

REPORT ON EXAMINATION

OF

PUTNAM/NORTHERN WESTCHESTER

HEALTH BENEFITS CONSORTIUM

AS OF

JUNE 30, 2002

DATE OF REPORT

JUNE 30, 2003

EXAMINER

VICTOR ESTRADA

TABLE OF CONTENTS

<u>ITEM NO.</u>	<u>PAGE NO.</u>
1. Scope of examination	2
2. Description of Plan	3
A. Management	4
B. Territory and plan of operation	6
C. Stop loss insurance	6
D. Conflict of interest	7
E. Accounts and records	7
3. Financial statements	9
A. Balance sheet	9
B. Statement of revenue, expenses and net worth	10
4. Premiums receivable	11
5. Claims payable (including IBNR)	11
6. Claim stabilization reserve and reserve for other obligations	13
7. Contingency reserves	13
8. Market conduct	15
A. Claims processing oversight	15
B. Utilization review	18
C. Explanation of benefits statements	21
D. Grievances	23
9. Conclusion	23
10. Compliance with prior report on examination	24
11. Summary of comments and recommendations	25



STATE OF NEW YORK
INSURANCE DEPARTMENT
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NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

June 30, 2003

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the directions contained in Appointment Number 21937, dated September 5, 2002, annexed hereto, I have made an examination into the condition and affairs of Putnam/Northern Westchester Health Benefits Consortium, a municipal cooperative health benefit plan licensed under the provisions of Article 47 of the New York Insurance Law at its home office located at 200 BOCES Drive, Yorktown Heights, New York 10598. The following report thereon is respectfully submitted.

Wherever the terms "PNW", "the Consortium" or "the Plan" appear herein, without qualification, they should be understood to refer to Putnam/Northern Westchester Health Benefits Consortium.

This examination has determined that the Plan was insolvent in the amount of (\$3,111,673), and its contingency reserve of \$3,513,300 was impaired in the amount of (\$6,624,973) as of June 30, 2002. (See item 7 herein.)

1. SCOPE OF EXAMINATION

A report on organization was issued as of March 31, 1998. This examination covers the period from July 1, 1998 through June 30, 2002. Transactions subsequent to this period were reviewed where deemed appropriate. It should be noted that the Plan operates on a fiscal year, which ends on June 30th.

The examination comprised a verification of assets and liabilities as of June 30, 2002, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

- History of the Plan
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of the Plan
- Reinsurance
- Accounts and records
- Financial statements
- Market conduct activities

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 PLAN

The Plan is a multi-employer self-funded health benefits program operated exclusively for the benefit of the employees/retirees and their dependents, of Component School Districts (“CSD”) and the Board of Cooperative Educational Services (“BOCES”). The Plan has been in existence since 1982 and is composed of fourteen school districts. It was issued a certificate of authority on November 1, 1999, pursuant to the provisions of Article 47 of the New York Insurance Law.

The Plan participants are as follows:

Brewster CSD	Putnam Valley CSD
Briarcliff CSD	Somers CSD
Croton-Harmon CSD	Yorktown CSD
Hendrick – Hudson CSD	Haldane CSD
Lakeland CSD	Peekskill CSD
Mahopac CSD	Chappaqua CSD
Putnam-Northern Westchester	Garrison CSD
BOCES	

The Plan’s home office is located at 200 BOCES Drive, Yorktown Heights, New York 10598. At this location, all administrative functions are performed, except certain claims functions detailed below.

The Plan entered into administrative services agreements, whereby certain third party administrators process health benefit claims submitted. For the fiscal year ended June 30, 2002, the Plan had administrative services agreements with the following:

- (1) Aetna Life Insurance Company – Claims processing
- (2) Segal Company – Claims review

The Plan is billed an administration fee by the third party administrators (TPA) for services rendered.

A. Management

Pursuant to its Municipal Cooperation Agreement and Joint Governance Board Agreement, the management of the Plan is vested in a board of trustees. The Municipal Cooperation Agreement of the Plan specifies that the board of trustees shall consist of five individuals who have been selected by the majority of Plan members, and shall serve unless and until removed from office by the majority of Plan members.

