

ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU

In the Matter of

EXCELLUS HEALTH PLAN, INC.

**ASSURANCE OF DISCONTINUANCE
PURSUANT TO EXECUTIVE LAW
SECTION 63, SUBDIVISION 15**

Pursuant to the provisions of Article 22-A of the New York State General Business Law, Article 63 of the New York State Executive Law, Article 49 of the New York State Public Health Law and Article 49 of the New York State Insurance Law, Eliot Spitzer, Attorney General of the State of New York, caused an investigation to be made into certain utilization review practices of Excellus Health Plan, Inc. Based upon his investigation, the Attorney General has made the following findings:

1. For purposes of this Assurance of Discontinuance, the following terms shall have the following meanings:

"Adverse Determination" means a decision by Respondent or its UR Contractors, with respect to an Enrollee, that a health care service, procedure or treatment, including but not limited to an inpatient admission or extension of stay, is not medically necessary. The term "Adverse Determination" encompasses decisions made at the Initial Adverse Determination level and on Appeal. Notice of an Adverse Determination must be given in writing, although in certain circumstances it must also be given by other means, e.g., by telephone in a Pre-authorization situation.

"Adverse Determination Letter" means the written notice of an Adverse Determination. The term "Adverse Determination Letter" encompasses Initial Adverse Determination Letters, Appeal Letters that uphold the Adverse Determination in whole or in part, and Final Adverse Determination Letters.

"Appeal" means a Standard Appeal or an Expedited Appeal.

"Appeal Letter" means the written notice of the decision on an Appeal. An Appeal Letter may uphold the underlying Adverse Determination, uphold it in part, or overturn it. Where the Adverse Determination is upheld, in whole or in part, and no further internal appeal is available, the Appeal Letter also constitutes a Final Adverse Determination Letter.

"BlueCross BlueShield of Central New York" was the corporate predecessor of Excellus Health Plan, Inc. In January of 1996, BlueCross BlueShield of Central New York was renamed "Excellus Health Plan, Inc.," but Excellus Health Plan, Inc. continues to do business under the name "BlueCross BlueShield of Central New York."

"Clinical Peer Reviewer" means a physician who possesses a current and valid non-restricted license to practice medicine; or a health care professional other than a licensed physician who (a) 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 (b) 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.

"Concurrent Review" refers to a situation in which coverage is sought for continued or extended health care services, procedures or treatments or additional services for an Enrollee undergoing a course of continued treatment.

"Document" means all written or graphic material, however produced or reproduced, including but not limited to records, correspondence, memoranda, notes, opinions, reports, summaries, charts, electronic mail, computerized data and any other form in which information is recorded or transmitted. To the extent that this Assurance of Discontinuance calls for Respondent to provide Documents to the Attorney General, the Documents shall include the translation and printout of computerized or other electronic information into reasonably usable form.

"Enrollee" means a person whose health care is subject to Utilization Review.

"Enrollee File" means the Documents maintained by a Utilization Review Agent with respect to an Adverse Determination, including any Appeal or other subsequent activity relating

to that Adverse Determination.

"Enrollee's Designee" means any person (including any entity) authorized by an Enrollee to assist the Enrollee in obtaining access to, coverage of or payment for health care services, procedures or treatments, including but not limited to the Enrollee's health care provider.

"Excellus Health Plan" or "Excellus" is an indemnity insurer that is: (1) licensed under Article 43 of the IL; and (2) authorized to operate a health maintenance organization ("HMO") under Article 44 of the PHL. As such, Excellus performs Utilization Review pursuant to Article 49 of the IL and Article 49 of the PHL. The constituent entities that are now part of Excellus include: (1) BlueCross BlueShield of Central New York, which was formed in 1985 and changed its corporate name to Excellus Health Plan, Inc. in January of 1996; (2) Finger Lakes Health Plan and Finger Lakes Medical Plan, doing business as BlueCross BlueShield of the Rochester Area, which became affiliated with Excellus in 1997 and was merged into Excellus on December 31, 1998; (3) Utica-Watertown Health Insurance Company, Inc., doing business as BlueCross BlueShield of Utica-Watertown, which became affiliated with Excellus in 1997 and was merged into Excellus on December 31, 1998; and (4) HMO-CNY, which was created as a wholly-owned subsidiary of Excellus in 1988 and was merged into Excellus in January 2001. Excellus does business in New York State with regard to indemnity products under the names "BlueCross BlueShield of Central New York," "BlueCross BlueShield of the Rochester Area" and "BlueCross BlueShield of Utica-Watertown," among others, and with regard to HMO products, under the names "HMO-CNY," "Finger Lakes HMO," and "HMO Blue," among others. Excellus conducts most of its operations through three divisions: the Central New York Division, the Rochester Division and the Utica-Watertown Division. Excellus' corporate headquarters are located at 165 Court Street, Rochester, New York, 14647.

