

**ORIGINAL**

**ATTORNEY GENERAL OF THE STATE OF NEW YORK  
HEALTH CARE BUREAU**

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**In the Matter of**

**THE PERFECTHEALTH INSURANCE COMPANY, INC.**

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

Pursuant to the provisions of Executive Law (“EL”) § 63(12), Article 22-A of the General Business Law (“GBL”) and Article 26 of the Insurance Law (“IL”), the Office of the Attorney General of the State of New York (the “OAG”), conducted an investigation of the PerfectHealth Insurance Company, Inc. (“PH”), and makes the following findings:

**I. Attorney General’s Findings**

1. PH is a commercial insurer that is authorized to transact accident and health insurance in the State of New York.
2. PH’s principal offices are located at 1200 South Avenue, Suite 203, Staten Island, New York 10314.
3. In the regular course of business, PH offers its health plan enrollees (“Enrollees”) coverage under its preferred provider organization (“PPO”) plans. The PPO is a network of doctors, hospital and other health care providers that agree to provide health care services to Enrollees at a pre-arranged discounted rate.
4. PH uses the MultiPlan Network ® as its primary PPO network through its

contract with MultiPlan, Inc. (“MultiPlan”). MultiPlan is a nationwide PPO whose providers are under contract to provide services at negotiated rates for various health plans and insurers, such as PH. PH pays MultiPlan providers for covered services provided to its Enrollees. MultiPlan does not offer insurance, nor does it administer benefit plans or pay claims to the providers in its PPO network.

5. Enrollees are only obligated to pay MultiPlan PPO providers a certain copayment for covered services. Thus, MultiPlan PPO providers may not bill Enrollees for any amounts that are higher than the pre-arranged copayment.

6. Enrollees are permitted to receive services from providers that are outside of the MultiPlan PPO network (“out-of-network” or “non-PPO” providers), but must pay a higher copayment and additional out-of-pocket fees for such out-of-network services. Enrollees are required to pay the out-of-network provider’s charges before requesting reimbursement from PH for the covered portion of the out-of-pocket expense.

7. PH offers its Enrollees a choice between two reimbursement plans, titled PPO and PPO Plus, for covered services that are rendered by out-of-network providers. Enrollees pay an enhanced insurance premium for the PPO Plus plan because out-of-network reimbursements are higher than that under the PPO plan.

8. The OAG’s Health Care Bureau began investigating PH after receiving a complaint that PH improperly under-reimbursed claims under its PPO Plus plan for services rendered by out-of-network providers. Such under-reimbursed out-of-network claims resulted in higher out-of-pocket costs to the Enrollee.

9. The Health Care Bureau reviewed a substantial amount of information provided

by PH relating to its PPO Plus out-of-network claims reimbursements and claims adjudication practices for the period beginning January 1, 2004 through April 20, 2005.

10. PH represents to its health plan enrollees in its certificate of coverage (“Certificate”) that out-of-network claim reimbursements are based on “reasonable” expenses:

[a]n expense is reasonable . . . if the charge is the usual and customary charge for that attention or care in the locale where it is received. If [PH] cannot determine the usual and customary charge for the attention or care because there are not enough providers of that attention or care in the locale to establish a prevailing charge, [PH] will calculate the reasonable charge for it based on:

- the complexity of the attention or care; and [sic]
- the degree of professional skill needed to provide it; and
- other pertinent factors. [Plan 10 PPO Plus Certificate, page 12]

11. Contrary to these representations, PH’s “usual and customary charge” does not reflect the treating provider’s actual or usual charge or the usual charge of other providers of similar services in the same geographic area. In determining its out-of-network reimbursement allowances under its PPO Plus plan, PH merely doubles the reimbursements that it allows for out-of-network services under its PPO plan. As a result, Enrollees in the PPO Plus plan pay a much greater share of the out-of-network provider bill than PH promises they should have to pay.

12. PH described its PPO and PPO Plus reimbursement plans in a letter to the OAG, dated September 29, 2005, as follows:

[PH] offers its [Enrollees] two fee methodologies for reimbursement of services received by an out-of-network provider. One fee schedule is titled PPO while the other is titled PPO Plus. The difference in these two fee schedules is that the fee reimbursement to an out-of-network provider with the PPO fee schedule is at one set amount as provided by the Ingenix MDR Aggregate Allowed Medical Module [the “Ingenix PPO Module”] while the other titled PPO Plus will reimburse at a higher amount than the PPO fee schedule (ie.: up to 200% of the [Ingenix PPO

Module] fee schedule).

