MARKET CONDUCT REPORT ON EXAMINATION

OF

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

AND

CDPHP UNIVERSAL BENEFITS, INC.

AS OF

DECEMBER 31, 2017

DATE OF REPORT **SEPTEMBER 15, 2023**

EXAMINER **GAIL A ROSS**

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September 15, 2023

Honorable Adrienne A, Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31694 and 31692, dated December 4, 2017, annexed hereto, I have made an examination into the affairs of CDPHP Universal Benefits, Inc., a Not-for-Profit Medical and Hospital Indemnity corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law and its parent, Capital District Physicians' Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York State Public Health Law, as of December 31, 2017, and submit the following report thereon.

The examination was conducted at the home office of Capital District Physicians' Health Plan, Inc., and CDPHP Universal Benefits, Inc., located at 500 Patroon Creek Boulevard, Albany, New York.

Wherever the designations, “CDPHP” or the “HMO” appear herein, without qualification, they should be understood to indicate Capital District Physicians’ Health Plan, Inc.

Wherever the designations “UBI” or the “Company” appear herein, without qualification, they should be understood to indicate CDPHP Universal Benefits, Inc.

Wherever the designation “CDPHP Companies” appears herein, without qualification, it should be understood to indicate Capital District Physicians’ Health Plan, Inc. and CDPHP Universal Benefits, Inc., collectively.

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 prior examination of the CDPHP Companies were conducted as of December 31, 2014. This market conduct examination of the CDPHP Companies covers the three-year period from January 1, 2015 through December 31, 2017. Market conduct activities occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

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

A review was also made to ascertain what actions were taken by the CDPHP Companies with regard to the comments and recommendations related to the market conduct items contained in the prior report on examination. The results of the examiner's review are contained in Item 7 of this report on examination.

Separate risk-focused examinations regarding the financial condition of the CDPHP Companies were conducted as of December 31, 2017. The resulting reports on examination were filed for both CDPHP and UBI.

2. DESCRIPTION OF THE COMPANIES

Capital District Physicians' Health Plan, Inc. was formed as a membership corporation on February 27, 1984, under Section 402 of the Not-for-Profit Corporation Law, and subsequently incorporated within the State of New York on April 13, 1984. The members consist of physicians licensed by the State of New York. CDPHP, a health maintenance organization ("HMO"), licensed pursuant to Article 44 of the New York Public Health Law, obtained its certificate of authority to

operate as an independent practice association ("IPA") model HMO from the New York State Department of Health ("DOH"), effective April 30, 1984. The HMO commenced business on July 12, 1984.

As of December 31, 2017, membership in the HMO was opened to physicians licensed by the State of New York, who applied for membership and met the criteria required by the HMO's by-laws to be accepted as member physicians.

The HMO is a not-for-profit health insurer and is exempt from income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code.

As of December 31, 2017, the HMO reported total surplus in the amount of $334,286,761 which is available for the fulfilment of its contractual obligations to policyholders and claimants.

UBI was formed on January 2, 1997 and incorporated on February 28, 1997, pursuant to Section 402 of the Not-for-Profit Corporation Law. The Company was subsequently licensed on August 14, 1997 under Article 43 of the New York Insurance Law for the purpose of providing indemnity based, prepaid comprehensive health care services through arrangements with physicians, hospitals and other providers.

The Company is a type D Corporation, as defined in Section 201 of the Not-for-Profit Corporation Law ("NPCL"). The sole member of the Company is CDPHP, a not-for-profit corporation operating as a health maintenance organization ("HMO"), pursuant to Article 44 of the New York Public Health Law.

UBI was capitalized initially by means of a $1,250,000 loan from its parent and sole member, CDPHP. As of December 31, 2017, the Company reported total surplus in the amount of

$124,846,345 which is available for the fulfilment of its contractual obligations to policyholders and claimants.

3. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE SERVICES ("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 within 45 days of receipt for 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 CDPHP Companies' compliance with Section 3224-a was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material issues were noted by the examiner.

4. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Contraceptives and Smoking cessation

Section 3221(l)(8)(E) of the New York Insurance Law, and additional implementing regulations, require non-grandfathered group health plans offering health insurance coverage in the group market to provide certain benefits and prohibit cost-sharing requirements for those benefits. These include the following,, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

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.

Similar references are included within New York Insurance Law Section 3216(i)(17)(E) for the individual market while Section 4303(j)(3) of the New York Insurance Law and Section 2713 of the Public Health Service Act offer similar supporting guidance.

The examiner reviewed 70 benefits of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims from the aforementioned 70 benefits for co-pay, deductible and coinsurance costs attributed to the member.

The CDPHP Companies provided the specific Codes associated with Contraceptive and smoking cessation prescription drugs and devices that were at no cost-sharing to the member. The examiner extracted from the total population all claims that had cost share. The following charts summarize the errors found:

Contraceptive and smoking cessation claims with cost sharing for year ended December 31, 2017:

CDPHP			UBI		
Total claims		Errors Acknowledged	Total claims		Errors Acknowledged
2017	**10,906**	**3**	2017	**2,059**	**4**

Preventive claims with cost sharing for year ended December 31, 2017:

CDPHP			UBI		
Total claims		Errors Acknowledged	Total claims		Errors Acknowledged
2017	**10,543**	**13**	2017	**441**	**370**

The population consisted, mostly, of grandfathered plans, religious exemption, or non-formulary drug claims, all of which are exempt from PPACA. It was noted that in some cases, cost-sharing were incorrectly applied. These cases were considered processed in error.

It is recommended that CDPHP Companies comply with the above mentioned Sections of the New York Insurance Law and Federal Patient Protection and the Public Health Service Act and not apply member cost-sharing to contraceptive and smoking cessation, and preventive care pharmaceutical claims, when not applicable.

It is also recommended that CDPHP Companies perform Quality Assurance testing of the effectiveness of its claim payment policy procedures on paid claims in order to ensure compliance with the various State laws and regulations. A similar recommendation was made in the prior report on report on examination.

5. UTILIZATION REVIEW

Article 49 of the New York State Public Health Law ("Public Health Law"), which applies to CDPHP, and Article 49 of the New York Insurance Law ("Insurance Law"), which applies to UBI, set forth the minimum utilization review program requirements including standards for: registration of utilization agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. The aforementioned Articles 49 of the Insurance and Public Health Laws also establish the enrollee's and insured's right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an enrollee's or insured's health care provider shall have the right to request a standard appeal and an external appeal.

With respect to the examiner's review of the CDPHP Companies utilization review processes and procedures the following was noted:

Section 4903(2) (a) of the New York Public Health Law states, in part:

> "… A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing *within three business days* of receipt of the necessary information…"

During the review of prospective utilization review cases filed in 2017, the examiner found two (2) out of nine (9) cases reviewed, whereby the HMO failed to make a determination within three (3) business days of receipt of the necessary information.

It is recommended that the HMO comply with Section 4903(2) (a) of the New York Public Law by making a utilization review determination involving health care services which require pre-authorization within the required time.

Section 4903(4) of the New York Public Health Law states, in part:

> "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…"

Section 4903(5)(b) of the New York Public Health Law states, in part:

> " … Notice of an adverse determination made by a utilization review agent shall be in writing and must include…
>
> (b) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and *an external appeal* pursuant to section forty-nine hundred fourteen of this article…"

During the review of the retrospective utilization review cases filed in 2017, the examiner found one (1) out of nine (9) retrospective cases whereby the HMO made the determination in more than thirty(30) days. Additionally, it was noted that, the determination notice for this case did not include the external appeal right instructions.

It is also recommended that the HMO comply with Section 4903(4) of the New York Public Health Law by making a utilization review determination involving health care services which have been delivered within the required time.

It is recommended that the HMO comply with Section 4903(5)(b) of the New York Public Health Law by including in the adverse determination notices the external appeal instructions.

Federal Regulation 45 C.F.R. §147.136(b)(2)(ii)(E)(1) states, in part:

> The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

CDPHP Companies have a third-party agreement with Evicore, a medical benefits management company, to perform preservice and retrospective utilization review for radiology and x-ray services.

During the review of retrospective cases, the examiner found that five (5) out of eight (8) retrospective cases did not have the date of service printed on the initial adverse determination letter**.**

It is recommended that UBI comply with 45 C.F.R. §147.136(b)(2)(ii)(E)(1) and include date of services on all initial adverse determination letters.

Section 4903(e)(1) and (2) of the New York Insurance Law states, in part:

> Notice of an adverse determination made by a utilization review agent shall be in writing and must include: (1) the reasons for the determination including the clinical rationale, if any; (2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and external appeals pursuant to four thousand nine hundred fourteen of this article

During the examination review of initial adverse determination cases, the examiner found one (1) out of eight (8) retrospective cases did not include the clinical rationale on the initial adverse determination letter. Additionally, it was noted that, the determination notice did not include the instructions on how to initiate external appeals right.

It is recommended that UBI comply with 4903(e)(1) and (2) of the New York Insurance Law and include the reasons for the determination, including clinical rationale, and the instructions on how to initiate standard appeals, expedited appeals and external appeals.

The following charts display the summary notations for CDPHP and UBI as of December 31, 2017.

2017 UTILIZATION REVIEW UBI AND EVICORE SUMMARY OF VIOLATIONS OF UTILIZATION REVIEW AND APPEALS				
	UTILIZATION REVIEW			
UBI	Prospective	Concurrent	Retrospective	Appeals
Total population	8,636	4,377	746	122
Sample size	9	9	9	9
Violations	0	0	0	0
EVICORE				
Total population	14,884	0	23	0
Sample size	8		8	0
Violations	0	0	7	0
GRAND TOTAL				
Total population	23,520	4,377	769	122

Sample size	17	9	17	9
Violations	0	0	7	0
Calculated violation rate	0%	0%	41.18%	
Estimated violations	0	0	317	

2017 UTILIZATION REVIEW CDPHP AND EVICORE SUMMARY OF VIOLATIONS OF UTILIZATION REVIEW AND APPEALS				
	UTILIZATION REVIEW			
CDPHP	Prospective	Concurrent	Retrospective	Appeals
Total population	9,045	4,517	692	191
Sample size	9	9	9	9
Violations	2	0	1	0
EVICORE				
Total population	12,213	0	29	0
Sample size	8	0	8	0
Violations	0	0	0	0
GRAND TOTAL, INCLUDING EVICORE				
Total population	21,258	4,517	721	191
Sample size	17	9	17	9
Violations	2	0	1	0
Calculated violation rate	11.76%		5.88%	
Estimated violations	2,500		42	

6. SCHEDULE M

Section 4900 (i) of the New York Insurance Law states in part:

> "… Utilization review agent" means any insurer subject to article thirty-two or forty-three of this chapter and any municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter performing utilization review and any independent utilization review agent performing utilization review under contract with such insurer or municipal cooperative health benefit plan. …"

In addition, The New York Supplement Instructions, pertaining to filling out Schedule M, states:

> "… Article 49 of the Insurance Law establishes utilization review ("UR") standards and reporting requirements for Article 43 corporations. UR is

> generally defined as the review to determine whether health care services are medically necessary. Subscribers who receive adverse UR determinations are entitled to appeal such determinations… The schedule should set forth results for the entire calendar year …"

Section 210(b) (2) of the New York Insurance Law states, in part:

> "… (b)Beginning September first, nineteen hundred ninety-nine and annually thereafter, the superintendent shall include in such guide, and insurers and entities certified pursuant to article forty-four of the public health law shall provide to the superintendent the information required for such guide in a timely fashion, the following information…
>
> (2) The number of appeals to utilization review determinations which were filed pursuant to article forty-nine of the public health law or article forty-nine of this chapter and the number of such determinations which were reversed versus the number of such determinations which were upheld."

