions

An analysis of MDNY’s commission schedules indicates that it did not maintain adequate supporting documentation of commissions paid its to various external general agents, insurance

agents, and brokers. In some cases, MDNY was unable to reconcile commissions deducted by general agents with net remittances from those agents. The Company was unable to provide copies of statements of commissions paid to twenty of the twenty-five external agents selected for review. In addition, MDNY was unable to produce fifteen of the twenty-five commission statements requested for external brokers.

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

Part 52.42(e) of Department Regulation 62 [11NYCRR 52.42] states in part:

“A health maintenance organization (HMO) issued a certificate of authority pursuant to article 44 of the Public Health Law...may, as authorized by 10NYCRR Part 98, pay commissions or fees to a licensed insurance broker. Such authority to pay commissions or fees by a corporation, other than a corporation solely holding a certificate of authority from the Commissioner of Health, shall be restricted to its HMO operation only...The actual rate per annum may not exceed four percent of the HMO’s approved premium for the contract sold.”

During a review of contracts that MDNY entered with its general agents, the examiners noted several instances where agent compensation appeared to exceed the maximum commissions permitted under Department Regulations. A review of seven contracts indicated that in three instances, the agreements permitted commissions payments to general agents ranging from 7.5% to 11.5% of contract premiums. This is in excess of the 4% limitation set forth in Department Regulation 62. Furthermore, some general agents were paid the following additional fees:

- ◆ Administrative fees ranging from 1% to 1.5% of written premiums;
- ◆ Billing fees ranging from 1% to 3.5% of written premiums;
- ◆ Commission production fees ranging from 0% to 1% of written premiums;
- ◆ Commission overrides ranging from 1% to 4% of written premiums;
- ◆ Advertising expense;
- ◆ Production bonuses ranging from 0.5% to 1% of written premiums; and
- ◆ Bonuses of 1% of written premiums.

The examination review indicated that MDNY paid commission overrides and the aforementioned additional fees for services that are generally part of the agents' business activities or for services which MDNY itself performed. In addition, MDNY was unable to provide the examiners with documentation to support payments for some of these services. Some of the services for which the general agents were paid included:

- ◆ The electronic transfer of enrollment data and remote activation of groups directly into MDNY's computer system;
- ◆ Soliciting applications, enrollment cards, and similar or related documents required by MDNY prior to effectuating group insurance coverage;
- ◆ Providing enrollment, billing, and collection of premiums from groups and eligible employees;
- ◆ Providing unique marketing and administrative services on behalf of MDNY;
- ◆ In the event a broker switches to a new general agent, the predecessor will receive commissions on all prior production for that broker for one year after the switch;
- ◆ Mailing cancellation notices for non payment of premiums;
- ◆ Appointing its in-house and/or affiliated producers; and
- ◆ Disciplining and/or terminating with or without a hearing subject to MDNY's review and approval which it shall not unreasonably withhold.

It is recommended that MDNY comply with the provisions of Part 52.42(e) of Department Regulation 62 [11NYCRR 52.42] with respect to commissions paid to general agents.

It is also recommended that MDNY seek to amend its general agent contracts to conform them to the services actually performed by the general agents.

6. UNDERWRITING AND RATING

A review was conducted to determine MDNY's underwriting procedures and practices. The examiners determined that MDNY did not maintain a comprehensive written underwriting manual. It maintains various underwriting policies and procedures in various documents throughout its underwriting department. This practice makes it difficult to review compliance with New York Insurance Law and Department Regulations.

§4308(a) of the New York Insurance Law states in pertinent part:

“No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a copy of the contract or certificate and of all applications, riders, and endorsements for use in connection with the issuance or renewal thereof, to be formally approved by him as conforming to the applicable provisions of this article and not inconsistent with any other provisions of law applicable thereto.”

The examination review of MDNY's group and individual contracts compared MDNY's list of contracts and riders with a list of approved contracts maintained by the Department. The examiners found that two contract riders were used before they were filed and approved by the Department.

