

REPORT ON EXAMINATION

OF

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN

AS OF

JUNE 30, 2011

DATE OF REPORT
EXAMINER

FEBRUARY 26, 2014
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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

February 26, 2014

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

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 30719, dated September 9, 2011, attached hereto, I have made an examination into the condition and affairs of State-Wide Schools Cooperative Health Plan, a municipal cooperative health benefit plan certified under the provisions of Article 47 of the New York Insurance Law, as of June 30, 2011, and submit the following report thereon.

The examination was conducted at the offices of Wright Risk Management Company (“WRM”), the administrator of State-Wide Schools Cooperative Health Plan. The home office of WRM is located at 333 Earle Ovington Boulevard, Uniondale, New York. A review of the claims was conducted at the office of POMCO, the third-party claims administrator utilized for the examination period, for State-Wide Schools Cooperative Health Plan, located at 2425 James Street, Syracuse, NY.

Wherever the designations “SWSCHP” or the “Plan” appear herein, without qualification, they should be understood to indicate State-Wide Schools Cooperative Health Plan.

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

1. 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:

- Elections of Executive Committee members did not occur at any of SWSCHP's annual general member meetings during the examination period. Such elections are required by the provisions of Section 14, Article IV of the Plan's Municipal Cooperation Agreement.
- Explanation of benefits statements issued by AliCare, Inc. on behalf of SWSCHP did not contain the required forfeiture notification of consumer's rights, in violation of Section 3234(b) of the New York Insurance Law.
- SWSCHP's TPA, Coordinated Care Program, LLC ("CCP"), acting on behalf of SWSCHP, failed to provide telephonic notification of its prospective utilization review determinations to the insured or insured's designee and the insured's health care provider, in violation of Section 4903(b) of the New York Insurance Law.
- CCP, acting on behalf of SWSHCP, failed to provide telephonic notification of its concurrent utilization review determinations to the insured or insured's designee or the insured's health care provider, in violation of Section 4903(c) of the New York Insurance Law.
- CCP, acting on behalf of SWCHP, failed to issue written notification of its utilization review appeals determinations in a timely basis, in violation of Section 4904(c) of the New York Insurance Law.
- CCP, acting on behalf of SWSCHP, violated Section 4904(d) of the New York Insurance Law when it made its utilization review appeal determinations based on the clinical report issued by the clinical reviewer who performed the original utilization review.
- CCP, acting on behalf of SWSCHP, violated Section 4904(c) of the New York Insurance Law when it failed to include the clinical rationale and the notification to the insured about his/her right to an external appeal in its written notifications of adverse determinations on first level utilization review appeals.
- CCP, acting on behalf of SWSCHP, failed to issued its final adverse determinations upon completion of its first level utilization review appeals, in violation of the requirements of Part 410.9(c) of Department Regulation No. 166 (11 NYCRR 410.9(c)) and Section 4910(c) of the New York Insurance Law.

- The Plan violated Section 4900(d-1) and Section 4903(a) of the New York Insurance Law when its adverse determinations of experimental or investigational medical treatments were not rendered by peer clinical reviewers.
- The Plan violated Sections 3201(b)(1) and 4709(b) of the New York Insurance Law when it failed to update its Summary Plan Description to reflect policy and benefits changes required by New York and Federal laws enacted during the examination period, and file with the Department for its prior approval.

The above exam findings, as well as others, are described in greater detail in the remainder of this report.

2. **SCOPE OF THE EXAMINATION**

This examination of the Plan covers the period July 1, 2004 through June 30, 2011. Transactions occurring subsequent to June 30, 2011, were also reviewed where deemed appropriate by the examiner.

This examination was conducted on a risk-focused basis in accordance with the provisions of the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2012 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 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 for the Plan. The examiner planned and performed the examination to evaluate the Plan’s current financial condition, as well as to identify prospective risks that may threaten the future solvency of SWSCHP.

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 organization 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 fiscal years 2004/2005 through 2010/2011, by the accounting firm of Rosen Seymour Shapss Martin & Company LLP ("RSSM"). The Plan received an unqualified opinion in each of those years. Certain audit workpapers of RSSM were reviewed and relied upon in conjunction with this 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 7 of this Report.

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

3. DESCRIPTION OF THE PLAN

The Plan is a multi-employer self-funded health benefits program operated exclusively for the benefit of the employees/retirees and their dependents of member City School Districts (“CSD”) and Union Free School Districts (“UFSD”). The Plan has been in existence since 1986 and is composed of twenty-three separate school districts. It was issued a Certificate of Authority on October 1, 2003 by the Department, pursuant to the provisions of Article 47 of the New York Insurance Law, to operate as a municipal cooperative health benefit plan in accordance with its approved Cooperation Agreement in the State of New York, including the county of Westchester, where it originated as the Southern Westchester Schools Cooperative Health Plan.

The Plan’s participants as of the examination date were as follows:

Ardley UFSD	Mt. Pleasant-Blythdale UFSD
Bronxville UFSD	Mt. Pleasant Central Schools
Byram Hills CSD	Mt. Pleasant Cottage School
Dobbs Ferry UFSD	Mount Vernon CSD
Eastchester UFSD	Pelham UFSD
Edgemont UFSD	Portchester-Rye UFSD
Greenburgh #11 UFSD	Rye City School District
Greenburgh Central Schools #7	Rye Neck UFSD
Harrison CSD	Tarrytown UFSD
Hastings-on-Hudson UFSD*	Tuckahoe UFSD
Hawthorne-Cedar Knolls UFSD	White Plains CSD
Irvington UFSD	

*Hastings-on-Hudson UFSD left SWSCHP, effective July 1, 2010, and then rejoined the Plan effective November 1, 2011.

