REPORT ON EXAMINATION

OF

PUTNAM/NORTHERN WESTCHESTER

HEALTH BENEFITS CONSORTIUM

AS OF

JUNE 30, 2010

DATE OF REPORT **JULY 31, 2012**

EXAMINER **VICTOR ESTRADA**

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July 31, 2012

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

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30739, dated June 30, 2011, attached hereto, I have made an examination into the condition and affairs of the Putnam/Northern Westchester Health Benefits Consortium, a municipal cooperative health benefit plan operating pursuant to Article 47 of the New York Insurance Law, as of June 30, 2010. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Putnam/Northern Westchester Health Benefits Consortium, located at 200 BOCES Drive, Yorktown Heights, New York.

Wherever the designations the "Plan", or "PNW" appear herein, without qualification, they should be understood to indicate the Putnam/Northern Westchester Health Benefits Consortium.

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

should be noted that the New York State Insurance Department merged with the New York State Banking Department on October 3, 2011 to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2007. This examination of the Plan was a combined (financial and market conduct) examination and covered the three-year period from July 1, 2007, through June 30, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2010, were reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually for the years 2008 through 2010, by the accounting firm of Sickler, Torchia, Allen and Churchill, CPAs, PC ("STAC"). The Plan received an unqualified opinion in each of those years. Certain audit workpapers of STAC were reviewed and relied upon in conjunction with this examination.

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

The examiner also reviewed the corrective actions taken by the Plan with respect to the recommendations contained in the prior report on examination.

2. DESCRIPTION OF THE PLAN

The Putnam/Northern Westchester Health Benefits Consortium was organized in 1987 pursuant to Article 5-G of the New York General Municipal Law for the purpose of providing health insurance benefits to its member districts. The Superintendent of Insurance issued a certificate of authority in the name of the Plan pursuant to Article 47 of the New York Insurance Law on November 1, 1999. The Plan is comprised of 13 municipal school districts and Putnam Northern Westchester BOCES. The Plan's objective is to administer a low-cost, self-funded, medical program of health insurance that provides hospital, medical and prescription drug benefits for more than 16,000 employees, retirees and dependents. The Plan provides benefits as defined in the Plan Document (the group contract issued by the municipal cooperative health benefit plan to participating municipal corporations describing the terms and conditions of coverage) to employees of the participating school districts and their eligible dependents, and retirees.

Districts applying for membership in the Plan may do so on approval of a majority of the Consortium's Board. The Plan's premium rates are established by its Finance Committee and such rates were developed in compliance with New York Insurance Law Section 4705(d)(5)(B).

As of June 30, 2010, thirteen (13) school districts, along with the Putnam/Northern Westchester BOCES, participated in the Plan. As of June 30, 2010, the Plan's participants were as follows:

Brewster Central School District	Lakeland Central School District
Briarcliff Manor Union Free School District	Mahopac Central School District
Chappaqua Central School District	Peekskill City School District
Croton-Harmon Union Free School District	Putnam Valley Central School District
Garrison Union Free School District	Putnam/Northern Westchester BOCES
Haldane Central School District	Somers Central School District
Hendrick Hudson Central School District	Yorktown Central School District

The Plan offers health insurance to the employees, spouses, dependents and retirees of each municipal corporation that are part of the Plan. Health benefits for covered enrollees are subject to a Plan Document that contains all the terms, provisions and limitations of the health benefit contract and is on file with the Department. The Plan is additionally subject to certain provisions of the General Municipal Law and the Education Law of New York State.

A. Management and Controls

Pursuant to its Municipal Cooperation Agreement, the management of the Plan is to be vested in a board of trustees. The municipal cooperation agreement of the Plan specifies that the board of trustees shall consist of five individuals selected by the majority of Plan members and

shall serve until and unless removed from office by the majority of Plan members. The board of trustees meets at least two times during each fiscal year, as required by Article IV of the Plan's Municipal Cooperative Agreement.