When this matter was brought to the Company's attention, the applicable contracts and riders were submitted to the Department for approval.

It is recommended that MDNY obtain the requisite approval of all its contracts or certificates and of all application, riders, and endorsements for use in connection with the issuance or renewal thereof in accordance with the provisions of §4308(a) of the New York Insurance Law.

A review was conducted of MDNY's rating procedures to determine compliance with applicable New York Insurance Laws and Regulations. This review was based on a number of complaints that the Department received that subscribers were given inadequate notice of premium rate increases. The complaints allege that MDNY effected "file and use" premium rate increases without providing subscribers the requisite notice.

§4308(g)(2) of the New York Insurance Law states in part:

"...No rate increase may be imposed unless at least thirty days advance written notice of such increase has been provided to each contract holder and subscriber."

The examiners requested a copy of the Plan's procedures concerning premium increase notices to individual (direct pay) subscribers to determine whether the statutorily required notice was given to these subscribers. However, MDNY had no written procedures and was unable to provide any documentation to support its assertion that it provided the required notice.

It is recommended that the MDNY adopt and implement procedures to oversee policy renewals and maintain supporting documentation of such as a prudent business practice.

It is also recommended that the MDNY comply with the provisions of §4308(g)(2) of the New York Insurance Law by providing the statutorily required notice when effecting “file and use” premium rate increases.

7. CLAIMS

A. Claims Processing

A review was performed using a statistical sampling methodology covering the period from January 1, 2000 through September 30, 2001 in order to evaluate the overall accuracy and compliance environment of MDNY’s claims processing. The Plan’s claims were segregated into separate hospital and medical claims populations. A random statistical sample of 167 claims was drawn from each of these populations and various pre-determined attributes, deemed necessary for successful claims processing activity, were tested.

To ensure the completeness of the claims population being tested, the total dollars paid were reconciled to the financial data reported by MDNY. To verify each service that resulted in no payment, reconciliation of transaction counts was performed.

Findings indicate there are serious internal control and claims processing deficiencies within MDNY’s claims processing system. These deficiencies appear to have an adverse impact on the Plan’s ability to process claims with minimal errors on a timely basis. The examination review revealed overall claims processing financial accuracy levels were only 89.82% each for Medical claims and Hospital claims. Overall, claims processing procedural accuracy levels were only 19.16% for Medical claims and 43.71% for Hospital claims, respectively. Financial

accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance MDNY’s claim processing guidelines. An error in processing accuracy may or may not affect the financial accuracy.

In summary, of the 334 claims reviewed, 229 (135 medical and 94 hospital) contained one or more claims processing procedural errors. Of these 229 claims, 34 (17 medical and 17 hospital) contained one or more financial errors. MDNY has established key performance indicators for quality of 99 percent for procedural and financial accuracy. The examination findings indicate a significant disparity.

The following chart illustrate the financial and procedural claims accuracy findings summarized above:

Summary of Financial Claims Accuracy

	<u>Medical</u>	<u>Hospital</u>
Claim Population	506,484	76,782
Sample Size	167	167
Number of claims with Financial errors	17	17
Calculated Error Rate	<u>10.18%</u>	<u>10.18%</u>
Upper Error limit	14.77%	14.77%
Lower Error limit	5.59%	5.59%
Upper limit Claims in error	<u>74,808</u>	<u>11,341</u>
Lower limit Claims in error	<u>28,312</u>	<u>4,292</u>

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.)

Summary of Procedural Accuracy

	<u>Medical</u>	<u>Hospital</u>
Claim Population	506,484	76,782
Sample Size	167	167
Number of claims with Procedural Errors	135	94
Calculated Error Rate	<u>80.84%</u>	<u>56.29%</u>
Upper Error limit	86.81%	63.81%
Lower Error limit	74.87%	48.76%
Upper limit Claims in error	<u>439,679</u>	<u>48,995</u>
Lower limit Claims in error	<u>379,205</u>	<u>37,439</u>

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.)

