MARKET CONDUCT REPORT ON EXAMINATION

OF

OXFORD HEALTH INSURANCE, INC.

AND

OXFORD HEALTH PLANS (NY), INC.

AS OF

DECEMBER 31, 2016

DATE OF REPORT: **NOVEMBER 16, 2020**

EXAMINER: **JEFFREY USHER, CFE**

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November 16, 2020

Honorable Linda A. Lacewell
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31575 and 31576, both dated February 22, 2017, attached hereto, I have made an examination into the affairs of Oxford Health Plans (NY), Inc., a for-profit individual practice association model health maintenance organization ("HMO") issued a certificate of authority pursuant to the provisions of Article 44 of the New York Public Health Law, and Oxford Health Insurance, Inc., an accident and health insurance company licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2016. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Oxford Health Plans (NY), Inc. and Oxford Health Insurance, Inc., located at 4 Research Drive, Shelton, Connecticut.

Wherever the designations "OHP-NY" or the "Plan" appear herein, without qualification, they should be understood to refer to Oxford Health Plans (NY), Inc.

Wherever the designation "OHI" appears herein, without qualification, it should be understood to refer to Oxford Health Insurance, Inc.

Wherever the designations "Oxford" or the "Oxford Companies" appear herein, without qualification, they should be understood to refer to both Oxford Health Plans, Inc. (NY) and Oxford Health Insurance, Inc., collectively.

The Parent of OHI is UnitedHealthcare Insurance Company ("UHIC"), while the ultimate parent is UnitedHealth Group, Inc.

The Parent of OHP-NY is Oxford Health Plans, LLC ("Oxford LLC."), while the ultimate parent is UnitedHealth Group, Inc.

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

1. SCOPE OF THE EXAMINATION

The previous market conduct examination of OHP-NY and OHI was conducted as of December 31, 2013. This current market conduct examination was performed to review the manner in which OHP-NY and OHI conducted their business practices and fulfilled their contractual obligations to policyholder and claimants. The examination covered a three-year period January 1, 2014 through December 31, 2016. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination contains the 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.

Concurrent examinations regarding the financial condition of OHP-NY and OHI were conducted by the Department as of December 31, 2016. The resulting reports on examination were filed on June 28, 2018 for Oxford Health Insurance Inc. and on August 2, 2018 for Oxford Health Plan of New York, Inc.

A review was also made to ascertain what actions were taken by the Oxford Companies with regard to the comments and recommendations concerning market conduct issues contained in the prior report on examination, as of December 31, 2013.

2. DESCRIPTION OF THE COMPANIES

OHP-NY is a for-profit HMO that was incorporated on April 19, 1985, under New York State Law for the purpose of providing comprehensive health care services on a prepaid basis and for the purpose of establishing and operating a health maintenance organization and health care delivery system. The Plan was granted a Certificate of Authority pursuant to the provisions of Article 44 of the New York Public Health Law and commenced business on June 1, 1986. The Plan has been deemed a Competitive Medical Plan by the Centers for Medicare & Medicaid Services for purposes of the Federal Medicare Program. The Plan's primary business is the provision of medical expense coverage for comprehensive health care services to its members on a prepaid basis.

OHI was incorporated in New York State on January 30, 1987, for the purpose of providing accident and health insurance products. It obtained its license from the then New York State Department of Insurance on July 1, 1987, and it commenced operations on that date. From its date of incorporation until December 31, 1997, OHI was a wholly-owned subsidiary of Oxford Health Plans, Inc., a Delaware corporation. On that date, with the Department's approval, Oxford Health Plans, Inc. transferred 100% ownership of OHI to OHP-NY. On January 24, 2014, the New York State Department of Health ("DOH") approved the redemption and retirement of 318 shares of OHP-NY stocks held by its immediate parent, Oxford LLC., in consideration for all the issued and outstanding shares of OHI ("OHI shares") held by OHP-NY. Subsequently, the OHI shares were transferred from Oxford LLC to its ultimate parent, UnitedHealth Group, Inc. and then through a series of subsequent transactions, were transferred to UHIC. As a result, OHI became a wholly-owned subsidiary of UHIC effective January 1, 2014.

3. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("PROMPT PAY LAW")

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

A review of the Oxford Companies' compliance with Section 3224-a was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material issues were noted by the examiner.

4. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Section 3221(l)(8)(E) of the New York Insurance Law and additional implementing regulations require non-grandfathered group health plans offering health insurance coverage in the group market to provide certain benefits but to prohibit the imposition of cost-sharing requirements for those benefits. These include the following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

- Evidenced-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;

- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Similar references are included within New York Insurance Law Section 3216(i)(17)(E) for the individual market while Section 4303(j)(3) of the New York Insurance Law and Section 2713 of the Public Health Service Act offer similar supporting guidance.

The examiner reviewed 70 elements of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims for OHI and OHP-NY with regard to the aforementioned 70 elements for co-pay, deductible and coinsurance costs attributed to the member.

The examiner also performed compliance testing on 4 samples of preventive service claims adjudicated by Oxford during calendar years 2015 and 2016. See the below exhibit showing the violation rate, total population and total claims in violation.

	Violation Rate %	**Total Population**	**Total Violations**
OHP-NY			
2015	22.2%	1,880	417
2016	21.3%	5,983	1,274
Total		7,863	1,691
OHI			
2015	28.7%	11,550	3,314
2016	6.2%	31,736	1,967
Total		43,286	5,281
Total (OHI + OHP-NY)		51,149	6,972

Oxford indicated that the errors resulted from system audit queues built to identify certain diagnosis codes and procedure codes to default to manual processing, that were not working correctly. Certain preventive service claims require the ability to look at the claims history in order to determine if the claim should be processed as a preventive service without cost-sharing.

The examiner conducted a separate review of the prescription drugs that were considered "preventive" within the 70 elements of preventive services identified by the USPSTF mentioned above. The review included approximately 13,000 pharmacy claims with cost-sharing for breast cancer prescribed medications. The examiner was advised that included in this total were breast cancer medications that were prescribed as preventive medications. Oxford provided samples of requirement instructions to the member/provider in the form of website links to drug lists, FAQs and forms. It was noted by the examiner that one of the links shows that the breast cancer drugs listed required no pre-authorization. A review of a separate link to a drug list revealed that the same drug(s) have a pre-authorization requirement. A review of the FAQs indicated that for "no cost share" preventive medications, the provider can get the pre-authorization. A review of the "no cost-sharing" application for breast cancer preventive medications included language which indicated the provider can complete the form on behalf of the member. If pre-authorization must be attained by the provider, there shall be no penalty to the member. The abovementioned lists, FAQs and forms used inconsistent wording and applied confusing, and at times, contradictory wording, with regard to the requirement(s) for a pre-authorization for no cost-sharing, and who is responsible for filing the application (the member or provider).

It is recommended that the Oxford Companies comply with the requirements of Sections 3216(i)(17)(E), 3221(l)(8)(E) and 4303(j)(3) of the New York Insurance Law and The Patient

Protection and Affordable Care Act by not applying, where applicable, member cost-sharing to preventive care claims.

It is also recommended that Oxford perform Quality Assurance testing of the effectiveness of their claims payment policies/procedures on paid claims in order to ensure compliance with Sections 3216(i)(17)(E), 3221(l)(8)(E) and 4303(j)(3) of the New York Insurance Law.

It is further recommended that Oxford clarify, the instructions to members/providers regarding the requirements for eligibility and receipt of cancer medications at no cost-sharing to treat breast cancer.

5. UTILIZATION REVIEW AND APPEALS

The Oxford Companies have four (4) third party administrators ("TPA"): EviCore, United Behavioral Health ("UBH"), OptumHealth Care Solutions ("Optum") and OrthoNet Global ("OrthoNet"). They are assigned as utilization review agents to conduct and provide utilization review services. This is in addition to the in-house utilization reviews by the Oxford Companies. The examiner reviewed Utilization Review and Appeal cases for the years 2015 and 2016 for the Oxford Companies and their TPAs.

For the Utilization Review cases, the examiner selected 4 samples: 50 cases for each OHP-NY and OHI, covering 2015 and 2016, (totaling 200) for review. The cases selected included retrospective, concurrent and prospective cases from the Oxford Companies as well as the TPAs mentioned above. Based on the examiner's review, the Oxford Companies and TPAs appeared to be in violation of the below listed sections of the New York Insurance Law.

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

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

Section 4903(2) of the New York Public Health Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information."

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 requests for inpatient substance use disorder treatment, 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..."

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 requests for inpatient substance use disorder treatment, 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..."

Section 4903(d) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

Section 4903(4) of the New York Public Health Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

Section 4903(e) of the New York Insurance Law states:

> "Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
>
> (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…"

Section 4903(5) of the New York Public Health Law states:

> "Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
>
> (b) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article…"

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

> "In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the insured's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination..."

Section 4903(6) of the New York Public Health Law states, in part:

> "In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the enrollee's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination..."

The examiner's review of the Utilization Review cases determined the following number of violations:

2016 OHI, EviCore, UBH, Optum and OrthoNet Utilization Review - Summary of Violations						
	OHI	**EviCore**	**UBH**	**Optum**	**OrthoNet**	**Total**
Prospective Cases						
Total Reviewed	4	5	4	0	10	23
NY Insurance Law Violations						
NYIL Section 4903	0	0	3	0	0	
Total Population	4,577	27,495	744	0	438	

Total Violations	0	0	558	0	0	**558**
Concurrent Cases						
Total Reviewed	3	0	3	5	0	11
NY Insurance Law Violations						
NYIL Section 4903	1	0	3	0	0	
Total Population	49	0	185	11,566	0	
Total Violations	16	0	185	0	0	**201**
Retrospective Cases						
Total Reviewed	3	5	3	5	0	16
NY Insurance Law Violations						
NYIL Section 4903	0	0	3	4	0	
Total Population	288	430	110	11,620	438	
Total Violations	0	0	110	9,296	0	**9,406**
Grand Total Violations	16	0	853	9,296	0	**10,165**

2015 OHI, EviCore, UBH, Optum and OrthoNet Utilization Review - Summary of Violations						
	OHI	**EviCore**	**UBH**	**Optum**	**OrthoNet**	**Total**
Prospective Cases						
Total Reviewed	4	5	4	0	6	19
NY Insurance Law Violations						
NYIL Section 4903	0	0	4	0	1	
Total Population	5,521	15,090	568	0	1,917	
Total Violations	0	0	568	0	320	**888**
Concurrent Cases						
Total Reviewed	3	0	3	5	3	14
NY Insurance Law Violations						
NYIL Section 4903	0	0	3	5	0	
Total Population	572	0	343	14,004	3	
Total Violations	0	0	343	14,004	0	**14,347**
Retrospective Cases						
Total Reviewed	3	5	3	5	1	17
NY Insurance Law Violations						
NYIL Section 4903	0	0	3	5	0	
Total Population	127	284	286	7,026	1	
Total Violations	0	0	286	7,026	0	**7,312**
Grand Total Violations	0	0	1,197	21,030	320	**22,547**

2016 OHP-NY, EviCore, UBH, Optum and OrthoNet Utilization Review - Summary of Violations						
	OHP-NY	**EviCore**	**UBH**	**Optum**	**OrthoNet**	**Total**
Prospective Cases						

Total Reviewed	4	5	4	0	10	23
NY Public Health Law Violations						
NYPHL Section 4903	1	0	4	0	0	
Total Population	874	4,131	80	0	36	
Total Violations	219	0	80	0	0	**299**
Concurrent Cases						
Total Reviewed	3	0	3	5	0	11
NY Public Health Law Violations						
NYPHL Section 4903	1	0	3	0	0	
Total Population	19	0	23	1,402	0	
Total Violations	6	0	23	0	0	**29**
Retrospective Cases						
Total Reviewed	3	5	3	5	0	16
NY Public Health Law Violations						
NYPHL Section 4903	0	0	3	4	0	
Total Population	40	54	11	1,078	0	
Total Violations	0	0	11	862	0	**873**
Grand Total Violations	225	0	114	862	0	**1,201**

2015 OHP-NY, EviCore, UBH, Optum and OrthoNet
Utilization Review - Summary of Violations

	OHP-NY	**EviCore**	**UBH**	**Optum**	**OrthoNet**	**Total**
Prospective Cases						
Total Reviewed	4	5	4	0	7	20
NY Public Health Law Violations						
NYPHL Section 4903	0	0	2	0	2	
Total Population	1,468	1,798	106	0	506	
Total Violations	0	0	53	0	145	**198**
Concurrent Cases						
Total Reviewed	3	0	3	5	3	14
NY Public Health Law Violations						
NYPHL Section 4903	1	0	3	4	0	
Total Population	173	0	64	1,250	3	
Total Violations	58	0	64	1,000	0	**1,122**
Retrospective Cases						
Total Reviewed	3	5	3	5	0	16
NY Public Health Law Violations						
NYPHL Section 4903	0	0	3	5	0	
Total Population	36	30	24	881	0	
Total Violations	0	0	24	881	0	**905**
Grand Total Violations	58	0	141	1,881	145	**2,225**

Note: The amounts listed in the above exhibits represent a summary of the Oxford Companies and TPA's of which there were separate error rates and total populations for prospective, concurrent and retrospective cases for each company and each TPA. All totals by year, Company and TPA cases for that company were summarized and totaled for the above exhibits.

It is recommended that OHI, OHP-NY and their TPA, OrthoNet, comply with the requirements of Section 4903(b) of the New York Insurance Law and Section 4903(2) of the New York Public Health Law by providing all notices of determination in writing to the member and the provider within three (3) business days of receipt of the necessary information.

It is also recommended that OHI, OHP-NY and their TPA, Optum, comply with the requirements of Section 4903(c) of the New York Insurance Law and Section 4903(3) of the New York Public Health Law by providing all notices of determination by telephone and in writing to the member within one (1) business day of receipt of the necessary information.

It is further recommended that the TPAs, UBH and Optum comply with the requirements of Section 4903(4) of the New York Public Health Law by providing the notice of determination to all members and providers within thirty (30) days of receipt of the necessary information.

It is recommended that the TPAs, UBH and Optum comply with the requirements of Section 4903(e)(2) of the New York Insurance Law and Section 4903(5)(b) of the New York Public Health Law by including the external appeal rights (with the timeframes to request an external appeal) in all initial adverse determination letters.

In addition, it was noted in the review of some initial adverse notices of the TPA, EviCore, that it limited the timeframe for providers to request a reconsideration of the determination to fourteen (14) days, in violation of Section 4903(f) of the New York Insurance Law and Section 4903(6) of the New York Public Health Law.

It is recommended that the TPA, EviCore, comply with the requirements of Section 4903(f) of the New York Insurance Law and Section 4903(6) of the New York Public Health Law by removing the fourteen (14) day timeframe from its initial adverse determination letters.

For the Appeal cases the examiner selected 4 samples. 24 cases were selected for each New York entity and for each year, totaling 96 cases for review in total. The cases selected included member and provider cases from the Oxford Companies and their TPAs, mentioned above. The review revealed that the Oxford Companies and their TPAs appeared to be in violation of 1 or more of the below New York Insurance Laws, Public Health Laws, Regulations and Federal Laws.

Sections 4904(c) and (c)(2) of the New York Insurance Law state, in part:

> "…The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.
>
> The notice of the appeal determination shall include:
>
> (2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals..."

Sections 4904(3) and (3)(b) of the New York Public Health Law state, in part:

> "…The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.
>
> The notice of the appeal determination shall include:
>
> (b) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required

> pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals..."

Section 4914(b)(1) of the New York Insurance Law states, in part:

> "…The insured's health care provider shall have sixty days to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal…"

Section 4914(2)(a) of the New York Public Health Law states, in part:

> "…The insured's health care provider shall have sixty days to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal…"

Parts 98-2.9(e)(2) and (3) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-2.9) state, in part:

> "Each notice of a final adverse determination of an expedited or standard utilization review appeal under section 4904 of the Public Health Law shall be in writing, dated and include the following:
>
> (2) a clear statement that the notice constitutes the final adverse determination...
>
> (3) the health care plan's contact person and his or her telephone number…"

Part 98-2.9(h)(1) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-2.9) states, in part:

> "Health care plans shall facilitate the prompt completion of external appeal requests, including but not limited to, the following:
>
> (1) Health care plans shall provide the enrollee with a copy of the standard description of the external appeal process… including a form and instructions for requesting an external appeal along with a description of the fee, if any, charged to enrollees for an external appeal, criteria for determining eligibility for a waiver of such fees based on financial hardship, and the process for requesting a waiver of such fees based on financial hardship…"

45 C.F.R. § 147.136(b)(2)(ii)(E)(1) and (5) state the following:

> "(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
>
> (5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes."

29 C.F.R. § 2560.503-1(j)(3), (4)(i) and (5)(i) state the following, in part:

> "(j) The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant -
>
> (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;
>
> (4)(i) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and
>
> (5) In the case of a group health plan - (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request…"

The review of the Utilization Review Appeal cases resulted in the following number of violations:

2016 OHI, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Member Appeal Cases				
	OHI	**UBH**	**Optum**	**Total**
Total Reviewed	3	3	3	9
NY Insurance Law Violations				
NYIL Section 4904	2	2	0	
Total Population	6,343	383	425	
Total Violations	4,229	255	0	**4,484**

2016 OHI, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Provider Appeal Cases				
	OHI	**UBH**	**Optum**	**Total**
Total Reviewed	7	2	6	15
NY Insurance Law Violations				
NYIL Section 4914	0	0	6	
Total Population	135	2	1,323	
Total Violations	0	0	1,323	**1,323**

2015 OHI, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Member Appeal Cases				
	OHI	**UBH**	**Optum**	**Total**
Total Reviewed	3	3	3	9
NY Insurance Law Violations				
NYIL Section 4904	1	0	0	
NYIL Section 4914	0	1	2	
Total Population	4,212	395	432	
Total Violations	1,404	132	288	**1,824**

2015 OHI, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Provider Appeal Cases				
	OHI	**UBH**	**Optum**	**Total**
Total Reviewed	6	3	6	15
NY Insurance Law & Federal Regulation Violations				
NYIL Section 4904	1	0	0	
NYIL Section 4914	0	0	6	
29 C.F.R 2560.503-1(j)(4)(i)	1	0	0	
45 C.F.R. 147.136(b)(2)(ii)(E)(5)	1	0	0	
Total Population	172	3	1,601	
Total Violations	29	0	1,601	**1,630**

2016 OHP-NY, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Member Appeal Cases				
	OHP-NY	**UBH**	**Optum**	**Total**
Total Reviewed	3	3	3	9
NY Public Health Law Violations				
NYPHL Section 4904	1	0	0	
NYPHL Section 4914	0	0	2	
Total Population	1,183	51	18	
Total Violations	394	0	12	**406**

2016 OHP-NY, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Provider Appeal Cases				
	OHP-NY	**UBH**	**Optum**	**Total**
Total Reviewed	8	0	7	15
NY Public Health Law, DOH Regulation & Federal Regulation Violations				
NYPHL Section 4904	2	0	0	
NYPHL Section 4914	0	0	5	
DOH Regulation10 NYCRR 98-2.9	2	0	0	
29 CFR 2560.503-1(j)(4)(i)	2	0	0	
45 CFR 147.136(b)(2)(ii)(E)(5)	2	0	0	
Total Population	64	0	17	
Total Violations	16	0	12	**28**

2015 OHP-NY, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Member Appeal Cases				
	OHP-NY	**UBH**	**Optum**	**Total**
Total Reviewed	3	3	3	9
NY Public Health Law Violations				
NYPHL Section 4914	0	0	3	
Total Population	1,080	65	40	
Total Violations	0	0	40	**40**
2015 OHP-NY, UBH and Optum Utilization Review Appeal - Summary of Violations Utilization Review Provider Appeal Cases				
	OHP-NY	**UBH**	**Optum**	**Total**
Total Reviewed	7	1	7	15
NY Public Health Law Violations				
NYPHL Section 4914	0	0	2	
Total Population	74	2	62	
Total Violations	0	0	18	**18**

Note: The amounts listed in the above exhibits represent a summary of the Oxford Companies and TPAs of which there were separate error rates and total populations for utilization review appeal cases for each company and each TPA. All totals by year, Company and TPA cases for that company were summarized and totaled for the above exhibits.

It is recommended that OHI, OHP-NY and their TPAs, UBH and Optum, comply with the requirements of Sections 4904(c) and (c)(2) of the New York Insurance Law and Sections 4904(3) and (3)(b) of the New York Public Health Law, respectively, by sending acknowledgement letters within fifteen (15) days, by sending appeal determinations within two (2) business days after rendering a determination, and including the timeframes to request an external appeal in all final adverse determination letters.

It is recommended that UBH and Optum comply with the requirements of Section 4914(b)(1) of the New York Insurance Law and Section 4914(2)(a) of the New York Public Health Law by giving providers sixty (60) days to initiate an external appeal after the insured or the insured's health care provider receives notice of a final adverse determination.

It is recommended that OHI and OHP-NY comply with the requirements of Parts 410.9(e)(2) and (3) of Insurance Regulation 166 and Parts 98-2.9(e)(2) and (3) of the Administrative Rules and Regulations of the New York Department of Health by including a clear statement that the appeal determination constitutes the final adverse determination and by including the health plan's contact person and telephone number in all the final adverse determination letters.

It is also recommended that OHI and OHP-NY comply with the requirements of Part 410.9(h)(1) of Insurance Regulation 166 and Part 98-2.9(h)(1) of the Administrative Rules and Regulations of the New York Department of by including a copy of the standard description of the external appeal process, including a form and instructions for requesting an external appeal; along with a description of the fee criteria for determining eligibility for a waiver of any fee based on financial hardship, and the process for requesting such waiver, with all the final adverse determination letters.

It is recommended that OHI and OHP-NY comply with the requirements of 45 C.F.R. §§147.136(b)(2)(ii)(E)(1) and (5), by including a notice of the availability, upon request, of the diagnosis code, treatment code and their corresponding meanings, and a statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established under 42 U.S.C § 300gg-93, to assist enrollees with the appeal process in all their final adverse determination letters.

It is further recommended that OHI and OHP-NY comply with the requirements of 29 C.F.R. §§2560.503-1(j)(3), (4)(i) and (5)(i) by including a notice of the availability, upon request, reasonable access to, and copies of, all documents, records and other information relied upon to make such determination, clinical review criteria, internal rule, protocol or guideline relied upon to make such determination, and a statement of the enrollee's right to bring a civil action under § 502(a) of ERISA, in all their final adverse determination letters.

6. GRIEVANCES

Section 4408-a(4)(iii) of the Public Health Law states in part:

> "(4)… All grievances shall be resolved in an expeditious manner, and in any event, no more than: (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered… and (iii) forty-five days after the receipt of all necessary information in all other instances."

The examiner selected a sample of forty-seven (47) member grievances and noted three (3) instances where OHP-NY did not resolve the grievance within forty-five (45) days after receipt of all necessary information. The total population of member grievances for OHP-NY for the calendar year 2016 was 1,915 cases, and with a determined error rate of 6%, there were 115 grievance cases in violation. There were no deficiencies noted in the examiner's review of OHI's member grievances.

It is recommended that OHP-NY comply with Section 4408-a(4)(iii) of the New York Public Health Law by resolving grievances within forty-five (45) days after receipt of all necessary information.

7. REPORTING OF GRIEVANCES AND UTILIZATION REVIEW APPEALS

A review of the "Exhibit of Grievances and Utilization Review Appeals" for OHI, and "N.Y. Schedule M" for OHP-NY, as contained in their respective 2016 (NY Supplement/Data Requirements) filings with the Department, found that both companies incorrectly reported the total number of grievances and utilization review appeals on their respective filed exhibit/ schedule.

The Oxford Companies were unable to reconcile the grievances and appeals totals listed in the Supplement/Data Requirements to the grievance and appeal data files given to the examiner for review.

It is recommended that the Oxford Companies report the correct data on the Exhibit of Grievances and Utilization Review Appeals and N.Y. Schedule M within their respective NY Supplement/Data Requirements' filings with the Department.

8. UNDERWRITING AND RATING

The examiner reviewed the procedures followed by Oxford to confirm the group size of an employer. It was noted that the confirmation of a group size was fully supported with tax documents such as NYS 45, Form 1120S, Form K1 or IRS Form 1094-C at time of enrollment. However, upon renewal, Oxford's confirmation of group size is based on a signed copy of an annual certification form.

In a sample of twelve (12) large group employers; 6 from OHI and 6 from OHP-NY, Oxford was unable to provide documentation to support the group size of the employers, other than a signed certification form.

It is recommended, as a good business practice, that Oxford obtain and maintain within its files, updated tax documents NYS 45, Form 1120S, Form K1 or IRS Form 1094-C as support to validate and classify the group size of employers, upon renewal.

9. OUT OF NETWORK DISCLOSURE NOTICE

Section 3217-a(a)(19)(C) of the New York Insurance Law states in part:

> "(a) Each insurer subject to this article shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below… The information to be disclosed shall include:
>
> (19) with respect to out-of-network coverage:
>
> (A) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;
>
> (B) the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and
>
> **(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;"**

Similar references are included within New York Insurance Law Section 4324(a)(20) and New York Public Health Law Section 4408(1)(t), which contain and offer similar requirements.

A review of the insured contract and certificate revealed that Oxford did not include examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services. Oxford acknowledged that for calendar years 2015-2016 there were 82,602 (79,105 OHI and 3,497 dual license OHI/OHP-NY) subscribers that that did not get a proper disclosure notice.

It is recommended that Oxford comply with Section 3217-a(a)(19)(C) of the New York Insurance Law, Section 4324(a)(20) of the New York Insurance Law and Section 4408(l)(t) of

the New York Public Health Law, by ensuring that all required disclosure information be addressed in the insured contracts and certificates, including examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services.

10. EARLY INTERVENTION

Section 4303(ll) of the New York Insurance Law states:

> "Every small group contract or association group contract delivered or issued for delivery in this state that provides coverage for hospital, medical or surgical expense insurance and is not a grandfathered health plan shall provide coverage for the essential health benefit package."

"Essential health benefits" as defined within New York Insurance Law requires insurers to include within its benefit package a minimum of sixty (60) visits per year combined within the treatment categories of physical, speech, and occupational therapy.

In order to test for compliance, the examiner obtained and tested for calendar year 2017, a total population of 74 denied early intervention claims (claims which provide pre-school age children with therapies within the above three treatment categories). Oxford acknowledged there were 5 errors out of the 74 denied claims, a 7% error rate.

It is recommended that Oxford take steps to ensure that all Early Intervention claims are adjudicated and paid accurately.

11. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2013, contained the following nine (9) comments and recommendations (page numbers below refer to the prior report on examination):

ITEM NO.		PAGE NO.
1.	It is recommended that OHP-NY comply with Section 2114 of the New York Insurance Law and cease the payment of compensation to unlicensed producers. It is noted that the relationship was terminated as of November 2013. *The Company has complied with this recommendation.*	5
2.	It is recommended that Oxford comply with Section 4802(d) of the New York Insurance Law and, upon receipt of a grievance, provide written acknowledgement of such receipt within 15 business days. *The Company has complied with this recommendation*.	7
3.	It is recommended that Oxford comply with Section 4802(d)(2) of the Insurance Law and resolve grievance cases for referrals or benefit coverage within the required timeframe. *The Company has complied with this recommendation.*	7
4.	It is recommended that the Plan comply with New York Department of Health Regulation 98-1.16 (10 NYCRR 98-1.16) and provide accurate totals in Schedule M of the New York Supplement to the Annual Statement. *The company did not comply with this recommendation.*	7
5.	It is recommended that Oxford comply with Part 52.40(f) of Insurance Regulation 62 (11 NYCRR 52.40) and obtain pre-approval from its board of directors for its experience rating formulas. *The Company has complied with this recommendation.*	8

ITEM NO.		PAGE NO.
6.	It is recommended that, as a best practice, OHI change the language in its Optum Rx Pharmacy Benefit Manager agreement to require compliance with New York Insurance Law 4325(h), instead of simply ensuring the PBM utilize its "best efforts" to obtain compliance. It is noted that OHI has submitted a revised agreement to the Department in compliance with this recommendation. *The Company has complied with this recommendation.*	9
7.	It is recommended that OHI comply with Section 4903 and 4904 of the New York Insurance Law and provide adverse determination notices to all members. *The Company did not comply with this recommendation*.	12
8.	It is recommended that Oxford establish a written policy for the write-off of improper claim payments that includes the establishment of an evidentiary trail. *The Company has complied with this recommendation*.	12
9.	It is recommended that Oxford comply with the record retention requirements of Part 243.2 (a) and (b) of Insurance Regulation 152 (11 NYCRR 243.2) and maintain appropriate records for all areas of operations. *The Company has complied with this recommendation.*	14

12. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

ITEM **PAGE NO.**

Respectfully submitted,

_____
Jeffrey L. Usher, CFE
Financial Services Manager 2

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

Jeffrey L. Usher, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
Jeffrey L. Usher, CFE

Subscribed and sworn to before me
this _____ day of_____2021

APPOINTMENT NO. 31575

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

Jeffrey Usher

as a proper person to examine the affairs of the

Oxford Health Plans (NY), Inc.

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

HMO

with such other information as he shall deem requisite.

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

this 22nd day of February, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. 31576

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

Jeffrey Usher

as a proper person to examine the affairs of the

Oxford Health Insurance, Inc.

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

Company

with such other information as he shall deem requisite.

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

this 22nd day of February, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau