

**MARKET CONDUCT REPORT ON EXAMINATION**

**OF**

**U.S. HEALTHCARE, INC.**

**AND**

**U.S. HEALTH INSURANCE COMPANY**

**AS OF**

**FEBRUARY 28, 2001**

**DATE OF REPORT:**

**AUGUST 30, 2001**

**EXAMINER:**

**MARTIN A. SCHWARTZMAN**



## TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of examination	2
2.	Executive summary	3
3.	Claims processing	5
4.	Schedule H (aging analysis of unpaid claims)	22
5.	Compliance with prior report on examination	26
6.	Summary of comments and recommendations	42



STATE OF NEW YORK  
INSURANCE DEPARTMENT  
25 BEAVER STREET  
NEW YORK, NY 10004

August 30, 2001

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 21618 and 21619 dated October 2, 2000, and annexed hereto, I have made an examination into the affairs of U.S. HealthCare, Inc. ("USHC-NY"), a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law and U.S. Health Insurance Company, ("USHIC-NY") an accident and health insurance company licensed under Article 42 of the New York Insurance Law. The following report, as respectfully submitted, deals with the findings concerning the manner in which USHC-NY and USHC-NY conduct their business practices and fulfill their contractual obligations to policyholders and claimants.

Whenever the term "U.S. HealthCare" appears herein without qualification, it should be understood to refer to both USHC-NY and USHC-NY. Wherever a distinction needs to be made, the terms "USHC-NY" and/or "USHIC-NY" shall be used.

## **1. SCOPE OF EXAMINATION**

A review of how U.S. HealthCare conducts its business practices and fulfills its contractual obligations to policyholders and claimants was performed. The performance dates of this review are January 1, 2000 through June 30, 2000. The primary purpose of this report is to assist U.S. HealthCare management in addressing problems that are of such a critical nature that immediate and corrective action is required. This report's comments chiefly involve matters that depart from New York laws, regulations and rules or those which are deemed to require an explanation or description from U.S. HealthCare's management.

A previous examination to ascertain the manner in which U.S. HealthCare conducted its business practices and fulfilled its contractual obligations to policyholders and claimants was performed as of March 30, 2000. A report thereon was filed on October 24, 2000. At that time, both the Department and U.S. HealthCare agreed that a second examination comprised of a more detailed statistical review of the claims process procedures and Schedule H (NY Claims Aging Analysis) preparation should be performed.

## 2. **EXECUTIVE SUMMARY**

The findings and recommendations noted herein reflect a weak management control structure as it pertains to claims processing. The statistical model utilized for testing both attribute (processing operations) and financial accuracy for this examination, revealed a number of diverse errors that together indicate underlying systemic problems. Examples of this are reflected in:

- deductible and/or maximum out-of-pocket amounts incorrectly applied;
- incorrect reimbursement rates and co-payments for both in-network and out-of-network providers;
- failure to remit required New York Health Care Reform Act (“HCRA”) surcharges;
- claims denied in violation of applicable New York mandates for coverage (possibly due to medium and large NY employers having employees in multiple locations);
- paper referrals imaged into the claims system were overlooked by the claims processors resulting in an improper rejection of claims;
- poor monitoring of the outsourcing of chiropractic services to American Chiropractic Network (“ACN”) resulting in claims outstanding for several months to over one year with no explanation or documentation either requested or on file;
- routine use of manual overrides;
- multiple re-processing of claims.
- unclear and often incorrect explanation of benefits language (“EOB”); and
- record maintenance and retention practices relating to claims processing in violation of New York Regulations.

These problems are further exacerbated by the need for enhanced claims processing monitoring and quality control and support the Department’s recommendations that management examine the current structure upon which the maintenance of performance statistics is analyzed.

U.S. Healthcare recently reported to the Department that it has initiated a wide scale project named “First Claim Resolution”. The initial step in this program is an internal in-depth review of claims processing, cross-functional operations and recommended information systems enhancements. The results of this review will be presented to senior management so that appropriate business decisions can be made. In addition, U.S. HealthCare has engaged an outside consultant (PriceWaterhouseCoopers LLP) specifically to assist in improving its quality programs including internal audits of claim processing activities.

It is recommended that U.S. HealthCare make periodic reports to the Department on any business decisions made by senior management in response to the “First Claim Resolution” project and provide the Department with final copies of any reports and recommendations rendered by any outside consultant including the PriceWaterhouseCoopers LLP engagement as denoted further herein under Item 3. “Claims Processing.”

### **3. CLAIMS PROCESSING**

This review was performed by using a statistical sampling methodology covering the scope period in order to evaluate the overall accuracy and compliance environment of U.S. HealthCare's claims processing. In order to achieve the goals of this review, claims were segregated into two primary populations:

- a) US HealthCare, Inc.; and
- b) US Health Insurance Company.

These primary populations were then further divided into hospital and medical claims segments. Therefore, a total of four groups were established. A random statistical sample was drawn from each of the four groups. It should be noted that for the purpose of this project, those medical costs characterized as Pharmacy, Medicare/Medicaid, Dental, Capitated Payments, Accrued Physician Distribution, SMC, SRR/FRO, and HCRA bulk payments were excluded.

This statistical random sampling process was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if 10 attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample. The following parameters were established to determine the sample size for the statistical

sampling model:

a) **Confidence Level** –

The rate was set at 95%, which infers that there is a 95% chance that the sample will yield an accurate result.

b) **Tolerance Error** -

The rate was set at 5%. It was determined that a 5% error rate would be acceptable for this sample.

c) **Expected Error** –

It was anticipated that a 2% error rate exists in the entire population subject to sampling, which was deemed acceptable for the model design.

d) **Sample Size** –

The sample size for each of the four populations described herein was comprised of 167 randomly selected unique claims. A second random sample of 50 items from each of the four groups was also generated as “replacement items” in the event it was determined a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized. In total, 668 claims for the scope period were selected for review. This reflects 334 claims for USHC-NY and 334 claims for USHIC-NY.

e) **Sample Unit** –

The term “claim” can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a “claim,” which is defined by U.S.

HealthCare 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 in a series of screens each containing up to four line items. Therefore, a “claim” as defined in this paragraph may consist of multiple screens. For example, for a claim submitted that contained twelve services, three screens would exist for this claim. It is possible, through the coding associated with each screen, to match or “roll-up” all screens with the original claim form submitted, which is the basis of the Department’s statistical sample of claims or the sample unit. This is an important distinction as U.S. HealthCare does not base its QAP on a “roll up” of all screens related to the original submission, only on the screen selected for audit.

Accordingly, the sampling results are based on the roll-up of screens to an original submission. For purposes of the sampling, U.S. HealthCare has agreed to this methodology.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by US HealthCare. To verify each service (item) that resulted in no payment, a reconciliation of transaction counts was performed.

Findings indicate there are serious internal control and claims processing deficiencies within U.S. HealthCare’s claims processing system. These deficiencies appear to have an adverse impact on U.S. HealthCare’s ability to process claims with minimal errors on a timely basis. The examination review revealed overall claims processing financial accuracy levels were

only 83.83% for USHC-NY Medical, 61.08% for USHC-NY Hospital, 66.47% for USHIC-NY Medical and 65.87% USHIC-NY Hospital respectively. Overall claims processing procedural accuracy levels were only 81.44% for USHC-NY Medical, 58.05% for USHC-NY Hospital, 41.92% for USHIC-NY Medical and 60.48% for USHIC-NY Hospital respectively. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance U.S. HealthCare's claim processing guidelines. An error in processing accuracy may or may not affect the financial accuracy.

In summary, of the 668 claims reviewed, 264 contained one or more claims processing procedural errors. Of these 264 claims, 205 contained one or more financial errors. U.S. HealthCare has currently established key performance indicators for quality of 99 percent for procedural and financial accuracy. The examination findings show a significant gap.

The following charts illustrate the financial and procedural claims accuracy findings summarized above:

### Summary of Financial Claims Accuracy

	USHC-NY Medical	USHC-NY Hospital	USHIC-NY Medical	USHIC-NY Hospital
Claim Population	322,534	2,512,588	304,081	35,326
Sample Size	167	167	167	167
Number of claims with Financial Errors	27	65	56	57
Calculated Error Rate	<u>16.17%</u>	<u>38.92%</u>	<u>33.53%</u>	<u>34.13%</u>
Upper Error limit	21.75%	46.32%	40.69%	41.32%
Lower Error limit	10.58%	31.53%	26.37%	26.94%
Upper limit Claims in error	<u>70,156</u>	<u>1,163,759</u>	<u>123,741</u>	<u>14,598</u>
Lower limit Claims in error	<u>34,124</u>	<u>792,219</u>	<u>80,189</u>	<u>9,517</u>

**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.)**

### Summary of Procedural Accuracy

	USHC-NY Medical	USHC-NY Hospital	USHIC-NY Medical	USHIC-NY Hospital
Claim Population	322,534	2,512,588	304,081	35,326
Sample Size	167	167	167	167
Number of claims with Procedural	31	70	97	66
Calculated Error Rate	<u>18.56%</u>	<u>41.92%</u>	<u>58.08%</u>	<u>39.52%</u>
Upper Error limit	24.46%	49.40%	65.57%	46.94%
Lower Error limit	12.67%	34.43%	50.60%	32.11%
Upper limit Claims in error	<u>78,981</u>	<u>1,241,215</u>	<u>199,378</u>	<u>16,581</u>
Lower limit Claims in error	<u>40,865</u>	<u>865,084</u>	<u>153,865</u>	<u>11,343</u>

**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 concept of internal control incorporates a number of key elements in the successful operation of any entity. These are embodied in such areas as manpower controls, compliance controls, operational controls, monitoring controls (usually the audit and/or quality assurance areas), accounting controls (books and records and management reporting, including information systems), and overall management standards (policies and procedures) set by the Board of Directors through to the line supervisor. The statistical sample findings not only show individual errors, both in terms of overpayments and underpayments – symptoms (which can be projected to the whole), but also management issues that relate to the cause of the errors. It is important that management recognizes and develops programs to address the control weaknesses noted herein.

U.S. HealthCare has a Quality Assurance Program (“QAP”) in place to review payment and financial accuracy of claims. As previously noted, U.S. HealthCare’s claims processing system is organized in a series of screens called “claims.” Each claim screen may include up to four unique detail lines. Therefore, an incoming claims form with a large number of services will be entered on multiple claim screens. All claims screens that will result in a payment greater than \$1,500 are sent to QAP for review prior to release of payment. Additionally, three percent of all claims processed are randomly selected for review by QAP.

The following chart below sets forth the number of claims reviewed, total dollars reviewed and the subsequent results (financial accuracy) for the Northeast Region (“NE”) - (New York, Connecticut, Massachusetts, New Hampshire, Rhode Island, Vermont and Maine)

HMO Claims Operations for the period under review. As defined by U.S. HealthCare, the NE Region HMO Claims Operations would include HMO and Out-of-Network claims including claims for USHC-NY and USHC-NY. U.S. HealthCare does not maintain statistics separately for USHC-NY and USHC-NY nor can they break out New York claims from the overall NE Region.

U.S. HealthCare Northeast Region 2000 Claim Operations QAP Reviews

<u>Month</u>	<u>Claims Reviewed</u>	<u>Dollars Reviewed</u>	<u>Number of Financial Errors</u>	<u>Financial Accuracy</u>
<b>January</b>	14,103	\$24,694,924.66	193	99.54%
<b>February</b>	15,213	\$27,768,573.12	296	98.41%
<b>March</b>	19,062	\$37,106,814.69	295	99.19%
<b>April</b>	23,093	\$47,742,367.50	252	99.25%
<b>May</b>	20,720	\$43,688,520.91	241	99.55%
<b>June</b>	21,889	\$49,660,336.34	272	99.35%
<b>July</b>	23,217	\$59,000,411.75	350	98.99%
<b>August</b>	23,001	\$55,238,531.00	399	99.04%
<b>September</b>	23,738	\$64,505,041.41	499	99.22%
<b>Totals</b>	<b><u>184,036</u></b>	<b><u>\$409,405,521.38</u></b>	<b><u>2,797</u></b>	<b><u>99.18%</u></b>

Albeit, the QAP process is performed on a screen by screen basis rather than a “roll-up” of all screens with the original claim form submitted, which is the basis of the Department’s statistical sample of claims or the sample unit (management indicating that multiple screens comprise less than 10 percent of the overall population), the examination findings are serious enough to warrant a management review of the QAP process.

It is important to note that some of the claims reviewed by the examiners that went through the QAP process were processed incorrectly. For example, from the examination

sample, nine claims had been forwarded to QAP for review and three of them or 33% were processed in error despite the quality review.

The following represents examples of substantive claims processing findings and issues:

1. In the vast majority of instances, U.S. HealthCare was not able to produce copies of correspondence, referrals, medical and/or utilization reviews for the claims reviewed. Therefore, the examiners were unable to reconstruct all events relating to the processing of specific claims. Claims correspondence, whether originated from the subscriber or internally generated, is a critical part of the claims review process. It also provides an audit trail that helps document the history of the claim should additional review or research in contested claims become necessary.

New York State Insurance Department Regulation No. 152 (11 NYCRR 243) sets forth standards of retention of records by insurance companies.

Section 243.2(b)(4) states that 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.”

U.S. HealthCare’s failure to retain all the requisite claims information is a violation of Department Regulation No. 152.

2. U.S. HealthCare's claims processors utilize overrides as a normal procedure to by-pass various systems edits within the claims processing system. For example, of the 668 claim files reviewed, 193 files or 29% were processed utilizing one or more manual overrides. Moreover, in almost all cases U.S. HealthCare was unable to explain why the claims processing system adjudicated these claims in such a manner that a manual override was required. Overrides should never be considered a routine procedure in a tight control environment.
  
3. A significant amount of the claims reviewed were reprocessed multiple times and were still not adjudicated correctly. In one instance, a claim was resubmitted six times and improperly denied five times as a duplicate. There is no evidence that the processors checked the reason for the initial non-payment. If this had been done, it would have revealed that the referral was not on file when the claim was originally adjudicated. Included with all five re-submissions was a copy of the referral, however, the claim was not processed correctly and paid until the sixth submission.

Of the 334 files reviewed pertaining to USHC-NY, 39 claims or 12% were reprocessed because the claim was not paid correctly on the initial adjudication. Additionally, 15 of the reprocessed claims required further re-processing because even upon multiple re-processing, the claims were not correctly adjudicated.

Of the 334 files reviewed pertaining to USHC-NY, 58 claims or 17% were reprocessed because the claim was not paid correctly on the initial adjudication. Additionally, 31 of the

reprocessed claims required further re-processing because even upon multiple re-processing, the claims were not correctly adjudicated.

4. Instances were noted where subscribers referred to non-participating providers by USHC-NY were incorrectly reimbursed at the lower participating provider rate fee. This caused the subscriber to be “balance billed” the difference. Only upon appeal and/or multiple resubmission of a claim were adjustments made. This matter was also a finding that was discussed in detail in the previous U.S. HealthCare Market Conduct Report on Examination as of March 30, 2000.
  
5. Instances were noted where deductibles and/or maximum out of pocket amounts were incorrectly applied. For example, in one claim reviewed, it was noted that U.S. HealthCare’s claims processing system showed that \$3,073 was accumulated as out of pocket expenses to a subscriber who contractually had a \$2,000 maximum out of pocket limit. In this situation, after co-insurance split, the subscriber should have been reimbursed at 100% after incurring \$2,000 in out of pocket costs. U.S HealthCare underpaid the member submitting these claims by \$1,073. Of the 334 files reviewed pertaining to USHC-NY 26 instances or 8% were noted with errors as to the application of a deductible and/or a maximum out-of-pocket limit.

One possible reason for this occurring is that when a manual adjustment is made, the

deductible accumulator, and/or the maximum out of pocket accumulator amount is not automatically adjusted. When manual adjustments outside the program's parameters are made, it is important to adjust all areas of impact. This further supports the Department's conclusions regarding the weak control environment and the need for additional training and an enhanced monitoring system.

6. Numerous instances were noted where U.S. HealthCare did not remit the required New York Health Care Reform Act ("HCRA") Surcharges to New York State. Currently surcharges (8.18% of the claim settlement) are applicable to claims from hospitals (all levels of care), freestanding clinical labs, ambulatory surgery centers, and diagnostic and treatment centers that have registered with the State of New York. It should be noted that some laboratory services from outpatient hospitals, freestanding ambulatory surgical facilities and comprehensive primary health care clinics for service dates on and after October 1, 2000 are exempt from the surcharge. No claims were selected for review with dates of service on or after October 1, 2000.

Of the 334 Hospital claim files reviewed, 76 instances or 23% were noted where U.S. HealthCare did not remit the required HCRA Surcharge to the State of New York. Moreover, in cases where U.S. HealthCare agreed to retroactive contract adjustments for certain providers, it was noted that the HCRA surcharges were not paid to the State of New York for the additional payments. U.S. HealthCare offered no explanation as to why or how this occurred. This matter will be referred for further investigation to the New York State Department of Health.