As of June 30, 2011, the Plan was a party to the following service agreements:

1. Wright Employees Service Company, LLC (“WESCO”) – Plan administrative services management;
2. POMCO, Inc.* – processed both hospital and medical claims;
3. Empire HealthChoice Assurance, Inc. – hospital and professional physician network managing and network claims pricing;
4. Medco Health Solutions, Inc. – prescription drug claims management and processing;
5. Coordinated Care Programs, LLC (a/k/a “Quantum”) – issuance of identification cards, patient education, medical management (utilization review), patient advocacy, and customer services;
6. Milliman Inc. – provides independent annual reviews on the Plan’s claims reserves;
7. The Segal Company – provides general consulting and compliance services.

*Effective September 1, 2011, POMCO, Inc. was replaced by Alicare, Inc., as SWSCHP’s third-party claims administrator.

A. Management and Controls

Pursuant to its Municipal Cooperation Agreement, management control and administration of the Plan is to be vested in a Board of Governors (“Board”). The Municipal Cooperation Agreement of the Plan specifies that the Board of Governors shall select, from members of the Board, an Executive Committee consisting of a minimum of seven “Governors”.

As of the examination date, the Executive Committee was comprised of the following seven members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Dr. Kimberly Bucci Hawthorne, NY	Assistant Superintendent Business, Rye Neck Union Free School
Dr. Norman Freimark Somers, NY	Superintendent, Mt. Pleasant Cottage School
James Reese Holmes, NY	Assistant Superintendent, Irvington UFSD
Fred Seiler Ossining, NY	Assistant Superintendent Business, White Plains CSD
Dr. Edward Shine Easton, CT	Superintendent, Rye City School District
Dr. Howard Smith Tarrytown, NY	Superintendent, Tarrytown UFSD
Louis Wool Shrub Oak, NY	Superintendent, Harrison CSD

Effective July 1, 2011, James Reese and Dr. Norman Freimark retired from their positions. They were succeeded by Angelo Rubbo and Dr. Marilyn Terranova, respectively.

A review of the minutes of the Executive Committee meetings conducted during the examination period indicated that the meetings were generally well attended with all members attending at least one-half of the meetings they were eligible to attend.

Section 5, Article IV of SWSCHP's Municipal Cooperation Agreement states, in part:

"The Board of Governors shall have not fewer than one regularly scheduled meeting(s) in each year, and more frequently as the Board of Governors may determine, at times and places, to be determined by the Board..."

Section 6, Article IV of SWSCHP's Municipal Cooperation Agreement states, in part:

"...The President shall conduct all the meetings of the Board of Governors and shall provide for the keeping of minutes of such proceedings..."

The Plan's Board of Governors met once a year at its annual general member meetings held during the examination period. However, the Board failed to take minutes for all of their six (6) annual general member meetings in violation of the requirements of Section 6, Article IV of its Municipal Cooperation Agreement.

It is recommended that SWSCHP's Board complies with the requirements of Section 6, Article IV of its Municipal Cooperation Agreement by taking minutes of its annual general member meetings and by having the President of the Board of Governors provide for the keeping of said minutes.

Section 14, Article IV of SWSCHP's Municipal Cooperation Agreement states:

“Not less than 15 days prior to the end of every fiscal year, a general meeting of all Plan members shall be held, at which each member may be represented by its general meeting, the Plan members may, by majority vote of the total membership, decide on any propositions which may be put to them by the Board of Governors, the Executive Committee, or by a group of Plan members aggregating not less than twenty-five percent (25%) in number of the total Plan membership; elect successors to an Executive Committee members whose terms are to expire at the end of the current fiscal year; and also, by two-thirds vote of the total membership, remove and replace any Executive Committee member.”(emphasis added)

It should be noted that elections of Executive Committee members did not occur at any of SWSCHP's annual general member meetings during the examination period. Such elections are required by the provisions of Section 14, Article IV of the Plan's Municipal Cooperation Agreement.

It is recommended that SWSCHP complies with Section 14, Article IV of its Municipal Cooperation Agreement by conducting elections of its Executive Committee members during its annual general member meetings.

In response to the aforementioned recommendations, on March 30, 2012, subsequent to the examination period, SWSCHP's Executive Committee adopted procedures to elect its Executive Committee members at its annual general member meetings. Additionally, SWSCHP recorded the minutes of its 2012 annual general member meeting.

The principal officers of the Plan as of June 30, 2011, were as follows:

<u>Name</u>	<u>Title</u>
Dr. Norman Freimark	President
Dr. Kimberly Bucci	Vice President
James Reese	Chief Financial Officer
Herb Friedman	Executive Director

Effective July 1, 2011, James Reese and Herb Friedman resigned from their respective Executive positions. On October 27, 2010, Dr. Norman Freimark was elected as SWSCHP's Executive Director; his election became effective July 1, 2011. On May 20, 2011, Dr. Howard Smith was elected as President and Fred Seiler was elected as Chief Financial Officer; both appointments becoming effective July 1, 2011.

A review of the Plan's Conflict of Interest policy was conducted. The policy requires that each Executive Committee member annually, at the beginning of each fiscal year, complete a questionnaire regarding activities or interests that might impair or have the appearance of impairing independence of judgment. The examiner reviewed the declarations for the examination period and no issues were noted.

In accordance with the requirements of Section 4703(b)(2) of the New York Insurance Law, the Plan maintains adequate fidelity bond coverage for its Chief Financial Officer.

B. Territory and Plan of Operation

Effective October 1, 2003, the Plan was granted a certificate of authority by the Department, under the provisions of Article 47 of the New York Insurance Law, to operate as a municipal cooperative health benefit plan in the State of New York.

The Plan's enrollment consisted of 20,127 members at June 30, 2011, which was approximately one percent (1%) more than the prior year-end enrollment of 20,005 members.

C. Stop-Loss Insurance

In accordance with the requirements of Sections 4707(a)(1) and (2) of the New York Insurance Law, the Plan maintained stop-loss insurance coverage, with Highmark Life Insurance Company of New York, a New York licensed life insurance company, during the examination period. The contract was renewed subsequent to the examination date, on July 1, 2011.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as contained in the Plan's filed annual statement as of June 30, 2011:

<u>Assets</u>	<u>Examination</u>	<u>Plan</u>
Cash	\$ 10,583,538	\$ 10,583,538
Premium receivable	2,213,088	2,213,088
Investment income receivables	265,873	265,873
Aggregate write-ins:		
Stop-loss reimbursement	713,627	713,627
Medicare D subsidy reimbursement	678,167	678,167
Medco claims settlement	2,527,000	2,527,000
Long-term investments	<u>47,408,413</u>	<u>47,408,413</u>
Total assets	\$ <u>64,389,706</u>	\$ <u>64,389,706</u>
 <u>Liabilities</u>		
Accounts payable	\$ 4,881,806	\$ 4,881,806
Claims payable	16,669,481	16,669,481
Additional reserve	4,664,439	4,664,439
Aggregate write-ins:		
Accrued premium deficiency	12,262,000	12,262,000
Due to broker on purchase of US Treasury note	<u>1,666,543</u>	<u>1,666,543</u>
Total liabilities	\$ <u>40,144,269</u>	\$ <u>40,144,269</u>
 <u>Net Worth</u>		
Contingency reserves	5,366,810	5,366,810
Retained earnings/ fund balance	<u>18,878,627</u>	<u>18,878,627</u>
Total net worth	\$ <u>24,245,437</u>	\$ <u>24,245,437</u>
 Total liabilities and net worth	\$ <u>64,389,706</u>	\$ <u>64,389,706</u>

Note: The Plan is a municipal cooperative health benefit plan which falls under IRC Section 115(1), which exempts the Plan from federal income tax. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Net Worth

This examination covered the period from July 1, 2004 through June 30, 2011. Net worth increased by \$8,467,531 during the examination period, detailed as follows:

Revenue

Premiums	\$ 741,488,689	
Net investment income	10,876,896	
Aggregate write-ins for other revenues	<u>19,726,235</u>	
Total revenue		\$ 772,091,820

Expenses

Medical and hospital expenses	706,468,638	
Administration expenses	<u>55,377,761</u>	
Total expenses		<u>761,846,399</u>
Net income		\$ <u>10,245,421</u>

Changes in Net Worth

Net worth, per report on examination as of June 30, 2004			\$ 15,777,906
	<u>Gains in Net Worth</u>	<u>Losses in Net Worth</u>	
Net income	\$ 10,245,421		
Increase in surplus	1,784,338		
Changes in retained earnings/ fund balance	<u> </u>	\$ <u>3,562,228</u>	
Net increase in net worth			\$ <u>8,467,531</u>
Net worth, per report on examination as of June 30, 2011			\$ <u>24,245,437</u>

5. CLAIMS PAYABLE

The examination liability of \$16,669,481 for the above captioned account is the same as the amount reported by the Plan in its filed June 30, 2011 annual statement. In June 2003, the Plan requested and was granted permission by the Department, to reduce its reserves for claims and related expenses to 17% (\$16,669,481 claims payable and a \$4,664,439 additional reserve, which are reflected in the balance sheet contained herein as liabilities) of the current year's expected incurred claims and expenses.

It should be noted that the reserves for the above captioned account are required to be established pursuant to Section 4706(a)(1) of the New York Insurance Law.

Section 4706(a)(1) of the New York Insurance Law states:

“(a) Notwithstanding any provision of law, the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan's chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:

(1) a reserve for 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 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.”(emphasis added)

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

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

- A. Claims processing
- B. Explanation of benefits
- C. Utilization review
- D. Summary Plan Description
- E. Central complaint log
- F. Audits of third-party administrators

A. Claims Processing

The examination included a review of the Plan's claims settlement practices and oversight of the claims adjudication process by the Plan's management. During the examination period, SWSCHP had two third-party claim administrators ("TPAs"): Empire HealthChoice Assurance, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law, (year 2000 to 2007), and POMCO, Inc. (January 1, 2008 to August 31, 2011). Both TPAs owned the provider and hospital networks utilized by SWSCHP members during the period they served.

On October 1, 2009, SWSCHP signed a Jointly Administered Arrangement Administrative-Service-only Agreement ("JAA ASO agreement") with Empire HealthChoice

Assurance, Inc. Under this agreement, SWSCHP members obtain access to the BlueCard program which is formed and administered by Empire HealthChoice Assurance, Inc., and other local BlueCross BlueShield plans (jointly, “Empire BCBS group”). The BlueCard program gives SWSCHP members access to all BCBS provider and hospital networks (jointly, “JAA network”) owned by the Empire BCBS group within the United States.

Under the JAA ASO agreement, the Empire BCBS group administered the filing, pricing, and the remittances of all of the BlueCard claims (“JAA claims”) while POMCO, Inc., verified member eligibility, coordination of benefits, pre-authorization, benefit coverage, and out-of-pocket costs, etc. for these JAA claims. All JAA claims were processed as in-network.

In addition to the JAA claims, POMCO, Inc. also administered and processed all non-JAA claims which consisted of out-of-network (out of both JAA and POMCO networks) claims and POMCO in-network claims.

On August 31, 2011, SWSCHP terminated its claims administrative agreement with POMCO, Inc. Via a Request-for-Proposals (“RFP”) process, the Plan selected Alicare, Inc. (“Alicare”), to be its new claims administrator, effective September 1, 2011. Alicare, Inc. does not have its own provider/ hospital network. SWSCHP will utilize the JAA network for its in-network benefits.

The following chart displays the claim administrators and provider/ hospital networks SWSCHP had from July 1, 2000 to August 31, 2012 (subsequent the examination date):

<u>Service Period</u>	<u>Claims Administrator</u>	<u>SWSCHP's Providers and Hospitals Network(s)</u>
07/01/2000 – 12/31/2007	Empire HealthChoice Assurance, Inc.	Empire HealthChoice Assurance, Inc.
01/01/2008 – 10/31/2009	POMCO, Inc.	POMCO, Inc.
11/01/2009 – 08/31/2011	POMCO, Inc.	POMCO, Inc. & JAA
09/01/2011 – present	Alicare, Inc.	JAA

A review of the Plan's claims practices and procedures was performed using a statistical sample of claims adjudicated during the period July 1, 2010 through June 30, 2011, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 167 hospital claims and 167 medical claims and evaluated the selected claims, testing various attributes deemed necessary for successful claims processing activities.

The statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually, or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each claim in the sample.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purposes of this report: "claim" is defined by the Plan as a grouping of all line items (i.e., procedures or services) on any one claim form. It was possible, through the computer system used for this examination, to match or "roll-up" all procedures on the original form, into one line, which is the basis of the Department's statistical 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 paid claims data reported by the Plan for the period July 1, 2010 through June 30, 2011.

There were no issues or areas of non-compliance identified during the claims review.

B. Explanation of Benefits Statements

Section 3234(b) of the New York Insurance Law states:

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

- (1) the name of the provider of service the admission or financial control number, if applicable;
- (2) the date of service;
- (3) an identification of the service for which the claim is made;
- (4) the provider’s charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
- (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.” (emphasis added)

Upon review of the explanation of benefits statements (“EOBs”) issued subsequent the examination period by Aicare, Inc., on behalf of SWSCHP, it was noted that the EOBs did not contain the forfeiture notification of the consumer’s right, as required by Section 3234(b)(7) of the New York Insurance Law.

It is recommended that SWSCHP ensure that its TPA, Alicare, Inc., provide the required aforementioned forfeiture notification on all of SWSCHP's member EOBs, in accordance with the requirements of Section 3232(b)(7) of the New York Insurance Law.

C. Utilization Review

Sections 4901, 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum program standards and requirements for utilization review ("UR") determinations and appeals of adverse determinations by utilization review agents.

The examiner reviewed medical utilization reviews performed during the twelve-month period July 1, 2010 through June 30, 2011, all of which were administered by the Plan's TPA, Coordinated Care Program, LLC ("CCP"). The Plan is not required to report utilization review cases in its filed annual or quarterly statements, nor its data requirements filings. Per the examiner's request, CCP provided a listing of cases requiring utilization review determinations covering the period July 1, 2010 through June 30, 2011. Thirty (30) cases (one (1) prospective, seventeen (17) concurrent reviews, and twelve (12) retrospective reviews) were selected for review by the examiner.

The examiner determined that six (6) of the selected UR cases had been misclassified in CCP's system: three (3) prospective cases were misclassified as concurrent; two (2) concurrent cases were misclassified as retrospective; and one (1) retrospective case was misclassified as concurrent. After the reclassification, the following was the new composition of the thirty (30) selected cases: four (4) prospective, fifteen (15) concurrent reviews, and eleven (11) retrospective reviews.

It is recommended that the Plan ensure that its TPA, CCP, properly classify its utilization reviews into the correct (prospective, concurrent, and retrospective) categories.

(i) Prospective Utilization Reviews

Four (4) cases selected for review pertained to “prospective” utilization review determinations.

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

“(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured’s designee and the insured’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

SWSCHP’s policy for its Utilization Reviews determinations entitled “*Clinical Review Process Timeframes - NY*” states in part:

“... *Once a determination is made the member and provider are to be notified telephonically and in writing within the timeframes established below...*”

For all four (4) cases reviewed, CCP, on behalf of the Plan, failed to provide telephonic notification of their determination to the insured or insured’s designee and the insured’s health care provider in violation of Section 4903(b) of the New York Insurance Law and of its Clinical Review Process Timeframes - NY policy.

It is recommended that in regard to prospective utilization reviews, the Plan ensure that its TPA, CCP, comply with the requirements of Section 4903(b) of the New York Insurance Law and with its Clinical Review Process Timeframes - NY policy by providing telephonic notices in

addition to the written notifications, of their determination to the insured or the insured's designee and the insured's provider.

(ii) Concurrent Utilization Reviews

Fifteen (15) cases selected for review pertained to "concurrent" utilization review determinations.

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

"A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday..."

SWSCHP's policy for its Utilization Reviews determinations entitled "*Clinical Review*

Process Timeframes - NY" states in part:

"... Once a determination is made the member and provider are to be notified telephonically and in writing within the timeframes established below.

*For continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within **one business day** of receipt of the necessary information, except, with respect to home health care services following an inpatient hospital admission, within **seventy-two hours** of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday..."*

Thirteen (13) of the fifteen (15) concurrent utilization review cases reviewed by the examiners were found to have one or more violations of Section 4903(c) of the New York Insurance Law and of the Plan's Clinical Review Process Timeframes - NY policy, detailed as follows:

- For four (4) of the thirteen (13) cases written notifications were sent after one business day of receipt of the necessary information.
- For twelve (12) of the thirteen (13) cases telephonic notification was not provided to the insured's health care provider or the insured.

It is recommended that the Plan require its TPA, CCP, to comply with the requirements of Section 4903(c) of the New York Insurance Law and with its Clinical Review Process Timeframes - NY policy by providing notices of determination within one business day, by telephone and in writing, to the insured, the insured's designee or the insured's health care provider.

(iii) First Level UR Appeals

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

“... The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination...”
(*emphasis added*)

For the period July 1, 2010 to June 30, 2011, the Plan's TPA, CCP, reviewed twenty-three (23) first-level appeal cases. The examiner selected and reviewed thirteen (13) of these cases.

For three (3) cases, the insured was informed in writing of the appeal determination, after two business days of the rendering of such determination, in violation of the requirements of Section 4904(c) of the New York Insurance Law.

It is recommended, with respect to first level UR appeals, that the Plan require its TPA, CCP to issue written appeal determinations within two business days of the rendering of its determination, in accordance with the requirements of Section 4904(c) of the New York Insurance Law.

Section 4904(d) of the New York Insurance Law states:

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

For one (1) case the examiner reviewed, the determination was made based on the clinical report issued by the clinical reviewer who performed the original utilization review, in violation of Section 4904(d) of the New York Insurance Law.

It is recommended that the Plan require its TPA, CCP, to ensure that both expedited and standard appeals are conducted by clinical peer reviewers who have not rendered the adverse determination, in accordance with the requirements of Section 4904(d) of the New York Insurance Law.

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

“(c) A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from

said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.

The notice of the appeal determination shall include:

(1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and

(2) a notice of the insured's right to an external appeal together with a description ...of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.” (emphasis added)

For all eleven (11) denials the examiner reviewed, the Plan failed to have its TPA, CCP, include in its notices of UR appeal determination, the clinical rationale for such determination and the notification to the insured about his/her right to external appeal, as required by Section 4904(c) of the New York Insurance Law.

It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of Section 4904(c) of the New York Insurance Law by including the clinical rationale and the notification to the insured about his/her right to an external appeal in their first level UR appeal adverse determination notice.

Part 410.9(e)(9) of Department Regulation No. 166 (11 NYCRR 410.9(e)(9)) states:

“(e) Each notice of an final adverse determination of an expedited or standard utilization review appeal ...shall be in writing, dated and include the following...

(9) For health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal.”

It should be noted that none of the adverse determination notifications issued by the Plan at its first level UR appeals included the above-mentioned statement required by Part 410.9(e)(9) of Department Regulation No. 166.

It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of Part 410.9(e)(9) of Department Regulation No. 166 by including the required aforementioned statement in all of its adverse determinations issued at the first level of UR appeals.

Part 410.9(c) of Department Regulation No. 166 (11 NYCRR 410.9(c)) states:

“If a health care plan offers two levels of internal appeals, the health care plan may not require the insured to exhaust the second level of internal appeal to be eligible for an external appeal.”

Section 4910(b) of the New York Insurance Law states in part:

“(b) An insured, the insured’s designee and, in connection with concurrent and retrospective adverse determinations, an insured’s health care provider, shall have the right to request an external appeal when:

(1)(A) the insured has had coverage of the health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service does not meet the health care plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, and

(B) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the insured have jointly agreed to waive any internal appeal, or the insured is deemed to have exhausted or is not required to complete any internal appeal...” (*emphasis added*)

Upon further review it was determined that the Plan failed to have its TPA, CCP, issue its final adverse determinations at their first level of UR appeals, in violation of the requirements of Part 410.9(c) of Department Regulation No. 166 (11 NYCRR 410.9(c)) and Section 4910(b) of the New York Insurance Law. It should be noted that failure to issue such final adverse

determinations causes the subscriber to lose valuable time with regard to proceeding to an external appeal.

It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of both Part 410.9(c) of Department Regulation No. 166 and Section 4910(b) of the New York Insurance Law by issuing the final adverse determinations at its first level of UR appeals.

(iv) Second Level Appeals

SWSCHP offered a second level Executive Review done by its Executive Committee, for its grievances and complaints. First level appeals for the Plan involving medical necessity determinations were done by a clinical peer reviewer as required by Section 4900(b) of the New York Insurance Law. The Executive Reviews of the Plan were offered in the adverse determination notices of its first level utilization reviews. However, the Plan failed to clarify in these notices that the Executive Review, conducted by the Executive Committee, was another review that SWSCHP offered to its members and that such reviews did not involve a clinical peer reviewer. Such clarification is necessary to prevent any confusion the members may have since second level appeals involving medical necessity reviews are required to be handled by clinical peer reviewers.

Section 4900(b) of the New York Insurance Law states in part:

“(b) “Clinical peer reviewer” means:

(1) for purposes of title one of this article:

(A) a physician who possesses a current and valid non-restricted license to practice medicine; or

(B) a health care professional other than a licensed physician who:

- (i) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and
 - (ii) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; and
- (2) for purposes of title two of this article:
- (A) a physician who:
 - (i) possesses a current and valid non-restricted license to practice medicine;
 - (ii) where applicable, is board certified or board eligible in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal; and
 - (iii) has been practicing in such area of specialty for a period of at least five years; and
 - (iv) is knowledgeable about the health care service or treatment under appeal; or
 - (B) a health care professional other than a licensed physician who:
 - (i) where applicable, possesses a current and valid non-restricted license, certificate or registration;
 - (ii) where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;
 - (iii) has been practicing in such area of specialty for a period of at least five years;
 - (iv) is knowledgeable about the health care service or treatment under appeal; and
 - (v) where applicable to such health care professional's scope of practice, is clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine..."

Section 4904(d) of the New York Insurance Law states:

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

Section 4904(d) of the New York Insurance Law requires that only clinical peer reviewers can review the expedited and standard medical necessity appeals. It should be noted that no member of the Plan's Executive Committee was qualified as clinical peer reviewers, as such term is defined by Section 4900(b) of the New York Insurance Law, to review any appeals that involves medical necessity reviews.

It is recommended that SWSCHP prevents any confusion the members may have with regard to their second level appeal rights by clarifying, in its final adverse determination notices, the purpose and nature of its Executive Review and its second level appeals process.

Furthermore, it was noted that SWSCHP did not keep a log of its Executive Reviews or second level appeals. In addition, the Plan did not assign sequential numbers to its Executive Reviews or second level appeals, as such, the examiner was not able to verify the total number of Executive Reviews or second level appeals handled by SWSCHP during the examination period.

It is recommended, as a good business practice, that SWSCHP keeps a log of all of its Executive Reviews and second level appeals.

It is also recommended that the Plan use sequential case numbers and include other relevant information for the purpose of tracking such Executive Reviews and second level appeals.

(v) *Experimental and Investigational Denials*

Section 4900(d-1) of the New York Insurance Law states:

“(d-1) “Experimental and investigational treatment review plan” means:

(1) a description of the process for developing the written clinical review criteria used in rendering an experimental and investigational treatment review determination; and

(2) a description of the qualifications and experience of the clinical peers who developed the criteria, who are responsible for periodic evaluation of the criteria, and who use the written clinical review criteria in the process of reviewing proposed experimental and investigational health services and procedures.”
(emphasis added)

Section 4903(a) of the New York Insurance Law states:

“(a) Utilization review shall be conducted by:

(1) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;

(2) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and

(3) A clinical peer reviewer where the review involves an adverse determination.”
(*emphasis added*)

In January 2012, the Department’s Consumer Assistance Unit received a complaint from a SWSCHP member. The member complained that the Plan denied the member-requested service on the ground that it was experimental and investigational. It should be noted that the denial of service was given because the service was considered to be a contract provision exclusion and additionally, no clinical review was performed in accordance with the requirements of Sections 4900(d-1) and 4903(a) of the New York Insurance Law.

It is recommended that the Plan ensures that its TPA, CCP, complies with the requirements of Sections 4900(d-1) and 4903(a) of the New York Insurance Law by having all adverse determinations of its utilization reviews on experimental and investigational medical treatments rendered by clinical peer reviewers.

The management of SWSCHP retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related regulations, and therefore must be diligent in its oversight of the delegated functions to its TPAs.

It is recommended that Plan management fulfills its responsibility for compliance with New York Insurance Law and regulations, as regards the all its delegated functions, via strong oversight of its TPAs' practices.

D. Summary Plan Description

Section 3201(b)(1) of the New York Insurance Law states in part:

“(b)(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law...”

Section 4709(b) of the New York Insurance Law states in part:

“(b) The summary plan description shall be subject to regulation as if it were a health insurance subscriber certificate, provided that the superintendent may modify or suspend any provision of this chapter or regulation promulgated thereunder pertaining to scope or type of coverage...”

During the examination period, a number of new State and Federal health related laws were enacted, such as the immediate market reform requirements of the Patient Protection and Affordable Care Act, Timothy's Law, and the "Age 29" Law. The Plan is required pursuant to the requirements of Section 3201(b)(1) of the New York Insurance Law to file its Summary Plan Description ("SPD") with the Department to confirm its compliance with these (new) laws. It should be noted that the Plan did not make any of the required filings during the examination period.

It is recommended that SWSCHP complies with the requirements of Section 3201(b)(1) and Section 4709(b) of the New York Insurance Law by making all the required filings with the Department.

It should be noted that on December 29, 2011, subsequent to the examination date, SWSCHP made the required filing with the Department. The filing was approved by the Department on May 29, 2012.

E. Central Complaint Log

Circular Letter No. 11 (1978) of the Department states in part:

“[As] part of its complaint handling function, the company’s consumer services department will maintain an ongoing central log to register and monitor all complaint activity. The log should be kept in a columnar form and list the following:

1. The date the complaint was received in-house.
2. The name of the complainant and the policy or claim file number.
3. The New York State Insurance Department file number.
4. The responsible internal division i.e. personal lines underwriting, property damage claims, etc.
5. The person in the company with whom the complainant has been dealing.
6. The person within the company to whom the matter has been referred for review.
7. The date of such referral.
8. Bearing in mind the appropriate regulation mandating timely substantive replies, the dates of correspondence to the Insurance Department’s Consumer Services Bureau.
 - A. The acknowledgement (if any).
 - B. The date of any substantive response.
 - C. The chronology of further contacts with this Department.
9. The subject matter of the complaint.
10. The results of the complaint investigation and the action taken.
11. Remarks about internal remedial action taken as a result of the investigation.”

Circular Letter No. 11 (1978) requires the Plan to establish an internal department specifically designated to investigate and resolve complaints filed by consumers with the Department’s Consumer Assistance Unit (“CAU”) and to take action necessitated as a result, of the complaint investigation findings.

The Plan's internal department is required to maintain an ongoing central log register and monitor all complaint activity. The log should be kept in a columnar format and include items 1 through 11 above.

It should be noted that SWSCHP kept the image copies of CAU complaints and maintained them in a centralized folder in ImageRight, WRM's server application. However, the Plan did not maintain a log in a columnar format with the information required by Department Circular Letter No. 11 (1978).

It is recommended that SWSCHP maintains a log of its CAU complaints in accordance with the requirements of Circular Letter No. 11 (1978).

In addition to the CAU complaints, the Plan, and its TPAs (CCP and POMCO, Inc.) also handle other non-CAU complaints directly from SWSCHP members. It should be noted that a central complaint log for these member complaints was not maintained, rather, each TPA maintained its own records of complaints. Without a central log tracking all complaints received for the Plan, it is difficult to identify the subject matter of the member's complaints, and whether a widespread problem exists.

It is recommended, as a good business practice, that SWSCHP maintains one central complaint log, which includes all complaints received with regard to its members, as a tool to monitor all of its complaint activities and identify potential problem areas.

F. Audits of Third-Party Administrators

During the examination period, SWSCHP delegated its various operational and insurance functions to the following third-party administrators ("TPAs"):

1. Wright Employees Service Company, LLC (“WESCO”) – Plan administrative services management;
2. POMCO, Inc.* – processed hospital and medical claims;
3. Empire HealthChoice Assurance, Inc. – hospital and professional physician network managing and network claims pricing;
4. Medco Health Solutions, Inc. –prescription drug claims management and processing;
5. Coordinated Care Programs, LLC (aka “CCP” or “Quantum”) – issuance of identification cards, patient education, medical management (utilization review), patient advocacy, and customer service.

*Effective September 1, 2011, POMCO, Inc., was replaced by Aicare, Inc., as SWSCHP’s third-party claims administrator.

It should be noted that while SWSCHP performed some audits of its TPAs during the earlier years of the examination period, there were no specific written policies or guidelines with regard to procedures used for these audits. The Plan maintains that other methods to monitor its TPA’s contractual obligations were utilized.

Good business practice dictates that in order to ensure proper oversight of its TPAs the Plan should develop and implement formal written policies and procedures with regard to when and how it will conduct the audits of its TPAs.

It is recommended that the Plan ensures compliance of the New York Insurance Law and proper oversight of its TPAs, by developing and implementing formal written policies and procedures on when and how it will conduct audits of its TPAs.

It is further recommended that a formal report be issued detailing the process used to conduct these audits and documenting whether any issues were found or not found and what actions, if any, were taken to rectify the issues.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

There were seven (7) comments and recommendations from the prior report on examination as of June 30, 2004. They are repeated herein as follows (page number refers to the prior report):

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	<p>It is recommended that the Board of Governors take corrective action by developing a policy to evaluate whether Executive Committee members who are unable or unwilling to attend meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the Executive Committee, a key criterion should be their willingness and commitment to attend meetings and participate in the Committee's responsibility to oversee the operations of the Plan.</p> <p><i>The Plan has complied with this recommendation.</i></p>	5
2.	<p>It is recommended that the Plan record and report all of its claims liabilities in its financial statements filed with this Department in accordance with the requirements of Statement of Statutory Accounting Principles (SSAP) No. 55 and §4706(a)(1) of the New York Insurance Law.</p> <p><i>The Plan has complied with this recommendation.</i></p>	12
3.	<p>It is recommended that Empire correct its claim processing errors in regard to the misapplication of co-payments, whether related to system problems or manual intervention.</p> <p><i>This recommendation is no longer applicable since the Plan terminated Empire as its third-party claim administrator effective January 1, 2008.</i></p>	17
4.	<p>It is also recommended that Empire share overpayment reports with SWSCHP to apprise them of any outstanding overpayment amounts and the current status of recovery activity. Additionally, Empire should consider the reduction of future benefit payments by the outstanding amounts due.</p> <p><i>This recommendation is no longer applicable since the Plan terminated Empire as its third-party claim administrator effective January 1, 2008.</i></p>	17

ITEM NO.**PAGE NO.**

5. It is recommended that Empire and SWSCHP implement adequate controls in regard to system updates on coordination of benefits (COB) and membership information, in order to avoid overpayment of claims where other coverage or no coverage may exist. 18
- This recommendation is no longer applicable since the Plan terminated Empire as its third-party claim administrator effective January 1, 2008.*
6. It is also recommended that Empire take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider retraining individuals who process claims. 18
- This recommendation is no longer applicable since the Plan terminated Empire as its third-party claim administrator effective January 1, 2008.*
7. It is recommended that in regard to prospective utilization reviews, the Plan (Empire) comply with the requirements of §4903(b) of the New York Insurance Law by providing notices of determination within three business days, by telephone and in writing, to the insured or the insured's designee and the provider. 19
- The Plan has not complied with this recommendation. A similar finding is contained in this Report with the Plan's TPA, Coordinated Care Program, LLC.*

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management and Controls</u>	
i. It is recommended that SWSCHP's Board complies with the requirements of Section 6, Article IV of its Municipal Cooperation Agreement by taking minutes of its annual general member meetings and by having the President of the Board of Governors provide for the keeping of said minutes.	9
ii. It is recommended that SWSCHP complies with Section 14, Article IV of its Municipal Cooperation Agreement by conducting elections of its Executive Committee members during its annual general member meetings.	9
B. <u>Explanation of Benefits Statements</u>	
It is recommended that SWSCHP ensure that its TPA, Alicare, Inc., provide the required aforementioned forfeiture notification on all of SWSCHP's member EOBs, in accordance with the requirements of Section 3232(b)(7) of the New York Insurance Law.	19
C. <u>Utilization Review</u>	
i. It is recommended that the Plan ensure that its TPA, CCP, properly classify its utilization reviews into the correct (prospective, concurrent, and retrospective) categories.	20
ii. It is recommended that in regard to prospective utilization reviews, the Plan ensure that its TPA, CCP, comply with the requirements of Section 4903(b) of the New York Insurance Law and with its Clinical Review Process Timeframes - NY policy by providing telephonic notices in addition to the written notifications, of their determination to the insured or the insured's designee and the insured's provider.	20
iii. It is recommended that the Plan require its TPA, CCP, to comply with the requirements of Section 4903(c) of the New York Insurance Law and with its Clinical Review Process Timeframes - NY policy by providing notices of determination within one business day, by telephone and in writing, to the insured, the insured's designee or the insured's health care provider.	22

<u>ITEM</u>	<u>PAGE NO.</u>
C. <u>Utilization Review (Cont'd)</u>	
iv. It is recommended, with respect to first level UR appeals, that the Plan requires its TPA, CCP to issue written appeal determinations <u>within two business days</u> of the rendering of its determination, in accordance with the requirements of Section 4904(c) of the New York Insurance Law.	23
v. It is recommended that the Plan require its TPA, CCP, to ensure that both expedited and standard appeals are conducted by clinical peer reviewers who have not rendered the adverse determination, in accordance with the requirements of Section 4904(d) of the New York Insurance Law.	23
vi. It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of Section 4904(c) of the New York Insurance Law by including the clinical rationale and the notification to the insured about his/her right to an external appeal in their first level UR appeal adverse determination notice.	24
vii. It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of Part 410.9(e)(9) of Department Regulation No. 166 by including the required aforementioned statement in all of its adverse determinations issued at the first level of UR appeals.	25
viii. It is recommended that the Plan ensure that its TPA, CCP, complies with the requirements of both Part 410.9(c) of Department Regulation No. 166 and Section 4910(b) of the New York Insurance Law by issuing the final adverse determinations at its first level of UR appeals.	26
ix. It is recommended that SWSCHP prevents any confusion the members may have with regard to their second level appeal rights by clarifying, in its final adverse determination notices, the purpose and nature of its Executive Reviews and its second level appeals process.	28
x. It is recommended, as a good business practice, that SWSCHP keeps a log of all of its Executive Reviews and second level appeals.	28
xi. It is also recommended that the Plan use sequential case numbers and include other relevant information for the purpose of tracking such Executive Reviews and second level appeals.	28
xii. It is recommended that the Plan ensures that its TPA, CCP, complies with the requirements of Sections 4900(d-1) and 4903(a) of the New York Insurance Law by having all adverse determinations of its utilization reviews on experimental and investigational medical treatments rendered by clinical peer reviewers.	29

<u>ITEM</u>	<u>PAGE NO.</u>
C. <u>Utilization Review (Cont'd)</u>	
xiii. It is recommended that Plan management fulfills its responsibility for compliance with New York Insurance Law and regulations, as regards the all its delegated functions, via strong oversight of its TPAs' practices.	29
D. <u>Summary Plan Description</u>	
It is recommended that SWSCHP complies with the requirements of Section 3201(b)(1) and Section 4709(b) of the New York Insurance Law by making all the required filings with the Department.	30
E. <u>Central Complaint Log</u>	
i. It is recommended that SWSCHP maintains a log of its CAU complaints in accordance with the requirements of Circular Letter No. 11 (1978).	32
ii. It is recommended, as a good business practice, that SWSCHP maintains one central complaint log, which includes all complaints received with regard to its members, as a tool to monitor all of its complaint activities and identify potential problem areas.	32
F. <u>Audits of Third-Party Administrators</u>	
i. It is recommended that the Plan ensures compliance of the New York Insurance Law and proper oversight of its TPAs, by developing and implementing formal written policies and procedures on when and how it will conduct audits of its TPAs.	33
ii. It is further recommended that a formal report be issued detailing the process used to conduct these audits and documenting whether any issues were found or not found and what actions, if any, were taken to rectify the issues.	33

Appointment No. 30719

**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:

Jo-Lo Hsia

as a proper person to examine into the affairs of the

State-Wide Schools Cooperative Health Plans

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 9th day of September, 2011



James J. Wrynn
Superintendent of Insurance

