

**REPORT ON EXAMINATION**

**OF THE**

**JEFFERSON-LEWIS et. al. SCHOOL EMPLOYEES'**

**HEALTHCARE PLAN**

**AS OF**

**JUNE 30, 2015**

**DATE OF REPORT**

**APRIL 3, 2017**

**EXAMINER**

**HUSSEIN AGOUDA, CFE**

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NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

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Andrew M. Cuomo  
Governor

Maria T. Vullo  
Superintendent

April 3, 2017

Maria T. Vullo  
Superintendent of Financial Services  
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31280, dated March 13, 2015, attached hereto, I have made an examination into the condition and affairs of Jefferson-Lewis et. al. School Employees' Healthcare Plan, a municipal cooperative health benefit plan certified pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2015. The following report is respectfully submitted thereon.

The examination was conducted at the administrative office of Jefferson-Lewis et. al. School Employees' Healthcare Plan located at 853 James Street, Clayton, New York.

Wherever the designations, the "Plan" or "J-LSEHP" appear herein, without qualification, they should be understood to indicate Jefferson-Lewis et. al. School Employees' Healthcare Plan.

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

## 1. SCOPE OF EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2010. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period of July 1, 2010 to June 30, 2015. The financial component of the examination was conducted as a financial examination, as such term is defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2015 Edition* (“the Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to fiscal year June 30, 2015 were also 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 utilized that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan’s current financial condition, as well as identify prospective risks that may threaten the future solvency of J-LSEHP.

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 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 examination also evaluated the Plan's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

The Plan was audited annually, for fiscal years 2010 through 2015 by the Plan's CPA firm, Poulsen & Podvin, LLC. The Plan received unqualified opinions for fiscal years 2010 through 2013 and unmodified opinions for fiscal years 2014 and 2015. Certain audit work papers of Poulsen & Podvin, LLC 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 require explanation or description.

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination.

## **2. DESCRIPTION OF THE PLAN**

Jefferson-Lewis Cooperative Board of Cooperative Educational Services (“J-LBOCES”) and its fifteen original member school districts (“Participants”) formed a Consortium in 1979. The purpose of the Consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance. The Plan provides benefits to covered employees and their eligible dependents as defined in the plan booklet.

On June 1, 2001, the Plan was issued a certificate of authority by the then Superintendent of Insurance, under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority, the Participants have agreed to share the costs and assume the liabilities for hospital, medical, and surgical benefits provided to the employees (and retirees) and their dependents.

There are fourteen school districts, one Board of Cooperative Educational Services (BOCES), and one Community College participating in the Plan. The Plan Participants are as follows:

Alexandria Bay Central School District	Jefferson-Lewis BOCES
Beaver River Central School	LaFargeville Central School
Belleville Henderson Central School	Lowville Central School
Carthage Central School	Lyme Central School
Copenhagen Central School	Sackets Harbor Central School
General Brown Central School	South Lewis Central School
Indian River Central School	Thousand Island Central School
Jefferson Community College	Watertown City School District

A. Corporate Governance

Pursuant to its revised and restated 2011 Municipal Cooperative Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from the Community College, BOCES, and each participating school district. The governing board of the Plan as of June 30, 2015 was as follows:

<u>Name</u>	<u>Affiliation</u>
Terry Fralick	Superintendent, Watertown City School District
Julie Gayne	District Treasurer, Sackets Harbor Central School District
Cathy Haug	Business Manager, Carthage Central School District
Brianne Kirchoff	Business Manager, Alexandria Bay Central School District
Karl Kofed	Director of Business and Finance, Belleville Henderson Central School District

<u>Name</u>	<u>Affiliation</u>
Dale Munn	Treasurer/Administrator, Copenhagen Central School District
Randy Myers	Business Manager, Beaver River Central School District
Nicky Parliament	Business Manager, LaFargeville Central School District
Sandra Rivers	Superintendent, Lowville Central School District
Sandy Dudley-Rooney	Business Manager, Lyme Central School District
Dennis Schrecengast	Human Resources Director, Indian River Central School District
Lisa Smith	Executive Director of Administrative Services, General Brown Central School District
Sally Switzer	Business Manager, Thousand Island Central School District
Michelle Traynor	Business Manager, Jefferson-Lewis BOCES
Barry Yette	Business Manager, South Lewis Central School District
Kerry Young	Executive Director for Finance & Human Resources, Jefferson Community College

The board met four times during each fiscal year of the examination period.

A review of the minutes of meetings of the governing board held during the period of examination revealed that the meetings of the governing board were well attended, with every



member attending at least 50% of the meetings they were eligible to attend. The minutes of the standing committees of the governing board which include the Executive Committee, the Appeals Review Committee, and the Finance Committee held during the examination period and subsequent were also reviewed.

Section 624(a) of the New York Business Corporation Law states in part:

“(a) Each corporation shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its shareholders, board and executive committee...”

It was noted that although the meetings of the governing board were well attended, some of the appointments of board members on the board were not recorded in the minutes.

It is recommended that the Plan comply with Section 624(a) of the New York Business Corporation Law by recording all board member appointments and replacements in the minutes of its board of directors' meetings.

The Plan entered into contractual agreements with the following vendors to provide various administrative services to the Plan:

- Progressive Management Consulting, LLC (“PMC”) is the general manager and Comptroller of the Plan. As Plan general manager, PMC defines a strategic plan of action for the Plan. PMC works with POMCO, Inc., which provides services to the Plan as described below, to ensure accurate and prompt payment of claims. PMC meets with the Board of Trustees as deemed necessary to conduct the business of the Plan. PMC provides mandated reports and documentation to regulators and others as required to keep Plan participants informed of benefit issues, and assists in the review and revision of plan benefit structure and design.
- POMCO, Inc. (“POMCO”) provides the Plan benefit management services relative to the design, development, and implementation of its employee health benefits program as well as

enrollment and benefit management services. In addition, POMCO provides the Plan with administrative and third party health claim adjudication services, including claims payment services. POMCO also provides the Plan with pharmacy management integration services relative to eligibility and claim transfer, pharmacy summary plan document development, and single identification card use by the plans with medical and pharmacy benefit descriptions. POMCO provides the Plan with access to POMCO's exclusive provider network in New York State, "POMCO PPO Allied Network", as well as access to the provider network of its contractual partner, Multi Plan/Private Healthcare System. The Multi Plan/Private Healthcare System provider network is available in all 50 states of the United States.

- Express Scripts is a pharmacy benefit manager ("PBM") that provides a prescription drug plan for eligible covered persons of the Plan. This includes a network of retail and mail service pharmacies, electronic claim adjudication, and a claim processing system for pharmacy claims adjudication. Express Scripts also provides a prescription drug benefit management service for designing and managing prescription drug benefits.
- Davis Vision provides administrative and information services to members of the plan relating to its vision plan benefits. Davis Vision provides laboratory services, processing of claims, data entry and clerical processing. Davis Vision provides management reporting of billing statements, quality care reports and/or other reports as required. Davis Vision provides a panel of private offices for eye exams and dispensing services to the members. Davis Vision also has a comprehensive program for quality assurance.
- KBM Management Inc. (KBM) provides consulting services to the Plan's board members, as required on matters regarding negotiations with employee groups. KBM also provides actuarial services and rate filings, filings of Quarterly and Annual Statements, and assists in obtaining alternative markets for stop-loss coverage as well as reviewing and investigating claims which affect stop-loss coverage. KBM assists in the negotiation of administrative agreements of the Plan. KBM also provides annual audit and administrative reviews of the Plan's claims management system.
- Bowers & Company PLLC, CPA provides external financial audit services to the Plan.

The principal officers of the Plan as of June 30, 2015 were as follows:

<u>Name</u>	<u>Title</u>
Terry Fralick	Chair
Brendan Higgins	Plan Manager
Nicole Parliament	Vice Chair
Sally Switzer	Treasurer
Diane Wright	Secretary

B. Territory and Plan of Operation

The Plan provides health benefits to its fourteen participating school districts, one community college and one BOCES, in the counties of Jefferson and Lewis in New York State. The Plan reported annual premiums written of \$62,852,948 for the fiscal year ending June 30, 2015. There was not any significant change in premium written or membership during the examination period. The Plan's Participants remained the same throughout the examination period.

C. Stop-Loss Coverage

In 2008, J-LSEHP discontinued its stop-loss coverage and instead maintained one hundred fifty (150) percent of the mandatory minimum statutory reserve per section 4707 (b)(1) of the New York Insurance Law. Since the minimum statutory reserve was based upon twenty-five (25) percent of claims incurred, the plan held thirty-seven and one-half (37.5) percent of incurred claims as the claims payable reserve. This also required a fifty (50) percent increase in the surplus account. The surplus account was increased from five (5) percent of annualized earned premium to seven and one-half (7.5) percent.

In 2010, the Plan purchased stop-loss coverage eliminating the need for the fifty (50) percent increase in reserves and net worth. Subsequently, the Department performed an actuarial analysis and on July 10, 2010 approved the Plan's request to lower its required claims payable reserve from twenty-five (25) percent of incurred claims to seventeen (17) percent.

As of the examination date, the Plan maintained a specific and aggregate stop-loss insurance policy with an effective date of July 1, 2010 and expiration date of June 30, 2015. The policy, issued by QBE Insurance Corporation, an insurer licensed in New York, provides medical and prescription drug stop-loss coverage in accordance with New York Insurance Law Sections 4707(a)(1) and (2).

Section 4707(a)(1) of the New York Insurance Law states in part:

“(a) The governing board of the municipal cooperative health benefit plan shall obtain and maintain on the behalf of the plan a stop-loss insurance policy or policies providing ...

(1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year; ...”

It was noted that the aggregate attachment point mandated by New York Insurance Law Section 4707(a) for fiscal years 2012 through 2016 was greater than one hundred twenty-five (125) percent of the expected claims for the fiscal year 2014 - 2015 based upon the Plan’s 2014 - 2015 budget.

In addition, the amounts of aggregate stop-loss coverage for fiscal years 2014-2015 and 2015-2016 were not certified by a qualified actuary to represent the expected claims of fiscal years 2014-2015 and 2015-2016. The projected claims for fiscal years 2014-2015 and 2015-2016 were \$62,911,551 and \$67,506,281, respectively. The minimum aggregate stop-loss attachment point for policy year July 1, 2014 through June 30, 2015 is \$84,944,024. The aggregate stop-loss attachment year for policy year July 1, 2015 through June 30, 2016 was \$87,641,361. Both of the

aggregate stop-loss policies maintained attachment points greater than one hundred twenty-five percent (125%) of the Plan's expected claims.

It is recommended that the Plan comply with Section 4707(a)(1) of the New York Insurance Law by reducing the aggregate attachment point of its stop-loss coverage to an amount not greater than one hundred twenty-five (125) percent of expected claims for any fiscal year.

It is also recommended that the Plan maintain aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the Plan.

The following is a summary of the Plan's stop-loss insurance specific coverage and aggregate coverage retentions (deductibles) and limits at June 30, 2015:

Specific excess-of-loss coverage

Coverage

Medical and prescription drug

100% of unlimited medical and prescription drug claims per covered person upon satisfaction of the specific deductible, excess of \$750,000 per covered person.

Limitation for treatment of drugs or alcohol abuse reimbursement

The terms, conditions and limits as stated in the accepted plan document.

Aggregate excess-of-loss coverage

Coverage

Medical and prescription drug

100% of paid medical and prescription drug claims after meeting aggregate losses of \$84,944,024. There is an individual claim limit of \$750,000 and \$1,000,000 maximum aggregate reimbursement per policy period.

D. Accounts and Records

The Plan did not maintain written policies for the processing of its financial transactions, compliance with HIPAA guidelines, and its code of ethics. The absence of documented written policy procedures by the Plan relative to financial transactions, HIPAA compliance, and its code of ethics are indications of operational risks.

Insurance Regulation No. 173 (11 NYCRR 421) Standards for Safeguarding Customer Information states in part:

“Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.”

It is recommended that the Plan establish written policies and procedures for the Plan’s financial transaction functions and written policies for HIPAA compliance with Insurance Regulation No. 173 (11 NYCRR 421), “Standards for Safeguarding Customer Information”.

The Plan has a fiduciary responsibility to uphold a code of ethics for the benefit of its enrolled members and to ensure that the Plan’s board members, officers, managers and consultants do not use their official positions to promote an interest which is in conflict with that of the Plan.

It is recommended, as a best practice, that the Plan’s board of directors establish a documented written code of ethics policy for distribution to its board of trustees, managers, and

consultants, and that compliance with such code of ethics be verified on no less than an annual basis.

E. Third Party Agreements

It was noted during the examination that the Plan entered into third party administrative agreements with POMCO for utilization review management, and medical and hospital claims processing, Express Script (ESI) for pharmacy benefit management, and Davis Vision for Vision benefit.

During the review it was noted that the contract agreement between the Plan and POMCO was properly executed, nevertheless the following was noted in the implementation of the contract agreement between the Plan and ESI, and the execution of the contract between the Plan and Davis Vision.

The agreement between the Plan and Express Scripts included a provision for the Plan to audit or have a third party audit the prescription drugs claims in order for the Plan to determine that Express Scripts has properly and accurately administered the financial aspect of the agreement. However, the Plan did not take advantage of this provision and no audit of the prescription drugs claims were performed during the examination period.

Article 2.4 of the Plan's Pharmacy Benefit Management Agreement ("PBM Agreement") states in part:

"(c) Sponsor Audit. Provided that this agreement has been duly executed by Sponsor and Sponsor is current in the payment of invoices under this agreement, Sponsor may, upon written request, audit the prescription management services provided pursuant to this agreement on an annual basis (unless additional audits are warranted), consistent with audit Protocol set forth in Exhibit B. Sponsor may use an independent third party auditor

(“Auditor”), so long as such Auditor does not have conflict of interest with ESI (as determined by ESI acting reasonably and in good faith), and provided that Sponsor’s Auditor executes a mutually acceptable confidentially agreement. Any request by Sponsor to permit an Auditor to perform an audit will constitute Sponsor’s direction and authorization to ESI to disclose PHI to the Auditor.”

It is recommended that the Plan initiate audits of its claims processed by its contracted pharmacy benefit manager, as allowed by its PBM Agreement.

The contract agreement between the Plan and Davis Vision did not include a provision for the Plan or a contracted entity to perform a periodic vision benefit claims audit; in order for the Plan to determine that Davis Vision has properly and accurately administered the agreement.

It is recommended, as a good business practice and risk mitigation strategy, that the Plan amend its agreement with Davis Vision to allow for the Plan or its contractor to perform periodic vision benefit claims audits.



### 3. **FINANCIAL STATEMENTS**

The following statements shows the assets, liabilities and surplus as of June 30, 2015, as contained in the Plan's 2015 filed annual statement, and condensed summary of operations and reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial conditions as presented in its June 30, 2015 filed annual statement.

#### Independent Accountants

The firm of Poulson & Podvin, LLC was retained by the Plan to audit the Plan's combined statutory basis financial statements of financial position as of December 31st for each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

Poulson & Podvin, LLC concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance SheetAssets

Cash and cash equivalents	\$ 36,686,039
Aggregate write-in for invested assets	<u>532,025</u>
Total assets	<u>\$ 37,218,064</u>

Liabilities

Accounts payable	\$18,191
Claims payable	<u>10,594,688</u>
Total liabilities	<u>\$ 10,612,879</u>

Surplus

Contingency reserves	\$ 3,142,647
Retained earnings/fund balance	<u>23,462,538</u>
Total	<u>\$ 26,605,185</u>
Total liabilities and surplus	<u>\$ 37,218,064</u>

B. Statement of Revenue and Expenses and Surplus

Surplus increased by \$18,173,857 during the five-year examination period, July 1, 2010 through June 30, 2015, detailed as follows:

Revenue

Premium and related revenue	\$287,000,693	
Investment and other income	488,145	
Total revenue		\$287,488,838

Medical and hospital expenses

Hospital/medical benefits	\$196,824,005	
Prescription drugs	68,934,439	
Reinsurance expenses	<u>(387,020)</u>	
Total medical and hospital expenses		\$265,371,424

Administrative expenses

Compensation	103,560	
Marketing	125,678	
Professional fees	59,144	
Administrative fees	7,571,681	
Consultant fees	194,727	
Aggregate write-ins	<u>3,414,379</u>	
Total administrative expenses		<u>11,469,169</u>
Total expenses		<u>276,840,593</u>
Net income		<u>\$10,648,245</u>

Change in Surplus

Surplus, per report on examination, as of June 30, 2010			\$8,431,328
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$10,648,245		
Statutory adjustment as per examination	<u>\$7,525,612</u>		<u>\$18,173,857</u>
Surplus, per report on examination, as of June 30, 2015			<u>\$26,605,185</u>

**4. CLAIMS UNPAID**

The Plan reported a liability for unpaid claims of \$10,594,688 within the Plan's June 30, 2015 filed annual statement.

Section 4706(a)(1) of the New York Insurance Law requires a reserve for payment of claims and expenses that are (A) reported and not yet paid and (B) incurred but not yet reported. The amount of this reserve should not be less than a percentage, approved by the Superintendent of the New York State Department of Financial Services of the expected incurred claims and expensed of the current plan year. The Plan has received approval by the Department to estimate this reserve at 17% of expected incurred claims and expenses of the current plan year. However, the Plan's reported unpaid claims liability of \$10,594,688 represented 15.8% of the Plan's total claims and expenses incurred as reported in its financial statement for fiscal year ending June 30, 2015. Thus, the Plan's reported unpaid claims liability for fiscal year ending June 30, 2015, was

not in compliance with Section 4706(a)(1) of the New York Insurance Law, at the level approved by the Superintendent..

It is recommended that the Plan comply with Section 4706(a)(1) of the New York Insurance Law by maintaining its estimated unpaid losses at 17% of expected incurred claims and expenses of the current plan year, as approved by the Superintendent.

## **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 examination.

The general review was directed at practices of the Plan in the following areas:

- A. Policy forms
- B. Prompt Pay
- C. Appeals, Grievances, & Utilization review
- D. Affordable HealthCare Act ('ACA')  
Compliance
- E. Provider network adequacy

### Policy Forms

Section 4710(a)(1) of the New York Insurance Law states in part:

“(a) the governing board of the municipal cooperative health benefit plan shall:

(1) file for approval with the superintendent a description of material changes in any information provided in the application for certificate of authority in the form and manner prescribed by the superintendent...”

The prior examination report noted that Jefferson Lewis et. al. School Employees’ Healthcare Plan obtained approval from the Department relative to its revised and restated plan document, effective July 1, 2011. The Plan subsequently submitted two policy form riders and amendments in 2013 for approval, which were withdrawn at the request of the Plan. The Plan has implemented since the last approval of the Plan document, ten (10) amendments and riders that were not submitted to the Department for approval.

It is recommended that the Plan comply with the requirements of Section 4710(a)(1) of the New York Insurance Law by obtaining Department approval for any new or revised benefit forms prior to use.

#### Prompt Pay Law Review

A review was made to determine the Plan’s compliance with the, Section 3224-a of the New York Insurance Law (“Prompt Pay Law”),

Section 3224-a(a) of the New York Insurance Law states in part:

“(a) Except in case where the obligation of an insurer or an organization or corporation ...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 shall pay the claim to a policyholder or covered person or make 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.”

Section 3224-a (b) (1) and (2) states in part:

“(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

Section 3224-a (c)(2) states in part:

“(c)(2) ....Where a violation of this section is determined by the superintendent as a result of the superintendent’s own investigation, examination, audit or inquiry, an insurer or organization or corporation ...shall not be subject to civil penalty prescribed in paragraph one this subsection, if the superintendent determined that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section...”

The Plan’s medical, hospital and prescription drug claims submitted during the fiscal year 2014/2015 were obtained. Since the Prompt Pay Law does not apply to health care services rendered out of the state of New York, the claims submitted from out of state providers were purged from the Plan’s claims data. The total medical and hospital claims count received and

processed in fiscal year 2014/2015 by POMCO was 150,513, and the total prescription drug claims received and processed in fiscal 2014 -2015 processed by Express Scripts was 167,339. The prompt payment days were determined by subtracting the date the claims was received by the Plan from the date the claim was adjudicated i.e. 30 days for electronic claims and 45 days for paper claims payments (30 days for denials).

Summary of claims processed per Sections 3224-a (a)&(b)&(c)(2) of the New York Insurance Law

	Medical & Hospital Claims (POMCO)	Prescription Drugs Claims (ESI)
Total population of claims	144,641	167,339
Population of claims adjudicated after 30 days of receipt	6,660	0
Number of claims with violations	6,660	0
<b>Calculated violation rate</b>	<b>4.61%</b>	<b>0</b>
<b>Calculated Claims in violation</b>	<b>6,660</b>	<b>0</b>
Total Plan claims processed	<b>144,641</b>	<b>167,339</b>
<b>% Plan total claims processed in Compliance</b>	<b>95.39%</b>	<b>100%</b>

Based on the above combined summary of medical and hospital, and prescription drugs claims processed, the Plan's prompt payment claims process is at 97.9%, which is .01% above the 2% threshold prescribed by Sections 3224-a(a)&(b) of the New York Insurance Law.

It is recommended that the Plan require its third party claims administrator, POMCO, to implement appropriate procedures to ensure that medical and hospital claims are processed in compliance with the time frame mandated by Section 3224-a of the New York Insurance Law.

Section 3224-a(c)(1) of the New York Insurance Law states in part:



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

In order to test compliance with this section of the law, the examiner calculated the interest on the Plan’s population of 6,660 claims that were processed and paid over 30 days for electronically submitted claims, and over 45 days for paper submitted claim. The result of the calculation revealed that 735 claims had interest amount of \$2.00 or more due for a total amount of \$12,104.25, for which the Plan had failed to pay to its providers/members.

It is recommended that the Plan make appropriate interest payments to providers and members in compliance with Section 3224-a(c)(1) of the New York Insurance Law.

It is recommended that the Plan take steps to recover any prompt payment interest payments made to its providers and members on behalf of the Plan by its claims administrator, POMCO.

Subsequent to the completion of the on-site portion of the field examination, the Plan made interest payments in the amount of \$12,104.25 to the affected providers/members, in compliance

with the aforementioned examination recommendation. However, such interest payment amount did not include additional interest on the interest not paid when the claim payment was made.

It is recommended that the Plan ensure that any additional interest owed to its providers and members be paid for the period between the date in which the claims payment was made and the date that the interest payment was made.

#### Explanation of Benefits Statements (“EOBs”)

Sections 3234(b)(7) of the New York Insurance Law states in part:

“(b) The explanation of benefits form must include at least the following... (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits...”

A review of a sample of the EOBs issued on behalf of the Plan indicated that such EOBs contained the following sentence:

“If you require further assistance in understanding this notice, please visit the Consumers Assistance Programs website at 1-866-NYINSHELP (1-866-694-6743).”

The above wording noted may be considered confusing to the reader in that it does not provide the correct name of the New York State Department of Financial Service’s Consumer Assistance Unit, the applicable website address and does not relate that the telephone numbers provided are the Department’s “Hotline” telephone numbers.

It is recommended that the Plan revise its EOBs to clearly provide the information required by Section 3224(b) of the New York Insurance Law.

In addition it was noted that the EOB notice was written in small font and thus not in compliance with the requirements for the standard of readability per Section 3102(c)(E) of the New York Insurance Law which states in part:

“(E) the text achieves a minimum score of forty-five on the Flesch reading ease test or an equivalent score on any other comparable test as provided in paragraph three of this subsection; (E) it is printed, except for specification pages, schedules and tables, in not less than ten point type, and except for applications, specification pages, schedules and tables, such type is at least one point leaded;”

It is recommended that the Plan increase the size of the font used within its EOB notices in order to comply with the requirements of Section 3102(c)(E) of the New York Insurance Law.

#### Utilization Review, Appeals & Grievance

The Plan contracted with POMCO, a third party administrator, as its utilization review agent. Samples of eight (8) grievances out of 231 total grievance cases received by the Plan during the examination period (July 1, 2010 through June 30, 2015) were selected for review. It was noted that the Plan failed to provide a written acknowledgment letter within 15 business days of the receipt of the grievance for 7 of the 8 sampled grievances reviewed.

Section 4802(d) of the New York Insurance Law states in part:

“(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance...”

It is recommended that the Plan comply with Section 4802(d) of the New York Insurance Law by providing written acknowledgment of all grievances, including name, address and telephone number of the individual or department designated by the insurer to respond to grievances within fifteen business days of receipt of such grievances.

#### Out-Of-Network Compliance Law

Part H of Chapter 60 of the 2014 Laws of New York provided new rights and obligations, effective March 31, 2015, concerning disputes involving bills by health care providers. Health care plans, physicians, and when applicable, other health care providers and patients, have the right to request a review by an Independent Dispute Resolution Entity “IDRE” to resolve a payment dispute regarding a bill for certain emergency services or surprise bills. This Part implements the requirements of Financial Services Law Article 6 by establishing a dispute resolution process and establishing the standards for such process, including criteria and the process for certifying and selecting an IDRE.

Insurance Regulation No. 23 (11 NYCRR 400(5)(b)(2)(3)) states that:

"(b) Upon receipt of a claim for a surprise bill that is submitted with an assignment of benefits form, or that the health care plan otherwise determines is a surprise bill, the health care plan shall:

(2) Provide notice to the non-participating physician or, as applicable, to the non-participating referred health care provider, describing how to initiate the independent dispute resolution process.

(3) Provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall: (i) explain that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or health care provider; (ii) explain that the insured's cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician or nonparticipating referred health care provider; and (iii) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating referred health care provider bills the insured for the out-of-network service.”

During the review of the Plan's explanation of benefits statements for the “surprise billing”, it was noted that the Plan was not in compliance with the Regulation stated above

It is recommended that the Plan's surprise bill notices provided to its insureds and providers include the required wording as stated in, and in compliance with Insurance Regulation No. 23 (11 NYCRR 400.5(b)(2)(3)).

#### Provider Network Adequacy

POMCO, the Plan's third party administrator, provides the Plan's members with access to POMCO's Participating Provider Organization (PPO). As such, the Plan and POMCO are responsible for making sure that the provider network is adequate. A review of Departmental correspondence to POMCO with regard to the Department's January 12, 2016 approval letter relative to POMCO's April 30, 2015 filing for its provider network adequacy, “POMCO North Country PPO” on behalf of the Plan, the Department indicated that POMCO's provider network was acceptable; however, there were certain provider inadequacies noted in the following counties of New York State: Jefferson, Lewis, Oneida, Onondaga, Oswego and St. Lawrence.

The Department recommended that the Plan permit enrollees to have access to non-participating providers in those counties until such time as an adequate network is established. In addition, enrollees accessing such non-participating providers would be responsible only for the in-network cost-share. However, neither the Plan nor POMCO addressed the provider network inadequacies noted within POMCO's North County PPO.

Section 3241(a) of the New York Insurance Law states in part:

“(a) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a health insurance policy or contract with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract...”.

It recommended that the Plan ensure that its provider network is adequate and amend its benefit summary document to reflect the changes required to comply with the requirements of Section 3241(a) of the New York Insurance Law.

## 6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on organization included fourteen (14) recommendations detailed as follows (page number refers to the prior report on organization).

<u>ITEM NO.</u>		<u>PAGE NO.</u>
	<u>Corporate Governance</u>	
1.	It is recommended that the Plan maintains formalized minutes of Committee meetings of the Governing Board.	6
	<i>The Plan has complied with this recommendation</i>	
2.	It is recommended that the members of the Appeal Review Committee be formally appointed through board resolution.	7
	<i>The Plan has complied with this recommendation</i>	
	<u>Reinsurance</u>	
3.	It is recommended that the Plan complies with New York Insurance Law Section 4707(a)(1) and reduce the aggregate attachment point of its stop loss coverage to one hundred twenty-five (125) percent of expected claims for the current fiscal year.	10
	<i>The Plan did not comply with this recommendation. A similar recommendation is included in this report under item A.</i>	
	<u>Investments</u>	
4.	It is recommended the Plan complies with New York Insurance Law section 1411(a) by obtaining approval of specific investments through resolution of the Governing Board or a subcommittee thereof.	11
	<i>The Plan has complied with this recommendation.</i>	
5.	It is recommended that the Plan establishes procedures relative to investments in accordance with its investment guidelines.	11
	<i>The Plan has complied with this recommendation.</i>	

**ITEM NO.****PAGE NO.**Accounts and Records

6. It is recommended that the Plan amends its prescription benefits management contract to reflect current corporate names. 12

*The Plan has complied with this recommendation.*

7. It is recommended that the Plan authorizes bank signatories through board resolution. 12

*The Plan has complied with this recommendation.*

Policy Forms

8. It is recommended that the Plan complies with the requirements of Section 4710(a)(1) of the New York Insurance Law and submit necessary documents in a timely manner to ensure compliance. 17

*The Plan did not comply with this recommendation. A similar recommendation is included in this report under item A.*

9. It is recommended that the Plan fully complies with Section 4903(d) of the New York Insurance Law and issue notices of adverse determination to members/providers when claims are denied based on utilization review decisions. 20

*The Plan has complied with this recommendation.*

10. It is recommended that the Plan complies in all instances with New York Insurance Law Section 4903(c) and provide a notice of determination to the insured or insured's designee by telephone and in writing within one business day of receipt of the necessary information on concurrent utilization review requests 21

*The Plan has complied with this recommendation.*



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

11. It is recommended that the Plan complies with the timeframe prescribed by Section 4903(b) of the New York Insurance Law and provide the required notice of determination within three business days, by telephone and in writing to the insured/insured's designee on prospective utilization reviews. 22

*The Plan has complied with this recommendation.*

12. It is recommended that the Plan provides written acknowledgement, within 15 days, of the filing of an appeal, in accordance with New York Insurance Law Section 4904(c). 22

*The Plan has complied with this recommendation.*

13. It is recommended that the Plan complies with Department Regulation No. 166, and include the nine mandated requirements within each notice of final adverse determination of an expedited or standard appeal issued pursuant to New York Insurance Law Section 4904. 23

*The Plan has complied with this recommendation.*

**Third Party Claims Negotiator**

14. It is recommended that the Plan ensures that its third party claim negotiators, Allmed and Multiplan, maintain a New York license to adjust claims, in compliance with New York Insurance Law Section 2108(a)(1). 24

*The Plan has complied with this recommendation.*

7. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
A. <u>Corporate Governance</u>	
It is recommended that the Plan comply with Section 624(a) of the New York Business Corporation Law by recording all board member appointments and replacements in the minutes of its board of directors' meetings.	7
B. <u>Stop-Loss Coverage</u>	
i. It is recommended that the Plan comply with Section 4707(a)(1) of the New York Insurance Law by reducing the aggregate attachment point of its stop-loss coverage to an amount not greater than one hundred twenty-five (125) percent of expected claims for any fiscal year.	11
ii. It is also recommended that the Plan maintain aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the Plan.	11
C. <u>Accounts and Records</u>	
i. It is recommended that the Plan establish written policies and procedures for the Plan's financial transaction functions and written policies for HIPAA compliance with Insurance Regulation 173 (11 NYCRR 421) "Standards for Safeguarding Customer Information".	12
ii. It is recommended, as a best practice, that the Plan's board of directors establish a documented written code of ethics policy for distribution to its board of trustees, managers, and consultants, and that compliance with such code of ethics be verified on no less than an annual basis.	12

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Third Party Agreements</u>	
i. It is recommended that the Plan initiate audits of its claims processed by its contracted pharmacy benefit manager, as allowed by its PBM Agreement.	14
ii. It is recommended, as a good business practice and risk mitigation strategy, that the Plan amend its agreement with Davis Vision to allow for the Plan or its contractor to perform periodic vision benefit claims audits.	14
E. <u>Unpaid Claims</u>	
It is recommended that the Plan comply with Section 4706(a)(1) of the New York Insurance Law by maintaining its estimated unpaid losses at 17% of expected incurred claims and expenses of the current plan year, as approved by the Superintendent.	19
F. <u>Policy Forms</u>	
It is recommended that the Plan comply with the requirements of Section 4710(a)(1) of the New York Insurance Law by obtaining Department approval for any new or revised benefit forms prior to use.	20
G. <u>Prompt Payment</u>	
i. It is recommended that the Plan require its third party claims administrator, POMCO, to implement appropriate procedures to ensure that medical and hospital claims are processed in compliance with the time frame mandated by Section 3224-a of the New York Insurance Law.	22
ii. It is recommended that the Plan make appropriate interest payments to providers and members in compliance with Section 3224-a (c)(1) of the New York Insurance Law.	23
iii. It is recommended that the Plan take steps to recover any prompt payment interest payments made to its providers and members on behalf of the Plan by its claims administrator, POMCO	23

<u>ITEM</u>	<u>PAGE NO.</u>
iv. It is recommended that the Plan ensure that any additional interest owed to its providers and members be paid for the period between the date in which the claims payment was made and the date that the interest payment was made.	24
H. <u>Explanation of Benefits Statements</u>	
i. It is recommended that the Plan revise its EOBs to clearly provide the information required by Section 3224(b) of the New York Insurance Law.	25
ii It is recommended that the Plan increase the size of the font used within its EOB notices in order to comply with Section 3102(c)(E) of the New York Insurance Law.	25
I. <u>Utilization Review, Appeals &amp; Grievances</u>	
It is recommended that the Plan comply with Section 4802(d) of the New York Insurance Law and provide written acknowledgment of all grievances, including name, address and telephone number of the individual or department designated by the insurer to respond to grievances within fifteen business days of receipt of such grievances.	26
J. <u>Out-Of-Network Compliance Law</u>	
It is recommended that the Plan’s surprise bill notices provided to its insureds and providers include the required wording as stated in, and in compliance with Insurance Regulation No. 23 (11 NYCRR 400.5(b)(2)(3)).	27
K. <u>Provider Network Adequacy</u>	
It recommended that the Plan ensure that its provider network is adequate and amend its benefit summary document to reflect the changes required to comply with the requirement of Section 3241(a) of the New York Insurance Law.	28

Respectfully submitted,

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Hussein Agouda  
Insurance Examiner, CFE

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

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

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Hussein Agouda

Subscribed and sworn to before me  
This \_\_\_\_ day of \_\_\_\_\_ 2017.

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

*Hussein Agouda*

*as a proper person to examine the affairs of*

*Jefferson-Lewis et.al School Employees Healthcare Plan*

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

*Municipal Cooperative Health Benefit Plan*

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

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

*this 13th day of March, 2015*

BENJAMIN M. LAWSKY  
Superintendent of Financial Services

By:



Lisette Johnson  
Bureau Chief  
Health Bureau

