Market Conduct Examination

OXFORD HEALTH PLANS NEW JERSEY INC.
(A Health Maintenance Organization)

TRUMBULL, CONNECTICUT

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

Division of Enforcement and Consumer Protection

Market Conduct Examination Section

Report Adopted: January 4, 2005

MARKET CONDUCT EXAMINATION

of the

OXFORD HEALTH PLANS NEW JERSEY INC

(A Health Maintenance Organization)

located in

TRUMBULL, CONNECTICUT

as of

July 17, 2003

BY EXAMINERS

of the

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF ENFORCEMENT AND CONSUMER PROTECTION
MARKET CONDUCT EXAMINATION SECTION

REPORT ADOPTED:
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I. INTRODUCTION

This is a report of the Market Conduct activities of Oxford Health Plan (NJ), Incorporated (hereinafter referred to as "Oxford" or "the Company"). Authority for this exam is found under N.J.S.A. 26:2J-18.1 and N.J.S.A. 17B:30-16, made applicable to the operations of a health maintenance organization (hereinafter "HMO") by N.J.S.A. 26:2J-15b and N.J.A.C. 8:38-13.5(a). Under the provisions of N.J.S.A. 26:2J-18.1 and N.J.A.C. 8:38-2.12(a), an HMO is required to open its books and records for an examination. Market Conduct Examiners of the New Jersey Department of Banking and Insurance (DOBI) conducted the examination. The examiners present their findings, conclusions and recommendations in this report as the result of their market conduct examination of the Company. The Market Conduct Examiners were Examiner-in-Charge Dean Turner, Rosalyn Benitez, William Sonntag, and Michael Buchinski.

A. SCOPE OF EXAMINATION

The scope of the examination included health coverage sold in New Jersey. The main purpose of this examination was to determine whether the Company complied with laws that impose mandated benefit coverages and time constraints on HMO claims processing operations. N.J.S.A. 26:2J-8.1, N.J.A.C. 11:2-17.6(b) and N.J.A.C. 11:22 et seq., made applicable to the operations of HMOs by N.J.A.C. 8:38-13.5(a), define time constraint limits. N.J.S.A. 26:2J-4.1 et seq., N.J.S.A. 17B:27-54 et seq. and N.J.A.C. 8:38-5.1 et seq. define mandated benefits.

The review period for this examination was October 1, 2001 to September 30, 2002 for all random sample and population review datasets. The examiners completed their fieldwork at the Company's Trumbull, Connecticut offices from March 24, 2003 to April 17, 2003. They composed this report on various dates thereafter.

There were several areas in this examination. The examiners reviewed prompt payment of claims, and performed electronic reviews of paid and denied claims for turnaround timeframes. They also performed electronic studies of turnaround timeframes in the Company's responses to complaints, utilization management appeals and provider appeals. The examiners also reviewed the Company's compliance with mandated benefits laws, and reviewed randomly selected mandated benefit claims. Finally, the examiners reviewed Oxford's provider contracts for conformity with provider appeal laws and for consistency with Department-approved format.

For the purpose of this examination, the examiners used a generic definition of "claim" – any demand or request for payment made by an

enrollee or medical provider. Whenever possible, the examiners utilized data from the Company's on-line systems.

In accordance with N.J.S.A. 26:2J-8.1 (Health Insurance Network Technology – "HINT" - legislation), a "clean" claim was defined in the examination as one that is:

1. Submitted by an eligible provider for a covered person
2. Free of defect or impropriety
3. Not in dispute as to the amount billed
4. Not suspect of being fraudulent
5. Not in need of special treatment

The random selection process that the examiners used in this examination is in accordance with the National Association of Insurance Commissioners' (hereinafter "NAIC") Market Conduct Examiners' Handbook.

B. ERROR RATIOS

Error ratios are the percentage of files reviewed which the Company handled in error. Each file mishandled or not handled in accordance with applicable statutes is an error, and the examiners cited all such errors in the report. Some files contained one error and others contained several. Even though a file may contain multiple errors, the examiners counted the file only once in calculating the error ratios; however, any file that contains more than one error will be cited more than once in the report. The examiners count a file in error when a company mishandles it or treats an insured unfairly, even if no statute or regulation is applicable. For the purpose of calculating the error ratios, the examiners counted only one error per file. In the event that the Company corrects an error because of a consumer complaint or due to the examiners' findings, the examiners included it in the error ratio. If a company corrected an error independent of a complaint or DOBI intervention, the examiners did not include the error in the error ratios.

There are errors cited in this report that define practices as specific acts that a carrier commits so frequently that it constitutes an improper general business practice. Whenever the examiners found that the errors cited constitute an improper general business practice, they have stated this in the report that follows.

The examiners sometimes find a business practice of a Company that may be technical in nature. Although such practice would not comply with law, the examiners would not count each of these files as an error in determining the error ratios. The examiners indicate in the report that follows whenever they did not count a particular file in the error ratio.

The examiners submitted written inquiries to company representatives on the errors and exceptions cited in this report. This provided Oxford the opportunity to respond to the examiners' findings and to provide comments on the statutory errors or mishandlings reported herein. On those errors and exceptions with which the Company disagreed, the examiners evaluated the individual merits of each response and considered all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors or exceptions remained as cited in the examiners' inquiries.

For the most part, this is a report by exception, in that findings reported are mostly files in error.

C. COMPANY PROFILE

Oxford Health Plans (NJ), Inc. is an HMO domiciled in the State of New Jersey. It was organized under the laws of New Jersey as Oxford Health Plans (NJ), Inc. on April 17, 1985. The Company applied for and was granted authority to operate as a New Jersey HMO by the State Departments of Health and Senior Services, and Banking and Insurance. It commenced operations on September 12, 1985. The primary business of the Company is to provide medical expense coverage for comprehensive health care services to its members on a prepaid basis.

The Company's main office is in Trumbull, Connecticut. The Company has approximately 3,500 employees located in Connecticut, New York, New Jersey, New Hampshire and Florida.

The parent company, Oxford Health Plans, Inc. (a Delaware corporation) offers an array of managed care benefit plans to groups and individuals through its HMO and insurance company subsidiaries.

As of December 2002, Oxford Health Plans (NJ), Inc. had approximately 5,355 providers in its network, providing services to 156,615 members. This results in a doctor-to-member ratio of approximately 1 to 30.