"Expedited Appeal" means an Appeal that must be handled more quickly than a Standard Appeal because: (1) it involves a Concurrent Review situation; (2) the Enrollee's health care provider believes an immediate appeal is warranted; or (3) there is imminent or serious threat to the health of the Enrollee [PHL, §§ 4902(1)(d), 4904(2); IL, §§ 4902(a)(4), 4904(b)]. An Expedited Appeal is not available in a Retrospective Review situation.

"External Appeal" means an appeal from a Final Adverse Determination, which is heard

by independent health professionals pursuant to Title II of Article 49 of the PHL and Title II of Article 49 of the IL.

"Final Adverse Determination" means an Adverse Determination at the final stage of the internal appeal process of Respondent or its UR Contractors.

"Final Adverse Determination Letter" means a written notice communicating a Final Adverse Determination.

"Green Spring" means Green Spring Health Services, Inc., a UR Contractor which conducts Utilization Review for Respondent with respect to mental health and substance abuse services.

"Health Plan" means a health maintenance organization, health insurer or health benefit plan, including but not limited to organizations certified under Article 44 of the PHL and insurers subject to Articles 32 or 43 of the IL.

"IL" means the New York State Insurance Law, as amended from time to time.

"Initial Adverse Determination" means the first Adverse Determination following an initial request for coverage of a medical service, treatment or procedure.

"Initial Adverse Determination Letter" means the written notice of an Initial Adverse Determination.

"PHL" means the New York State Public Health Law, as amended from time to time.

"Pre-authorization" refers to a situation in which coverage is sought for a proposed medical service, treatment or procedure that has not yet been provided.

"Reasons and Clinical Rationale" means the individualized medical basis for an Adverse Determination. A statement of Reasons and Clinical Rationale must demonstrate that the UR Agent made an individualized medical assessment of the Enrollee by referring to the specific medical data relating to the Enrollee, which the Clinical Peer Reviewer took into consideration when making the Adverse Determination. Merely stating that the service at issue is not medically necessary is not sufficient, nor is a statement that the proposed service does not meet the UR Agent's criteria. A statement of Reasons and Clinical Rationale must be sufficiently specific to enable the Enrollee and/or the Enrollee's health care provider to make an informed decision about whether or not to appeal the Adverse Determination and to determine the issue or

issues to address in the appeal. Examples of statements of Reasons and Clinical Rationale which meet this definition are attached hereto as Exhibit A.

"Reconsideration" means the review of an Initial Adverse Determination that was made by Respondent or its UR Contractors without attempting to discuss it with the Enrollee's health care provider who specifically recommended the health care service, procedure or treatment in question.

"Respondent" means Excellus and all of its divisions, subsidiaries and affiliates, to the extent that their operations affect Enrollees in New York State. An "affiliate" of Excellus encompasses any entity that controls, is controlled by or is under common control with Excellus, including any operation that Excellus manages but does not own. For purposes of all terms and conditions of this Assurance of Discontinuance which are to be performed or satisfied in the future, Respondent includes all future divisions, subsidiaries and affiliates of Excellus, including but not limited to any entities or operations which Excellus may hereafter acquire, or with which it may merge or otherwise become affiliated. Nonetheless, any entities or operations that Excellus hereafter acquires, or with which it may merge or otherwise become affiliated, will not be subject to the terms of this Assurance until six months after the date of such merger or acquisition.

"Retrospective Review" refers to a situation in which coverage is sought for a medical service, treatment or procedure that has already been provided.

"Standard Appeal" means the internal, non-expedited review of an Adverse Determination.

"UR" or "Utilization Review" means the review by Respondent or its UR Contractors to determine whether a health care service, treatment or procedure that has been provided, is being provided or is proposed to be provided to an Enrollee - whether such review is undertaken prior to, concurrently with or subsequent to the provision of the service, treatment or procedure - is medically necessary.

"UR Agent" means a Health Plan or UR Contractor.

"UR Contractor" means a company, organization or other entity performing Utilization Review for a Health Plan, directly or through one or more subcontractors.

"UR Law" means Article 49 of the PHL, Article 49 of the IL and the rules and regulations promulgated thereunder.

2. The Attorney General's Health Care Bureau commenced an investigation concerning compliance by various UR Agents, including Respondent, with the UR Law. A primary focus of this investigation was compliance during the period January 1, 1999 through June 30, 1999.