U.S. HealthCare should establish a liability on its financial statements since the sample findings indicate that the amount payable may be material.

7. U.S. HealthCare utilizes American Chiropractic Network “(ACN)” to review and process claims for all in-network chiropractic services for its New York HMO/QPOS subscribers, and to review prior to payment, claims for all out-of-network chiropractic services. All out-of-network chiropractic claims received by U.S. HealthCare are pended “CHRO” and forwarded to ACN for review and/or approval prior to payment. Unless ACN instructs U.S. HealthCare how to pay the claim, it retains its pended status. Documentation regarding ACN’s instructions with respect to payment for out-of-network chiropractic services is not maintained within U.S. HealthCare’s claims system in violation of Department Regulation 152 as previously described herein.

The examination review revealed that ACN did not forward completed reviews to U.S. HealthCare in a timely manner. For example, one claim for chiropractic services was submitted to U.S. HealthCare on three separate occasions. Each time U.S. HealthCare referred it to ACN. ACN did not instruct U.S. HealthCare on how to adjudicate the claim until one year later.

8. Findings also revealed instances where incorrect co-payment amounts were applied to the claim files reviewed. U.S. HealthCare’s claims processing system is designed to

automatically apply co-payments as applicable to specific contracts. Of the 334 files reviewed pertaining to USHC-NY, 8 instances or 2% were noted where incorrect co-payment amounts were applied. U.S. HealthCare was not able to explain how these errors occurred.

9. Examination reviews revealed claims where incorrect participating provider reimbursement rates were applied. U.S. HealthCare's claim processing system is designed to automatically apply participating provider rates as applicable to the specific contract. Of the 334 files reviewed analyzed pertaining to USHC-NY, 40 instances or 12% were noted as having incorrect participating provider rates. U.S. HealthCare was not able to explain how these errors occurred.

10. Examination findings revealed instances where incorrect non-participating provider payment amounts were applied. Of the 334 files reviewed pertaining to USHC-NY, 25 instances or 7% used incorrect non-participating provider payment rates applied. U.S. HealthCare was not able to explain how these errors occurred.

11. Instances were noted where participating provider claims were incorrectly paid at the out-of-network benefit level. In the majority of these instances, this occurred with claims that consisted of multiple screens. As previously described U.S. HealthCare's claims processing system cannot accommodate more than four lines of information per claim number. In other words, if a claim has more than four procedures, the system assigns a new

claim number to the next screen consisting of the next four procedures until the claim has been fully entered into the system. Therefore, a claim may consist of multiple screens. Claims processors must confirm that all parts of the claim are accounted for in order to accurately process the claim. This was not done and various claims were paid incorrectly. In these cases services contained within one screen were correctly processed at the in-network level while other screens that were part of the same claim were incorrectly processed as an out-of-network benefit level. Additionally, in some instances, the referral attached to some claims with single screens was overlooked. Of the 334 files reviewed pertaining to USHIC-NY, 16 instances or 5% were noted as having been incorrectly paid at the out-of network benefit level, which resulted in members being required to pay additional co-insurance and/or a higher deductible.

12. Examination revealed that the language contained in the Explanation of Benefits statements (“EOBs”) sent to subscribers and/or providers was unclear and/or wrong . EOB Language should clearly communicate to the subscriber and/or provider that U.S. HealthCare has processed a claim and how it was adjudicated. An EOB is an important link between the subscriber, provider and U.S. HealthCare. The language should clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered and show any balance owed the provider. It can also serve as the basis for the recovery of any money from coordination of benefits with other insurance carriers.

There are indications that are related to the reasons for the confusion surrounding the EOB

problems such as inapplicable processing codes that resulted from the previously described manual overrides. This situation coupled with the issue of confusing language for some of the correct processing codes render the EOB inadequate or in error in many cases.

13. USHC-NY denied claims due to no referrals submitted by participating provider specialists despite their presence. The usual procedure for a USHC-NY member to receive covered care from a specialist physician involves obtaining a referral from the member's participating primary care provider ("PCP") to a participating specialist.

For example, it was noted that upon receipt of a claim accompanied by a paper referral, both the claim and referral are imaged into the system, and a flag is added to the claim screen to instruct the processor to check for an additional document. If the claims processor fails to note the flag and check for the presence of a referral, the claim might be improperly denied for lack of a referral. Within the claims processing sample, this has occurred on several instances.

Further, in instances when a referral arrives after a claim has been denied for lack of referral, and the referral is entered into U.S. HealthCare's claims processing system, no action is taken relative to the denied claim. This processing practice creates the necessity for the member or provider to complain and/or resubmit the claim for proper payment. This problem is further compounded, as upon resubmission, the matter is not always resolved. U.S. Health Care's claims processing system should be improved by a change in

programming to ensure that paper referrals are properly administered.

With respect to many of the claims reviewed wherein a paper referral was utilized, no determination could be made as to when USHC-NY actually received the referral. This is due to USHC-NY's inability to produce a copy of paper referrals received.

14. U.S. HealthCare does not require a claim form to be submitted as part of a claims submission process. As long as a subscriber ID number is indicated on the bill, the claim will be adjudicated. Numerous instances were noted where U.S. HealthCare adjudicated claims without having the signature of either the subscriber or the provider on the bill. Additionally, important information with respect to coordination of benefits information and/or other insurance coverage cannot be detected without the filing of a claim form.

Section 86.2 of 11 NYCRR 86 (Regulation 95) reads as follows:

“§86.4 Warning statements.

All applications provided to applicants for [non-automobile] commercial insurance and **all claim forms** for insurance, except personal automobile insurance, delivered to any person residing or located in this State (on and after February 2, 1994) in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation." Emphasis added.

Although U.S. HealthCare does not require the use of a claim form, it would be prudent to require the use of a signed claim form or envelope that contains the fraud warning denoted above as well as requiring information with respect to coordination of benefits and/or other insurance coverage.

15. When a claim is received in U.S. HealthCare's mailroom, procedures require that the receipt date to be embossed on the claim form. This date is critical in determining the timeliness of claims processing since it represents the starting point in the claims processing cycle. However, the embossed date did not always appear on the imaged copy. Additionally, for unexplained reasons, many claims were processed before the date was embossed. In these cases, the examiners had to use the date the claim was entered into U.S. HealthCare's claims processing system as the starting point. A "system entry date" may or may not be the same date the claim was received.

In summary, of the 668 claims reviewed, 292 or 44% either did not have the either receipt date of the claim embossed on the claim form or it contained the wrong date.

Other weaknesses in claim processing activities were also noted. Although instances of these issues occur less frequently than those addressed above, it further supports the Department's concern regarding the inadequate control structure within the claims processing system. Some of these issues are as follows:

- not all services that were part of a claim were processed;
- claims were denied with insufficient explanation;
- documentation to support the dates of member terminations were not maintained;
- services were incorrectly denied as exceeding the contract benefit;
- pre-certification penalties were not correctly applied;
- incorrect CPT codes were used to process claims;
- claims were incorrectly processed at the in-network level benefit;
- Two instances were noted where services were denied in violation of applicable NY mandates for such coverage. Although the requisite information to process the claim correctly resided within the claims processing system, it appears that the processor failed to apply the proper contract requirements.
- inconsistencies were noted relative to the denial of claims due to a late submission; and
- no documentation was maintained relative to a few claim submissions.

It should be noted that over the last year, U.S. HealthCare has initiated a number of projects and systems enhancements that should address many of the underlying issues that are the subject of some of the items identified in this report. The most comprehensive of these projects is called “First Claim Resolution” which includes a thorough evaluation and implementation process. The evaluative phase of this project has, in large part, been completed. This included a large-scale analysis of quality assurance processes, which was conducted by PriceWaterhouseCoopers, LLP. The “First Claim” project focuses on identifying and eliminating the root cause problems which could preclude finalizing a claim the first time it is submitted. As part of this effort, U.S. HealthCare conducted focus groups with employers, members and providers, and improved data reporting was initiated.

Specific initiatives included in the “First Claim Resolution” project are:

- 1) improving communication and efficiencies between the utilization management teams and the claims processing teams;

- 2) developing targeted claims units to work with particular hospitals, customers, etc, in order to improve relationships and increase efficiencies; and
- 3) identifying and addressing gaps in claim adjudication processes and systems capabilities.

Additionally, being addressed under the “First Claim Resolution” umbrella, is a claims re-work project, with the goal of reducing claims that need to be re-processed more than once.

U.S. HealthCare has also undertaken broader initiatives that focus on redesigning business processes including re-engineering information technology systems, improving physician/member relationships and addressing claim payment issues. Specifically, these initiative focus on:

- improving the accuracy as well as the timeliness of HMO claims payments, including making the adjudication process more automatic so as to eliminate human error and reduce human intervention;
- documenting and reporting on the reasons that claims may have been processed incorrectly;
- improving claim payment accuracy by redesigning processes related to duplicate claims; and
- improving accuracy on claim payments based on contracted rates, with the goal of reducing the number of claims having to be resubmitted for additional consideration, as well as provide more timely payment of claims.

Other enhancements include: previous implementation of the Total Utilization Management System (“TUMS”), improved utilization management reporting and documentation, and improvements to address certain of the record retention issues identified in the exam.

#### **4. SCHEDULE H (“AGING ANALYSIS OF UNPAID CLAIMS”)**

A follow-up review of U.S. HealthCare’s Schedule H submissions (“Aging Analysis of Unpaid Claims”) as filed with the Department for the period June 30, 2000 was performed. Ernst & Young LLP (“E&Y”) was engaged, pursuant to Section 313 of the New York Insurance Law, as advisor to assist the Department in evaluating the validity of the data submitted on U.S. HealthCare’s Schedule H as of June 30, 2000. Accordingly, Agreed Upon Procedures to assess Schedule H data were developed.

As part of the Agreed Upon Procedures, appropriate reconciliations were performed from the filed Schedule H’s to U.S. HealthCare’s underlying books and records. Additionally, claim samples were selected for each of the areas contained within Schedule H. This resulted in no exception items. Therefore, it was deemed appropriate that no further sampling be done.

U.S. HealthCare's preparation of Schedule H was a finding that was discussed in detail in the previous U.S. HealthCare Market Conduct Report on Examination as of March 30, 2000. That report evidenced U.S. HealthCare's inability to adequately ascertain the aging of its unpaid claims. At that time U.S. HealthCare only aged and reported unpaid claims that were in its accounts payable system. In other words, only claims that were fully adjudicated and forwarded to U.S. HealthCare's accounts payable system for payment were reflected in Schedule H. Claims received by U.S. HealthCare that were in various stages of the claims processing cycle prior to release to accounts payable were excluded. U.S. HealthCare was instructed to take the necessary steps to enable it to complete its Schedule H ("Aging Analysis of Unpaid Claims") in accordance with the Department's instructions.

Based on the findings of E&Y that no significant issues were noted relative to the accuracy of Schedule H, the Department is satisfied that U.S. HealthCare has completed this schedule in compliance with all the reporting requirements prescribe by the Department.

## 5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of March 30, 2000 contained nineteen comments and recommendations as follows (Page numbers refer to the prior report):

<u>ITEM</u>	<u>PAGE NO.</u>
<u>MANAGEMENT</u>	
<p>A. It is recommended that U. S. HealthCare distribute detailed, accurate and timely reports relative to its claims processing activities to senior management, its board of directors and the directors of the parent corporation on a regular basis so that management can be in a better position to make informed business decisions.</p> <p>U.S. HealthCare has complied with this recommendation.</p>	<p>2-5</p>
<p>B. It is recommended that U.S. HealthCare's board of directors and its parent company's board of directors immediately adopts the necessary written procedures in accordance with Circular letter No. 9 (1999).</p> <p>U.S. HealthCare has complied with this recommendation.</p>	<p>2-5</p>

**ITEM****PAGE NO.****CONDUCT OF EXAMINATION**

- C. It is strongly recommended that U.S. HealthCare's board of directors and its parent company's board of directors establish and implement a policy designed to ensure that U.S. HealthCare fully complies with the requirements of §310 of the New York Insurance Law. 6-8

U.S. HealthCare has complied with this recommendation.

**SALES**

- D. It is recommended that U.S. HealthCare ensure that its agents, brokers and employees maintain the requisite license in compliance with New York Insurance Law §2102(a)(1). 8-13

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.

- E. It is recommended that U.S. HealthCare comply with NYSID licensing requirements as to all U.S. HealthCare's employees who earn a commission or fee based on sales and to comply with New York Insurance Law §2114(a)(3) and §2116 to ensure that commissions are only paid to licensed agents and brokers. 8-13

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.

<b><u>ITEM</u></b>		<b><u>PAGE NO.</u></b>
F.	<p>It is recommended that U.S. HealthCare comply with New York Insurance Law §2112(a) and file all certificates of appointment for its agents with the Department as prescribed by statute.</p> <p>U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.</p>	8-13
G.	<p>It is recommended that U.S. HealthCare comply with New York Insurance Law §2112(d) and report terminated agents to the Department as prescribed by statute.</p> <p>U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.</p>	8-13
H.	<p>It is recommended that U.S. HealthCare implement the necessary internal control procedures in order to maintain adequate supporting documentation of its commission payments to various external insurance agents and brokers.</p> <p>U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.</p>	8-13

**ITEM****PAGE NO.****ADVERTISING**

- I. It is recommended that U.S. HealthCare comply with 11 NYCRR 215 (Regulation No. 34) Section 215.17 to: 14-15
- a) Maintain at its home or principal office a complete advertising file containing every printed, published or prepared advertisement of its policies.
  - b) Retain a complete advertising file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

U.S. HealthCare has complied with this recommendation

**WRITTEN DISCLOSURE OF INFORMATION**

- J. It is recommended that U.S. HealthCare comply with the requirements of §4324 of the New York Insurance Law and ensure that each subscriber, and upon request each prospective subscriber prior to enrollment, is provided with the required written disclosure information in a timely manner. 15-17

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.

**ITEM****PAGE NO.****UNDERWRITING AND RATING**

- K. It is recommended that U.S. HealthCare comply with the provisions of New York Insurance Law Section 4308 and Regulation 62 (11 NYCRR 52) and cease the practice of applying an experience rating methodology to the entire large group POS product until such time as its large group POS experience-rating methodology complies with Circular Letter No. 26 (2000). 17-21

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.

- L. It is recommended that U.S. HealthCare undertake a study to accurately determine the percentage of in-network vs. out of network utilization for its POS product in NY and adjust the premium allocation accordingly so that USHC-NY receives an appropriate share of the premium. 18-24

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
<p>M. It is recommended that U.S. HealthCare cease offering its “Oxford Power Play” discounts”, “Full Profit, NY/NJ Profit, X% Profit, NY Profit” discounts and its “Field Manager –5%” discount to selected groups.</p> <p>U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.</p>	18-24
<p>N. It is recommended that U.S. HealthCare discontinue offering “Multi-Year Rate Guarantees” to selected groups.</p> <p>U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.</p>	18-24
<p>O. It is recommended that U.S. HealthCare implement procedures whereby the underwriting experience of individual large groups in NY are monitored and reviewed.</p> <p>U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.</p>	18-24

**ITEM****PAGE NO.****CLAIMS**

- P. It is recommended that USHC-NY comply with §4403 6(a) of the New York State Public Health Law, §2601(a)(4) of the New York State Insurance Law and its member handbook and provide full reimbursement beyond the contracted co-payment to all subscribers who are properly referred to a non-participating provider. 21-24

U.S. HealthCare has not complied with this recommendation.

**PROMPT PAY**

- Q. It is recommended that U.S. HealthCare implement the necessary procedures in order to ensure compliance with §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”. 24-32

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation.

**ITEM****PAGE NO.**

- R. It is recommended that U.S. HealthCare consider the date a claim is received by Envoy, its electronic data interchange to be the receipt date with respect to compliance with §3224-a of the New York Insurance Law. 24-32

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

- S. It is recommended that U.S. HealthCare perform a comprehensive review of all claims that were not processed within 45 days for the period 1998 through present and reprocess those claims where which interest is due pursuant to §3224-a of the New York Insurance Law. Said results should be forwarded to the Department for review. 24-32

As of the date of this Report U.S. HealthCare has not complied with this recommendation.

- T. It is recommended that U.S. HealthCare implement the necessary procedures to ensure compliance with §3224-a(b) of the New York Insurance Law and send out requisite notifications within 30 days where applicable. 24-32

U.S. HealthCare has implemented the necessary procedures to

effectuate compliance with this recommendation

**ITEM**

**PAGE NO.**

- U. It is recommended that U.S. HealthCare automate the interest paying process within its claims processing system. 24-32

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

- V. It is recommended that U.S. HealthCare implement the necessary claims processing training in the application of §3224-a of the New York Insurance Law. 24-32

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

- W. It is recommended that U.S. HealthCare's Quality Assurance Department establish procedures to periodically test New York claims for compliance with §3224-a of the New York Insurance Law. 24-32

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

**ITEM****PAGE NO.****SCHEDULE H (“AGING ANALYSIS OF UNPAID CLAIMS”)**

- X. It is recommended that U.S. HealthCare take the necessary steps to enable it to complete its Schedule H (“Aging Analysis of Unpaid Claims”) in accordance with the Department’s instructions. 32-34

U.S. HealthCare has complied with this recommendation.

- Y. It is recommended that U.S. HealthCare submit corrected Schedules H’s to the Department forthwith. 32-34

U.S. HealthCare has complied with this recommendation.

**EMERGENT CARE**

- Z. It is recommended that U.S. HealthCare comply with the prudent layperson person standard for emergency care as defined in §3216(i)(9) and §3221(k)(4)(A) of the New York State Insurance Law. 35-37

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

<b><u>ITEM</u></b>		<b><u>PAGE NO.</u></b>
AA.	It is recommended that U.S. HealthCare review all emergency care claims that were submitted for the period 1998 through present and reprocess those claims that were inappropriately denied.	35-37

U.S. HealthCare has complied with this recommendation.

**UTILIZATION REVIEW**

BB.	It is recommended that USHC-NY maintain complete and a separate logs for all Utilization Reviews and appeals.	38-41
-----	---	-------

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

CC.	It is recommended that USHC-NY comply with §4903(4) of the New York State Public Health Law and complete utilization reviews within thirty days of receipt.	38-41
-----	---	-------

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
DD. It is recommended that USHC-NY comply with §4903(5) of the New York State Public Health Law and provide notices of adverse determinations in accordance with said statute.	38-41

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

EE. It is recommended that USHC-NY comply with §4904(3) of the New York State Public Health Law and resolve utilization review appeals within the specified timeframe.	38-41
--	-------

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

**EXPLANATION OF BENEFITS STATEMENTS**

FF. It is recommended that U. S. HealthCare modify its EOB to comply with §3234 of the New York Insurance Law.	41-43
--	-------

U.S. HealthCare has complied with this recommendation.

<b><u>ITEM</u></b>		<b><u>PAGE NO.</u></b>
GG.	It is recommended that U. S. HealthCare include a fraud warning and disclose on the EOB a toll free number where subscribers can call in the event they suspect that a fraud has been committed.	41-43

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

HH.	It is recommended that U.S. HealthCare include the date a claim was received on the EOB so that a subscriber and/or the provider cannot determine if any interest is due relative to a claim that took longer than 45 days to process.	41-43
-----	--	-------

U.S. HealthCare has not complied with this recommendation.

### **FRAUD PREVENTION AND DETECTION**

II.	It is recommended that U. S. HealthCare adequately and appropriately staff its Special Investigation Unit so that frauds can be detected and investigated more effectively.	44-47
-----	---	-------

U.S. HealthCare has complied with this recommendation.

- JJ. It is recommended that USCH-NY and USHC-NY each maintain 44-47  
statistics pertaining to the activities of the Special Investigation Unit as  
it relates to their individual operations.

U.S. HealthCare has implemented the necessary procedures to  
effectuate compliance with this recommendation.

**ITEM**

**PAGE NO.**

- KK. It is recommended that USHC-NY and USHC-NY each maintain 44-47  
documentation relating to budgeted amounts and actual expenses  
incurred for U.S. HealthCare's Special Investigation Unit.

U.S. HealthCare has implemented the necessary procedures to  
effectuate compliance with this recommendation

- LL. It is recommended that U.S. HealthCare comply with New York 44-47  
Insurance Law §405 and Department Regulation 95 and ensure that  
all cases of suspected fraud are reported to the Department as  
required.

U.S. HealthCare has implemented the necessary procedures to  
effectuate compliance with this recommendation

**GRIEVANCES, APPEALS AND COMPLAINTS**

- MM. It is recommended that USHC-NY provide a written 48-51

acknowledgement for grievances filed as required by §4408-a(4) of the New York State Public Health Law.

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

**ITEM**

**PAGE NO.**

NN. It is recommended that USHC-NY resolve grievances within thirty days when the grievance pertains to questions of coverage as required by §4408-a (4)(ii) of the New York State Public Health Law.

48-51

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

OO. It is recommended that USHC-NY resolve grievances within forty-five days for grievances pertaining to issues other than questions of coverage as required by §4408-a (4)(iii) of the New York State Public Health Law.

48-51

U.S. HealthCare has implemented the necessary procedures to effectuate compliance with this recommendation

PP. It is recommended that USHC-NY provide a written 48-51  
 acknowledgement of all appeals filed as required by §4408 (9) of the  
 New York State Public Health Law.

U.S. HealthCare has implemented the necessary procedures to  
 effectuate compliance with this recommendation

**ITEM**

**PAGE NO.**

QQ. It is recommended that USHC-NY resolve appeals within thirty days 48-51  
 after the receipt of all necessary information as required by §4408  
 (11) (ii) of the New York State Public Health Law.

U.S. HealthCare has implemented the necessary procedures to  
 effectuate compliance with this recommendation

6. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

**ITEM** **PAGE NO.**

**EXECUTIVE SUMMARY**

- |    |   |     |
|----|---|-----|
| 1. | It is recommended that U.S. HealthCare make periodic reports to the Department on any business decisions made by senior management in response to the “First Claim Resolution” initiative and provide the Department with final copies of any reports and recommendations rendered by its outside consultant including the PriceWaterhouseCoopers LLP engagement as denoted further herein under Item 3. “Claims Processing”. | 3-4 |
|----|---|-----|

**CLAIMS PROCESSING**

- |    |  |      |
|----|--|------|
| 2. | It is recommended that U.S. HealthCare implement a comprehensive review process that will monitor claims processing accuracy and institute the necessary corrective actions in order to bring the claims processing accuracy to an acceptable level. | 5-21 |
| 3. | It is recommended that U.S. HealthCare’s review its Quality Assurance Program. A number of exception items noted during the examination point to failures in the application of the quality control functions.                                       | 5-21 |

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
4. It is recommended that claims processing statistics be maintained separately for USHC-NY and USHIC-NY.	5-21
5. It is recommended that U.S. HealthCare comply with standards of retention of records by insurance companies as set forth in New York State Insurance Department Regulation No. 152 (11 NYCRR 243).	5-21
6. It is recommended that U.S. HealthCare re-evaluate its internal control procedures and policies regarding the acceptability of claims processing overrides. Overrides should never be considered as a routine procedure in a tight control environment.	5-21
7. It is recommended that U.S. HealthCare perform a comprehensive review of claims that have been reprocessed multiple times to determine the causes and implement the necessary corrective actions.	5-21
9. It is recommended that U.S. HealthCare implement the necessary changes to its claims processing system to ensure that deductible accumulator and maximum out of pocket accumulator calculations are working properly and that any adjustments to these items are properly reflected within the claims processing system.	5-21
<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
10. It is recommended that U.S. HealthCare implement the necessary	5-21

changes to its claims processing system to ensure that the required New York Health Care Reform Act (“HCRA”) Surcharges are paid to the State of New York. The Department will refer the issue of U.S. HealthCare’s failure to properly remit the required New York Health Care Reform Act (“HCRA”) Surcharges to the New York State Department of Health for further investigation.

- |     |  |      |
|-----|--|------|
| 11. | It is recommended that U.S. HealthCare establish a liability for the unpaid New York Health Care Reform Act (“HCRA”) Surcharges on its financial statements since the sample findings indicate that the amount payable may be material.  | 5-21 |
| 12. | <p>A. It is recommended that U.S. HealthCare institute the necessary procedures to monitor the activities of ACN and ensure there is follow-up for those reviews not forwarded to U.S. HealthCare on a timely basis.</p> <p>B. It is recommended that U.S. HealthCare make the necessary adjustments so that documentation relative to ACN’s payment instructions is maintained within U.S. HealthCare’s claims processing system.</p> | 5-21 |

13. It is recommended that U.S. HealthCare take the necessary steps to ensure that its claims processing system correctly applies proper co-payments and reimbursement rates for participating and non-participating providers as applicable to specific contracts. 5-21
14. It is recommended that U.S. HealthCare implement the necessary claims processing procedures to ensure that all screens reflecting the sum total of all parts of a claim are associated with all of the underlying documentation including referrals. 5-21
15. It is recommended that U.S. HealthCare implement the necessary changes to the claims processing system to ensure that its EOB language clearly communicates to the subscriber and/or provider that U.S. HealthCare has processed a claim and how it was adjudicated. This includes the requisite programming that should ensure that inapplicable processing codes that result from manual overrides are not reflected on the EOB. 5-21
16. It is recommended that U.S. HealthCare implement the necessary changes to its claims processing system to ensure that paper referrals are properly administered. 5-21

<b><u>ITEM</u></b>		<b><u>PAGE NO.</u></b>
17.	It is recommended that U.S. HealthCare require the use of a signed claim submission form or envelope that includes the fraud warning statement as described in Section 86.2 of 11NYCRR 86 (Regulation 95) and require that important information such as coordination of benefits information and/or other insurance coverage be supplied.	5-21
18.	It is recommended that U.S. HealthCare take the necessary steps to ensure that the date embossed on the claim form, which represents the date the claim is received, is clearly displayed on any electronically imaged and optically stored document.	5-21
19.	It is recommended that due to the high number of claims found to be in error and the weaknesses described in this report that U.S. HealthCare prepare for the Department's consideration a corrective action plan that addresses the identified claim processing errors and weaknesses, including the re-adjudication of claims processed in error.	5-21



STATE OF NEW YORK  
INSURANCE DEPARTMENT

I, NEIL D. LEVIN, Superintendent of Insurance of the State of New York,  
pursuant to the provisions of the Insurance Law, do hereby appoint:

**Martin Schwartzman**

*as a proper person to examine into the affairs of the*

**US HealthCare, Inc.**

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

**Company**

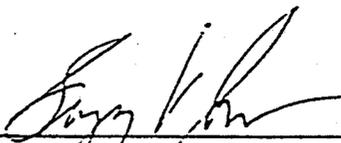
*with such other information as he shall deem requisite.*

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

*this 2nd day of October 2000*

**NEIL D. LEVIN**

*Superintendent of Insurance*



(by) **Gregory Serio**

*First Deputy Superintendent*



STATE OF NEW YORK  
INSURANCE DEPARTMENT

I. NEIL D. LEVIN . Superintendent of Insurance of the State of New York,  
pursuant to the provisions of the Insurance Law, do hereby appoint:

**Martin Schwartzman**

*as a proper person to examine into the affairs of the*

**US Health Insurance Company**

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

**Company**

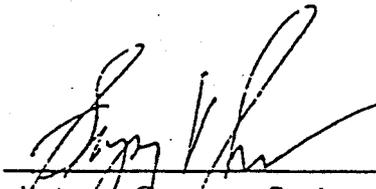
*with such other information as he shall deem requisite.*

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

this 2nd day of October 2000

**NEIL D. LEVIN**

Superintendent of Insurance

  
\_\_\_\_\_  
(by) **Gregory Serio**

**First Deputy Superintendent**