The following table is a reproduction from the Annual Report that Oxford provided for calendar year 2002. It shows the breakdown of the Company's New Jersey membership by county at the end of the year:

County	Individual	Small Group	Large Group	Total
Atlantic	19	0	371	390
Bergen	1,585	23	23,059	24,667
Burlington	18	0	1,424	1,442
Camden	18	0	696	714
Cape May	0	0	0	0
Cumberland	2	0	119	121
Essex	419	6	13,980	14,405
Gloucester	9	0	322	331
Hudson	386	0	11,364	11,750
Hunterdon	59	7	1,486	1,552
Mercer	122	0	4,022	4,144
Middlesex	343	0	17,113	17,456
Monmouth	433	0	10,162	10,595
Morris	377	12	9,990	10,379
Ocean	242	0	5,870	6,112
Passaic	298	4	10,349	10,651
Salem	1	0	24	25
Somerset	188	8	5,818	6,014
Sussex	49	2	2,489	2,540
Union	270	4	11,545	11,819
Warren	40	2	1,236	1,278
Out of State	21	4	20,187	20,212
Unknown	0	0	18	18
TOTAL	4,899	72	151,644	156,615

D. IDENTIFYING MANDATED BENEFIT CLAIMS

This examination focused in part on how Oxford complied with New Jersey HMO mandated benefit laws. The intent of these laws is to create legal rights to medical and other services for members and their dependents. Generally, they vary in the rights they establish, and vary in the degree of reliable data that they make possible. For example, N.J.S.A. 26:2J-4.20 mandates coverage for biologically based mental illness. In that example, an examination can create a reliable claim population by identifying specific diagnostic codes. On the other hand, N.J.S.A. 26:2J-4.25 requires HMOs to offer coverage to for certain infant formulas, data that is generally not identified in company records. In that example, an examination has access to data that is less definitive.

The examiners were able to identify 12 mandated benefits in Company datasets because they equate to specific codes from Current Procedural Terminology (hereinafter "CPT") or International Classification of Diseases (hereinafter "ICD") manuals. The Company also used its own codes on some of the mandates. The examiners were then able to acquire random samples from the resulting populations.

Please See Appendix A for 12 Mandated Benefits Examined by Codes

An additional 13 mandated benefits lacked specific codes, or were not productive of definitive data. For example, N.J.S.A. 26:2J-4.18 mandates coverage for treatment of illness or injury due to domestic violence, but there are no CPT or ICD codes for that injury. In all cases for which there were no existing CPT or ICD codes commonly associated with particular mandated benefits, or for which programming could not produce reliable results, the examiners sent inquiries to the Company. In the inquiries, the examiners asked Oxford to explain how it complied with the mandates, and asked for copies of documents to support the Company's responses.

Please See Appendix B for 13 Mandated Benefits Examined by Inquiry

II. UTILIZATION MANAGEMENT APPEAL, COMPLAINT AND PROVIDER APPEAL REVIEW

A. INTRODUCTION

The examiners evaluated Oxford's Utilization Management Appeals, Complaint Handling and Provider Appeals, reviewing for compliance with turnaround guidelines. Applicable laws included N.J.A.C. 8:38-8.1 et seq. (Utilization Management Appeals), N.J.S.A. 17B:30-13.2, N.J.A.C. 11:2-17.6(d) and N.J.A.C. 8:38-3.7(a)4 (Complaints), and N.J.A.C. 11:22-1.8(a) and N.J.A.C. 8:38-15.3 (Provider Appeals). These laws set forth requirements for timely responses.

During the period October 1, 2001 through September 30, 2002, Oxford processed 944 Utilization Management Appeals, 1,179 Complaints and 1,534 Provider Appeals. The examiners queried Company-provided datasets of these communications for compliance with turnaround times.

B. EXCEPTION RATIOS

The type of communication that an HMO receives determines which of several turnaround guidelines apply. N.J.A.C. 8:38-8.5 requires an HMO to respond to Stage One Utilization Management Appeals within five business days. N.J.A.C. 8:38-8.6(d) requires a response to a Stage Two Appeal within 20 business days. N.J.A.C. 11:2-17.6(d) requires a company to respond to a Department of Banking and Insurance claim-related complaint within 15 working days. N.J.A.C. 8:38-3.7(a)4 requires a 30-calendar day response on directly received complaints. In addition, the Provider Contract Addendum that Oxford submitted to the Department for approval under N.J.A.C. 8:38-15.3(a) contains a limit of ten business days for responses to Provider Appeals. After applying these guidelines, the examiners found the following exceptions in the datasets:

	Population	Exceptions	Exception Ratio
Utilization Management Appeals	**944**	**75**	**7.94%**
Complaints	**1,179**	**16**	**1.36%**
Provider Appeals	**1,534**	**386**	**25.16%**
Total	**3,657**	**477**	**13.04%**

As this chart shows, Provider Appeals accounted for 80.92% (386/477=80.92%) of the exceptions, while accounting for 41.95% (1,534/3,657=41.95%) of the files. In response to an inquiry, Oxford explained this high ratio. "During the exam period, Oxford migrated the review and resolution of provider correspondence from its Connecticut office to its New Hampshire office. This transition was completed in December 2001. Simultaneously, the provider correspondence work transitioned from a paper to electronic environment. Oxford made these business changes with the goal of improving consistency, accuracy and response time. However, due in part to these business changes, Oxford's response time was negatively impacted."

The Company disagreed with the examiners' findings of Complaints, stating that the examiners should not have counted ten of the 16 exceptions. Oxford explained that it had to take time to retrieve written authorizations from members before responding to the complaints. In response to an inquiry, the Company wrote, "Oxford's Quality Management process requires that we obtain written authorization from the member prior to soliciting information from the provider relative to the member's complaint. Therefore, the period during which we await the member's authorization, the provider's response and the necessary medical records for review is not included in our complaint handling turnaround time." However, the examiners could not find extra time allotted in N.J.A.C. 8:38-3.7(a)4 for these processes. Rather, the regulation requires the resolution of complaints with the "Establishment of a specified response time for complaints, not to exceed 30 days from receipt thereof by the HMO."

Oxford also explained the 75 exceptions in its dataset of 944 Utilization Management Appeals. In response to an inquiry, the Company wrote, "The time frames were not met due to Oxford's current mail sorting and routing process, which does not identify UM vs. non UM appeals, nor does it identify NJ vs. NY or CT. A process is currently being created by the Appeals and Operations Departments, to improve the mail sorting and routing process pertaining to appeals."

C. ADDITIONAL BREAKDOWN OF DATA

Oxford provided an additional breakdown of data listed in the error chart above. For Utilization Management Appeals, the examiners requested a separation of First Stage Appeals from Second Stage, and the following chart of exceptions resulted:

	Population	Exceptions	Exception Ratio
First Stage Appeals	**892**	**72**	**8.07%**
Second Stage Appeals	**52**	**3**	**5.77%**
Total	**944**	**75**	**7.94%**

As this chart shows, the Company processed more First Stage appeals than Second Stage appeals. This was due in part to the Company's resolution of the First Stage appeals in favor of the appellant, which eliminated the need for a Second Stage appeal.

The Company also provided a breakdown of Complaints between those received from the Department of Banking and Insurance, those received directly from members, and those received from members and providers that addressed Quality Management issues. The following chart displays the exceptions that occurred for each of these areas:

	Population	Exceptions	Exception Ratio
DOBI	**45**	**4**	**8.89%**
Members	**1,109**	**2**	**0.18%**
Quality Management	**25**	**10**	**40.00%**
Total	**1,179**	**16**	**1.36%**

The Company also provided a breakdown of the 1,534 Provider Appeals, producing 89 sub-categories. The categories included one titled, "Additional Information Received for Denied Claim," with 473 appeals. Another category was "Denied Unauthorized Services," with 51 appeals. There was also one category titled, "Billing Issue," which accounted for 311 appeals. The examiners asked for a further breakdown of this category. The breakdown showed that there were 12 types of "billing issues," including one titled, "NJ prompt pay." Oxford estimated that one

percent of its Billing Issue appeals were prompt pay matters, for a total of approximately three prompt pay appeals during the examining period.

Please see Appendix C for a Breakdown of Provider Appeals

III. PROVIDER CLAIM REVIEW

A. INTRODUCTION

The examiners queried databases of mailed and electronic claims that Oxford received during the examining period of October 1, 2001 through September 30, 2002. In that time, the Company did not delegate any claim processing functions to vendors, processing a total of 1,244,561 claims in its own systems instead. This total included 423,583 mailed and 820,978 electronic claims. Itemized differently, the total contained 1,009,680 paid and 234,881 denied claims. In arriving at these populations, the examiners requested the Company to exclude all Medicare/Medicaid, federal employee health benefit plans (FEHBP) claims as well as ERISA self-funded plans.

The examiners reviewed the population of 1,244,561 claims to verify compliance with statutory and regulatory guidelines regarding prompt claim payments and denials. Oxford supplied the examiners with databases for each of the following: Paid Mandated benefits (60,478 Claims), Paid Non-Mandated benefits (949,202 Claims), Denied Mandated benefits (9,722 Claims) and Denied Non-Mandated benefits (225,159 Claims).

In reviewing these claims, the examiners checked for compliance with statutes and regulations that govern the handling of claims, particularly N.J.S.A. 26:2J-8.1 et seq. ("HINT" - the Health Insurance Network Technology Act), and N.J.S.A. 8:38-16.1 et seq. (HMO Claim Payments). They also checked for compliance with N.J.A.C. 11:22 et seq. (Prompt Payment of Claims), N.J.S.A. 17B:30-13.1 (Unfair Claim Settlement Practices Act), N.J.A.C. 11:2-17.1 et seq. (Unfair Claim Settlement Practices Regulations) and the NAIC Market Conduct Examiners' Handbook, Chapter XVII, Conducting the Health Examination. That chapter includes the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HMOs must provide certain coverages that were once the subject of common policy exclusions. Each contract, member booklet, certificate or agreement for health care services delivered or issued in the State to any enrollee must set out the services and benefits to which the enrollee is entitled. These include all New Jersey mandated benefits, coverages and offers that conform to provisions in N.J.S.A. 26:2J et seq., N.J.S.A. 8:38 et seq. and N.J.S.A. 17B: 27-54, 55, 57, 58, 59, 60, 62, 63 and 66. HMOs must provide these coverages to the same extent as for any other illness or injury.

B. ERROR/EXCEPTION RATIOS

1. Random Sample Errors – Mandated versus Non-Mandated Benefits

a. Random Sample Review, all Errors

The Introduction section of this report previously referred to Appendix A. This Appendix lists 12 mandated benefits that produce reliable populations because they equate to specific ICD, CPT, or in-house codes. This section reports results from randomly selected samples of these populations.

The examiners reviewed 105 denied mandated benefit claims from a population of 9,722, and a sample of 107 paid mandated benefit claims from a population of 60,478. The examiners report an overall error ratio of 1.89%. The following chart displays all of the errors that the examiners found during this review:

	Population	Error	Error Ratio
Paid Mandated	107	2	1.87%
Denied Mandated	105	2	1.90%
Total	212	4	1.89%

b. Random Sample, Prompt Pay Errors Only:

"Prompt pay" laws include N.J.S.A. 26:2J-8.1d(1) and N.J.A.C. 1:22-1.5(a)2, which require a company to pay a mailed claim within 40 days, and N.J.S.A. 26:2J-8.1d(1) and N.J.A.C. 11:22-1.5(a)1, which require a company to pay an electronically transferred Claim within 30 days. In addition, N.J.S.A. 17B:30-13.1e and N.J.A.C. 11:22-1.6(a) require a company to deny a claim within 30 days if electronic, or within 40 days if mailed. The following chart contains the results of the prompt pay review, showing the number of claims from the random samples that did not conform to these rules:

	Population	Error	Error Ratio
Paid Mandated	107	1	0.93%
Denied Mandated	105	1	0.95%
Total	212	2	0.94%

The results of the prompt pay review revealed that the Company maintained a low error ratio (0.94%) in processing the randomly selected mandated benefit claims.

2. Population Review, Prompt Pay Errors

a. Population Review, Mailed Paid Claims:

	Population	Exceptions	Exception Ratio
Mandated Mailed Paid	10,764	388	3.60%
Non-Mandated Mailed Paid	297,684	10,256	3.45%
Total	308,448	10,644	3.45%

The examiners queried populations of Mandated and Non-Mandated Benefit claims for the examining period (October 1, 2001 through September 30, 2002). As noted above, Oxford's overall exception rate was 3.45%.

b. Population Review, Electronic Paid Claims:

	Population	Exceptions	Exception Ratio
Mandated Electronic Paid	49,714	1,436	2.89%
Non-Mandated Electronic Paid	651,518	18,910	2.90%
Total	701,232	20,346	2.90%

Oxford's population of 701,232 electronically paid claims contained 20,346 exceptions. This was a 2.90% exception ratio, similar to the Company's mailed claim exception ratio of 3.45%.

c. Summary of Mailed and Electronic Paid Claim Population Review

The review indicates similar results between paid electronic and paid mailed claims in populations of the 12 mandated benefits listed in Appendix A. As the preceding charts show, the examiners cited Oxford with an overall 3.45% exception ratio on paid mailed claims and a 2.90% exception ratio on electronically submitted paid claims. Variation between mandated and non-mandated benefit exception ratios was negligible and therefore insignificant. Oxford held its prompt pay exception ratio for electronically submitted claims to a slightly lower figure than for mailed claims even though the Company processed more than twice as many electronic claims (701,232 electronic claims vs. 308,448 mailed claims).

d. Population Review, Mailed Denied Claims:

	Population	Exceptions	Exception Ratio
Mandated Mailed Denied	4,823	93	1.93%
Non-Mandated Mailed Denied	110,312	2,261	2.05%
Total	115,135	2,354	2.04%

The examiners queried the entire population of denied mailed claims for the examining period (October 1, 2001 through September 30, 2002). As the examiners note above, Oxford's mailed denied claim exception rate was 2.04%.

e. Population Review, Electronic Denied Claims:

	Population	Exceptions	Exception Ratio
Mandated Electronic Denied	4,899	119	2.43%
Non-Mandated Electronic Denied	114,847	2,650	2.31%
Total	119,746	2,769	2.31%

Oxford's population of 119,746 electronically denied claims contained 2,769 exceptions. This was a 2.31% exception ratio, similar to the Company's mailed claim exception ratio of 2.04%.

f. Summary of Mailed and Electronic Denied Claim Population Review

The results of this analysis indicate similar results between denied claims that claimants submitted electronically and those they submitted by regular mail. The exception ratios were low; at 2.31% and 2.04% respectively. In addition, the examiners found no significant difference in Oxford's handing of mandated versus non-mandated benefits.

C. EXAMINERS' FINDINGS, PAID MANDATED BENEFITS

The examiners' review of random samples taken from Appendix A produced the following findings:

1. Failure to Pay Full Benefits When Full Benefits are Due (One Error)

N.J.A.C. 11:2-17.8(i) states that no insurer shall deny payment of a claim when it is reasonably clear that either full or partial benefits are payable. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 10, which calls on examiners to review company benefit checks and drafts to determine whether they reflect appropriate claim-handling practices. Standard 6 of the handbook also states that examiners should verify whether companies handle claim files in accordance with policy provisions and state law. Contrary to these guidelines, the Company processed one claim for less than full benefits when full benefits were actually due.

On Claim Number 2238502528, Oxford applied 50% coinsurance, or $52.11, when a co-payment of $5.00 was correct. The underpayment on the claim was $47.11. This was not in conformity with the regulation or the NAIC Handbook guidelines. The Company agreed with the examiners' findings.

2. Failure to Pay an Electronic Claim Within 30 Days (One Error)

N.J.S.A. 26:2J-8.1(d)1 and N.J.A.C. 11:22-1.5(a)1 require an HMO to pay an electronic claim within 30 days of receipt. Standard 6 of the NAIC Market Conduct Examiners' Handbook also states that examiners should verify whether companies handle claim files in accordance with policy provisions and state law. In claim number 2183N10478, however, the receipt date was July 2, 2002, and the paid date was September 26, 2002, which was an 86-day turnaround time. The Company disagreed with this cite, stating that the claim was paid on July 29, 2002. However, the Company erroneously denied a portion of the claim that was not paid until September 26, 2002 (86 days after initial submission) as a result of a complaint.

D. EXAMINERS' FINDINGS – INTEREST ERRORS ON PAID MANDATED AND NON-MANDATED BENEFITS

1. Failure to Pay Interest on Late Claims – 1,092 Exceptions in 30,990 Late Claim Payments

N.J.S.A. 26:2J-8.1d(7) and N.J.A.C. 11:22-1.6(c) require interest on claims that a company pays late. This requirement is applicable if a company fails to pay mailed claims within 40 days or electronic claims within 30 days. Also, the NAIC Market Conduct Examiners' Handbook addresses this topic with Standard 10, which calls on examiners to review company benefit checks and drafts to determine whether they reflect appropriate claim-handling practices. In addition, Standard 6 of the handbook states that examiners should verify whether companies handle claim files in accordance with policy provisions and state law.

The examiners ran a query of all 30,990 mandated and non-mandated paid claims that the Company failed to process within the required time frames. They found 1,092 claims for which the Company failed to pay interest. This was a 3.52% exception rate, as the following chart displays:

	Late Payments	No Interest	Exception Ratio
Non-Mandated Electronic	18,910	728	3.85%
Non-Mandated Mailed	10,256	247	2.41%
Mandated Electronic	1,436	110	7.66%
Mandated Mailed	388	7	1.80%
Total	30,990	1,092	3.52%

As they reported in section III.B.1.a above, the examiners also reviewed 107 randomly selected paid mandated benefit claims, finding one that the Company failed to pay within the required time frame of 30 days. That error ratio was 0.93%, and is less than the Company's general population exception ratio of 3.07% (30,990 late claims divided by 1,009,680 paid claims). The Company paid interest on the one random sample error, giving it a 0.0% error ratio in the random sample.

E. EXAMINERS' FINDINGS, DENIED MANDATED BENEFITS

Oxford denied 9,722 mandated benefit claims during the examining period, and the examiners' review for compliance with mandated benefit laws included the Company's use of denial codes in these claims. For example, using code D4, the Company denied 5,115 claims because they were duplicates of prior claims. Using code D3, the Company denied 1,354 claims because the claimant had no coverage at the time of service. Oxford denied 307 claims with code D22 because a specialist performed the services without prior authorization by the Primary Care Provider.

Once their review of these and other denial codes was complete, the examiners found no exceptions to mandated benefit laws in the general population of denied claims.

The examiners also reviewed 105 randomly selected denied mandated benefit claims from the population of 9,722. The examiners outline these findings below:

1. Failure to Deny an Electronic Claim Within 30 Days (One File In Error)

N.J.A.C. 11:22-1.6 requires an HMO to deny an electronically submitted claim within 30 days. In addition, Standard 9 of the NAIC Market Conduct Examination Handbook requires an HMO to process a denied claim in accordance with state law.

Oxford received claim number 1347H78864 on December 13, 2001 and denied it on January 14, 2002, which was two days beyond that allowed by these guidelines. In response to an inquiry, the Company agreed with this cite.

2. Improperly Denying a Mandated Benefit Claim (One File in Error)

N.J.S.A. 26:2J-4.10 and N.J.A.C. 8:57-8.1 require an HMO to provide coverage for routine well childcare, including immunizations. N.J.S.A.17B:30-13.1(d) and (f) require a denial to be fair. In addition, Standard 9 of the NAIC Market Conduct Examination Handbook requires an HMO to process a denied claim in accordance with state law. Contrary to these guidelines, Oxford improperly denied a well-child visit with immunizations for an infant-dependent in claim number 1342N68662. The Company reprocessed the claim for payment after the member telephoned to object to the denial. The Company agreed that the claim should have been paid, writing in response to an inquiry, "Please be advised that Claim number 2129401596.01, which is a duplicate to the claim in question, was reprocessed and paid on June 2, 2002."

F. COMPLIANCE WITH APPENDIX B, MANDATED BENEFITS

Appendix B lists 13 mandated benefits that the examiners could not identify, or could not reliably identify, by codes. For example, N.J.S.A. 26:2J-4.19 mandates coverage for general anesthesia and hospitalization, when the claim is for dental services, when an enrollee is under age five or severely disabled. In this example, there would be a number of problems in producing a reliable population of such claims. Providers rarely if ever submit all such data, and companies rarely store them in their entirety. Additionally, since defining "severe disability" is not within the scope of the exam, identifying the files that document those cases would not be feasible.

The examiners sent inquiries to Oxford and asked the Company how it complied with 20 New Jersey mandated benefits for which coding is unreliable or unavailable. In all 20 cases, the examiners found that the Company complied with the mandate. Appendix B lists these mandates, and the documents or evidence that the Company provided to establish its compliance in each case.

Please See Appendix B for a List of the Mandated Benefits

The Company produced an array of documents and evidence. For example, N.J.A.C. 8:38-5.4 requires an HMO to provide coverage for supportive services such as ambulance in certain non-emergent situations. Oxford established its compliance with this regulation by providing copies of its Certificate of Coverage, Section IV, H, titled "Medical Social Services." The Company also provided a copy of its Corporate Policy, document number TR ME 001.1. Together, these showed that the Company complied with the regulation during the examining period (October 1, 2001 through September 30, 2002). Another example was N.J.S.A. 17B:27-59, which requires an HMO to provide enrollees with credit for prior health insurance coverage (with the effect of negating pre-existing condition limits). The Company established its compliance with this mandate by referring the examiners to its Intranet site, "At Your Service, " in effect during the examining period. There, under "Creditable Coverage Policy," Oxford provided instructions that conformed to the statute.

Appendix B lists all documents and evidence that the Company provided to establish its compliance with the 20 New Jersey mandated benefit laws. Although these procedures indicate compliance, it should be noted that the examiners could not conduct an independent file review as a means to confirm compliance for the reasons stated above.

IV. FORMS AND FILING REVIEW

A. INTRODUCTION

N.J.S.A. 26:2J-1 et seq. (the Health Maintenance Organization Act) and particularly N.J.S.A. 26:2J-42 (titled, "The Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act"), require HMOs to submit all provider contracts and health insurance forms for approval. The statutes call for HMOs to submit these documents to the Departments of Health and Senior Services and Banking and Insurance. Within their meaning, they include applications, riders, endorsements, and evidences of coverage. N.J.S.A. 26:2J-2 further defines "evidence of coverage" as any booklet, certificate, agreement, or contract issued to an enrollee setting out the services and other benefits to which the enrollee is entitled.

The examiners reviewed Oxford's Provider Agreements, certificates of coverage, riders, endorsements, and the Company's 2002 Provider Reference Manual for conformity with these laws. The examiners outline their findings below.

B. ERROR RATIOS

The examiners' review of forms produced the following error chart:

	Reviewed	In Error	Error Ratio
Provider Contracts	5	3	60%
Certificate of Coverage	6	0	0%
Riders	8	0	0%
Endorsements	1	0	0%
Total	20	3	15%

C. EXAMINERS' FINDINGS

1. Use of Unapproved Provider Agreements (2 Errors)

N.J.A.C. 8:38-15.3 requires HMOs to submit Provider Agreements to the Department of Health and Senior Services, Office of Managed Care, and the Department of Banking and Insurance, Managed Care Bureau, for approval. Additionally, Standard 4 in the Underwriting and Rating section of the NAIC Market Conduct Handbook directs examiners to verify that HMOs file contracts, riders, endorsements, and certificates with appropriate Departments for approval. Contrary to these guidelines, Oxford failed to await approval for two of its provider agreements from the Department of Banking and Insurance. These were the Primary Care Physician Agreement, and the Consultant Physician Agreement.

The examiners asked the Company to document that it had received approval for the two agreements. In response to an inquiry, Oxford wrote, "Oxford initially filed both the Primary Care Physician Agreement and the Consultant Physician Agreement with the Department in July of 2000. These filings lead to extensive discussions with the Department on the documents during 2000, throughout 2001 and the spring of 2002. Once the Department approved Oxford's arbitration language there was agreement on all terms and approval by the Department. Oxford recently submitted a wrap-up filing to the Department, requesting that formal approval for these documents be issued." The Company, however, failed to submit final versions of the Agreements during the examining period (October 1, 2001 to September 30, 2002). This was not in conformity with N.J.A.C. 8:38-15.3, which requires a company to submit provider agreements for approval prior to use.

The Company submitted final versions of the Primary Care Physician Agreement and the Consultant Physician Agreement to the Department on July 17, 2003. The Department approved these versions on July 28, 2003.

Oxford provided the examiners with copies of letters of approval from both Departments for three additional provider agreements. These included a letter of approval dated 11/12/02 for the Hospital Agreement, a letter dated 11/12/02 for the Ancillary Provider Agreement, and one dated 7/24/02 for the Provider Contract Addendum. The approval letters acknowledged Oxford's substantial compliance with New Jersey HMO laws, including N.J.S.A. 26:2S-1 et seq. (the Health Care Quality Act).

2. Use of Provider Prompt Pay Appeal Language That Could Exclude Open Claims (1 Error)

N.J.A.C. 11:22-1.8(a) states, "Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their agents and participating health care providers relating to payment of claims..." This language establishes a system in which an HMO participating provider may make a prompt payment appeal of an open claim (a claim received but not processed). In addition, Standard 2 of the Grievance Procedures section of the NAIC Market Conduct Examiners' Handbook directs the examiners to confirm that HMOs establish and maintain grievance procedures in compliance with regulations.

Contrary to these guidelines, however, Oxford used a Provider Contract Addendum with language that could limit appeals to closed claims (those already paid or denied). The examiners found this language in Section VI, 3 of Oxford's Provider Contract Addendum, which read, "If a provider believes that a claim was improperly denied or paid incorrectly, the Provider may appeal that claim and the claim will be handled as follows:" The examiners found that this language was contrary to N.J.A.C. 11:22-1.8(a) because it could restrict appeals to closed claims.

The Company disagreed with this finding. In response to an inquiry, it wrote, "Oxford does not interpret the language contained in its provider agreements and the Regulatory Addendum to mean that the provider does not have the right to file an appeal in the instance of an open claim. To address the Department's concern, Oxford would be agreeable to clarifying its policy regarding inquiries and appeals of open claims through an update to its provider reference manual."

Oxford provided a database of the 1,534 provider appeals that it processed during the examining period (October 1, 2001 - September 30, 2003). A summary of the database appears in Appendix C (previously referenced) of this report. In response to an inquiry, the Company estimated that only three appeals were from providers who had prompt pay complaints. Oxford indicated that it could not report whether any of these appeals concerned open claims.

3. Certificates of Coverage, Member Handbooks, and Riders

N.J.S.A. 26:2J-43(a) requires an HMO to file its certificates of coverage with the Commissioner of Banking and Insurance. Additionally, Standard 4 in the Underwriting and Rating section of the NAIC Market Conduct Handbook requires such filings. The Company combines its certificates with member handbooks, titling them, "Evidence of Coverage & Member Handbook." Appendix D1 lists the Oxford certificates that the examiners reviewed for the examining period, finding that all of them complied with the requirements of N.J.S.A. 26:2J-43(a).

Please See Appendix D1 for a List of the Five Certificates

N.J.S.A. 26:2J-43(a) also requires a company to file any riders with the Commissioner of Banking and Insurance for approval. Accordingly, the examiners reviewed the eight riders that the Company used during the examining period, finding that the Company gained approval for all eight. Appendix D2 lists these riders, and the dates that the Department approved them.

Please See Appendix D2 for a List of the Eight Riders

4. The Provider Reference Manual

HMOs do not have to submit Provider Reference Manuals to the Department of Banking and Insurance for approval, but the examiners reviewed Oxford's to confirm that it complied with N.J.A.C. 11:22-1.8(a), which addresses the provider appeal mechanism. Upon review, the examiners found that the manual conformed to the language of the regulation.

V. RECOMMENDATIONS

Oxford should inform all responsible personnel and third party entities who handle the files and records cited as errors in this report of the remedial measures which follow in the report sections indicated. The examiners also recommend that the Company establish procedures to monitor compliance with these measures.

Throughout this report, the examiners cite all errors found. If the report cites a single error, the examiners often include a "reminder" recommendation because a single error may indicate that more errors may have occurred.

The examiners acknowledge that during the examination, the Company agreed and had already complied with, either in whole or in part, some of the recommendations. For the purpose of obtaining proof of compliance and for the Company to provide its personnel with a document they can use for future reference, the examiners have listed all recommendations below.

A. GENERAL INSTRUCTIONS

All items requested for the Commissioner and copies of all written instructions, procedures, recommended forms, etc. should be sent to the Commissioner, c/o Clifton J. Day, Manager of Market Conduct Examinations, 20 West State Street, PO Box 329, Trenton, NJ 08625, within thirty (30) days of the date of the adopted report.

On claims reopened for supplemental payments, the claim payment should be sent to the insured with a cover letter containing the following first paragraph (variable language is included in parentheses): "During a recent examination, the Market Conduct Examiners of the New Jersey Department of Banking and Insurance found errors in our claim files and recommended a further Company review. Subsequently, our review showed that we owe you interest relating to a previously submitted claim or claims. We are providing details regarding the claim or claims in question in the enclosed Explanation of Benefits. We have mailed the check associated with this amount separately. If you have any questions regarding this payment, please contact us at (toll free number) or write us at the address listed on the Explanation of Benefits."

B. UTILIZATION MANAGEMENT APPEALS, COMPLAINTS, AND PROVIDER APPEALS

1. Oxford should advise all personnel who process Utilization Management Stage One appeals that N.J.A.C. 8:38-8.5 requires a company to conclude non-emergency appeals within five business days and emergency appeals within 72 hours.

2. The Company should advise all employees who process Utilization Management Stage Two appeals that N.J.A.C. 8:38-8.6(d) requires non-emergency Stage Two appeals to be concluded within 20 business days, and emergency appeals to be concluded within 72 hours.

3. Oxford should advise all personnel who process complaints that N.J.A.C. 8:38-3.7(a)4 requires the Company to respond to complaints sent directly to the Company within 30 days of receipt.

4. The Company should advise all personnel who process complaints that N.J.A.C. 11:2-17.6(d) requires the Company to respond to complaints from the Department within 15 working days of receipt.

5. Oxford should advise all personnel who process Provider Appeals that N.J.A.C. 11:22-1.8(a) requires a company to process appeals from providers that address claims not yet paid or denied. The Company should also remind these personnel that it filed Provider Contract Addendum language as a requirement of N.J.A.C. 8:38-15.3, and that that filing commits the Company to a 10-day turnaround for all provider appeals.

C. CLAIMS

6. The Company should remind all personnel who handle claims that N.J.A.C. 11:2-17.8(i) requires an HMO to pay a claim when it is reasonably clear that either full or partial benefits are payable.

7. Oxford should remind all claim-handling personnel that N.J.S.A. 26:2J-8.1(d)1 and N.J.A.C. 11:22-1.5(a)1 require an HMO to pay electronically submitted claims within 30 days of receipt.

8. The Company should remind all personnel who process claims that N.J.S.A. 26:2J-8.1d(7) and N.J.A.C. 11:22-1.6(c) require a company to pay simple interest of 10% per annum on all claims that it fails to process within prompt pay guidelines. These guidelines are 30 days for electronically submitted claims and 40 days for mailed claims.

9. The Company should remind all personnel who process claims that N.J.A.C. 11:22-1.6(a) requires an HMO to deny electronically submitted claims within 40 days of receipt.

10. The Company should remind all personnel who process claims that N.J.S.A. 26:2J-4.10 and N.J.A.C. 8:57-8.1 require an HMO to provide coverage for routine well childcare, including immunizations.

D. FORMS AND FILING

11. Oxford should remind appropriate personnel that the Company must file all provider agreements with the Department of Banking and Insurance, Managed Care Bureau, for approval before use. In order to comply with the requirements of N.J.A.C. 8:38-15.3, Oxford must file the two non-submitted and unapproved provider agreements cited in the report with the Department. It must then forward a copy of the approval letter to the Commissioner in accordance with the instructions in Section A of the recommendation section of the report.

12. The Company should remind all personnel who file Provider Contracts for approval by the Department that N.J.A.C. 11:22-1.8(a) requires a company to process an appeal by a Provider whether the claim is open or closed. The Company should change the wording of its Provider Addendum (Form Number 2002 NJ Re. Addendum) to conform to this requirement. The first paragraph of Section VI, 3 currently reads, "If the Provider believes that a claim was improperly denied or paid incorrectly, the Provider may appeal that claim and the claim will be handled as follows." The language of the first paragraph should be replaced by, "This Addendum establishes an internal appeals mechanism to resolve disputes between Oxford or our agents and the Provider relating to payment of claims, but not including appeals made pursuant to N.J.A.C. 8:38-8.5 through 8.7 and N.J.A.C. 8:38A-32.6 and 3.7. Any Provider Appeal made under this Section will be handled as follows:" The Company should submit the corrected Addendum to the Department within 30 days of the adoption of this report for approval.