Internal controls incorporate a number of essential elements in the successful operation of any entity. These are embodied in such areas as manpower controls, compliance controls, operational controls, monitoring controls (usually the audit and/or quality assurance areas), accounting controls (books and records and management reporting, including information systems), and overall management standards (policies and procedures) set by the board of directors through to the line supervisor. The statistical sample findings not only show individual errors, both in terms of overpayments, but also management issues that relate to the cause of the errors. It is important that management recognizes and develops programs to address the control weaknesses noted herein.

The following represents examples of substantive claims processing findings and issues:

1. In the vast majority of instances, MDNY was not able to produce copies of correspondence, referrals, medical and/or utilization reviews for the claims reviewed.

Therefore, the examiners were unable to reconstruct all events relating to the processing of specific claims. Claims correspondence, whether originated from the subscriber or internally generated, is a critical part of the claims review process. It also provides an audit trail that helps document the history of the claim should additional review or research in contested claims become necessary. The need for the Company to retain all relevant documentation concerning claims is supported by the fact that in some instances, MDNY's claims adjudicators over-wrote the prior comments in the claims processing systems of claims that were reprocessed multiple times.

New York State Insurance Department Regulation No. 152 [11 NYCRR 243] sets forth standards of retention of records by insurance companies. §243.2(b)(4) states that an insurer shall maintain:

“a claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.”

MDNY's failure to retain all the requisite claims information is a violation of Department Regulation No. 152.

2. MDNY's claims processors utilize overrides as a normal procedure to by-pass various systems edits within the claims processing system. MDNY was unable to explain why the claims processing system adjudicated these claims in such a manner that a manual override was required. Overrides should never be considered a routine procedure in a

tightly controlled environment.

Management should implement claims system modifications to ensure that claims adjudication personnel do not routinely apply manual claims overrides without supervisory approvals.

3. Of the 334 files reviewed, 75 claims or 22% were reprocessed because the claim was not paid correctly on the initial adjudication. Additionally, 19 of the reprocessed claims required further re-processing because even upon multiple re-processing, the claims were not correctly adjudicated. In one instance, a claim was resubmitted four times and improperly denied four times for late filing. The examination review of the documentation supporting this claim indicated that the claimant submitted the claim on time and that the claim should have been adjusted and paid on the first submission. The examiner noted that the requisite interest was not paid on this claim in accordance with the provisions of §3224-a of the New York Insurance Law. There is no evidence that the various claim processors checked the reason for the initial non-payment.
4. When a claim is received in MDNY's mailroom, procedures require that the receipt date be embossed on the claim form. This date is critical in determining the timeliness of claims processing since it represents the starting point in the claims processing cycle. However, the embossed date did not always appear on claims that were scanned into the claims systems. During the analysis of paid claims, the examiners noted that 131 claims or 39 % of the 334 claims reviewed did not have the receipt date of the claim embossed on the claim form.

Other weaknesses in claim processing activities were also noted. Although instances of these issues occur less frequently than those addressed above, it further supports the Department's concern regarding the inadequate control structure within the claims processing system. Some of these issues are as follows:

- Several claims were denied with inadequate explanations;
- In some cases, documentation to support the dates of member terminations was not maintained;
- Services were incorrectly denied as exceeding the contract benefit;
- Pre-certification penalties were not correctly applied;
- Some out of network claims were incorrectly processed at the in-network level benefit;
- Inconsistencies were noted relative to the denial of claims due to a late submission; and
- The Plan did not maintain any documentation relative to a few claim submissions.

It is recommended that MDNY amend its claims and record retention procedures so that ALL relevant comments and/or documentation regarding claims processing is maintained in accordance with the provisions of Department Regulation 152 [11 NYCRR 243].

