REPORT ON EXAMINATION

OF THE

CATSKILL AREA SCHOOLS EMPLOYEES BENEFIT PLAN

AS OF

JUNE 30, 2016

DATE OF REPORT **JULY 10, 2018**
EXAMINER **CHARLES J. McBURNIE**

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Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

July 10, 2018

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31557, dated December 13, 2016, attached hereto, I have made an examination into the condition and affairs of Catskill Area Schools Employees Benefit Plan, a municipal cooperative health benefit plan certified pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2016, and respectfully submit the following report thereon.

The examination was conducted at the administrative office of Catskill Area Schools Employees Benefit Plan located at 2020 Jump Brook Road, Grand Gorge, New York.

Wherever the designations the "Plan" or "CASEBP" appear herein, without qualification, they should be understood to indicate the Catskill Area Schools Employees Benefit Plan

Wherever the designation, the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of June 30, 2011. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period from July 1, 2011 through June 30, 2016. The financial component of the examination was conducted on a risk-focused basis in accordance with the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2016 Edition* (the "Handbook"). The financial examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2016 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of CASEBP.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, and annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The examination also evaluated the Plan's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

The Plan was audited annually for fiscal years 2011 through 2016, by the accounting firm D'Arcangelo & Co., LLP. The Plan received an unmodified opinion in each of those years. Certain audit work papers of D'Arcangelo & Co., LLP were reviewed and relied upon in conjunction with this examination.

The examiner reviewed the corrective actions taken by the Plan with respect to the recommendations concerning issues contained in the prior report on examination. The results of the examiner's review are contained in Item No. 5 of this report.

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

2. DESCRIPTION OF THE PLAN

The Otsego-Northern Catskill Board of Cooperative Educational Services ("BOCES") and eighteen (18) member school districts (collectively, the "Participants") formed a Consortium, effective April 1, 2001. The purpose of the Consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance.

On April 1, 2001, the Plan was issued a certificate of authority by the Superintendent of Insurance under Article 47 of the New York Insurance Law ("NYIL"). Pursuant to such certificate of authority, the Participants agreed to share the costs and assume the liabilities for medical, surgical, prescription drugs, and hospital benefits provided to covered employees (including retirees) and their dependents.

There are currently eighteen school districts and the BOCES participating in the Plan. The Plan Participants are as follows:

Andes Central School District	Milford Central School District
Charlotte Valley Central School District	Morris Central School District
Cherry Valley/Springfield Central School District	Otsego-Northern Catskill Board of Cooperative Educational Services (BOCES)
Delhi Central School District	Roxbury Central School District
Edmeston Central School District	Sidney Central School District
Gilboa/Conesville Central School District	South Kortright Central School District
Hunter-Tannersville Central School District	Stamford Central School District
Jefferson Central School District	Windham-Ashland-Jewett Central School District
Laurens Central School District	
Margaretville Central School District	Worcester Central School District

A. Corporate Governance

Pursuant to its Municipal Cooperation Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from each participating school district, and BOCES. The governing board of the Plan as of June 30, 2016 was as follows:

Name and Residence	Principal Affiliation
Patricia Norton-White Bloomville, New York	Superintendent, South Kortright Central School District
Dr. Robert Chakar White Lake, New York	Superintendent, Andes Central School District
Dr. Jennifer Bolton-Carls Oneonta, New York	Superintendent, Otsego-Northern Catskill Board of Cooperative Educational Services
Thomas O'Brien Roxbury, New York	Superintendent, Roxbury Central School District
Susan Vickers Tannersville, New York	Superintendent, Hunter-Tannersville Central School District

Name and Residence	Principal Affiliation
James Harter Millport, New York	Superintendent, Charlotte Valley Central School District
Mark Place Milford, New York	Superintendent, Milford Central School District
TheriJo Climenhaga Cherry Valley, New York	Superintendent, Cherry Valley/Springfield Central School District
Jason Thompson Delhi, New York	Superintendent, Delhi Central School District
Brian Corey Berne, New York	Superintendent, Jefferson Central School District
Dr. Robert Chakar White Lake, New York	Superintendent, Margaretville Central School District
Gary Furman Edmeston, New York	Superintendent, Edmeston Central School District
Dr. Glen Huot Windham, New York	Superintendent, Stamford Central School District
William Diamond Jefferson, New York	Superintendent, Worcester Central School District
Ruth Reeve Harpersfield, New York	Superintendent, Gilboa-Conesville Central School District
Matthew Sheldon Morris, New York	Superintendent, Morris Central School District
Romona Wenck Laurens, New York	Superintendent, Laurens Central School District
John Wiktorko Hadley, New York	Superintendent, Windham-Ashland-Jewett Central School District
William Christensen Sidney, New York	Superintendent, Sidney Central School District