APPENDIX A

MANDATED BENEFITS IDENTIFIED BY CODES			
Authority	Mandated Benefit	CPT	ICD
N.J.S.A. 26:2J-4.1 N.J.A.C. 8:38-5.6	Treatment of Wilm's Tumor		189.0
N.J.S.A. 26:2J-4.8	Autologous bone marrow transplants.	38241	
N.J.S.A. 26:2J-4.4	Mammogram Examination Benefit	76092 76085 GO202 GO203	
N.J.S.A. 26:2J-4.9 N.J.A.C. 8:38-5.2(a)3i	Coverage for Birth and Natal Care 48/96 hours of Inpatient Maternity Care	RMNEW RMNEO RMOBS	
N.J.S.A. 26:2J-4.10 N.J.A.C. 8:57-8.1	Child Screening and Immunizations, Blood Lead, Screening for hearing loss (PL 2001, c. 337) Childhood Immunization Insurance Coverage	83655 92551 90702 90708 90705 90706 90371 90657 90633 90634 90669	984.9
N.J.S.A. 26:2J-4.11 N.J.A.C. 8:38-5.4(a)2	Coverage for Diabetes Treatment (Equipment, Supplies, Self-Management Education)	A4206 A4210-11 A4230-32 A4244-47 A4250 A4253-54 A4256 A4258-59 A6257 E0607 E0609 96152 97802-04 99078 G0108-09 E2100-01	250.0-.9
N.J.S.A. 26:2J-4.14	Re-constructive Breast Surgery, Surgery to Restore and Achieve Symmetry, Prostheses	19357 19361 19364	V45.71
N.J.S.A. 26:2J-4.17	Treatment of Inherited Metabolic Diseases, including medical food and food products		270.1
N.J.S.A. 26:2J-4.20 Bulletin 01-06 (5/25/01)	Coverage for Biologically-Based Mental Illnesses (Mental Health Parity Law PL 1999, c.106)		295.0-.6 296.2-.7 297.1 300.3 300.01 299.0
N.J.S.A. 26:2J-4.23 N.J.A.C. 8:38-5.4(a)5, and N.J.S.A. 17B:27-46.1	Reproduction Assisting Technologies - Diagnosisand Treatment of Infertility - Shall include, but not limited to: diagnosis, diagnostic testing, medications, surgery, in vitro fertilization, embryo transfer, artificial insemination, 4 completed egg retrievals	58970 58974 58976 58321-22 89252	
N.J.S.A. 26:2J-4.24	Coverage for the diagnosis and treatment of colorectal cancer screening	HCPCS G0104-07 G0120-22	
N.J.A.C. 8:38-5.3	Provision for Emergency and Urgent Care Services	ERHOS	

APPENDIX B

MANDATED BENEFITS ESTABLISHED BY INQUIRY AND SUPPORTING DOCUMENTS

AUTHORITY	MANDATE	SUPPORTING DOCUMENTS
N.J.S.A. 26:2J-4.5, N.J.A.C. 8:38-5.7(b)	Off-Label Drugs	Certificate of Coverage, Section XIV "Definitions;" Form # NJ LG DPS, Prescription Drug Rider, Section A, Section E-Exclusions #18
N.J.S.A. 26:2J-4.7; N.J.A.C. 8:38-5.7	Prescription Drugs, Pharmacy Services	Filed Prescription Drug Rider, Form #NJ LG DPS 4/00
N.J.S.A. 26:2J-4.8	Dose-intensive chemotherapy	Certificate of Coverage, Section L; Corporate Policy Form #TRANS-PLANT 002.1
N.J.S.A. 26:2J-4.12; N.J.A.C. 8:38-5.2(a)8i; N.J.A.C. 11:22-2.3(a)5	Pap Smear Benefits	Certificate of Coverage, Section C, "Well Woman Examinations;" Corporate Policy Form #Preventive 001.2
N.J.S.A. 26:2J-4.13	Prostate Cancer Screening for Men Age 50 and over and for Men Age 40 and over with Risk or Family History	Certificate of Coverage and Corporate Policy; Form #Cancer 001.1
N.J.S.A. 26:2J-4.15	Inpatient Care following mastectomy	Corporate Policy Form #ADMIN 012.1
N.J.S.A. 26:2J-4.18;	Treatment of Domestic Violence	Certificate of Coverage, Section V, Exclusions & Limitations, "Non-Covered Services and Supplies"
N.J.S.A. 26:2J-4.19	Dental Procedures for the Disabled, and Children Age 5 & Under	Certificate of Coverage, Section IV, "Dental Care and Treatment"; Corporate Policy and Rationale on Outpatient Anesthesia Services for Dental/Oral Surgical Procedures
N.J.S.A. 26:2J-4.21	Continuing Nursing Home Care	Intra-net site, "At Your Service," under "Any Willing Provider: Skilled Nursing Facilities"
N.J.S.A. 26:2J-4.22; N.J.S.A. 26:2S-10.1; N.J.S.A. 26:2S-10.2	Hemophilia	Certificate of Coverage, Section IV, Covered Services; Corporate Policy on Laboratory Services
N.J.S.A. 26:2J-4.25	Coverage for Certain Infant Formulas	Corporate Policy Form #REHAB 004.1 T2, "Nutritional Therapy"
N.J.S.A. 17B:27-57	Genetic Information Not Preexisting	Certificate of Coverage, Section V, Exclusions & Limitations Number 44; Corporate Policy Form # Admin 045.2 "Genetic Information excluded from the Preexisting Condition"
N.J.A.C. 8:38-5.4	Provision for Supportive Services	Certificate of Coverage, Section IV, H, "Medical Social Services;" Corporate Policy # TR ME 001.1

APPENDIX C

PROVIDER APPEALS

N.J.A.C. 8:38-15.3(a). Failure to adhere to filed contract provisions to respond to Provider Appeals within 10 working days. A breakdown of the categories of Provider Appeals that Oxford received during the examining period, and the number of exceptions in each category.

Nature of the Provider Appeal	Population	Exceptions
Billing Issue (includes approx. 3 prompt pay appeals)	311	79
Auth Liability Needs Updating	1	1
Additional Info Rec For Pd/Denied Claim	1	0
Additional Info Recv'd For Denied Claim	473	106
Appeal Time Expired	21	10
Auth not on file for Inpatient Admit.	1	0
Authorization Ignored	37	8
Balance Issue	2	1
Benefit Exclusion Issue	2	1
Billing dispute – General	1	0
Claim Not On File	1	0
Clarification of Order of Benefits	1	1
Clms. Require clin. Review per unbundler	3	2
Contest Clm Type - In-Net vs Out-Network	13	3
Contract Incorrectly Applied	11	4
Coordination of Benefits Questionnaire Returned	1	0
Corrected/Revised Bill Received	37	9
CPT Coding Input Error	2	0
CPT has no fee	1	1
CPT not in Authorization or Different	2	1
Date of Service differs from Auth'd Date	1	1
Deductible Incorrectly Applied (System)	2	0
Denial for lack of clinical info issue	2	1
Denial Incorrect - Claim Not A Duplicate	25	6
Denial Incorrect - Covered Service	48	7
Denial Incorrect - Sh/Not deny D7 (benefit limit)	1	0
Denial of Assistant Surgeon	7	4
Denial of Chiropractic Care	1	0
Denial of Custodial Care	1	0

APPENDIX C

PROVIDER APPEALS (continued)

Nature of the Provider Appeal	Population	Exceptions
Denial of Medical Vision Services	1	1
Denial of Pain Management	2	1
Denial of PT/OT or Speech Therapy	1	0
Denied Exclusion - Unspecified	2	1
Denied Exclusion-Cosmetic Surg	2	1
Denied Unauthorized Service (specify)	51	18
Determination of Medical/Dental Benefit	3	0
Diagnosis Received	1	0
Disputing Claims Filing Deadline	99	18
Disputing D11 Denial (included service)	37	14
Disputing D13 Denial (need add'l info)	1	1
Disputing D22 Denial (not auth'd by PCP)	4	0
Disputing Denial of Ambulance Charges	2	0
Disputing Denial of Durable Medical Equipment	3	1
Disputing Denial Unauth'd Ambulatory Surgery	17	3
Disputing Denied ER Visit	1	0
Disputing Lab Service Denial	1	0
DX/LAB Testing Denial	1	0
EOB from Other Carrier Ignored	1	0
EOB from Primary Carrier Received	7	2
EOB Ignored	3	1
Exception Made	5	3
First Incident Balance Bill-Commercial	1	0
Grievance Issue	2	0
Hospital Disputing Ambulatory Surgery per diem	1	1
Hospital Disputing Contract Rate-Inpt.	8	2
Hospital Disputing Contract Rate-Outpt.	1	0
Include denied services	4	3
Incorrect Claim Type Used	3	0
Incorrect Member # Paid	3	0
Input Error - Requested Amount	1	1
Interim Tracking Use Only -Init.Iss.Code	35	7
Items Omitted/wrong quantity on Claim	2	0
Mbr Requested Less Than 20 EOBS	1	0

APPENDIX C

PROVIDER APPEALS (continued)

Nature of the Provider Appeal	Population	Exceptions
Member Disputing Enrollment Termination	1	0
Member ineligible/disenrolled	2	0
Member termed but still appears	1	0
Missing/Incomplete Info On Sr	2	0
MVA Issue	2	1
NYMI-Radiology Denial	51	12
Orthonet Denial	3	0
Outpatient Non-Surgical Denial	2	0
Outpatient Surgical Denial	2	0
Oxford is Primary Carrier	2	0
Paid Wrong Provider	1	0
Pre-certification Issue	21	6
Provider Disenrollment Request	1	0
Radiology/Denial	6	1
Reconciliation -Retro Rate Adjustment	1	1
Reduction of Acuity Level (Inpatient)	1	0
Referral Ignored	21	5
Referral Issue	31	11
Referral Received-Original Not On File	2	0
Request for review of D19 (not a covered specialty)	7	3
RX Authorization Status Request	1	0
Second Incident Balance Billing-Medicare	1	0
Seeking Additional Payment/UCR Increase	49	19
UCR Appeals	3	2
Verification of Coordination of Benefits	2	0
0ther	1	0
Totals	**1,534**	**386**

APPENDIX D

CERTIFICATES AND RIDERS

D1. Certificates of Coverage Filed with the Department of Banking and Insurance in conformity with N.J.S.A. 26:2J-43(a).

Approved 11/12/99
OHPNJ - Oxford Freedom Plan 4/00 - OHPNJ HMO/POS EOC 4/97
OHPNJ - Oxford Freedom Plan 7/01 - OHPNJ HMO/POS EOC 4/97
OHPNJ - Oxford HMO/Liberty Network 4/00 - OHPNJ HMO EOC 7/97
OHPNJ - Oxford HMO Freedom Network 7/01 - OHPNJ HMO EOC 7/97
OHPNJ - Oxford Liberty Plan 7/01 - OHPNJ HMO/POS EOC 4/97

D2. Riders Filed with the Department of Banking and Insurance in conformity with N.J.S.A. 26:2J-43(a).

Date Approved	Rider Form Number
2/3/98	Long Term Physical Therapy Rider - NJ Large G PT- OHPNJ LT 100 11/97
2/3/98	Long Term Physical Therapy Rider - NJ Large NG PT-OHPNJ LT 100 11/97
7/7/98	Alternative Medicine Rider - OHP NJ Alt Med Rider-OHPNJ AM 5/97
2/6/96	Durable Medical Equipment Rider - NJ DME Rider-OHPNJ DME 12/95
7/7/98	Infertility Treatment Rider - OHPNJ INF 2/98 - Infertility Rider w/ RX
7/7/98	Infertility Treatment Rider - OHPNJ INF 2/98 - Infertility Rider in Network Only
7/7/98	Infertility Treatment Rider - OHPNJ INF 2/98 - Infertility Rider in Network Only w/RX
7/7/98	Infertility Treatment Rider - OHPNJ INF 2/98 - Infertility Rider

VERIFICATION PAGE

I, Dean Turner, am the Examiner-in-Charge of the Market Conduct Examination of Oxford Health Plans (NJ), Inc. conducted by examiners of the New Jersey Department of Banking and Insurance. This verification is based on my personal knowledge as acquired in my official capacity.

The findings, conclusions and recommendations contained in the foregoing report represent, to the best of my knowledge, a full and true statement of the Market Conduct examination of Oxford Health Plans (NJ) Inc. as of July 17, 2003.

I certify that the foregoing statements are true. I am aware that if any of the foregoing statements made by me is willfully false, I am subject to punishment.

Date

Dean Turner, F.L.M.I.
Examiner-In-Charge
New Jersey Department
of Banking and Insurance