During the review of UBI's December 31, 2017 Schedule M – Grievance and Utilization Review Appeals, the examiner noted that the utilization review cases processed by the CDPHP companies third-party administrator, Evicore, was not included in Schedule M. Evicore performs preservice and retrospective review for authorization for radiology and x-ray services.

It is recommended that UBI comply with The New York Supplement instructions and Section 210(b) (2) of the New York Insurance Law and complete Schedule M by providing all utilization review cases, including those of its TPA.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2014 contained nine (9) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
1.	It is recommended that the CDPHP Companies comply with Section 403(d) of the New York Insurance Law and Insurance Regulation No. 95 by ensuring that CDPHP and UBI provide the requisite fraud warning statement at the time of the members' submission of claims for reimbursement when the claim is filed by a means other than the hardcopy claim form. The CDPHP Companies have complied with recommendation.	7
2.	It is recommended that UBI comply with Section 4901(a) of the New York Insurance Law by filing biennially with the Department, a report of its utilization review plan. The Company has complied with this recommendation.	8
3.	It is recommended that the CDPHP Companies update their Administrative Manual to reflect the additional requirement of Sections 4408-a(7) of the New York State Public Health Law (CDPHP) and 4802(g) of the New York Insurance Law (UBI) that a grievance appeal form is to be included with the CDPHP Companies' issuance of adverse determination notices. The CDPHP Companies have complied with this recommendation.	9
4.	It is further recommended that the CDPHP Companies update their Corporate Policy and Procedures – "Specialist as Primary Care Physician," to fully comply with Sections 4403-6(c) of the New York State Public Health Law (CDPHP) and 4804(c) of the New York Insurance Law (UBI). Specifically, the CDPHP Companies' Corporate Policy and Procedure – "Specialist as Primary Care Physician" should be revised to include the wording that a referral	10

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	from the enrollee's/insured's primary care physician is not required in the case of a medical specialist performing dual primary care and specialty treatment on enrollees/insureds diagnosed with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease. The CDPHP Companies have complied with this recommendation.	
5.	It is recommended that the CDPHP Companies comply with Sections 4408-a (2)(b) of the New York State Public Health Law and 4802(b)(2) of the New York Insurance Law when issuing EOBs and apprise the enrollees/insureds of their right to designate a representative to file a grievance on their behalf. The CDPHP Companies have complied with this recommendation.	11
6.	It is recommended that the CDPHP Companies in their compliance with the Department's Circular Letter No. 9 (1999), establish additional monitoring/oversight procedures regarding its PBM's claims payments to the retail pharmacies and other prescription drugs suppliers. Such procedures should ensure that the PBM's data files to CDPHP's and UBI's paid pharmacy claims include all payment dates, including the original and adjustment payment dates for each claim. The CDPHP Companies have complied with this recommendation.	14
7.	It is recommended that the CDPHP Companies comply with Sections 3216(i)(17)(E) and 3221(l)(8)(A)(E)(F) of the New York Insurance Law by refraining from applying cost sharing to members on covered contraceptive benefits which are subject to the "no cost sharing" provision of the aforementioned statutes. The CDPHP Companies have complied with this recommendation.	16
8.	It is also recommended that the CDPHP Companies comply with Section 4303(j)(3) of the New York Insurance Law by refraining from applying cost sharing to members on covered contraceptive benefits which are subject to the "no cost sharing" provision of the aforementioned statutes The CDPHP Companies have complied with this recommendation. A similar recommendation will be made.	16

ITEM NO. **PAGE NO.**

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
	It is recommended that UBI comply with The New York Supplement instructions and Section 210(b)(2) of the New York Insurance Law and complete Schedule M by providing all utilization review cases.	12

Respectfully submitted,

_____
Gail A Ross
Financial Services Examiner 2

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

GAIL A ROSS, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
Gail A Ross

Subscribed and sworn to before me
This ____ day of _____ 2023

APPOINTMENT NO. 31692

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 the

Capital District Physicians Health Plan

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

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 4th day of December, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. **31694**

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 the

CDPHP-Universal Benefits, Inc.

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

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 4th day of December, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau