# REPORT ON EXAMINATION

# OF

# ORANGE-ULSTER SCHOOL DISTRICTS HEALTH PLAN

# AS OF

# DECEMBER 31, 2010

| | |
|---|---|
| **DATE OF REPORT** | **MAY 15, 2012** |
| **EXAMINER** | **VICTOR ESTRADA** |

## TABLE OF CONTENTS

May 15 2012

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

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30706, dated April 14, 2011, annexed hereto, I have made an examination into the condition and affairs of Orange-Ulster School Districts Health Plan, a municipal cooperative health benefit plan licensed pursuant to the provisions of Article 47 of the New York Insurance Law, as of December 31, 2010. The following report is respectfully submitted thereon.

The examination was conducted at the Plan's home office located at 163 Harriman Heights Road, Monroe, New York.

Wherever the designation, "the Plan" appears herein, without qualification, it should be understood to indicate Orange-Ulster School Districts 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. It should be noted that the New York State Insurance Department merged with the New York State Banking Department on October 3, 2011 to become the New York State Department of Financial Services.

## 1. SCOPE OF THE EXAMINATION

The previous examination of the Plan was conducted as of December 31, 2006. This examination of the Plan was a combined financial and market conduct examination and covered the four-year period from January 1, 2007, through December 31, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 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 December 31, 2010, 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 utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified 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, Statutory Accounting Principles, as adopted by the Department and NAIC 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 Plan was audited annually for the years 2007 through 2010, by the accounting firm of UHY, LLP. The Plan received an unqualified opinion in each of those years. Certain audit workpapers of UHY, LLP were reviewed and relied upon in conjunction with this examination.

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

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination.

## 2. EXECUTIVE SUMMARY

This examination uncovered certain operational deficiencies of the Plan that had an impact on the Plan's ability to comply with Article 47 and other provisions of the New York Insurance Law. Within this report, the following significant findings can be found in more detail:

- The Plan did not comply with the requirements of Section 312(b) of the New York Insurance Law when it failed to confirm that each board member had received and read the prior report on examination.
- The Plan did not comply with the requirements of Section 4707(a)(1) of the New York Insurance Law when it failed to obtain and maintain aggregate stop-loss coverage.
- The Plan did not comply with the requirements of Section 4705(e)(3) of the New York Insurance Law when it failed to obtain an annual independent actuarial opinion on the soundness of the Plan, which includes the actuarial soundness of the contribution of premium equivalent rates.
- The Plan did not comply with the requirements of Sections 4903(f) and 4910(b)(1) of the New York Insurance Law when its denial letters did not accurately and completely reflect the member's rights.
- The Plan did not comply with the requirements of Section 3234(b)(7) of the New York Insurance Law in that it was ambiguous in describing the time limit in which an appeal may be brought.

## 3. DESCRIPTION OF THE PLAN

The Plan is a municipal cooperative health benefit plan operating under the provisions of Article 47 of the New York Insurance Law. It operates exclusively for the benefit of the employees/retirees and their dependents, of member school districts ("SD") and the Orange-Ulster Board of Cooperative Educational Services ("BOCES"). The Plan has been in existence

since 1982 and is composed of eighteen school districts and the Orange-Ulster BOCES. It was issued a certificate of authority on November 1, 2000, pursuant to the provisions of Article 47 of the New York Insurance Law.

The Plan participants are as follows:

Chester Union Free SD
Cornwall Central SD
Eldred Central SD
Florida Union Free SD
Goshen Central SD
Greenwood Lake Union Free SD
Highland Falls Central SD
Kiryas Joel Village SD
Marlboro Central SD
Middletown City SD
Minisink Valley Central SD
Monroe-Woodbury Central SD
Orange-Ulster BOCES
Pine Bush Central SD
Port Jervis City SD
Tuxedo Union Free SD
Valley Central SD
Warwick Valley SD
Washingtonville SD

The Plan's home office is located at 163 Harriman Heights Road, Monroe, New York. Most administrative functions are performed at this location, with the exception of the claims functions detailed below. In addition, accounting functions are performed at the Orange-Ulster BOCES' office located in Goshen, New York.

The Plan has entered into administrative service agreements whereby certain third party administrators ("TPAs") process health benefit claims or provide other member services. As of December 31, 2010, the Plan maintained the following administrative services agreements:

(1) Caremark, Inc. – Prescription drugs claims processing;
(2) Empire Blue Cross Blue Shield – Provider network;

(3) HealthCare Strategies ("HCS") – Utilization review;
(4) Independent Employee Consultation Services, Inc. ("INDECS") – Claims processing;
(5) Managed Physical Network – Chiropractic, Physical therapy and Occupational therapy services.

The Plan is billed an administration fee by such TPAs for services rendered.

It should be noted that in the prior examination report, it was recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs, either directly or indirectly by the Plan.

The Plan stated in its response to the report the following:

> "It is the opinion of the Plan that being a signed party to any contract under direction of our TPA unnecessarily binds the Plan….It is not our intent to comply with this recommendation at this time either and would ask that the financial arm of the NYSID to review this item with their legal department."

In consideration of the Plan's concerns, the examiner notes the following:

- It is incumbent on all insurance entities regulated by this Department to comply with all New York laws and regulations;
- It is acceptable for any insurer to delegate its authority, but it cannot delegate its responsibilities.

Under these tenets, the examiner concludes that there is no requirement that the Plan physically endorse the agreement between the Plan's third-party claim processor and that entity's own third-party Utilization Review agent. However, it is incumbent upon the Plan to perform appropriate due diligence and ensure that the agreement between those two third parties is in full

compliance with all applicable New York laws and regulations and to ensure that the Utilization Review agent is in full compliance with its agreement.

It is recommended that the Plan perform appropriate due diligence and ensure that the agreement between INDECS and its Utilization Review agent is in full compliance with New York laws and regulations and that the Plan's Utilization Review agent is in full compliance with its agreement.

A. Management and Controls

Pursuant to its Municipal Cooperation Agreement ("MCA"), management of the Plan is to be vested in a board of directors consisting of the Superintendent of Schools, or his/her designee, for the aforementioned School Districts and the Orange-Ulster BOCES. As of the examination date, the board of directors was composed of 19 members. The board met at least once in each calendar quarter in compliance with its MCA.

As of December 31, 2010, the members of the board of directors of the Plan, with their principal business affiliations, were as follows:

| Name and Residence | Principal Business Affiliation |
|---|---|
| Steven Bangert<br>Clintondale, New York | Assistant Superintendent-Business,<br>Valley Central S D |
| Janet Barbour<br>Newburgh, New York | Assistant Superintendent-Business,<br>Washingtonville SD |

| Name and Residence | Principal Business Affiliation |
|---|---|
| Erin Brennan<br>Newburgh, New York | Business Official,<br>Chester Union Free SD |
| Deborha Brush<br>Pine Bush, New York | Assistant Superintendent-Administrative Services,<br>Pine Bush Central SD |
| Patrick Cahill<br>Fishkill, New York | Assistant Superintendent-Business,<br>Highland Falls SD |
| Lorelei Case<br>Cuddebackville, New York | Assistant Superintendent-Business,<br>Port Jervis City SD |
| Howard Cohen<br>Florida, New York | Business Official,<br>Florida Union Free SD |
| Deborah McBride Heppes<br>Goshen, New York | Assistant Superintendent-Finance,<br>Orange-Ulster BOCES |
| Timothy Holmes<br>Warwick, New York | Assistant Superintendent-Business,<br>Warwick SD |
| Mary Lou Lewis<br>Chester, New York | Assistant Superintendent-Business,<br>Minisink Valley Central SD |
| Ann Lierow<br>Lagrangeville, New York | Assistant Superintendent-Business,<br>Greenwood Lake SD |
| Elizabeth McKean<br>Jeffersonville, New York | Deputy Superintendent,<br>Middletown City SD |
| Robert Miller<br>Johnson, New York | Assistant Superintendent-Business,<br>Goshen SD |
| Joel Petlin<br>Spring Valley, New York | Superintendent,<br>Kiryas Joel SD |
| Neysa Sensenig<br>Grahamsville, New York | Assistant Superintendent-Business,<br>Marlboro SD |
| Harvey Sotland<br>Poughquaq, New York | Assistant Superintendent-Business,<br>Cornwall Central SD |
| William Thornton<br>Monticello, New York | School Business Administrator,<br>Eldred SD |

| Name and Residence | Principal Business Affiliation |
|---|---|
| Jeffrey White<br>Central Valley, New York | Assistant Superintendent-Business,<br>Monroe-Woodbury SD |
| Joseph Zanetti<br>Middletown, New York | Superintendent,<br>Tuxedo Union Free SD |

The principal officers of the Plan as of December 31, 2010 were as follows:

| Name | Title |
|---|---|
| Harvey Sotland | Chairman |
| Erin Brennan | Chief Financial Officer |
| Ike A. Lovelass | Executive Director |
| Elizabeth McKean | Secretary |

The minutes of all of the board of directors' meetings held during the period under examination were reviewed. The review revealed that the meetings were generally well attended. However, designees from Eldred Central SD, Florida Union Free SD and Kiryas Joel Village SD attended less than 50% the meetings that were held during the examination period for which they were eligible. It should be noted, however, that sufficient members were present at the board meetings to establish a quorum. It should also be noted that Eldred Central SD is not located in Orange County and the Municipal Cooperation Agreement calls for only school districts in Orange County to be entitled to vote at board meetings.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the

board. Board members who fail to attend at least one-half of the board's meetings, unless appropriately excused, do not fulfill such criteria.

It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.

A similar finding was cited in the previous two reports on examination.

B. Report on Examination

Section 312(b) of the New York Insurance Law states in part:

> "A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report."

The Plan was unable to provide any evidence of such signed statement by each member of its board of directors as required by Section 312(b) of the New York Insurance Law. This matter is particularly troubling, since the examiner determined that several of the findings contained herein were also noted during the previous exam but not corrected by the Plan's management.

It is recommended that the Plan obtain signed statements by each board member confirming that such member has received and read the report on examination, in compliance with Section 312(b) of the New York Insurance Law.

C. Territory and Plan of Operation

As of December 31, 2010, the Plan held a certificate of authority to operate the business of a municipal cooperative health benefit plan as authorized by Section 4704 of the New York Insurance Law in the counties of Orange, Sullivan and Ulster. Pursuant to the requirements of Article 47 of the New York Insurance Law, the Plan is required to maintain contingency reserves equal to 5% of the annualized earned premium. The Plan met the contingency reserve requirement throughout the examination period.

The Plan's enrollment has grown steadily during the examination period, consisting of 8,968 members at December 31, 2010, as compared to 8,281 members, at December 31, 2006.

D. Stop-Loss Coverage

As of the examination date, the Plan had stop-loss coverage in effect with Trustmark Insurance Company, an authorized insurer, in accordance with the requirements of Section 4707(a)(2) of the New York Insurance Law, as follows:

Specific/Individual Excess Loss

| | |
|---|---|
| Excess of loss | 100% of $500,000 excess of $100,000 per member, per contract year, |

Aggregate Excess of Loss

Section 4707(a)(1) of the New York Insurance Law states:

> "The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:

> (1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year."

The Plan did not have in place aggregate stop-loss coverage as required by Section 4707(a)(1) of the New York Insurance Law.

It is recommended that the Plan obtain and maintain aggregate stop-loss coverage in compliance with Section 4707(a)(1) of the New York Insurance Law.

A similar finding was cited in the prior report on examination.

E. Fidelity Bonds

The Plan has a Crime Policy with Travelers Casualty and Surety Company of America, covering employee theft for a single loss limit of $500,000. While the calculation of fidelity bond policy limits is not a substitute for the risk assessment that should be made by the Plan in establishing a reasonable level of insurance coverage, the examiner determined that the Plan's coverage was below the suggested minimum coverage amount of $700,000 to $800,000 as calculated from the Handbook.

It is recommended that the Plan increase its fidelity bond coverage to at least $700,000, in order to meet the suggested minimum amount of fidelity bond coverage as outlined in the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners.

# 4. FINANCIAL STATEMENTS

## A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2010. This statement is the same as the balance sheet filed by the Plan.

| Assets | Examination | Plan |
|---|---|---|
| Cash and cash equivalents | $ 2,941,425 | $ 2,941,425 |
| Short-term investments | 83,984,839 | 83,984,839 |
| Premium receivable | 897,374 | 897,374 |
| Total Assets | $ 87,823,638 | $ 87,823,638 |
| Liabilities | | |
| Accounts payable | $ 2,856,761 | $ 2,856,761 |
| Claims payable | 16,752,707 | 16,752,707 |
| Claim stabilization reserve | 14,200,000 | 14,200,000 |
| Unearned premiums | 8,890,406 | 8,890,406 |
| Total liabilities | $ 42,699,874 | $ 42,699,874 |
| Net Worth | | |
| Contingency reserves | $ 5,240,753 | $ 5,240,753 |
| Retained earnings | 39,883,011 | 39,883,011 |
| Total net worth | 45,123,764 | 45,123,764 |
| Total liabilities and net worth | $ 87,823,638 | $ 87,823,638 |

B. Statement of Revenue and Expenses and Net Worth

Net worth increased $20,265,130 during the four-year examination period, January 1, 2007 through December 31, 2010, detailed as follows:

| | | |
|---|---|---|
| Revenue | | |
| Premiums | $399,464,098 | |
| Net investment income | 6,122,936 | |
| Total revenue | | $405,587,034 |
| Expenses | | |
| Medical and hospital expenses | $264,485,435 | |
| Drug | 98,968,923 | |
| Reinsurance expense-net | 1,460,524 | |
| Administration expenses | 19,857,446 | |
| Total expenses | | 384,772,328 |
| Net Income | | $ 20,814,706 |

Changes in Net Worth

| | | | |
|---|---|---|---|
| Net worth, as of December 31, 2006, per report on examination | | | $ 24,858,634 |
| | Gains in Net Worth | Losses in Net Worth | |
| Net income | $20,814,706 | | |
| (Increase) in non-admitted assets | | $(549,576) | |
| Net increase in net worth | | | 20,265,130 |
| Net worth, as of December 31, 2010, per report on examination | | | $ 45,123,764 |

## 5. CLAIMS PAYABLE (INCLUDING CLAIM STABILIZATION RESERVE)

The examination liabilities for claims payable in the amount of $16,752,707 and claims stabilization reserve in the amount of $14,200,000 are the same as the amounts reported by the Plan as of December 31, 2010.

Section 4706(a)(1) of the New York Insurance Law requires that the governing board of a municipal cooperative health benefit plan establish a reserve fund, including a reserve for the payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported, which shall not be less than an amount equal to twenty-five percent (25%) 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 will be adequate. The Plan was granted approval by this Department on June 15, 2005 to reduce its reserves for claims and related expenses to 17% ($16,752,707 claims payable and a $14,200,000 claim stabilization reserve, which are reflected in the balance sheet contained herein as liabilities) from 25% of the current year's expected incurred claims and expenses.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Company's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2010.

## 6. MARKET CONDUCT

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 review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The general review was directed at practices of the Plan in the following major areas:

A. Claims processing
B. Rating
C. Utilization review

### A. Claims Processing

The examination included a review of the Plan's claims settlement practices and oversight of the claims adjudication process by Plan management. INDECS is the Plan's Third Party Administrator of claims. As such, INDECS is responsible for some aspects of claims settlement, including out-of-network claim payments, issuance of explanation of benefits statements ("EOBs"), and appeals. However, the management of Orange-Ulster School Districts Health Plan retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related Regulations, and therefore its management must be diligent in its oversight of the claims settlement function.

A review of INDECS' claims practices and procedures was performed by using a sample covering only hospital and medical claims adjudicated during the period of January 1, 2010 through December 31, 2010, in order to evaluate the accuracy and compliance environment of its claims processing. The examiner judgmentally selected forty-five (45) claims for review and

evaluated the selected claims based on the denial codes, and tested the procedural and financial accuracy of the adjudication of those claims.

The term, "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. A "claim" is defined by INDECS as groupings of up to six line items (e.g. procedures or services) on any claim form. Each additional six lines on the claim form are entered into the claims system as a separate claim. This claim may consist of various lines, or procedures. It is possible, through the computer software used for this examination, to match or "roll-up" all procedures on the six line items into one line, which is the basis of the Department's judgmental sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by the Plan for the period January 1, 2010 through December 31, 2010.

The results of the review revealed that eight of the forty-five claims resulted in procedure errors, four of which were violations of Section 3224-a of the New York Insurance Law, which requires such claims or bills to be paid to a policyholder or covered person or make a 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. It should be noted that the potential number of claims in the total population that may have been paid in excess of 30 days was 1,174, which is less than two percent (2%) of the total number of claims adjudicated during the year examined. Other issues noted during the review of claims related to

medical necessity denials. These findings are detailed within this report under the section "Utilization Review".

It was noted that during the examination period that neither the Plan nor INDECS performed any formal quality control reviews or audits to check the accuracy of recorded claims transactions (e.g., payment dollar, payment incidence, coding, procedural and total claim accuracy). Nor did INDECS have any benchmarks by which to measure accuracy or timeliness of payments made. INDECS does, however, utilize a "daily error register" to track claim "exceptions" (calls received from provider or members regarding amount paid and or provider status) as they occur and makes the necessary adjustments. A copy of the July 2011 daily error register capturing errors that were adjusted for that month, was provided to the examiners for review.

The following represents examples of errors included within INDECS' daily error register:

- Duplicate payments / claims adjuster errors
- Other coverage primary, did not coordinate benefits
- Excess co-pays taken

It is recommended that the Plan require INDECS to implement periodic audits within a proactive quality assurance program in order to identify and correct errors that may be occurring on an ongoing basis, in addition to retroactive reviews resulting from external contact. The results of such audits should be reported to the Plan's management, at least annually.

A similar finding was cited in the previous two reports on examination.

B. Rating

Rates are developed by the Plan based on a review of the Plan's evaluation of past claims experience and projections of the Plan's future financial performance. Rates are established and are approved by the Plan's Board of Directors in advance of the Plan year and must be community-rated in compliance with Section 4705(d)(5)(B) of the New York Insurance Law.

Section 4705(e)(3) of the New York Insurance Law states in part:

> "The municipal cooperation agreement shall provide the following to be prepared and furnished to the governing board, to participating municipal corporations, to unions which are exclusive bargaining representatives of employees covered by the plan and to the superintendent:
>
> (3) an annual independent actuarial opinion on the financial soundness of the plan, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid and in the current year and projected for the next fiscal year."

For the examination period, the Plan was unable to provide the examiner with an independent actuarial opinion with regard to the soundness of its premium equivalent rates.

It is recommended that the Plan obtain an annual independent actuarial opinion on the soundness of the Plan, which includes the actuarial soundness of the contribution of premium equivalent rates, in compliance with Section 4705(e)(3) of the New York Insurance Law.

C. Utilization Review

During the examination, the examiner reviewed documents used by the Plan to communicate appeal rights to the members. The following was noted, related to the form "ou-appeals kit 3-21-01" Appeals procedure:

a.) The document notes that an appeal requires the Local School District Representative to become involved with an appeal. This could create a conflict when Plan members wish to keep their health concerns confidential. Alternatively, other documents define this process as optional.

b.) New York Insurance Law Article 49 requires that an insurer allow at least one internal appeal. If an insurer deems the initial appeal to be the Final Adverse Determination, then the member has the right to an External Appeal. The presentation on this document is confusing in that the section on External Appeal is presented on page 1 before the Plan's Appeals procedure, which makes the External Appeal look like it should thus come before internal appeals. This is confusing to the reader and should be revised.

c.) The document does not clarify the difference between a medical necessity denial and an administrative denial. The processes for these are different and there should be separate instructions for each one. Additionally, the document does not clearly note that the Level One appeal is the Final Adverse Determination.

It is recommended that the Plan not require members to utilize a School District Representative as ombudsman during the appeal of claims.

It is also recommended that the Plan ensure that the appeal instructions it issues to its members are orderly, complete, and consistent, stating specifically that the Level One appeal is also the Final Adverse Determination.

The examiner also reviewed the documentation supporting a small number of denials and appeals and noted the following:

1. Pre-Authorization letter for Member

a.) This document appears to be a pre-authorization, in that it references "the proposed treatment" although it was later revealed that the letter was for a

retrospective review. During further discussion with the Plan, it was revealed that the prospective denial letters that the Plan uses do not describe the member's right, under New York Insurance Law 4904(b)(2), to an expedited review, if the member or the member's provider believes such is warranted.

b.) New York Insurance Law Section 4903(f) requires that if a utilization review agent did not attempt to discuss the denial with the provider, then the provider shall have the opportunity to request a reconsideration of the adverse determination. The denial letters should describe this right.

c.) New York Insurance Law Section 4910(b)(1)(B) states that an External Appeal is only permitted before the Final Adverse Determination if the insurer waives the internal appeal. The denial letter used by the Plan and reviewed by the examiner states that the member may go directly to External Appeal, but it does not clarify that the insurer has waived its right to the internal appeal. This should be clarified so that the insurer cannot come back in the future to refute the member's right to the External Appeal.

It is recommended that the Plan's Denial letters accurately and completely reflect the member's rights of appeal in accordance with Article 49 of the Insurance Law.

2. Explanation of Benefits Statements

a.) The language relaying the appeal rights states the following: "If you have received an adverse determination for reasons due to Experimental Services or Medical Necessity, submit a written request for an appeal…" This is violative of New York Insurance Law Section 4904(c), which requires the Utilization Review agent to "establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone".

No instances were noted where the Plan did not accept an appeal because it was not written down.

b.) One EOB was reviewed wherein the language relaying the appeal rights states the following: "If your claim is not paid in full, you … may appeal the claim within 60 to 180 days (check your plan). This ambiguity does not comply with New York Insurance Law Section 3234(b)(7), which

requires that the EOB describe the time limit in which an appeal must be brought.

It is recommended that the Explanation of Benefits statements utilized by the Plan accurately and clearly explain member appeal rights.

## 7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained thirteen (13) comments and recommendations as follows (page numbers refer to the prior report):

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Description of Plan | |
| 1. | It is recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs either directly or indirectly by the Plan.<br><br>*A revised recommendation regarding this concern has been included within this report.* | 6 |
| | Management | |
| 2. | It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.<br><br>*The Plan has not complied with this recommendation. A similar recommendation is included in this report.* | 8 |
| 3. | It is recommended that the Plan comply with the annual and quarterly statement instructions and submit its required annual and quarterly statements to the Superintendent of Insurance, within one hundred and twenty (120) days after the close of the Plan's fiscal year and forty-five (45) days after the close of each quarter, respectively.<br><br>*The Plan has complied with this recommendation.* | 10 |

**ITEM NO.** **PAGE NO.**

4. It is also recommended that the Plan comply with Section 4710(a)(2) of the New York Insurance Law and submit its required annual statements to the Superintendent of Insurance, within one-hundred and twenty (120) days after the close of the Plan's fiscal year. 10

*The Plan has complied with this recommendation.*

5. It is recommended that the Plan comply with Section 4705(c)(2) of the New York Insurance Law and maintain custody of all administrative service contracts relative to services provided to the Plan by INDECS and HCS. 10

*The Plan has complied with this recommendation.*

6. It is recommended that the Plan comply with Section 4705(e) of the New York Insurance Law by preparing and furnishing an annual independent actuarial opinion to the entities indicated in such section of the New York Insurance Law. 11

*The Plan has not complied with this recommendation. A similar recommendation is included in this report.*

Stop Loss Reinsurance Coverage

7. It is recommended that the Plan obtain and maintain aggregate stop-loss coverage in compliance with Section 4707(a)(1) of the New York Insurance Law. 12

*The Plan has not complied with this recommendation. A similar recommendation is included in this report.*

Conflict of Interest

8. It is recommended that all board members sign the required conflict of interest disclosure form on an annual basis. 13

*The Plan has complied with this recommendation.*

**ITEM NO.** **PAGE NO.**

Report of Independent Certified Public Accountant

9. It is recommended that the Plan comply with Section 307(b)(2) of the New York Insurance Law and submit to this Department the applicable CPA report relative to the Plan's financial statements, including a reconciliation of the differences between amounts reported in the filed annual statements and the amounts reported in the CPA report. 13

*The Plan has complied with this recommendation.*

Claims Processing

10. It is recommended that the Plan require INDECS to implement a proactive quality assurance program in order to identify and correct errors that may be occurring on an ongoing basis, in addition to retroactive reviews resulting from external contact. 19

*The Plan has not complied with this recommendation. A similar recommendation is included in this report.*

Utilization Review

11. It is recommended that the Plan, in its oversight of the claims settlement function, require that third parties acting on its behalf, comply with Sections 4901(a) and (b)(1) of the New York Insurance Law and submit the Plan's utilization review plan with the New York Insurance Department on a biennial basis. 20

*The Plan has complied with this recommendation.*

Plan Document

12. It is recommended that the Plan comply with its plan document and request pertinent documentation of eligibility when enrolling members. 20

*The Plan has complied with this recommendation.*

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Fraud Prevention and Detection | |
| 13. | It is recommended that the Plan comply with Section 405 of the New York Insurance Law and report any known or suspected incidents of fraud to the New York Insurance Department's Frauds Bureau. | 21 |
| | *No known fraud cases were noted during this exam period.* | |

## 8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

| ITEM | | PAGE NO. |
|---|---|---|
| A. | Description of the Plan | |
| | It is recommended that the Plan perform appropriate due diligence and ensure that the agreement between INDECS and its Utilization Review agent is in full compliance with New York laws and regulations and that the Plan's Utilization Review agent is in full compliance with its agreement. | 7 |
| B. | Management and Controls | |
| | It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan. | 10 |
| C. | Report on Examination | |
| | It is recommended that the Plan obtain signed statements by each board member confirming that such member has received and read the report on examination, in compliance with Section 312 (b) of the New York Insurance Law. | 10 |
| D. | Stop Loss Coverage | |
| | It is recommended that the Plan obtain and maintain aggregate stop-loss coverage in compliance with Section 4707(a)(1) of the New York Insurance Law. | 12 |
| E. | Fidelity Bonds | |
| | It is recommended that the Plan increase its fidelity bond coverage to at least $700,000, in order to meet the suggested minimum coverage amount of fidelity bond coverage as outlined in the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners. | 12 |

Respectfully submitted,

_____/S/_____

Victor Estrada

Senior Insurance Examiner

STATE OF NEW YORK )

) SS.

)

COUNTY OF NEW YORK )

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

_____/S/_____

Victor Estrada

Subscribed and sworn to before me

this _____ day of _____2011

Appointment No. **30706**

# 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:

**Victor Estrada**

as a proper person to examine into the affairs of the

**Orange Ulster School Districts Health Plan**

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

**Municipal Cooperative Health Benefit 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 14th day of April, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR