STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Market Conduct Report

of

Oxford Health Plans, LLC

October 21, 2024

From June 26, 2024 through October 21, 2024, the Market Conduct Division of the Connecticut Insurance Department examined the utilization review practices of Oxford Health Plans, LLC (the Company), using a sample period of February 15, 2022 through December 31, 2022. The examination was limited to Connecticut enrollees.

Oxford Health Plans, LLC has its home office in the State of Connecticut and is licensed as a utilization review entity in the State of Connecticut under license number 2390709. By authority granted under §38a-591 of the Connecticut General Statutes, this examination was conducted by Market Conduct examiners of the State of Connecticut Insurance Department (the Department) at the Department's offices in Hartford, Connecticut.

The purpose of the examination was to evaluate the Company's utilization review practices in the State of Connecticut. From a listing of utilization reviews performed by the Company, the examiners reviewed one hundred eighty-eight (188) sample files, which included complaints and approved, denied and appeal certifications during the examination period.

The Department's findings are as follows:

- The examiners verified that two (2) determinations letters not to certify care did not reflect forty-eight hours after the health carrier receives such request or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend regarding an urgent care request.

- The examiners verified that three (3) determinations not to certify care were not made within the required 15 days of the receipt of the request for review, upon the receipt of all information reasonably required to make denial determinations.

- The examiners verified that one (1) determination to certify care was not made within the required 15 days of the receipt of the request for review, upon the receipt of all information reasonably required to make approval determinations.

- The examiners verified that two (2) appeal determinations were not made within the required 30 days of the receipt of the request for review, upon the receipt of all information reasonably required to make appeal determinations.

- The examiners verified that one (1) expedited appeal determination was not made within the required forty-eight hours after the health carrier receives such request or seventy-two

hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend regarding an urgent care request.

- The examiners verified that sixty-two (62) determination letters not to certify care did not reflect an external appeal may be filed within 120 calendar days after receiving an adverse determination or a final determination.

- The examiners verified that three (3) appeal determinations failed to provide proper Connecticut external appeal language as they did not note the internal appeal process had been exhausted.

- The examiners verified that one (1) retrospective Explanation of Benefits failed to provide Connecticut external appeal language.

- The examiners verified that two (2) sample files concerning a determination not to certify care did not provide the requisite forty-five (45) calendar days after the date of receipt of the notice to provide the specified information.

- The examiners verified that one (1) appeal determination was not reviewed by an appropriate clinical peer for the service requested.

- The examiners verified that there were two (2) instances where the Company did not have sufficient documentation for regulatory review.

It is recommended that the Company review its policies and procedures to ensure that expedited denial determinations are made within the 48-hour requirement, denial and certification determinations are made within the 15 day requirement, appeal determinations are made within the 30 day requirement, expedited appeal determinations are made within the 48-hour requirement, proper Connecticut external appeal language is provided for appeal determinations, determinations not to certify care and Explanations of Benefits, to afford the forty-five calendar days as noted in the notification letter to provide the specified information, and appeal determinations are reviewed by an appropriate clinical peer, as required by statute.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

IN THE MATTER OF	:	DOCKET MC 24-145
Oxford Health Plans, LLC	:	

STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between Oxford Health Plans, LLC and the State of Connecticut Insurance Department by and through Andrew N. Mais, Insurance Commissioner ("Insurance Commissioner") to wit:

I

WHEREAS, pursuant to a market conduct examination, the Insurance Commissioner alleges the following with respect to Oxford Health Plans, LLC:

1. Oxford Health Plans, LLC, hereinafter referred to as Respondent, is domiciled in the State of Connecticut and is licensed to transact the business of a utilization review entity in the State of Connecticut under license number 2390709.

2. From June 26, 2024 through October 21, 2024, the Department conducted an examination of Respondent's utilization review practices in the State of Connecticut covering the period from February 15, 2022 through December 31, 2022.

3. During the period under examination, Respondent failed to establish practices and procedures to ensure compliance in all instances with statutory requirements for:

   a. notification of a determination not to certify care, admission or procedure within 48 hours of the receipt of the request for review, upon the receipt of all information reasonably required to make urgent denial determinations;

   b. notification of a determination not to certify care, admission or procedure within 15 days of the receipt of the request for review, upon the receipt of all information reasonably required to make denial and approval determinations;

   c. notification of an appeal determination within 30 days of the receipt of the request for review, upon the receipt of all information reasonably required to make appeal determinations;

   d. responding to an urgent care request within forty-eight hours after the health carrier receives such request or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend regarding an urgent care request;

   e. providing proper Connecticut external appeal language;

   f. providing forty-five days after the date of receipt of the notice to provide the specified information;

g. providing an appropriate clinical peer to review an appeal request;

h. providing sufficient documentation for regulatory review.

4. The conduct as described above violates §38a-591b and §38a-591d of the Connecticut General Statutes, and §38a-591-8 of the Regulations of Connecticut State Agencies and constitutes cause for the imposition of a fine or other administrative penalty under §38a-591k of the Connecticut General Statutes.

II

1. WHEREAS, Respondent neither admits nor denies the allegations contained in paragraphs three and four of Article I of this Stipulation and accepts those allegations as the findings of the Department; and

2. WHEREAS, Respondent agrees to review its utilization review practices and procedures and correct those identified as concerns during the market conduct examination, as described in the Examination of Utilization Review Practices Report and this Stipulation, and bring them into immediate compliance with Connecticut Statutes; and

3. WHEREAS, Respondent agrees to provide the Insurance Commissioner with a full report of finding and a summary of actions taken to comply with the requirements of paragraph two of this section within ninety (90) days of the date of this document; and

4. WHEREAS, Respondent, being desirous of terminating this proceeding without the necessity of a formal proceeding or further litigation, does consent to the making of this Final Order and voluntarily waives:

   a. any right to a hearing; and

   b. any requirement that the Insurance Commissioner's decision contain a statement of findings of fact and conclusion of law; and

   c. any and all rights to object to or challenge before the Insurance Commissioner or in any judicial proceeding any aspect, provision or requirement of this Stipulation.

5. WHEREAS, Respondent agrees to pay a fine in the amount of $21,500.00 for the violations described herein.

NOW THEREFORE, upon the consent of the parties, it is hereby ordered and adjudged:

1. That the Insurance Commissioner has jurisdiction of the subject matter of this administrative proceeding.

2. That Respondent is fined the sum of Twenty-One Thousand Five Hundred Dollars ($21,500.00) for the violations herein above described.

OXFORD HEALTH PLANS, LLC

BY: _____
(Representative of Utilization Review Entity)

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 5 day of December 2024 for and on behalf of Oxford Health Plans, LLC that he/she is the Assistant Secretary of such company, and he/she has authority to execute and file such instrument.

BY: _____

State of Minnesota

County of Hennepin

Personally appeared on this 5 day of December 2024, Heather Lang signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

Brenda L Ryan
Notary Public/Commissioner of the Superior Court

BRENDA LOUISE RYAN
Notary Public
Minnesota
My Commission Expires
Jan 31, 2026

Section Below To Be Completed by State of Connecticut Insurance Department

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Dated at Hartford, Connecticut this 11th day of December 2024.

Andrew N. Mais
Insurance Commissioner