REPORT ON EXAMINATION

OF THE

ALLEGANY-CATTARAUGUS SCHOOLS

MEDICAL HEALTH PLAN

AS OF

JUNE 30, 2015

DATE OF REPORT **JUNE 15, 2018**

EXAMINER **CHARLES J. MCBURNIE**

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June 15, 2018

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

Madam:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31425, dated February 4, 2016, attached hereto, I have made an examination into the condition and affairs of Allegany-Cattaraugus Schools Medical Health Plan, a municipal cooperative health benefit plan certified pursuant to the provisions of Article 47 of the New York Insurance Law as of June 30, 2015, and respectfully submit the following report thereon.

The examination was conducted at the home office of Allegany-Cattaraugus Schools Medical Health Plan located at 1825 Windfall Road, Olean, New York.

Wherever the designation, the "Plan" appears herein, without qualification, it should be understood to refer to Allegany-Cattaraugus Schools Medical 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 was conducted as of June 30, 2010. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period from July 1, 2010 through June 30, 2015. 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, 2016 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2015 were also reviewed.

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

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

These categories are as follows:

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

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

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

The Plan was audited annually, for fiscal years 2010 through 2015, by the accounting firm Raymond F. Wager, CPA, P.C. and Thomas C. Zuber CPA. The Plan received an unmodified opinion in each of those years. Certain audit work papers of the CPA's 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 require explanation or description.

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

The examiner reviewed the corrective actions taken by the Plan with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 5 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 explanation or description.

2. DESCRIPTION OF THE PLAN

On November 1, 2001, the Plan was issued a certificate of authority by the Superintendent of Insurance under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority and in accordance with the Municipal Cooperative Agreement, each of the Plan's participants have agreed to share the costs and assume the liabilities for hospital, surgical, prescription drug, and major medical benefits provided to covered employees (including retirees) and their dependents under the Plan. The Certificate of Authority also authorizes the Plan to conduct the business of a municipal cooperative health benefit plan in the State of New York in the counties of Cattaraugus, Allegany, Erie and Wyoming.

The Plan provides medical coverage through self-insurance administered by a third party administrator in accordance with the Summary Plan Description, to covered employees, retirees and their eligible dependents as defined in the plan booklet. Effective January 1, 2010 the Plan entered into an Administrative Services Agreement with Blue Cross and Blue Shield of Western New York where Blue Cross and Blue Shield processes medical and hospital claims on behalf of the Plan.

There are currently twenty-one school districts and one BOCES participating in the Plan. The Plan participants as of June 30, 2015 were as follows:

Allegany-Limestone
Central School District

Andover
Central School District

Belfast
Central School District

Bolivar-Richburg
Central School District

Cattaraugus-Allegany-Erie-Wyoming
Board of Cooperative Educational
Services (BOCES)

Cattaraugus-Little Valley
Central School District

Cuba-Rushford
Central School District

Ellicottville
Central School District

Fillmore
Central School District

Franklinville
Central School District

Friendship
Central School District

Genesee Valley
Central School District

Hinsdale
Central School District

Olean City
Central School District

Portville
Central School District

Randolph Academy
Union Free
Central School District

Randolph
Central School District

Salamanca City
Central School District

Scio
Central School District

Wellsville
Central School District

West Valley
Central School District

Whitesville
Central School District

A. Corporate Governance

Pursuant to the Municipal Cooperative Agreement, management of the Plan is to be vested in the Governing Board, comprised of one representative from each participating school district, including BOCES. The governing board of the Plan as of June 30, 2015 was as follows:

Names	**Affiliation**
Karen Geelan Allegany, New York	Superintendent, Allegany-Limestone Central School District
Lawrence Spangenburg Andover, New York	Superintendent, Andover Central School District
Judy May Belfast, New York	Superintendent, Belfast Central School District
John Marshall Bolivar, New York	Superintendent, Bolivar-Richburg Central School District
Lynda Quick Olean, New York	Superintendent, Cattaraugus-Allegany BOCES
Sharon Huff Cattaraugus, New York	Superintendent, Cattaraugus-Little Valley Central School District
Carlos Gildemeister Cuba, New York	Superintendent, Cuba-Rushford Central School District
Mark Ward Ellicottville, New York	Superintendent, Ellicottville Central School District
Ravo Root Fillmore, New York	Superintendent, Fillmore Central School District
Michelle Spasiano Franklinville, New York	Superintendent, Franklinville Central School District
Judy May Friendship, New York	Superintendent, Friendship Central School District
Brian Schmitt Belmont, New York	Superintendent, Genesee Valley Central School District
Lawrence Ljungberg Hinsdale, New York	Superintendent, Hinsdale Central School District
Dr. Colleen Taggerty Olean, New York	Superintendent, Olean City Central School District

