

REPORT ON EXAMINATION

OF THE

CAYUGA-ONONDAGA AREA

SCHOOL EMPLOYEES' HEALTHCARE PLAN

AS OF

JUNE 30, 2015

DATE OF REPORT

JUNE 6, 2017

EXAMINER

CHARLES J. McBURNIE

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

June 6, 2017

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 31356, dated June 17, 2015, attached hereto, I have made an examination into the condition and affairs of Cayuga-Onondaga Area School Employees' Healthcare 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, 2015, and respectfully submit the following report thereon.

The examination was conducted at the administrative office of Cayuga-Onondaga Area School Employees' Healthcare Plan located at 1879 West Genesee Street, Auburn, New York.

Wherever the designations the "Plan" or "COASEHP" appear herein, without qualification, they should be understood to indicate the Cayuga-Onondaga Area Schools Employees' Healthcare 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, 2010. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period from July 1, 2010 through June 30, 2015. The financial component of the examination was conducted as a financial examination as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2016 Edition* (the “Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2015 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis, which provides guidance for the establishment of an examination plan based on the examiner’s assessment of risk in the Plan’s operations and utilized 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 COASEHP.

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,

Statutory Accounting Principles, as adopted by the Department, 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 ending 2011 through 2015, by the accounting firm Cuddy and Ward, LLP. The Plan received an unmodified opinion in each of those years. Certain audit work papers of Cuddy and Ward, LLP were reviewed and relied upon in conjunction with this examination.

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

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 6 of this report.

2. DESCRIPTION OF THE PLAN

The Board of Cooperative Educational Services ("BOCES") and eight (8) member school districts ("Participants") formed a Consortium, effective July 1, 1981. 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 August 1, 2001, the Plan was issued a certificate of authority by the Superintendent of Insurance under Article 47 of the New York Insurance Law. 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.

Cayuga-Onondaga Area School Employees' Healthcare Plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). To be a grandfathered health plan, the policy or group health plan must have had at least one individual enrolled in coverage on March 23, 2010, and the policy or plan must have continuously covered someone since March 23, 2010. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan means the plan has the discretion not to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

There are currently eight school districts and the BOCES participating in the Plan.

The Plan Participants are as follows:

| | |
|--|--|
| Cato-Meridian Central School District | Skaneateles Central School District |
| Cayuga-Onondaga Board of Cooperative Educational Services | Southern Cayuga Central School District |
| Jordan-Elbridge Central School District | Union Springs Central School District |
| Moravia Central School District | Weedsport Central School District |
| Port Byron Central School District | |

A. Corporate Governance

Pursuant to the Municipal Cooperative Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from each participating school district, including BOCES. The governing board of the Plan as of June 30, 2015 was as follows:

| <u>Name and Residence</u> | <u>Principal Affiliation</u> |
|---|---|
| Dale Bates Cincinnatus, New York | Assistant Superintendent, Skaneateles Central School District |
| Peter Colucci Oswego, New York | Assistant Superintendent, Cayuga-Onondaga Board of Cooperative Educational Services |
| Jeffrey Carmichael Moravia, New York | Business Administrator, Moravia Central School District |
| Douglas Tomand Auburn, New York | Business Administrator, Weedsport Central School District |
| James Mahaney Syracuse, New York | Treasurer, Jordan-Elbridge Central School District |
| Crosby Lamont Elba, New York | Assistant Superintendent, Cato-Meridian Central School District |
| Margaret Robbins Otisco, New York | Business Manager, Union Springs Central School District |
| Patricia Shaw Owasco, New York | Business Administrator, Port Byron Central School District |
| Kimberly Vile Marietta, New York | Business Administrator, Southern Cayuga Central School District |

According to its Municipal Cooperative Agreement, the governing board is to meet annually in the month of July and shall call special meetings at any time. The governing

board scheduled regular monthly meetings during the period under examination. The minutes of all meetings of the governing board were reviewed. All such meetings were well attended with all board members attending at least one-half of the meetings they were eligible to attend.

A review of the Plan's corporate governance structure revealed that the governing board did not adopt written procedures that would allow the board to obtain a certification, annually, from either an internal auditor or independent CPA that the responsible officers have implemented the procedures adopted by the board, and from the Plan's general counsel, a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.

It is recommended that, as a prudent business practice, the board adopt written procedures that would require the board to obtain annual certification, either from its internal auditor, the Plan's independent CPA firm or the Plan's general counsel, to the effect that the Plan's responsible officers have implemented procedures adopted by the board and that the Plan's current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable statutes, rules and regulations.

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

Also, as part of the corporate governance structure, the Plan's responsibilities include overseeing management's handling of the claims adjudication process relative to outside parties who, pursuant to an agreement with the Plan, perform claims adjudication procedures.

It is recommended that, as a prudent business practice, the Plan's board of governors 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.

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

The principal officers of the Plan as of June 30, 2015 were as follows:

| <u>Officers</u> | <u>Title</u> |
|------------------------|---|
| Peter Colucci | Chairperson and Chief Financial Officer |
| Dale Bates | Vice Chairperson |
| Debra Beyor | Treasurer |
| Evelyn Waterman | Secretary |

The board of governors have designated Mathew Fletcher as the Attorney-in-Fact and custodian for all Plan reports, records, and statements.

B. Territory and Plan of Operation

The Plan provides health benefits to Plan members in Cayuga and Onondaga counties within New York State. The Plan had annual written premiums of \$23,046,303 for the fiscal year ending June 30, 2015. The Plan's enrollment as of June 30, 2015 was 2,396 members. There was no significant change in membership during or subsequent to the examination period. The Plan's participating school districts remained the same throughout the examination period.

C. Internal Controls

A review of the Plan's service contract with Cuddy and Ward, 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.

Article 8 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 the Department of Insurance:

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 (emphasis added)..."

Further, 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 (emphasis added)...”

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 comply with the requirements of Section 4705(e)(1) of the New York Insurance Law and the Plan’s municipal cooperation agreement.

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

D. Stop-Loss Coverage

Section 4707(a)(2) of the New York Insurance Law states:

“(a) The governing board of the municipal cooperative health benefit plan shall obtain and maintain on the behalf of the plan a stop-loss insurance policy or policies providing ...

(2) specific stop loss coverage with specific retention amount or attachment point not greater than four percent of the amount certified by a qualified actuary to represent the plan's expected claims for the current fiscal year.”

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. The following is a summary of the Plan’s stop-loss program as of June 30, 2015:

| <u>Type</u> | <u>Limits</u> |
|----------------------------|---|
| Excess-of-loss (one layer) | 100% of \$1,000,000 excess of \$350,000 per member, per contract year |
| Aggregate excess-of-loss | \$1,000,000 excess of annual aggregate attachment point (\$30,227,377), for the current contract period |

The stop-loss agreement in effect at June 30, 2015, included the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

E. Administrative Services 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”)

LBS processes the Plan’s claims. According to its agreement with the Plan, LBS is to ensure accurate and prompt payment of claims, meet with the Plan’s board of governors as deemed necessary to conduct the business of the Plan, provide mandated reports and documentation to regulators and others as required, keep the Plan’s participants informed of benefit issues, assist in the review and revision of plan benefit structure and design, provide a computerized on-line system for developing and maintaining comprehensive employee benefit records, provide third-party claims processing services relative to the payment of claims and provide the Plan with access to its provider network.

Section 2101(g)(1) of the New York Insurance Law states in part:

“(g) In this article “adjuster” means any “independent adjuster” as defined below:

(1) the term “independent adjuster” means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer as are incidental to such

claims and also includes any person who for compensation or anything of value investigates and adjusts claims on behalf of any independent adjuster...”

Section 2102(a)(1) of the New York Insurance Law states in part:

“(a)(1) No person, firm, association or corporation shall act as an 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.”

Section 2108(a)(3) of the New York Insurance Law states in part:

“(a)(3) No adjuster shall act on behalf of an insurer unless licensed as an independent adjuster...”

A review of the claims adjudication process by the examiner revealed that neither LBS nor any of its employees assigned to process the Plan’s claims possessed a New York claims adjuster license, while acting in its capacity for the Plan. This is a violation of Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law.

It is recommended that the Plan contract with a claims adjustment firm that is licensed in accordance with Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law, and that the employees of such contracted claim adjustment firm who perform claim adjusting services in New York (on behalf of the Plan) be licensed as independent claims adjusters in accordance with such Sections of the New York Insurance Law.

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 cost claim reviews and retrospective claim reviews (including reviews of appeals).

3. Beech Street Corporation

Beech Street Corporation arranges for the provision of health care services from selected health care providers. In this regard LBS purchases access to the Beech Street Corporation health care networks on behalf of the Plan.

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).

5. Cuddy & Ward, LLP

Cuddy & Ward, LLP audits the financial statements of the Plan.

F. Accounts and Records

1. Pharmaceutical rebates receivable

Paragraph 24 of Statements of Statutory Accounting Principles (“SSAP”) No. 84 of the *NAIC Accounting Practices and Procedures Manual* states:

“(24) the financial statements shall disclose the method used by reporting entity to estimate pharmaceutical rebate receivables. Furthermore, for the most recent three years and for each quarter therein, the reporting entity shall also disclose the following: a.) the estimated balance of pharmacy rebate receivable as reported on the financial statements; b.) Pharmacy rebates as invoiced or confirmed in writing; and c.) Pharmacy rebates collected.”

The Plan did not comply with Paragraph 24 of SSAP No. 84 of the *NAIC Accounting Practices and Procedures Manual* when it failed to disclose in its annual statements, the method used to estimate its reported pharmaceutical rebate receivables.

It is recommended that the Plan comply with Paragraph 24 of SSAP No. 84 of the *NAIC Accounting Practices and Procedures Manual* by disclosing within its annual statements the method used to estimate its reported pharmaceutical rebate receivables.

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

FINANCIAL STATEMENTSA. Balance Sheet

The following statements show the assets, liabilities and surplus as of June 30, 2015, as contained in the Plan's 2015 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, 2015 filed annual statement.

The firm of Cuddy and Ward, LLP ("C&W") was retained by the Plan to audit the Plan's combined statutory-basis statements of financial position as of December 31, 2011, and the related statutory-basis statements of operations and surplus for the year then ended.

C&W 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.

Assets

Cash and cash equivalents \$27,330,347

Total assets \$27,330,347

Liabilities

Claims Payable \$ 3,264,282

Total liabilities \$3,264,282

Net worth

Unassigned funds (surplus) \$ 22,826,735

Surplus per section 4706(a)(5) 1,239,330

Total Surplus \$24,066,065

Total liabilities and surplus \$27,330,347

B. Statement of Revenue and Expenses and Surplus

Surplus increased \$12,880,875 during the five-year examination period, July 1, 2010 through June 30, 2015, detailed as follows:

Revenue

| | | |
|---------------------------------------|------------------|----------------|
| Premiums | \$141,860,279 | |
| Investment income | 164,861 | |
| Aggregate write-ins for other revenue | <u>4,941,819</u> | |
| Total revenues | | \$ 146,966,959 |

Expenses

| | | |
|--|-------------------|----------------------|
| Hospital and medical claims | \$ 110,560,096 | |
| Drug claims | <u>14,008,101</u> | |
| Claims subtotal | \$124,568,196 | |
| Reinsurance expenses net of recoveries | <u>1,008,281</u> | |
| Net claims incurred | \$125,576,477 | |
| Administrative expenses | <u>4,994,760</u> | |
| Total expenses | | <u>130,571,237</u> |
| Net income | | \$ <u>16,395,722</u> |

| | | | |
|--|-----------------------------------|------------------------------------|-----------------------|
| Surplus, per report on examination, as of June 30, 2010 | | | <u>\$11,185,192</u> |
| | <u>Gains in</u> <u>Surplus</u> | <u>Losses in</u> <u>Surplus</u> | |
| Net income | \$16,395,722 | | |
| Increase in contingency reserve | 33,684 | | |
| Aggregate write-ins for changes in retained earnings | | \$ 232,447 | |
| Aggregate write-ins for change in other surplus items | <u> </u> | <u>3,316,085</u> | |
| Net increase in surplus | | | <u>12,880,875</u> |
| Surplus, per report on examination, as of June 30, 2015 | | | * <u>\$24,066,067</u> |

* Note: \$2 rounding error compared to reported surplus as of June 30, 2015.

4. CLAIMS PAYABLE

The Plan reported a liability for unpaid claims of \$ 3,264,282 within the Plan's June 30, 2015 filed annual statement.

Section 4706(a)(1) requires a reserve for payment of claims and expenses that are (A) reported and not yet paid and (B) incurred but not yet reported. The amount of this reserve should not be less than a percentage approved by the Superintendent of Department of Financial Services DFS, of the expected incurred claims and expensed of the current plan year. The Plan has been approved by the Department of Financial Services, to estimate this reserve at 17% of expected incurred claims and expenses of the current plan year. The Plan's reported unpaid claims liability of \$3,264,282 represented approximately 15% of the Plan's total claims and expenses incurred as reported in its financial statement for fiscal year ending June 30, 2015. Thus, the Plan's reported unpaid claims liability for fiscal year ending June 30, 2015, was not in compliance with Section 4706(a)(1) of the New York State Insurance Law as approved by the Superintendent.

It is recommended that the Plan comply with Section 4706(a)(1) of the New York Insurance Law by maintaining its estimated unpaid losses at 17% of expected incurred claims and expenses of the current plan year, as approved by the Superintendent.

5. 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 Claims processing
- B Policy forms / benefits
- C Utilization review
- D Underwriting and rating

A. Claims Processing

Prompt Pay Law

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

“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 reasonable 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 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”.

A review to test for compliance with the requirements of Section 3224-a of the New York Insurance Law (“Prompt Pay Law”), was performed by using a statistical sampling methodology covering medical and hospital claims submitted to the Plan during the period July 1, 2014 through June 30, 2015.

Potential violations of Section 3224-a(a) of the New York Insurance Law were reviewed through the isolation of all claims that took more than 30 days to deny a claim or request additional information regarding a claim. The result of the examiner’s analysis revealed a population of 40,327 possible violations. A sample of 167 medical and hospital of only electronically submitted claims was extracted from the total claims population and reviewed. Of this sample, there were 133 confirmed violations.

The review of the Plan’s electronically submitted medical and hospital claims data for the period, July 1, 2014 through June 30, 2015 relative to compliance with Section 3224a(a) of the New York Insurance Law revealed the following:

Potential violations of Section 3224a(a) of the New York Insurance Law were reviewed through the isolation of all electronically submitted medical and hospital claims that took more than 30 days to pay such claim or request additional information regarding such claim. The result of the examiner’s analysis revealed a population of 22,385 possible violations. A sample of 167 claims was extracted from the population and reviewed. Of this sample, there were 133 confirmed violations.

The following chart illustrates the Plan's compliance with Section 3224-a(a) of the New York Insurance Law for electronically submitted medical and hospital paid claims as determined by this examination:

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

| | |
|---|---------|
| Total claim population | 308,500 |
| Population of claims adjudicated after 30 days of receipt | 22,365 |
| Sample size | 167 |
| Number of claims with violations | 133 |
| Calculated violation rate | 79.64% |
| Upper Violation Limit | 85.75% |
| Lower Violation Limit | 73.53% |
| Calculated claims in violation | 17,811 |
| Upper limit claims in violation | 19,178 |
| Lower limit claims in violation | 16,445 |

Note: The lower and upper 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).

The following chart illustrates the Plan's compliance with Section 3224-a(a) of the New York Insurance Law relative to non-electronic hospital and medical claims submissions, as determined by this examination:

| | |
|---|---------|
| Total claim population | 308,500 |
| Population of claims adjudicated after 45 days of receipt | 5,872 |
| Sample size | 167 |
| Number of claims with violations | 35 |
| Calculated violation rate | 20.95% |
| Upper Violation Limit | 27.13% |
| Lower Violation Limit | 14.78% |
| Calculated claims in violation | 1,230 |
| Upper limit claims in violation | 1,593 |
| Lower limit claims in violation | 868 |

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

It is recommended that the Plan comply with Section 3224-a(a) of the New York Insurance Law, by making payments to a policyholder or covered person or make payment to a health care provider within thirty (30) days of receipt of an electronic submitted claim or bill for services rendered that is transmitted via the internet or electronic mail and within forty-five (45) days of receipt of a claim or bill for services rendered that is submitted by paper or facsimile.

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

“(b) In a case where the obligation of an insurer or an organization or corporate or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability or 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 days of the receipt of the claim:”...

Violations of Section 3224-a(b) of the New York Insurance Law were determined through the isolation of all claims that took more than 30 days to deny or request additional information. The result of the examiner’s analysis revealed a population of 20,159 possible violations. A sample of 167 claims was extracted from this population and reviewed. Of this sample, there were 64 confirmed violations.

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

| | |
|---|---------|
| Total claim population | 308,500 |
| Population of claims adjudicated after 30 days of receipt | 20,159 |
| Sample size | 167 |
| Number of claims with violations | 135 |
| Calculated violation rate | 80.83% |
| Upper violation limit | 86.81% |
| Lower violation limit | 74.87% |
| Calculated claims in violation | 16,295 |
| Upper limit claims in violation | 17,500 |
| Lower limit claims in violation | 15,093 |

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

It is recommended that the Plan comply with Section 3224-a(b) of the New York Insurance Law, by making payment for any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider of denied or denied portions of claims in writing within thirty (30) days of the receipt of the claim.

B. Policy Forms / Benefits

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

“(a) Except with respect to automobile insurance, all claims 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 material false information, or conceals to 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 claims 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 claims forms to comply with the requirements of Insurance Regulation No. 95 (11NYCRR 86.4).

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 comply with the requirements of Insurance Regulation No. 95 (11 NYCRR 86.4).

C. Utilization Review (UR)

Cayuga-Onondaga Area School Employee’s Healthcare Plan contracted with Corporate Care Management, a third party administrator, as its utilization review agent.

Section 4904(c) of the New York Insurance Law states in part:

“(c)...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 respect to the appeal within sixty days of receipt of necessary information to conduct the appeal ...”

Corporate Care failed to provide written acknowledgment of the filing of the appeal to three members within fifteen (15) days of such filing.

It is recommended that the Plan ensure that Corporate Care Management provides written acknowledgment of the filing of the appeal to the appealing party within fifteen (15) days of such filing, in accordance with Section 4904(c) of the New York Insurance Law.

Corporate Care Management also failed to make a UR determination within sixty (60) days of receipt of necessary information for two (2) members who filed appeals.

It is recommended that the Plan ensure that Corporate Care Management make an appeal determination within sixty days (60) of receipt of necessary information to conduct the appeal, in accordance with Section 4904(c) of the New York Insurance Law.

Section 4904(c)(2) of the New York Insurance Law states in part:

“The notice of the appeal determination shall include...

“a notice of the insured’s right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of the external appeal process established pursuant to title two of this article and the time frames for such external appeals”.

Corporate Care Management failed to include a notice to the Plan's insureds of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health within its notices of appeal determinations as required pursuant to Section 4904(c)(2) of the New York Insurance Law.

It is recommended that the Plan ensure that Corporate Care Management include a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health within its notices of appeal determinations as required pursuant to Section 4904(c)(2) of the New York Insurance Law.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

| <u>ITEM NO.</u> | | <u>PAGE NO.</u> |
|------------------------|--|------------------------|
| | <u>Management and Controls</u> | |
| 1. | It is recommended that the Plan, revise its Municipal Cooperative Agreement or by-laws to include the additional standing committees or eliminate such standing committees. <i>The Plan has complied with this recommendation.</i> | 7 |
| 2. | It is recommended that the Plan comply with the requirements of Section 624(a) of the New York Business Corporation Law by maintaining minutes of all meetings held. <i>The Plan has complied with this recommendation.</i> | 7 |
| 3. | It is recommended that the Plan and its board of governors comply with the requirements of Section 312(b) of the New York Insurance Law. <i>The Plan has complied with this recommendation.</i> | 8 |
| | <u>Corporate Governance</u> | |
| 4. | 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 comply with the requirements of Section 4705(e)(1) of the New York Insurance Law and the Plan's municipal cooperation agreement. <i>The Plan has not complied with this recommendation.</i> <i>A similar recommendation has been included within this report on examination.</i> | 10 |

ITEM NO.**PAGE NO.**

5. It is recommended that, as prudent business practice, the board adopt written procedures that would require the board to obtain annual certification, either from an internal auditor, the Plan's independent CPA firm or the Plan's general counsel, to the effect that the Plan's responsible officers have implemented procedures adopted by the board and that the Plan's current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable statutes, rules and regulations.

10

The Plan has not complied with this recommendation.

A similar recommendation has been included within this report on examination.

6. It is recommended that, as a prudent business practice, the Plan's Board of Governors 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.

11

The Plan has not complied with this recommendation.

A similar recommendation has been included within this report on examination.

Stop-Loss Coverage

7. It is recommended that the Plan comply with the requirements of Section 4707(a)(2) of the New York Insurance Law and maintain specific stop-loss coverage with a retention amount not greater than four percent of the amount certified by a qualified actuary to represent the plan's expected claims for the current year.

12

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Administrative Service Agreements

8. It is recommended that RMSCO, Inc. and each of its employees who perform claim adjusting services in New York (for the Plan) be licensed as independent claims adjusters, in accordance with Section 2102(a)(1) and 2108(a)(3) of New York Insurance Law. 14

The Plan has not complied with this recommendation.

A similar recommendation has been included within this report on examination.

Conflict of Interest Policy

9. It is recommended that all board members and officers of the Plan sign the required conflict of interest disclosure statement on an annual basis. 15

The Plan has complied with this recommendation.

Accounts and Records

10. It is recommended that the Plan comply with Paragraph 24 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual and disclose in its annual statements the method used to estimate its reported pharmaceutical rebate receivables. 16

The Plan has not complied with this recommendation.

A similar recommendation has been included within this report on examination.

11. It is recommended that the Plan comply with the requirements of Section 4710(a)(2) of the New York Insurance Law and submit its required annual statements to the Superintendent of Financial Services, within the required filing period. 16

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Claims Payable

12. It is recommended that the Plan comply with Section 4706(a)(1) of the New York State Insurance Law and maintain its estimated unpaid losses at 17% of expected incurred claims and expenses of the current plan year as approved by the Superintendent. 19

The Plan has not complied with this recommendation.

A similar recommendation is included within this report.

Policy Forms/Benefits

13. It is recommended that the Plan comply with the requirements of 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. 22

The Plan has complied with this recommendation.

14. It is recommended that the Plan comply with the requirements of Section 1251 of the Patient Protection and Affordable Care Act and include the required disclosure statement to its members. 23

The Plan has complied with this recommendation.

Utilization Review

15. It is recommended the Plan ensure that Corporate Care Management include the Plan as an entity covered under Corporate Care's utilization review program filed with the Superintendent, as required by Section 4901(a) of the New York Insurance Law. 24

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Rating

16. It is recommended that the Plan comply with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law by establishing premium rates based upon a community rating methodology formula which has been filed with and approved by the Superintendent of Financial Services.

25

The Plan has complied with this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

| <u>ITEM</u> | <u>PAGE NO.</u> |
|---|------------------------|
| <p>A. <u>Corporate Governance</u></p> <p style="margin-left: 40px;">i. It is recommended that, as a prudent business practice, the board adopt written procedures that would require the board to obtain annual certification, either from its internal auditor, the Plan’s independent CPA firm or the Plan’s general counsel, to the effect that the Plan’s responsible officers have implemented procedures adopted by the board and that the Plan’s current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable statutes, rules and regulations.</p> <p style="margin-left: 40px;">A similar recommendation was made in the prior report on examination.</p> <p style="margin-left: 40px;">ii. It is recommended that, as a prudent business practice, the Plan’s board of governors 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.</p> <p style="margin-left: 40px;">A similar recommendation was made in the prior report on examination.</p> | <p>7</p> <p>8</p> |
| <p>B. <u>Internal Controls</u></p> <p style="margin-left: 40px;">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 comply with the requirements of Section 4705(e)(1) of the New York Insurance Law and the Plan’s municipal cooperation agreement.</p> | <p>10</p> |
| <p>C. <u>Administrative Service Agreements</u></p> <p style="margin-left: 40px;">It is recommended that the Plan contract with a claims adjustment firm that is licensed in accordance with Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law, and that the employees of such contracted claim adjustment firm who perform claim adjusting services in New York (on behalf of the Plan) be licensed as independent claims adjusters in accordance with such Sections of the New York Insurance Law.</p> | <p>12</p> |

| <u>ITEM</u> | <u>PAGE NO.</u> |
|--|-----------------|
| D. <u>Accounts and Records</u> | |
| It is recommended that the Plan comply with Paragraph 24 of SSAP No. 84 of the <i>NAIC Accounting Practices and Procedures Manual</i> by disclosing within its annual statements the method used to estimate its reported pharmaceutical rebate receivables. | 14 |
| A similar recommendation was made in the prior report on examination | |
| E. <u>Claims Payable</u> | |
| It is recommended that the Plan comply with Section 4706(a)(1) of the New York State Insurance Law and maintain its estimated unpaid losses at 17% of expected incurred claims and expenses of the current plan year as approved by the Superintendent. | 19 |
| A similar recommendation was made in the prior report on examination. | |
| F. <u>Prompt Pay Law</u> | |
| i. It is recommended that the Plan comply with Section 3224-a(a) of the New York Insurance Law, by making payments to a policyholder or covered person or make payment to a health care provider within thirty (30) days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mails and within forty-five (45) days of receipt of a claim or bill for services rendered that is submitted by paper or facsimile. | 23 |
| ii. It is recommended that the Plan comply with Section 3224-a(b) of the New York Insurance Law, by making payment for any undisputed portion of the claim in accordance with this subsection and notify the policyholder covered person or health care provider of the denied or denied portions of claims in writing within thirty (30) days of the receipt of the claim. | 24 |
| G. <u>Policy Forms/Benefits</u> | |
| i. It is recommended that the Plan amend its claim forms to comply with the requirements of Insurance Regulation No. 95 (11 NYCRR 86.4). | 25 |

| <u>ITEM</u> | <u>PAGE NO.</u> |
|--|------------------------|
| ii. It is recommended that the Plan amend its enrollment forms to comply with the requirements of Insurance Regulation No. 95 (11 NYCRR 86.4). | 25 |
| H. <u>Utilization Review</u> | |
| i. It is recommended that the Plan ensure that Corporate Care Management provides written acknowledgment of the filing of the appeal to the appealing party within fifteen (15) days of such filing in accordance Section 4904(c) of the New York Insurance Law. | 26 |
| ii. It is recommended that the Plan ensure that Corporate Care Management makes an appeal determination within sixty (60) days of receipt of necessary information to conduct the appeal in accordance with Section 4904(c) of the New York Insurance Law. | 26 |
| iii. It is recommended that the Plan ensure that Corporate Care Management include a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health, within its notices of appeal determinations as required pursuant to Section 4904(c) (2) of the New York Insurance Law. | 27 |

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

Charles McBurnie

as a proper person to examine the affairs of

Cayuga-Onondaga Area Schools Employees' Healthcare Plan

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

Municipal Cooperative Health Benefit Plan

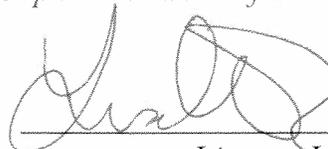
with such other information as he shall deem requisite.

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

this 17th day of June, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