As of June 30, 2010, the five members of the board of trustees were as follows:

Name and Residence	Principal Affiliation
David Chapman New Windsor, NY	Assistant Superintendent for Business, Mahopac Central School District
Gloria Colucci Hopewell Junction, NY	Superintendent, Garrison Union Free School District
Mark Space Garrison, NY	Superintendent, Putnam Valley Central School District
Dr. Thomas P. Higgins, Jr. Brookfield, CT	Assistant Superintendent for Administration, Putnam Northern Westchester BOCES
Raymond Morningstar Mohegan Lake, NY	Assistant Superintendent for Business, Lakeland Central School District

Additionally, pursuant to the Municipal Cooperation Agreement, the Plan has established a joint governance board comprised of twelve members, including the five Plan trustees. The joint governance board operates in accordance with the terms of a Joint Governance Agreement (the "Agreement"), effective July 1, 1992. Such Agreement provides for the joint governance board to act on matters affecting the administration of the Plan. The Agreement requires the board to meet at least two times during each calendar year.

The members of the governing board of the Plan as of June 30, 2010 were as follows:

Name and Residence	Principal Affiliation
Douglas Andreotti Yorktown Heights, NY	Teacher Mahopac Central School District
George Benack Millwood, NY	Teacher, Chappaqua Central School District
Diane Chaissan Newburgh, NY	Director of Finance and Administrative Services, Croton-Harmon Union Free School District
David Chapman New Windsor, NY	Assistant Superintendent for Business, Mahopac Central School District
Gloria Colucci Hopewell Junction, NY	Superintendent, Garrison Union Free School District
Dr. Thomas P. Higgins, Jr. Brookfield, CT	Assistant Superintendent of Administration, Putnam Northern Westchester BOCES
Jane Hitney Buchanan, NY	School Nurse, Hendrick Hudson Central School District
Winnie McCarthy Poughkeepsie, NY	Retired, BOCES
Raymond Morningstar Mohegan Lake, NY	Assistant Superintendent for Business, Lakeland Central School District
John Roden Carmel, NY	Retired, Yorktown Central School District
Mark Space Garrison, NY	Superintendent, Putnam Valley Central School District
Mary Uhle Patterson, NY	Retired, Brewster Central School District

The principal officers of the Plan as of June 30, 2010 were as follows:

Name	Title
Dr. Thomas P. Higgins, Jr.	President
Gloria Colucci	Secretary
Todd Currie	Chief Financial Officer

The minutes of all meetings of the board of trustees, the Joint Governance Board and committees thereof held during the examination period were reviewed. The minutes revealed that the meetings were generally well attended, with all members attending at least 50% of the meetings they were eligible to attend.

The Plan entered into contractual arrangements with the following consultants for services:

- Aetna Life Insurance Company ("ALIC") - effective January 1, 2001
  Aetna Life Insurance Company provides claims administration, patient management and network access services to Plan members.

- Deloitte & Touche LLP - effective July 1, 2007
  Deloitte & Touche LLP provides general consulting services

- Thomson Reuters f/k/a Healthcare Data Management ("HDM") - effective July 1, 2007
  HDM replaced The Segal Company and has provided claims auditing services to the Plan since the beginning of 2008. Additional services are listed on page 16 of this report.

- MBIA, Inc. - effective January 1, 2005
  Provides fund management services to the Plan using a cooperative asset pool.

- Express Scripts - effective January 1, 2009
  Provides claims administration for prescription drugs.

Other third parties utilized by the Plan include Towers Perrin for actuarial services,

Aquarius Capital for actuarial services, Sayles Evans for legal counsel, and Sickler, Torchia, Allen and Churchill, CPAs, PC for financial auditing and annual statement certification.

B. Territory and Plan of Operation

As of June 30, 2010, the Plan held a certificate of authority to operate a municipal cooperative health benefit plan, as authorized by Section 4704 of the New York Insurance Law, in the counties of Putnam and Westchester. Pursuant to the requirements of Article 47 of the New York Insurance Law, the Plan is required to maintain contingency reserves equal to 5% of the annualized earned premium. The Plan met the contingency reserve requirement throughout the examination period.

As of June 30, 2010, the Plan provided coverage to 8,052 members. Membership was stable during the examination period. Plan members were enrolled at the local school district level.

The total direct premiums written and the membership census during the examination period were as follows:

Plan Year	Direct Premiums Written	Membership
2010	96,372,050	8,052
2009	85,851,758	8,100
2008	79,532,581	8,050

C. Stop-Loss Insurance

The Plan is required to maintain both specific and aggregate stop-loss insurance in order to limit its exposure to medical and prescription drug expense losses. At June 30, 2010, and in accordance with Section 4707(a) of the New York Insurance Law, the Plan had the following stop-loss coverage in place with US Fire Insurance Company, an authorized insurer:

Specific excess stop-loss coverage

Excess of loss coverage:	100% of $2,000,000, excess of $1 million loss level, individual lifetime stop-loss level $2,000,000

Aggregate excess stop-loss coverage

Excess of loss coverage:	125% of annual expected claims up to $1 million aggregate maximum liability

During February 1997, the Plan received a waiver from the Department from the requirement that the Plan maintain stop-loss insurance coverage. Then, due to a deteriorating financial condition, the Department directed the Plan to either obtain the requisite stop-loss coverage or to establish a higher reserve in lieu of stop-loss coverage, as specified by Section 4707(b)(1) of the New York Insurance Law. Although the Plan did obtain the requisite stop loss insurance coverage, it continued to maintain the reserve it had already established. Subsequent to this examination, as of December 31, 2011, this reserve fund was eliminated, effectively ending the Plan's waiver for the purchase of stop-loss insurance coverage.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of June 30, 2010. This statement is the same as the balance sheet filed by the Plan.

Assets	Examination	Plan
Cash and cash equivalents	$ 38,633,485	$ 38,633,485
Premiums receivable	2,884,775	2,884,775
Aggregate-write ins for current receivable	680,878	680,878
Total assets	$ 42,199,138	$ 42,199,138
Liabilities		
Accounts payable	$ 133,832	$ 133,832
Claims payable	9,268,532	9,268,532
Claim stabilization reserve	7,400,000	7,400,000
Additional reserve for IBNR	6,431,468	6,431,468
Additional reserve for unearned premium	400,000	400,000
Additional reserve for other obligations	1,000,000	1,000,000
Additional reserve in lieu of stop-loss	1,000,000	1,000,000
Total liabilities	$ 25,633,832	$25,633,832
Net worth		
Contingency reserve	$ 4,900,000	$ 4,900,000
Retained earnings/fund balance	11,665,306	11,665,306
Total net worth	$ 16,565,306	$ 16,565,306
Total liabilities and net worth	$ 42,199,138	$ 42,199,138

B. Statement of Revenue and Expenses and Net Worth

Net worth increased $10,683,660 during the four-year examination period, July 1, 2007 through June 30, 2010, detailed as follows:

Revenue		
Premiums and related revenue	$ 261,756,379	
Investment income	1,857,307	
Aggregate write-ins for other revenues	9,857,351	
Total revenue		$ 273,471,037
Expenses		
Hospital/medical benefits	$ 175,733,831	
Prescription drugs	71,058,333	
Aggregate write-ins for other expenses	(447,897)	
Reinsurance expenses	963,160	
Total medical and hospital expenses		247,307,427
Net underwriting gain		$ 26,163,610
Administrative expenses		
Third-party administration expenses		11,404,208
Net income		$ 14,759,402

Changes in Net Worth

	Gains in Net Worth	Losses in Net Worth	
Net worth as of June 30, 2007, per report on examination			$ 5,881,646
Net income	$14,759,402		
Change in IBNR		$ 3,088,082	
Change in claim stabilization reserve		587,658	
Change in contingency reserves	1,343,011		
Change in termination reserve		1,343,011	
Change in reserve for other expenses		400,000	
Net increase in net worth			10,683,660
Net worth as of June 30, 2010, per report on examination			$16,565,306

4. CLAIMS PAYABLE (INCLUDING CLAIM STABILIZATION RESERVE)

The examination liabilities for Claims Payable in the amount of $9,268,532 and the Claims Stabilization Reserve in the amount of $7,400,000 are the same as the amounts reported by the Plan as of June 30, 2010.

Section 4706(a)(1) of the New York Insurance Law requires that the governing board of a municipal cooperative health benefit plan establish a reserve fund, including a reserve for the payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported, which shall not be less than an amount equal to twenty-five

percent (25%) of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the Superintendent's satisfaction that a lesser amount will be adequate. The Plan was granted such approval by the Department on April 11, 2007, to reduce its reserves for claims and related expenses required by Section 4706(a)(1) of the New York Insurance Law, from the statutorily mandated 25%, to 17% of the Plan's current year's expected incurred claims and expenses.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2010.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct investigation.

Aetna Life Insurance Company ("ALIC" or "Aetna") is the Plan's third-party administrator ("TPA") for claims processing as established through an Administrative Services

Agreement ("ASA"). Subject to this agreement, ALIC is responsible for all claims processing results, including utilization review, claim payments and check issuance, subscriber notices, grievances, appeals, and explanation of benefits statements. Certain of the recommendations to Plan management that are included herein under the Market Conduct Activities subsection resulted from ALIC's failure to adhere to claim processing rules in full compliance with applicable statutes. Therefore, these recommendations also apply to Aetna Life Insurance Company in its role as a third-party administrator, with regard to the performance of its contractual duties on behalf of the Plan, and as a licensed insurer outside the scope of this report.

The review of claims adjudication was directed at practices of the Plan in the following major areas:

A. Operational
B. Claims processing
C. Utilization review
D. Explanation of benefits statements
E. Prompt payment of claims

A. Operational

The Plan utilizes Thomson Reuters, an independent third-party, to determine if ALIC is in compliance with the terms of the ASA, and other applicable documents. In addition, Thomson Reuters is engaged to perform an operational review to assess the policies, procedures, and controls that support the administration of PNW's health plan.

The examiner reviewed the results of the audits that were performed during the examination period and noted that Thomson Reuters had not specifically tested any claims for compliance with New York laws and regulations.

It is recommended that the Plan ensures that its independent third-party auditor, Thomson Reuters, include statutory compliance as part of the scope of its audits of the Plan's TPA, Aetna Life Insurance Company.

B. Claims Processing

The examiner reviewed a sample of forty-seven (47) claims to evaluate the Plan's overall claims processing accuracy and regulatory compliance. These forty-seven (47) claims were selected from a population that included: denials due to the Plan being secondary payor; non-covered treatment; and benefit maximums being exceeded. Also included were claims involving medical necessity, experimental and/or cosmetic treatment, and claims where fraud or over-billing by the provider were suspected.

The results of the testing revealed that eighteen (18) claims contained at least one procedural financial error or one failure to comply with a statutory requirement, with several containing multiple errors and/or statutory failures. Six (6) of the claims were adjudicated in violation of various New York laws and regulations related to Utilization Review. Four (4) of the claims either included, or were solely violations of New York Insurance Law 3224-a, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay"). Two (2) of the Prompt Pay violations were due to delays

within the Clinical Review Department. Two (2) claims utilized an inaccurate description of the cause for the denial on the explanation of benefits statement ("EOB").

Other exceptions were as follows:

- One (1) claim was incorrectly denied upon its original submission as being a workers compensation claim and on its second submission, as being beyond the timely filing deadline, though neither conclusion was accurate.
- Three (3) claims paid an incorrect rate.
- Two (2) claims were inappropriately paid in full or in part.
- One (1) claim was denied correctly, but was later reopened inappropriately to pay.
- One (1) claim was denied inaccurately as indicating that the benefit maximums had been achieved.
- One (1) claim was not paid in full because not all lines on the claim were considered.

It is noted that in some cases, these errors were detected and corrected by Aetna prior to this examination.

It is recommended that the Plan ensures that its TPA, Aetna Life Insurance Company, is processing and paying claims accurately.

C. Utilization Review

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

> "(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
> (1) the reasons for the determination including the clinical rationale, if any;
> (2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and
> (3) notice of the availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal."

Section 4904(c) of the New York Insurance Law states, in part:

> "(c) …The notice of the appeal determination shall include:
> (1) the reasons for the determination…
> (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."

Parts 410.9(e)(2), (8), and (9) of Department Regulation No. 166 (11 NYCRR 410.9) state the following:

> "(e) Each notice of a final adverse determination of an expedited or standard utilization review appeal under Section 4904 of the Insurance Law shall be in writing, dated and include the following:
>
> (2) a clear statement that the notice constitutes the final adverse determination;
>
> (8) a statement that the insured may be eligible for an external appeal and the timeframes for requesting an appeal; and
>
> (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal."

There were six claims that contained violations of the various tenets of New York Insurance Law Article 49 and/or Department Regulation No. 166 (11 NYCRR 410.9), as follows:

- Four denied or partially denied claims did not include a proper appeal notification as required by New York Insurance Law Section 4903(e).

- Two claims that had been denied upon appeal, either partially or in full, did not include communications as required by Section 4904(c) of the New York Insurance Law or Parts 410.9(e)(2), (8), and (9) of Department Regulation No. 166 (11 NYCRR 410.9). In one of those cases, not all lines of the claim were considered during the appeal.

It is recommended that the Plan ensures its contracted claims processor, Aetna Life Insurance Company complies with New York Insurance Law Sections 4903(c), 4904(e), and Department Regulation No. 166.

D. Explanation of Benefits Statements ("EOBs")

EOBs are the tool through which an insurer communicates with its members how their claims have been adjudicated. They are the primary link by which members can understand their rights and responsibilities when their claims for coverage have been denied or otherwise not paid in full.

The examiner reviewed the EOBs generated for the claims from the aforementioned claim sample in order to review the documents for compliance with the various precepts of New York Insurance Law Section 3234, "Explanation of benefit forms relating to claims under certain accident and health insurance policies".

New York Insurance Law Sections 3234(b)(3) and (6) state:

> "(b) The explanation of benefits form must include at least the following:
>
> (3) an identification of the service for which the claim is made;
>
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed…"

In multiple instances, the Plan, through its TPA Aetna, was in violation of New York Insurance Law Sections 3234(b)(3) for using identifications of services that had been performed

that were unclear or excessively broad. The TPA acknowledged the deficiencies and indicated that, in November, 2010, it had initiated a new format for its EOBs that contained more specific descriptions of the services performed. A single sample of the new EOB was provided to the examiner and that document did appear to be in compliance with the tenets of New York Insurance Law 3234(b)(3).

In violation of New York Insurance Law Section 3234(b)(6), multiple cases were noted wherein Aetna used explanations for claim denials or reductions that were either inaccurate or did not clearly explain the adjudication. These, along with comments regarding the deficiencies, were as follows:

- *"Your plan does not provide coverage for charges that you are not legally responsible to pay for."*

This explanation does not specifically delineate the reason why the member does not have liability. Should a provider pursue the member for any part of the charge, the member will not be able to explain why they are not legally responsible to pay.

- *"This amount is not payable because either…or… Refer to your plan coverage information for details."*
- *"This entity or provider is not recognized for coverage or cannot be located."*

It is not sufficient to give an either/or cause for denial. Nor is it sufficient to refer members to their contract as most members would not know where to look.

- *"Your plan provides benefits for covered expenses at the plan's recognized percentile level of charges received by Aetna for the same service."*

- *"You are covered for expenses at a level set by your plan sponsor. The charge exceeds that amount."*

In both instances, the level referenced is due to a Usual, Customary and Reasonable payment methodology. In both instances, the explanations should be more clear.

The examination also revealed a small number of explanations that did not accurately describe the reason for the denial.

Although ALIC, pursuant to its contractual agreement with the Plan, is responsible for sending EOBs on behalf of the Plan to the Plan's members and providers, the management of PNW retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related regulations. Therefore, the Plan's management must be diligent in its oversight of its market conduct activities, including the dissemination of EOBs. In this regard, although ALIC is regulated by the State of Connecticut, it is incumbent upon ALIC to be aware of and comply with pertinent New York Insurance Laws and regulations when processing the Plan's claims and in providing appropriate documents, including EOBs to the Plan's members and providers on the Plan's behalf.

It is recommended that the Plan ensures its claim processing TPA, Aetna, comply with New York Insurance Law Section 3234 and provide its members with explanation of benefits statements that are complete, clear, accurate, and otherwise comply with all aspects of that law.

E. Prompt Payment of Claims

Sections 3224-a(a) and (b) of New York Insurance Law 3224-a, ("Prompt Pay Law") state the following in part:

> "(a) Except in a case where the obligation … [of an entity regulated under Article 47 of the Insurance Law] to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.
>
> (b) In a case where the obligation… [of an entity regulated under Article 47 of the Insurance Law]to pay a claim or make a payment for health care services rendered is not reasonably clear…[an] organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment."

Implementation of the above Law, revised July 2009, was effective for all claims received after January 1, 2010, regardless of the date of service. In other words, this Law applied to claims that were received in 2009, but not adjudicated until 2010.

The examiner utilized the software program ACL to "roll up" or summarize the population of PNW's claims that were paid between January 1, 2010 and June 30, 2010 by claim number. This was done in order to ensure that adjusted claims were not counted multiple times. As a result of this summarization, the claim population consisted of 153,871 claims. From that population, ACL was used to isolate potential Prompt Pay violations consisting of electronically

submitted claims and claims submitted by paper. The result of this work revealed the following number of potential violations:

Category	Potential number of violations
30 day closure required	5,346
45 day closure required	1,246
Total	6,592

The 6,592 potentially late claims represent 4.2% of the total claims population of 153,871. From these populations, the examiner selected a sample of forty-nine claims from the first category and ten claims from the second category. The results of the testing revealed the following:

Category	Sample size	Violation rate	
	#	#	%
30 day closure required	49	34	69.4%
45 day closure required	10	2	20.0%
Total	59	36	61.0%

Subsection (c) of New York Insurance Law Section 3224-a establishes the requirement that, where claim payments are not paid within the timeframes mandated by §3224-a (a), interest must be paid when the interest due is $2.00 or greater. During the testing of compliance with New York Insurance Law 3224-a, it was revealed that twelve of the claims that had been paid late, in violation of the Prompt Pay Law, were due interest, although none had such interest paid. Discussion with ALIC revealed that in the third quarter of 2010, ALIC self-identified that their systems were not applying interest payments to the Plan's claims, when such interest was due. In order to remediate this, during September, 2011, a system enhancement was implemented, at which time ALIC manually reviewed and reprocessed claims where interest payments were

owed and not appropriately paid. This reprocessing took place for claims with dates of service after January 1, 2010 through the remediation date in July 2012. The claims within the sample that did not have interest paid as appropriate, however, were not part of this project because they had been received prior to January 1, 2011.

It is recommended that Aetna institute controls to ensure that it is in full compliance with Section 3224-a of the New York Insurance Law.

It is also recommended that the Plan institute audits of its claim-adjudicating TPA, Aetna, to ensure that it maintains full compliance with all aspects of New York Insurance Law 3224-a.

The Market Conduct Activities section of this report details numerous instances of non-compliance with various Department statutes. Whereas the Plan's management has the ultimate responsibility for such compliance, the examiner noted that most areas of non-compliance involved processes performed by Aetna.

It is recommended that the Plan, through its TPA Aetna, ensures that claims affected by the aforementioned areas of compliance, occurring during and subsequent to the examination period be corrected. The Plan or its designee should ensure that such remediation is performed.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on organization included twelve (12) recommendations detailed as follows (page numbers refer to the report on examination):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that the Plan amend its municipal cooperation agreement to include the complete statement regarding the sharing of costs and the assumption of liabilities for medical, surgical and hospital benefits provided under the municipal cooperative health benefit plan as required by Section 4705(a)(2) of the New York Insurance Law.	7
	The Plan has complied with this recommendation.	
	Accounts and Records	
2.	It is recommended that the Plan put in place additional controls such as a second signatory requirement in regard to the activities of the Plan's Treasurer.	10
	The Plan has complied with this recommendation.	
	Custodial Agreements	
3.	It is recommended that the Plan comply with Section 4710(a)(1) of the New York Insurance Law by submitting its custodial agreements to the New York Insurance Department for approval.	11
	The Plan has complied with this recommendation.	
	Unearned Premium Reserve	
4.	It is recommended that the Plan establish and maintain a reserve for unearned premium in accordance with the requirements of Section 4706(a)(2) of the New York Insurance Law.	15
	The Plan has complied with this recommendation.	

ITEM NO.		PAGE NO.
	Explanation of Benefits Statements ("EOBs")	
5.	It is recommended that the Plan comply with the requirements of Section 3234(b)(7) of the New York Insurance Law and ensure that the requirement that a member's failure to comply with appeals procedures can lead to that member's forfeiture of the right to challenge a denial of benefits is included on all of the explanation of benefits statements issued to its members and providers. *The Plan has complied with this recommendation.*	19
6.	It is further recommended that Plan management fulfill its responsibility for compliance with New York Insurance statutes, rules, and regulations, and ensure that ALIC, as its TPA, acts in accordance with Section 3234(b)(7) of the New York Insurance Law and issues the required notification with its EOBs that a member's failure to comply with appeals procedures can lead to that member's forfeiture of the right to challenge a denial of benefits. *The Plan has complied with this recommendation.*	19
7.	It is recommended that the Plan identify, and notify by letter, all members who had an appeal rejected because of timeliness, of their right to appeal a claim made during the period January 1, 2004 through June 30, 2007, where the member received an EOB without adequate appeal rights language. In addition, for members who had an appeal rejected because of timeliness during the period July 1, 2002 through December 31, 2003 (a time frame in which the Plan has indicated its TPA would not be able to identify members who had an appeal of a claim rejected because of timeliness), where the member received an EOB without adequate appeal rights language, it is recommended that the Plan advise members, by means of a notice within the next two printings of the Consortium Newsletter, of their right to appeal a past claim where the member received an EOB without adequate appeal rights language. *The Plan has complied with this recommendation.*	19

ITEM NO.		PAGE NO.
	Complaints, Appeals and Grievances	
8.	It is recommended that the Plan maintain a complaint log in a manner consistent with Circular Letter No. 11 (1978).	20
	The Plan has complied with this recommendation.	
9.	It is further recommended that the Plan include all complaints received by it, or by its TPA on behalf of its members, in one document.	20
	The Plan has complied with this recommendation.	
10.	It is also recommended that the Consortium amend its Plan Document to contain specific information as to the procedure an affected person may follow in order to file a complaint with the New York Insurance Department and the Plan's Office of Risk Management, including the mailing address, phone numbers, website and e-mail address for such complaint filings.	20
	The Plan has complied with this recommendation.	
11.	It is recommended that the Consortium perform, or retain a consultant to perform, a case-level audit of its grievance and appeals practices and all such practices performed on its behalf by any third parties.	22
	The Plan has complied with this recommendation.	
	Rating	
12.	It is recommended that the Plan submit its community rating methodology to the Superintendent of Insurance for his approval in accordance with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law.	23
	The Plan has complied with this recommendation.	

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Operational	
	It is recommended that the Plan ensures that its independent third-party auditor, Thomson Reuters, include statutory compliance as part of the scope of its audits of the Plan's TPA, Aetna Life Insurance Company.	16
B.	Claim Processing	
	It is recommended that the Plan ensures that its TPA, Aetna Life Insurance Company, is processing and paying claims accurately.	17
C.	Utilization Review	
	It is recommended that the Plan ensures its contracted claims processor, Aetna Life Insurance Company complies with New York Insurance Law Sections 4903(c), 4904(e), and Department Regulation No. 166.	19
D.	Explanation of Benefits statements	
i.	Although ALIC, pursuant to its contractual agreement with the Plan, is responsible for sending EOBs on behalf of the Plan to the Plan's members and providers, the management of PNW retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related regulations. Therefore, the Plan's management must be diligent in its oversight of its market conduct activities, including the dissemination of EOBs. In this regard, although ALIC is regulated by the State of Connecticut, it is incumbent upon ALIC to be aware of and comply with pertinent New York Insurance Laws and regulations when processing the Plan's claims and in providing appropriate documents, including EOBs to the Plan's members and providers on the Plan's behalf.	21
ii.	It is recommended that the Plan ensures its claim processing TPA, Aetna, comply with New York Insurance Law Section 3234 and provide its members with explanation of benefits statements that are complete, clear, accurate, and otherwise comply with all aspects of that Law.	21

ITEM **PAGE NO.**

E. Prompt Payment of Claims

Appointment No. **30739**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Victor Estrada

as a proper person to examine into the affairs of the

Putnam/ Northern Westchester Health Benefits Consortium

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

Municipal Cooperative Health Benefit Plan

with such other information as he shall deem requisite.

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

This 30th day of June, 2011

James J. Wrynn
Superintendent of Insurance