

**REPORT ON MARKET CONDUCT EXAMINATION**

**OF**

**GROUP HEALTH INCORPORATED**

**AS OF**

**MARCH 31, 2001**

**DATE OF REPORT:**

**OCTOBER 30, 2002**

**EXAMINER:**

**KATHLEEN GROGAN**

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STATE OF NEW YORK  
INSURANCE DEPARTMENT  
25 BEAVER STREET  
NEW YORK, NY 10004

October 30, 2002

Honorable Gregory V. Serio  
Superintendent of Insurance  
Albany, New York 12257

Sir:

Pursuant to instructions contained in Appointment Number 21712 dated March 29, 2001, attached hereto and in accordance with the New York Insurance Law, I have made an examination into the condition and affairs of Group Health Incorporated (GHI), a not-for-profit health insurance company licensed pursuant to the provisions of Article 43 of the Insurance Law. The following report, as respectfully submitted, deals with findings concerning the manner in which GHI conducts its business and fulfills its contractual obligations to policyholders, potential policyholders and claimants. This examination was conducted at the administrative office of Group Health Incorporated located at 441 Ninth Avenue, New York, New York 10001.

Whenever the terms "the Company" or "GHI" appear in this report without qualification, they refer to Group Health Incorporated.

The Company maintains a wholly owned subsidiary, GHI-HMO. A separate report was made on the subsidiary and will be submitted under separate cover.

## **1. SCOPE OF EXAMINATION**

A review of GHI's business practices and how it fulfills its contractual obligations to policyholders and claimants has been performed. The review covers the period January 1, 1999 through March 31, 2001. As necessary, the examiner reviewed transactions occurring subsequent to March 21, 2001 but prior to the date of this report. This report is confined to comments on those matters that involve departures from laws, regulations or rules or which are deemed to require an explanation or description.

## **2. UNDERWRITING AND RATING**

A review of GHI's underwriting and rating procedures was performed. The Company's enrollment, by number of participants, as of March 31, 2001 was comprised of 94% experience rated contracts and 6% community rated contracts. A random sample of community rated contracts was reviewed for compliance in the following areas: underwriting, rating and use of policy forms. A random sample of policy forms used with experience rated contracts was performed.

### **A. Community Rated Contracts**

Regulation No. 145, Section 360.3 does not allow use of income-based criteria to restrict or limit eligibility for individual or small group policies. GHI maintained a practice of using such criteria in reviewing applications for coverage by groups of one/sole proprietors. Specifically, applicants earning less than \$15,000 per year were required to meet additional standards in order to obtain coverage, and in some instances, were denied coverage when these additional standards were not met. As a result of discussions with the Department in May of 2000, GHI agreed to eliminate the income requirement for sole proprietors and to apply the same underwriting requirements to all sole proprietors regardless of income.

B. Experience Rated Contracts

The Company uses a "deferred premium" arrangement with some of its experience rated groups. This arrangement provides for the group to retain a portion of the premium rather than paying the total amount due to GHI. At the end of the contract period, GHI would "settle up" with the group based on the experience of the group.

Section 4308(a) of the Insurance Law 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 copy of the contract or certificate and of all applications, riders and endorsements for use in connection with the issuance or renewal thereof, to be formally approved by him as conforming to the applicable provisions of this article and not inconsistent with any other provision of law applicable thereto."

Contrary to Section 4308(a), GHI did not file the policy forms used to delineate the arrangement with the Department. It is recommended that GHI file the deferred premium arrangements with the Department.

GHI insures the employees of the City of New York under a large group contract. The certificates of coverage that are based upon this contract and issued to NYC employees who are GHI subscribers were submitted to and approved by the Department. However, the actual group master contract was not filed with the Department.

It is recommended that GHI submit the group contract itself for approval as required by Section 4308(a).

C. Written Disclosure of Information

Section 4910 of the New York Insurance Law, effective July 1, 1999, requires that subscribers have the right to external appeal. In addition, Section 4324 requires that companies advise insureds of their rights to external appeal.

Section 4324(a) of the New York Insurance Law states:

"Each health service, hospital service, or medical expense indemnity corporation subject to this article shall supply each subscriber, and upon request each

prospective subscriber prior to enrollment, written disclosure information, which may be incorporated into the subscriber contract or certificate, containing at least the information set forth below...