13. Thus, when an Enrollee in the PPO Plus plan is seen by a MultiPlan PPO provider for covered services, that provider is reimbursed in accordance with MultiPlan's negotiated rate schedule. If that Enrollee is seen by an out-of-network or non-PPO provider, the Enrollee is reimbursed 200% of the fee allowed under the Ingenix PPO Module minus any applicable copayment. Typically, a non-PPO provider's charge is higher than that allowed under the Ingenix PPO Module. Thus, an Enrollee is responsible to the non-PPO provider for the balance beyond PH's allowance.

14. PH also mislead its PPO Plus Enrollees by failing to disclose, in advance of their receiving services, that its "usual and customary" allowance is further reduced by a certain percentile, i.e., level of reimbursement.

15. In a letter dated April 26, 2005 from PH to an Enrollee, explaining the reasons for its low reimbursements for the out-of-network services rendered to Enrollee, PH stated that it uses the 75<sup>th</sup> percentile of the Ingenix PPO Module in determining the allowed PPO reimbursement.

16. At the 75<sup>th</sup> percentile of the Ingenix PPO Module, PPO reimbursements are at or below that which 25% of PPO providers, in the same geographic data pool analyzed by Ingenix, would accept as payment for services rendered. Thus, 25% of PPO providers whose negotiated fee data are reflected in the Ingenix PPO Module would be reimbursed at rates higher than that allowed by PH.

17. No where in the PPO Plus Certificate does PH represent that it relies on the Ingenix PPO Module at the 75<sup>th</sup> percentile to determine its "usual and customary" charges for

out-of-network claims reimbursements. Moreover, despite OAG's request for substantiation, PH provided no justification to support its view that doubling the reimbursement allowed at the 75<sup>th</sup> percentile under the Ingenix PPO Module is equivalent to "usual and customary charges", as defined in the Certificate. Thus, PH's reliance on 200% of the Ingenix PPO Module data at the 75<sup>th</sup> percentile for out-of-network reimbursements under the PPO Plus plan is a deceptive business practice.

18. Since May 2005, PH has advised employers who renewed their PPO Plus plan by letter that Enrollees who received out of network services are reimbursed up to 200% of the PPO schedule. However, PH is unable to substantiate that such revised information regarding out-of-network reimbursements was communicated by employers to Enrollees who were their employees.

19. Beginning in March 2006, PH provided new PPO Plus plan Enrollees a written explanation of its reimbursement policy for out-of-network services as follows: "medical care rendered by a non-participating, out-of-network Provider will be reimbursed up to 200% of the PPO fee schedule." However, PH provided no such explanation of its out-of-network reimbursement policy to existing PPO Plus plan Enrollees who were not the employers.

20. Since September 1, 2007, PH is distributing its Certificate to new PPO Plus plan Enrollees that contains a revised definition of "reasonable" expense for out-of-network claims reimbursements ("Revised Certificate"). The Revised Certificate states in relative part:

[a]n expense is reasonable if . . . [f]or a Non-PPO Provider, the charge is up to 200% of the fee consistent with a PPO Provider Negotiated Fee . . . .

## II. Statutory Violations

21. New York law prohibits insurers from engaging in unfair claim settlement practices. Specifically, IL § 2601(a) provides:

Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:

(1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue; . . . .

(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear . . . .

22. Additionally, GBL § 349(a) prohibits “deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state.”

23. The OAG has concluded that PH failed to reimburse out-of-network claims in accordance with it’s own PPO Plus plan representations to Enrollees. The failure to properly adjudicate out-of-network claims resulted in Enrollees being underpaid by PH.

24. PH engages in unfair claims settlement practices whereby its Enrollees are under-reimbursed on their out-of-network claims in violation of IL § 2601(a), and deceptive business acts and practices in violation of GBL § 349(a).

25. **IT NOW APPEARS** that PH is willing to enter into this Assurance of Discontinuance without admitting to the correctness of the assertions herein or to any violation of law and the OAG is willing to accept this Assurance of Discontinuance pursuant to EL § 63(15) in lieu of commencing a statutory or other proceeding against PH pursuant to EL § 63.

## III. Prospective Relief

26. PH shall revise all of its internal policies and procedures to conform with this

Assurance of Discontinuance and New York State law.

27. PH shall adjudicate all out-of-network claims in accordance with its Certificate.

28. PH shall distribute its Revised Certificate to all Enrollees by December 31, 2007.

#### **IV. Restitution**

29. Enrollees in the PPO Plus plan who received services by out-of-network providers in the period beginning January 1, 2004 up until 5 business dates following the distribution date of the Revised Certificates (“Qualified Enrollees”) shall be entitled to receive a refund, including 12% interest, for any monies paid on a claim that is in excess of their annual deductible (“Restitution”). The term Qualified Enrollees includes employers up until the renewal date of their PPO Plus plan if renewed after April 30, 2005 and excludes those Enrollees newly enrolled as of April 1, 2006.

30. By February 1, 2008, PH shall submit to the OAG:

- (a) an accounting of monies owed to each of the Qualified Enrollees; and
- (b) a notice (“Notice”) to all Qualified Enrollees that they may be eligible for a refund. The Notice’s content, form and delivery mechanism shall be subject to OAG approval and the Notice shall include:

- (1) the amount of the Restitution that may be payable by PH;
- (2) a form to be executed by the Qualified Enrollee either (a) providing a copy of proof of payment of amounts in excess of PH’s reimbursement for the claims in question or (b) certifying that s/he is entitled to the Restitution as a result of paying claims in excess

of PH's reimbursement (the "Certification");

- (3) procedures and time frames for submitting the Certification; and
- (4) a statement that responding to the Notice and providing the Certification has no impact on the Enrollee's rights with respect to separately filing a complaint with the OAG and including the OAG's website address and toll-free helpline telephone number.

31. PH shall send the Notice to all Qualified Enrollees within 30 days of obtaining OAG approval of the Notice.

32. PH agrees to make Restitution to Qualified Enrollees within 30 days of receiving the Certification.

33. Within six months of the Effective Date of this Assurance of Discontinuance, PH shall submit to the OAG a report documenting all of the Qualified Enrollees who submitted the Certification to PH and to whom Restitution was paid, including a unique identifier for each such Enrollee, date Certification was received, CPT Code, Restitution amount and date paid.

#### **V. Affidavit of Compliance**

34. PH shall submit to the OAG , within three months after the execution of this Assurance of Discontinuance, and subsequently one year after execution of this Assurance of Discontinuance, an affidavit, subscribed to by an officer of PH authorized to bind PH, setting forth PH's compliance with the provisions of this Assurance of Discontinuance.

#### **VI. Costs**

35. PH shall pay a total of \$10,000 to the OAG 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.

## **VII. Miscellaneous**

36. All correspondence and payment submitted by PH to the OAG pursuant to this Assurance of Discontinuance shall be sent to the attention of:

Dorothea Caldwell-Brown, Assistant Attorney General  
Office of the New York State Attorney General  
Health Care Bureau  
120 Broadway  
New York, New York 10271

37. Excepting the Notice set forth in paragraph 30(b), receipt of materials referenced in this Assurance of Discontinuance by the OAG, with or without comment, shall not be deemed or construed as approval by the OAG of any of the materials, and PH shall not make any representations to the contrary.

38. Nothing in this Assurance of Discontinuance shall limit in any way the ability of the OAG to investigate or take other action with respect to any non-compliance at any time by PH with respect to this Assurance of Discontinuance or any applicable law.

39. Nothing herein shall be construed to deprive any Enrollee or other person or entity of any private right under the law.

40. PH 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.

41. This Assurance of Discontinuance shall be binding on and apply to PH and their parent HIP Health Plan of New York ("HIP") and all PH and HIP officers, directors, employees, affiliates, agents, assignees, successors in interest, and any individual, corporation, subsidiary or

division through which PH or HIP may now or hereinafter act.

42. This Assurance of Discontinuance shall be effective on the date that it is signed by an authorized representative of the OAG ("Effective Date").

43. Pursuant to the terms of Executive Law § 63(15), in the event that this Assurance of Discontinuance is violated, evidence of such violation shall be prima facie proof of a violation of General Business Law § 349 in any civil action or proceeding thereafter commenced by the OAG.

44. The terms stated herein constitute the entire terms of this Assurance of Discontinuance.

**WHEREFORE**, the following signatures are affixed hereto this \_\_\_\_ day of December, 2007.

**THE PERFECT HEALTH INSURANCE COMPANY, INC.**

By: 

**CARMINE MORANO**  
President & Chief Executive Officer

CONSENTED TO:

Dated: New York, New York

December \_\_, 2007

*January 29, 2008*

**ANDREW M. CUOMO**  
Attorney General of the State of New York

**TIMOTHY A. CLUNE**  
Bureau Chief, Health Care Bureau

By: 

**DOROTHEA CALDWELL - BROWN**  
Assistant Attorney General, Health Care Bureau