

MARKET CONDUCT REPORT ON EXAMINATION

OF

EXCELLUS HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2007

DATE OF REPORT

MAY 19, 2011

EXAMINER

BRUCE BOROFSKY, CFE

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Andrew M. Cuomo
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Honorable James J. Wyrnn
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May 19, 2011

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 22747, dated November 17, 2008, attached hereto, I have made an examination into the affairs of Excellus Health Plan, Inc., a non-profit health service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2007, and submit the following report thereon.

The examination was conducted at the home office of Excellus Health Plan, Inc., located at 165 Court Street, Rochester, New York.

Wherever the designations the "Plan" or "Excellus" appear herein, without qualification, they should be understood to indicate Excellus Health Plan, Inc., a wholly-owned subsidiary of Lifetime Healthcare, Inc.

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

1. SCOPE OF THE EXAMINATION

A previous market conduct examination was conducted as of October 10, 2003. A separate financial examination was conducted as of December 31, 2003, and filed on March 21, 2005. It included a review of certain “market conduct” items. This market conduct examination covers the period from October 10, 2003 through December 31, 2007. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

This report contains the significant findings of the examination and 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 Plan with regard to comments and recommendations contained in the prior market conduct reports on examination.

A separate examination regarding the financial condition of the Plan was conducted as of December 31, 2008, and a separate financial report on examination will be issued thereon.

2. EXECUTIVE SUMMARY

The findings and recommendations noted herein reflect Excellus' failure to comply with New York Insurance and New York Public Health Laws and regulations as follows:

- The Plan failed to provide claims data in a complete and timely manner, which hindered the examiner's ability to conduct a complete and accurate assessment of the Plan's treatment of policyholders.
- Excellus failed to comply with Section 4303(a)(2) of the New York Insurance Law when it denied coverage for emergency treatment to its members in one hundred and sixty-six (166) cases.
- Excellus did not comply with Section 3234 of the New York Insurance Law, when in 337,689 instances, it failed to send explanation of benefits statements to members who had submitted pharmaceutical claims involving deductibles or co-insurance.
- At least 163,253 of Excellus' explanation of benefits statements (EOBs) were in violation of Section 3234 of the New York Insurance Law for the following reasons:
 - In some cases the Plan did not send EOBs, as required.
 - In other cases, the EOBs did not contain all of the required information, or were unclear as to content.
- There were at least 42,846 occasions in which Excellus violated Section 3224-a of the New York Insurance Law (Prompt Payment Law) when it failed to adjudicate claims timely and/or failed to pay appropriate interest during the period January 1, 2007 through December 31, 2007. This total represents the results of the examiner's analyses of two of the Plan's seven claim systems.
- There were multiple issues discovered during the examiner's review of Excellus' compliance with Article 49 of the New York Insurance Law (Utilization review and External appeals) that resulted in violations of such sections of the New York Insurance Law.
- Excellus did not retain images of the explanation of benefits statements it sent to its members, thus violating Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and Part 216.11 of Department Regulation No. 64 (11 NYCRR 216.11).

The above findings are described in greater detail in the remainder of this report.

3. DESCRIPTION OF THE PLAN

Excellus Health Plan, Inc. is a not-for-profit health service corporation organized and licensed under Article 43 of the New York Insurance Law. The Plan also holds a Certificate of Authority under Article 44 of the New York Public Health Law, as a health maintenance organization (HMO). The Plan operates using three assumed names for its Article 43 business, Excellus BlueCross BlueShield, Univera HealthCare and Univera. The assumed names for the Article 44 business are Upstate HMO and Univera Healthcare HMO.

At the examination date, Excellus, Inc. was the sole member of Excellus Health Plan, Inc. Excellus Inc. changed its name on January 23, 2004 to Lifetime Healthcare, Inc. d/b/a The Lifetime Healthcare Companies. Excellus Health Plan, Inc. is the surviving entity resulting from the mergers of the Blue Cross/Blue Shield Plans in the Rochester, Central New York, and Utica-Watertown regions and HMOs in Central and Western New York including HMO-CNY and Univera Healthcare of Central and Western New York.