(3)...(H) a notice of the right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this chapter, of the external appeal process established pursuant to title two of article forty-nine of this chapter and the time frames for such appeals..."

GHI received the approval of its policy form advising community rated subscribers of these rights on September 30, 1999. The distribution of this form to its community rated subscribers was delayed until May 15, 2000. It is recommended that GHI distribute mandatory policy form changes in a more timely manner.

### **3. ADVERTISING**

On June 27, 1999 GHI published an advertisement in the Albany Times Union that made the following statements, "We're financially sound at a time when so many other health plans are struggling. Our membership has grown to over 3 million strong...."

Regulation No. 34, Section 215.16 states:

"An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business..."

Regulation No. 34, Section 215.9(a) states:

"An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts..."

When the advertisement was published and as reflected in its March 31, 1999 financial statement, GHI's financial position was impaired. GHI's actual membership, according to its March 31, 1999 filed financial statement reported insured membership of 1.5 million subscribers. GHI stated that the 3 million figure includes administrative services only (ASO) business.

It is recommended that GHI comply with Regulation No. 34 by accurately reflecting its financial position and membership in its advertisements.

#### **4. CLAIMS**

##### **A. Claims processing**

A review of GHI's claims accuracy and compliance environment was performed using a statistical sampling methodology covering the period January 1, 2000 through March 31, 2001. GHI maintains three separate claims processing systems: hospital, medical and dental. Random samples from each system were selected for review. For purposes of the review the following medical costs were excluded: pharmacy, Medicare, federal employee, bulk HCRA payments and specified medical conditions pool payments.

The statistical random sampling process was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to test and to be able to 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 reached from each item in the sample.

The sample size for each of the three populations described herein was comprised of 167 randomly selected unique transactions. A second random sample of 50 items from each of the three populations was produced as "replacement items," if it was determined a particular transaction should not be tested. Accordingly, replacement items were appropriately utilized. In total, 501 claims were selected for review.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purposes of this report. Each claim submitted to GHI is a unique item in each of GHI's claims systems. Adjustments to claims are linked to the original claim, but are also unique items in GHI's claims systems. Claims processing transactions are composed of claims

and adjustments to claims. Accordingly, the sample results are based on all claims processing transactions.

To ensure completeness of the claims population, the total dollars paid and the total number of paid claims were accumulated and reconciled to the financial data reported by GHI for the periods ended December 31, 2000 and March 31, 2001.

In summary, three samples of 167 from each of GHI's claims systems, hospital, medical and dental, were reviewed. The review resulted in accuracy rates of: Medical, 97.6 percent; Hospital, 97 percent; and Dental, 96.4 percent. GHI has established key performance indicators for quality of 98 percent for procedural and financial accuracy. The examination results are consistent with GHI's internal quality indicators. The findings noted herein reflect an adequate control structure as it pertains to claims processing. The statistical model used for testing both attribute (processing/operations) and financial accuracy for this examination did, however, reveal a number of issues that indicate a few systemic problems that need to be addressed.

Financial accuracy is defined as the percentage of times the dollar value of the transaction payment was correct. Procedural accuracy is defined as the percentage of times a transaction was processed in accordance with GHI's claims processing guidelines. An error in processing accuracy may or may not affect the financial accuracy. All financial errors are included as procedural errors. The review revealed overall claims processing financial accuracy levels were as follows:

### Summary of Financial Accuracy

|  | Medical        | Hospital      | Dental        |
|--|----------------|---------------|---------------|
| Claims Processing Transactions               | 16,651,629     | 359,558       | 1,035,998     |
| Sample Size                                  | 167            | 167           | 167           |
| Number of transactions with Financial Errors | 4              | 4             | 4             |
| Calculated Error Rate                        | <u>2.40%</u>   | <u>2.40%</u>  | <u>2.40%</u>  |
| Upper Error limit                            | 4.71%          | 4.71%         | 4.71%         |
| Lower Error limit                            | .08%           | .08%          | 0.08%         |
| Upper limit transactions in error            | <u>784,997</u> | <u>16,950</u> | <u>48,839</u> |
| Lower limit transactions in error            | <u>12,686</u>  | <u>274</u>    | <u>789</u>    |

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

It is noted that the dollar value of two of the four medical claim errors reported above was less than \$10.

The review revealed overall claim processing procedural accuracy levels were as follows:

### Summary of Procedural Accuracy

|   | Medical        | Hospital      | Dental        |
|---|----------------|---------------|---------------|
| Claim Population                        | 16,651,629     | 359,558       | 1,035,998     |
| Sample Size                             | 167            | 167           | 167           |
| Number of claims with Procedural Errors | 4              | 5             | 6             |
| Calculated Error Rate                   | <u>2.40%</u>   | <u>2.99%</u>  | <u>3.59%</u>  |
| Upper Error limit                       | 4.71%          | 5.58%         | 6.42%         |
| Lower Error limit                       | .08%           | 0.41%         | .77%          |
| Upper limit Transactions in error       | <u>784,997</u> | <u>20,059</u> | <u>66,465</u> |
| Lower limit Transactions in error       | <u>12,686</u>  | <u>1,471</u>  | <u>7,978</u>  |

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.)

During the examination of the claims processing transactions within the various claim adjudication samples, the following findings, not included in the errors reflected in the above charts, were noted:

- There were three instances of medical claims in which the rate paid for the service provided could not be verified. GHI stated that the rate was changed subsequent to the payment date of the sampled claims, but documentation was not provided to support the changes. It is recommended that GHI retain documentation for changes in rates for covered medical procedures. This is discussed further under Section 7. Record Retention.

- All claims in which a dependent student's eligibility status is not certified are denied. After the eligibility is certified, a claim must be resubmitted for payment. It is recommended that GHI pay claims when the certifications of the dependent student's eligibility are received rather than requiring the claims to be resubmitted. GHI stated that this has been addressed and the specifics will be provided to the Department with GHI's response to this Report.
- As a general rule GHI does not "pend" claims for receipt of additional information. If additional information is required, these claims are processed and denied awaiting additional information and then reopened when resubmitted. Generally the claims are linked to the original, however in some cases the claims are reopened with a distinct claim number. If a claim is denied incorrectly and then resubmitted, the "Date received" from the original claim is not cross-referenced to the claim resubmission. The practice of closing claims when additional information is required to process the claim can distort the aging of claims for Schedule H reporting purposes as well as for compliance with the prompt pay law. This is discussed further under Item C. Schedule H – Section 1, Aging Analysis of Unpaid Claims below. It is recommended that GHI link the original date received to all claims including resubmitted claims.

B. 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" requires all insurers to pay claims within forty-five days of receipt. If such claims are not paid within forty-five days of receipt, interest may be payable. Additionally, it requires that denials or requests for additional information be made within thirty calendar days of receipt.

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

"(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law 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 healthcare 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.

(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim,

the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

- (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
  - (2) to request all additional information needed to determine liability to pay the claim or make the health care payment.
- (c) ...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... "

Statistical samples of GHI's paid and denied claims from each claims system: medical, hospital and dental, were reviewed to determine compliance with Section 3224-a of the New York Insurance Law. (As noted above the term, "claim" refers to original claims and financial adjustments to original claims.) The populations were analyzed, for the period January 1, 2000 through March 31, 2001, to identify all claims that were not paid or denied within 45 days and to determine compliance regarding the payment of interest. Random statistical samples of claims settled over 45 days were selected to determine compliance with Section 3224-a (a), (b) and (c).

The results of the review with respect to the claim data provided are as follows:

### **GHI Prompt Pay Claims Review**

|   | Medical       | Hospital      | Dental        |
|---|---------------|---------------|---------------|
| Claim Population                                  | 16,651,629    | 359,558       | 1,035,998     |
| Population of transactions processed over 45 days | 45,154        | 7,441         | 17,037        |
| Percentage of transactions processed over 45 days | .27%          | 2.07%         | 1.64%         |
| Sample Size                                       | 167           | 167           | 167           |
| Number of transactions with errors                | 70            | 136           | 37            |
| Calculated Error Rate                             | <u>41.92%</u> | <u>81.44%</u> | <u>22.16%</u> |
| Upper Error Limit                                 | 49.40%        | 87.33%        | 28.46%        |
| Lower Error Limit                                 | 34.43%        | 75.54%        | 15.86%        |
| Upper limit transactions in error                 | <u>22,306</u> | <u>6,499</u>  | <u>4,848</u>  |
| Lower limit transactions in error                 | <u>15,548</u> | <u>5,621</u>  | <u>2,702</u>  |

The following is noted regarding the errors cited above:

- ◆ Thirty-one of the hospital transaction errors were payments to the hospitals in which the claim was processed prior to the forty-five day limit, but the processing of the check was delayed because GHI rolled-up separate payments into one check. None of these resulted in interest due to the providers.
- ◆ Seventeen of the hospital transaction errors and fifty-four of the medical transaction errors were processed by GHI's third-party administrator, Value Options (VO). GHI contracted with VO to process and evaluate mental health claims.

It is recommended that GHI assure that all claims, including those processed by third-party administrators are processed in accordance with Section 3224-a(c).

C. Schedule H - Section 1, "Aging Analysis of Unpaid Claims"

A review of GHI's Schedule H - Section 1, "Aging Analysis of Unpaid Claims" as filed with GHI's 2000 Annual Statement was performed. As of December 31, 2000, GHI filed the following data with respect to its Schedule H - Section 1, "Aging Analysis of Unpaid Claims":

GHI December 31, 2000 Schedule H - Section 1, Aging Analysis of Unpaid Claims

| <u>Account</u>                                 | <u>1-30 days</u> | <u>31-60 days</u> | <u>61-90 days</u> | <u>91-120 days</u> | <u>Over 120 days</u> | <u>Total</u>         |
|--|------------------|-------------------|-------------------|--------------------|----------------------|----------------------|
| Reserve for Claims in the course of settlement | \$29,445,437     | \$590,913         | \$0               | \$0                | \$0                  | \$30,036,350         |
| <b>IBNR</b>                                    |                  |                   |                   |                    |                      | <u>\$244,330,211</u> |
| <b>Total</b>                                   |                  |                   |                   |                    |                      | <u>\$274,366,561</u> |

The underlying theory behind the Department's promulgation of Schedule H was to have Schedule H indicate the amount of financial pressure placed on health insurance companies by claimants. A second purpose of Schedule H was to have health insurance companies accurately age and report aged claims, so that a measure of claims processing efficiency could easily be obtained. The instructions for Schedule H state, "For both Sections 1 and 2, age reported claims payable from the date of receipt by Company..."

GHI performs an analysis of aged claims payable using the receipt date of resubmitted claims that were previously denied, rather than the original date of the claim. The Company's practice is to close all claims in which additional information is required, with the exception of some dental claims. GHI does not "pend" claims, other than some dental claims, for additional information; rather claims are denied and closed out.

GHI's dental system has the capability to pend claims; however, GHI does not have a procedure that requires that a resubmitted, previously denied claim be reopened as an adjustment to the original claim. Therefore, the original date received is not necessarily linked to the adjusted transaction and as a result, sometimes the dental claims are aged from the original receipt date and sometimes they are not.

When additional information is required in order to process a claim, the claimant is required to submit the requisite information and resubmit the claim. This practice results in distortions in Schedule H because once closed, these claims are not counted in Schedule H until resubmitted. Additionally, GHI is not properly aging reopened, previously denied claims since reopened claims are not aged from the date of original receipt.

It is recommended that GHI account for claims in which additional information was requested, rather than closing those claims and counting them as denied claims and then creating new claims when the information is received. Additionally, it is recommended that GHI take the necessary steps to complete its Schedule H - Section 1, "Aging Analysis of Unpaid Claims" in accordance with the Department's instructions.

As of December 31, 2000, GHI did not include approximately 2,100 aged claims received by VO in the reported claims totals in Schedule H.

It is recommended that GHI include VO claims in its Schedule H.

D. Explanation of Benefits Statements (EOBs)

A review of GHI's Explanation of Benefits statements ("EOBs") sent to subscribers and/or providers was performed. An EOB is an important link between the payer and the subscriber or provider which should clearly communicate that a claim has been processed and how the claim was processed. An EOB should, at a minimum, contain relevant information such as the provider's identity, date of service, description of the service, the provider's charges, the contractual allowance for the service, and any balance due the provider. It should also serve as the necessary documentation to recover money from other insurance carriers due to coordination of benefits.

Section 3234 of the New York Insurance Law requires EOBs to be sent to insureds or subscribers for all claims for health services except in cases when the services were performed by a participating provider and the provider was paid in full, except for the ordinary co-payment. Section 3234(a) states:

"Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits."

Section 3234(c) of the New York Insurance Law states:

"Except on demand by the insured or subscriber, insurers including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer directly to the participating facility or provider."

GHI furnishes EOBs to all GHI subscribers and/or providers for every dental, medical and hospital claim submitted, regardless of whether the subscriber used a participating or non-participating provider.

Section 3234(b) of the New York Insurance Law states that the explanation of benefits form must include at least:

- "(1) the name of the provider of service the admission or financial control number, if applicable;
- (2) the date of service;
- (3) an identification of the service for which the claim is made;
- (4) the provider's charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
- (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

GHI could not reproduce EOBs nor were copies retained. (See Item 6. Record Retention herein.) If a reissue of an EOB is requested, a customized letter is sent in lieu of the actual copy of the EOB. It is noted that the letters did not contain all of the required language as provided for in Section 3234 of the Insurance Law. Accordingly, the examiners were unable to review the EOBs that were generated for the 501 random claims selected for the claims review.

It should be noted that the examination review revealed that GHI's EOBs did not include adequate appeals disclosure as required by Section 3234(b) of the New York Insurance Law. Specifically, the EOBs did not state that failure to comply with the appeal procedure requirements (time limit, place and manner) may lead to forfeiture of the consumer's right to appeal. It is noted that GHI maintains that appeals were accepted over the 45-day statutory limit as prescribed by Section 4914(b) of the Insurance Law. This has not been verified by the examiners.

It is recommended that GHI modify its EOBs to include all the requisite appeals disclosure language pursuant to Section 3234(b) of the New York Insurance Law.

Additionally, a review was performed of the letters that were issued in lieu of EOBs for each sampled claim. It is noted that these letters show certain aspects of the original claim submission such as certificate and claim numbers, patient and provider identification, dates of service and payment amount. However, these letters do not contain all items required by Section 3234(b) of the New York Insurance Law. The following information was excluded from the letters:

- an identification of the hospital service provided
- the amount or percentage payable after deductibles, co-payments or other reductions on hospital EOBs
- specific details describing how an insured or subscriber can appeal the claim

Some letters pertaining to dental claims did not include the name of the provider and a specific explanation of the denial, reduction or other reason that the claim was not paid in full.

It is recommended that GHI make the necessary programming changes to its claims processing systems so that duplicate EOBs can be reproduced. This is discussed further under item 6. Record Retention.

## **5. GRIEVANCES, APPEALS AND COMPLAINTS**

### A. Schedule M – "Grievances and Utilization Review Appeals"

GHI's filed annual statement reflected the following number of Utilization Review (UR) and External Appeal (EA) cases filed for 1999 and 2000.

| Year | Number of UR cases filed | Number of EA cases filed |
|------|--------------------------|--------------------------|
| 1999 | 2,049                    | 22                       |
| 2000 | 1,531                    | 100                      |

According to the detail provided by GHI to support the number of utilization review cases reported in Schedule M, "Grievances and Utilization Review Appeals", the amounts

reported were understated by 59 cases in 2000 and by 123 cases in 1999.

It is recommended that GHI include all appealed cases on Schedule M and retain the documentation to support the appeals reported in Schedule M.

B. Utilization Review

Article 49 of the New York Insurance Law sets forth standards for a utilization review program and procedures for external appeal determinations. Section 4903 of the New York Insurance Law delineates specific guidelines for handling pre-authorizations, concurrent reviews and retroactive reviews. Utilization reviews performed during the period under examination were administered by GHI and third party administrators contracted by GHI. GHI used third party administrators for the evaluation of mental health utilization reviews (VO), radiological utilization reviews (NYMI Management Services, LLP) and chiropractic utilization reviews (Alignis, Inc.).

The examiners noted that documentation supporting medical information obtained over the telephone from providers during the evaluation of utilization reviews was not retained. (See Section 6. Record Retention.)

Pre-authorizations

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

"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 insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

Fourteen files, selected from the third quarter of 2000, were evaluated to determine compliance with Section 4903(b) of the New York Insurance Law. In one of the fourteen cases the Company failed to notify the subscriber within the three-business-day requirement. Additionally, in six cases (43%) the Company failed to notify the insured by phone.

It is recommended that the Company notify the insured or the insured's designee of the

determination of a pre-authorization review both by telephone and in writing in accordance with Section 4903(b) of the New York Insurance Law.

#### Utilization Review Notices

None of the final determination notifications of concurrent and retrospective reviews were retained and the final determination notices in thirteen of the fourteen pre-authorizations reviewed were not retained. It was apparent that the Company generated letters to the subscribers, but these letters were not retained and could not be reconstructed. During the course of the examination, the examiners recommended that the Company retain copies of all correspondence sent to subscribers. The Company stated that beginning September 2001 all correspondence was retained. A subsequent review of ten utilization review cases filed after September 1, 2001 was performed and the examiners found that the all letters were retained.

#### Adverse Determination Notices

Article 49 requires specific information to be included in adverse determination notices to members or providers. Section 4903(e) of the New York State Insurance Law states:

"(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

- (1) the reasons for the determination including the clinical rationale, if any;
- (2) instructions on how to initiate standard appeals and expedited appeals...
- (3) notice of availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal. "

It is noted that certain of GHI's adverse determination notices, sent during the period under examination, were found to be objectionable by this Department for reasons such as: unnecessary language was included, and certain required details regarding the specifics of the case and all of the rights of the insured or the provider were not included.

The Company agreed to modify the letters in response to the Department's criticism. The modified letters were reviewed and found them to be in compliance with Section 4903(e).

### Appeals requiring additional information

GHI's practice was to close (deny) all appeals in which the information provided was insufficient to render a decision. The Department advised GHI that it is more appropriate to "pend" cases for additional information.

GHI modified its practice and is currently "pending" cases in which no information was received with the appeal filing. If the information provided with the appeal is inadequate, GHI issues an adverse determination with the right of appeal.

### Appeals of adverse determinations

Section 4904(c) of the New York State Insurance Law states:

"(c) A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone... 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.

The notice of the appeal determination shall include:

- (1) the reasons for the determination...
- (2) a notice of the insured's right to an external appeal together with a description... of the external appeals process... and the time frames for such external appeals."

In twelve (48%) of twenty-five files reviewed, the examiners could not verify acknowledgement of receipt of the appeals. It should be noted that VO, the Company's administrator for mental health claims, reviewed all of the twelve cases. VO asserted that notification was done by phone.

Additionally, in three (12%) of twenty-five files, the Company failed to notify the subscriber of the decision within the two-business-day requirement.

It is recommended that GHI assure that appeals of adverse determinations are handled in

accordance with Section 4904(c) of the New York Insurance Law, by requiring VO to acknowledge receipt of all appeals in writing. It is further recommended that GHI notify the insured, the insured's designee and, where appropriate, the insured's health care provider in writing within the two-business-day requirement of an adverse determination.

C. Complaints

A review of complaints filed with the Insurance Department regarding GHI was reviewed for compliance with Section 2404 of the Insurance Law, to assure that GHI responded in a timely manner to the Insurance Department investigation of the complaint. Section 2404 states:

"...In the event any person does not provide a good faith response to a request for information from the superintendent, within a time period specified by the superintendent of not less than fifteen business days, as part of an examination or investigation initiated by the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance or health maintenance organization coverage, the superintendent is authorized, after notice and hearing to levy a civil penalty against such person in an amount not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response, but in no event shall such penalty exceed ten thousand dollars."

The Insurance Department's Consumer Services Bureau investigates complaints and has established a fifteen-business-day response requirement on health insurance companies. A review of the response timeframes of thirty complaints filed between January 1, 2001 and March 31, 2001 revealed that eleven (37%) of the response times were greater than fifteen-business-days. Additionally, a review of forty-four claims filed between January 1, 1996 through December 31, 1999 revealed that ten of the forty-four (23%) of the response times were greater than fifteen-business-days. It is recommended that the Company respond to inquiries about complaints from the Insurance Department's Consumer Services Bureau within the fifteen-business-day requirement specified by Section 2404 of the New York Insurance Law.

## **6. RECORD RETENTION**

Regulation No. 152, Section 243.3(c) requires that insurers establish and maintain a

record retention plan. GHI's record retention plan was formalized on January 28, 1997. As noted above and repeated below, there were instances in which the Company's actual practices did not comply with Regulation No. 152 and its own record retention plan.

Sections 243.2(b)(4) and (e) of Regulation No. 152 state:

"(b)(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received."

"(e) The records shall be readily available and easily accessible to the superintendent in accordance with Insurance Law Section 310. The records shall be in a readable form. If any such records are kept in a language other than English, they shall be accompanied by accurate translations. Upon request of the superintendent, the insurer shall provide a hard copy of the record, or, if the record is maintained in a medium which is used by the superintendent, the insurer may provide the record in that medium. Failure to produce and provide a record within a reasonable time frame shall be deemed a violation of Insurance Law Section 308 unless the insurer can demonstrate that there is a reasonable justification for that delay. "

Further, Section 243.3(a) states:

"(3) Upon transfer of an original record to a durable medium, the insurer may destroy the original record after assuring that all information contained in the original record, including signatures, handwritten notations, or pictures, is contained in the durable medium.

(4) If the insurer does not retain the original paper record, or if there was no original paper record, a duplicate or back-up system sufficient to permit reconstruction of the record shall be established at a separate location..."

New York Regulation Nos. 64 and 152 set forth minimum standards for claim file maintenance and retention of records. Section 216.11 of Regulation No. 64 states, in part:

"...To enable department personnel to reconstruct an insurer's activities, all insurers ... must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurers shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants."

While reviewing GHI's claims processing cycle, the examiners noted instances in which

the Company's record retention practices deviated from its formalized plan. Specifically, the Company could neither produce copies of nor reproduce in complete detail the following documentation:

- Explanation of benefits statements – GHI instead issued a custom letter in lieu of an actual duplicate EOB;
- The date of receipt of dental claims in which the dental work performed had been pre-determined by GHI;
- Records supporting all rate changes for medical and hospital procedures;
- Records indicating the date new rates for hospital, medical and dental procedures became effective;
- Documentation supporting the medical information furnished by providers, via telephone for utilization reviews;

It is recommended that GHI adhere to the guidelines of its record retention plan and maintain complete claim files pursuant to Regulation Nos. 64 and 152 by either retaining paper copies or establishing a system that allows for exact duplication of all EOBs. Additionally, it is recommended that GHI retain the date of receipt of pre-determined dental claims and the documentation supporting new reimbursement rates and the date the new reimbursement rates went into effect.

It is recommended that GHI document and retain the medical information furnished by providers via telephone, used for determination of utilization reviews.

It is noted that GHI maintains that they are working to institute procedures to retain the following records: the date of receipt of dental claims in which the dental work performed had been pre-determined, records supporting new rates for medical and hospital procedures, records indicating the date new rates for hospital, medical and dental procedures became effective; documentation supporting the medical information furnished by providers, via telephone for utilization reviews.

## **7. SUMMARY OF COMMENTS AND RECOMMENDATIONS**

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| <br><b><u>Underwriting and rating</u></b>   |                        |
| A. GHI maintained a practice of using income-based criteria in reviewing applications for coverage by groups of one/sole proprietors. Specifically, applicants earning less than \$15,000 per year were required to meet additional standards in order to obtain coverage, and in some instances, were denied coverage when these additional standards were not met. In May 2000, GHI agreed to eliminate the income requirement for sole proprietors and to apply the same underwriting requirements to all sole proprietors regardless of income. | 2                      |
| B. GHI did not submit, for approval, policy forms delineating the "deferred premium" payment arrangement to the Department. It is recommended that GHI file these arrangements with the Department.   | 3                      |
| C. GHI insures the employees of the City of New York under a large group contract. The certificates of coverage that are based upon this contract and issued to NYC employees who are GHI subscribers were submitted to and approved by the Department. However, the actual group master contract was not filed with the Department. It is recommended that GHI submit the group contract itself for approval as required by Section 4308(a).   | 3                      |
| D. The Company delayed issuance to community rated contract holders of the external appeal rider for eight months. It is recommended that GHI distribute mandatory policy form changes in a more timely manner.   | 4                      |
| <br><b><u>Advertising</u></b>   |                        |
| E. It is recommended that GHI comply with Regulation No. 34 by accurately reflecting its financial position and membership in its advertisements.   | 5                      |
| <br><b><u>Claims processing</u></b>   |                        |
| F. It is recommended that GHI retain the documentation to support changes in rates for covered medical procedures.  | 7                      |
| G. It is recommended that GHI pay claims denied for student dependent eligibility status when the student dependent certification is received rather than requiring that the claim be resubmitted.  | 8                      |

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|--|------------------------|
| H. It is recommended that GHI link the original date received to all claims including resubmitted claims.  | 8                      |
| <br><b><u>Prompt Pay</u></b>   |                        |
| I. It is recommended that GHI assure that all claims, including those processed by third-party administrators are processed in accordance with Section 3224-a(c).  | 10                     |
| <br><b><u>Schedule H</u></b>   |                        |
| J. It is recommended that GHI complete its Schedule H "Aging Analysis of Unpaid Claims" in accordance with the Department's instructions and account for those claims in which additional information was requested, rather than counting those claims as denied claims and creating new claims when the claim is resubmitted. | 11                     |
| K. It is recommended that GHI include VO claims in Schedule H.   | 11                     |
| <br><b><u>Explanation of Benefit Statements (EOBs)</u></b>   |                        |
| L. It is recommended that GHI modify its EOBs to include all requisite appeals disclosure language pursuant to Section 3234(b) of the New York Insurance Law.  | 13                     |
| M. It is recommended that GHI make the necessary programming changes to its claims processing systems so that duplicate EOBs can be reproduced.  | 14                     |
| <br><b><u>Grievances, Appeals And Complaints</u></b>   |                        |
| N. It is recommended that GHI include all appealed cases in Schedule M and that GHI retain the documentation to support the appeals reported in its Schedule M.  | 15                     |
| O. It is recommended that GHI notify the insured or the insured's designee both in writing and by telephone of the determination of pre-authorization for health care services within three business days, in accordance with Section 4903(b) of the Insurance Law.  | 16                     |

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- P. It is recommended that GHI assure that appeals of adverse determinations are handled in accordance with Section 4904(c) of the New York Insurance Law by requiring its third party administrator, VO, to acknowledge receipt of all appeals in writing. It is further recommended that GHI notify the insured, or the insured's designee and where appropriate the insured's health care provider in writing within the two business days requirement of an adverse determination. 18
- Q. It is recommended that the Company respond to inquiries about complaints from the Insurance Department's Consumer Services Bureau within the fifteen-business-day requirement specified by Section 2404 of the New York Insurance Law. 18

**Record Retention**

- R. It is recommended that GHI adhere to Regulation Nos. 152 and 64 and to the guidelines of its record retention plan by either retaining paper copies or by establishing a system that allows for exact duplication of all EOBs. Additionally, it is recommended that GHI retain the date of receipt of pre-certified dental claims and the documentation supporting new reimbursement rates and the date the new reimbursement rates went into effect. 20
- S. It is recommended that GHI document and retain documentation supporting the medical information furnished by providers via telephone used for determination of utilization reviews. 20

Appointment No. 21712

STATE OF NEW YORK  
INSURANCE DEPARTMENT

I, NEIL D. LEVIN, Superintendent of Insurance of the State of New York,  
pursuant to the provisions of the Insurance Law, do hereby appoint:

**Kathleen Grogan**

as a proper person to examine into the affairs of the

**Group Health Inc.**

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

**Company**

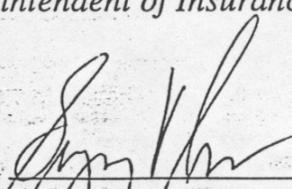
with such other information as she shall deem requisite.

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 29th day of March 2001

\_\_\_\_\_  
NEIL D. LEVIN

Superintendent of Insurance

(by)   
Gregory Serio

First Deputy Superintendent