According to its Municipal Cooperation Agreement, the governing board is to meet annually at a site within the geographic area served by the Otsego-Northern Catskill BOCES. A Chairperson is to be elected each year at the annual meeting. The governing board scheduled

regular quarterly meetings during the period under examination. The minutes of all meetings of the governing board were reviewed. All such meetings were well attended; however, it was noted that relative to the board meetings held during the period under examination, three participants of the board failed to attend at least one-half of such board meetings that they were eligible to attend.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate decisions may be reached by the board.

It is recommended that board members who are unable or unwilling to consistently attend meetings resign or be replaced.

A similar recommendation was made in the prior report on examination.

Additionally, as part of its corporate governance structure, the Plan's responsibilities include overseeing management's handling of the claims adjudication process via contracted third-party administrators who, pursuant to a written agreement with the Plan, perform claims adjudication procedures of claims submitted by members of the Plan's participants.

It is recommended that, as a prudent business practice, the Plan's board either initiate audits of the Plan's third-party claims administrators (relative to claims submitted by the Plan's participants in accordance with the Plan Document) or obtain annual certifications from its third-party claims administrators that claims are being processed in accordance with the Plan Document and applicable statutes, rules and regulations.

Upon review of the Plan's conflict of interest policy it was determined that the Plan's board, officers, managers and consultants did not have an established conflict of interest policy.

The Plan has a fiduciary responsibility to implement and maintain a conflict of interest policy for the benefit of its enrolled members and to ensure that the Plan's board members, officers, managers and consultants do not use their official position to promote an interest which is in conflict with that of the Plan.

It is recommended, as a prudent business practice, that the Plan's board of governors establish a documented written conflict of interest policy which is distributed to its board of governors, officers, managers, and consultants and certified/signed by such individuals on an annual basis.

A similar recommendation was made in the prior report on examination.

The principal officers of the Plan as of June 30, 2016, were as follows:

Officers	Title
Dr. Jennifer Bolton-Carls	Chairperson and President
Dr. Robert Chakar	Vice Chairperson
Patricia Powell-Wagner	Chief Financial Officer
Kevin Kreis	Benefits Coordinator
Kathy Schmiedel	Secretary

The board of governors has designated John Lynch as the Attorney-in-Fact who is authorized to receive service of process or other legal paper in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Plan.

Plan Document / Summary Plan Description

Section 4709(c) of the New York Insurance Law states in part:

> "(c) Conspicuously printed on the first page of the plan document and summary plan description, in at least ten point bold-face type, shall be the following statement:
>
> "This municipal cooperative health benefit plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the superintendent of financial services. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability."

It is recommended that the Plan adhere to the requirements of Section 4709(c) of the New York Insurance Law by including the required statement on the first page of its Plan Document and Summary Plan Description.

Certificate of Authority

As of June 30, 2016, the Plan was certified within the State of New York, to do the business of a municipal cooperative health benefit plan as authorized by Section 4704 of the New York Insurance Law in the counties of Greene, Otsego, and Schoharie. However, it was noted that the Plan also did business in the County of Delaware.

It is recommended that the Plan amend its Certificate of Authority to include Delaware County in order to be in compliance with Section 4704 of the New York Insurance Law.

It was also noted that the Plan's Certificate of Authority included its previous home office address, not its current home office address.

It is recommended that the Plan amend its Certificate of Authority to indicate its current home office address of Grand Gorge, New York.

B. Territory and Plan of Operation

The Plan provides health benefits to Otsego, Delaware, Schoharie and Greene counties within New York State. The Plan provides its members with medical and hospital coverage, prescription drug coverage and vision benefits. The Plan reported annual written premiums of $34,991,798 for the fiscal year ending June 30, 2016, a decrease of $4,490,104 from fiscal year 2015. The Plan's enrollment as of June 30, 2016 was 2,287 members, a decrease of 496 members

from fiscal year 2015. The decrease in enrollment was caused by two (2) school districts (Cooperstown and Schenevus), that discontinued their coverage with the Plan.

C. Internal Controls

A review of the Plan's service contract with D'Arcangelo & Co., LLP, the Plan's Certified Public Accounting ("CPA") firm, indicated that such CPA firm was not responsible for rendering an opinion on the Plan's internal control systems.

Section 4705(e)(1) of the New York Insurance Law states in part:

> "(e) The municipal cooperation agreement shall provide for the following to be prepared and furnished to the governing board… and to the superintendent:
>
> (1) an annual audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the municipal cooperative health benefit plan…"

Article 7 of the Plan's Municipal Cooperation Agreement states in part:

> "The following reports are to be prepared and furnished to the Board, to participating school districts and BOCES, to unions which are the exclusive collective bargaining representatives of employees covered by the Plan, and to the Superintendent of Financial Services:
>
> a. annually, not later than one hundred and twenty days after the close of the Plan's fiscal year, a report showing the financial condition and affairs of the Plan, in such form and providing such other information as the Superintendent may prescribe, together with an audit, and opinions thereon, by an independent certified public accountant, of the financial *condition, accounting procedures and internal control systems of the Plan…"*

It is recommended that the Plan amend its contract with its CPA firm to include a review and rendering of an opinion of the Plan's internal control systems on an annual basis in order to be in compliance with the requirements of Section 4705(e)(1) of the New York Insurance Law and the Plan's Municipal Cooperation Agreement.

D. Stop-Loss Coverage

As required by Section 4707 of the New York Insurance Law, the Plan maintains both aggregate stop-loss coverage and specific stop-loss coverage with an insurer authorized in New York State. The following is a summary of the Plan's stop-loss program as of June 30, 2016:

Type	Limits
Excess-of-loss (one layer)	100% of $1,000,000 excess of $375,000 per member, per contract year
Aggregate excess-of-loss	$1,000,000 excess of annual aggregate attachment point ($30,227,377)

The stop-loss coverage in effect at June 30, 2016, included the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

E. Administrative Service Agreements

The Plan entered into contractual agreements with the following vendors that provided various administrative services to the Plan:

1. Lifetime Benefits Solution, Inc. ("LBS")

   During the examination period, LBS was the Plan's primary third-party processor of the Plan's claims. According to its agreement with the Plan, LBS processed claims, met with the Plan's board of governors as deemed necessary to conduct the business of the Plan, provided mandated reports and documentation to regulators and others as required, kept the Plan's participants informed of benefit issues, assisted in the review and revision of plan benefit structure and design, provided a computerized on-line system for developing and maintaining comprehensive employee benefit records, provided third-party claims processing services relative to the payment of claims and provided the Plan with access to its provider network.

   LBS was replaced by Excellus Health Plan, Inc. as the Plan's third-party claims administrator effective July 1, 2016.

2. Corporate Care Management ("Corporate Care")

   Corporate Care provides utilization review services to the Plan and its members in accordance with the Plan's utilization review program. Such services include: prospective case identification services (including pre-certification services), case management services, high-dollar claim reviews and retrospective claim reviews (including review of appeals).

3. KBM Management, Inc. (KBM)

   KBM provides the Plan with assistance/advice as needed, including, but not limited to benefit analysis, plan design, cost control measures and economic-medical developments. KBM Management, Inc. also provides consulting services to the Plan's board of governors as required, including but not limited to, matters regarding negotiations with employee groups, actuarial services, including annual cost projections for plan modifications, determination of budget requirements, and actuarial opinions.

4. Express Scripts ("ESI")

   ESI provides on-line claims processing services for covered drugs dispensed by participating pharmacies, mail service pharmacies, or CuraScript (specialty drugs). ESI requires each participating pharmacy to meet their participation requirements, including but not limited to licensure, insurance and provider agreement requirements. ESI does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services at a participating pharmacy.

   ESI also performs an annual reconciliation of rebates for employer groups, comparing the financial value of the applied rebate option and the traditional pricing option.

