

MARKET CONDUCT REPORT ON EXAMINATIONS

OF

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

AND

CDPHP UNIVERSAL BENEFITS, INC.

AS OF

DECEMBER 31, 2009

DATE OF REPORT

JULY 9, 2012

EXAMINER

KENNETH I. MERRITT

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

July 9, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 30579, and 30580, dated August 20, 2010, annexed hereto, I have made an examination into the affairs of Capital District Physicians' Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, and its wholly-owned subsidiary, CDPHP Universal Benefits, Inc., a Non-Profit Medical and Hospital Indemnity corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2009, and submit the following report thereon.

The examination was conducted at the home office of Capital District Physicians' Health Plan, Inc., and CDPHP Universal Benefits, Inc., located at 500 Patroon Creek Boulevard, Albany, New York.

Wherever the designations "CDPHP" or the "HMO" appear herein, without qualification, they should be understood to indicate Capital District Physicians' Health Plan, Inc.

Wherever the designations “UBI” or the “Plan” appear herein, without qualification, they should be understood to indicate CDPHP Universal Benefits, Inc.

Wherever the designations, “CDPHP Companies” or “CDPHP/HMO and UBI/Plan” appear herein, without qualification, they should be understood to indicate Capital District Physicians’ Health Plan, Inc. and CDPHP Universal Benefits, Inc., collectively.

Wherever the designation, the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services. On October 3, 2011, the New York State Insurance Department merged with the New York State Banking Department to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous market conduct examinations of the CDPHP Companies were conducted as a component of combined (financial and market conduct) examinations of the HMO and the Plan, as of December 31, 2004. This market conduct examination of the CDPHP Companies covers the five-year period from January 1, 2005 through December 31, 2009. Market conduct activities occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

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

A review was also made to ascertain what actions were taken by the CDPHP Companies with regard to the comments and recommendations related to the market conduct items contained in the prior reports on examination.

Separate risk-focused examinations regarding the financial condition of the CDPHP Companies were conducted as of December 31, 2009. The resulting reports on examination were filed on January 20, 2012 for both CDPHP and UBI (separate report for each entity).

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicated areas of weakness and/or that directly impacted the CDPHP Companies' compliance with the New York Insurance Law, the New York Public Health Law and related Regulations. The examination findings are described in greater detail within this report.

The most significant findings relative to this examination include the following:

- CDPHP Companies did not treat inpatient hospital stay denials, referred to as "Level of Care Change", as medical necessity denials that require issuance of first adverse determination letters as required by Sections 4903(3) of the New York Public Health and 4903(c) of the New York Insurance Law, relative to its concurrent utilization reviews.

- CDPHP did not fully comply with Section 4408-a(7) of the New York Public Health Law, when it failed to include appeals forms along with the HMO's determination of grievance notices provided to its enrollees.
- CDPHP Companies violated Section 4224(c) of the New York Insurance Law by making a prohibited offering of a gift card as an inducement for the public to contact the HMO and the Plan for information regarding insurance coverage.

3. DESCRIPTION OF THE CDPHP COMPANIES

Capital District Physicians' Health Plan, Inc.

The HMO was formed as a membership corporation on February 27, 1984, under Section 402 of the New York Not-for-Profit Corporation Law, and incorporated within the State of New York on April 13, 1984. The members consist of physicians licensed by the State of New York. CDPHP was licensed as a health maintenance organization (HMO) pursuant to Article 44 of the New York Public Health Law and obtained its certificate of authority to operate as an individual practice association (IPA) model HMO, effective April 30, 1984.

At December 31, 2000, membership in the HMO was opened up to physicians licensed by the State of New York, who applied for membership and met the criteria required by the HMO's by-laws to be accepted as member physicians.

The HMO is exempt from income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code.

CDPHP Universal Benefits, Inc.

The Plan was formed on January 2, 1997 and incorporated on February 28, 1997 pursuant to Section 402 of the New York State Not-for-Profit Corporation Law. It was subsequently licensed on August 14, 1997, pursuant to Article 43 of the New York Insurance Law for the purpose of providing indemnity based, prepaid comprehensive health care service through arrangements with physicians, hospitals, and other providers.

The Plan is a type D Corporation, as defined in Section 201 of the Not-for-Profit Corporation Law. The sole member of the Plan is CDPHP.

UBI was capitalized initially by means of a \$1,250,000 loan from its parent and sole member, CDPHP.

4. UTILIZATION REVIEW

Article 49 of the New York Public Health Law (“Public Health Law”), which applies to CDPHP, and Article 49 of the New York Insurance Law (“Insurance Law”), which applies to UBI, set forth the minimum utilization review program requirements including standards for: registration of utilization agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. The aforementioned Articles 49 establish the enrollee’s and insured’s right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an enrollee’s or insured’s health care provider shall have the right to request a standard appeal and an external appeal.

An examination review was made of the CDPHP Companies' utilization review files and denied claims classified as: (i) "medically unnecessary"; and (ii) "experimental or investigational" in 2009. The review revealed the following:

Concurrent review

Section 4903(3) of the New York Public Health Law states in part:

"A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date..."

Section 4903(c) of the New York Insurance Law states in part:

"A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date..."

(Underline added for emphasis).

CDPHP and UBI did not comply with Section 4903(3) of the Public Health Law and Section 4903(c) of the Insurance Law, respectively, based on instances wherein the HMO and Plan failed to notify the enrollee/insured within one business day of a determination relative to their concurrent utilization review cases. This finding was ascertained based on the examiner's review of a sample of the CDPHP Companies' concurrent utilization review cases made during 2009 that involved the practice of "Level of Care Change", used by both the HMO and the Plan.

Level of Care Change ("LOCC") occurs when an enrollee/insured ("patient") visits the hospital emergency room ("ER") with a complaint. After being in the ER for several hours and receiving initial examinations, with more examinations to be performed, the patient is admitted to an inpatient hospital stay. The following morning (day two), the patient receives the remaining examinations and by early afternoon, all of the examination results are ready for review, including the consultation between the patient and the attending physician. In some instances, the physician does not meet with the patient and the patient spends a second night in the hospital. The next morning (day three), the physician meets with the patient who is discharged from the hospital. Under both the Plan and the HMO's LOCC, the CDPHP Companies would pay for the first day inpatient hospital stay. However, in the case of the second night, UBI and CDPHP would deem this stay to be the result of the extensive waiting time and delay of the physician to meet with the patient. Accordingly, UBI and CDPHP would not pay the hospital for the second night at the higher priced inpatient hospital rate, but considered this to be an "observation" and adjusted the hospital's original billed amount to reflect the

significantly less costly “observation rate”. The CDPHP Companies indicated that their decision to pay at the observation rate was derived from Milliman’s diagnostic and procedure coding guidelines.

Although the CDPHP Companies indicated that the LOCC essentially involved a contractual arrangement with their hospital facilities, in 2009, at least one of the hospital facilities began questioning the HMO and the Plan about this practice. The CDPHP Companies contacted the Department about this matter and, over the course of several discussions, the Department advised the HMO and the Plan that any LOCC determinations made by them must be considered “medical necessity denials”.

The CDPHP Companies’ practice during the examination period of not treating the LOCC determinations as medical necessity denials, was based on their interpretation of the applicable statutes, specifically Sections 4900.8(c) and 4900.8(d) of the New York Public Health Law, as well as, Section 4900(h)(3) of the New York Insurance Law. However, when directed by the Department to treat the LOCC determinations as medical necessity denials, the HMO and Plan commenced doing so, effective January 1, 2011.

It is recommended that the CDPHP Companies continue to treat their LOCC determinations as medical necessity denials. Accordingly, the HMO and the Plan must comply with Section 4903(3) of the New York Public Health Law and Section 4903(c) of the New York Insurance Law by issuing to their enrollees/insureds notices of adverse determinations within one business day, respectively, as required, when denying medical necessity care to the enrollee/insured on the basis of CDPHP Companies’ concurrent utilization review process.

5. GRIEVANCES

Section 4408-a(7) of the New York Public Health Law states the following:

“7. The notice of a determination shall include: (i) the detailed reasons for the determination; (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination; and (iii) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.”

A review of the HMO’s standard first level determination notices revealed that CDPHP did not enclose an enrollee appeal form with its first determination correspondence.

It is recommended that CDPHP fully comply with Section 4408-a(7) of the New York Public Health Law and ensure that an appeal form is included along with its notice of determination of the grievance that CDPHP issues to its enrollee.

6. RECORD RETENTION

Parts 243.2(b)(2) and (5) of Department Regulation No. 152 (11 NYCRR 243.2(b)) state, in part:

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

(2) An application where no policy or contract was issued for six calendar years or until after the filing of the report on examination in which the record was subject to review, whichever is longer.

“(5) A licensing record for six calendar years after the relationship is terminated for each Insurance Law licensee with which the insurer establishes a relationship. Licensing records shall be maintained so as to show clearly the dates of appointment and termination of each licensee.”

CDPHP and UBI's record retention was deficient in the following areas:

i. Based on the examiner's review of a sample of agent and broker appointments and terminations during the examination period, the CDPHP Companies failed to provide copies of the producers' corresponding certificates of appointment and notices of termination.

It is recommended that CDPHP and UBI comply with Department Regulation No. 152 (11 NYCRR 243.2(b)(5)) by maintaining proper records of their agent certificates of appointment and agent termination notices.

ii. CDPHP's and UBI's record maintenance for their denied applications relative to the direct payment, small and large group (experienced rated group) lines of business, lacked a suitable process to allow the CDPHP Companies to specifically identify denied application forms for the examiners to review. According to the CDPHP Companies, they scan the applications only, and do not maintain any formal manual or system-generated listing of such denied applications. The scanned applications are warehoused within the CDPHP Companies' electronic MACESS System and it was not feasible for the Companies' management to search for the denied applications.

The CDPHP Companies' failure to maintain records of its declined commercial applicant cases, in a manner providing easy access, impeded the examiners from ascertaining the basis for the declinations and also for determining whether any of the individual and group applicants may have been improperly denied coverage.

It is recommended that the CDPHP Companies establish internal procedures that include either a manual or system-generated listing by applicant name, lines of business, date applied, date declined, and reason(s) for the declinations and that enable CDPHP and UBI to have easy access to their denied application forms.

7. ADVERTISING AND MARKETING

Section 4224(c) of the New York Insurance Law states, in part:

“Except as permitted by section three thousand two hundred thirty-nine of this chapter;... no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy or life insurance or annuity contract or policy of accident and health insurance,... any valuable consideration or inducement whatever not specified in such policy or contract;...”

A review of the CDPHP Companies’ advertising files revealed that CDPHP and UBI engaged in prohibited advertising by offering to the public “free \$5.00 Dunkin’ Donuts Cards” as an inducement for groups to call the CDPHP Companies for information regarding their health insurance coverages. The advertising materials included multiple mail offerings during 2008 and 2009.

It is recommended that the CDPHP Companies comply with Section 4224(c) of the New York Insurance Law and refrain from the practice of offering inducements for the purposes of attracting prospective enrollees/insureds to enroll with the HMO and the Plan.

8. CLAIMS REVIEW

A review was made of the CDPHP Companies claims processing procedures and internal controls to assure compliance with 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).

No discrepancies were noted.

9. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior reports on examination included forty-eight (48) market conduct related recommendations detailed as follows (page number refers to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
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CDPHP Report

Provider/TPA Arrangements

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| 1. | It is recommended that the HMO clarify within its provider contracts the methodology to be utilized in the calculation of withhold. | 19 |
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The HMO has complied with this recommendation.

Claim Processing

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| 2. | It is recommended that the HMO improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law. | 31 |
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The HMO has complied with this recommendation.

Explanation of Benefits Statements

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| 3. | It is recommended that CDPHP issue EOB forms that contain all of the requisite information required by Section 3234(b) of the New York Insurance Law for claims involving payments to members and non-participating providers. | 33 |
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The HMO has complied with this recommendation.

ITEM NO.**PAGE NO.****CDPHP Report**Explanation of Benefits Statements

4. It is recommended that CDPHP issue EOBs in all situations that require CDPHP to issue an EOB in accordance with Circular Letter 7(2005). EOBs should include all of the requisite information required by Section 3234(b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed. 34

The HMO has complied with this recommendation.

5. It is recommended that CDPHP issue an EOB for denied claims of non-participating providers and members relative to requests for missing information and change its policy by completing the adjudication process in a date certain in accordance with the requirement of Department of Labor, Part 2560 for non-participating providers/member claims. 35

The HMO has complied with this recommendation.

6. It is recommended that CDPHP revise its EOB forms to show the amount payable to participating providers instead of amount paid to ensure that EOB forms issued to its subscribers cross balance from the allowed amount to payable amount. 35

The HMO has complied with this recommendation.

7. It is recommended that CDPHP review all of its explanation codes and ensure that the text utilized on the EOP and EOB forms for denials or requesting missing information clearly indicates the reason for denial and what information is missing. In addition, EOP forms should indicate the subscriber's additional claim payment liability, if any. 36

The HMO has complied with this recommendation.

8. It is recommended that CDPHP cease using EOP forms to request missing information from its members. 36

ITEM NO.**PAGE NO.****CDPHP Report**Explanation of Benefits Statements

The HMO has complied with this recommendation.

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| 9. | It is recommended that CDPHP cease the practice of requesting its members provide a proof of payment during its adjudication of claims. | 36 |
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The HMO has complied with this recommendation.

Utilization Review

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| 10. | It is recommended that CDPHP comply with Section 4903.3 of the New York Public Health Law and issue a notice of the first adverse determination to its subscribers when CDPHP decides not to pay for medical services based on a concurrent review because medical services are no longer considered medically necessary. | 37 |
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The HMO has complied with this recommendation.

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| 11. | It is recommended that CDPHP revise its notice of first adverse determination to its subscribers/providers, when claims are denied retrospectively for medical reasons, to fully comply with the requirement of Section 4903.5 of the New York Public Health Law. | 39 |
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The HMO has complied with this recommendation.

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| 12. | It is recommended that CDPHP comply with Section 4903.5 of the New York Public Health Law and issue a notice of the first adverse determination letter to members and participating providers, when claims are denied retrospectively for medical reasons. | 40 |
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The HMO has complied with this recommendation.

ITEM NO.**PAGE NO.****CDPHP Report**Utilization Review

13. It is recommended that CDPHP comply with Sections 4903.5 and 4904.3 of the New York Public Health Law by ceasing the practice of requesting additional medical information in the acknowledgement letter of an appeal of medical adverse determination from its providers/members. 40

The HMO has complied with this recommendation.

14. It is recommended that CDPHP issue a notice of first adverse determination to its members at date certain as required by Section 4903.4 of the New York Public Health Law and DOL Regulation, Part 2560 relative to retrospective reviews of non-participating provider/member submitted claims and also, claims of participating providers in those cases where the member is financially liable for additional payment, when missing medical necessity information is not received. 41

The HMO has complied with this recommendation.

15. It is recommended that CDPHP include all retrospective utilization review appeals made by its participating providers on Schedule M of its annual statements in future filings to the New York Insurance Department. 41

The HMO has complied with this recommendation.

Underwriting and Rating

16. It is recommended that the HMO discontinue its practice of citing the need for New York Insurance Department approval for rate increases unless it cites specifically which portion of the rate or rate package is awaiting such approval. 42

The HMO has complied with this recommendation.

ITEM NO.**PAGE NO.****CDPHP Report**Underwriting and Rating

17. It is recommended that the HMO comply with Section 4308(g)(2) of the New York Insurance Law and state within its rate increase letters the specific rate or percentage increase that will be charged. 43

The HMO has complied with this recommendation.

Agents and Brokers

18. It is recommended that the HMO comply with New York Insurance Law Section 2114(a)(3) and only pay commissions to licensed agents of the HMO. 43

It is noted that the HMO has subsequently complied with this recommendation.

Contract Period – Non-Payment of Premiums

19. It is recommended that the HMO refrain from reversing claims for delinquent members when the HMO maintains the coverage beyond the grace period. It is further recommended that the HMO repay providers for those claims it inappropriately reversed and pay prompt pay interest where due. 44

It is noted that the HMO subsequently discontinued this practice and on December 7, 2005, the HMO repaid the claims which had been reversed under its former policy.

Third Party Claim Negotiator

20. It is recommended that the HMO take steps to ensure that its third party claim negotiator, Medcal, Inc., maintains a New York license to adjust claims in compliance with Section 2108(a)(1) of the New York Insurance Law if it is the intent of the HMO to continue to use the claims adjustment services of Medcal, Inc. 45

ITEM NO.**PAGE NO.****CDPHP Report**Third Party Claim Negotiator

The HMO has complied with this recommendation.

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| 21. | It is recommended that the HMO preclude its third-party negotiator from using prompt payment of claims as justification for the negotiation of discounted rates. Additionally, the implication that a reduced liability will occur if a negotiated settlement is agreed upon should only be stated in the text of the letter in those cases where an actual savings will occur. | 45 |
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The HMO has complied with this recommendation.

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| 22. | It is recommended that the negotiated agreement between the third party negotiator and the provider clearly indicate what charges may be billed and by whom. | 46 |
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The HMO has complied with this recommendation.

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| 23. | It is recommended that the negotiated agreement between the third party negotiator and the provider clearly spell out the terms of the agreement and indicate that a signature on the letter serves as an affirmation of that agreement. | 46 |
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The HMO has complied with this recommendation.

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| 24. | It is recommended that the HMO conduct an audit of its third party negotiator, Medcal. | 46 |
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The HMO has complied with this recommendation.

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| 25. | It is recommended that that the HMO comply with New York Regulation 152 (11 NYCRR 243.2(b)) and maintain a copy of its agreements with third party negotiator, Medcal, Inc. | 47 |
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The HMO has complied with this recommendation.

ITEM NO.**PAGE NO.****UBI Report**Explanation of Benefits Statements

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| 1. | It is recommended that UBI issue EOB forms that contain all of the requisite information required by Section 3234(b) of the New York Insurance Law for claims involving payments to members and non-participating providers. | 21 |
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The Plan has complied with this recommendation.

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| 2. | It is recommended that UBI issue EOBs in all situations that require UBI to issue an EOB. EOBs should include all of the requisite information required by Section 3234(b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed. | 22 |
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The Plan has complied with this recommendation.

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| 3. | It is recommended that UBI issue an EOB for denied claims of non-participating providers and members relative to requests for missing information and change its policy by completing the adjudication process in a date certain in accordance with the requirement of Department of Labor (DOL) Part 2560 for non-participating provider/member claims. | 22 |
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The Plan has complied with this recommendation.

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| 4. | It is recommended that UBI review all of its explanation codes and ensure that the text utilized on the EOP and EOB forms for denials or requesting missing information clearly indicates the reason for denial and what information is missing. In addition, EOP forms should indicate the subscriber's additional claim payment liability. | 23 |
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The Plan has complied with this recommendation.

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| 5. | It is recommended that UBI cease using EOP forms to request missing information from its members. | 23 |
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The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.****UBI Report**Explanation of Benefits Statements

6. It is recommended that UBI cease the practice of requesting its members for a proof of payment during its adjudication of claims. 23

The Plan has complied with this recommendation.

Utilization Review

7. It is recommended that UBI comply with Section 4903(c) of the New York State Insurance Law and issue a notice of the first adverse determination to its subscribers when UBI decides not to pay for medical services based on a concurrent review because medical services are no longer considered medically necessary. 25

The Plan has complied with this recommendation.

8. It is recommended that UBI revise its notice of first adverse determination to its subscribers/providers, when claims are denied retrospectively for medical reasons to fully comply with the requirement of Section 4903(e)(3) of the New York Insurance Law. 26

The Plan has complied with this recommendation.

9. It is recommended that UBI comply with Section 4903(e) of the New York Insurance Law and issue a notice of the first adverse determination letter to members and participating providers when claims are denied retrospectively for medical reasons. 27

The Plan has complied with this recommendation.

10. It is recommended that UBI comply with Sections 4903(e) and 4904(c) of the New York Insurance Law and cease the practice of requesting additional medical information in the acknowledgment letter of an appeal of medical adverse determination from its providers/members. 27

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.****UBI Report**Third Party Claim Negotiator

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| 11. | It is recommended that the Plan take steps to ensure that its third party claim negotiator, Medcal, Inc., maintains a New York license to adjust claims in compliance with Section 2108(a)(1) of the New York Insurance Law if it is the intent of the Plan to continue to use the claims adjustment services of Medcal, Inc. | 28 |
| | The Plan has complied with this recommendation. | |
| 12. | It is recommended that the Plan establish a HIPAA compliant Business Associate Agreement with its third party claims negotiator, Medcal, Inc. | 29 |
| | The Plan has complied with this recommendation. | |
| 13. | It is recommended that the Plan preclude its third-party negotiator from utilizing prompt payment of claims as justification for the negotiation of discounted rates. Additionally, the implication that a reduced liability will occur if a negotiated settlement is agreed upon should be stated in the text of the letter only in those cases where an actual savings will occur. | 29 |
| | The Plan has complied with this recommendation. | |
| 14. | It is recommended that the negotiated agreement between the third party negotiator and the provider clearly indicate what charges may be billed and by whom. | 29 |
| | The Plan has complied with this recommendation. | |
| 15. | It is recommended that the negotiated agreement between the third party negotiator and the provider clearly spell out the terms of the agreement and indicate that a signature on the letter serves as an affirmation of that agreement. | 30 |
| | The Plan has complied with this recommendation. | |
| 16. | It is recommended that the Plan conduct an audit of its third party negotiator, Medcal. | 30 |
| | The Plan has complied with this recommendation. | |

ITEM NO.**PAGE NO.****UBI Report**Recordkeeping

17. It is recommended that that the Plan comply with New York Regulation 152 (11 NYCRR 243.2 (b)) and maintain a copy of its agreements with the third party negotiator, Medcal, Inc. 30

The Plan has complied with this recommendation.

18. It is recommended that the Plan ensure that the letters used by Medcal clearly indicate for which corporate entity Medcal is negotiating. 31

The Plan has complied with this recommendation.

Rating

19. It is recommended that a checklist be utilized with separate check off areas for review of specific critical areas such as the construction of age/sex factors and underwriting discretion. 31

The Plan has complied with this recommendation.

20. It is recommended the Company institute procedures to confirm the accuracy of the age/sex data provided by new groups. 31

The Plan has complied with this recommendation.

21. It is recommended that Plan's underwriters prepare a short summary for the rationale behind the weight applied to each year in a group's medical history. 32

The Plan has complied with this recommendation.

Contract Period – Non-Payment of Premium

22. It is recommended that the Plan refrain from reversing claims for delinquent members when the Plan maintains the coverage beyond the grace period. It is further recommended that the Plan repay providers for those claims it inappropriately reversed and pay prompt pay interest where due. 32

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.****UBI Report**Advertising

23. It is recommended that the Plan comply with New York Insurance Department Regulation 34 (11 NYCRR 215.5(a)) by ensuring that all media and communications containing any information about the various products offered by the Plan or any of its subsidiaries clearly specify the product(s) each particular company is offering. 33

The Plan has complied with this recommendation.

10. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM.</u>	<u>PAGE NO.</u>
<p>A. <u>Utilization Review</u></p> <p>It is recommended that the CDPHP Companies continue to treat their LOCC determinations as medical necessity denials. According, the HMO and the Plan must comply with Section 4903.3 of the New York Public Health Law and Section 4903(c) of the New York Insurance Law by issuing to their enrollees/insureds notices of adverse determinations within one business day, respectively, as required, when denying medical necessity care to the enrollee/insured on the basis of CDPHP Companies' concurrent utilization review process.</p>	8
<p>B. <u>Grievances</u></p> <p>It is recommended that CDPHP fully comply with Section 4408-a(7) of the New York Public Health Law and ensure that an appeal form is included along with its notice of determination of the grievance that CDPHP issues to its enrollee.</p>	9
<p>C. <u>Record Retention</u></p> <p>i. It is recommended that CDPHP and UBI comply with Department Regulation No. 152 (11 NYCRR 243.2(b)(5)) by maintaining proper records of their agent certificates of appointment and agent termination notices.</p> <p>ii. It is recommended that the CDPHP Companies establish internal procedures that include either a manual or system-generated listing by applicant names, lines of business, date applied, date declined, and reason(s) for the declinations and that enable CDPHP and UBI to have easy access to their denied application forms.</p>	10 11
<p>D. <u>Advertising and Marketing</u></p> <p>It is recommended that the CDPHP Companies comply with Section 4224(c) of the New York Insurance Law and refrain from the practice of offering inducements for the purposes of attracting prospective enrollees/insureds to enroll with the HMO and the Plan.</p>	11

Appointment No. 30579

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Kenneth Merritt

as a proper person to examine into the affairs of the

Capital District Physicians Health Plan

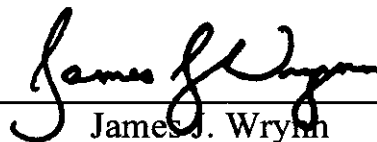
and to make a report to me in writing of the condition of the said

Plan

with such other information as he shall deem requisite.

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

this 20th day of August, 2010



James J. Wrynn
Superintendent of Insurance



Appointment No. 30580

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Kenneth Merritt

as a proper person to examine into the affairs of the

CDPHP-Universal Benefits, Inc.

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

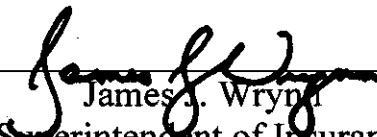
Company

with such other information as he shall deem requisite.

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

this 20th day of August, 2010




James J. Wrynn
Superintendent of Insurance