At June 30, 2002, the five members of the board of trustees, together with their principal business affiliations, were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
David Chapman New Windsor, NY	Trustee, Mahopac School District
Dr. Thomas Higgins Brookfield, CT	Trustee, President BOCES, Putnam/Northern Westchester BOCES
Dr. Mark Lewis Carmel, NY	Trustee, Brewster Central School District
Dr. Joseph Sabatella Mahopac, NY	Trustee, Mahopac School District
Henrietta Starace Chappaqua, NY	Trustee, Secretary, Chappaqua Central School District

A review of the attendance records at joint governance board meetings held during the period under examination revealed that meetings were generally not well attended. Joseph Sabatella, Mark Lewis and Mike McDowell failed to attend at least one-half of the board meetings 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 policy decisions may be reached by the board. Board members who fail to attend at least one-half of the board's meetings, unless appropriately excused, do not fulfill such criteria. It should be noted that Mike McDowell was replaced by Winnie McCarthy in December 2002.

It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.

The following were the principal officers of the Plan as of June 30, 2002:

<u>Name</u>	<u>Title</u>
Dr. Thomas Higgins	President
Henrietta Starace	Secretary
Linda Carpenter	Chief Financial Officer

B. Territory and Plan of Operation

As of June 30, 2002, the Plan held a certificate of authority to operate the business of a municipal cooperative health benefit plan as authorized by §4704 of the New York Insurance Law in the counties of Putnam and Westchester.

The Plan's enrollment consisted of 7,363 members at June 30, 2002, which represents a 7% increase from June 30, 2001, when the enrollment level was 6,904.

C. Stop Loss Insurance

§4705(d)(5)(B)(iii) of the New York Insurance Law requires that the Plan maintain a stop-loss policy or policies, to the extent required by §4707 of the New York Insurance Law.

§4707(a)(1) and (2) of the New York Insurance Law state in part:

“(a) The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:

(1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year; and

(2) specific stop-loss coverage with a 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.”

At June 30, 2002, the Plan did not maintain the stop-loss coverage required by Section 4707(a) of the New York Insurance Law. However, in February 1997, the Plan received a letter from the Superintendent waiving the requirement to purchase stop-loss insurance pursuant to §4707(b) of the New York Insurance Law, “as long as the Plan maintained its present size and

financial condition.” Subsequently, in 2001, and again in 2002, due to its deteriorating financial condition, the Plan was directed by the Department to either obtain stop-loss insurance coverage, or establish the higher reserves specified by §4707(b)(1) of the New York Insurance Law. The matter is detailed further herein under Item 5 of this Report.

It is recommended that the Plan maintain the required stop-loss policies in accordance with §4707(a) of the New York Insurance Law or request a waiver as set forth in §4707(b)(1) of the New York Insurance Law.

Subsequent to the exam date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department.

D. Conflict of Interest

The Plan does not maintain a code of ethics, nor does it require its officers or trustees to annually complete conflict of interest statements.

It is recommended that the Plan adopt a formal code of ethics and require that its directors and trustees annually sign conflict of interest statements.

E. Accounts and Records

A review of the Plan’s Schedule F (“Claims Payable Analysis”) in its filed annual statement with the Department for the fiscal year-end June 30, 2002, revealed that the Plan incorrectly prepared Schedule F. Specifically the following was noted:

- Contrary to the annual statement instructions, the Plan incorrectly reported “paid claims” rather than “incurred claims” in its filed annual statement. In addition, this error affected Report #2, statement of revenue, expenses and net worth, of the annual statement. When the examiners brought this to the attention of the Plan, the affected pages of the annual statement were corrected and submitted to the Department in February of 2003.

It is recommended that the Plan take the necessary steps to complete its Schedule F (“Claims Payable Analysis”) and Report #2, Statement of Revenue, Expenses and Net Worth, in accordance with the annual statement instructions.

- The Plan consistently failed to follow the annual statement instructions with regard to the preparation of the “Net Worth” section of its filed annual statement and reported the aggregate increase/(decrease) in retained earnings instead of the details, as called for in the annual statement instructions.

It is recommended that the Plan take the necessary steps to complete the Net Worth section of the annual statement in accordance with the annual statement instructions.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination and as reported by the Plan in its filed June 30, 2002 annual statement:

<u>Assets</u>	<u>Examination</u>	<u>Plan</u>	Net Worth Increase (Decrease)
Cash	\$ 8,252,110	\$ 8,252,110	
Short-term investment	6,882,836	6,882,836	
Premiums receivables	<u>112,530</u>	<u>163,843</u>	\$ (51,313)
Total assets	<u>\$15,247,476</u>	<u>\$15,298,789</u>	<u>(\$51,313)</u>
 <u>Liabilities</u>	 <u>Examination</u>	 <u>Plan</u>	
Accounts payable	\$ 136,149	\$ 136,149	
Claims Payable (incl. IBNR)	18,123,000	12,082,257	\$ (6,040,743)
Claim stabilization reserve	50,000	400,000	350,000
Reserve for other obligations	<u>50,000</u>	<u>400,000</u>	<u>350,000</u>
Total liabilities	<u>\$18,359,149</u>	<u>\$13,018,406</u>	<u>\$ (5,340,743)</u>
 <u>Net Worth</u>			
Contingency reserves	\$ 3,513,300	\$ 2,342,007	\$ 1,171,293
Retained earnings (fund balance)	<u>(6,624,973)</u>	<u>(61,624)</u>	<u>(6,563,349)</u>
Total net worth	<u>(3,111,673)</u>	<u>2,280,383</u>	<u>\$ (5,392,056)</u>
Total liabilities and net worth	<u>\$15,247,473</u>	<u>\$15,298,789</u>	

For the period under examination, the Internal Revenue Service has not performed any audits of the Plan's tax returns. The examiner is unaware of any potential exposure of the Plan to any further tax assessment and no liability has been established herein relative to such contingency.

This examination has determined that the Plan was insolvent in the amount of (\$3,111,673), and its contingency reserve of \$3,513,300 was impaired in the amount of (\$6,624,973) as of June 30, 2002. (See item 7 herein.)

B. Statement of Revenue, Expenses and Net Worth

A report on organization was issued as of March 31, 1998. This examination covers the period from July 1, 1998 to June 30, 2002. Reserves and unassigned funds decreased \$15,861,208 during the examination period, July 1, 1998 through June 30, 2002, detailed as follows:

<u>Revenue</u>		
Premiums	\$166,196,483	
Net investment income	5,226,235	
Aggregate write-ins	<u>824,318</u>	
Total revenue		<u>\$172,247,036</u>
<u>Expenses</u>		
Total medical and hospital expenses	172,333,543	
Administration expenses	<u>10,581,532</u>	
Total expenses		<u>182,915,075</u>
Net Loss		<u>\$ (10,668,039)</u>
<u>Changes in Net Worth</u>		
Net Worth as of June 30, 1998 per report on organization		\$ 12,749,535
	<u>Gains in Net Worth</u>	<u>Losses in Net Worth</u>
Net Loss		\$ (10,668,039)
Increase in estimated health claims payable		(6,040,743)
Adjustment in Article 47 Reserves	\$198,887	
Decrease in claim stabilization reserve and reserve for other obligations	700,000	
Increase in non-admitted assets	<u> </u>	<u>(51,313)</u>
Total gains and losses	<u>\$898,887</u>	<u>\$ (16,760,095)</u>
Net Decrease in Net Worth		<u>(15,861,208)</u>
Net Worth as of June 30, 2002 per report on examination		<u>\$ (3,111,673)</u>

4. PREMIUMS RECEIVABLE

The examination asset of \$112,530 is \$51,313 less than the \$163,843 reported by the Plan in its filed annual statement as of June 30, 2002.

The examination non-admitted this balance of \$51,313 due to the fact that it was more than ninety days over due as of June 30, 2002. Furthermore, the Plan had not made any collections on this account through the second quarter (December 31, 2002).

5. CLAIMS PAYABLE (INCLUDING IBNR)

The examination liability of \$18,123,000 is \$6,040,743 more than the \$12,082,257 reported by the Plan in its filed annual statement as of June 30, 2002. The reserves reported under this caption are required to be established pursuant to §4706(a) of the New York Insurance Law.

§4706(a) of the New York Insurance Law states in part:

“(a) the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan’s chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:

(1) a reserve for the payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year.”

The examination analysis of this liability was conducted in accordance with generally accepted actuarial standards and practices and utilized statistical information contained in the Plan’s internal records and in its filed annual and quarterly statements, as well as additional

information provided by the Plan. The analysis found the liability to be adequate. The entire examination increase in this liability is due to the inclusion herein of higher reserve requirements dictated by statute as follows:

§4707(b)(1) of the New York Insurance Law states in part:

“(b) Upon application to the governing board, the superintendent may waive the requirement for stop-loss insurance, in whole or in part, or modify the maximum retention amounts or attachment points for stop-loss insurance, provided that:

(1) the plan maintains reserve and surplus equal to or greater than one hundred fifty percent of the amounts specified in paragraphs **one** and five of subsection (a) of section four thousand seven hundred six of this article;”

As noted earlier herein, the Plan did not maintain stop-loss coverage as required by §4707(a). As a result, the Plan was subject to the higher reserve requirements as prescribed in §4707(b)(1) of the New York Insurance Law. The examination liability reflects an increase from twenty-five percent of incurred claims as set forth in §4706(a)(1) of the New York Insurance Law, to thirty-seven and one-half percent (150%).

It is recommended that the Plan maintain the required reserves as called for in §4707 of the New York Insurance Law.

Subsequent to the examination date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department.

6. **CLAIM STABILIZATION RESERVE AND
RESERVE FOR OTHER OBLIGATIONS**

The examination liability of \$100,000 is \$700,000 less than the \$800,000 reported by the Plan in its filed annual statement.

§4706(a)(3) and (4) of the New York Insurance Law state in part:

“(a) the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan’s chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:

(3) a claim stabilization reserve;

(4) a reserve for other obligations of the municipal cooperative health benefit plan,”

Based on the actuarial analysis described under item 5 above, and a review by the Plan, it was determined that these liabilities could be reduced to the examination amount.

7. **CONTINGENCY RESERVES**

The contingency reserve reported by the Plan in the amount of \$2,342,007 has been increased by \$1,171,293 to the amount of \$3,513,007. The examination amount reflects an increase from five-percent of earned premiums set forth in §4706(a)(5)(A) of the New York Insurance Law, to seven and one-half percent (150%), resulting from the application of the provisions of §4707(b) of the New York Insurance Law in order to address the lack of stop loss insurance.

§4706(a)(5)(A) of the New York Insurance Law states in part:

“(a) the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan’s chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:

(5) a surplus account, established and maintained for the sole purpose of satisfying unexpected obligations...which shall not be less than:

(A) five percent of the annual premium equivalents during the fiscal year...”

Further, §4707(b)(1) of the New York Insurance Law states in part:

“(b) Upon application to the governing board, the superintendent may waive the requirement for stop-loss insurance, in whole or in part, or modify the maximum retention amounts or attachment points for stop-loss insurance, provided that:

(1) the plan maintains reserve and surplus equal to or greater than one hundred fifty percent of the amounts specified in paragraphs one and **five** of subsection (a) of section four thousand seven hundred six of this article;”

It is recommended that the Plan maintain the required contingency reserve as called for in §4707(b)(1) of the New York Insurance Law.

The examination increase in the Contingency Reserve, combined with an increase in the Claims Payable Liability (see item 5 herein), both of which resulted from the lack of stop loss insurance coverage, resulted in the determination that the Plan is insolvent as of June 30, 2002.

Subsequent to the examination date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department.

8. MARKET CONDUCT

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 policyholders 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 major areas:

- A. Claims processing oversight
- B. Utilization review
- C. Explanation of benefits statements
- D. Grievances and appeals

The following are the examiner's findings:

A. Claims processing oversight

The examination included a review of the Plan's claims settlement practices and oversight of the claims adjudication process by Plan management. Aetna Life Insurance Company ("Aetna") is the Plan's third party administrator ("TPA") of claims. As such, Aetna is responsible for most aspects of claims settlement, including utilization review, grievances and appeals, and issuance of explanation of benefits statements. Almost all of the recommendations to Plan management included herein under the various Market Conduct subsections resulted from failures by Aetna to process claims in full compliance with applicable Insurance Law provisions. Therefore, the recommendations included herein also apply to Aetna in its role as TPA, and as a licensed insurer outside the scope of this report.

However, it must be emphasized that PNW management retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law, and therefore its management must be diligent in its oversight of the claims settlement function.

It is recommended that Plan management fulfill its responsibility for compliance with New York Insurance Department statutes, rules, and regulations, as regards claims settlement practices via stronger oversight over its TPA's practices.

It is further recommended that all claims settlement recommendations noted herein be immediately brought to Aetna's attention and remedied.

In addition, the provisions of the TPA agreement with Aetna or its successor should be strengthened to specifically address the processing of claims in compliance with New York Insurance Department statutes, rules and regulations, and Plan guidelines.

The Plan executed a contract with Segal Company ("Segal") to review the Aetna claims settlement process for claims processed during the period January 1 through September 30, 2001. The examiners utilized the administrative review and claims audit conducted by Segal on behalf of the Plan. In a report to the Plan, dated March 5, 2002, Segal noted numerous findings of its claims audit, including the following comments and recommendations:

- Aetna fell below industry standards for the performance measurements of: financial accuracy (dollar value), processing accuracy (number without payment or procedural error), payment accuracy (number free from payment error), and turnaround time (processed within 14 calendar days).

- Aetna should provide an outstanding refund report to the Plan on a monthly or quarterly basis. This report will allow the Plan to monitor the reason, frequency, financial impact, and recovery rate of overpayments. Aetna should provide explanations for excessive payments in order to dispel questions of inadequate processor training, administrative control measures, or incorrect system programming.
- Aetna should emphasize the importance of accurate application of copayments and provide training as necessary. A system report should be generated identifying additional claims affected by this error. Once the financial impact has been determined, Aetna and the Plan should discuss the most effective recovery effort.
- Aetna should generate a report identifying all eligible New York State facility claims to determine what steps are necessary to accurately administer (e.g. initial assessment, corrected assessment, or refund) the (HCRA) surcharge.*

* Based upon the Plan's selection, the New York Health Care Reform Act of 1996 ("HCRA") mandates that services provided by all hospitals, diagnostic and treatment centers, and certain freestanding clinical laboratories located in New York be subject to an 8.18% surcharge that is payable to the New York Department of Health.

- Aetna should investigate possible system enhancements that will facilitate the application of prior usual, customary, and reasonable allowances to ensure aged claims do not receive a higher level of benefit.
- Refund requests should be issued for identified overpayments. The underpayments should be reopened and reimbursement issued to the member or provider (copy to member) with an explanation for the additional payment.

Aetna was advised of Segal's findings.

It is recommended that Aetna comply with the comments and recommendations in the Segal report, and that the Plan's management receive a report from Aetna detailing all remedial action that has been implemented, or will be implemented, to address said comments and recommendations.

It is further recommended that the Plan or its TPA prepare a report identifying all HCRA eligible New York State facility claims during the examination period, and subsequent thereto, in order to determine its potential HCRA surcharge liability, and immediately effect payment to the New York Department of Health.

It is also recommended that the Plan, via Aetna as its TPA, implement immediate steps to accurately administer the surcharge.

It is recommended that the Plan obtain periodic reports from its TPA that measure claims processing accuracy and the timeliness of claim payments.

B. Utilization review

§4902, §4903 and §4904 of the New York Insurance Law set forth the minimum program standards and requirements for utilization review determinations and appeals of adverse determinations by utilization review agents, respectively.

All utilization reviews performed during 2002 were administered by Aetna, the Plan's TPA. The examiners reviewed thirteen utilization review cases for the fiscal year ended June 30,

2002. All files were reviewed to determine compliance with §4902, §4903 and §4904 of the New York Insurance Law.

§4903(b) of the New York Insurance Law states:

“(b) 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 insured or insured’s designee and insured’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

It is noted that for one of the six pre-certification cases reviewed, the Plan failed to complete the review and notification within three days, as required.

It is recommended that the Plan comply with §4903(b) of the New York Insurance Law and make utilization review determinations which require pre-authorization within three days of receipt of the necessary information.

§4903(e) of the New York Insurance Law states in part:

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

- (1) the reasons for the determination including the clinical rationale, if any;
- (2) instructions on how to initiate standard appeals and expedited appeals...
- (3) notice of the availability, upon request of the insured, or the insured’s designee, of the clinical review criteria relied upon to make such determination.”

It is noted that for four cases with adverse determinations, the examiner was unable to verify compliance with §4903(e) of the New York Insurance Law because Aetna, the Plan’s TPA, did not provide copies of the adverse determination letters. The utilization management system used by Aetna did not have the functional capacity to archive copies of adverse

determination letters during the period from May 2002 through September 2002. Since the files selected for review fell within the May to September 2002 time period, they do not contain a copy of the approval letter, but they do contain the correspondence history screen documenting the dates sent and recipients of the letter.

Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)(4)} states:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain:

(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed 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 clearly show the inception, handling and other disposition of the claim, including dates that forms and other documents were received.”

It is recommended that the Plan comply with Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)(4)}, by retaining all documentation necessary to verify a claim, for a period of six years, or until after the filing of the report on examination, whichever is longer.

Aetna states that beginning October 2002, its eTUMS utilization management system retains copies of the adverse determination letters.

Certain of the above violations were due to Aetna’s inability to extract certain information from its utilization management computer system. Subsequent to the exam date, Aetna began utilizing a new utilization management system that is expected to be able to retrieve certain archived data, thereby giving it the further capability to comply with the above statutes. However, the examination did not verify the capabilities of this new system.

The utilization review recommendations noted above are the result of the failure of Aetna, as the Plan's TPA, to process claims in a compliant manner. A previous recommendation was made herein regarding Plan management's oversight of the claims processing function.

C. Explanation of benefits statements ("EOB")

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

Overall, the Plan's EOBs are easy to read and understand. However, the following was noted:

§3234(b)(2), (3) and (7) of the New York State Insurance Law state in part:

"(b) The explanation of benefits form must include at least the following:

(2) the date of service.

(3) an identification of the service for which the claim is made.

(7)...a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

The Plan contends that it includes the date of service in the column titled “Bills Submitted”. This should be clarified by changing the column title to “Date of Service”.

The Plan does not include the information required by §3234(b)(3) and (7) on its EOBs. The service description is not sufficient and does not provide the recipient with enough information to determine the appropriation of the claim adjudication. Furthermore, subscribers and/or providers are not being properly informed of their appeal rights, in that there is no clear and specific information on where and how to submit an appeal, nor does it contain language on potential forfeiture of members’ rights.

It should be noted that subsequent to the examination date, the Plan, through its TPA, Aetna, provided the examiner with “sample” revised EOBs. The information and wording on these sample EOBs appear to comply with the requirements of the aforementioned Sections of §3234(b)(2) and (3). However, these EOBs had not been formally put in use at the time of the examiner’s review.

It is recommended that the Plan modify its EOBs to comply with §3234(b)(2), (3) and (7) of the New York Insurance Law.

This recommendation is the result of the failure of the Plan’s TPA, Aetna, to issue EOBs in a manner compliant with §3234(b) of the New York Insurance Law. A previous comment was made herein regarding Plan management’s oversight of the claims processing function.

D. Grievances

§4704(a)(8) of the New York Insurance Law states:

“(a) The superintendent shall issue a certificate of authority to a municipal cooperative health benefit plan if all of the following conditions, after examination and investigation, have been met to the superintendent’s satisfaction:

(8) the municipal cooperative health benefit plan has established a fair and equitable process for claims review, dispute resolution and appeal procedures including arbitration of rejected claims, and procedures for handling claims for benefits in the event of plan dissolution, which are satisfactory to the superintendent.”

The Plan has a grievance and appeals process included in its filed Plan Document, which appears to be “fair and equitable”. Subscribers are notified in the Plan Document to contact Aetna regarding grievances.

No notices were reviewed that communicated appeals rights to the members, beyond the notice in the Plan Document.

It is recommended that the Plan’s management evaluate Aetna’s implementation of the grievance process.

9. CONCLUSION

This examination has determined that the Plan was insolvent in the amount of (\$3,111,673), and its contingency reserve of \$3,513,300 was impaired in the amount of (\$6,624,973) as of June 30, 2002. (See item 7 herein.)

10. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained one comment and recommendation as follows
(page numbers refer to the prior report):

<u>ITEM</u>		<u>PAGE NO.</u>
N/A.	<p>It is the recommendation of this Department that the Plan (P-NWHBP) follow with due diligence the general instructions included in the Quarterly and Annual Statements.</p> <p>The Plan did not comply with this recommendation. A similar recommendation is made in this report.</p>	7

11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Insolvency</u>	
This examination has determined that the Plan was insolvent in the amount of (\$3,111,673), and its contingency reserve of \$3,513,300 was impaired in the amount of (\$6,624,973) as of June 30, 2002. (See item 7 herein.)	1, 9, 23
B. <u>Management</u>	
It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.	5
C. <u>Stop Loss Insurance</u>	
It is recommended that the Plan maintain the required stop-loss policies in accordance with §4707(a) of the New York Insurance Law or request a waiver as set forth in §4707(b)(1) of the New York Insurance Law.	7
Subsequent to the exam date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department.	
D. <u>Conflict of Interest</u>	
It is recommended that the Plan adopt a formal code of ethics and require that its directors and trustees annually sign conflict of interest statements.	7
E. <u>Accounts and Records</u>	
i. It is recommended that the Plan take the necessary steps to complete its Schedule F ("Claims Payable Analysis") and Report #2, Statement of Revenue, Expenses and Net Worth, in accordance with the annual statement instructions.	8
ii. It is recommended that the Plan take the necessary steps to complete the Net Worth section of the annual statement in accordance with the annual statement instructions.	8

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Claims Payable (including IBNR)</u>	
It is recommended that the Plan maintain the required reserves as called for in §4707 of the New York Insurance Law.	12
Subsequent to the examination date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department.	
G. <u>Contingency Reserve</u>	
It is recommended that the Plan maintain the required contingency reserve as called for in §4707(b)(1) of the New York Insurance Law.	14
Subsequent to the examination date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department.	
H. <u>Claims Processing Oversight</u>	
i. It is recommended that Plan management fulfill its responsibility for compliance with New York Insurance Department statutes, rules, and regulations, as regards claims settlement practices via stronger oversight over its TPA's practices.	16
ii. It is further recommended that all claims settlement recommendations noted herein be immediately brought to Aetna's attention and remedied.	16
iii. In addition, the provisions of the TPA agreement with Aetna or its successor should be strengthened to specifically address the processing of claims in compliance with New York Insurance Department statutes, rules and regulations, and Plan guidelines.	16
iv. It is recommended that Aetna comply with the comments and recommendations in the Segal report, and that the Plan's management receive a report from Aetna detailing all remedial action that has been implemented, or will be implemented, to address said comments and recommendations.	18
v. It is further recommended that the Plan or its TPA prepare a report identifying all HCRA eligible New York State facility claims during the examination period, and subsequent thereto, in order to determine its potential HCRA surcharge liability, and immediately effect payment to the New York Department of Health.	18
vi. It is also recommended that the Plan, via Aetna as its TPA, implement immediate steps to accurately administer the surcharge.	18

<u>ITEM</u>	<u>PAGE NO</u>
vii. It is recommended that the Plan obtain periodic reports from its TPA that measure claims processing accuracy and the timeliness of claim payments.	18
I. <u>Utilization review</u>	
i. It is recommended that the Plan comply with §4903(b) of the New York Insurance Law and make utilization review determinations which require pre-authorization within three days of receipt of the necessary information.	19
ii. It is recommended that the Plan comply with Section 243.2(b)(4) of Department Regulation 152 {11NYCRR 243.2(b)}, by retaining all documentation necessary to verify a claim, for a period of six years, or until after the filing of the report on examination, whichever is longer.	20
J. <u>Explanation of Benefits Statements (“EOB”)</u>	
It is recommended that the Plan modify its EOBs to comply with §3234 (b)(2),(3) and (7) of the New York Insurance Law.	22
This recommendation is the result of the failure of the Plan’s TPA, Aetna to issue EOBs in a manner compliant with §3243(b) of the New York Insurance Law. A previous comment was made herein regarding Plan management’s oversight of the claims processing function.	
K. <u>Grievances</u>	
It is recommended that the Plan’s management evaluate Aetna’s implementation of the grievance process.	23

Appointment No. 21937

**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:

Victor Estrada

as a proper person to examine into the affairs of the

Putnam/Northern Westchester Health Benefits Consortium

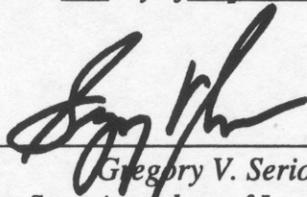
and to make a report to me in writing of the said

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 5th day of September 2002



Gregory V. Serio
Superintendent of Insurance