It is further recommended that MDNY implement mail processing procedures to ensure that ALL scanned claims be embossed with the receipt date of the claims.

It is also recommended that MDNY:

- (i) Issue, review, and up-date as necessary, the claims manual which sets forth its claims adjudication procedures;
- (ii) Distribute the claims manual and necessary up-dates to all personnel responsible for the supervision, processing and settlement of claims; and

- (iii) Provide the training necessary to ensure the claim manual's implementation including a formal educational program and documented, periodic re-training of claims adjudication personnel.

MDNY HealthCare did not include the required warning statement on any of the explanation of benefits statements issued to enrollees and/or providers, in accordance with the provisions of Department Regulation 95. Part 86.4 of Department Regulation 95, [11 NYCRR 86] states in part:

*“a. All applications provided to applicants for [non-automobile] commercial insurance and **all claim forms** for insurance...delivered to any person residing or located 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.” Emphasis added.

It is recommended that MDNY comply with the provisions of Department Regulation 95. by including the required fraud warning statement denoted above in ALL explanation of benefits statements issued to enrollees and/or providers.

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” which was enacted effective January 22, 1998 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 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.*
- (b) *“In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:*
- (1) *that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or*
 - (2) *to request additional information needed to determine liability to pay the claim or make the health care payment.*

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

- (c) *“Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full*

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

The examination analysis determined that MDNY failed to process claims in accordance with the provisions of §3224-a(b) of the New York Insurance Law. The examiners noted that MDNY’s claim practices and procedures failed to include a mechanism to handle claims where the obligation to pay a claim or make a payment for health care services rendered was not reasonably clear due uncertainty as to:

- the eligibility of a person for coverage;
- the liability of another insurer for all or part of the claim;
- the benefits covered under a contract or agreement; and
- the manner in which services were accessed or provided.

MDNY failed to pay the undisputed portion of the above-mentioned claims in accordance with the provisions of §3224-a(b) of the New York Insurance Law, and notify the insured and/or provider in writing within thirty calendar days of the receipt of the claims. MDNY’s practice is to deny such claims during the claim adjudication process. When these denied claims are resubmitted with the additional information for processing, they are assigned new claim numbers, new dates received, and adjudicated according to MDNY’s normal claim practices and procedures without taking in to consideration the original date of submission. This is contrary to the provisions of §3224-a of the New York Insurance Law, because the insured and/or provider

is not notified of the denial in writing within thirty calendar days of the receipt of the claim. Consequently, a true indication of claims processing timeliness could not be ascertained in many instances without reviewing all claims submitted by an insured or provider, by claim amount and service date.

It is recommended that MDNY implement the requisite claim practices and procedures to include a mechanism to handle claims where the obligation to pay a claim, or make a payment for health care services rendered was not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage.

It is recommended that MDNY implement the requisite claim practices and procedures to include a mechanism to handle claims where the obligation to pay a claim or make a payment for health care services rendered was not reasonably clear due to the liability of another insurer for all or part of the claim.

It is recommended that MDNY implement the requisite claim practices and procedures to include a mechanism to handle claims where the obligation to pay a claim or make a payment for health care services rendered was not reasonably clear due to uncertainty as to the benefits covered under a contract or agreement, and the manner in which services were accessed or provided.

It is recommended that MDNY comply with the provisions of §3224-a(b) of the New York Insurance Law, and notify the insured and/or provider in writing within thirty calendar days of the receipt of the claims where the obligation to pay the claim is not reasonably clear.

Examination objectives included selecting 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. Because MDNY failed to process claims in accordance with the provisions of §3224-a(b) of the New York Insurance Law, it was not possible to reliably segregate all claims that were paid more than 45 days from receipt during the period January 1, 2000 through September 30, 2001 and on which the calculated interest payable amount would have exceeded the two-dollar threshold. As an alternative, the examiners elected to utilize the same statistical claims sample used during the review of procedural and financial claims processing accuracy to determine whether the claims were subject to interest as required by statute. Of the 334 claims reviewed, 61 (29 medical and 32 hospital) were not paid within forty-five days of receipt of the claim. Upon review, all 61 claims that took more than 45 days to pay appeared to be violations of Section 3224-a(a) of the Insurance Law.

