

**REPORT ON EXAMINATION**

**OF**

**STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN**

**AS OF**

**JUNE 30, 2016**

**DATE OF REPORT**

**MAY 25, 2018**

**EXAMINER**

**GAIL A. ROSS**

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NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

Andrew M. Cuomo  
Governor

Maria T. Vullo,  
Superintendent

May 25, 2018

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

Madam:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31536, dated September 28, 2016, attached hereto, I have made an examination into the condition and affairs of State-Wide School Cooperative Health Plan, a municipal cooperative health benefit plan operating under a certificate of authority pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2016, and respectfully submit the following report thereon.

The examination was conducted at the office of Wright Risk Management Company (WRM), the administrator of State-Wide Schools Cooperative Health Plan, located at 333 Earle Ovington Boulevard, Uniondale, New York.

Wherever the designation, the “Plan” appears herein, without qualification, it should be understood to indicate State-Wide Schools Cooperative Health 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 THE EXAMINATION

The previous examination was conducted as of June 30, 2011. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period from July 1, 2011 through June 30, 2016. 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, 2017 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, 2016 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 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, 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 2012 through 2014 by the accounting firm Rosen Seymour Shapss Martin & Company, LLP. The Plan was audited annually for fiscal years 2015 and 2016 by the accounting firm Nawrocki Smith, LLP. The Plan received an unmodified

opinion in each of the audited years. Certain audit workpapers of Nawrocki Smith, LLP were reviewed and relied upon in conjunction with this examination.

The examiner reviewed the corrective actions taken by the Plan with respect to the comments and recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 6 of this report.

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 explanation or description.

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

The Plan is a multi-employer self-funded health benefits program operated exclusively for the benefit of the employees/retirees and their dependents of member City School Districts ("CSD") and Union Free School Districts ("UFSD"). The Plan has been in existence since 1986 and is composed of twenty-three separate school districts. It was issued a Certificate of Authority on October 1, 2003 by the Department, pursuant to the provisions of Article 47 of the New York Insurance Law, to operate as a municipal cooperative health benefit plan in accordance with its approved Municipal Cooperation Agreement in the State of New York, including the county of Westchester, where it originated as the Southern Westchester Schools Cooperative Health Plan.

The Plan participants are as follows:

Ardsley UFSD  
Bronxville UFSD  
Byram Hills CSD  
Dobbs Ferry UFSD  
Eastchester UFSD

Mt. Pleasant-Blythdale UFSD  
Mt. Pleasant Central Schools  
Mt. Pleasant Cottage School  
Mt Vernon CSD  
Pelham UFSD

Edgemont UFSD	Portchester-Rye UFSD
Greenburgh #11 UFSD	Rye City School District
Greenburg Central Schools #7	Rye Neck UFSD
Harrison CSD	Tarrytown UFSD
Hastings-on-Hudson UFSD	Tuckahoe UFSD
Hawthorne-Cedar Knolls UFSD	White Plains CSD
Irvington UFSD	

The Plan's home office is located at 12 Metro Park Road, Suite # 208, Colonie, New York. Most administrative functions are performed at this location, with the exception of the claims functions detailed herein. In addition, accounting functions are performed at the office of WRM located in Uniondale, New York.

A. Corporate Governance

Pursuant to its Municipal Cooperation Agreement ("MCA"), management control and administration of the Plan is to be vested in a Board of Governors ("Board"). The Municipal Cooperation Agreement of the Plan specifies that the Board of Governors shall select, from members of the Board, an Executive Committee consisting of a minimum of seven "Governors".

As of June 30, 2016, the Executive Committee members, with their principal affiliation, were as follows:

<u>Name and Residence</u>	<u>Principal Affiliation</u>
Dan Carlin Lograngeville, New York	Assistant Superintendent, Bronxville UFSD
Dr. Kristopher Harrison Allamuchy, New Jersey	Superintendent, Irvington UFSD
Maura McAward Stamford, Connecticut	Assistant Superintendent, Port Chester UFSD
Dr. Peter Mustich New Rochele, New York	Assistant Superintendent, Rye Neck UFSD

<u>Name and Residence</u>	<u>Principal Affiliation</u>
Angelo Rubbo Town of Pelham, New York	Assistant Superintendent, Pelham UFSD
Fred Seiler Ossining, New York	Assistant Superintendent, White Plains CSD
Dr. Louis Wool Shrub Oak, New York	Superintendent, Harrison UFSD

Effective June 30, 2016 Fred Seiler retired.