5. Benefit Plan Administrative Services ("BPAS")

   BPAS provides actuarial and consulting services in support of the Plan's annual statement filings with the New York State Department of Financial Services, as well as consulting with the Plan regarding any issues related to its actuarial methodologies and assumptions.

   BPAS also calculates the valuation of the incurred but not paid claims reserve liability as of the Plan's fiscal year, which is consistent with the requirements of Schedule F of the New York State Municipal Cooperative Health Benefit Plan (MCHBP) annual statement.

6. Excellus Health Plan, Inc. (d/b/a BlueCross BlueShield)

Effective July 1, 2016, Excellus Health Plan, Inc. provided services to assist the Plan in the administration of benefits under the Benefit Plan. Such services included claims processing and administrative services, as set forth in the agreement, the preparation and delivery of reports required under the agreement, medical review and managed care services, the arrangement for the provision of benefits to members of the Plan's Participants who require covered services outside of the Plan's service area, maintenance of an adequate provider network for the provision of covered services outside the Service Area, and completion of certain mandated filings.

F. Accounts and Records

During the examination period, the Plan revised its annual and quarterly statements numerous times. It was noted that the Plan filed a notarized Jurat page with its completed annual statement blank and other required statement filings for the fiscal year ending June 30, 2016. However, the filing was late since it was provided to the Department on November 10, 2016.

It is recommended that the Plan take the necessary steps to complete and file, in a timely manner, its annual and quarterly statements to this Department in accordance with the annual and quarterly statement instructions.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities and surplus as of June 30, 2016, as contained in the Plan's 2016 filed annual statement, a condensed summary of operations, and a reconciliation of the surplus account for each of the years under examination. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the June 30, 2016 filed annual statement.

The firm of D'Arcangelo & Co., LLP was retained by the Plan to audit the Plan's combined statutory-basis statements of financial position as of June 30, 2016, and the related statutory-basis statements of operations and surplus for the year then ended.

D'Arcangelo & Co., LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets	
Cash and cash equivalents	$ 17,685,862
Aggregate write-ins	158,134
Total assets	$ 17,843,996
Liabilities	
Claims payable	$ 6,213,917
Total liabilities	$ 6,213,917
Net Worth	
Unassigned funds (surplus)	$ 9,880,489
Surplus per Section 4706(a)(5) of the NYIL	1,749,590
Total surplus	$ 11,630,079
Total liabilities and surplus	$ 17,843,996

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2017. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Surplus

Surplus decreased $4,570,382 during the five-year examination period, July 1, 2011 through June 30, 2016, detailed as follows:

Revenue		
Premiums	$ 186,447,846	
Investment income	184,744	
Aggregate write-ins for other revenue	2,929,026	
Total revenues		$ 189,561,616
Expenses		
Hospital and medical claims	$ 137,208,093	
Drug claims	45,699,119	
Claims subtotal	$ 182,907,212	
Reinsurance expenses net of recoveries	1,653,564	
Net claims incurred	$ 184,560,776	
Administrative expenses	5,423,602	
Total expenses		189,984,378
Net income		$ (422,762)

Surplus, per report on examination, as of June 30, 2011			$16,200,461
	Gains in Surplus	Losses in Surplus	
Net income		$ 422,762	
Change in surplus	$ 321,959		
Dividend paid to participating school districts**		4,000,000	
Liability adjustments		469,579	
Net decrease in surplus			(4,570,382)
Surplus, per report on examination as of June 30, 2016			$11,630,079

** The payment of a dividend to the participating school systems was done based on an accumulated surplus. It was not approved by the DFS as no such approval was required.

4. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to subscribers and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The general review was directed at practices of the Plan in the following areas:

A. Prompt Pay Law
B. Policy forms / benefits
C. Grievances
D. Website disclosure

A. Prompt Pay Law

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt of a claim that is transmitted via the internet or electronic mail, or 45 days of receipt of a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

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

> "(c)(1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim."

The examiner reviewed the Plan's compliance with the above sections of the Insurance Law for both the latest examination year July 1, 2015 to June 30, 2016 and the prior period July 1, 2014 to June 30, 2015. The review of the prior period was completed due to claim processing problems the TPA had during this period.

The Catskill Area Schools Employees Benefit Plan contracted with EBS-RMSCO to use its computer system (GBAS) and provider network in order to pay medical claims. Beginning on January 1, 2015, EBS-RMSCO changed its name to Lifetime Benefit Solution ("LBS") and switched to the Javelina computer system to process medical claims.

Due to numerous problems LBS had with the Javelina computer system, CASEBP was unable to process claims from January 1, 2015 through March 31, 2015. As a result, CASEBP had a backlog of thousands of claims (3,131) that went unpaid until the Javelina computer system was up and running in April of 2015. This caused CASEBP to have numerous claims adjudicated past the prompt pay timeline requirements.

Since these violations were caused by the failure of LBS to have the Javelina system operational on January 1, 2015, LBS will be issuing payments for the interest due to these providers for late payments per Section 3224 of the New York Insurance Law.

The Plan identified the late claim payments adjudicated during the period July 1, 2014 through June 30, 2017, where interest was due on Medical or Dental claims. There were 3,130 claims adjudicated during 2015 where interest was due on late claims payments. There were only nine dental claims and four medical and dental claims where interest was due for 2016 and 2017 respectively. As of the date of this report on examination, the Plan's TPA had not yet issued the appropriate applicable interest payments.

It is recommended that the Plan pay appropriate interest in those instances where the interest calculated pursuant to Section 3224-a(c) of the New York Insurance Law is $2.00 or more, and where there is not an appropriate reason for delay in payment, as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

It is also recommended that the Plan ensure that all appropriate interest relative to the July 1, 2014 – June 30, 2017 period is paid.

It is further recommended that the Plan notify and provide the Department with supporting detail relative to such interest payments, when all such applicable interest payments have been made.

A statistical sample of claims not adjudicated within 30 days of receipt for claims transmitted via the internet or electronic mail, or 45 days of receipt for claims submitted by other means such as paper or a facsimile by the Plan was reviewed by the examiner to determine whether the claims were processed in compliance with the timeframe requirements of Section 3224-a(a) of the New York Insurance Law ("NYIL"), and, if interest was required and appropriately paid pursuant to Section 3224-a(c)(1) of the NYIL. Accordingly, all claims that were not adjudicated within the respective 30 or 45-day time frames during the period July 1, 2014 through June 30, 2015 and July 1, 2014 through June 30, 2015, were segregated and analyzed.

For the period July 1, 2014 through June 30, 2015 a review was done as the population of claims that were paid past 30 or 45 days and denied past 30 days which exceeded 2% of the overall claim population for the period.

A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated and paid.

The claims population of the Plan was separated and further divided into medical and hospital claim segments. A random statistical sample was drawn from each segment.

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

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

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

	Medical and Hospital Claims
Total population of claims	58,283
Population of claims paid past 30/45 days or denied past 30 days	17,333
Sample size	167
Number of claims with violations	166
Calculated violation rate	**99.40%**
Upper violation limit	100.00%
Lower violation limit	98.23%
Calculated claims in violation	**17,229**
Upper limit claims in violation	17,333
Lower limit claims in violation	17,026

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

The population of claims adjudicated after thirty days for electronic submission or forty-five days for paper submission from the date of receipt for the Plan consisted of 17,333 medical and hospital claims, out of 58,283 medical and hospital claims processed during the period July 1, 2014 through June 30, 2015.

It is recommended that the Plan put procedures in place to monitor its third-party claim administrators to ensure that such third-party administrators adjudicate the Plan's claims in accordance to Section 3224-a of the New York Insurance Law.

B. Policy Forms / Benefits

Insurance Regulation No. 95 (11 NYCRR 86.4) states in part:

> "(a) Except with respect to automobile insurance, all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation..."

A review of the Plan's claim forms revealed that said forms did not contain the wording required by Insurance Regulation No. 95 (11 NYCRR 86.4).

It is recommended that the Plan amend its claim forms to include the aforementioned wording required by Insurance Regulation No. 95.

A review of the Plan's enrollment forms revealed that said forms did not contain the language required by Insurance Regulation No. 95 (11 NYCRR 86.4).

It is recommended that the Plan amend its enrollment forms to include the aforementioned wording required by Insurance Regulation No. 95.

C. Grievances

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

> "(d)… All grievances shall be resolved in an expeditious manner, and in any event, no more than…

> (2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract…"

A review of the Plan's grievance log determined that the Plan failed to resolve six (6) out of forty (40) grievances in an expeditious manner (i.e., more than 30 days…).

It is recommended that the Plan comply with Section 4208(d)(2) of the New York Insurance Law by issuing written decisions in an expeditious manner after completing its first level grievance reviews.

D. Website Disclosure

Part 400.5(f) of Financial Services Regulation No. 23 (NYCRR 400) states in part:

> "(f) A health care plan should prominently post on its website the information in paragraphs (1)-(5) of this subdivision and include in disclosure materials provided to insureds pursuant to Insurance Law sections 3217-a(a), 4324(a) and Public Health Law section 4408(1) the information in paragraphs (1)-(4) of this subdivision, as follows:
>
> (1) a description of what constitutes a surprise bill;
> (2) a description of the independent dispute resolution process;
> (3) an assignment of benefits form for surprise bills;
> (4) the health care plan's designated electronic and mailing address where the assignment of benefits form can be submitted; and
> (5) information on how an insured… may submit a dispute to an IDRE (Independent Dispute Resolution Entity)."

Upon review of the Plan's website, it was noted that none of the required above-mentioned information was posted.

It is recommended that the Plan comply with Part 400.5(f) of Financial Services Regulation No. 23 (NYCRR 400) by prominently posting the required information on its website and by including the required disclosure information.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included thirteen (13) recommendations detailed as follows (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Corporate Governance	
1.	It is recommended that board members who are unable or unwilling to attend meetings consistently resign or be replaced. *The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.*	7
2.	It is recommended that the committees established by the board of governors either conduct meetings or be disbanded. *The Plan has complied with this recommendation*	7
3.	It is recommended that Plan comply with Section 4710(a)(1) of the New York Insurance Law and file for approval with this Department all unapproved amendments to its municipal cooperation agreement. *Subsequent to the completion of the examination, the Plan filed for approval its amended Municipal Cooperation Agreement with this Department. At the time of this writing, such amended Municipal Cooperation Agreement is being reviewed by the Department.*	9
4.	It is recommended that the Plan clearly indicate within the document entitled, "Catskill Area Schools Employee Benefit Plan Membership," that such document contains the Plan's by-laws and update such by-laws where necessary to comply with the provisions outlined within the Plan's Municipal Cooperation Agreement. It is also recommended that the Plan file for approval its updated, revised by-laws with this Department. *The Plan has complied with this recommendation.*	10

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Accounts and Records

9. It is recommended that, either the Plan collect the late payment fee or if it is the intent of the board of governors to not charge its participants a late payment fee relative to overdue monthly installments, the Plan amend its Municipal Cooperation Agreement to delete such late payment fee requirement and submit such amendment to the Department for approval. 16

The Plan has complied with this recommendation.

10. It is recommended that the Plan follow the annual statement instructions when preparing and filing its annual and quarterly statements with the Department. 17

The Plan did not comply with this recommendation. A similar recommendation is included within this report on examination.

11. It is recommended that the Plan, in the future, provide notice of its proposed payment of dividends to its members for review with this Department at least ninety (90) days in advance of the proposed payment of such dividends. 18

The Plan has complied with this recommendation.

Plan Document

12. It is recommended that the Plan comply with Section 4710(a)(1) of the New York Insurance Law and submit all new or revised policy forms to the Superintendent of Financial Services for approval prior to implementation. 24

The Plan has complied with this recommendation.

Rating

13. It is recommended that the Plan file its current community rating methodology with the Superintendent of Financial Services. 25

The Plan has complied with this recommendation.

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____

Charles J. McBurnie
Insurance Examiner

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

Charles J. McBurnie**,** being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____

Charles J. McBurnie

Subscribed and sworn to before me
this _____ day of _____2018

APPOINTMENT NO. 31557

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Charles McBurnie

as a proper person to examine the affairs of

Catskill Area Schools Employees Benefit Plan

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

Municipal Cooperative Health Benefit Plan

with such other information as he shall deem requisite.

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

this 13th day of December, 2016

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau