MARKET CONDUCT REPORT ON EXAMINATION

OF

OXFORD HEALTH INSURANCE, INC.

AND

OXFORD HEALTH PLANS (NY), INC.

AS OF

SEPTEMBER 30, 2001

DATE OF REPORT: NOVEMBER 20, 2002
EXAMINER: BRUCE BOROFSKY
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scope of examination</td>
<td>2</td>
</tr>
<tr>
<td>2. Description of Plan</td>
<td>2</td>
</tr>
<tr>
<td>3. Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>4. Rating</td>
<td>3</td>
</tr>
<tr>
<td>5. Claim processing</td>
<td>6</td>
</tr>
<tr>
<td>6. Prompt Pay</td>
<td>11</td>
</tr>
<tr>
<td>7. Usual, customary and reasonable</td>
<td>15</td>
</tr>
<tr>
<td>8. Explanation of benefit statements</td>
<td>17</td>
</tr>
<tr>
<td>9. Complaints/Grievances</td>
<td>18</td>
</tr>
<tr>
<td>10. Compliance with prior report on examination</td>
<td>19</td>
</tr>
<tr>
<td>11. Summary of comments and recommendations</td>
<td>24</td>
</tr>
</tbody>
</table>
Honorable Gregory V. Serio  
Superintendent of Insurance  
Albany, New York 12257  

Sir:  

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 21798 and 21799 dated September 30, 2001 and annexed hereto, I have made an examination into the affairs of Oxford Health Insurance, Inc. (“OHI”), an accident and health insurance company licensed under Article 42 of the New York Insurance Law and Oxford Health Plans (NY), Inc. (“OHPNY” or “the Plan”), a for-profit individual practice association model health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law. The following report as respectfully submitted deals with the findings concerning the manner in which OHI and OHPNY conduct their business practices and fulfill their contractual obligations to policyholders and claimants.

Whenever the term “Oxford” or “the Company” appears herein without qualification, it should be understood to refer to both OHI and OHPNY. Wherever a distinction needs to be made, the terms “OHI” and/or “OHPNY” shall be used respectively. The ultimate parent of the two entities is Oxford Health Plans, Inc.(“OHP”).
1. **SCOPE OF EXAMINATION**

The prior examination was conducted as of May 31, 2000, (report filed October 16, 2000) and had as its objective, addressing the findings and issues noted in Oxford’s Market Conduct Report on Examination as of November 1, 1997 (report filed December 22, 1997). This current Market Conduct examination, covers the period January 1, 2001 through September 30, 2001.

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

2. **DESCRIPTION OF PLAN**

The Plan is a health maintenance organization (“HMO”) incorporated on April 19, 1985 under New York State Law as a for-profit corporation. The Plan was licensed as a for-profit Individual Practice Association (IPA) Model HMO under Article 44 of the New York State Public Health Law on June 1, 1986, and began operations on that date. OHPNY has been deemed a Competitive Medical Plan by the Federal Centers for Medicare and Medicaid Services (formerly the Health Care Finance Administration) for purposes of the Federal Medicare Program.

OHI was incorporated in New York State on January 30, 1987 for the purpose of providing accident and health insurance products. It obtained its license from New York State to do the business of accident and health insurance on July 1, 1987 and it commenced operations on that date. From its date of incorporation until December 31, 1997, OHI was a wholly owned subsidiary of Oxford Health Plans, Inc., a Delaware corporation. On that date,
Oxford transferred 100% ownership of OHI to Oxford Health Plans (NY), Inc. per Department approval.

3. **EXECUTIVE SUMMARY**

The results of this examination indicate substantial improvement relative to the management and controls deficiencies noted in the prior market conduct report as of November 1, 1997. However, certain deficiencies in such controls and procedures are noted in this report. The most significant findings include the following:

- Experience Rating Formula Violations
- Failure to make bad debt and charity pool payments for claims paid to certain hospitals
- Inconsistent application of penalties on claims that were not pre-authorized
- Improper initial claim denials due to inconsistent interpretation of authorizations
- Failure to send EOBs to members in certain instances where an in-network claim has been denied for administrative reasons.

Although most of the problems noted above do not impact large segments of Oxford’s members, they must be addressed by management. These, and other findings, are described in greater detail in the remainder of this report. Action already taken by management in response to the findings is also described herein as applicable.

4. **RATING**

A review was conducted of Oxford’s rating procedures to determine compliance with applicable New York State Insurance Laws and Regulations. This review revealed that Oxford violated New York Insurance Law §4308(b), which states:

“No corporation subject to the provisions of this article shall enter into any
contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent’s approval thereof…”

These violations are detailed as follows:

- Oxford understated premiums for certain groups by adding formula factors after the commission was determined, instead of before. This error had the effect of lowering premiums approximately twelve cents per member per month and impacted approximately 26,100 members over a two-year period.

- Oxford overcharged for one particular rider by rounding the factor up, instead of using the filed factor. This error had the effect of raising premiums approximately fifteen cents per member per month, and impacted approximately 36,600 members over a twelve-month period.

- Several non-systematic errors were noted, including cases whereby Oxford utilized improper industry rating factors. In other cases, while the proper rate was calculated, an improper rate was communicated to the group in question. No consistency was noted regarding whether the effect of such errors resulted in either higher or lower premiums.

- In certain cases, the only reason Oxford was able to offer for rate deviations was that of rounding. In some cases, these “rounding errors” were fairly significant, ranging up to seventeen cents per subscriber per month.

- Cases were noted whereby Oxford charged improper or expired per member per month rate factors. Oxford indicated that in some cases, this was the result of its need to provide its groups with rates for upcoming periods before the Company had established the factors.

- Oxford utilized trend factors that, in some cases, were not filed with the Department. Oxford indicated its belief that it was in compliance with such requirements because, for the period in question, it had relied upon Part 52.40(f)(1) of Department Regulation 62
(11NYCRR Part 52.40(f)(11)), which allows such factors to be used if they are approved by the Company’s Board of Directors. The cited regulation does not apply, however, because the factors in question relate to Point-of-Service contracts that involve both OHI and OHPNY.

The cited Regulation pertains to factors utilized strictly for an accident and health insurance product.

- Oxford was not able to provide source documentation for its weighting of experience in certain cases. While Oxford’s rating formulae does leave room for it to vary the weight it applies to the experience of its members, such weighting must be carefully documented at the time the decisions are made, in order to avoid the appearance of a discriminatory practice. It should be noted that in the cases examined, no such discriminatory practices appeared to exist.

It is recommended that Oxford comply with New York Insurance Law §4308(b) and charge rates and utilize formulas, that have been approved by the Superintendent.

During testing of the commissions paid to agents and brokers, it was noted that the commission rates paid for certain groups were not the rates on file with the Department. This is a violation of Part 52.40(j) of Department Regulation 62 (11NYCRR Part 52.40(j)), which states, in part:

“Schedules of commissions, compensation, fees and allowances required to be filed under [Section 4235] of the Insurance Law shall be filed as part of the group rate manual…”

It is recommended that Oxford file its commission schedule with the Department, as
required by Part 52.40(j) of Department Regulation 62 (11NYCRR Part 52.40(j)).

It is noted that as of November 12, 2002, Oxford has filed its commission schedule, as recommended. The schedule has not yet been approved.

5. **CLAIM PROCESSING**

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

a) Oxford Health Plans (NY), Inc.; and
b) Oxford Health Insurance, Inc.

These primary populations were then further divided into hospital and medical claims segments for each of the above entities. Therefore, a total of four groups were established. A random statistical sample was drawn from each of the four groups. It should be noted that for the purpose of this examination, those medical costs characterized as Medicare or self-insured were excluded. Also excluded were non-New York lines of business.

This statistical random sampling process, which was performed using the computer software program ACL, was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample.
The sample size for each of the four populations described herein was comprised of 167 randomly selected claims. Additional random samples were also generated as “replacement items” when it was determined that particular claims within the sample should not be tested (i.e., out-of-state providers for Prompt Pay). Accordingly, various replacement items were appropriately utilized. In total, 668 claims for the scope period were selected for review. This reflects 334 claims for OHPNY and 334 claims for OHI.

The term “claim” can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a “claim,” which is defined by Oxford as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It is possible, through the computer systems used for this examination, to match or “roll-up” all procedures on the original form into one line, which is the basis of the Department’s statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by Oxford for the period January 1, 2001 through September 30, 2001.

The examination review revealed that overall claims processing financial accuracy levels were 94.61% for OHPNY Medical, 85.03% for OHPNY Hospital, 88.63% for OHI Medical and 76.05% for OHI Hospital respectively. Overall claims processing procedural accuracy levels were 93.41% for OHPNY Medical, 81.44% for OHPNY Hospital, 86.83% for OHI Medical and 73.66% for OHI Hospital respectively. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with Oxford’s claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy.
The following charts illustrate the financial and procedural claims accuracy findings summarized above:
Summary of Financial Claims Accuracy

<table>
<thead>
<tr>
<th></th>
<th>OHPNY Medical</th>
<th>OHPNY Hospital</th>
<th>OHI Medical</th>
<th>OHI Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Population</td>
<td>7,777,233</td>
<td>286,154</td>
<td>1,443,769</td>
<td>49,691</td>
</tr>
<tr>
<td>Sample Size</td>
<td>167</td>
<td>167</td>
<td>167</td>
<td>167</td>
</tr>
<tr>
<td>Number of claims with Financial Errors</td>
<td>9</td>
<td>25</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Calculated Error Rate</td>
<td>5.39%</td>
<td>14.97%</td>
<td>8.98%</td>
<td>23.95%</td>
</tr>
<tr>
<td>Upper Error limit</td>
<td>8.81%</td>
<td>20.38%</td>
<td>13.32%</td>
<td>30.43%</td>
</tr>
<tr>
<td>Lower Error limit</td>
<td>1.96%</td>
<td>9.56%</td>
<td>4.65%</td>
<td>17.48%</td>
</tr>
<tr>
<td>Upper limit Claims in error</td>
<td>685,174</td>
<td>583,189</td>
<td>192,310</td>
<td>15,120</td>
</tr>
<tr>
<td>Lower limit Claims in error</td>
<td>152,434</td>
<td>27,356</td>
<td>67,135</td>
<td>8,686</td>
</tr>
</tbody>
</table>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Note 2: This chart reflects incidents of financial error. It does not reflect the amount of the financial errors.

Relative to financial accuracy (and Note 2, above), Oxford states that it does not review or measure financial accuracy solely on the basis of the number of times claims are processed incorrectly, regardless of amount. It gauges financial accuracy based upon the overall dollar error of claims processed during a specified period. This resulted in a lower internal financial error rate since it places greater emphasis on the financial magnitude of the errors, rather than on the number of instances of errors.

Summary of Procedural Accuracy

<table>
<thead>
<tr>
<th></th>
<th>OHPNY Medical</th>
<th>OHPNY Hospital</th>
<th>OHI Medical</th>
<th>OHI Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Population</td>
<td>7,777,233</td>
<td>286,154</td>
<td>1,443,769</td>
<td>49,691</td>
</tr>
<tr>
<td>Sample Size</td>
<td>167</td>
<td>167</td>
<td>167</td>
<td>167</td>
</tr>
<tr>
<td>Number of claims with Procedural Errors</td>
<td>11</td>
<td>31</td>
<td>18</td>
<td>44</td>
</tr>
<tr>
<td>Calculated Error Rate</td>
<td>6.59%</td>
<td>18.56%</td>
<td>10.78%</td>
<td>26.34%</td>
</tr>
<tr>
<td>Upper Error limit</td>
<td>10.35%</td>
<td>24.46%</td>
<td>15.48%</td>
<td>33.03%</td>
</tr>
<tr>
<td>Lower Error limit</td>
<td>2.82%</td>
<td>12.67%</td>
<td>6.08%</td>
<td>19.67%</td>
</tr>
<tr>
<td>Upper limit Claims in error</td>
<td>804,944</td>
<td>69,9935</td>
<td>223,495</td>
<td>16,414</td>
</tr>
<tr>
<td>Lower limit Claims in error</td>
<td>219,318</td>
<td>36,256</td>
<td>87,781</td>
<td>977</td>
</tr>
</tbody>
</table>

Note: The Upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)
In summary, of the 668 claims reviewed, 104, or 15.59%, contained one or more claims processing procedural errors. Of these 104 claims, 89, or 13.3% of the 668 claims reviewed, contained one or more financial errors. It should be noted that, of the 104 errors, 37 consist of hospital claims upon which the only error is the omission of the Bad Debt Charity Pool assessment, as described below. Removal of these claims from the overall totals reduces the error rate to 10.0%.

During the process of examining the claims within the various claim adjudication samples, the following was noted:

- For a period of eighteen months, Oxford did not pay the Bad Debt and Charity Pool assessment that was due to the State of New York for ten New York hospitals.

It is recommended that Oxford establish a balance sheet liability for the amount of its unpaid Bad Debt and Charity Pool liability for these ten facilities and pay any assessment that is due.

It is noted that Oxford has indicated that, during October 2002, it paid $3,761,312 to New York State for this unpaid liability. Such payment has not been confirmed by the Department.

It is recommended that Oxford update its list of facilities upon which the assessment is due, as often as is necessary to ensure it does not neglect such payments in the future.

It is noted that Oxford has indicated it initiated such a process subsequent to the examination period from which the claim samples were drawn.
The Company utilized a calculation methodology to establish its liability under the Bad Debt and Charity Pool assessment in situations where fixed dollar copayments or deductibles apply that differed from the calculation on the Department of Health website. Discussion of the issue with Oxford revealed it had a good faith dispute with the calculation methodology illustrated on the website. Specifically, Oxford believed it had received verbal notification from the Department of Health that the method Oxford used was correct.

Claims within the sample that contained calculations different from those on the website were not counted as inaccurate.

This issue will be referred to the New York Department of Health for review.

Oxford imposes a penalty on its policyholders and providers when they fail to obtain required pre-authorizations for certain treatments. This penalty is imposed upon the providers when such care is provided on an in-network basis, and on the policyholders when the care is provided on an out-of-network basis. According to Oxford’s policy, the penalty should equal 50% of the reimbursement that Oxford would normally pay.

The examination revealed that Oxford’s application of the penalty was inconsistent and the staff assessing the penalties was poorly supervised as pertains to this issue. Of the 38 penalties imposed on claims within the sample selected from OHI’s facility claims, twenty were calculated incorrectly.

It is recommended that Oxford re-adjudicate all claims containing a non-authorization penalty and adjust payment in cases where the penalty was improperly calculated and / or applied.

Further, it is recommended that Oxford provide training on this issue to its claims
processors, and customer service personnel.

- In certain cases, it was noted that claim processors did not sufficiently research pre-authorizations when processing claims. This resulted in the improper initial denial of such claims. Examples include claims where the procedures were performed a short time prior to the authorization date and procedures performed by a different provider within the same practice. In all cases, when appealed, the denials were quickly overturned. However, requiring such claims to be put through the appeals process is an unnecessary burden on the policyholders, the providers, and on the Company itself.

It is recommended that Oxford provide training to its claim processors or adjust its policy to ensure they understand the process of how to interpret authorizations.

Effective October 16, 2003, Oxford will be required to comply with the HIPAA Electronic Transaction and Code Sets Rule which sets forth standards for the content and format of electronically submitted data. Oxford is aware of these changes and has indicated it will be in compliance with such rules by the required deadline.

6. **PROMPT PAY**

§ 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”) requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

§ 3224-a(a) of the New York Insurance Law states that:

“Except in a case where the obligation of an insurer to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently,
such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered.”

§3224-a(b) of the New York Insurance Law states that:

“In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to …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 pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

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

“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 then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim.”

The examination included a statistical sample to determine whether or not interest was appropriately paid pursuant to § 3224-a(c) of the New York Insurance Law to those claimants not receiving payment or denials within the timeframes required by §3224-a(a) and (b) of the New York Insurance Law. Accordingly, all claims that were not paid within 45 days during the
period January 1, 2001 through September 30, 2001 were segregated. Further, claims from non-New York groups, non-New York providers, and Medicare claims were excluded from the population. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:

**Summary of Violations of Section 3224-a(a)**

<table>
<thead>
<tr>
<th></th>
<th>OHP(NY) Outpatient</th>
<th>OHP(NY) Inpatient</th>
<th>OHI Outpatient</th>
<th>OHI Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Population</td>
<td>155,337</td>
<td>11,799</td>
<td>19,188</td>
<td>773</td>
</tr>
<tr>
<td>Sample Size</td>
<td>167</td>
<td>167</td>
<td>167</td>
<td>167</td>
</tr>
<tr>
<td>Number of claims with Errors</td>
<td>15</td>
<td>36</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>Calculated Error Rate</td>
<td>8.98%</td>
<td>21.56%</td>
<td>6.59%</td>
<td>17.37%</td>
</tr>
<tr>
<td>Upper Error limit</td>
<td>13.32%</td>
<td>27.79%</td>
<td>10.35%</td>
<td>23.11%</td>
</tr>
<tr>
<td>Lower Error limit</td>
<td>4.65%</td>
<td>15.32%</td>
<td>2.82%</td>
<td>11.62%</td>
</tr>
<tr>
<td>Calculated claims in error</td>
<td>13,949</td>
<td>2,544</td>
<td>1,264</td>
<td>134</td>
</tr>
<tr>
<td>Upper limit Claims in error</td>
<td>20,691</td>
<td>3,279</td>
<td>1,986</td>
<td>179</td>
</tr>
<tr>
<td>Lower limit Claims in error</td>
<td>7,223</td>
<td>1,808</td>
<td>541</td>
<td>89</td>
</tr>
</tbody>
</table>

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

**Summary of Violations of Section 3224-a(b)**

<table>
<thead>
<tr>
<th></th>
<th>OHPNY Medical</th>
<th>OHPNY Hospital</th>
<th>OHI Medical</th>
<th>OHI Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Population</td>
<td>155,337</td>
<td>11,799</td>
<td>19,188</td>
<td>773</td>
</tr>
<tr>
<td>Sample Size</td>
<td>167</td>
<td>167</td>
<td>167</td>
<td>167</td>
</tr>
<tr>
<td>Number of claims with Errors</td>
<td>0</td>
<td>10</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Calculated Error Rate</td>
<td>0.00%</td>
<td>5.99%</td>
<td>1.20%</td>
<td>4.19%</td>
</tr>
<tr>
<td>Upper Error limit</td>
<td>0.00%</td>
<td>9.59%</td>
<td>2.85%</td>
<td>7.23%</td>
</tr>
<tr>
<td>Lower Error limit</td>
<td>0.00%</td>
<td>2.39%</td>
<td>0.00%</td>
<td>1.15%</td>
</tr>
<tr>
<td>Calculated claims in error</td>
<td>0</td>
<td>707</td>
<td>230</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>OHPNY Medical</td>
<td>OHPNY Hospital</td>
<td>OHI Medical</td>
<td>OHI Hospital</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------</td>
<td>---------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Claim Population</td>
<td>155,337</td>
<td>11,799</td>
<td>19,188</td>
<td>773</td>
</tr>
<tr>
<td>Sample Size</td>
<td>167</td>
<td>167</td>
<td>167</td>
<td>167</td>
</tr>
<tr>
<td>Number of claims with Errors</td>
<td>5</td>
<td>25</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Calculated Error Rate</td>
<td>2.99%</td>
<td>14.97%</td>
<td>2.40%</td>
<td>10.18%</td>
</tr>
<tr>
<td>Upper Error limit</td>
<td>5.58%</td>
<td>20.38%</td>
<td>4.71%</td>
<td>14.77%</td>
</tr>
<tr>
<td>Lower Error limit</td>
<td>.41%</td>
<td>9.56%</td>
<td>.08%</td>
<td>5.59%</td>
</tr>
<tr>
<td>Calculated claims in error</td>
<td>4,644</td>
<td>1,766</td>
<td>460</td>
<td>79</td>
</tr>
<tr>
<td>Upper limit Claims in error</td>
<td>8,668</td>
<td>2,405</td>
<td>904</td>
<td>115</td>
</tr>
<tr>
<td>Lower limit Claims in error</td>
<td>637</td>
<td>1,128</td>
<td>15</td>
<td>43</td>
</tr>
</tbody>
</table>

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those not paid within forty-five days from receipt during the period from January 1 through September 30, 2001. The total population of claims that were processed within the above four categories during the same nine-month period was 9,556,847.

It is also noted that, until May 1, 2001, the Company paid interest to the original received date of the claim, while NY Insurance law §3224-a(c) only requires such interest be paid from the 45th day of the claim.

Further, it is noted that the Company pays interest to all providers, including those providers who operate outside of New York. Such providers are exempted from coverage under the Prompt Pay Law, and as such, the payment of interest to those providers increases
unnecessarily the expenses of the Company, expenses that will ultimately be passed along to the policyholders. However, these providers may be subject to “prompt pay” requirements in the states where they are located.

Prior to this examination, the Oxford was found to be in violation of Section 3224-(a) of the New York Insurance Law for prompt pay violations cited by the Department’s Consumer Services Bureau. The Plan executed stipulations resulting in fines covering the following periods:

- 4/1/98 - 9/30/98 $40,900
- 10/1/98 - 2/1/99 $51,900
- 2/2/99 - 4/26/99 $30,200
- 4/27/99 - 7/31/99 $28,650
- 8/1/99 - 11/30/99 $215,000
- 12/1/99 - 12/31/00 $918,200

7. **USUAL, CUSTOMARY AND REASONABLE**

Oxford’s filed and approved contract language should more sufficiently describe the amounts it will reimburse policyholders when they obtain out-of-network care.

The amount an insurer or HMO pays for out-of-network care is referred to as the Usual, Customary and Reasonable fee. The contract language utilized by Oxford for its large and small groups, both HMO and OHI Supplemental coverage, defines Usual, Customary and Reasonable as follows:

“The amount charged or the amount We determine to be the reasonable charge, whichever is less, for a particular Covered Service in the geographical area it is performed.”

Because the policyholder is responsible for the difference between the amount charged
by the physician and the amount reimbursed by Oxford, he or she has a right to be advised of his or her potential obligation before obtaining such care. Notwithstanding the fact that these contracts were approved by the Department of Insurance, this language does not do this.

It is recommended that Oxford rewrite its contract language to more specifically inform its policyholders of the amount they will be reimbursed for out-of-network treatment.

When asked how Oxford does establish amounts to be paid when the policyholders receive out-of-network care, the Company advised the examiners it utilizes, among other sources, data published by the Health Insurance Association of America, Inc. (“HIAA/Ingenix”). This data consists of rates charged by various providers within all zip codes in the US over a certain time period. Generally, the data is published twice annually.

Data supplied by Oxford revealed that Oxford does not consistently utilize the most current HIAA/Ingenix data available. In some cases, the data utilized was out-of-date by as much as eighteen months.

It is recommended that Oxford update the HIAA/Ingenix data used to reimburse policyholders for out-of-network treatment within 60 days after the new data is available.

It is noted that Oxford has agreed to comply with this recommendation, but such compliance has not been tested.

Additionally, Oxford does not utilize 100% of the zip codes published by HIAA/Ingenix. Instead, it defaults most non-metropolitan New York counties to one general zip code, and most out-of-New York areas to a different general zip code, with the exception of New Jersey, Connecticut, Pennsylvania, New Hampshire, Delaware and Florida which default to a small number of separate zip codes. When asked to justify such treatment, the Company indicated the treatment was acceptable, because the areas it used to represent the
non-listed counties and states generally had higher reimbursement rates than those established by HIAA/Ingenix. It is the Department’s position that, while Oxford has an obligation to ensure the amounts it reimburses for such treatment are

reasonable, it may not be serving the best interests of all its members, if it overpays such claims.

It is recommended that Oxford utilize the appropriate HIAA/Ingenix area to establish the amounts it will reimburse policyholders for receiving out-of-network care.

8. **EXPLANATION OF BENEFIT STATEMENTS**

New York Insurance Law §3234 requires the Company to provide the insured or subscriber with an explanation of benefits form (EOB) in response to the filing of any claim unless such service is provided by a facility or provider participating in the insurer’s program and full reimbursement for the claim is paid by the insurer directly to the participating facility or provider.

The examination revealed that the Company does not send EOBs to its members in all cases when claims submitted by its participating providers have been denied for administrative purposes. Because full reimbursement has not been made for these claims, EOBs should be provided to the subscribers in all cases. This is to ensure that both parties involved are aware that the providers cannot attempt to collect any unpaid portion of the bill from the subscriber. Additionally, such a communication will advise the subscriber of his/her appeal rights in regard to the denial.

It is recommended that Explanation of Benefit statements be sent to policyholders in those cases where full reimbursement has not been made for claims to participating providers.
9. COMPLAINTS/GRIEVANCES

New York Insurance Law requires that insurers establish two separate mechanisms for subscribers seeking re-consideration of claim determinations. The first track, Appeals, is reserved for Utilization Review denials based upon medical necessity. The second track, Grievances, is reserved for denials based upon benefit or payment issues.

Oxford maintains two levels of internal review for both utilization review appeals and for grievances. First level appeals are handled by Oxford’s Clinical Appeals Department, while Oxford’s Issues Resolution Department handles first level grievances. Second level appeals and second level grievances are both handled by Oxford’s Grievance Review Board. Because the applicable laws for appeals and grievances differ in such areas as the response times that Oxford is required to meet, and whether a right of External Appeal is available, such treatment can lead to confusion on the part of the subscriber. It is noted that there was no indication of confusion during the examination.
10. **COMPLIANCE WITH PRIOR REPORT ON EXAMINATION**

The prior report on examination (May 31, 2000) contained several comments and recommendations as follows (the page numbers refer to the prior report):

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLAIMS</strong></td>
<td></td>
</tr>
<tr>
<td>A. It is recommended that for management reporting of aging and claims inventory, Oxford should provide a summary of claims activity for the report period indicating total claims entered, paid, suspended and denied and the dollar amounts associated with each category.</td>
<td>7-12</td>
</tr>
</tbody>
</table>

Oxford has complied with this recommendation.

B. It is recommended that a statistical report be produced consolidating all manual changes into a format that could be used to monitor, control and verify the process. | 7-12 |

Although Oxford has not complied with this recommendation exactly as written, it does maintain such data in a format that achieves the same goals.

C. It is recommended that interface control statistics be presented in as few reports as possible and that they should represent a specific time period. These reports should be available to management in a consistent presentation so as to avoid inaccurate conclusions. | 7-12 |

The reports presented to management appear to be consistently prepared and presented.
D. It is recommended that a systematic method of retiring suspend codes and preventing their subsequent use be devised and implemented.

Oxford has complied with this recommendation.

E. It is recommended that the manual adjustment process be continuously evaluated with the intent of reducing this significantly high proportion of intervention in the claims process.

Oxford has complied with this recommendation.

F. It is recommended that consideration be given to modifying the PICK system to perform a search of the tables via a “hot key” or cursor position function key combination to increase speed and accuracy.

Although Oxford has not complied with this recommendation as written, it has taken steps and continue to seek methods to increase the accuracy and speed of processing.

G. It is recommended that all historic data be maintained in one place so that reporting and information queries can be done simply and quickly.

Although Oxford has not complied with this recommendation exactly as written, it has taken steps to achieve the same goals.
H. It is recommended that an executive overview claims report be developed with a paragraph or two of explanation of the significant differences or volume trends.

Oxford has complied with this recommendation.

I. It is recommended that the Production of Management Reports include claims reports in such detail as necessary to indicate trends in significant components of Oxford’s business.

Oxford has complied with this recommendation.

J. It is recommended that Oxford prepare a needs analysis for its anticipated growth and prepare a formal plan for meeting those needs. The analysis and plan should be submitted to the Department for review within a prescribed time frame.

Oxford has complied with this recommendation.

K. It is recommended that the outdated paper versions of documents be archived or destroyed.

Oxford has complied with this recommendation.
ITEM NO. | PAGE NO.  
--- | ---  
L. It is recommended that Oxford cease the practice of data scrubbing. This minimizes the risk of potential liability resulting from the changing of provider and/or member information as submitted.  
13-18  
Oxford has initiated steps to comply with this recommendation.  

**DISASTER RECOVERY PLAN**  
M. A high level review of Oxford’s Disaster Recovery Plan indicated that a fundamental outline is in place at a high level, but the details to support such a plan are lacking.  
18-22  
Oxford has initiated steps to comply with this recommendation. The anticipated completion date is fourth quarter, 2002.  

N. It is recommended that Oxford place greater priority on the timely completion of each departmental section of the BCP.  
18-22  
Oxford anticipates the completion date of the BCP project to be the fourth quarter 2002.  

O. It is recommended that Oxford review and update the appendices of its BCP to ensure that all relevant information is included.  
18-22  
Oxford has indicates it will comply with this recommendation upon the completion of the BCP project.
<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>PAGE NO.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.</td>
<td>18-22</td>
<td>It is recommended that a Vital Records program be instituted to make the BCP a more complete and operational document. Oxford has complied with this recommendation.</td>
</tr>
<tr>
<td>Q.</td>
<td>18-22</td>
<td>It is recommended that the BCP material be reviewed with affected personnel annually and briefings held when changes have been incorporated. Oxford has taken steps to comply with this recommendation.</td>
</tr>
<tr>
<td>R.</td>
<td>18-22</td>
<td>It is recommended that Oxford include Escalation Procedures in its BCP documentation. Oxford has complied with this recommendation.</td>
</tr>
</tbody>
</table>
11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>ITEM</th>
<th>RATING</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>It is recommended that Oxford comply with New York Insurance Law §4308(b) and charge rates and utilize formulas, that have been submitted to the Superintendent for approval.</td>
<td>5</td>
</tr>
<tr>
<td>ii.</td>
<td>It is recommended that Oxford file its commission schedule with the Department, as required by Part 52.40(j) of Department Regulation 62 (11NYCRR Part 52.40(j)).</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>It is noted that, as of November 12, 2002, Oxford has filed its commission schedule, as recommended. The schedule has not yet been approved.</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>CLAIM PROCESSING</td>
<td>9</td>
</tr>
<tr>
<td>i.</td>
<td>It is recommended that Oxford establish a balance sheet liability for the amount of its unpaid Bad Debt and Charity Pool liability for these ten facilities and pay any assessment that is due.</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>It is noted that Oxford has indicated that, during October 2002, it paid $3,760,312 to New York State for this unpaid liability. Such payment has not been confirmed by the Department.</td>
<td></td>
</tr>
<tr>
<td>ii.</td>
<td>It is recommended that Oxford update its list of facilities upon which the assessment is due as often as is necessary to ensure it does not neglect such payments in the future.</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>It is noted that Oxford has indicated it initiated such a process</td>
<td></td>
</tr>
</tbody>
</table>
subsequent to the examination period from which the claim samples
were drawn.
<table>
<thead>
<tr>
<th>ITEM</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii. It is recommended that Oxford re-adjudicate all claims containing a non-authorization penalty and adjust payment in cases where the penalty was improperly calculated and/or applied. Further, it is recommended that Oxford provide training on this issue to its claims processors, and customer service personnel.</td>
<td>10</td>
</tr>
<tr>
<td>iv. It is recommended that Oxford provide training to its claim processors or adjust its policy to ensure they understand the process of how to interpret authorizations.</td>
<td>11</td>
</tr>
</tbody>
</table>

**C. USUAL, CUSTOMARY AND REASONABLE**

| i. It is recommended that Oxford rewrite its contract language to more specifically inform its policyholders of the amount they will reimburse for out-of-network treatment. | 16 |
| ii. It is recommended that Oxford update the HIAA/Ingenix data used to reimburse policyholders for out-of-network treatment within 60 days after the new data is received. | 16 |

It is noted that Oxford has agreed to comply with this recommendation, but such compliance has not been tested.

| iii. It is recommended that Oxford utilize the appropriate HIAA/Ingenix area to establish the amounts it will reimburse policyholders for receiving out-of-network care. | 17 |
D. **EXPLANATION OF BENEFIT STATEMENTS**

It is recommended that Explanation of Benefit statements be sent to policyholders in those cases where full reimbursement has not been made for claims to participating providers.
Respectfully submitted,

__________________________

Bruce E. Borofsky,
Associate Examiner

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

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

__________________________

Bruce E. Borofsky

Subscribed and sworn to before me
this _____ of _____________ 2000
STATE OF NEW YORK
INSURANCE DEPARTMENT

1. GREGORY V. SERIO, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

OXFORD HEALTH INSURANCE

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

Company

with such information as he shall deem requisite.

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

this 30th day of October 2001

Gregory V. Serio
Superintendent of Insurance
STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

OXFORD HEALTH PLANS OF NEW YORK

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

Company

with such information as he shall deem requisite.

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

this 30th day of October 2001

[Signature]

Gregory V. Serio
Superintendent of Insurance