Effective July 1, 2016 the Board appointed Ann Vaccaro-Teich, Asst. Superintendent White Plains CSD.

The minutes of all meetings of the Executive Committee thereof held during the examination period were reviewed. The review indicated that the meetings were generally well attended, with all members attending at least one-half of the meetings they were eligible to attend.

Section 1411(a) of the New York Insurance Law states in part:

“(a) No domestic insurer shall make any loan or investment, ..., unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan...”

A review of the minutes of the Board meetings for the period under examination found that specific investment transactions were not approved through Board resolution. Instead, investment reports were provided to the Governing Board periodically for review.

It is recommended that State-Wide Schools Cooperative Health Plan and its Board comply with the provisions of Section 1411(a) of the New York Insurance Law by authorizing and approving investments on at least a quarterly basis, and by recording such approvals in the minutes of the governing board.



The Plan entered into contractual agreements with various vendors to provide certain administrative services to the Plan: As of June 30, 2016, the Plan maintained the following administrative services agreements:

- (1) Express Script, Inc. – Pharmacy benefit management (PBM);
- (2) Anthem/Empire Blue Cross Blue Shield – hospital and professional physician network managing and network claims pricing;
- (3) Coordinated Care Programs, LLC (aka “Quantum”) – Medical management (utilization review) and customer services;
- (4) Alicare, Inc – processes in-network and out-of-network medical and hospital claims;
- (5) Aetna – provides Medicare Advantage program to retirees;
- (6) Wright Employees Service company, LLC (WESCO) – Plan administrative services management;
- (7) The Segal Group – provides independent actuarial services on the Plan’s claims reserves and provides general consulting and compliance services;
- (8) IPC/Evergreen Rx – Pharmaceutical Consulting; and
- (9) PFM Asset Management – Investment management.

**Notes:**

The Pharmacy Benefit Manager (PBM) changed from Medco-ESI to CVS-Silverscript, effective July 1, 2016 for SWSCHP’s active employee and early retiree populations, and effective January 1, 2017 for SWSCHP’s Medicare retiree’s population (Employer Group Waiver Program (EGWP)).

The medical care management for SWSCHP’s active employees and early retirees changed from Quantum-Coordinated Health/Care to Alicare Medical Management, effective August 1, 2016.

Customer services and website development changed from Quantum-Coordinated Health/Care to Alicare, Inc., which had been serving SWSCHP as Claims Administrator, for SWSCHP’s active employees and early retirees populations, effective August 1, 2016.

The Plan is billed administration fees by the third-party vendors for services rendered.

The principal officers and administrator of the Plan as of June 30, 2016 were as follows:

<u>Name</u>	<u>Title</u>
Dr. Louis Wool	President
Angelo Rubbo	Vice President
Fred Seiler	Chief Financial Officer
Dr. Norman Freimark	Executive Director

Effective July 1, 2016, Dan Carlin was appointed as CFO to replace Fred Seiler

B. Territory and Plan of Operation

As of October 1, 2003, the Plan held a certificate of authority to operate as a municipal cooperative health benefit plan pursuant to Section 4704 of the New York Insurance Law in the State of New York. Pursuant to the requirements of Article 47 of the New York Insurance Law, the Plan is required to maintain a contingency reserve equal to 5% of its annualized earned premium equivalents. The Plan met the contingency reserve requirement throughout the examination period.

The Plan's premiums and enrollment during the five-year examination period were as follows:

<u>Calendar Year</u>	<u>Premium</u>	<u>Enrollment</u>
2012	\$120,659,459	21,381
2013	\$135,935,860	22,224
2014	\$146,375,879	22,385
2015	\$154,525,874	22,889
2016	\$167,184,493	23,008

C. Conflict of Interest Statement

The Statement of Policy on Conflict of Interest states, in part:

“As Executive board members of the State-Wide Schools Cooperative Health Plan, you are required to annually sign a declaration regarding conflict of interest.”

The Governing Board members did not sign the conflict of interest statement in calendar years 2013, 2014, or 2015, in contravention of the above stated policy.

It is recommended that the Plan comply with its Conflict of Interest policy and ensure that each Board member and Officer complete the conflict of interest statement annually.

D. Custodial Agreement

The National Association of Insurance Commissioners (NAIC) guidelines provides clauses that should be included in custodial agreements:

“If the custodial agreement has been terminated or if 100% of the account assets in any one custody account have been withdrawn, the custodian shall provide written notification, within three business days of termination or withdrawal, to the insurer’s domiciliary commissioner;

The custodian shall provide, upon written request from a regulator or an authorized officer of the insurance company, the appropriate affidavits, with respect to the insurance company’s securities held by the custodian.”

The Plan’s custody agreement with M&T Bank did not include the above recommended clauses.

It is recommended, as a good business practice, that the Plan amend its agreement with M&T Bank to include the above clauses.

E. Municipal Cooperation Agreement

Section 4705(a)(1) of the New York Insurance Law states:

- (a) The municipal cooperation agreement, under which the municipal cooperative health benefit plan is established and maintained, and any amendment thereto, shall be approved by each participating municipal corporation by majority vote of each such corporation’s governing body, and shall:
  - (1) specify all municipal corporations participating in the municipal cooperative health benefit plan and describe the form or type of municipal corporations eligible for participation.

The Plan did not specify the participating school districts within its Municipal Cooperation Agreement.

It is recommended that the Plan complies with the requirements of Section 4705(a)(1) of the New York Insurance Law by specifying all twenty-three participating municipal corporations in its Municipal Cooperation Agreement.

The Plan must amend its Municipal Cooperation Agreement (“MCA”) to include all of its participating municipal corporations and file the revised MCA for approval with the Superintendent. It should be noted that the Plan is obligated to comply with the most recently approved version of its MCA until such time as the Department approves an amended version.

F. Stop-Loss Coverage

In accordance with the requirements of Sections 4707(a)(1) and (2) of the New York Insurance Law, the Plan maintained both aggregate excess of loss and specific excess of loss insurance coverages, with Reliastar Life Insurance Company of New York, a New York licensed life insurance company, during fiscal year 2016, as follows:

<u>Specific excess of loss</u>	100% of unlimited medical and prescription drug claims per covered person upon satisfaction of the specific deductible, excess of \$450,000 per covered person.
<u>Aggregate excess of loss</u>	\$1,000,000 limit of liability per coverage period in excess of annual aggregate attachment point (deductible) of \$149,749,586, for the current contract year.

The contract was renewed subsequent to the examination date, July 1, 2016.

G. Accounts and Records

The General Information and Instructions for Filing the New York Data Requirements for Municipal Cooperative Health Benefit Plans indicates that prescription drugs are to be reported in

Report #2: Statement of Revenue, Expenses and Surplus, (NY4, Line 11), which includes “expenses for prescription drugs and other pharmacy benefits covered by the reporting entity,” but deducts “Pharmaceutical rebates relating to insured plans...”

It is noted that SWSCHP reported pharmaceutical rebates of \$16,508,731 as a revenue item under the heading “aggregate write-in for other healthcare related revenues” on NY4, Line 4 of the Plan’s filed statement. As noted above, pharmaceutical rebates are not to be reported as a revenue item, but instead shall be deducted from prescription drug expenses.

It is recommended that SWSCHP complete its annual statements per the General Information and Instructions for Filing the New York Data Requirements for Municipal Cooperative Health Benefit Plans, and report pharmaceutical rebates as a reduction of the Plan’s prescription drug expenses.

### 3. **FINANCIAL STATEMENTS**

The following statements show the assets, liabilities, and surplus as of June 30, 2016, as contained in the Plan’s 2016 filed annual statement, a condensed summary of operations and a 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 condition as presented in its June 30, 2016 filed annual statement.

#### Independent Accountants

The firm of Rosen Seymour Shapss Martin and Company was retained by the Plan to audit the Plan’s combined statutory-basis statements of financial position as of June 30<sup>th</sup> of each of the

fiscal years 2012 through 2014, and the related statutory-basis statements of operations and surplus for the years then ended. For the fiscal years 2015 and 2016, the Plan retained Nawrocki & Smith, LLP to audit the aforementioned financial statements.

Rosen Seymour Shapss Martin & Company and Nawrocki & Smith, LLP 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

Bonds	\$ 55,339,603
Cash	13,799,557
Premiums receivable	234,779
Investment income due and accrued	186,803
Amounts recoverable from reinsurers	640,990
Aggregate write-ins for other than invested assets	2,000
Health care and other amounts receivable	<u>4,116,275</u>
Total assets	<u>\$ 74,320,007</u>

Liabilities

Claims payable	\$ 13,553,400
Accounts payable	7,824,770
Additional reserve required by Section 4706 (a)(1)	16,924,931
Premium deficiency reserve	5,052,400
Premiums received in advance	<u>930,411</u>
Total liabilities	<u>\$ 44,285,912</u>

Net Worth

Surplus (per NYIL §4706(a)(5))	\$ 8,359,225
Unassigned funds	<u>21,674,870</u>
Total surplus	<u>30,034,095</u>
Total liabilities and surplus	<u>\$ 74,320,007</u>

**Note:** The Plan is a municipal cooperative health benefit plan which falls under IRC Section 115(1), which exempts the Plan from federal income tax. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Surplus

Surplus increased \$5,788,658 during the five-year examination period, July 1, 2011 through June 30, 2016, detailed as follows:

Revenue

Premiums		\$724,681,565
Aggregate write-ins for other health care related revenues:		
Commercial ESI (Medco) Rebate	14,837,230	
Medicare EGWP Subsidy/ESI (Medco) rebate EGWP	15,609,929	
Medicare EGWP Coverage Gap Disc	7,514,890	
Medicare EGWP Reinsurance Subsidy Annual	6,462,642	
Stop loss in 2015 but not in in 2016 prior year	<u>7,123,773</u>	
Total write-ins	51,548,464	
Misc. Income	800	
Net investment income	<u>1,563,236</u>	<u>53,112,500</u>
Total revenue		\$777,794,065

Expenses

Medical and hospital expenses	\$492,227,796	
Prescription drugs	203,753,221	
Aggregate write-ins for other hospital & medical:		
Decrease premium deficiency reserve	(7,209,600)	
Aetna Medicare Advantage	16,860,549	
Medicare Part D-IRMAA Reimbursement	422,710	
Stop Loss	7,010,938	
ACA Transitional reinsurance fee	876,422	
Administrative expenses	46,669,980	
Less: Reinsurance expense-net	<u>867,048</u>	
Total expenses		<u>759,744,968</u>
Net income		\$ <u>18,049,097</u>



Changes in Surplus

Surplus, as of June 30, 2011, per report on examination			\$ 24,245,437
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$ 18,049,097		
Change in surplus per Section 4706(a)(5)	\$ 2,992,415		
Aggregate write-ins for losses in surplus		\$ 15,252,854	
Net Increase in surplus			<u>5,788,658</u>
Surplus, as of June 30, 2016, per report on examination			<u>\$ 30,034,095</u>

**4. RESERVES**

The examination liabilities for unpaid claims in the amount of \$13,553,400 and the required additional reserves of \$16,924,931 are the same as the amounts reported by the Plan as of June 30, 2016.

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 approval by this Department on June 30, 2003, to reduce its reserves for claims and related expenses to 17% from 25% of the current year's expected incurred claims and expenses. The Plan maintained its claims reserves at a level of 17.3%, or \$30,478,331, of the total claims and expenses incurred as reported in the financial statement for the fiscal year ending on June 30, 2016.

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 June 30, 2016.

## **5. MARKET CONDUCT**

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 major areas:

- A. Prompt Pay Law
- B. Patient Protection and Affordable Care Act
- C. Utilization Review and Appeals
- D. Grievance

A. Prompt Pay Law

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

A review of the Plan’s submitted medical and hospital claims data for the period July 1, 2015 through June 30, 2016, relative to compliance with Section 3224-a of the New York Insurance Law did not reveal any problem areas.

B. Patient Protection and Affordable Care Act

Section 3221(l)(8)(E) of the New York Insurance Law states the following:

In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every group policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (G) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for preventive care and screenings that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

In addition, non-grandfathered group health plans offering health insurance coverage in the group market are required to provide certain benefits and are prohibited from imposing cost-sharing requirements for those benefits. The following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury also address the application of cost sharing to preventive care benefits:

- Evidenced-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

During the review of preventive care services, it was noted that the Plan erroneously deducted copays on certain preventive care claims.

Specifically, Alicare applied cost sharing on sixty-two (62) preventive care claims (thirty-eight (38) medical claims and twenty-four (24) hospital claims) adjudicated from January 1, 2016 through December 31, 2016. All sixty-two (62) claims where cost sharing was applied were reviewed to ascertain if mandated preventive services were processed correctly. The review found that twenty-two (22) of the thirty-eight (38) medical claims and eleven (11) of the twenty-four (24) hospital claims included copays when none should have been applied. Research on the preventive

care claims where cost sharing was applied revealed that the issue was not systemic, but rather was the result of processing errors.

As a result, the Company was in violation of New York Insurance Law Section 3221(l)(8)(E) and the US Department of Labor Regulation 45 C.F.R. 147.130(a)(2) for assessing copayments for claims defined as preventive care by the USPSTF.

It is recommended that the Plan comply with New York Insurance Law Section 3221(l)(8)(E) and US Department of Labor Regulation 45 C.F.R. 147.130(a)(2), by not charging co-payments for claims defined as preventive care by the USPSTF.

C. Mental Health Parity

The examination included a review of the Plan's claims settlement practices on mental health claims processed by the Plan's third-party administrator, Alicare, to ensure that mental health benefits have parity with medical and hospital benefits. It is noted that management of the Plan retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related Regulations, and therefore management must be diligent in its oversight of the claims settlement and related functions.

A review of Alicare's mental health claims processing practices and procedures was performed by using a sample covering mental health claims adjudicated during the period of July 1, 2015 through June 30, 2016, in order to evaluate compliance with the mental health parity requirements of the Mental Health Parity and Addiction Equity Act of 2008. The examiner selected a sample of sixty (60) mental health claims out of 88,949 processed during the fiscal year to test for claims accuracy.

The Plan erroneously denied four (4) out of the sixty (60) claims sampled as having no authorization on file or exceeding authorized visits. The errors were manual errors and did not reflect issues with the Plan's vendor's claims processing guidelines with regard to mental health parity.

It is recommended that the Plan review procedures to ensure claims are not erroneously denied.

D. Utilization Review and Appeals

The Plan reported 4,851 utilization review cases and 85 utilization review appeal cases opened and closed during the fiscal year 2016. Twenty (20) utilization review cases and ten (10) appeal cases were reviewed to ensure compliance with Article 49 of the New York Insurance Law.

The following violations were noted:

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

“(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.”

It was noted that for one case, all information was received, but notification to the member was not made within thirty days of receipt of all information necessary to make determination.

It is recommended that the Plan comply with Section 4903(d) of the New York Insurance Law by providing a response within the required time frame.

Section 4904(c) of the NYIL states, in part:

“(c)...The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.”

In six out of the ten cases reviewed by the examiner, the Plan failed to send acknowledgement letters to members. Also, the Plan failed to notify, in writing, the insured's and the insured health care provider, within two days of rendering the appeal determination in two out of the ten cases reviewed.

It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law by providing written acknowledgment letters and responses to appeals within the required time frame.

#### E. Grievances

The Plan reported one hundred and three (103) grievance cases open and closed during fiscal year 2016. The examiner reviewed fifteen (15) cases to ensure compliance with Section 4802 of the New York Insurance Law. The following violations were noted:

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

“...All grievances shall be resolved in an expeditious manner, and in any event, no more than:

(1) forty-eight hours after receipt of all necessary information when a delay would significantly increase the risk to an insured's health;

- (2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and
- (3) forty-five days after the receipt of all necessary information in all other instances:"

Seven (7) cases were noted where the Plan failed to issue a determination letter to the insured or the insured's designee in accordance with the requirements of Section 4802(d)(2) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4802(d)(2) of the New York Insurance Law by responding to all grievance within the required time frame.

There was one instance where the Plan failed to issue a determination letter to the insured or the insured's designee in accordance with the requirements of Section 4802(d)(3) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4802(d)(3) of the New York Insurance Law by issuing a determination letter to the insured or the insured's designee.

Section 4802(g)(3) of the New York Insurance Law states:

- "The notice of a determination shall include:
  - (3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal."

There were four (4) instances where the Plan failed to include a form for the filing of an appeal, in accordance with the requirements of Section 4802(g)(3) of the New York Insurance Law.



It is recommended that the Plan comply with Section 4802(g)(3) of the New York Insurance Law by including the required form for the filing of a grievance appeal with its determination letters.

Section 4802(h) of the New York Insurance Law states:

“An insured or an insured’s designee shall have not less than sixty business days after receipt of notice of grievance determination to file a written appeal, which may be submitted by letter or by a form supplied by the insurer.”

In four (4) cases reviewed by the examiner, the Plan’s notification letter indicated that the member has thirty (30) days to file a grievance appeal instead of the required sixty (60) days. The 30-day appeal time is not in compliance with New York Insurance Law Section 4802(h), which requires that the letter describe the time limit of 60 days in which an appeal of a grievance may be brought.

It is recommended that the Plan comply with Section 4802(h) of the New York Insurance Law by ensuring its grievance determination letters accurately and clearly explain members’ rights and the statutory time frame for filing an appeal.

The Plan indicated a determination letter with the incorrect information was put in use on August 1, 2016, when Alicare took over as the Plans medical care manager. The failure to send the grievance appeal form to the insured also started on that date. A review by the Plan found that a total of 43 grievance cases had an incorrect grievance determination letter issued to subscribers and did not send a form for filing a grievance appeal resulting in violations of Section 4802G)(3) and (h) of the New York Insurance Law.

It is recommended that the Plan take steps to provide the affected subscribers the correct grievance information and appeal forms and ensure the subscribers are allowed to implement their grievance appeal rights as required by the above sections of the New York Insurance Law.

Section 4802(i) of the New York Insurance Law (“NYIL”) states, in part:

“Within fifteen business days of receipt of the appeal, the insurer shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the insurer to respond to the appeal and what additional information, if any, must be provided in order for the insurer to render a decision.”

There was one case where the Plan failed to provide an acknowledgment of the appeal within the time required of Section 4802(i) and failed to identify the individual designated to respond to the appeal.

It is recommended that the Plan comply with Section 4802(i) of the New York Insurance Law by acknowledging an appeal and identifying the individual designated to respond to the appeal.

6. **COMPLIANCE WITH PRIOR REPORT ON EXAMINATION**

The prior report on examination contained twenty-one (21) comments and recommendations as follows (page numbers refer to the prior report):

<b><u>ITEM NO.</u></b>		<b><u>PAGE NO.</u></b>
	<u>Management and Controls</u>	
1.	It is recommended that SWSCHP's board complies with the requirements of Section 6, Article IV of its Municipal Cooperation Agreement by taking minutes of its annual general member meetings and by having the President of the Board of Governors provide for the keeping of said minutes.	9
	<i>The Plan has complied with this recommendation.</i>	
2.	It is recommended that SWSCHP complies with Section 14, Article IV of its Municipal Cooperation Agreement by conducting elections of its Executive Committee members during its annual general member meetings.	9
	<i>The Plan has complied with this recommendation.</i>	
	<u>Explanation of Benefits Statements</u>	
3.	It is recommended that SWSCHP ensure that its TPA, Alicare, Inc., provide the required aforementioned forfeiture notification on all of SWSCHP's member EOBs, in accordance with the requirements of Section 3232(b)(7) of the New York Insurance Law.	19
	<i>The Plan has complied with this recommendation.</i>	
	<u>Utilization Review</u>	
4.	It is recommended that the Plan ensure that its TPA, CCP, properly classify its utilization reviews into the correct (prospective, concurrent, and retrospective) categories.	20
	<i>This recommendation is no longer valid as CCP is no longer the Plan's medical management</i>	

**ITEM NO.****PAGE NO.**Utilization Review

5. It is recommended that in regard to prospective utilization reviews, the Plan ensure that its TPA, CCP, comply with the requirement of Section 4903(b) of the New York Insurance Law and with its Clinical Review Process Timeframes – NY policy by providing telephonic notices in addition to the written notifications, of their determination to the insured or the insured’s designee and the insured’s provider. 20

*This recommendation is no longer valid as CCP is no longer the Plan’s medical management*

6. It is recommended that the Plan require its TPA, CCP, to comply with the requirements of Section 4903(c) of the New York Insurance Law and with its Clinical Review Process Timeframes – NY policy by providing notices of determination within one business day, by telephone and in writing, to the insured, the insured’s designee or the insured’s health care provider. 22

*This recommendation is no longer valid as CCP is no longer the Plan’s medical management*

7. It is recommended, with respect to first level UR appeals, that the Plan requires its TPA, CCP to issue written appeal determinations within two business days of the rendering of its determination, in accordance with the requirements of Section 4904(c) of the New York Insurance Law. 23

*This recommendation is no longer valid as CCP is no longer the Plan’s medical management*

8. It is recommended that the Plan require its TPA, CCP, to ensure that both expedited and standard appeals are conducted by clinical peer reviewers who have not rendered the adverse determination, in accordance with the requirements of Section 4904(d) of the New York Insurance Law. 23

*This recommendation is no longer valid as CCP is no longer the Plan’s medical management*

**ITEM NO.****PAGE NO.**Utilization Review

9. It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of Section 4904(c) of the New York Insurance Law by including the clinical rationale and the notification to the insured about his/her right to an external appeal in their first level UR insured appeal adverse determination notice. 24
- This recommendation is no longer valid as CCP is no longer the Plan's medical management*
10. It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of Part 410.9(e)(9) of the Department Regulation No. 166 by including the required aforementioned statement in all of its adverse determinations issued at the first level of UR appeals. 25
- This recommendation is no longer valid as CCP is no longer the Plan's medical management*
11. It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of both Part 410.9(c) of the Department Regulation No. 166 and Section 4910(b) of the New York Insurance Law by issuing the final adverse determinations at its first level of UR appeals. 26
- This recommendation is no longer valid as CCP is no longer the Plan's medical management*
12. It is recommended that SWSCHP prevents any confusion the members may have with regard to their second level appeal rights by clarifying, in its adverse determination notices, the purpose and nature of its Executive Reviews and its second level appeals process. 28
- The Plan has complied with this recommendation.*
13. It is recommended, as good business practice, that SWSCHP keeps a log of all its Executive Reviews and second level appeals. 28
- The Plan has complied with this recommendation.*

**ITEM NO.****PAGE NO.**Utilization Review

14. It is recommended that the Plan use sequential case numbers and include other relevant information for the purpose of tracking such Executive Reviews and second level appeals. 28

*The Plan has complied with this recommendation*

15. It is recommended that the Plan ensures that its TPA, CCP, complies with the requirements of Section 4900(d-1) and 4903(a) of the New York Insurance Law by having all adverse determination of its utilization reviews on experimental and investigational medical treatments rendered by clinical peer reviewers. 29

*This recommendation is no longer valid as CCP is no longer the Plan's medical management*

16. It is recommended that the Plan management fulfills its responsibility for compliance with New York Insurance Law and Regulations, as regards all its delegated functions, via strong oversight of its TPAs' practice. 29

*The Plan has complied with this recommendation.*

Summary Plan Description

17. It is recommended that SWSCHP complies with the requirements of Section 3201(b)(1) and Section 479(b) of the New York Insurance Law by making all the required filings with the Department. 30

*The Plan has complied with this recommendation*

Central Complaint Log

18. It is recommended, as good business practice, that SWSCHP maintains a log of its CAU complaints in accordance with the requirements of Circular Letter No. 11(1978) 32

*The Plan has complied with this recommendation*

**ITEM NO.****PAGE NO.**Central Complaint Log

19. It is recommended, as good business practice, that SWSCHP maintains one central complaint log, which includes all complaints received with regard to its members, as a tool to monitor all of its compliant activities and identify potential problem areas. 32

*The Plan has complied with this recommendation.*

Audits of Third-Party Administrators

20. It is recommended that the Plan ensures compliance of the New York Insurance Law and proper oversight of its TPAs, by developing and implementing formal written policies and procedures on when and how it will conduct audits of its TPAs. 33

*The Plan has complied with this recommendation*

21. It is further recommended that a formal report be issued detailing process used to conduct these audits and documenting whether any issues were found or not found and what actions, if any, were taken to rectify the issues. 33

*The Plan has complied with this recommendation.*

7. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<b><u>ITEM NO.</u></b>	<b><u>PAGE NO.</u></b>
<p>A. <u>Corporate Governance</u></p> <p>It is recommended that State-Wide Schools Cooperative Health Plan and its Board comply with the provisions of Section 1411(a) of the New York Insurance Law by authorizing and approving investments on at least a quarterly basis, and by recording such approvals in the minutes of the governing board.</p>	6
<p>B. <u>Conflict of Interest Statement</u></p> <p>It is recommended that the Plan comply with its conflict of interest policy and ensure that each Board member and Officer complete the conflict of interest statement annually.</p>	8.
<p>C. <u>Custodial Agreement</u></p> <p>It is recommended, as a good business practice, that the Plan amend its agreement with M&amp;T Bank to include the above clauses.</p>	9
<p>D. <u>Municipal Cooperation Agreement</u></p> <p>It is recommended that the Plan complies with the requirements of Section 4705(a)(1) of the New York Insurance Law by specifying all twenty-three participating municipal corporations in its Municipal Cooperation Agreement.</p>	10
<p>E. <u>Accounts and Records</u></p> <p>It is recommended that SWSCHP complete its annual statements per the General Information and Instructions for Filing the New York Data Requirements for Municipal Cooperative Health Benefit Plans, and report pharmaceutical rebates as a reduction of the Plan's prescription drug expenses.</p>	11
<p>F. <u>Patient Protection and Affordable Care Act</u></p> <p>It is recommended that the Plan comply with New York Insurance Law Section 3221(l)(8)(E) and US Department of Labor Regulation 45 C.F.R. 147.130(a)(2), by not charging co-payments for claims defined as preventive care by the USPSTF.</p>	19
<p>G. <u>Mental Health Parity</u></p> <p>It is recommended that the Plan review procedures to ensure claims are not erroneously denied.</p>	20



<b><u>ITEM NO.</u></b>	<b><u>PAGE NO.</u></b>
H. <u>Utilization Review and Appeals</u>	
i.     It is recommended that the Plan comply with Section 4903(d) of the New York Insurance Law by providing a response within the required time frame.	20
ii.    It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law by providing written acknowledgement letters and response to appeals within the required time frame	21
I. <u>Grievance</u>	
i.     It is recommended that the Plan comply with Section 4802(d)(2) of the New York Insurance Law by responding to all grievance within the required time frame.	22
ii.    It is recommended that the Plan comply with Section 4802(d)(3) of the New York Insurance Law by issuing a determination letter to the insured or the insured's designee.	22
iii.   It is recommended that the Plan comply with Section 4802(g)(3) of the New York Insurance Law by including the required form for the filing of a grievance appeal with its determination letters.	23
iv.    It is recommended that the Plan comply with Section 4802(h) of the New York Insurance Law by ensuring its grievance determination letters accurately and clearly explain members' rights and the statutory time frame for filing an appeal.	23
v.     It is recommended that the Plan take steps to provide the affected subscribers the correct grievance information and appeal forms and ensure the subscribers are allowed to implement their grievance appeal rights as required by the above sections of the New York Insurance Law.	24
vi.    It is recommended that the Plan comply with Section 4802(i) of the New York Insurance Law by acknowledging an appeal and identify the individual designated to respond to the appeal.	24



NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

**Gail Ross**

as a proper person to examine the affairs of

**State-Wide Schools Cooperative Health 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 she 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 28th day of September, 2016

MARIA T. VULLO  
Superintendent of Financial  
Services

By:



Lisette Johnson  
Bureau Chief  
Health Bureau