The results of the review with respect to compliance with Section 3224-a(c) of the Insurance Law are as follows:

<u>TYPE OF CLAIM</u> (1)	<u>NUMBER OF CLAIMS SELECTED *</u> (2)	<u>NUMBER OF CLAIMS ELIGIBLE FOR INTEREST</u> (3)	<u>NUMBER OF CLAIMS WITH SECTION 3224-a(c) VIOLATION</u> (4)	<u>ERROR RATIO</u> (4/3)
MEDICAL	167	7	6	86%
HOSPITAL	167	8	8	100%
<u>TOTAL</u>	<u>334</u>	<u>15</u>	<u>14</u>	<u>93%</u>

With respect to the above chart it should be noted that the error ratio noted reflects the number of interest violations within the number of claims that were eligible for interest. Although this methodology should not be used to draw inferences about the total potential number of violations in the over forty-five day population, it can be used to support a finding of a potential systemic problem with compliance with §3224-a(c). A true indication of claims processing timeliness could not be ascertained from the foregoing analysis due to MDNY's failure to comply with the provisions of §3224-a(b) of the New York Insurance Law. In addition, the examination review noted that 131 of the 334 claims selected were scanned into MDNY's claims system and had not been date-stamped. Therefore, it was not possible select a statistical sample of eligible claims that could have been subject to interest payments for review.

It is recommended that MDNY 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 MDNY undertake a comprehensive review of all claims processed with dates of service beginning after January 22, 1998 to determine all claims that were not processed within 45 days, and submit a plan to the Department which addresses those claims where interest is due.

It is recommended that claims that are scanned into MDNY's claims system be embossed with the date the claim is received.

It is recommended that MDNY automate the interest paying process within its claims processing system.

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

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

C. Utilization Review

An examination review of MDNY's utilization review policies and procedures was performed to determine its compliance with the provisions of Article 49 of the New York Public Health Law (PHL).

§4903 of the New York Public Health Law states in pertinent part:

- “2. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information.*
- 3. 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.*

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.”*

A review of the policy and procedure manual indicated that MDNY utilized combined procedures for handling utilization review determinations subject to Article 49 of the PHL as well as handling determinations that were deemed to be within the scope of §4408-a (“Grievance procedure”) of the PHL. In addition, the utilization review log provided the examiners for the period January 1, 2001 through December 31, 2001 contained files other than Utilization review files. The utilization review process requires MDNY to provide specific procedures for enrollees to appeal adverse determinations of services deemed to be not medically necessary. Consequently, MDNY could not provide an accurate count of utilization review appeals reported on Schedule M of the filed 2001 New York Data Requirements for Health Maintenance Organizations.

It is recommended that MDNY maintain separate records of utilization review appeals from its grievance and appeal records in order to provide accurate data on Schedule M of filed New York Data Requirements for Health Maintenance Organizations.

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

“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.”

MDNY provided the examiners two detailed schedules of 55 opened and 86 closed appeals and grievances filed by claimants for the period January 1, 2001 through December 31, 2001 on its commercial business. A review of these schedules indicates that MDNY failed to resolve utilization review appeals within sixty days of the receipt of all necessary information in 29 cases in accordance with the provisions of §4904(3) of the New York Public Health Law.

It is recommended that MDNY comply with the provisions of §4904(3) of the New York Public Health Law and resolve utilization review appeals within the prescribed timeframes.

D. Explanation of Benefits Statements

As part of the review of MDNY’s claim 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 MDNY and must provide certain information in order to comply with the provisions of New York Insurance Laws, Rules, and Regulations. The examination review of MDNY’s practices and procedures indicate that it failed to comply with the provisions of §3234 of the New York Insurance Law. §3234 of the New York Insurance Law as regards “Explanation of benefits forms relating to claims under certain accident and health insurance policies” states in part:

“(a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, 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 or certificate providing coverage for hospital or medical expenses,

including policies and certificates providing nursing home expense or home care expense benefits.

- (b) *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.*
- (c) *Except on demand by the insured or subscriber, insurers, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, 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 by the insurer directly to the participating facility or provider..."*

During the review of MDNY's claims processing procedures and practices, the examiners noted numerous instances where MDNY failed to provide insureds and/or providers with the required explanation of benefits statements. In addition, the examiners noted several instances where explanation of benefits statements did not contain the type of information as described in §3234(b) of the New York Insurance Law.

It is recommended that MDNY comply with the provisions of §3234 of the New York Insurance Law by providing insureds and/or providers with the required explanation of benefits statements.

It is recommended that MDNY comply with the provisions of §3234(b) of the New York Insurance Law as regards the type of information included in the explanation of benefits statements.

8. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
<u>MANAGEMENT</u>	
A. It is recommended that MDNY's board of directors immediately adopt the necessary written procedures in accordance with Circular Letter No. 9 (1999).	7
<u>SALES</u>	
B. It is recommended that MDNY ensure that its agents, brokers and employees obtain and maintain the requisite license to solicit health insurance in compliance with the provisions of §2102(a)(1) of the New York Insurance Law.	9
C. It is also recommended that MDNY comply with the licensing requirements of the New York State Insurance Department with respect to its employees who earn commissions or fees based on sales, and to comply with the provisions of §2114(a)(3) and §2116 of the New York Insurance Law to ensure that commissions are paid only to licensed agents and brokers.	9
D. It is recommended that MDNY comply with the provisions of §2112(a) of the New York Insurance Law by submitting certificates of appointment for all insurance agents to the Department as prescribed by statute and by maintaining evidence of such filings.	10
E. It is recommended that MDNY comply with the provisions of §2112(d) of the New York Insurance Law by reporting terminated insurance agents to the Department as prescribed by statute.	10
F. It is recommended that MDNY implement the necessary internal control procedures in order to maintain adequate supporting documentation of its commission payments to its various general agents, external insurance agents and brokers.	11

<u>ITEM</u>	<u>PAGE NO.</u>
G It is recommended that MDNY comply with the provisions of Part 52.42(e) of Department Regulation 62 [11NYCRR 52.42] with respect to commissions paid to general agents.	12
H It is also recommended that MDNY seek to amend its general agent contracts to conform them to the services actually performed by the general agents.	13
<u>UNDERWRITING AND RATING</u>	
I It is recommended that MDNY obtain the requisite approval of all its contracts or certificates and of all application, riders, and endorsements for use in connection with the issuance or renewal thereof in accordance with the provisions of §3201(b)(1) and §4308(a) of the New York Insurance Law	14
J It is recommended that the MDNY adopt and implement procedures to oversee policy renewals and maintain supporting documentation of such as a prudent business practice.	14
K It is also recommended that the MDNY comply with the provisions of §4308(g)(2) of the New York Insurance Law by providing the requisite notice when effecting “file and use” premium rate increases.	15
<u>CLAIMS PROCESSING</u>	
L Management should implement claims system modifications to ensure that claims adjudication personnel do not routinely apply manual claims overrides without supervisory approvals.	19
M It is recommended that MDNY amend its claims and record retention procedures so that <u>ALL</u> relevant comments and/or documentation regarding claims processing is maintained in accordance with the provisions of Department Regulation 152 [11 NYCRR 243].	20
N It is further recommended that MDNY implement mail processing procedures to ensure that <u>ALL</u> scanned claims be embossed with the receipt date of the claims.	20

<u>ITEM</u>	<u>PAGE NO.</u>
<p>O It is also recommended that MDNY:</p> <ul style="list-style-type: none"> (i) Issue, review, and up-date as necessary, the claims manual which sets forth its claims adjudication procedures; (ii) Distribute the claims manual and necessary up-dates to all personnel responsible for the supervision, processing and settlement of claims; and (iii) Provide the training necessary to ensure the claim manual's implementation including a formal educational program and documented, periodic re-training of claims adjudication personnel. 	20 - 21
<p>P It is recommended that MDNY comply with the provisions of Department Regulation 95 by including the required fraud warning statement denoted above in ALL explanation of benefits statements issued to enrollees and/or providers.</p>	21
<u>PROMPT PAY</u>	
<p>Q It is recommended that MDNY implement the requisite claim practices and procedures to include a mechanism to handle claims where the obligation to pay a claim, or make a payment for health care services rendered was not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage.</p>	24
<p>R It is recommended that MDNY implement the requisite claim practices and procedures to include a mechanism to handle claims where the obligation to pay a claim or make a payment for health care services rendered was not reasonably clear due to the liability of another insurer for all or part of the claim.</p>	24
<p>S It is recommended that MDNY implement the requisite claim practices and procedures to include a mechanism to handle claims where the obligation to pay a claim or make a payment for health care services rendered was not reasonably clear due uncertainty as to the benefits covered under a contract or agreement, and the manner in which services were accessed or provided.</p>	24
<p>T It is recommended that MDNY comply with the provisions of §3224-a(b) of the New York Insurance Law, and notify the insured and/or provider in writing within thirty calendar days of the receipt of the claims where the obligation to pay the claim is not reasonably clear.</p>	24

<u>ITEM</u>	<u>PAGE NO.</u>
U It is recommended that MDNY 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”.	26
V It is recommended that MDNY undertake a comprehensive review of all claims processed with dates of service beginning after January 22, 1998 to determine all claims that were not processed within 45 days, and submit a plan to the Department which addresses those claims where interest is due.	26
W It is recommended that claims that are scanned into MDNY’s claims system be embossed with the date the claim is received.	26
X It is recommended that MDNY automate the interest paying process within its claims processing system.	27
Y It is recommended that MDNY implement the necessary claims processing training in the application of §3224-a of the New York Insurance Law.	27
Z It is recommended that MDNY’s Quality Assurance Department establish procedures to periodically test claims for compliance with §3224-a of the New York Insurance Law.	27
 <u>UTILIZATION REVIEW</u>	
AA It is recommended that MDNY maintain separate records of utilization review appeals from its grievance and appeal records in order to provide accurate data on Schedule M of filed New York Data Requirements for Health Maintenance Organizations	28
BB It is recommended that MDNY comply with the provisions of §4904(3) of the New York Public Health Law and resolve utilization review appeals within the prescribed timeframes.	29
 <u>EXPLANATION OF BENEFITS STATEMENTS</u>	
CC It is recommended that MDNY comply with the provisions of §3234 of the New York Insurance Law by providing insureds and/or providers with the required explanation of benefits statements.	31

ITEM

PAGE NO.

DD	It is recommended that MDNY comply with the provisions of §3234(b) of the New York Insurance Law as regards the type of information included in the explanation of benefits statements.	31
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Respectfully submitted,

Pearson A. Griffith
Senior Insurance Examiner

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

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

Pearson Griffith

Subscribed and sworn to before me

this _____ day of _____ 2002.

Appointment No. 21768

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine into the affairs of the

MDNY HEALTHCARE, INC.

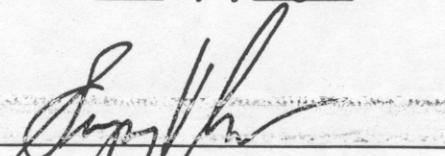
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 23rd day of August 2001



Gregory V. Serio
Superintendent of Insurance