Names	**Affiliations**
Thomas Simon Portville, New York	Superintendent, Portville Central School District
Lori DeCarlo Randolph, New York	Superintendent, Randolph Academy Union Free Central School District
Kimberly Moritz Randolph, New York	Superintendent, Randolph Central School District
Robert Breidenstein Salamanca, New York	Superintendent, Salamanca City Central School District
Gregory Hardy Scio, New York	Superintendent, Scio Central School District
Kim Mueller Wellsville, New York	Superintendent, Wellsville Central School District
Eric Lawton West Valley, New York	Superintendent, West Valley Central School District
Laurie Sanders Whitesville, New York	Superintendent, Whitesville Central School District

According to the Plan's by-laws, the Governing Board shall meet quarterly and call special meetings at any time upon giving board members seventy-two hours written notice. The minutes of all meetings of the governing board were reviewed. All such meetings were well attended.

Item 2 of the Plan's Municipal Cooperative Agreement states in part:

> "The governing body of the Plan shall be a Board of Directors comprised of either the chief executive officer or other designated officer of each Participant, and shall meet at least annually at a time and place in this state designated in accordance with Article 1…"

However, the Plan's By-laws states the following:

> "Regular meetings of the Board of Directors shall be held in New York at least quarterly, at such times and places as determined by the Board of Directors. Special meetings of the Board of Directors shall be held on 72 hours written notice to the Board members."

It is recommended that the Plan amend its Municipal Cooperative Agreement to reflect the Board of Directors' meeting times detailed in the Plan's By-Laws.

The minutes of all meetings of the Board of Directors were reviewed. Such meetings were generally well attended. However, it was noted that relative to the Board meetings held during the period under examination, one member of the Board failed to attend at least one-half of such Board meetings they were eligible to attend.

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 decisions may be reached by the Board.

It is recommended that Board members who are unable or unwilling to consistently attend meetings resign or be replaced.

The principal officers of the Plan as of June 30, 2015 were as follows:

Officers	Titles
Michelle Spasiano	President
Michael Watson	Secretary
Thomas C. Potter	Chief Financial Officer

The Board of Governors has designated an Attorney in-Fact who is authorized to receive service on a summons or other legal paper in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Plan.

B. Territory and Plan of Operation

The Plan provides health benefits in the counties of Cattaraugus, Allegany, Erie and Wyoming within New York State. The Plan's enrollment as of June 30, 2010 was 3,434. The Plan's enrollment during fiscal years 2011-2015 was as follows:

Year	2011	2012	2013	2014	2015
Enrollment	3,327	3,261	3,133	3,083	3,093
Disenrollment Ratio		1.98%	3.93%	1.6%	(.32%)

The Plan experienced a decrease in enrollment of 9.9% during the period under examination.

C. Stop-loss coverage

As required by Section 4707 of the New York Insurance Law, the Plan maintains both aggregate stop-loss coverage and specific stop-loss coverage. The Company providing such coverage is authorized in New York. The following is a summary of the Plan's stop-loss program as of June 30, 2015:

The Plan has a stop-loss policy with H.M. Life Insurance Co., an authorized reinsurer that provides 100% reimbursement after the $350,000 specific attachment point and also has 125% (aggregate) coverage for the Plan's experience in total. The $350,000 specific attachment point is below 4% of expected claims, as required by Section 4707(a)(2) of the Insurance Law. The Plan's policy is in compliance with the all requirements of Section 4707 of the New York Insurance Law.

D. Administrative Services Agreements

As of June 30, 2015, the Plan was a party to the following service agreements.