3. A Health Plan, such as Respondent, that delegates any UR function is responsible for assuring that all contractors, subcontractors, sub-vendors, agents and employees and others who perform such functions adhere to the standards and requirements of the UR Law [PHL, § 4901(m); IL, § 4901(13)]. Therefore, non-compliance with the UR Law by any UR Contractor acting on behalf of Respondent constitutes non-compliance by Respondent, and references in this Assurance of Discontinuance to non-compliance by Respondent may encompass non-compliance by Respondent's UR Contractors.

4. Respondent and its UR Contractors perform UR with respect to Respondent's approximately 1.7 million (1,700,000) Enrollees in New York State.

5. In compliance with the subpoena issued by the Attorney General, the Attorney General's Health Care Bureau reviewed a substantial amount of information provided by Respondent relating to Utilization Review performed by Respondent and its UR Contractors. The findings set forth below are based on this review.

6. Respondent's Adverse Determination Letters consistently failed to state the Reasons and Clinical Rationale for the determination as required by the UR Law [PHL, § 4903(5)(a); IL, § 4903(e)(1)]. In ninety-six percent of cases, Respondent's Adverse Determination Letters simply stated, without further explanation or elaboration of any kind, that the service, procedure or treatment was "not medically necessary." In some cases, Respondent used an additional phrase such as "care could have been provided in an alternate setting," but gave no basis for this assertion. These formulations fall far short of the UR Law's requirement to state the Reasons and Clinical Rationale for an Adverse Determination. They are conclusory statements, providing no information concerning the individual Enrollee, reflecting no individual evaluation of the Enrollee's medical condition, and offering no insight into any clinical reasoning

that might support the Adverse Determination.

7. Likewise, approximately ninety percent of Respondent's Appeal Letters and Final Adverse Determination Letters failed to include an adequate statement of Reasons and Clinical Rationale, in violation of the UR Law [PHL, § 4904(3)(a); IL, § 4904(c)(1)].

8. Adverse Determination Letters that fail to provide the required statement of Reasons and Clinical Rationale create doubt in the minds of Enrollees and the public generally as to whether UR Agents such as Respondent that deny coverage of health care are basing these denials on appropriate individualized medical evaluations as required by the UR Law. Such Adverse Determination Letters reinforce the public perception that such denials are being made solely for financial reasons by non-medical personnel, without regard for the Enrollee's medical needs and circumstances. They also undermine the right to appeal from an Adverse Determination because the absence of a specific statement of the basis for the determination makes it difficult if not impossible for the Enrollee (and/or the Enrollee's health care provider) to: (1) make an informed decision regarding whether or not to appeal; and (2) formulate and present an effective challenge to the Adverse Determination.

9. Approximately ten percent of Respondent's Initial Adverse Determinations were not made within the applicable statutory time frame, in violation of the UR Law [PHL, §§ 4903(2), (3) & (4); IL, §§ 4903(b) & (c)]. Even in Retrospective Review situations, such delays cause uncertainty on the part of Enrollees and their health care providers regarding whether care will be paid for. This may discourage Enrollees from seeking care they need and may discourage providers from rendering such care.

10. In certain Concurrent Review situations, Respondent and Green Spring repeatedly issued coverage denial letters to health care providers, on letterhead bearing both Respondent's and Green Spring's names, asserting that they lacked sufficient information to determine whether an extension of care was medically necessary when in fact, the necessary information had already been provided.

11. In virtually all cases involving Appeals, Respondent failed to provide a written acknowledgment of the request for an Appeal, in violation of the UR Law [PHL, § 4904(3); IL, § 4904(c)].

12. The UR Law in effect during the period January 1, 1999 through June 30, 1999 provided that any decision to uphold an Initial Adverse Determination on Appeal must be made by a "clinical peer review," i.e., a licensed physician in the same or similar specialty as the health care provider who would typically manage the medical condition, procedure or treatment under review [Public Health Law (1998), § 4901(2); Insurance Law (1998), § 4901(b)]. Effective July 1, 1999, this requirement was modified by the current definition of Clinical Peer Reviewer (see above). Under the UR Law in effect currently (as well as during the January 1, 1999 through June 30, 1999 period), the decision to uphold an Initial Adverse Determination on Appeal must be made by a Clinical Peer Reviewer other than the Clinical Peer Reviewer who made the initial determination [PHL, § 4904(4); IL, § 4904(d)]. In twenty-five percent of cases reviewed by the Attorney General's Health Care Bureau, it was impossible to determine from the information provided by Respondent whether Adverse Determinations of Appeals were made by someone who satisfied both of the legal requirements then in effect, *i.e.*, the prior definition of "clinical peer reviewer" and the requirement that the Appeal be decided by a new reviewer.

13. With respect to the timing of Respondent's Appeal decisions, it was not possible in nine percent of cases to determine whether the statutory time frame had been met, because files lacked essential information. Less than 5 percent were late [PHL, § 4904(3); IL, § 4904(c)].

14. Appeal Letters are to be sent within two business days of the decision in the Appeal [PHL, § 4904(3); IL, § 4904(c)]. In sixty percent of cases involving an Appeal, the Enrollee Files did not contain an Appeal Letter. It was therefore impossible to determine whether the statutory time frame had been met. Where Enrollee Files contained an Appeal Letter, the letters were late 15 percent of the time (and on time 85% of the time).

15. The Health Care Bureau's review revealed a number of other practices which detract significantly from the quality of the UR performed by or on behalf of Respondent:

1. In approximately one-third of all cases, the Enrollee File lacked a copy of the Adverse Determination Letter. While Respondent's printouts of computer records indicate that in a number of cases such a letter was prepared, there is no proof that it was in fact sent, and no evidence of the date on which it was sent. It is impossible in such cases to determine whether the time requirements of the UR Law were complied with

[PHL, § 4903(2), (3) & (4); IL, § 4903(b), (c) & (d)]. It is also impossible to determine the extent to which the Enrollees were given the required statement of the Reasons and Clinical Rationale and whether they included information concerning the right to appeal and the right to see the clinical review criteria [PHL, §§ 4903(4), 4904(3); IL, §§ 4903(5), 4904(c)].

2. As already noted, approximately sixty percent of Enrollee Files which involved an Appeal lacked an Appeal Letter. This made it impossible to determine whether Respondent complied with the statutory requirement to communicate the Appeal determination, in writing, within two business days of the rendering of such determination. It also made it impossible to determine the extent to which, if the Appeal determinations were adverse, the Enrollees were given the required statement of the Reasons and Clinical Rationale. It was also impossible to tell whether, if letters were sent, they included information concerning the right to appeal and the right to see the clinical review criteria [PHL, §§ 4903(4), 4904(3); IL, §§ 4903(5), 4904(c)].

3. A significant number of Enrollee Files did not clearly show key dates in the UR process, such as when requests for coverage or Appeals were made, when decisions were made, and when requests for additional information were made and responded to. Such gaps in documentation may impair the quality of UR services, and may make it difficult or impossible to assess compliance with the UR Law and this Assurance of Discontinuance.

16. It is because of such deficiencies in the management of Enrollee Files that the prospective relief set forth in this Assurance of Discontinuance includes specific provisions concerning the contents of Enrollee Files.

17. Respondent disagrees with the Attorney General's conclusions and denies all allegations of wrongdoing. Respondent desires to comply fully with the UR Law and other applicable law. This Assurance does not constitute and shall not be deemed to be an admission by Respondent as to the accuracy or validity of the Attorney General's findings.

18. In order to avoid the uncertainty time, expense and distraction of litigation, Respondent enters into this Assurance of Discontinuance, for purposes of settlement only,

without admitting to any violation of law, and the Attorney General accepts this Assurance of Discontinuance pursuant to Executive Law § 63(15) in lieu of commencing a statutory or other proceeding against Respondent pursuant to Article 22-A of the General Business Law, Article 63 of the Executive Law, Article 49 of the PHL and Article 49 of the IL in connection with compliance with the UR Law by Respondent and its UR Contractors during the period April 1, 1997 through December 31, 2000.

THEREFORE, in lieu of commencing a civil action against Respondent, the Attorney General accepts Respondent's agreement to all of the following terms and conditions:

I. UTILIZATION REVIEW PRACTICES AND PROCEDURES

A. Timing of Notices; Related Requirements

All Utilization Review notices, whether adverse or otherwise, issued by Respondent or its UR Contractors must at a minimum satisfy all requirements of applicable law, including but not limited to those set forth in this Section I.A.

1. Initial Determinations

All of Respondent's or its UR Contractors' Utilization Review determinations in Pre-authorization situations shall be made and communicated to the Enrollee or the Enrollee's Designee and the Enrollee's health care provider, by telephone and in writing, within three business days of Respondent's receipt of the request for coverage or its receipt of the necessary information, whichever is later; provided that, if the request or information is received by Respondent's UR Contractor before it is received by Respondent, the three days shall be measured from the time of receipt by the UR Contractor [PHL, § 4903(2); IL, § 4903(b)].

All Utilization Review determinations by Respondent or its UR Contractors in Concurrent Review situations shall be made and communicated to the Enrollee or the Enrollee's Designee (or to the Enrollee's health care provider), by telephone and in writing, within one business day of Respondent's receipt of the request for coverage or its receipt of the necessary information, whichever is later; provided that, if the request or information is received by Respondent's UR Contractor before it is received by Respondent, the one day shall be measured

from the time of receipt by the UR Contractor [PHL, § 4903(3); IL, § 4903(c)].

All Utilization Review determinations by Respondent or its UR Contractors in Retrospective Review situations shall be made and communicated to the Enrollee or the Enrollee's Designee, and to the Enrollee's health care provider when the UR determination involves a claim filed by the provider, within thirty days of Respondent's receipt of the request for coverage or its receipt of the necessary information, whichever is later provided that, if the request or information is received by Respondent's UR Contractor before it is received by Respondent, the thirty days shall be measured from the time of receipt by the UR Contractor [PHL, § 4903(4); IL, § 4903(d)].

All Adverse Determinations issued by Respondent or its UR Contractors at the initial level must be communicated in writing [PHL, § 4903(5); IL, § 4903(e)].

2. Appeals and Reconsideration

All determinations of Standard Appeals shall be made within sixty days of Respondent's receipt of the request for the Appeal or its receipt of necessary information to conduct the Appeal, whichever is later; provided that, if the request or information is received by Respondent's UR Contractor before it is received by Respondent, the sixty days shall be measured from the time of receipt by the UR Contractor [PHL, § 4904(3); IL, § 4904(c)]. The determination of a Standard Appeal must be rendered by a Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the Initial Adverse Determination [PHL, § 4904(4); IL, § 4904(d)]. Notice of the determination of a Standard Appeal must be communicated in writing to the Enrollee, the Enrollee's Designee and, where appropriate, the Enrollee's health care provider, within two business days of the determination [PHL, § 4904(3); IL, § 4904(c)].

In the case of an Expedited Appeal, the determination shall be made within two business days of Respondent's receipt of the request for the Appeal or its receipt of necessary information to conduct the Appeal, whichever is later; provided that, if the request or information is received by Respondent's UR Contractor before it is received by Respondent, the two days shall be measured from the time of receipt by the UR Contractor [PHL, § 4904(2)(b); IL, § 4904(b)].

All Adverse Determinations on Appeals must be communicated in writing [PHL, § 4903(5); IL, § 4903(e)].

If an Enrollee's health care provider requests a Reconsideration, the decision thereon must be rendered within one business day of the receipt of the request by the Respondent or its UR Contractor, whichever is earlier, except in Retrospective Review situations [PHL, § 4903(6); IL, § 4903(f)].

Failure by Respondent or its UR Contractor to determine an Appeal within the applicable time period shall be deemed to be a reversal of the Adverse Determination. In such a situation, the health care service, treatment or procedure in question shall automatically be covered [PHL, § 4904(5); IL, § 4904(e)].

B. Clinical Peer Reviewers

All Adverse Determinations must at a minimum satisfy all requirements of applicable law, including but not limited to those set forth in this Section I.B.

All Adverse Determinations shall be rendered by a Clinical Peer Reviewer. All Adverse Determinations on an Appeal shall be rendered by a Clinical Peer Reviewer who is someone other than the Clinical Peer Reviewer who rendered any prior Adverse Determination in the same case [PHL, § 4904(4); IL, § 4904(d)].

C. Contents of Adverse Determination Letters

The contents of all Adverse Determination Letters must at a minimum satisfy all requirements of applicable law, including but not limited to those set forth in this Section I.C.

Each Initial Adverse Determination Letter shall contain the following:

- a. A statement of Reasons and Clinical Rationale for the Adverse Determination;
- b. Instructions on how to initiate a Standard Appeal, Expedited Appeal and External Appeal;
- c. Notice of the availability, upon request by the Enrollee or the Enrollee's Designee, of the clinical review criteria relied upon to make the Adverse Determination; and
- d. A description of what, if any, additional necessary information must be

provided to, or obtained by, Respondent or its UR Contractor in order to render a decision in the event of an Appeal [PHL, § 4903(5); IL, § 4903(e)].

Each Appeal Letter upholding an Adverse Determination in whole or in part shall contain the following:

- a. A statement of Reasons and Clinical Rationale for the Adverse Determination; and
- b. A notice of the right to an external appeal, together with a description of the external appeal process and the time frames for such appeal [PHL, § 4904(3); IL, § 4904(c)].

D. Acknowledgment of Requests for Appeals; Effect of Failure by Respondent to Adhere to Appeal Deadlines

1. Respondent or its UR Contractor shall acknowledge each request for a Standard Appeal in writing within fifteen days of the receipt of the request by Respondent or its UR Contractor, whichever is earlier, unless the Appeal is decided and the result communicated within fifteen days, in which case an Acknowledgment Letter is not required. The letter acknowledging the request shall contain the following:

- a. A statement that Respondent (or its UR Contractor, as applicable) is required by law to determine the Appeal within 60 days of receipt of information necessary to conduct the Appeal;
- b. A statement that Respondent (or its UR Contractor, as applicable) is required by law to notify the Enrollee, the Enrollee's Designee and, where appropriate the Enrollee's health care provider, in writing, of the determination within two business days of rendering such determination; and
- c. A statement that, if Respondent (or its UR Contractor, as applicable) fails to adhere to the deadline for determining the Appeal, the Initial Adverse Determination shall automatically be reversed [PHL, § 4904(5); IL, § 4904(e)].

2. Respondent shall monitor its own adherence (and that of its UR Contractors, as applicable) to all determination deadlines for both Standard and Expedited Appeals. If and when

Respondent or its UR Contractor fails to meet the deadline for determining any Appeal, Respondent or its UR Contractor shall immediately notify the Enrollee, the Enrollee's Designee and, where appropriate, the Enrollee's health care provider of this, in writing, stating clearly that the effect of such failure is the automatic reversal of the Adverse Determination [PHL, § 4904(5); IL, § 4904(e)].

E. Record-keeping

Respondent shall improve both its paper and its computerized record-keeping practices and procedures, so as to: (1) ensure that all material information concerning UR determinations is available upon reasonable notice; and (2) facilitate assessment of Respondent's compliance with this Assurance of Discontinuance, the UR Law and other laws applicable to UR.

The Enrollee File must contain all materials received, considered or generated by Respondent in connection with the Adverse Determination, on paper or in electronic form, including but not limited to: materials submitted by the Enrollee, the Enrollee's Designee and the Enrollee's health care provider; correspondence; notes of conversations; requests for coverage and appeals; requests for information and the information provided in response to such requests; medical records; evaluations and opinions; and benefit documents. The Enrollee File should also indicate which type of review is being conducted: Pre-authorization, Concurrent or Retrospective.

The Enrollee File must clearly indicate: the date of the initial request for coverage; the date(s) on which additional information was requested, and from whom it was requested; the date(s) on which additional information was received, and from whom it was received; the date(s) on which the Initial Adverse Determination was made; the date(s) of any telephone calls communicating an Adverse Determination, and by and to whom such calls were made; the date(s) of any Adverse Determination Letter(s), and to whom they were sent; the date(s) on which request(s) for any Expedited or Standard Appeals were received, and by whom they were received; the date(s) of any letter(s) acknowledging receipt of a request for an Appeal, and by and to whom such letter(s) were sent; the date(s) on which any Appeals were determined; the date(s) of any telephone calls communicating the determination of any Appeals, and by and to

whom such calls were made; the date(s) on which the determination of any Appeals was communicated by non-telephonic means, and by whom and to whom such communications were made; and the name, qualifications and specialization, as applicable, of each Clinical Peer Reviewer and all other medical personnel involved in the case.

Respondent's implementation of compliance with the foregoing record-keeping requirements shall be completed by the Implementation Date. At that time, Respondent shall submit to the Attorney General an affidavit of its [IDENTIFY APPROPRIATE OFFICER] verifying that such implementation has been completed.

F. Respondent's Monitoring of UR Contractors

1. Respondent shall take all necessary steps to assure that each of its UR Contractors complies with this Assurance of Discontinuance, the UR Law and all other laws applicable to UR.

2. At a minimum, these steps shall include the following:

a. For each of its UR Contractors, Respondent shall have a contract, letter or other mutually agreed on document (the "UR Delegation Agreement") that sets forth: (1) Respondent's accountability for all UR decisions made with respect to Respondent's Enrollees, regardless of the delegation of some or all UR functions; (2) the UR Contractor's specific activities, duties and responsibilities, which shall encompass adherence to the terms and conditions in Sections I.A through I.E in this Assurance of Discontinuance, including but not limited to compliance with the UR Law and all other laws applicable to UR; (3) requirements for routine reporting by the UR Contractor to Respondent, which reporting shall be sufficient to enable Respondent to reasonably assess the UR Contractor's ongoing compliance with the UR Delegation Agreement; (4) the method and frequency of Respondent's monitoring and evaluation of the UR Contractor's performance; and (5) the remedies available to Respondent if the UR Contractor does not fulfill its obligations, including but not limited to revocation of some or all of the delegation of UR functions.

b. Respondent shall monitor each UR Contractor's performance by: (1)

having the right to review and approve the UR Contractor's UR program (including the right to prior review and approval of any material changes to such program); (2) receiving routine reports from the UR Contractor as specified in the UR Delegation Agreement; and (3) conducting an evaluation of the UR Contractor's performance at least once a year to determine whether the UR functions are being carried out in accordance with this Assurance of Discontinuance, the UR Law, all other laws applicable to UR, and the UR Delegation Agreement.

c. Where the monitoring described above reveals deficiencies in the UR Contractor's performance, Respondent will work with the UR Contractor to correct such deficiencies; provided that Respondent will have the right to revoke some or all of the delegation of UR functions if: (1) it does not appear likely that the UR Contractor will be able to correct the deficiencies within a reasonable period of time; or (2) the deficiencies appear to pose an imminent threat of serious injury to Respondent's Enrollees. Nothing in this Section I.F.2 shall prevent Respondent from providing for additional grounds for limitation or termination of the UR Delegation Agreement.

d. Each evaluation of the UR Contractor by Respondent shall result in a written report by Respondent. This report shall include a description of the methods used to monitor and evaluate the UR Contractor, the underlying materials on which the evaluation was based, any deficiencies revealed by the evaluation, and any corrective steps to be taken by the UR Contractor. Within four months of Respondent's request to the UR Contractor that it take corrective steps (or such shorter period as may be appropriate under the circumstances), Respondent will conduct a follow-up evaluation to assess the extent to which the previously identified deficiencies have or have not been remedied. Respondent will prepare a written report setting forth the results of this follow-up evaluation.

e. Where serious problems cannot be corrected, Respondent will revoke the delegation.

II. HEALTH CARE BUREAU MONITORING OF RESPONDENT'S COMPLIANCE WITH THIS ASSURANCE OF DISCONTINUANCE

A. Monitoring Period

The Health Care Bureau will monitor compliance by Respondent and its UR Contractors as set forth in this Section II for two years from the Implementation Date. This monitoring period may, however, be extended for an additional year if the Health Care Bureau finds material non-compliance by Respondent or its UR Contractors. The Health Care Bureau will be free, when assessing Respondent's compliance with this Assurance of Discontinuance, to consider information received in the ordinary course of its business, such as complaints from Respondent's members.

B. Biennial Reports Pursuant to the UR Law.

Respondent is required by the UR Law to provide biennial reports to the New York State Superintendent of Insurance and/or the New York State Commissioner of Health, detailing certain aspects of its UR program [PHL, § 4901(2); IL, § 4901(b)]. At the same time as Respondent submits each such biennial report, it shall provide a copy to the Health Care Bureau.

C. HCB Quarterly Examinations

To assess Respondent's compliance with this Assurance of Discontinuance, the UR Law and other laws applicable to UR, the Health Care Bureau will conduct quarterly reviews of certain Enrollee Files and related Documents.

1. HCB Complaint List

At the end of each calendar quarter, beginning with the quarter commencing after the Implementation Date, the Health Care Bureau will review all complaints or inquiries which it received in that quarter relating to Adverse Determinations. The Health Care Bureau will then provide to Respondent, in writing, a list of any such matters as to which the Health Care Bureau would like further information (the "HCB Complaint List").

If in any one quarter there has been an insufficient number of complaints or inquiries

relating to Adverse Determinations to allow the Health Care Bureau to monitor Respondent's compliance with this Assurance of Discontinuance, the Health Care Bureau will be free to include in its Complaint List up to ten complaints or inquiries relating to coverage denials other than Adverse Determinations.

2. HCB Appeal List

In addition, beginning with the quarter commencing after the Implementation Date, within fourteen business days of the end of each calendar quarter, Respondent will provide to the Health Care Bureau, in writing, a list of all Appeals determined during the quarter that: (1) involved Enrollees in New York State; and (2) were determined adversely to the Enrollee and/or the Enrollee's health care provider. This list shall identify the nature and date(s) of the health care service(s), procedure(s) or treatment(s) in question and the date on which the Appeal was determined. The Health Care Bureau will then, in its discretion, provide to Respondent, in writing, a list of up to ten such Appeals as to which the Health Care Bureau would like further information (the "HCB Appeal List").

3. Respondent's Document Production

Within thirty days of its receipt of the HCB Complaint List and the HCB Appeal List, as the case may be, Respondent shall provide to the Health Care Bureau copies of all responsive Enrollee Files and any other relevant Documents in its possession, custody or control concerning the listed matters (including Enrollee Files and Documents in the possession, custody or control of Respondent's UR Contractors). Respondent will also, on request with reasonable advance notice, make its personnel (including outside consultants or advisors, as well as personnel of Respondent's UR Contractors) available to answer any questions the Health Care Bureau may have. The Health Care Bureau will review the foregoing information to evaluate compliance by Respondent and its UR Contractors with this Assurance of Discontinuance, the UR Law and other applicable laws.

4. Supplemental Examinations

If the Health Care Bureau finds any material indication of non-compliance by Respondent or any of its UR Contractors with this Assurance of Discontinuance or applicable law, the Health Care Bureau will be free to examine additional Documents of Respondent or its UR Contractors

relating to compliance with the UR Law and any personnel thereof to determine whether there may be further non-compliance. The Health Care Bureau will notify Respondent in writing of its intent to conduct such a supplemental examination, requesting any additional Enrollee Files, other Documents or personnel to be examined. Within thirty days of its receipt of this request, Respondent shall provide copies of all requested Enrollee Files and other Documents, and shall arrange to make the requested personnel available.

5. Non-compliance and Corrective Action

If, as a result of a Quarterly Examination, the Health Care Bureau discovers any non-compliance with this Assurance of Discontinuance or applicable law, it will identify such non-compliance in writing to Respondent. If Respondent agrees to such corrective actions and other remedies (including but not limited to monetary penalties and damages) as may be requested by the Attorney General, it will enter into a supplemental Assurance of Discontinuance, Consent Decree or other appropriate resolution of the matter, setting forth its agreement to such measures. If not, the Health Care Bureau will be free to take any and all legal actions against Respondent and/or its UR Contractors with respect to such non-compliance.

D. Review of Respondent's Monitoring of UR Contractors

By December 31, 2001 and December 31, 2002, Respondent will submit to the Health Care Bureau the following documents: (1) all "routine reports" referred to in Section I.F.2.a and b above from Respondent's UR Contractors; and (2) Respondent's own written reports of its evaluations of its UR Contractors' performance, referred to in Section I.F.2.b,c and d above, including any follow up reports.

III. OTHER APPLICABLE LAW

This Assurance of Discontinuance addresses only violations of the UR Law. Nothing in this Assurance of Discontinuance shall limit in any way the ability of the Attorney General to investigate or take other action with respect to any non-compliance by Respondent with the Prompt Pay Law or other applicable law.

IV. COST

Respondent shall pay a total of \$150,000 to the Attorney General's Office pursuant to Executive Law § 63(15) for costs incurred during the investigation of this matter by the Attorney General. This payment shall be made within thirty days of the effective date of this Assurance of Discontinuance.

V. VALID GROUNDS AND WAIVER

Respondent hereby accepts the terms and conditions of this Assurance of Discontinuance and waives any right to challenge it in a proceeding pursuant to Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

VI. CHANGES TO UR LAW OR REGULATIONS

If, after execution of this Assurance of Discontinuance, Article 49, Title I of the IL or Article 49, Title I of the PHL is amended or if the Department of Health promulgates regulations pursuant to Article 49, Title I of the PHL or if the Department of Insurance promulgates regulations pursuant to Article 49, Title I of the IL, then, to the extent that any such statutory amendment or any such regulation revises (by adding to, eliminating, increasing, decreasing, heightening or relaxing) the requirements relating to specific statutory provisions referenced in this Assurance of Discontinuance, then to that extent the requirements set forth in the statutory amendment or regulation will be incorporated into the Assurance of Discontinuance and replace the existing requirements set forth therein.

VII. BINDING ASSURANCE

This Assurance of Discontinuance shall be binding on and enforceable against Respondent and any successors or assigns of Respondent, including but not limited to any future

owner or operator of Respondent.

VIII. EFFECTIVE DATE

The effective date of this Assurance of Discontinuance is ~~June~~ ^{July 9}, 2001.

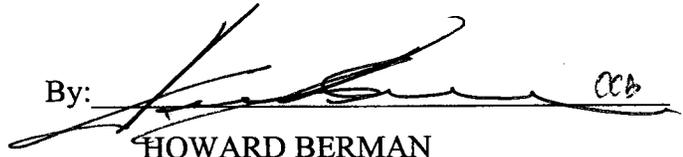
Respondent shall implement all required elements of this Assurance of Discontinuance no later than forty five (45) days after the effective date. The date forty five (45) days after the effective date shall be known as the "Implementation Date."

IN WITNESS THEREOF, the undersigned subscribe their names:

Dated: Rochester, New York

~~June~~ ^{July} 9, 2001

EXCELLUS HEALTH PLAN, INC.

By:  ^{ccb}

HOWARD BERMAN
President and CEO

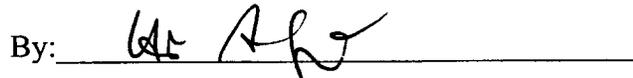
CONSENTED TO:

Dated: New York, New York

~~June~~ _____, 2001
^{July 13}

ELIOT SPITZER

Attorney General of the State of New York

By: 

HOWARD A. GOOTKIN
Deputy Bureau Chief
Health Care Bureau