4. FACILITATION OF THE EXAMINATION

The following are examples whereby examination requests were not provided in a complete or timely manner:

- In many cases, the Plan failed to provide full responses to the examiner's requests for information. In one example, at the onset of the examination, the examiner requested the claims data from all of the Plan's claim adjudication systems. For one of those systems, containing several million claims, it was revealed after the review had been completed, that only one adjudication code per claim line was provided, while the system contained, up to nine. This failure to provide full and complete claims data to the examiner resulted in significant issues with regard to the assessment of such claims data. As an example, the examiners were unable to obtain assurance that, when claims with certain adjudication codes were extracted from the claim data, that all such claims had been obtained.
- On several occasions, the Plan provided information that was incorrect. In one example during the testing of claims for the timeliness of payments, the Plan changed its response three times, resulting in significant additional work for the examiner, and delaying the outcome of the testing. In another example, when asked for evidence that an explanation of benefits statement (EOB) had been sent to a member for a particular denial, the Plan indicated that no EOB had been produced because EOBs were not statutorily required for that denial code. When it was pointed out that EOBs are required for that particular code, the Plan acquiesced and had EOBs printed up as evidence that they had been sent. In addition, when the Plan was requested to provide certain documents associated with third party service provider contracts, it indicated that the documents did not exist. When it became clear to the Plan that failure to maintain the documents could be a statutory violation, the documents were provided.

It is recommended that the Plan enhance its procedures to ensure it facilitates examination requests completely and in a timely manner.

5. UNDERWRITING AND RATING

Excellus utilizes a formula filed with and approved by the Department for its Large Group Experience Rated business that contains certain factors that permit the Plan to adjust the final rate based on written criteria, as included within the filed formula. It is the Department's position that such adjustment factors are permitted but that these adjustments should be utilized as clearly defined within the formula. The examiner's review of the Plan's rating indicated that, in certain instances, the Plan lowered the rate using criteria not included in the formula.

It is recommended that Excellus abide by its Large Group Experience Rated formula filed with and approved by the Department.

6. CLAIMS

A. Claims Processing

Excellus utilizes seven different claim systems to adjudicate claims. Many of these systems were acquired as the Plan merged or acquired other insurers. Each of the systems adjudicates different types of claims, including full indemnity, HMO and Medicare. Their use is also broken out by region. The Plan is engaged in a "Transformation Project" in which it intends to consolidate its claims processing into one primary system, a new, enhanced FACETS platform. The examiner reviewed a total of 222 claims; 97 from the TOPS system and 125 from the old FACETS system from the period January 1, 2007 through December 31, 2007. These particular systems were

chosen as they are the primary systems utilized by the Plan and were deemed to be representative of the various claims systems. The sample items were used to test for verification of eligibility, fee schedules, co-payments, deductibles, treatment plan authorization, explanation of benefits statements (EOBs) and, where appropriate, compliance with Article 49 of the New York Insurance Law (Utilization review / External appeals).

The sample included ten claims that had been denied with the explanation, “Service not covered when rendered by this provider”. Four of the ten sampled claims were denied erroneously, because the claims were entered manually into the claim system with a revenue code instead of an appropriate Healthcare Common Procedures Code (“HCPC”).

The sample also included three claims adjudicated with the explanation, “*Priced at 25% reasonable and customary*”. These claims require manual fee schedule pricing. Of the three claims reviewed, an inaccurate payment rate was paid on two such claims. A total of eight other claims were erroneously denied for various reasons. Several of the reviewed claims were detected and corrected by the Plan prior to the completion of the examination.

It is recommended that the Plan take steps to ensure that those claims requiring manual pricing are priced accurately.

Certain Excellus subscriber contracts contain the following language to describe the procedures to be followed when claims are received that do not have sufficient information to permit final claim adjudication:

“If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.”

Throughout the examiner’s review of claims, multiple examples were found where claims were denied, seeking additional information that was not received and the claims were not closed. These instances are a violation of the Plan’s subscriber contracts.

In addition, it is the Department’s position that coverage offered by the Plan is subject to United States Department of Labor Regulation No. 29 CFR (2560.503-1(f)(2)(iii)(B)), which requires similar procedures as those described within the Excellus subscriber contracts. Excellus maintains that, at the time of the examination, it was not subject to the cited regulation but acknowledges that, with federal adoption of the Patient Protection and Affordable Care Act in 2010 (“PPACA”), it has since become subject to the federal requirement.

It is recommended that the Plan follow the procedures defined in its subscriber contracts by sending formal denials in the circumstance that additional information is not received after a request for such has been made.

It is also recommended that the United States Department of Labor be requested to clarify the applicability to health insurers of United States Department of Labor Regulation No. 29 CFR (2560.503-1(f)(2)(iii)(B)), prior to the implementation of PPACA.

B. Mandated Benefits

In addition to the general claims review described above, claims were extracted from the two claim systems, TOPS and FACETS, in order to test for compliance with Section 4303 of the New York Insurance Law, which mandates coverage of certain health benefits.

Section 4303(a)(2) of the New York Insurance Law establishes the requirement that every contract issued provide coverage, “for services to treat an emergency condition in hospital facilities.”

During the review of claims it was noted that two claims for emergency services were denied as “not a covered benefit”, when such benefits were in fact covered under the contract provisions. As a result, the denials are in violation of the above cited Law. When asked how these errors occurred, the Plan indicated it was due to a systems error that it had previously identified and corrected, though some claims were missed during that effort. A re-evaluation by the Plan, as a result of the examiner’s review, found an additional 166 claims that were denied inappropriately, in violation of Section 4303(a)(2) of the New York Insurance Law.

It is recommended that Excellus comply with the requirements of Section 4303(a)(2) of the New York Insurance Law.

The prior examination contained a similar recommendation although the cause for the violation was not the same.

Also noted during the review for mandated benefits were two claims from students covered under their school system's health policies. Those claims were denied due to the school system's failure to submit a student accident form, as required under the policy. When the claims were denied, however, only the provider was notified of the school system's oversight. The school system, which was the party responsible for correcting the error, was never notified.

It is recommended that Excellus send denial notices to the insured school systems, in those instances where claims have been denied as a result of the school system's failure to submit an accident report form as required under the policy.

7. EXPLANATION OF BENEFITS STATEMENTS

New York Insurance Law §3234(a) states in part:

“Every insurer, including health maintenance organizations... is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy...”

During the review of claims it was noted that, in violation of Section 3234(a) of the New York Insurance Law, Excellus did not send explanation of benefits statements (EOBs) to members in response to 337,689 submitted claims involving the purchase of pharmaceutical drugs, where the members had contributed to the cost of the drug through either co-insurance or a deductible. While there are certain circumstances under which

EOBs need not be sent, involvement of either co-insurance or a deductible disqualifies all claims from that exemption.

It is recommended that Excellus comply with the requirements of Section 3234(a) of the New York Insurance Law and send explanation of benefits statements to members when those members have purchased pharmaceutical drugs and either co-insurance or a deductible is involved, or when an EOB is requested.

Section 3234(b) of the New York Insurance Law states:

“The explanation of benefits form must include at least the following:

- (1) the name of the provider of service the admission or financial control number, if applicable;
- (2) the date of service;
- (3) an identification of the service for which the claim is made;
- (4) the provider’s charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
- (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.”

During the review of claims, explanation of benefits statements were reviewed for compliance with the above cited Law. The following was noted for claims processed by the Plan's FACETS claim system:

- In multiple cases, the pertinent EOB did not include an explanation as to why a portion of the claim was denied. The Plan indicated this was an anomaly that it was not able to explain. Such omission is a violation of Section 3234(b)(6) of the New York Insurance Law.
- In those instances where EOBs required adjustments, the presentation of the adjustment on the EOB was not clear. This is a violation of Section 3234(b)(6) of the New York Insurance Law.
- When the Plan is required to recreate copies of adjusted claims, the EOBs included a line that referenced the earlier claim number, but the actual claim number of the adjusted claim did not appear on such EOB.
- The Plan's EOBs did not consistently present the accumulated year-to-date deductible or the amount of the remaining deductible. This is a violation of Section 3234(b)(5) of the New York Insurance Law.
- EOBs should reflect the amount billed for each procedure and then show all deductions from that original total so that the reader has a clear understanding of his or her liability. In some cases, the totals on the EOBs did not balance. That is, the billed amount minus the amounts deducted from that total did not equal the amount paid to the provider or due from the member. As a result, the liability for portions of the billed amounts was not always clearly assigned. This is a violation of Sections 3234(b)(5) and 3234(b)(6) of the New York Insurance Law.
- EOBs were presented with explanations that did not always clearly explain the exact cause for the denial. One example is the explanation, "Denied after medical review", although the actual reason was determined that the claims were denied because the treatments had not been pre-authorized. This is a violation of Section 3234(b)(6) of the New York Insurance Law.
- The Plan used two descriptions for service codes "Ancillary Services" and "Misc. Medical Equipment" to explain the billed amounts. These descriptions were not specific, as required by Section 3234(b)(3) of the New York Insurance Law, as cited above.

In order to enumerate these deficiencies, a statistical sample of claims was selected from the Plan's FACETS claims system for the period January 1, 2007 through December 31, 2007. From this sample, the EOBs were obtained and tested to determine compliance with Section 3234 of the New York Insurance Law.

The results of such review testing are included in the table below:

Total Population of claims	765,614
Sample Size	167
Number of claims with violations	47
Calculated violation rate	28.14%
Upper violation limit	34.96%
Lower violation limit	21.32%
Calculated claims in violation	215,472
Upper limit claims in violation	267,691
Lower limit claims in violation	163,253

It is recommended that Excellus issue Explanation of Benefits statements that contain all of the information that is required under Section 3234 of the New York Insurance Law and that such information be presented clearly and completely.

With regard to claims reviewed on its other claim systems, it was noted that, for some of these systems, Excellus did not report within its EOBs, the amount of the HCRA (Health Care Reform Act) surcharge that may be the responsibility of the member. This surcharge can be significant when co-insurance or a deductible is involved, and should be reported on the Plan's EOBs.

While not directly required under New York statute, it is recommended that Excellus disclose the surcharge that is the responsibility of the subscriber on its Explanation of Benefits statements.

8. PROMPT PAYMENT LAW COMPLIANCE

Section 3224-a of the New York Insurance Law (Prompt Pay Law) requires all insurers to pay undisputed health care claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

“Except in a case where the obligation of an insurer to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered.”

§3224-a (b) of the New York Insurance Law states that:

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

§ 3224-a(c) of the New York Insurance Law states in part that:

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

A review of the Plan’s compliance with Section 3224-a of the New York Insurance Law was performed by the examiner for claims adjudicated during the period January 1, 2007 through December 31, 2007. A statistical sample of claims paid on the TOPS and FACETS systems during 2007 was selected from a population of claims that were paid more than 45 days or denied more than 30 days from receipt. The sample size for each of the three populations (Section 3224-a(a), (b), (c)) described herein was comprised of 167 unique transactions.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purposes of this report. The receipt of a “claim”, which is defined by Excellus as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It is possible, through the computer software used by the examiners, to match or “roll-up” all procedures on the original form into one line. Adjustments to claims are linked to the original claim, and are thus indiscernible

without an in-depth look at the claim history.

To ensure completeness of the claims population, the total dollars paid and the total number of paid claims were accumulated and reconciled to the financial data reported by Excellus for the period January 1, 2007 through December 31, 2007.

The following chart illustrates the Plan's prompt payment compliance for claims adjudicated within the TOPS system, as determined by this examination:

	§3224-a(a)	§3224-a(b)	§3224-a(c)
Total Population of claims	96,198	71,632	7,372
Sample Size	167	167	167
Number of claims with violations	38	75	14
Calculated violation rate	22.75%	44.91%	8.38%
Upper violations limit	29.11%	52.45%	12.59%
Lower violations limit	16.40%	37.37%	4.18%
Upper limit claims in violation	21,889	32,170	618
Lower limit claims in violation	15,772	26,766	308

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

The following chart illustrates the Plan's prompt payment compliance for claims adjudicated within the FACETS claims system, as determined by this examination:

	§3224-a(a)	§3224-a(b)	§3224-a(c)
Total Population of claims	36,599	24,939	17,168
Sample Size	167	167	167
Number of claims with violations	50	67	1
Calculated violation rate	29.94%	40.12%	.60%
Upper violations limit	36.89%	47.55%	1.77%
Lower violations limit	22.99%	32.69%	0%
Upper limit claims in violation	13,500	11,859	304
Lower limit claims in violation	8,415	8,152	1

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

The claim populations for the Plan were divided into medical and hospital claim segments. A random statistical sample was drawn from each segment, for each entity. It should be noted that for the purpose of this analysis, medical costs characterized by Excellus as “Medicare/Medicaid”, “Capitated Payments”, “Self insured”, as well as other claims not under the regulatory authority of the Department for Prompt Pay purposes were excluded from the examiner’s review. After removal of those claims, the total number of 2007 claims from which the TOPS sample was drawn was 7,401,810. The total number of 2007 claims from which the FACETS sample was drawn was 765,614.

It is recommended that the Plan improve its internal claim procedures to ensure compliance with Sections 3224-a (a), (b) and (c) of the New York Insurance Law.

The prior report contained a similar recommendation.

Prior to and during this examination period, Excellus was found to be in violation of Section 3224-a of the New York Insurance Law for prompt payment violations cited by the Department’s Consumer Services Bureau. The Plan executed stipulations with this Department, which included the following penalties for prompt payment claims violations for the following periods:

<u>Period</u>	<u>Assessed Penalty</u>
10/1/03 - 3/31/04	\$ 2,800.00
4/01/04 - 9/30/04	\$ 4,800.00
10/1/04 - 3/31/05	\$ 2,000.00
4/1/05 - 9/30/05	\$ 1,900.00
10/01/05 - 3/31/06	\$ 3,200.00
4/1/06 - 9/30/06	\$ 3,800.00
10/1/06 - 3/31/07	\$ 5,300.00
4/1/07 - 9/30/07	<u>\$ 14,400.00</u>
Total	<u>\$ 38,200.00</u>

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) states the following:

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

The prior examination noted that the Plan’s filed Schedule H (Aging Analysis of Claims Unpaid) contained incorrect totals relative to its year-end claim counts and aging statistics. This examination revealed that the Plan did not include claims data for the period ending December 31, 2007, within its filed December 31, 2007, Schedule H. It was also noted that the Plan did not comply with Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and retain the pertinent supporting claims data as documentation for such schedule.

It is recommended that the Plan take the necessary steps to ensure that accurate paid claim amounts and claim counts are included in its future filed Schedules H. The prior report contained a similar recommendation.

Further, it is recommended that the Plan comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and maintain the adequate support documentation relative to the information reported within its filed Schedules H.

9. UTILIZATION REVIEW

Article 49 of the New York Insurance Law sets forth the minimum utilization review program requirements, including standards for: registration of utilization review agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. Article 49 of the Public Health Law, which is identical to Article 49 of the New York Insurance Law, applies to the Plan's HMO business. These statutes establish the enrollee'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 health care provider has the right to request a standard appeal and an external appeal.

Section 4903(e) of the New York Insurance Law requires the following, in part:

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

- (1) The reason for the determination including the clinical rationale, if any;
- (2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article...”

During the general review of claims, it was noted that one claim was denied with the reason code, “AZJ Not Medically Necessary”, but the notice of adverse determination required by Section 4903(e) of the New York Insurance Law was not sent to the affected member.

An examination review was made of Excellus' utilization review files and denied

claims that fell into the categories of “not medically necessary”, “experimental” or “investigational” for year 2007.

Section 4903(e) of the New York Insurance Law establishes a list of information that must be provided to the insured when treatment is determined to be not medically necessary.

Section 4903(e)(1) of the New York Insurance Law requires the following:

“the reasons for the determination including the clinical rationale, if any.”

In one sampled case, the medical necessity denial did not include such information.

Section 4903(e)(3) of the New York Insurance Law states the following in part:

“...notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on appeal.”

In one case that the examiner reviewed, the request for additional information named the provider of record, but instead of being mailed to the provider’s office, was sent to the Plan’s own headquarters. During discussion regarding how this occurred, Plan management noted that this is a common practice for new non-participating providers and that the letters are routinely hand re-addressed when they are returned though, in this case, this apparently did not occur. Instead, the records from the case indicate the provider was notified telephonically, a standard which does not effect compliance with the Law. Failing to send the letters to the providers directly is inappropriate, since the providers lose significant time to participate in the appeal process.

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

“...Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal...”

In two instances, the Plan failed to achieve this deadline. Upon one of the failures to achieve the deadline, the Plan reversed its determination, as required by Section 4904(e) of the New York Insurance Law. In the other case, the Plan did not reverse its determination until it was advised to do so by this examiner.

It is recommended that the Plan comply with all the requirements of Sections 4903(e)(1), 4903(e)(3) and 4904(b) of the New York Insurance Law and ensure that its members are provided with their full and appropriate rights under such laws.

The Plan is affiliated with other Blue Cross/Blue Shield plans throughout the United States, via its affiliation with the Blue Cross/Blue Shield Association, whereby members who reside out-of-state have their claims sent to the closest Blue Cross/Blue Shield Plan (“Host Plan”) for adjudication, instead of to the Plan of which they are a member (“Home Plan”). This allows each of the affiliated entities to take advantage of any negotiated discounts that may be in place between that local Plan and its network of providers. In such cases, when claims are denied, the Explanation of Benefits statements and appeal notifications only show the name of the Host Plan. As a result, when appeals are submitted by out-of-state members, they go to the Host Plan instead of to the Home Plan.

During the review of claims, one appeal was found that took an excessive amount of time to reach Excellus and as a result, was closed outside the time parameters permitted by Section 4904(e) of the New York Insurance Law. When this was discussed with Plan management, Excellus indicated that it is the practice of the Blue Cross/Blue Shield Association Plans to send appeals by common carrier and that there is no way to know how long it takes for those appeals to actually be sent. The practice of using affiliated Plans should not be a reason for appeals to be resolved outside the statutory deadlines. The date the appeals are originally received by the Host Plan should be established as the date the appeal was originally received.

It is recommended that Excellus and other Blue Cross/Blue Shield plans which process Excellus' claims on Excellus' behalf, comply with the timeline requirements of Section 4904 of the New York Insurance Law relative to the appeal of adverse determinations.

The Plan reported to the Department that this is now the practice of the Blue Cross and Blue Shield Association Plans.

10. DISCLOSURE OF INFORMATION

The Plan uses a single manual, which was approved by the New York State Department of Health, for its HMO Direct Blue Point of Service line of business that contains two sections, one related to HMO rights and benefits, the other related to member's rights and benefits when they go out of network. During the review of this manual, it was noted that it contained inaccurate information. The details are as follows:

Page 19 of the Handbook's section, "*How Providers are Reimbursed*" states:

"We pay non-participating providers the same amount we would pay if the provider was participating with us. This is based on the allowed amount and is subject to any co-pays or co-insurance..."

This statement is not accurate in that non-participating providers are not paid the same as if they were participating with the Plan's network.

The Handbook section "*Frequently Asked Questions*", on page 38, in response to the question, "*Can I see a provider without a referral?*", states the following:

"Yes, depending on the type of provider and services you need. Women may see a participating OB/GYN provider of her choice for covered gynecologic and obstetric services. If you have behavioral health and/or vision coverage, you may access behavioral health and/or routine vision care without a referral from a participating provider."

Although the same section of the Handbook states that members can receive care from any provider without a referral for out-of-network benefits, the response to this question may be confusing to the extent that it does not make it clear that it applies only to the receipt of in-network benefits.

The definition for "*Allowable Expense*", on page 3 of the Plan's POS contract with its members includes the following:

"the amount we determine to be the most common charge for a particular service, procedure or health care item in the geographic area where the service is rendered. The Allowable Expense shall not be less than the 80th percentile of the appropriate HIAA Schedule for the service, if listed."

This is inappropriate because the definition is incomplete in that it does not define a source for pricing in the event the service is not listed in the source book.

It is recommended that the Plan amend its approved HMO Direct Blue Point of Service manual to eliminate misleading and/or inaccurate content.

11. PRIVACY

Part 421.3(b) of Department Regulation No. 173 (11 NYCRR 421.3(b)) establishes the requirement that an insurance company's information security program be designed to:

“Protect against any anticipated threats or hazards to the security or integrity of such information.”

Part 421.7 of Department Regulation No. 173 (11 NYCRR 421.7) establishes the requirement that an insurance company:

“...exercise appropriate due diligence in selecting its service providers.”

In two cases, the Plan failed to comply with Parts 421.3(b) and 421.7 of Department Regulation No. 173 by failing to include adequate privacy protections in the signing of a service agreement with independent third party claims administrators which had access to Personal Health Information (PHI). The Plan indicated to the Department that no PHI was compromised as a result of the noted finding.

It is recommended that the Plan comply with the privacy provisions of Department Regulation No. 173 and ensure that it has signed Business Associate Agreements which contain such privacy provisions with all third parties with which Excellus shares Personal Health Information.

It is noted in the above cases, subsequent to the examination date, that the Plan included such privacy protections within the pertinent service agreements.

12. RECORD RETENTION

Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) states the following:

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

Section 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) states in part:

“...to enable department personnel to reconstruct an insurer’s activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to the claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.”

During the general review of claims, the Plan was not able to provide original versions of the explanation of benefits statements (“EOBs”) it sent to its members. Instead, it recreated the documents using the claims adjudication system. Without the original documents, it was not possible for the examiner to confirm that the EOBs provided were identical to those actually sent.

It is recommended that Excellus comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and maintain images of the explanation of benefits statements sent to its members, as well as the information supporting filed annual and quarterly statement schedules.

It is also recommended that the Plan comply with the requirements of Part 216.11 of Department Regulation 64 (11 NYCRR 216.11) by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.

13. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of October 10, 2003, contained the following twenty (20) comments and recommendations (The page numbers included in the table below refer to that prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Sales</u>	
1.	4
It is recommended that the Plan, pursuant to Section 2114(a)(3) of the New York State Insurance Law, refrain from paying any commissions or compensation directly dependent upon the amount of business obtained to any person that does not possess a valid agent's or broker's license.	
<i>The Plan has complied with this recommendation.</i>	
<u>Underwriting and Rating</u>	
2.	5
It is recommended that the Plan maintain signed copies of a Department approved rider or remitting agent agreement with all groups receiving level premium or guaranteed rates.	
<i>The Plan has complied with this recommendation except in certain existing cases where the insured parties have refused to sign.</i>	
3.	6
It is recommended that the Plan, pursuant to Part 52.42(b)(3)(ii)(a) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(b)(3)(ii)(a)), obtain New York Insurance Department approval for its level premium agreements and amendments of previously approved agreements used by the Plan.	
<i>The Plan has complied with this recommendation.</i>	

ITEM NO.**PAGE NO.**

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|----|--|----|
| 4. | It is recommended that the Plan file, pursuant to Section 4308(b) of the New York State Insurance Law and Department Regulation 62 (11 NYCRR 52.40), and obtain the Superintendent's prior approval for its experience rating agreements. | 7 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 5. | It is recommended that the Plan comply with the thirty (30) day grace period included in its contracts relative to cancellations for non-payment of premium. | 9 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 6. | It is recommended that the Plan refrain from retracting or denying affected claims when the grace period is extended by the Plan beyond the thirty (30) day grace period included within its contracts. | 9 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 7. | It is further recommended that the Plan comply with the provisions of Section 4235(k) &(1) of the New York State Insurance Law and New York Insurance Department Regulation 78 (11 NYCRR 55.2(a)) relative to the requirements of termination notices of group policies or contracts of accident, health or accident and health insurance. | 10 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 8. | It is recommended that the Plan include the appropriate pre-existing condition provisions wording, prescribed by Section 4318(b) of the New York State Insurance Law, in all group certificates issued by the Plan. | 10 |
| | <i>The Plan has complied with this recommendation.</i> | |

ITEM NO.**PAGE NO.**

Claims

9. It is recommended that, at a minimum, the Plan's internal audit section make periodic reviews and reconciliations of system data to the Plan's underlying books and records. 11

The Plan has complied with this recommendation.

10. It is recommended that the Plan comply with the requirements of Section 3224-a of the New York State Insurance Law and make appropriate payment of all claims within the forty-five (45) day receipt of claim period provided by such section of the New York State Insurance Law where there is not an appropriate reason for delay. 21

The Plan has not fully complied with this recommendation. This report contains a similar recommendation.

11. It is further recommended that the Plan comply with the requirements of Section 3224-a(c) of the New York State Insurance Law and pay appropriate interest on all applicable claims paid over forty-five (45) days from date of receipt. 21

The Plan has not fully complied with this recommendation. This report contains a similar recommendation.

12. It is recommended that the Plan take the necessary steps to ensure that accurate paid claim amounts and claim counts are included in its future filed Schedules H. 22

The Plan has not complied with this recommendation. This report contains a similar recommendation.

13. It is recommended that the Plan continue to comply with the requirements of Section 4303(a)(2) of the New York State Insurance Law relative to the payment of emergency care claims. 23

The Plan has not fully complied with this recommendation. This report contains a similar recommendation, although the reason for the violation differs.

14. It is recommended that the Plan send proper notices of first adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York State Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law, as applicable. 25

The Plan has complied with this recommendation.

15. It is recommended that the Plan comply with Section 4904(c) of the New York State Insurance Law and Section 4904.3 of the New York Public Health Law and provide written acknowledgement of the filing of an appeal from its participating providers, within fifteen days of such filings. 26

The Plan has complied with this recommendation.

16. It is recommended that the Plan include all retrospective utilization review appeals, made by its participating providers, on Schedule M of its annual statements in future filings made to this Department. 27

The Plan has complied with this recommendation.

Explanation of Benefits Statements

17. It is recommended that the Plan include all required wording prescribed by Section 3234(b) of the New York State Insurance Law within its Explanation of Benefits statements and applicable denial letters sent to its subscribers. 28

The Plan has not complied with this recommendation. This report contains a similar recommendation.

Fraud Prevention and Detection

18. It is recommended that the Plan appropriately segregate its SIU employees from its other employees and contracted workers within all of its divisions. 29

The Plan has complied with this recommendation.

19. It is recommended that the Plan develop an annual in-service training program for its claims and underwriting unit employees as required by Part 86.6(a)(6) of New York Insurance Department Regulation 95 (11 NYCRR 86.6(a)(6)). 29

The Plan has complied with this recommendation.

Home Health Care Providers

20. It is recommended that the Plan submit all active contracts with its providers, including Home Health Care provider agreements, to the Commissioner of Health for approval in compliance with Department of Health Regulation (10 NYCRR 98-1.8(b)). 30

The Plan has complied with this recommendation.

The prior report on examination as of December 31, 2003, contained the following five (5) Market Conduct comments and recommendations (The page numbers included in the table below refer to that prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Treatment of Policyholders and Claimants</u>	
1.	29
<p>It is recommended that the Plan limit its funded member welfare programs to those which directly affect the general health of its members.</p> <p><i>The Plan has complied with this recommendation.</i></p>	
2.	30
<p>It is further recommended that in order for the cost of such programs to be included as part of claims cost, such programs should be established as policy riders so that Plan members have a choice as to whether or not they wish to have such options available.</p> <p><i>The Plan has complied with this recommendation.</i></p>	
3.	30
<p>Finally, it is recommended that the Plan comply with Section 4224(c) of the New York State Insurance Law and not utilize Plan funded “member benefit” programs as an inducement to enroll Members.</p> <p><i>The Plan has complied with this recommendation.</i></p>	
4.	30
<p>It is recommended that the Plan maintain its stored data for six years within a current database or data warehouse from which such data may be obtained in a timely and efficient manner.</p> <p><i>The Plan has initiated a “Transformation Project” that it expects will resolve this ongoing issue.</i></p>	
5.	30
<p>It is recommended that the Plan establish an internal control to ensure that all claims over a certain threshold are reviewed prior to processing.</p> <p><i>The Plan has complied with this recommendation.</i></p>	
14.	<u>SUMMARY OF COMMENTS AND RECOMMENDATIONS</u>

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Facilitation of Examination</u>	
It is recommended that the Plan enhance its procedures to ensure it facilitates examination requests completely and in a timely manner.	5
B. <u>Underwriting and Rating</u>	
It is recommended that Excellus abide by its Large Group Experience Rated formula filed with and approved by the Department.	6
C. <u>Claims</u>	
i. It is recommended that the Plan take steps to ensure that those claims requiring manual pricing are priced accurately.	7
ii. It is recommended that the Plan follow the procedures defined in its subscriber contracts by sending formal denials in the circumstance that additional information is not received after a request for such has been made.	8
iii. It is also recommended that the United States Department of Labor be requested to clarify the applicability to health insurers of United States Department of Labor Regulation No. 29 CFR (2560.503-1(f)(2)(iii)(B)), prior to the implementation of PPACA.	9
iv. It is recommended that Excellus comply with the requirements of Section 4303(a)(2) of the New York Insurance.	9
v. It is recommended that Excellus send denial notices to the insured school systems, in those instances where claims have been denied as a result of the school system's failure to submit an accident report form as required under the policy.	10
D. <u>Explanation of Benefits Statements</u>	
i. It is recommended that Excellus comply with the requirements of Section 3234(a) of the New York Insurance Law and send explanation of benefits statements to members when those members have purchased pharmaceutical drugs and either co-insurance or a deductible is involved, or when an EOB is requested.	11

<u>ITEM</u>	<u>PAGE NO.</u>
ii. It is recommended that Excellus issue Explanation of Benefit statements that contain all of the information that is required under Section 3234 of the New York Insurance Law and that such information be presented clearly and completely.	13
iii. While not directly required under New York statute, it is recommended that Excellus disclose the surcharge that is the responsibility of the subscriber on its Explanation of Benefit statements.	13
E. <u>Prompt Payment Law Compliance</u>	
i. It is recommended that the Plan improve its internal claim procedures to ensure compliance with Sections 3224-a (a), (b) and (c) of the New York Insurance Law. The prior report contained a similar recommendation.	17
ii. It is recommended that the Plan take the necessary steps to ensure that accurate paid claim amounts and claim counts are included in its future filed Schedules H. The prior report contained a similar recommendation.	18
iii. Further, it is recommended that the Plan comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and maintain the adequate support documentation relative to the information reported within its filed Schedules H.	18
F. <u>Utilization Review</u>	
i. It is recommended that the Plan comply with all the requirements of Sections 4903(e)(1), 4903(e)(3) and 4904(b) of the New York Insurance Law and ensure that its members are provided with their full and appropriate rights under such laws.	21
ii. It is recommended that Excellus and other Blue Cross / Blue Shield plans which process Excellus' claims on Excellus' behalf, comply with the timeline requirements of Section 4904 of the New York Insurance Law relative to the appeal of adverse determinations. The Plan reported to the Department that this is now the practice of the Blue Cross and Blue Shield Association Plans.	22

<u>ITEM</u>	<u>PAGE NO.</u>
G. <u>Disclosure of Information</u>	
It is recommended that the Plan amend its approved HMO Direct Blue Point of Service manual to eliminate misleading and/or inaccurate content.	24
H. <u>Privacy</u>	
It is recommended that the Plan comply with the privacy provisions of Department Regulation No. 173 and ensure that it has signed Business Associate Agreements which contain such privacy provisions with all third parties with which Excellus shares Personal Health Information.	25
It is noted in the above cases, subsequent to the examination date, that the Plan included such privacy protections within the pertinent service agreements.	
I. <u>Record Retention</u>	
i. It is recommended that Excellus comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2) and maintain images of the explanation of benefits statements sent to its members, as well as the information supporting filed annual and quarterly statement schedules.	26
ii. It is also recommended that the Plan comply with the requirements of Part 216.11 of Department Regulation 64 (11 NYCRR 216.11) by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.	26

Appointment No. 22747

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, **Eric R. Dinallo**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Excellus Health Plan, Inc.

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

Plan

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 17th day of November 2008



Eric R. Dinallo
Superintendent of Insurance