- Effective date January 1, 2005 with Nova Healthcare Administrators, Inc. ("NOVA"), a wholly owned subsidiary of Independent Health Corporation, which provided third party claim administrative services, established utilization management criteria for review of medical and pharmacy authorizations and claims and acted as the pharmacy administrator for the PBM, Express Scripts. The Plan subsequently contracted with BlueCross BlueShield of Western New York to provide these administrative services and the contract with NOVA was terminated as of January 1, 2015

- Effective January 1, 2010 with BlueCross BlueShield of Western New York, ("BCBSWNY"), a division of HealthNow New York Inc. ("Health Plan"), which provides Administrative Services and network access to the Plan. BCBSWNY makes the initial determination as to whether benefit claims submitted by Participants qualify for payment under the Plan and also determines the amount of benefits due and payable pursuant to the terms of the Plan. To the extent required by New York State Insurance Law or as required by BCBSWNY's agreement with participating providers, BCBSWNY pays interest on benefit claims processed under the agreement in accordance with Section 3224-a of the Insurance Law.

- Effective July 1, 2009 with Premier Consulting Associates, LLC ("Premier"), Premier provides the following services: assessment of the Plan's risks, monitor, develop and design the Plan's medical health plans, help the Plan comply with regulatory policies as they apply to the Plan's health plan, assist in the development of communications to employees and retirees, assess the appropriateness of experience rating and self-funding and provide to the Plan a written status of projected plan costs for each plan year, prepares bid specifications and solicit proposals from third party administrators, and provides assistance with labor negotiation.

- Effective April 24, 2008, the Plan contracted with Manning & Napier Information Services, LLC, (MNIS). MNIS provides the Plan with on-line business application with features that augment or enhance the current business application, including the Benefficiency Online Platform and Modules, the Benefficiency Content, and the Benefficiency Materials.

- Effective April 1, 2010 with Express Scripts, Inc. (ESI), the Plan contracted with (ESI) to provide the following services: maintain a network(s) of participating pharmacies and make available an updated list of participating pharmacies on-line, perform claims processing services for covered drugs dispensed by participating pharmacies, and conduct standard concurrent drug utilization review ("DUR"). ESI also provides

prior authorization services as specified and directed by the Plan for designated drugs and processes.

- Effective July 1, 2010 with Cattaraugus-Allegany BOCES, the Plan entered into a coordination services agreement with the BOCES which is required to act as coordinator and liaison between and for employers, enrollees, third party administrators, consultants, auditors, actuaries, the New York Department of Financial Services, Board of Directors, Committees, and other parties as appropriate. Further, the BOCES is required to maintain a database of all Plan enrollees, and all financial transactions such as accounts receivables, accounts payable, revenues, expenses, receipts, investments, and all other necessary ledger accounts will be maintained.
- Throughout the examination period, Harbridge Consulting Group, LLC, (Harbridge) provides actuarial consulting services. Harbridge performs their services on the basis of the information the Plan provides and in consideration of the applicable federal, foreign, state or local tax laws, regulations and associated interpretations relative to the appropriate jurisdiction as of the date the services are provided. Both parties will carry out procedures to protect the integrity of data. In particular, it is the recipient's responsibility to carry out a virus check on any attachments before launching or otherwise using any documents, whether received by E-mail or on desk or otherwise.

E. Conflict of Interest Policy

The Plan does not have a conflict of interest policy in place. It is a good business practice to have board members and senior officers sign a conflict of interest disclosure form annually.

It is recommended, as a good business practice, that the Plan establish a conflict of interest policy and require its board members, officers and key employees to sign a conflict of interest disclosure form on an annual basis.

3. FINANCIAL STATEMENTS

The following shows the assets, liabilities and surplus as of the June 30, 2015, filed annual statement, a condensed summary of operations, and a reconciliation of the surplus account for each of the years under examination. 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 financial statements contained in the June 30, 2015 filed annual statement.

The firm of Raymond F. Wager, CPA, P.C and Thomas C. Zuber, CPA was retained by the Plan to audit the Plan's combined statutory-basis statements of financial position as of June 30, 2015, and the related statutory-basis statements of operations and surplus for the year then ended.

Raymond F. Wager and Thomas C. Zuber 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	Plan
Cash and cash equivalents	$29,305,124
Premiums receivable	10,571
Amounts recoverable from reinsurers	280,778
Health care and other receivable	157,440
Prepaid expense	78,000
Total assets	$29,831,913
Liabilities	
Accounts payable	$ 66,819
Claims payable	9,951,632
Unearned premiums	138,976
Claim stabilization reserve	1,990,326
Total liabilities	$12,147,753
Surplus	
Stop loss reserves	$ 5,970,979
Unassigned funds	9,626,112
Surplus per Section 4706(a)(5)	2,087,069
Total surplus	17,684,160
Total liabilities and surplus	$29,831,913

B. Statement of Revenue, Expenses and Surplus

Surplus increased $9,641,873 during the five-year examination period, July 1, 2010 through June 30, 2015, detailed as follows:

Revenues		
Premiums	$206,475,226	
Investment income	300,539	
Aggregate write-ins for other revenue	12,236,042	
Total revenues		$ 219,011,807
Expenses		
Hospital and medical claims	$ 134,208,819	
Drug claims	54,583,565	
Aggregate write-ins for other hospital and medical	6,240,897	
Aggregate write-ins for other expenses	550,725	
Claims subtotal	195,584,006	
Reinsurance expenses net of recoveries	2,149,102	
Net claims incurred	$197,733,108	
Administrative expenses	9,172,720	
Total expenses		206,905,858
Net income		$12,105,949

	Increases In Surplus	Decreases In Surplus	
Surplus, per report on examination, as of June 30, 2010			$ 8,042,287
Net income	$12,105,949		
Change in valuation basis aggregate policy and claim reserve		2,488,924	
Aggregate Write in for other net worth items	24,848	0	
Net increase in surplus			9,641,873
Surplus, per report on examination, as of June 30, 2015			$17,684,160

4. MARKET CONDUCT ACTIVITIES

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

(A) Claims
(B) Utilization review
(C) Underwriting and rating

A. Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services ('Prompt Pay Law")

Section 3224-a(a) and (b) of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires certain entities, including New York Insurance Law Article 47 entities, to pay all undisputed claims or in cases where the obligation is unclear deny or request additional information within 30 days of receipt of a claim that is transmitted via the internet or electronic mail or pay within 45 days of receipt of a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim 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."

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

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

A statistical sample of claims not adjudicated within 30 days of receipt for claims transmitted via the internet or electronic mail, or 45 days of receipt for claims submitted by other means such as paper or a facsimile by the Plan was reviewed by the examiner to determine whether the claims were processed in compliance with the time frame requirements of Section 3224-a(a) and (b) of the New York Insurance Law ("NYIL"), and, if interest was required and appropriately paid pursuant to Section 3224-a(c) of the NYIL. Accordingly, all claims that were not adjudicated within the respective 30 or 45-day time frames during the period July 1, 2014 through June 30, 2015, were segregated.

The claim population for the Plan was separated and further divided into a medical / hospital claim segment and a pharmacy claim segment. Pharmacy claims were reviewed separately from Medical / Hospital claims due to the large number of pharmacy claims that were not adjudicated within 30 days. The Plan uses a pharmacy benefit manager (PBM) to process its pharmacy claims. It is noted that the PBM's claim processes are entirely automated and does not receive paper claim submissions.

A random statistical sample of 167 claims was drawn from the Medical/Hospital claim data. A sample was not reviewed for the Pharmacy claims as the Plan's pharmacy benefit manager ("PBM") provided the examiner with an analysis of the PBM compliance with the prompt pay law.

Medical and Hospital Claim Review

From a population of 89,744 medical and hospital claims, 2,272 claims or 2.53% of the population were paid (or denied) more than 30 days or more than 45 days after receipt, respectively. A sample of 167 medical/hospital claims were selected for review, however only 75 of the claims were reviewed.

Out of the 75 claims reviewed, 34 of the claims were late payments or denials, an error rate of approximately forty-five percent, or 1,022 out of 2,272. The number of calculated claims in error extrapolated over the total medical / hospital population of 89,744 claims resulted in an error ratio of approximately 1.15%.

Pharmacy Claims

The table below reflects an analysis performed by the Plan's PBM of the timeliness of claim payments made by the PBM for the Plan. The pharmacy claims are from July 2014 through June/July 2015 and total 105,333 claims.

Express Scripts (ESI) bills the Plan every two weeks for pharmacy claims incurred and pays the claims after reimbursement by the Plan. As of November 1, 2015, the billings are sent on a weekly basis. All claims are received and processed electronically from the pharmacies.

The table below identifies the total number of claims that were processed after and before 30 days from the date of the invoice to the Plan, the date of service, and the bill date.

For the examination review, the bill date is the receipt date and the check date is the paid date used to determine compliance with the prompt pay requirements. Based on the table below, the PBM paid 40.89% of the claims after 30 days of the date of receipt, in violation of Section 3224-a(a) of the New York Insurance Law.

For the 12-month period, the percentage of claims paid over/under 30 days from the check date, and the three other date stamps, were as follows:

Various Date Stamps	# of Claims 30 days or under	# of Claims >30	Percentage of Late Claims
Billable Date – (date available for billing)	62,262	43,071	40.89%

Note: ESI removed all claims for home delivery and specialty pharmacy, as these pharmacies are part of the ESI family, and act as wholly owned subsidiaries. There are also Medicaid subrogation claims mixed in with these claims. These are typically batches submitted by pharmacies, once or twice annually for payment.

It is recommended that the Plan and its PBM take steps to comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims.

B. Review of Mental Health and Substance Abuse Claims

A review was done of the Plan's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) parity requirements of the Affordable Care Act as well as the mental health parity provisions of Timothy's Law.

Section 3221(l)(5)(A) of the New York Insurance Law states:

> "Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services shall provide as part of such policy broad-based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, however defined in such policy, at least equal to the coverage provided for other health conditions and…"

Section 3221(l)(5)(B)(i) of the New York Insurance Law states:

> "Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services, shall provide comparable coverage for adults and children with biologically based mental illness. Such group policies issued or delivered in this state shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the policy, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a policy provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the policy is written under one license or two licenses.

A sample of 50 mental health/substance abuse claims were selected for review from a population of 6,626 mental health/substance claims adjudicated July 1, 2014 through June 30, 2015.

Twenty (20) out of the fifty (50) claims reviewed were denied due to the insured exceeding the 20 visit limit for outpatient behavioral health visits per year, or exceeding the number of additional visits authorized by the Plan after the yearly 20 visit limit was exceeded.

It is noted that in an agreement with the New York Attorney General's office signed on August 18, 2016, it was agreed that the Plan's 20 visit per year limit on outpatient behavioral health visits would be eliminated as of the date of the agreement. The agreement notes that the

restriction was not applied to outpatient medical services and was not based on any clinical standards.

An additional sixteen (16) of the fifty (50) mental health and substance abuse claims sampled, incorrectly denied a visit for failure to have a pre-authorization on file or for exceeding the number of authorized visits, when the insured actually had a valid pre-authorization on file or did not exceed the number of visits that had been authorized.

It is recommended that the Plan comply with Sections 3221(l)(5)(A)(B)(i) of the New York Insurance Law states and the Mental Health Parity and Addiction Equity Act (MHPAEA) parity requirements of the Affordable Care Act by ensuring requirements for outpatient behavioral health visits are no less restrictive than for medical services.

It is recommended that the Plan put in place procedures to ensure claims are not erroneously denied for failure to have a pre-authorization or exceeding the number of authorized visits.

C. Utilization Review (UR)

The Plan's PBM has been designated as one of the Plan's utilization review agents. It was determined that the PBM did not file a utilization review plan with the Department, as required by New York Insurance Law Sections 4704(a)(8) and 4901(a) and (b).

Section 4704(a)(8) of the New York Insurance Law states as follows:

> "The municipal cooperative health benefit plan…established a fair and equitable process of claims review, dispute resolution and appeal procedures including arbitration of rejected claims…which are satisfactory to the superintendent."

Section 4901(a) of the New York Insurance Law states:

> "Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section."

It is recommended the Plan (and its PBM) ensure that all utilization review agents that perform medical necessity reviews for its claimants comply with the filing requirements of Sections 4704(a)(8) and 4901(a) and (b) of the New York Insurance Law.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included fourteen (14) recommendations detailed as follows (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that the Plan comply with Item 2 of its Municipal Cooperative agreement and Article 1, Item B of its by-laws with regard to appointments to the Plan's Board of Directors or amend its Municipal Cooperative Agreement and its by-laws to reflect the current practice of allowing either the Superintendent or Superintendent's designee to attend board meetings. *The Plan has complied with this recommendation.*	8
2.	It is recommended that the board members who are unable or unwilling to consistently attend board meetings resign or be replaced. *The Plan has not complied with this recommendation. A similar recommendation is made in this report.*	9
3.	It is recommended that The Board of Directors comply with Article 1(E) of its by-laws and elect the Chairman of the Board and Secretary of the Board annually at last scheduled quarterly meeting of the fiscal year. *The Plan has complied with this recommendation.*	9
4.	It is recommended that Plan amend its by-laws and its Municipal Cooperation Agreement to reflect the establishment of the position of Vice-Chairman of the Board of Directors. *The Plan has complied with this recommendation.*	10
5.	It is recommended that the Plan comply with Section 312(b) of the New York Insurance Law and ensure that a complete copy of the Report on Examination, together with all recommendations and statements relating thereto, is furnished to each member of the Board of Directors and that each such member shall sign a statement which shall be retained in the Plan's files confirming that such board member has received and read such Report on Examination.	11

ITEM NO.		PAGE NO.
	Management and Controls	
	The Plan has complied with this recommendation.	
6.	It is recommended that the Plan comply with Section 4705(a) of the New York Insurance Law with regard to its Participant's approval of the Plan's municipal cooperation agreement amendment thereto and that a record of such approvals be maintained in its files.	11
	The Plan complied with this recommendation.	
7.	It is recommended that the Plan comply with Section 4709(c) of the New York Insurance Law by amending its Plan Document to contain the required statement.	12
	The Plan has complied with this recommendation.	
8.	It is recommended that, as a prudent business practice, the Plan's Board of Directors obtain annual certifications from its third party claims administrators that claims are being processed in accordance with the Plan Document and applicable Department statues, rules and regulations.	14
	The Plan has not complied with this recommendation. A similar recommendation is made in this report on examination.	
	Conflict of Interest	
9.	It is recommended as a prudent business practice, that the Plan establish a conflict of interest policy and require its board members, officers and key employees sign a conflict of interest disclosure form on an annual basis.	16
	The Plan have not complied with this recommendation. A similar recommendation is made in this report on examination.	
	Accounts and Records	
10.	It is recommended that, in the future, the Plan provide at least thirty (30) days advance notice to the Department of any foreseeable significant reporting changes, including prior period adjustments, which may result in significant changes in reporting amounts compared to prior period reported amounts within its filed annual and quarterly statements.	17

ITEM NO.		PAGE NO.
	Accounts and Records	
	The Plan has complied with this recommendation.	
	Premium Receivable	
11.	It is recommended the Plan comply with the requirements of Item 6 of its Municipal Cooperative Agreement and require payment of interest for late payment or file with this Department, an amended Municipal Cooperative Agreement, approved by the Plan's participants which provides for the waiver of required interest of it is the intention of the board, in certain circumstances, to waiver interest on delinquent payment of premiums.	22
	The Plan has complied with this recommendation.	
	Plan Document – Mandated Benefits	
12.	It is recommended that the Plan include all required mandated benefits within its Plan Document and obtain Department approval of such amended Plan Document in compliance with Section 4709(b) of the New York Insurance Law.	25
	The Plan has complied with this recommendation.	
	Utilization Review	
13.	It is recommended the Plan Ensure that all utilization review agents that perform medical necessity reviews for its claimants comply with the filing requirements of Section 4704(a)(b) and Section 4901(a) and (b) of the New York Insurance Law.	26
	The Plan did not comply with this recommendation. The recommendation is again repeated on this report on examination.	
	Rating	
14.	It is recommended that the Plan file a copy of its current rating methodology with the Department of Financial Services.	27
	The Plan has complied with this recommendation.	

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO**

Respectfully submitted,

_____

Charles J. McBurnie
Insurance Examiner

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

Charles J. McBurnie, being duly sworn, deposes and says that the foregoing submitted report is true to the best of her knowledge and belief.

_____

Charles J. McBurnie

Subscribed and sworn to before me
This _____ day of _____2018

APPOINTMENT NO. **31425**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***SHIRIN EMAMI****, Acting 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:*

Charles McBurnie

as a proper person to examine the affairs of

Allegany-Cattaraugus Schools Medical Health Plan

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

Municipal Cooperative Health Benefit 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 4th day of February, 2016

SHIRIN EMAMI
Acting Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau