# REPORT ON EXAMINATION

# OF

# ORANGE-ULSTER SCHOOL DISTRICTS HEALTH PLAN

# AS OF

# DECEMBER 31, 2013

**DATE OF REPORT** **MARCH 24, 2016**

**EXAMINER** **VICTOR ESTRADA**

## TABLE OF CONTENTS

March 24, 2016

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31199, dated June 3, 2014, attached hereto, I have made an examination into the condition and affairs of Orange-Ulster School Districts Health Plan, a municipal cooperative health benefit plan operating under a certificate of authority pursuant to the provisions of Article 47 of the New York Insurance Law, as of December 31, 2013, and submit the following report thereon.

The examination was conducted at the home office of Orange-Ulster School Districts Health Plan, 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.

## 1. SCOPE OF THE EXAMINATION

The previous examination covered the period January 1, 2008 through December 31, 2010. This combined (financial and market conduct) examination of the Plan covered the period January 1, 2011 through December 31, 2013. The financial component of the examination was conducted on a risk-focused basis as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2014 Edition (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 assessment in formulating the nature and extent of the examination. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2013 were also reviewed.

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 2011 through 2013 by the accounting firm of UHY, LLP. The Plan received an unmodified opinion in each of those years. Certain audit workpapers of UHY, LLP were reviewed and relied upon in conjunction with this examination.

The examiner reviewed the corrective actions taken by the Plan with respect to the comments and recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item Seven of this report.

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.

## 2. EXECUTIVE SUMMARY

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

- 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 fully comply with the requirements of Section 4705(e)(3) of the New York Insurance Law since its annual independent actuarial opinion did not include a statement on the actuarial soundness of its premium equivalent rates.

- The Plan did not comply with the requirements of Sections 4904(c) the New York Insurance Law because its standard appeals process did not include procedures for appeals to be filed by telephone.

- 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.

These matters are particularly troubling since several of the findings contained herein were also noted during previous examinations but were not corrected by the Plan's management. In fact, of the eleven recommendations made in the December 31, 2010 examination report, the Plan failed to comply with nine. Of those nine, several were also in the December 31, 2006 examination report. Where a recommendation includes a reference to a law or regulation, compliance is mandatory.

## 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 dependents of the Plan's 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 twenty 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 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
Rondout Valley Central 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, 2013, the Plan maintained the following administrative services agreements:

(1) Envision Pharmaceutical Services, Inc. – Pharmacy benefit management;
(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; and
(6) Segal Consulting – Actuarial services.

The Plan is billed administration fees by the TPAs for services rendered.

## 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 21 members. The board met at least once in each calendar quarter during the exam period, in compliance with its MCA.

As of December 31, 2013, the members of the board of directors of the Plan, with their principal business affiliations, were as follows:

| Name and Residence | Principal Business Affiliation |
|---|---|
| Erin Brennan<br>Newburgh, New York | Business Official,<br>Chester Union Free 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 |
| Dawn Cupano<br>Newburgh, New York | Business Official,<br>Tuxedo Union Free SD |
| Gregory Dale<br>Pine Bush, New York | Assistant Superintendent-Administrative Services,<br>Valley Central SD |
| Cheryl Gross<br>Fishkill, New York | Assistant Superintendent-Business,<br>Eldred Central SD |
| Deborah McBride Heppes<br>Goshen, New York | Assistant Superintendent-Finance,<br>Orange-Ulster BOCES |
| Timothy Holmes<br>Uniondale, New York | Assistant Superintendent-Business,<br>Warwick Valley SD |
| Gregory Kern<br>Middletown, New York | Assistant Superintendent-Business,<br>Washingtonville 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 |
| Louise Lynch<br>Salt Point, New York | Deputy Superintendent,<br>Highland SD |
| Kim McEvoy<br>Accord, New York | Deputy Superintendent,<br>Rondout Valley Central SD |

| Name and Residence | Principal Business Affiliation |
|---|---|
| Elizabeth McKean<br>Jeffersonville, New York | Deputy Superintendent,<br>Middletown City SD |
| Robert Miller<br>Johnson, New York | Assistant Superintendent-Business,<br>Goshen SD |
| Michael Pacella<br>Newburgh, New York | Superintendent,<br>Pine Bush Central SD |
| Harvey Sotland<br>Poughquaq, New York | Assistant Superintendent-Business,<br>Cornwall Central SD |
| Lori Stevens<br>Campbell Hall, New York | School Business Administrator,<br>Florida Union Free SD |
| Schaye Wercberger<br>Central Valley, New York | Assistant Superintendent-Business,<br>Kiryas Joel Village SD |
| Jeffrey White<br>Central Valley, New York | Assistant Superintendent-Business,<br>Monroe-Woodbury SD |
| Patrick Witherow<br>Middletown, New York | Superintendent,<br>Marlboro Central SD |

The principal officers of the Plan as of December 31, 2013 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. It was noted that the designees from Eldred Central SD, Greenwood Lake Union Free SD, Highland SD, Kiryas Joel Village SD, Rondout Valley Central

SD and Tuxedo Union Free SD attended less than 50% of the meetings that were held during the examination period for which they were eligible.

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.

The Department recommends 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. While the Plan's Risk Manager has made some efforts to increase board member attendance, additional steps should be taken. A similar finding was cited in the previous three 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 exams, but not corrected by the Plan's management.

The Department recommends that the Plan comply with Section 312(b) of the New York Insurance Law and obtain signed statements by each board member confirming that such member has received and read the report on examination. A similar finding was cited in the prior report on examination.

## C. Territory and Plan of Operation

As of December 31, 2013, 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 premiums and enrollment during the three-year examination period were as follows:

| Calendar Year | Premium | Enrollment |
|---|---|---|
| 2011 | $108,460,940 | 19,961 |
| 2012 | $114,749,388 | 20,752 |

| | | |
|---|---|---|
| 2013 | $121,408,421 | 21,212 |

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

| | Amounts | Ratios |
|---|---|---|
| Claims | $349,298,698 | 101.2% |
| General administrative expenses | 18,714,624 | 5.4% |
| Net underwriting gain (loss) | (22,774,855) | (6.6%) |
| Premium revenue | $ 345,238,468 | 100.0% |

D. Stop-Loss Coverage

As of the examination date, the Plan had stop-loss coverage in effect with American Alternative Insurance Corporation, 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 $650,000 per covered person |
| Aggregating specific deductible | $300,000 |

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 noted that the Plan may be eligible for a waiver of such stop-loss coverage through submission of a request waiver under New York Insurance Law 4707(b), which states the following:

> "Upon application of the governing board, the superintendent may waive the requirement for stop-loss insurance, in whole or part, or modify the maximum retention amounts or attachment points for stop loss insurance, provided that:
>
> (1) the plan maintains reserves and surplus equal to or greater than one hundred fifty percent of the amounts specified in paragraphs one and five of subsection (a) of section four thousand seven hundred six of this article; or
>
> (2) the superintendent is satisfied that such waiver or modification of retention amounts or attachment points would not be detrimental to the plan's solvency and stability, after considering such factors as availability and affordability of stop-loss insurance, the plan's past and expected experience, plan size, reserves, surplus, and premium equivalent rates, and the contingent liability of participating municipal corporations."

The Department recommends 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. Municipal Cooperative Agreement

Section 4710(a)(1) of the New York Insurance Law states:

> "The governing board of the municipal cooperative health benefit plan shall:
>
> (1) file for approval with the superintendent a description of material changes in any information provided in the application for a certificate of authority in the form and manner proscribed by the superintendent."

During the examination period, the Plan amended its Municipal Cooperation Agreement ("MCA") without filing for approval with the Superintendent. It should be noted that the Plan is obligated to comply with the most recently approved version of its MCA until such time as the Department approves an amended version.

The Department recommends that the Plan comply with Section 4710(a)(1) of the New York Insurance Law by filing for approval with the Superintendent, a description of the material changes in any information provided in the application for certificate of authority.

## 4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2013, as contained in the Plan's 2013 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its December 31, 2013 filed annual statement.

Independent Accountants

The firm of UHY, LLP was retained by the Plan to audit the Plan's combined statutory basis financial statements of financial position as of December 31st for each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

UHY LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets

| | |
|---|---|
| Bonds | $ 49,908,070 |
| Cash | 1,987,145 |
| Cash equivalents | 28,180,325 |
| Investment income due and accrued | 148,786 |
| Health care and other amounts receivable | 1,204,650 |
| Total assets | $ 81,428,976 |

Liabilities

| | |
|---|---|
| Claims payable | $ 32,048,929 |
| Accounts payable | 1,839,149 |
| Claim stabilization reserve | 14,200,000 |
| Unearned premiums | 10,442,414 |
| Total liabilities | $ 58,530,492 |

Net Worth

| | |
|---|---|
| Surplus (per Insurance Law §4706(a)(5)) | $ 6,070,421 |
| Unassigned funds | 16,828,063 |
| Total surplus | 22,898,484 |
| Total liabilities and surplus | $ 81,428,976 |

B. Statement of Revenue and Expenses and Surplus

Surplus decreased $22,225,280 during the three-year examination period, January 1, 2011 through December 31, 2013, detailed as follows:

| | | |
|---|---|---|
| Revenue | | |
| Premiums | $344,618,749 | |
| Net investment income | 619,719 | |
| Total revenue | | $345,238,468 |
| Expenses | | |
| Medical and hospital expenses | $248,271,896 | |
| Prescription drugs | 99,348,811 | |
| Reinsurance expense-net | 1,677,991 | |
| Administrative expenses | 18,714,625 | |
| Total expenses | | 368,013,323 |
| Net Loss | | $ (22,774,855) |

Changes in Surplus

| | | | |
|---|---|---|---|
| Surplus, as of December 31, 2010, per report on examination | | | $ 45,123,764 |
| | Gains in Surplus | Losses in Surplus | |
| Net income/(loss) | | $22,774,855 | |
| Increase/(decrease) in non-admitted assets | $ 549,575 | | |
| Net decrease in surplus | | | (22,225,280) |
| Surplus, as of December 31, 2013, per report on examination | | | $ 22,898,484 |

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

The examination liabilities for claims payable in the amount of $32,048,929 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, 2013.

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% from 25% of the current year's expected incurred claims and expenses. However, as of December 31, 2013 the Plan maintained its claims reserves at a level of 25.5%, or $32,048,929, which is reflected in the balance sheet contained herein as a liability.

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 Plan'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 Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2013.

## 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. Plan Document
B. Claims processing
C. Rating
D. Utilization review
E. Explanation of Benefits statements

### A. Plan Document

The Plan Document ("PD") defines the health benefits to which Plan members are entitled. The currently-approved Plan Document has been in effect since 2011. The implementation of the Affordable Care Act changed multiple requirements for the Plan and as such, the current document is no longer valid.

It is recommended that the Plan revise its Plan Document to comply with the Affordable Care Act and submit such document to the Superintendent for approval.

B. 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 ("EOB"), and appeals. However, 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 and related functions.

A review of INDECS' claims practices and procedures was performed by using a sample covering only out-of-network hospital and medical claims adjudicated during the period of January 1, 2013 through December 31, 2013, in order to evaluate the accuracy and compliance environment of its claims processing. The examiner selected a sample of 167 claims and reviewed 40 of those claims to test 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 random 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, 2013 through December 31, 2013.

There were no exceptions noted in the review of the claims selected for review, therefore the examiner did not evaluate the remaining claims in the sample. However, an issue was noted during the review of claims related to medical necessity denials. These findings are detailed within this report under the section "Utilization Review."

INDECS does not perform 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). INDECS does, however, utilize an "Adjustment-Quality Daily Log" 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 2013 and year-to-date September 2014 Adjustment-Quality Daily Log capturing errors that were adjusted for those periods were provided to the examiner 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; and
- Excess co-pays taken.

The Department recommends that the Plan require INDECS to implement or undergo 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. The results of such audits should be reported to the Plan's management, at least annually. A similar finding was cited in the prior report on examination.

C. Rating

Premium rates for the Plan are developed based on an 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 as required by 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 provided the examiner with an independent actuarial opinion, however, it did not include an evaluation of the actuarial soundness of its premium equivalent rates.

The Department recommends that the Plan comply completely with Section 4705(e)(3) of the New York Insurance Law by obtaining an annual independent actuarial opinion on the

soundness of the Plan's premium equivalent rates. A similar finding was cited in the prior report on examination.

D. Utilization Review

During the examination, the examiner reviewed documents used by the Plan to communicate appeal rights to its members. These documents were identical to those utilized by the Plan in the prior exam. The following was noted relative to the form "ou-appeals kit 3-21-01" Appeals procedure:

i. The document notes that an appeal requires the Local School District Representative to serve as ombudsman for a member appeal. This could create a conflict when Plan members wish to keep their health concerns confidential. It is noted that other documents define this process as optional.

The Department recommends that the Plan not require members to utilize a Local School District Representative as ombudsman during the appeal of claims. A similar finding was cited in the prior report on examination.

ii. New York Insurance Law Article 49 Title 1 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 order of appeal provisions shown on form "ou-appeals kit 3-21-01" is confusing in that the section on External Appeal is presented on page 1, before the Plan's appeal procedure,

which gives the impression to readers that the External Appeal takes precedence over an internal appeal. The document also 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. Additionally, the document does not clearly note that the Level One appeal is the Final Adverse Determination.

The Department recommends that the Plan ensure that the appeal instructions issued to its members are orderly, complete, and consistent, stating specifically that the Level One appeal is also the Final Adverse Determination. A similar finding was cited in the prior report on examination.

The Department recommends that the Plan's Denial letters accurately and completely reflect the member's right of appeal, in accordance with the requirements of Article 49 of the Insurance Law. A similar finding was cited in the prior report on examination.

E. Explanation of Benefits Statements

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

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

Many of the Explanation of Benefits Statements ("EOB") reviewed include language regarding appeal rights. The language relaying appeal rights stated 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…"

The above is violative of New York Insurance Law Section 4904(c), which requires the Utilization Review agent establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. It is noted that no instances were noted where the Plan did not accept an appeal because it was not written.

One EOB was reviewed wherein the language relaying the appeal rights stated the following:

> "If your claim is not paid in full, you … may appeal the claim within 60 to 180 days (check your plan)".

This appeals language is ambiguous and 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.

The Department recommends that the Plan comply with Section 3234(b)(7) of the New York Insurance Law by ensuring that its Explanation of Benefits statements accurately and clearly explain member appeal rights. A similar finding was cited in the prior report on examination.

## 7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained eleven (11) 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 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.<br><br>*The Plan has partially complied with this recommendation. A similar recommendation is included in this report.* | 7 |
| | Management and Controls | |
| 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.* | 10 |
| | Report on Examination | |
| 3. | 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.<br><br>*The Plan has not complied with this recommendation. A similar recommendation is included in this report.* | 10 |

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

Stop Loss Reinsurance Coverage

4. 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.*

Fidelity Bonds

5. 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

*The Plan has complied with this recommendation.*

Claims Processing

6. 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. 18

*The Plan has partially complied with this recommendation. A similar recommendation is included in this report.*

Rating

7. 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. 19

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

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

Utilization Review

8. It is recommended that the Plan not require members to utilize a School District Representative as ombudsman during the appeal of claims. 20

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

9. 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 Level One Appeal is also the Final Adverse Determination. 20

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

10. It is recommended that the Plan's Denial Letters accurately and completely reflect the member's right of appeal in accordance with Article 49 of the Insurance Law. 21

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

11. It is recommended that the Explanation of Benefit statements utilized by the Plan accurately and clearly explain member appeal rights. 22

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

## 8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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_____2016.

*APPOINTMENT NO.* 31199

*NEW YORK STATE*

# *DEPARTMENT OF FINANCIAL SERVICES*

*I,* ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

***Victor Estrada***

*as a proper person to examine the affairs of*

***Orange-Ulster School Districts Health Plan***

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

***Plan***

*with such other information as he shall deem requisite.*

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

*this 3rd day of June, 2014*

*BENJAMIN M. LAWSKY*
*Superintendent of Financial Services*

*By:* _____

*Lisette Johnson*
*Bureau Chief*
*Health Bureau*