

MARKET CONDUCT REPORT ON EXAMINATION

OF

OXFORD HEALTH INSURANCE, INC.

AND

OXFORD HEALTH PLANS (NY), INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT

APRIL 3, 2012

EXAMINER

BRUCE BOROFSKY, CFE

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of the examination	2
2.	Description of the Companies	3
3.	Executive summary	4
4.	Cooperation and facilitation of the examination	5
5.	Policyholder service	6
6.	Prompt payment of claims	6
7.	Claims processing	11
8.	Explanation of benefits statements	16
9.	Usual, customary and reasonable	18
10.	Special investigations unit	21
11.	Utilization review	22
12.	Compliance with prior reports on examination	30
13.	Summary of comments and recommendations	33



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

April 3, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with instructions contained in Appointment Numbers 30356 and 30357, both dated September 21, 2009, and annexed hereto, I have made an examination into the affairs of Oxford Health Plans (NY), Inc., a for-profit individual practice association model health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law and its subsidiary, Oxford Health Insurance, Inc., an accident and health insurance company licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the home office of Oxford Health Plans (NY), Inc. and Oxford Health Insurance, Inc., located at 48 Monroe Turnpike, Trumbull, Connecticut.

Wherever the designation “OHP” appears herein, without qualification, it should be understood to indicate Oxford Health Plans (NY), Inc.

Wherever the designation “OHI” appears herein, without qualification, it should be understood to indicate Oxford Health Insurance, Inc.

Wherever the designations “Oxford” or the “Companies” appear herein, without

qualification, they should be understood to indicate both, Oxford Health Plans (NY), Inc. and Oxford Health Insurance, Inc., collectively.

The Parent of the Companies is Oxford Health Plans, LLC, while the ultimate parent is UnitedHealth Group, Inc.

Wherever the designation, the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services. On October 3, 2011, the New York State Department of Insurance merged with the New York State Banking Department to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

A comprehensive market conduct examination of OHP and OHI was conducted as of September 30, 2001, and filed on November 20, 2002. A special market conduct examination conducted as of September 30, 2004, and filed as of November 10, 2005, reviewed certain OHP and OHI underwriting and rating practices. A financial condition examination was conducted as of December 31, 2007 and filed as of April 27, 2009. This market conduct examination covers the period October 1, 2001 through December 31, 2008. Events subsequent to this date were reviewed where deemed appropriate by the examiner. A review was also made to ascertain what actions were taken by the Companies in regard to comments and recommendations contained in the prior market conduct reports on examination.

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

2. DESCRIPTION OF THE COMPANIES

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

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

On July 29, 2004, Oxford’s ultimate parent Oxford Health Plans, LLC was acquired by UnitedHealth Group, Inc. (“United”). Oxford Health Plans, LLC is a subsidiary of United.

3. EXECUTIVE SUMMARY

The results of this examination revealed operational deficiencies that occurred during the examination period. The most significant findings of this examination include the following:

- Oxford violated New York Insurance Law §310(a)(3) by failing to consistently provide complete and accurate information or to respond to the examiner's requests in a timely manner.
- Oxford failed to enforce its contractual grace period.
- The following illustrates the calculated number of occurrences in which OHP violated the various Sections of 3224-a of the New York Insurance Law (Prompt Pay Law), during the period January 1, 2008 to December 31, 2008:

Part (a)	15,007	Part (b)	2,962	Part (c)	5,939
----------	--------	----------	-------	----------	-------

- The following illustrates the calculated number of occurrences in which OHI violated the various Sections of 3224-a of the New York Insurance Law (Prompt Pay Law), during the period January 1, 2008 to December 31, 2008:

Part (a)	58,267	Part (b)	2,990	Part (c)	15,118
----------	--------	----------	-------	----------	--------

- OHP failed to comply with New York Insurance Law §3234 in 105,224 instances, while OHI failed to comply with New York Insurance Law §3234 in 194,200 instances, when the Companies failed to send EOBs for claims from participating providers that had been denied for administrative reasons.
- Oxford utilized claim adjudication codes that were not, in all cases, clear, full and accurate.
- Oxford failed to pay its contractual Usual, Customary and Reasonable fee in those instances where it based the reimbursement on an Ingenix region not reflective of the region where the medical service was performed.
- The Companies had an eighteen percent (18%) violation rate noted during the examiner's testing of a sample of Utilization Review cases for compliance with Section 4903 of the New York Insurance Law (for OHI) and Section 4903 of the Public Health Law (for OHP). It was noted that the violations were due to insufficient controls within the Utilization Review process.
- The Companies had a twenty-five percent (25%) violation rate noted during the examiner's testing of a sample of Utilization Review cases for compliance with Section 4904 of the New York Insurance Law (for OHI) and Section 4904 of the Public Health

Law (for OHP). It was noted that the violations were due to insufficient controls within the Utilization Review process.

- In certain instances, Oxford utilized language within their appeal notification letters that was not clear or accurate.

4. COOPERATION AND FACILITATION OF THE EXAMINATION

New York Insurance Law §310(a)(3) states:

“The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so.”

During the examination, there were several occasions where Oxford failed to provide complete and accurate information or failed to respond in a timely manner. Some examples are as follows:

- Certain claim information was not provided in the format requested by the examiner.
- During the testing of Utilization Review, Oxford was requested to supply copies of the explanation of benefits statements (“EOBs”) that accompanied the files under review. After detailed analysis of the documents that were provided in response to the request, multiple irregularities were noted by the examiner. When these were pointed out to Oxford, the examiner was advised that the documents were not replicas of the actual EOBs that had been issued. Several months later, the actual documents were provided.
- During the examination, Oxford disputed the examiner’s understanding of the circumstances under which explanation of benefits statements were sent. Thereafter, it was shown that the examiner’s understanding was, in fact, accurate.
- During the testing of claims paid using a “Usual and Customary” methodology, Oxford was given a sample of claims and asked to explain and document the rationale for the amount paid. In several instances, the Companies’ initial response was inaccurate, and in all cases, Oxford failed to include documentation until additional requests were made.

It is recommended that Oxford comply with New York Insurance Law §310(a)(3) and provide complete and accurate examination responses in a timely manner.

5. POLICYHOLDER SERVICE

Oxford's policyholder contracts provide groups and members with a thirty (30) day grace period in which to pay premiums. The contracts stipulate that if premiums are not paid within the grace period, coverage will be terminated. The examiner selected a sample of twenty groups that had been terminated by Oxford during calendar year 2008, in order to test Oxford's application of this policy requirement. Of those twenty groups, two failed to pay their premiums timely, within the thirty days, but were permitted to maintain their policies beyond the contractual period.

This inaction can impact providers, as when Oxford finally does terminate delinquent groups, it retroactively applies the termination date and reclaims all of the dollars that may have been paid on claims after the coverage lapse. This passes to the providers the responsibility and expenses for fee collection from the terminated member. Timely termination at the conclusion of the grace period would shorten the period in which providers are forced to rely on the assumption that insurance coverage is in force for the treatments being provided.

It is recommended that Oxford enforce its contractual grace period.

6. PROMPT PAYMENT OF CLAIMS

New York Insurance Law §3224-a, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

New York Insurance Law §3224-a(a) states in part:

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

New York Insurance Law §3224-a(b) states in part:

“In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to ...article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

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

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

The examination included selecting statistical samples to determine whether claims were paid appropriately, pursuant to New York Insurance Law §3224-a. First, medical and hospital claims from non-New York groups, non-New York providers, and Medicare Advantage contracts were excluded from the January 1, 2008 through December 31, 2008 general claim population. Then, for New York Insurance Law 3224-a(a), all claims that were not paid within 45 days during the period January 1, 2008 through December 31, 2008, were segregated. From that segregated population of potential New York Insurance Law 3224-a(a) violations, those claims that were qualified for interest, as defined by New York Insurance Law 3224-a(c), were further segregated. Samples were selected for testing from each of the segregated populations. For New York Insurance Law 3224-a (b), claims that took greater than 30 days to deny or request additional information were segregated from the same general claim population and a third sample was selected for testing.

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

Summary of OHP Violations

	3224-a(a)	3224-a(b)	3224-a(c)
Eligible population	113,915	54,956	76,298
Sample size	167	167	167
Number of violations	22	9	13
Calculated violation rate	13.17%	5.39%	7.78%
Upper violation limit	18.30%	8.81%	11.85%
Lower violation limit	8.04%	1.96%	3.52%
Calculated claims in violation	15,007	2,962	5,939
Upper limit claims in violation	20,850	4,844	9,040
Lower limit claims in violation	9,163	1,080	2,839

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

Summary of OHI Violations

	3224-a(a)	3224-a(b)	3224-a(c)
Eligible population	231,682	71,338	132,876
Sample size	167	167	167
Number of violations	42	7	19
Calculated violation rate	25.15%	4.19%	11.38%
Upper violation limit	31.73%	7.23%	16.19%
Lower violation limit	18.57%	1.15%	6.56%
Calculated claims in violation	58,267	2,990	15,118
Upper limit claims in violation	73,513	5,158	21,517
Lower limit claims in violation	43,021	822	8,718

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

It should be noted that the extrapolated number of violations in each case relates to the population of claims used to obtain each of the samples, as described above. The total population of claims that were processed within the above three categories, during the same twelve month period, was 5,925,397 for OHP and 8,997,853 for OHI.

It is recommended that Oxford comply with New York Insurance Law §3224-a and process all claims within the required time parameters, paying interest where appropriate. It is further recommended that Oxford pay interest on those claims within the Prompt Pay population identified in the foregoing section of this report.

The Companies pay interest to all providers, including those who operate outside of New York State. Such providers are not covered under the New York Prompt Pay Law, and as such, the payment of interest to those providers increases unnecessarily, the expenses of the Companies; expenses that will ultimately be passed along to the policyholders. While some of

these providers may be subject to “Prompt Pay” requirements in the states where they are located, not all are.

It is recommended that, except in those instances where it is specifically mandated by statute, payments for prompt pay interest not be proffered.

Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2) states in part:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain...

(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.”

It was also noted during the Prompt Pay review that in many cases, claims that had been denied by Oxford for various reasons had been overturned to pay, often based on information received beyond the deadline maintained by Oxford for the timely filing of claims within its provider contracts. As a result, though Oxford was not required to make the payments, Oxford did so, it maintains, for business reasons. Oxford did not pay interest in these cases and when asked why, Oxford maintained that the providers had agreed to forego such interest. While it is acceptable for Oxford to waive its own policy and pay claims it is not contractually obligated to pay; and while the provider is permitted to forego such interest in these cases, Oxford is required, under Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2) to maintain documentation proving the providers’ agreement to forego the interest payment.

It is recommended that when providers agree to forego a Prompt Pay interest payment,

Oxford maintain documentation to support that agreement.

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

<u>Period Covered</u>	<u>Financial Penalty</u>	
	<u>OHP</u>	<u>OHI</u>
October 1, 2005 – March 31, 2006	\$15,000	\$ 4,100
April 1, 2006 – September 30, 2006	\$ 8,000	\$ 4,100
October 1, 2006 – March 31, 2007	\$12,900	\$ 5,200
April 1, 2007 – September 30, 2007	\$11,600	\$ 4,300
<u>October 1, 2007 – September 30, 2008</u>	<u>\$30,700</u>	<u>\$ 8,000</u>
Totals	<u>\$78,200</u>	<u>\$25,700</u>

7. CLAIMS PROCESSING

Upon receipt by Oxford, a claim may be processed electronically or it may be processed manually, depending upon its complexity. After processing, either a Remittance Advice or an Explanation of Benefits form (“EOB”) is prepared using adjudication codes to explain how the claim was processed. The codes may also indicate the member's financial responsibility for the claim. In order to review Oxford's claim processing for financial and processing accuracy, the examiner selected samples of claims based on adjudication codes. The following was noted during the review:

- In one tested sample, a claim for a piece of Durable Medical Equipment was inappropriately “bundled” into the other procedures that had been performed and no payment was made. The error was noted by Oxford and corrected. The examiner increased the sampling to review multiple claims for that piece of equipment and noted an additional five providers that had claims denied

inappropriately that were never corrected by Oxford. Oxford maintained these errors were all the result of a single claims processor.

- In another instance, a claim that included two injections had one of the two injections denied erroneously. The error was noted when the provider called to complain. The examiner extracted additional denied claims that had multiple injections and tested them to determine whether other uncorrected errors existed. Of the nine claims tested, there were similar uncorrected errors on four.

It is recommended that when Oxford becomes aware of processing errors, it expands its review to enable it to locate and correct all claims with similar errors.

Other items noted by the examiner include the following:

- In two instances, members had a 50% penalty applied to their claims because the doctor visits were not pre-authorized, as was required under the particular circumstances involved. However, based upon the members' contract, the penalty should have been ten percent. These errors had not been detected by Oxford.
- One instance was noted wherein a group changed its benefits, but the benefit changes were not implemented for six weeks. Oxford discovered this error itself and performed a project to correct the claims that were involved.
- Two instances were noted where labs were paid a capitated fee, while the contracted arrangement called for these services to be paid as fee-for-service.

Oxford utilizes an independent third party administrator ("TPA"), OmniClaim, to negotiate claim discounts from providers who have provided services to an Oxford member, but do not participate in Oxford's network. In order to obtain the discounts, OmniClaim sends a letter to the provider that states the following:

"In exchange for the discount, payor agrees to reimburse to provider within 10 business days from the date on which a signed copy of this agreement is received by OmniClaim."

Part 216.6 of Department Regulation No. 64 (11 NYCRR 216.6) states in part:

“(a) In any case where there is no dispute as to coverage, it shall be the duty of every insurer to offer claimants, or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions...”

Further, New York Insurance Law §2403 states:

“No person shall engage in this state in any trade practice constituting a defined violation or a determined violation as defined herein.”

A review of claims paid through OmniClaim showed that the claims were paid no more quickly than those that were not paid through OmniClaim. In fact, one of the claims sampled under the testing for compliance with New York’s Prompt Pay Law requirements was paid outside the parameters of that Law because of negotiations with OmniClaim. Not paying the claim when all information is available would be a violation of Part 216.6 of Department Regulation No. 64 (11 NYCRR 216.6) and thus Section 2403 of the New York Insurance Law.

It is recommended that Oxford not permit its TPA Omniclaim to use the prompt payment of claims in exchange for providers’ acceptance of a discount on their claims.

Oxford also utilizes the “Beech Street Program” (“Beech Street”), a provider network owned by another independent company, Viant Health Payment Solutions (“Viant”). Through the use of Viant’s network, Oxford can reduce the amount it pays to non-participating providers, in return, Viant receives a percentage of the discounted amount. During the review of claims, it was noted that two providers who had discounts applied to their claims due to their alleged participation with the Viant network did not actually belong to the network. As a result, these providers were underpaid and Viant received fees erroneously. Applying such discounts

inappropriately is also a violation of Department Regulation No. 64 (11 NYCRR 216.6), as cited above.

When advised of these findings, Oxford detailed for the examiner the processes used by Viant to ensure the integrity of its network and noted that Viant had previously launched an initiative to re-contract with its participating providers. Regardless, the possibility exists that additional providers may have inappropriately had a Beech Street discount applied, prior to Beech Street's record update.

It is recommended that Oxford implement procedures to ensure that Beech Street discounts are applied appropriately.

Health care providers may submit claims to Oxford using electronic data interchanges ("EDI") pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. §§ 1320d-1320d-9 and the regulations and standards adopted. Once a provider decides to use an electronic process to submit a claim, HIPAA transaction standards apply to the submission and processing of the claim.

Providers start the process by submitting claims to electronic clearinghouses. Some providers may use a clearinghouse they contract with, but eventually the claims reach a clearinghouse under contract by Oxford. The Oxford clearinghouse tests the submissions for certain criteria. Those that do not meet the criteria are deemed to be incomplete, are rejected and sent back to the provider or the provider's clearinghouse with an explanation for why the transaction failed.

Those that do meet the criteria are passed to Oxford where they are tested for additional criteria. Once there, but prior to entering Oxford's claims adjudication system and receiving a claim number, the claims are subject to additional HIPAA validation. Claims that do not meet the appropriate standards are again rejected back to the provider or to its clearinghouse. Those that do meet the standards may now enter Oxford's claim system, where they finally receive a claim number. Still, though, such claims may be rejected for certain reasons.

As noted, there are two opportunities for claims to be rejected after they have been passed along to Oxford: before a claim number is affixed and after. In either case, when a provider calls Oxford seeking information about a rejected claim, Oxford has an obligation to make the information available. At the time of this examination, Oxford's procedures for providing such information were not clear and as a result, some providers may have been advised that the claims had never been received.

It is recommended that Oxford update its Customer Service documentation in order to ensure that the Customer Service Representatives consistently search the Oxford intake system for rejected claims when providers call seeking information about a claim not found within Oxford's claim adjudication system.

8. EXPLANATION OF BENEFITS STATEMENTS

New York Insurance Law §3234(a) states in part:

“(a) 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...”

The explanation of benefits statement (“EOB”) is a critical document that assists the insured in understanding their liability for medical services received. By informing the patient of the services being billed under their name, it can also serve to ensure that the services being charged actually occurred.

Once claims enter Oxford’s claims adjudication system, they can be denied for administrative reasons, such as for failure to have obtained a prior authorization, or for failure to have submitted the claim on a timely basis. The examination revealed that when claims submitted by participating providers have been denied in this manner, Oxford does not, in all cases, comply with the requirements of New York Insurance Law Section 3234 and send EOBs. The examination revealed that there were 105,224 such violations for OHP and 194,200 such violations for OHI during calendar year 2008. Additionally, there were circumstances where, instead of sending EOBs, Oxford denied claims for a lack of medical necessity. In those instances, Oxford considered the letters of denial for a lack of medical necessity to suffice. These letters, however, did not include a detailed description of the services performed or the provider’s charge or the amount or percentage payable under the policy. As such, they did not fulfill the statutory requirements for an EOB.

It is recommended that Oxford comply with New York Insurance Law §3234(b) and send Explanation of Benefits statements to policyholders in those cases where full reimbursement has not been made for claims to participating providers.

It should be noted that a similar recommendation was included in the prior market conduct report on examination, dated September 30, 2001, but the cause for the violation was not the same.

New York Insurance Law §3234(b)(6) states in part:

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

(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...”

During the review of claims, it was noted that the adjudication codes “A950” and “D950”, which were used to reverse claims and reclaim funds already paid, were explained simply by stating “Overpayment Recovery”. Another code, “T520” advises the member that the claim lacks sufficient information to complete the adjudication, but does not specify what information should be included. Oxford deems these claims to be deferred. Code D20 is used to explain to members that their claims are being denied because information that Oxford had requested to clarify the claim was not received. The text, however, does not describe the information that had been requested, instead referencing the member to the original letter. These explanations are insufficient to explain the adjudications and they should be expanded to include such cause. In certain instances, the Companies use the code “A79” to advise participating providers that they are being paid according to a Usual and Customary methodology when the providers are, in fact, being paid according to their contracts. As such, the explanation is

inaccurate.

It is recommended that Oxford comply with New York Insurance Law §3234(b)(6) and ensure that its claim adjudication explanations include full and accurate explanations for the causes of the adjudication.

Part 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) states in part, the following:

“To enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim.”

It was noted that when Oxford receives paper claims in hard copy that lack sufficient information to permit an adjudication of the claim, Oxford sends a letter to the provider and to the member informing them that in order to get their claim paid, the missing information must be submitted. In violation of Part 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) and Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2), as cited earlier in the report, Oxford does not maintain a copy of any communications that have been sent to the member.

It is recommended that Oxford comply with Part 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) and Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2), and maintain a copy of all communications that have been sent to a member.

9. USUAL, CUSTOMARY AND REASONABLE

In many cases, Oxford pays for out-of-network care through the use of a Usual,

Customary and Reasonable fee (“UCR”). Oxford, in its certificate, defines its UCR fee, as follows:

“The UCR fee is a compilation of the maximum allowable fees for covered medical services, supplies and drugs. The maximum allowable fee on the UCR schedule will be the lesser of (1) the amount charged, (2) the amount the provider agrees to accept as reimbursement for the particular covered services, supplies and/or drugs, or (3) the amount that in our discretion is the usual, customary and reasonable fee for particular covered services, supplies and/or drugs. When we determine the usual, customary and reasonable fee, Oxford will consider data compiled by, and guidelines from, Ingenix, Medicare and other sources recognized by the health insurance industry and federal government payers of health care claims as a basis for evaluating and establishing fees for covered services, supplies and drugs. Normally, the data utilized to compile the UCR fee schedule will be based upon the geographic location where the services are provided or a comparable locale. There will be instances where national data will be utilized when the data source does not compile data geographically. The data we choose to consider when establishing a UCR fee schedule will be based upon the level of reimbursement purchased by an employer for the benefit of the employers group plan.”

The selection of a UCR amount is critical because whatever amount Oxford chooses to pay leaves the remaining balance to be paid by the member. Thus, if Oxford is paying less than contractually required, the amount owed by the member is comparably higher than contractually appropriate.

As noted above, when Oxford determines the UCR fee, it may rely on data compiled by Ingenix. Oxford notes also that it may utilize the geographical location where the services are provided or a comparable locale. The Ingenix data contains reimbursement rates based on region and the examiner’s review noted that when Oxford relies on the Ingenix fees, it limits its use of those fees to only a small number of geographical areas. When a claim is from any area outside those assigned geographical areas, Oxford establishes all payments based on a single region. The examiner’s review showed that the use of the fees from this single region is not consistently comparable to the region where the service was actually performed. Thus, the rate being reimbursed may or may not fit the definition of “Customary” as defined within the Oxford

contract and thus, Oxford is not in compliance with its contract language.

It is recommended that where Oxford is going to utilize a national price setting database to establish a UCR rate for out-of-network treatment, it utilizes the regional area defined by such database and/or update its Certificate language to provide a clearer explanation of its reimbursement methodology.

It should be noted that, subsequent to this examination, Fair Health, Inc., an independent not-for-profit agency, was established to serve a function similar to that of Ingenix and the use of Ingenix by Oxford has been discontinued. In its place, Oxford moved to a reimbursement methodology for direct pay and small groups of using 140% of the reimbursement amounts established by the Center for Medicare Services (“CMS”). Large groups have the option of providing their covered members with either the Medicare 140% methodology or they may purchase the use of Fair Health, Inc. at a higher cost. Where Fair Health, Inc. is used, reimbursement continues to be based on a limited number of regions.

The examiner also performed testing to confirm that the payment methodology Oxford used to establish out-of-network reimbursement was in compliance with its contract requirements. Accordingly, the examiner selected a sample of 45 claims that indicated through the adjudication associated with the claim that they had been remunerated through a Usual, Customary and Reasonable payment methodology. The results of that testing showed the following:

- Three providers were compensated improperly as they were assigned to an incorrect fee region.

- One claim was adjudicated to pay all or a portion of the claim with a UCR fee although the provider was in fact participating in an Oxford network.
- One claim was paid inaccurately due to human error.
- Three claims contained either incorrect adjudication codes, incorrect authorization codes or both, although each was paid properly in accordance with the provider's contract, in spite of the error. The use of the adjudication codes, however, is tied to the explanation for how the claim is paid to both the provider and to the member and is an important part of the EOB.

It is recommended that Oxford ensure that providers are being remunerated properly according to their appropriate fee region or participating agreement and that the adjudication codes clearly and accurately describe the adjudication cause.

10. SPECIAL INVESTIGATIONS UNIT

During the examination period and prior, Oxford conducted audits of multiple providers to test for abusive billings. The letters sent to the providers announcing the audits stated, "*As part of Oxford's practice of evaluating and understanding the care provided to our Members...*" and "*the audit will include a review of the care provided to these patients (sic) care ...*" These phrases are misleading in that only the medical billing and coding was reviewed.

The examiner's review of a sample of files indicated that one doctor did in fact believe the files were being reviewed for patient care and was surprised when a demand for payment was received.

It is recommended that Oxford ensure that audit notification letters sent to providers accurately reflect the purpose of the audit.

New York Insurance Law §3224-b(b)(1) states in part:

“...Other than recovery for duplicate payments, a health plan shall provide thirty days written notice to physicians before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims to such physicians. Such notice shall state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.”

The audit procedure utilized by Oxford to test for abusive billing included testing a sample of claims submitted by the provider to ensure that the billing was appropriate under the circumstances. At the conclusion of the audit, where the Companies determined that abusive billing had taken place, the Companies established the amount of overpayment by extrapolating the results of the audit into the population of claims submitted by the provider for a period ending with the date the audit initiated, going back to the onset of the audit conclusion’s statutory limit deadline. The use of extrapolation does not permit specific identification of the claims being reversed however, as is required by the above cited Law.

11. UTILIZATION REVIEW

Utilization review is the process through which a health insurer makes its initial determination whether the treatment being received by its members is medically necessary. These initial determinations can be made either prospectively, concurrently, or retrospectively and when deemed to be not medically necessary, treatments are not covered by the insurer. OHI’s utilization review program is regulated by New York Insurance Law Section 4903, while New York Public Health Law Section 4903, applies to OHP.

Oxford maintains a listing of cases opened by its Utilization Management Department, the department which conducts Oxford's utilization reviews. During the course of the examination, a small number of cases were noted that were not properly logged by Oxford's Utilization Management Department.

It is recommended that all utilization review cases be properly logged.

New York Insurance Law Section 4903 (New York Public Health Law Section 4903 is worded similarly) states in part:

“(b) 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.

(c) A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

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

(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 pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article...”

In order to test Oxford's compliance with the above cited Laws, a sample of twenty-seven (27) utilization review cases was selected at random from both Companies and reviewed. In performing the sample selection, twenty-four (24), or ninety percent (90%), involved denials of medical treatment. The following violations were noted:

- One violation of New York Insurance Law §4903(b), failure to make a timely decision regarding a request for pre-authorization;
- One violation of New York Insurance Law §4903(c), failure to make a timely decision regarding a concurrent treatment request;
- Two violations of New York Insurance Law §4903(e), failure to send an initial adverse determination notice; and
- One violation of New York Insurance Law §4903(e)(1), failure to include a clinical rationale in the initial adverse determination notice.

Each of the above cited violations involved cases where the treatments were denied in whole or in part. This means that there were five (5) violations out of the twenty-seven (27) denied utilization review cases tested; a violation rate of eighteen percent (18%). This error rate appears to be outside of acceptable parameters.

The examiner's review of the procedures followed by Oxford's Utilization Management Department revealed that key controls, which could have prevented the foregoing violations, were deficient. These include the following:

- The only auditing that took place consisted of management's routine auditing of its own staff's work in regard to verifying statutory compliance. This is insufficient to ensure objectivity;
- There was no daily inventory of open cases which would allow management to monitor when statutory deadlines were approaching;
- There was no method for management to reconcile the number of adverse determination letters sent, to the number of cases denied; and
- As to the record retention issue, there was no policy requirement that, when determinations were sent via fax, that the "send confirmation" sheets be maintained.

It is recommended that Oxford Health Plans (NY), Inc. and Oxford Health Insurance, Inc. implement controls to ensure that their Utilization Management Departments are in compliance with New York Public Health Law Article 49 and New York Insurance Law Article 49, respectively.

Oxford utilizes a third party, CareCore, to manage certain aspects of its radiology services. During the examination, it was noted that when CareCore denied a treatment as not medically necessary; rather than describe the member's appeal rights on the denial notification, the document directed the members and providers to the description of the appeal rights that were contained in the original denial notification. This is a violation of New York Insurance Law §4903(e)(2) for OHI, enumerated above, and New York Public Health Law §4903(5)(b) for OHP.

It is recommended that Oxford ensure that its third party administrators provide full appeal rights on their medical denial notification. It should be noted that Oxford has complied with this recommendation.

When an insurer makes a determination that the treatment being performed is not medically necessary, New York Insurance Law establishes a right of appeal. .

New York Insurance Law Section 4904, applicable to OHI (New York Public Health Law Section 4904, applicable to OHP, is worded similarly), states:

“(a) An insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, may appeal an adverse determination rendered by a utilization review agent.

(a-1) An insured or the insured's designee may appeal an out-of-network denial by a health care plan by submitting: (1) 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 services sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and (2) two documents from the available medical and scientific evidence, that the out-of-network health service is likely to be more clinically beneficial to the insured than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal.

Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable.

(c) A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. 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; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and

(2) 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.

(d) Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

(e) Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

Part 56.3(a) of Department Regulation No. 183 (11 NYCRR 56.3) states the following, in part:

“A claim or request for coverage of reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect shall not be considered by a health plan to be cosmetic.”

The examiner selected thirty-two (32) appealed denials from both Companies arbitrarily for review. The results of the testing revealed that seven (7) appeals contained at least one statutory violation of New York Insurance Law Section 4904, and one contained a violation of Part 56.3(a) of Department Regulation No. 183 (11 NYCRR 56.3), “Health Claims Processing and Procedure”.

With eight (8) errors out of the thirty-two (32) appeals tested, this is a statutory violation rate of 25%. There were an additional six appeals that contained procedural errors related to the processing of appeals. In some cases, there were multiple violations within a single file.

New York Insurance Law §4903(f) for OHI and New York Public Health Law §4903(6) for OHP state in part:

“In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the insured’s health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination...”

During the examination period, Oxford maintained a policy wherein, when an appeal for a CareCore denial was received, Oxford would turn the request over to CareCore for a reconsideration review under New York Insurance Law §4903(f). This is not appropriate in that

reconsideration under the above cited Law is a right granted to the physician and it should not be used to preclude an official appeal when an appeal is requested.

Oxford's internal policy on expedited appeals states:

“An appeal is considered expedited when a condition or situation is urgent and has a potential to become an emergency in the absence of treatment. This applies if the Member and/or their physician believe that the decision, or delay in making a decision may have an adverse impact on the Member's health and well-being.”

The policy further states:

“If Oxford determines not to grant an expedited request, the appeal will be redirected through the standard appeals process.”

Under the circumstances cited within Section 4904(b)(1) of the New York Insurance Law and Section 4904(2)(a) of the Public Health Law, providers are given the right to decide if a treatment can be expedited.

It is recommended that Oxford change its internal policy language to make clear those circumstances under which it may conclude that an appeal can be expedited.

Oxford's Final Adverse Determination (“FAD”) notices do not make clear the status of those denials as FADs. Specifically, Oxford makes the notification of FAD within the letter attachment, “Explanation of Appeal Rights”, under the heading *“How do I appeal this determination?”* The notification of the FAD is not an appeal right; it is a type of denial and as such, should first be imparted on the denial notification itself.

Oxford utilizes a form letter, Appeal notice “APX814.07 - New York Member and Provider Second-Level Appeal Rights” and “APX051.18 - Explanation of Member Appeal

Rights”. The examiner’s review of these documents revealed that the notices do not open with a section on “*How to appeal*”, but with “*Who can represent me for this appeal*”, which though seemingly benign, may give members the idea that they cannot represent themselves.

Both documents stipulate that a member’s provider cannot act as a designee to file an appeal without the written consent of the member except where urgent care is involved. This is clarified later in the letter and thus, is not a statutory violation but its presence at the end makes it more difficult for the member to be fully aware of their rights and obligations.

It is recommended that Oxford clarify the text within its appeal notification letters to ensure member comprehension of their appeal rights.

12. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior report on examination as of September 30, 2001, contained the following ten (10) comments and recommendations (Page numbers refer to the prior report on examination):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
	<u>Rating</u>	
1.	It is recommended that Oxford comply with New York Insurance Law §4308(b) and charge rates and utilize formulas that have been submitted to the Superintendent for approval.	5
	<i>This area was not tested during the examination.</i>	
2.	It is recommended that Oxford file its commission schedule with the Department, as required by Part 52.40(j) of Department Regulation 62 (11 NYCRR Part 52.40(j)).	5
	<i>Oxford has complied with this recommendation.</i>	
	<u>Claim Processing</u>	
3.	It is recommended that Oxford establish a balance sheet liability for the amount of its unpaid Bad Debt and Charity Pool liability for these ten facilities and pay any assessment that is due.	9
	<i>Oxford has complied with this recommendation.</i>	
4.	It is recommended that Oxford update its list of facilities upon which the assessment is due as often as is necessary to ensure it does not neglect such payments in the future.	9
	<i>Oxford has complied with this recommendation.</i>	

<u>ITEM NO.</u>		<u>PAGE NO.</u>
5.	It is recommended that Oxford re-adjudicate all claims containing a non-authorization penalty and adjust payment in cases where the penalty was improperly calculated and/or applied. Further, it is recommended that Oxford provide training on this issue to its claims processors, and customer service personnel. <i>Oxford has complied with this recommendation.</i>	10
6.	It is recommended that Oxford provide training to its claim processors or adjust its policy to ensure they understand the process of how to interpret authorizations. <i>Oxford has complied with this recommendation.</i> <u>Usual, Customary and Reasonable</u>	11
7.	It is recommended that Oxford rewrite its contract language to more specifically inform its policyholders of the amount they will reimburse for out-of-network treatment. <i>Oxford has complied with this recommendation.</i>	16
8.	It is recommended that Oxford update the HIAA/Ingenix data used to reimburse policyholders for out-of-network treatment within 60 days after the new data is received. <i>Oxford has complied with this recommendation.</i>	16
9.	It is recommended that Oxford utilize the appropriate HIAA/Ingenix area to establish the amounts it will reimburse policyholders for receiving out-of-network care. <i>This examination report contains a similar recommendation.</i>	17
	<u>Explanation of Benefit Statements</u>	
10.	It is recommended that Explanation of Benefit statements be sent to policyholders in those cases where full reimbursement has not been made for claims to participating providers. <i>This examination report contains a similar recommendation although the cause for the violation is different.</i>	17

The Special Market Conduct report on examination as of September 30, 2004, contained the following two (2) comments and recommendations (Page numbers refer to the prior report on examination):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	It is recommended that Oxford comply with New York Insurance Law §4308(b) and charge rates and utilize formulas that have been submitted to the Superintendent for approval.	4
	<i>This area was not tested during the examination.</i>	
2.	It is recommended that the Plan comply with the four percent commission rate payment limitation of Part 52.42(e) of New York Insurance Department Regulation No. 62 (11 NYCRR 52.42(e)).	5
	<i>Oxford has complied with this recommendation.</i>	

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Cooperation and Facilitation of the Examination</u>	
It is recommended that Oxford comply with New York Insurance Law §310(a)(3) and provide complete and accurate examination responses in a timely manner.	5
B. <u>Policyholder Service</u>	
It is recommended that Oxford enforce its contractual grace period.	6
C. <u>Prompt Payment of Claims</u>	
i. It is recommended that Oxford comply with New York Insurance Law §3224-a and process all claims within the required time parameters, paying interest where appropriate.	9
ii. It is further recommended that Oxford pay interest on those claims within the Prompt Pay population identified in the foregoing section of this report.	9
iii. It is recommended that, except in those instances where it is specifically mandated by statute, payments for prompt pay interest not be proffered.	10
iv. It is recommended that when providers agree to forego a Prompt Pay interest payment, Oxford maintain documentation to support that agreement.	10
D. <u>Claims Processing</u>	
i. It is recommended that when Oxford becomes aware of processing errors, it expands its review to enable it to locate and correct all claims with similar errors.	12
ii. It is recommended that Oxford not permit its TPA Omniclaim to use the prompt payment of claims in exchange for providers' acceptance of a discount on their claims.	13

<u>ITEM</u>	<u>PAGE NO.</u>
iii. It is recommended that Oxford implement procedures to ensure that Beech Street discounts are applied appropriately.	14
iv. It is recommended that Oxford update its Customer Service documentation in order to ensure that the Customer Service Representatives consistently search the Oxford intake system for rejected claims when providers call seeking information about a claim not found within Oxford's claim adjudication system.	15
E. <u>Explanation of Benefits Statements</u>	
i. It is recommended that Oxford comply with New York Insurance Law §3234(b) and send Explanation of Benefits statements to policyholders in those cases where full reimbursement has not been made for claims to participating providers. It should be noted that a similar recommendation was included in the prior market conduct report, dated September 30, 2001, but the cause for the violation was not the same.	17
ii. It is recommended that Oxford comply with New York Insurance Law §3234(b)(6) and ensure that its claim adjudication explanations include full and accurate explanations for the causes of the adjudication.	18
iii. It is recommended that Oxford comply with Part 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) and Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2), and maintain a copy of all communications that have been sent to a member.	18
F. <u>Usual, Customary and Reasonable</u>	
i. It is recommended that where Oxford is going to utilize a national price setting database to establish a UCR rate for out-of-network treatment, it utilizes the regional area defined by such database and/or update its Certificate language to provide a clearer explanation of the reimbursement methodology	20
ii. It is recommended that Oxford ensure that providers are being remunerated properly according to their appropriate fee region or participating agreement and that the adjudication codes clearly and accurately describe the adjudication cause.	21

<u>ITEM</u>	<u>PAGE NO.</u>
G. <u>Special Investigations Unit</u>	
It is recommended that Oxford ensure that audit notification letters sent to providers accurately reflect the purpose of the audit.	21
H. <u>Utilization Review</u>	
i. It is recommended that all utilization review cases be properly logged.	23
ii. It is recommended that Oxford Health Plans (NY), Inc. and Oxford Health Insurance, Inc. implement controls to ensure that their Utilization Management Departments are in compliance with New York Public Health Law Article 49 and New York Insurance Law Article 49, respectively.	24
iii. It is recommended that Oxford ensure that its third party administrators of services provide full appeal rights on their medical denial notification. It should be noted that Oxford has complied with this recommendation.	25
iv. It is recommended that Oxford change its internal policy language to make clear those circumstances under which it may conclude that an appeal can be expedited.	28
v. It is recommended that Oxford clarify the text within its appeal notification letters to ensure member comprehension of their appeal rights.	29

Appointment No. 30356

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Oxford Health Plans of New York, Inc.

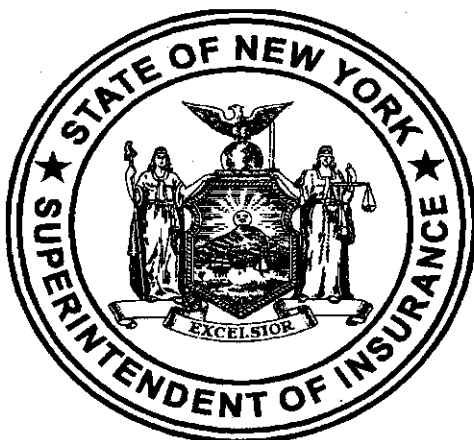
and to make a report to me in writing of the condition of the said

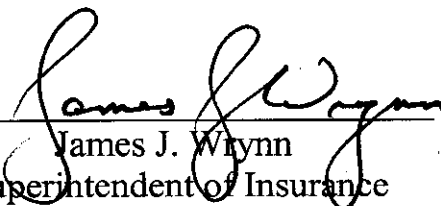
Plan

with such other information as he shall deem requisite.

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

this 21st day of September, 2009




James J. Wrynn
Superintendent of Insurance

Appointment No. 30357

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Oxford Health Insurance, Inc.

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

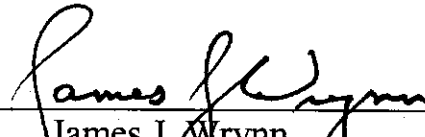
Company

with such other information as he shall deem requisite.

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

this 21st day of September, 2009




James J. Wrynn
Superintendent of Insurance