

REPORT ON EXAMINATION

OF THE

CORNELL UNIVERSITY STUDENT HEALTH PLAN

AS OF

AUGUST 16, 2016

DATE OF REPORT

MARCH 5, 2020

EXAMINER

HUSSEIN AGOUDA, CFE

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Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Acting Superintendent

March 5, 2020

Linda A. Lacewell
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31619, dated April 5, 2017, attached hereto, I have made an examination into the condition and affairs of Cornell University Student Health Plan, a self-funded student health plan certified pursuant to the provisions of Section 1124 of the New York Insurance Law, as of August 16, 2016. The following report is respectfully submitted thereon.

The examination was conducted at the main administrative office of Cornell University Student Health Plan, located at 395 Pine Tree Road, Suite 110, Ithaca, NY 14850.

Wherever the designations “SHP” or the “Plan” appear herein, without qualification, they should be understood to indicate Cornell University Student Health Plan.

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

1. SCOPE OF EXAMINATION

This is the first examination of the Plan. The examination of the Plan was a combined (financial and market conduct) examination and covered the two-year period from August 17, 2014 to August 16, 2016. The financial component of the examination was conducted as a financial examination, as such term is defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2017 Edition* (the “Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to August 16, 2016 (fiscal year end) were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner’s assessment of risk in the Plan’s operations and utilized that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan’s current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key functional areas and their corresponding key processes, assessed the risks within those processes, and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management’s compliance with the Department’s statutes and guidelines, and annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

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

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

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

Cornell University (“Cornell” or the “University”) operates the Plan as an “Organization” within the University. The University’s fiscal year runs from July 1st through June 30th of the following year, whereas the SHP fiscal year runs from August 17th through August 16th of the following year. For the University’s fiscal years 2014 to 2015 and 2015 to 2016, the University engaged PricewaterhouseCoopers LLP (the “CPA” or “Pricewaterhouse”) to perform its annual financial statement audit. The University received unmodified opinions for its audited financial statements for the period July 1, 2014 through June 30, 2016.

It was noted that Pricewaterhouse did not scope the SHP into its audit as instructed by the Department’s June 19, 2015 letter to Cornell, which states in part:

“The notes to the financial statement shall show the financial results of the student health plan operations and a description as to how the institution meets the reserve requirements in paragraph one of subsection (h) of this section, including the amounts reported for each of the reserves, the method used to calculate the reserves, and the change in the reserves from the beginning of the plan's fiscal year to the end of the plan's fiscal year. In addition, the notes to financial statement shall detail the assets comprising the contingent reserve fund to demonstrate compliance with paragraph one of subsection (h) of this section.”

In lieu of scoping the Plan into the University’s annual independent financial audit, the Plan engaged a separate public accounting firm, Insero & Co. CPAs, LLP (“Insero”), to perform an independent audit of the Plan to supplement Cornell’s consolidated annual audit. Insero’s audit covered the Plan’s fiscal year periods of August 17, 2014 through August 16, 2016, as well as subsequent events. SHP received an unmodified opinion for the above period.

2. DESCRIPTION OF THE PLAN

On July 1, 2014, Cornell was issued a certificate of authority to operate a student health plan by the Superintendent of Financial Services, pursuant to Section 1124 of the New York Insurance Law. The initial name used for the student health plan was “Cornell University Student Health Insurance Plan.” Thereafter, the Plan changed its name to “Cornell University Student Health Plan.” Prior to August 17, 2014, the University provided a fully-insured student health insurance plan for medical and prescription drug coverage, as well as optional dental and vision insurance through Aetna Student Health.

Cornell University Student Health Plan is a self-funded plan established to provide extensive health benefits to students at the University’s Ithaca-based campuses. The SHP was developed especially for students to provide access to convenient and comprehensive care that compliments the health services offered on campus. Cornell requires that all students enrolled in the University have health insurance. Spouses and dependents of students are eligible to be on the plan and have the option to enroll. The SHP is a comprehensive plan including, but not limited to, extensive coverage for most on or off-campus medical care and maintains a preferred provider network that includes the local hospital in Ithaca. The SHP provides only medical and prescription drug benefits. According to the SHP’s actuarial memorandum from Mercer Health and Benefits LLC, optional coverage for dental and vision benefits are available for adults on a fully insured basis.

Undergraduate students enrolled in Medicaid in New York State are eligible for the New York State Department of Health premium payment program. This benefit plan design, Student Health Plan-Medicaid (“SHP-M”), is similar to the student health plan for the non-Medicaid

eligible students, but with no cost-sharing for the first tier of coverage. The cost sharing under SHP-M is identical to the cost sharing under Medicaid and includes access to the features of the Student Health Plan designed for non-Medicaid eligible students.

Enrollment in the SHP is achieved by means of individual contracts made with registered students. The premiums are collected together with the students' tuition. For the school's 2015/2016 fiscal year, the Plan covered approximately 11,340 students.

A. Corporate Governance

Corporate governance of the SHP is vested in the Cornell University Board of Trustees. However, until the beginning of the 2017-18 fiscal year, Cornell did not have a governance committee specific to the Plan and instead relied on the Cornell University board, which focuses on the University as a whole. In July 2017, during the course of this examination, the Plan established an Oversight Committee, which is subject to Cornell Board of Trustees governance.

The list of the Oversight Committee group members was submitted to the Department for review and approval. On November 22, 2017, the Department communicated to the Plan that it is not acceptable to substitute an internally created committee for Cornell's board of Trustees, and that Cornell's principal officers must sign the annual statement Jurat Page.

Not-For-Profit Corporation Law - Section 621(a) states in part:

“(a) Except as otherwise provided herein, every corporation shall keep, at the office of the corporation, correct and complete books and records of account and minutes of the proceedings of its members, board and executive committee, if any, and shall keep at such office or at the office of its transfer agent or registrar in this state, a list or record containing the names and addresses of all members, the class or classes of membership or capital certificates and the number of capital certificates held by each and the dates when they respectively became the holders of record thereof. A corporation may keep

its books and records of account in an office of the corporation without the state, as specified in its certificate of incorporation. Any of the foregoing books, minutes and records may be in written form or in any other form capable of being converted into written form within a reasonable time.”

During the examination period, the Cornell University Board did not maintain any board minutes for the Plan. While the Plan may not have been established as a corporation, as a good business practice, the Plan should keep correct and complete books and records of account and maintain minutes of the proceedings of its board and executive committee.

It is recommended that the Plan, as a best practice, and in conformance with the Not-For-Profit Corporation Law - Section 621(a), keep minutes of quarterly and annual board meetings.

The principal officers of the University as of August 16, 2016 were as follows:

<u>Name</u>	<u>Title</u>
Hunter Ripley Rawlings III	Interim President
James John Mingle	Secretary
Joanne Marie DeStefano	Chief Financial Officer

B. Territory and Plan of Operation

As of the examination date, the Plan maintained a stop-loss insurance policy with an effective date August 17, 2014, renewable at August 17, of each succeeding year. The policy was issued by the National Union Fire Insurance Company of Pittsburgh, PA, a New York licensed insurer, to provide medical excess loss coverage.

During the fiscal year 2014-2015, the Plan maintained the following medical and prescription drug stop-loss insurance coverage:

Specific percentage reimbursable per covered participant at 100%. Specific deductible amount per covered participant per covered period at \$500,000. No annual limit of

liability per covered participant per covered period. Unlimited lifetime liability per covered participant

In addition to the specific excess-of-loss coverage, during the fiscal year 2014-2015, the Plan maintained an aggregate stop-loss policy with a retention of \$1 million with an attachment point not greater than one hundred twenty-five percent of the number of expected claims, payable on a 12-month incurred and 18-month reported basis.

During fiscal year 2015-2016 and the following fiscal years, the Plan removed the aggregate coverage, but maintained the specific excess-of-loss coverage limit, with an increase in the deductible from \$500,000 to \$550,000 per member.

C. Third Party Agreements

The Plan entered into an administrative service agreement (herein, the “Master Agreement”) with Aetna Student Health (“Aetna”), a Connecticut corporation and subsidiary of Aetna Life Insurance Company, to provide the Plan with claims processing, pharmacy benefit management, and utilization review management services. The contract was effective August 17, 2014.

During the review of the Master Agreement it was noted that the Plan was unable to provide a Service Organization Control 2 (“SOC2”) Certification demonstrating that it had performed due diligence of Aetna to support the following areas: IT regarding security, availability, processing integrity, confidentiality, and privacy.

It is recommended that the Plan include a requirement in its service agreement with Aetna that Aetna annually provide a Service Organization Control 2 (“SOC2”) Certification relating to, at minimum: IT security, availability, processing integrity, confidentiality, and privacy.

D. Accounts and Records

Allocation of Expenses

New York Insurance Law Section 1505, “Transactions within a holding company system affecting controlled insurers”, states the following:

“Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:

- (1) The terms shall be fair and equitable;
- (2) Charges or fees for services performed shall be reasonable; and
- (3) Expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied.”

In addition, Insurance Regulation 30 (11 NYCRR 106.6) “Records required,” states the following:

- (a) The methods followed in allocating joint expenses shall be described, kept and supported as set forth under "detail of allocation bases,"
- (b) The effects of the application, to each operating expense classification of all bases of allocation shall be shown on records kept in clear and legible form. Such records shall be readily available for examination.

The Plan operates under the umbrella of, and benefits from, the institutional support structures of Cornell. Services received include, but are not limited to, student services (admissions, registrar, bursar), investment management, and finances (accounting, cash management, procurement). Cornell Health’s Office of Student Health Benefits provides enrollment and customer service support to the Plan and the Office of Risk Management and Insurance provides consulting and management services to the Plan.

Through the above arrangements, the Plan incurred administrative expenses described as Cornell Student Health Benefits Customer Service of \$747,791 and \$479,837, for the fiscal years

ended August 16, 2015, and August 16, 2016, respectively. Per the review of the Plan's CPA workpapers, these expenses were based on a flat amount of \$3.167 per participant per month. There was no formal documentation of this amount; the University developed the amount to approximate the budgeted costs of the SHP.

Beginning in fiscal year 2016, all students (regardless of whether they are enrolled in the Plan) were required to pay a Student Health Fee of \$350. Per the Plan, 10.8% of this fee is to be allocated to the Student Health Benefits Office, based on the Plan's projected costs, with the amount netted to the projected Student Health Benefit Administrative Expenses.

New York Insurance Law Section 1505, "Transactions within a holding company system affecting controlled insurers" and Insurance Regulation 30 (11 NYCRR 106.6) establish the requirement that expenses allocated to the Plan by the University be determined utilizing a fair and accurate method and that records be maintained showing how the allocation was determined. During the examination, the Plan was not able to disclose the nature of the allocation methodology used or provide the accounting information necessary to support the reasonableness of the charges or fees from the respective parties.

It is recommended, as a best practice, that the Plan conform with the requirements of Section 1505 of the New York Insurance Law by ensuring that fees allocated to the Plan by the University are fair and reasonable and that expenses allocated to the Plan are determined on an equitable basis in conformity with customary accounting practices.

It is also recommended, as a best practice, that the Plan conform with Part 106.6 of Insurance Regulation 30 (11 NYCRR 106.6) by maintaining proper records to support the allocation percentages charged for its expenses.

Investment and Cash Management

The following is a description of the Plan’s investment process, as obtained from the Plan’s financial audit report:

“Funds held in the contingency reserve are invested in Cornell’s Long-Term Investment Pool (LTIP) on behalf of the Plan, and are reported at fair value.”

New York Insurance Law Section 1124(h)(4) states the following:

“The Plan’s assets, liabilities, income and expenses shall be accounted for separate and apart from all other assets, liabilities, income and expenses of the university.”

During the examiner’s review of the Plan’s cash management, it was noted that the Plan did not maintain its own cash balances or bank accounts. Instead, under the Plan’s prescribed accounting methodology, the Plan has a claim on cash held by Cornell, and the cash attributable to the Plan is reflected in the statement of financial position as “Due from Cornell.”

It is recommended, as a best practice, that a separate cash account be maintained apart from the University.

E. Significant Operating Ratios

The table below indicates the premiums during the examination period:

<u>Fiscal Year</u>	<u>Net Premium Income</u>	<u>No. of Students Covered</u>
2014/2015	\$25,772,362	11,497
2015/2016	\$28,222,774	11,340

The underwriting ratios presented below are on an earned-incurred basis and encompass the two-year period covered by this examination:

	<u>Amounts</u>	<u>Ratios</u>
Claims	\$42,419,579	78.57%
General administrative expenses	5,146,430	9.53%
Net underwriting gain	<u>6,425,599</u>	<u>11.90%</u>
Premiums	<u>\$53,991,608</u>	<u>100.00%</u>

3. FINANCIAL STATEMENTS

Cornell University's financial fiscal year is a twelve-month period, beginning July 1 and ending June 30. It is not the same as the Plan's fiscal year, which runs from August 17 through August 16 of each following year.

The following statement shows the assets, liabilities and surplus, as of August 16, 2016, as contained in the Plan's 2016 filed annual statement, and a condensed summary of operations and reconciliation of the surplus account for the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial conditions as presented in its August 16, 2016 filed annual statement.

Independent Accountants

The firm of PricewaterhouseCoopers LLP, was retained by Cornell to audit the University's consolidated financial statements as of June 30th for each fiscal year in the examination period, and the related consolidated statements of operations, surplus, and cash flows for the fiscal year then ended. PricewaterhouseCoopers LLP concluded in its report that the consolidated financial statements presented fairly, in all material respects, the financial position of the University at the respective audit dates.

The Plan engaged a separate public accounting firm, Inero & Co. CPAs, LLP (“Inero”), to perform an independent audit of the Plan to supplement Cornell’s consolidated annual audit. Inero concluded in its report that the Plan’s financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates.

A. Balance Sheet

Assets

Cash and cash equivalents	\$ 39,917,832
Other invested assets	<u>1,581,778</u>
Total assets	\$ <u>41,499,610</u>

Liabilities

Unpaid claims	\$ 3,203,192
Premiums received in advance	29,660,282
General expenses due or accrued	<u>603,731</u>
Total liabilities	33,467,205

Surplus

Aggregate write-ins for special surplus funds	\$ 170,816
Gross paid-in and contributed surplus	3,203,192
Unassigned funds (surplus)	3,249,521
Total contingent reserve per NYIL 1124(h)(1)(C)	<u>1,408,876</u>
Total surplus	\$ <u>8,032,405</u>
Total liabilities and surplus	\$ <u>41,499,610</u>

B. Statement of Revenue and Expenses and Surplus

Surplus increased by \$4,480,193 during the two-year examination period, August 17, 2014 through August 16, 2016, detailed as follows:

Revenue

Premiums received	\$	<u>53,991,608</u>	
Total revenue			\$ 53,991,608

Medical and hospital expenses

Hospital/medical benefits	\$	25,374,661	
Other professional services		9,273,377	
Prescription drugs		<u>7,771,541</u>	
Total medical and hospital expenses			\$ 42,419,579

Administrative expenses

Professional fees	\$	36,000	
Administrative fees		3,798,103	
Consulting fees		84,699	
Aggregate write-ins		<u>1,227,628</u>	
Total administrative expenses			\$ <u>5,146,430</u>
Total expenses			\$ <u>47,566,009</u>
Net income			\$ <u><u>6,425,599</u></u>

Change in Surplus

Surplus as of July 1, 2014			\$3,552,212
		<u>Gains in Surplus</u>	<u>Losses in Surplus</u>
Net income	\$ 6,425,599		
Return of contributed capital			2,158,334
Statutory Adjustment	<u>212,928</u>		<u>4,480,193</u>
Surplus, per report on examination, as of August 16, 2016			<u>\$8,032,405</u>

4. CLAIMS UNPAID

SHP reported \$3,203,192 in unpaid claims in its annual statement as of August 16, 2016.

Section 1124(h)(1)(A) of the New York Insurance Law requires Cornell to establish reserves with the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including: a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported. The amount of this reserve shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the Superintendent's satisfaction that a lesser amount would be adequate.

As part of its Certificate of Authority application process, the Plan was granted approval by the Department to use 14.5% for medical/hospital benefits and 5.0% for prescription drug benefits in calculating the unpaid claims reserve. Using the Department's approved percentages, the Plan would have reported an unpaid claim liability of \$3,249,182, as derived from developed

claims and expenses incurred, and \$3,299,447, as derived from the total claims and expenses reported in the financial statement for the plan year ending on August 16, 2016. It is noted that the Plan did not include capitation claims and expenses in the calculation of the unpaid claims reserve and therefore, the examination calculated reserve amounts are slightly more than the unpaid claim reserve amount of \$3,203,192, reported in the annual statement. Furthermore, the Plan uses the weighted average percentages of the administrative expenses over claims expenses in calculating the unpaid claims reserve.

It is recommended that the Plan include the capitation claims expense payment in the calculation of its unpaid claims reserve.

It is further recommended that the Plan use the Department approved percentages of 14.5% for medical/hospital benefits and 5.0% for prescription drug benefits, respectively, when calculating its unpaid claims reserve.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

The Plan maintains an agreement with Aetna Life Insurance Company (on behalf of itself and its applicable affiliates (collectively “Aetna Student Health”)), a third-party claims administrator, to process claims and conduct Utilization Review. As part of that agreement, Aetna Student Health (“Aetna” or “ASH”) is paid a contractual administration fee per enrolled member.

Claims are adjudicated and paid by ASH, with reimbursement to ASH made by the Plan. The agreement allows Plan participants access to the Aetna healthcare provider network.

A. Prompt Payment of Claims

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

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

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

Sections 3224-a (b) (1) and (2) of the New York Insurance Law states in part:

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

To test Cornell's compliance with the Prompt Pay Law, claims paid during fiscal year 2015/2016 were sampled and tested by the examiners. First, claims were “rolled up” so that each

claim submitted was only represented a single time. Then, the number of days to pay them were determined by subtracting the date the claims were received by the Plan from the date the claim was adjudicated and applying the standards of Section 3224-a of the NYIL (i.e. 30 days for electronic claims, 45 days for paper claims payments and 30 days for claim denials). Claims that appeared to be violations of Parts (a) and (b) of Section 3224-a of the New York Insurance Law were extracted into separate populations of potential violations so that statistically valid samples could be drawn. Once selected, the samples were tested to determine compliance with the statutory requirements. Thereafter, the results of the sampling were extrapolated.

During fiscal year 2015/16, Aetna received and processed 32,591 medical/hospital claims and 36,649 prescription drug claims. From that population, the examiner's testing revealed that there were 962 medical/hospital and 19 prescription drug claims paid late in violation of the requirements of Section 3224-a of the NYIL, for a combined violation rate of 1.4%. This is detailed in the following table:

	Medical/Hospital Claims (Aetna)	Prescription Drugs Claims (Aetna)
Total population of claims	32,591	36,649
Population of claims adjudicated after 30 days of receipt	1,659	486
Violation rate within the sample	58%	4%
Number of claims with violations	962	19
Calculated violation rate	2.95%	0%

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

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

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

As noted, the examiner’s review of claims determined that there were 981 claims paid or denied outside of the parameters of the prompt pay law. However, the Plan paid interest on only 3 of these claims, totaling \$78.68 in interest. As such, it does not appear that interest is being paid as required by statute.

It is recommended that the Plan establish a procedure wherein the Plan calculates and pay interest, where applicable, in compliance with Section 3224-a(c)(1) of the New York Insurance Law.

B. Grievances

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

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

During the examination period, the Plan received five grievances, all of which were reviewed by the examiner. The review revealed that, in violation of Section 4802(d) of the New

York Insurance Law, there were three instances where written acknowledgment notices were not provided to members within the required time frame

It is recommended that the Plan comply with Section 4802(d) of the New York Insurance Law by providing its members with an acknowledgement notice of the complaint within the requisite time frame.

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

“(g) The notice of a determination shall include:

(3) “the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal...”

In testing this requirement, the determination letters that were sent for the five complaint cases reviewed by the examiner were found to be in violation of Section 4802(g)(3) of the New York Insurance Law, as they failed to include the procedures for the filing of an appeal of the determination, including a form for the filing of such appeal.

It is recommended that the Plan comply with Section 4802(g)(3) of the New York Insurance Law by including appeal procedures and forms within its complaint determination letters.

C. Explanation of Benefits Statements (“EOBs”)

Sections 3234(a) and (b)(7) of New York Insurance Law state the following in part:

“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.

(b) The explanation of benefits form must include at least the following:

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, 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.”

A review of the Plan’s EOB’s sent to subscribers for submitted and processed claims revealed that none included the appeals timeframe required by Sections 3234(a) and (b)(7) of the New York Insurance Law.

In order to quantify the approximate number of EOBs that were required to be sent, each of which would have been in violation for their lack of appeal rights, the examiner considered the circumstances in which an EOB should be provided to the insured, as stipulated in Insurance Circular Letter No. 7 (2005). These instances include the following:

1. An EOB must be issued to an insured or subscriber whenever a claim involves a service rendered by a nonparticipating provider.
2. An EOB must be issued to an insured or subscriber if, for whatever reason, the insured or subscriber submits a claim for a service rendered by a participating provider.
3. An EOB must be issued to an insured or subscriber whenever a claim submitted by a participating provider involves a denial based on the participating provider’s failure to follow the insurer’s protocol for coverage, even where the contract between the provider and the insurer contains a "hold harmless" provision.

For example, an EOB would be required when the denial of a claim is based on the provider’s failure to obtain pre-approval of a service from the insurer where it is the provider’s obligation to obtain such approval.

4. An EOB must be issued to the insured or subscriber when an insurer denies a claim on the basis that the coverage for the insured or subscriber was no longer in effect on the date of the service.

The examiner used ACL to extract the Plan’s claims that met the criteria listed in the Circular Letter. The result of the analysis revealed that 18,536 of 32,591 claims met the test.

It is recommended that the Plan comply with the requirements of Sections 3234(a) and (b)(7) of the New York Insurance Law by including a description of the time limit for external appeal in the EOB form.

Section 4802(b)(1) of the New York Insurance Law states in part the following:

“An insurer shall provide to all insureds written notice of grievance procedure... at the time that the insurer denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract... In the event that an insurer denies a service as an adverse determination as defined in article forty-nine of this chapter, the insurer shall inform the insured or the insured’s designee of the appeal rights provided for in article forty-nine of this chapter.”

A review of the EOB’s that were sent to subscribers for submitted and processed claims did not include a provision for how to file a grievance, in violation of Section 4802(b)(1) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4802(b)(1) of the New York Insurance Law by including a provision for subscribers’ grievance rights. It is noted that in response to this finding, the Plan has already updated its EOBs to include the provision for subscribers’ grievance rights, in compliance with Section 4802(b)(1) of the New York Insurance Law.

It was also noted during the review that the Plan’s EOBs include a section titled “Resources Available for Help.” This section includes the name of the state regulatory agency that members can contact to pursue complaints against the Plan. However, for students that reside permanently outside of New York State, instead of listing the New York State Department of Financial Services, where the contact is listed, the form improperly listed the regulatory agency for the subscriber’s permanent residence.

It is recommended that the Plan update the “Resource Available to Help” section of its Explanation of Benefit forms so that subscribers are directed to the New York State Department of Financial Services.

D. Utilization Review

Section 4903(b)(1) of the New York Insurance Law states in part:

“The utilization review agent shall make a utilization review determination involving healthcare 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.”

A review of a sample selection of ten denied utilization review cases (out of the 53) by the examiner, revealed that in one case, a written notice of the determination was not provided to the insured or insured’s designee and the insured’s health care provider within the required time frame, in violation of Section 4903(b)(1) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4903(b)(1) of the New York Insurance Law by providing a written notice of determination to the insured or insured's designee and the insured's health care provider within the required time frame.

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

(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
(2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article...”

A review of the same selected sample of ten denied utilization review case notices for adverse determination revealed that in all instances, the instructions on how to initiate standard and expedited appeals pursuant to Section 4904 of the New York Insurance Law, and an external

appeal pursuant to Section 4914 of the New York Insurance Law, were not included in the notices, in violation of Section 4903(e)(2) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4903(e)(2) of the New York Insurance Law by including the instructions on how to initiate a standard appeal, and an expedited appeal.

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

“...The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing... 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...”

During the examination period, the Plan received 53 denied utilization review appeals cases, from which the examiner reviewed a sample of ten. The review revealed that, in 6 instances, written acknowledgments of appeal filings were either not provided within fifteen days or were never sent to the appealing party, and in one instance, a written appeal determination was not provided within two business days of the rendering of the determination, in violation of Section 4904(c) of the New York Insurance Law.

It is recommended that SHP comply with Section 4904(c) of the New York Insurance Law by providing a written acknowledgement of the appeal filing within fifteen days of the receipt of the appeal, and by providing to its members a notice of the appeal of determination within two business days of the rendering of such determination.

Section 4904(c)(2) of the New York Insurance Law states in part:

“...a notice of the insured's 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 article, of the

external appeal process established pursuant to title two of this article and the time frames for such external appeals.”

A review of a selected sample of ten appeals of utilization review adverse determination case notices revealed that in 5 instances the notices did not include the insured’s right to an external appeal, in violation of Section 4904(c)(2) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4904(c)(2) of the New York Insurance Law by including a notice of the insured's right to an external appeal process in its final determination letters sent to its members.

Furthermore, Part 410.9(e)(2) of Insurance Regulation 166 (11 NYCRR 410) states in part:

“Each notice of a final adverse determination of an expedited or standard utilization review appeal under section four thousand nine hundred and four of the Insurance Law shall be in writing, dated and include the following:
“(2) a clear statement that the notice constitutes the final adverse determination”

A review of the same selected sample of ten utilization review determination case notices revealed that in two instances, the notice did not include a clear statement that the notices constitute the final adverse determination as required by Part 410.9(e)(2) of Insurance Regulation 166 (11 NYCRR 410).

It is recommended that the Plan comply with Part 410.9(e)(2) of Insurance Regulation 166 (11 NYCRR 410) by including a clear statement that the notice constitutes the final adverse determination in the final determination letter sent to the members.

E. Affordable Care Act (“ACA”) Compliance

Out of Network Claims

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

Part 400.5(b)(2)(3) of Financial Services Regulation (23 NYCRR 400) states in part:

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

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

(3) Provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall:

(i) explain that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or health care provider;

(ii) explain that the insured’s cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician or nonparticipating referred health care provider; and

(iii) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating referred health care provider bills the insured for the out-of-network service.”

While the examiner's review of paid claims did not locate any claims that triggered the captioned law, Aetna Student health noted that it did not have processes in place to communicate the required information.

It is recommended that the Plan implement processes to ensure that any out-of-network surprise bills it receives are processed in compliance with the requirements of Part 400.5(b)(2)(3) of Financial Services Regulation 400 (23 NYCRR 400).

Out-Of-Network Emergency Services

Part 400.5 (a) of Financial Services Regulation (23 NYCRR 400), states in part:

“Upon receipt of a claim for emergency services rendered by a non-participating physician a health care plan shall:

(2) If the claim is submitted by the non-participating physician, or if payment is made to the non-participating physician, provide notice to the non-participating physician describing how to initiate the independent dispute resolution process.

(3) If the health care plan pays an amount less than the non-participating physician's charge, provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall:

(i) explain that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician;

(ii) explain that the insured's cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician; and

(iii) direct the insured to contact the health care plan in the event that the non-participating physician bills the insured for the out-of-network service.”

During the examiner's review of claims processing, it was noted that there were 98 claims for out-of-network emergency services. A review of a sample of the claims revealed that the Plan's EOBs and the letters sent to insureds and providers were not in compliance with Part 400.5 (a) of Financial Services Regulation (23 NYCRR 400), as stated above.

It is recommended that the Plan's out-of-network emergency services notices and explanation of benefits include the information required by Part 400.5(a) of Financial Services Regulation (23 NYCRR 400).

Out-Of-Network Referral

Section 4904(a-2) of the New York Insurance Law states in part:

“An insured or the insured's designee may appeal an out-of-network referral denial by a health care plan by submitting a written statement from the insured's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, provided that:

(1) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the insured for the health service; and

(2) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service.”

The examiners obtained and reviewed seven (7) appeal letters sent to members that met the criteria for Out-Of-Network utilization review denials. During the review, it was noted that; in violation of Section 4904(a-2) of the New York Insurance Law, the letters did not include a provision advising members of the availability of in-network provider (s) with the appropriate training and experience to meet the particular health care needs of the insured, and who would be able to provide the requested health service.

It is recommended that the Plan comply with Section 4904(a-2) of the New York Insurance Law by advising the members in the utilization review denial letters the availability of in-network provider(s) with the appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service in its final adverse determination letters.

7. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Corporate Governance</u>	
It is recommended that the Plan, as a best practice, and in conformance with the Not-For-Profit Corporation Law - Section 621(a), keep minutes of quarterly and annual board meetings.	7
B. <u>Third Party Agreements</u>	
It is recommended that the Plan include a requirement in its service agreement with Aetna that Aetna annually provide a Service Organization Control 2 (“SOC2”) Certification relating to, at minimum: IT security, availability, processing integrity, confidentiality, and privacy.	8
C. <u>Accounts and Records</u>	
i. It is recommended, as a best practice, that the Plan conform with the requirements of Sections 1505 of the New York Insurance Law by ensuring that fees allocated to the Plan by the University are fair and reasonable and that expenses allocated to the Plan are determined on an equitable basis in conformity with customary accounting practices.	10
ii. It is also recommended, as a best practice, that the Plan conform with Part 106.6 of Insurance Regulation No. 30 (11 NYCRR 106.6) by maintaining proper records to support the allocation percentages used for its expenses.	10
D. <u>Investment and Cash Management</u>	
It is recommended, as a best practice, that a separate cash account be maintained apart from the University.	11

<u>ITEM</u>	<u>PAGE NO.</u>
E. <u>Claims Unpaid</u>	
i. It is recommended that the Plan include the capitation claims expense payment in the calculation of the unpaid claims reserve.	16
ii. It is further recommended that the Plan use the Department approved percentages of 14.5% for medical/hospital benefits and 5.0% for prescription drug benefits, respectively, when calculating its unpaid claims reserve.	16
F. <u>Prompt Payment of Claims</u>	
i. It is recommended that the Plan require its third-party claims administrator, Aetna, to implement appropriate procedures to ensure that claims are processed in compliance with the timeframes mandated by Section 3224-a of the New York Insurance Law.	18
ii. It is recommended that the Plan establish a procedure wherein the Plan calculates and pay interest, where applicable, in compliance with Section 3224-a(c)(1) of the New York Insurance Law.	19
G. <u>Grievances.</u>	
i. It is recommended that the Plan comply with Section 4802(d) of the New York Insurance Law by providing its members with an acknowledgement notice of the complaint within the requisite time frame.	20
ii. It is recommended that the Plan comply with Section 4802(g)(3) of the New York Insurance Law by including appeal procedures and forms within its complaint determination letters.	20
H. <u>Explanation of Benefits Statements</u>	
i. It is recommended that the Plan comply with the requirements of Sections 3234(a) and (b)(7) of New York Insurance Law by including a description of the time limit for external appeal in the EOB form.	22

<u>ITEM</u>	<u>PAGE NO.</u>
H. <u>Explanation of Benefits Statements</u>	
ii. It is recommended that the Plan comply with Section 4802(b)(1) of the New York Insurance Law by including a provision for subscribers' grievance rights. It is noted that in response to this finding, the Plan updated its EOBs to include the provision for subscribers' grievance rights, in compliance with Section 4802(b)(1) of the New York Insurance Law.	22
iii. It is recommended that the Plan update the "Resource Available to Help" section of its Explanation of Benefit forms so that subscribers are directed to the New York State Department of Financial Services.	23
I. <u>Utilization Review</u>	
i. It is recommended that the Plan comply with Section 4903(b)(1) of the New York Insurance Law by providing a written notice of determination to the insured or insured's designee and the insured's health care provider within the required time frame.	23
ii. It is recommended that the Plan comply with Section 4903(e)(2) of the New York Insurance Law by including the instructions on how to initiate a standard appeal, and an expedited appeal.	24
iii. It is recommended that SHP comply with Section 4904(c) of the New York Insurance Law by providing a written acknowledgement of the appeal filing within fifteen days of the receipt of the appeal, and by providing to its members a notice of the appeal of determination within two business days of the rendering of such determination.	24
iv. It is recommended that the Plan comply with Section 4904(c)(2) of the New York Insurance Law by including a notice of the insured's right to an external appeal process in its final determination letters sent to its members.	25
v. It is recommended that the Plan comply with Part 410.9(e)(2) of Insurance Regulation 166 (11 NYCRR 410) by including a clear statement that the notice constitutes the final adverse determination in the final determination letter sent to the members.	25

ITEM**PAGE NO.**

- J. Affordable HealthCare Act (“ACA”) Compliance.
- i. It is recommended that the Plan implement processes to ensure that any out-of-network surprise bills it receives are processed in compliance with the requirements of Part 400.5(b)(2)(3) of Financial Services Regulation 400 (23 NYCRR 400). 27
 - ii. It is recommended that the Plan’s out-of-network emergency services notices and explanation of benefits include the information required by Part 400.5(a) of Financial Services Regulation (23 NYCRR 400). 28
 - iii. It is recommended that the Plan comply with Section 4904(a-2) of the New York Insurance Law by advising the members in the utilization review denial letters the availability of in-network provider(s) with appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service in its final adverse determination letters. 28

Respectfully submitted,

Hussein Agouda
Insurance Examiner, CFE

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

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

Hussein Agouda

Subscribed and sworn to before me
This ____ day of _____ 2020.

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:

Hussein Agouda

as a proper person to examine the affairs of the

Cornell University (Student Health Plan)

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

Plan

with such other information as he shall deem requisite.

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

this 5th day of April, 2017

*MARIA T. VULLO
Superintendent of Financial
Services*

By:



*Lisette Johnson
Bureau Chief
Health Bureau*

