MARKET CONDUCT REPORT ON EXAMINATION

OF

OXFORD HEALTH INSURANCE, INC.

AND

OXFORD HEALTH PLANS (NY), INC.

AS OF

DECEMBER 31, 2013

DATE OF REPORT **DECEMBER 18, 2015**

EXAMINER **JEFFREY USHER**

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Shirin Amami
Acting Superintendent

December 18, 2015

Honorable Shirin Amami
Acting 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 30876 and 30874, both dated September 4, 2012, and 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") licensed 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, 2013. 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 48 Monroe Turnpike, Trumbull, 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 “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 the two entities is Oxford Health Plans, 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

A comprehensive market conduct examination of OHP-NY and OHI was conducted as of December 31, 2008, and filed on April 3, 2012. Financial condition examinations were conducted for the two companies as of December 31, 2012 and filed May 29, 2014. This current market conduct examination covers the period January 1, 2009 through December 31, 2013. Where deemed appropriate by the examiner, events subsequent to December 31, 2013 were also reviewed. A review was also made to ascertain what actions were taken by the Companies in regard to comments and recommendations contained in the prior reports on examination.

This report deals with the manner in which Oxford conducts its business practices and fulfills its contractual obligations to policyholders and claimants. This report is confined to comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

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 pre-paid 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 New York State 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. Subsequent to the examination, on January 24, 2014, the New York State Department of Health approved the transfer of OHI from OHP-NY to its parent, Oxford Health Plans, LLC.

3. AGENTS AND BROKERS

Section 2114(a)(3) of the New York Insurance Law states:

> "No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating or selling in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state..."

In a review of OHP-NY's long-standing agreement with the Metropolitan Golf Association ("MGA"), it was noted that between 2008 and 2013, OHP-NY provided compensation for services related to the soliciting, negotiating or selling of insurance. MGA is not a licensed insurance producer as defined within Section 2114(a)(3) of the New York Insurance Law. As a result, OHP-NY payment of compensation to MGA was violative of the above cited law. The number and total of payments made to MGA are noted in the following exhibit:

	No. of Payments Made	Total Commission paid
2008	395	$43,060
2009	306	$35,571
2010	230	$29,408
2011	215	$22,205
2012	153	$18,997
2013	124	$15,572
Total	1423	$164,813

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.

4. GRIEVANCES

New York Insurance Law Section 3217-d (a) states in part:

> "An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall establish and maintain a grievance procedure consistent with the requirements of section four thousand eight hundred two of this chapter."

New York Insurance Law Section 4802(d) and (d) (2) states in part:

> "(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:
>
> (2) 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 pursuant to the contract…"

In order to establish compliance with the cited laws, the examiner obtained a single sample of 25 member grievances from the overall population of 9,665 cases, of which 6,476 represented OHI.

In violation of Section 4802(d) of the New York Insurance Law, OHI had five violations while OHP-NY had two violations for a combined violation rate of 28% for the sample population, for their failure to acknowledge receipt of the grievance within 15 business days, as required by the cited law.

Utilizing the same sample, it was determined that OHI had nine violations and OHP-NY had two violations for a combined violation rate of 44% of the sample population, for their failure to resolve said grievances within 30 days, as required by the cited law.

After discussion with Oxford, it was determined that between the two types of violations, for OHI, there were a total of 4,625 violations within the original population, while for OHP-NY, there were 1,148 violations.

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.

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.

It is noted that the Companies have complied with these recommendations.

New York Department of Health Regulation 98-1.16(a)(3) (10 NYCRR 98-1.16) states the following, in part:

> "(a) Every MCO... shall file in duplicate with both the commissioner and the superintendent a financial statement on or before April 1st of each year, in the form and containing such information as the commissioner and the superintendent shall prescribe, showing its condition at last year-end and containing information required by section 4408 of the Public Health Law and the following information:
>
> (3) An analysis of utilization of services, including all services covered by the MCO."

The examiner noted that the total listing of grievances recorded by the Plan did not coincide with the total noted within the 2012 filed New York Annual Statement Supplement.

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.

5. UNDERWRITING AND RATING

Part 52.40(f) of Insurance Regulation 62 (11 NYCRR 52.40) states in part:

> "Experience-rated group insurance of insurers other than article 43 corporations. The following rules shall apply to the readjustment of the rate of premium for those policies rated in accordance with subsections (g), (h) and (j) of section 4235 of the Insurance Law.
>
> (1) Policies may be experience-rated in accordance with a written plan or formula approved by the board of directors of the insurer or designee thereof..."

During the underwriting and rating review of Oxford large group policy premiums, it was noted that the Companies did not receive the approval of the board of directors for their experience rating formulas.

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.

6. CLAIMS PROCESSING

New York Insurance Law Section 4325(h) states in Part:

> "(h) No corporation or insurer organized or licensed under this chapter which provides coverage for prescription drugs shall require, or enter into a contract that permits a copayment that exceeds the usual and customary cost of the prescribed drug."

Sections 3.4(b) of the approved Agreements between OHP-NY and OHI and their third-party Pharmacy Benefit Manager ("PBM"), Optum, states the following:

> *"Network Pharmacy Agreements (b). Except as otherwise required by Oxford's Certificate of Coverage, Plan Documents, and/or Summary Plan Description, Administrator shall use its best efforts to ensure that Network Pharmacy Agreements require Network Pharmacies to collect a charge from members for the provision of Covered Prescription Services that is either (A)the lesser of (i)the Cost-Sharing Amount (ii) the usual and customary charge; or (iii)the Prescription Drug Compensation or (B) the lesser of (i) the Cost-Sharing Amount or (ii) the usual and customary charge. Oxford will determine whether charge (A) or charge (B) will be collected from which Members."* (underline added for emphasis)

The language in the Agreements must require specific compliance with New York Insurance Law 4325(h) instead of simply ensuring the PBM utilize its "best efforts" to obtain compliance.

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.

7. UTILIZATION REVIEW

New York Insurance Law Section 4903 states the following, in part:

> "(d) 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.
>
> (e) 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 rational, if any;
> (2) instruction 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: and
> (3) notice of availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon…"

New York Insurance Law Section 4904(a) and (c) state the following, in part:

> "(a) An insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, may appeal an adverse determination rendered by a utilization review agent."
>
> "(c) A utilization review agent shall establish a standard 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."

While these laws apply only to OHI, the New York Public Health Law has identical requirements, which are applicable to OHP-NY. For ease of reference, all instances below reference the Insurance Law.

Federal law and regulations also contain requirements regarding notice of adverse determinations and appeal determinations. See 42 U.S.C. § 300gg-19, 42 C.F.R. § 147.136 and 29 C.F.R. § 2560.503-1. Department of Labor Regulation 29 C.F.R. § 2560.503-1(g) states the following in part regarding notification of adverse determinations:

> "(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv)."

Department of Labor Regulation 29 C.F.R. § 2560.503-1(j) states the following in part, regarding the notification of appeal determinations:

> "(j) Manner and content of notification of benefit determination on review. 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)."

The examiners reviewed a sample of twenty Initial adverse Determination ('IAD") cases. Three of five retrospective cases revealed that the member was sent an IAD that did not meet all of the requirements of New York Insurance Law Section 4903, cited above. The IAD's did not contain the reason for the determination including the clinical rationale.

The examiners noted that seven of the aforementioned twenty IAD's were appealed. The examiners reviewed the seven appeals for compliance with New York Insurance Law Section 4904, also cited above. Three of three retrospective cases, one of two prospective cases, and one of two concurrent cases revealed that the member was not sent an Appeal Determination Letter ("ADL") in accordance with New York Insurance Law Section 4904. In all of the above described cases the provider is a participating facility, the service was not a planned service, the claims were for inpatient stays, and the member was not at financial risk.

It is recommended that Oxford comply with Sections 4903 and 4904 of the New York Insurance Law and 29 C.F.R. § 2560.503-1(h) and provide adverse determination notices to all members.

8. OVER-PAYMENT REFUNDS

New York Insurance Law Section 3224-b (b)(3) states in part:

> "A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a health care provider."

In order to test compliance with this law, the examiner extracted a statistical sample of 167 claims for each of the two entities from the total population of claims that appeared to have been reversed over 24 months beyond the original pay date. For this sample, the Companies were unable to document sufficient cause for late recovery efforts for 23 OHP-NY claims (13.7%) and 44 OHI claims (26.3%). When asked to explain, the Companies indicated that these transactions were not claim overpayment recoveries but instead were accounting transactions wherein the original claim payments were reversed in order to write the payments out of the accounting system. The Companies indicated that no money actually changed hands. In this event, the Companies should establish a policy that will provide a method to track the write-off of improper claim payments in order to create an evidentiary trail for the transactions.

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.

9. RECORD RETENTION

Insurance Regulation 152 Part 243.2 (a) and (b) 4 and 8 state the following, in part:

> "(a) In addition to any other requirement contained in Insurance Law, section 325, any other section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part.
>
> (b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.
> (8) Any other-record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

During the examination, there were multiple occasions when Oxford was unable to provide specific documentation to support their compliance with the law, regulation and/or Oxford policy. These include the following:

- During the sample review of fifteen providers credentialing records, it was noted that Oxford could not locate the credentialing documents for one out of the fifteen sampled items.
- During the underwriting and rating review, Oxford was unable to provide copies of documents for four of five sample declinations of coverage files. There were two files that did not contain declination letters and one of the two files also did not contain the underwriting quote worksheets. There were two additional files that did not contain the underwriting quote worksheets. These missing items should be included within the declination of coverage file along with the application. As a result, the examiner could not make any determination on whether the declinations were in compliance with applicable rules and regulations.
- During the review of 50 member utilization review cases, the examiner found that in two instances, OHI, and in nine instances, OHP-NY were unable to provide copies of acknowledgement letters and initial decision letters. Although the system had reference numbers for the eleven items, Oxford was unable to provide copies.

- During the review of claims in accordance with Section 3224-a of the Insurance Law, Oxford was unable to provide support for retroactively adjusted claims that were delayed. These claims contributed to 47% of the samples that were delayed in violation of Section 3224-a.

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.

11. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2008, contained the following comments and recommendations (The page numbers included below refer to that prior report on examination):

ITEM NO.		PAGE NO.
1.	It is recommended that Oxford comply with New York Insurance Law §310(a)(3) and provide complete examination requests accurately and in a timely manner. *Oxford has complied with this recommendation.*	
2.	It is recommended that Oxford enforce its contractual grace period and terminate those groups that do not pay their premiums timely. *Oxford has complied with this recommendation.*	7
3.	Further, it is recommended that if Oxford does terminate members outside of the contractual grace period, that it only reverses claims for dates of service that took place in the most recent thirty day period. *Oxford has complied with this recommendation.*	7
4.	It is recommended that Oxford comply with New York Insurance Law §3224-a and process all claims within the required time parameters, paying interest where appropriate. *Oxford has complied with this recommendation for at least 98% of claims processed.*	11
5.	It is further recommended that Oxford pay interest on those claims within the Prompt Pay population identified in the foregoing section of this report. *Oxford has complied with this recommendation for at least 98% of claims processed.*	11

ITEM NO. **PAGE NO.**

ITEM NO. **PAGE NO.**

12. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO. **PAGE NO.**

Respectfully submitted,

_____/S/_____
Jeffrey Usher, AFE
Associate Insurance Examiner

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

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

_____/S/_____
Jeffrey Usher

Subscribed and sworn to before me
this _____ day of_____2015.

APPOINTMENT NO. 30876

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

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 4th day of September, 2017

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: Stephen J. Wiest

Stephen J. Wiest
Deputy Bureau Chief
Health Bureau

APPOINTMENT NO. 30874

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

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 4th day of September, 2012

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: Stephen J. Wiest

Stephen J. Wiest
Deputy Bureau Chief
Health Bureau