

REPORT ON EXAMINATION
OF
AMERICHoice OF NEW YORK, INC.
AS OF
DECEMBER 31, 2000

DATE OF REPORT

AUGUST 16, 2002
Revised December 31, 2002

EXAMINER

ARCELIO VEGA

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

December 31, 2002

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Number 21748, dated August 1, 2001, and annexed hereto, I have made an examination into the condition and affairs of AmeriChoice of New York, Inc., a for-profit health service corporation licensed under the provisions of Article 44 of the New York Public Health Law, at its home office located at 7 Hanover Square; New York, New York 10004. The following report as respectfully submitted, deals with the findings concerning the manner in which AmeriChoice conducts its financial business transactions and fulfills its contractual obligations to policyholders and claimants.

Wherever the terms "Americhoice", "ACNY", or "Plan" appear herein, without qualification, they should be understood to refer to AmeriChoice of New York, Inc.

1. SCOPE OF EXAMINATION

This is the first examination of AmeriChoice. The examination covers the period January 1, 1996 through December 31, 2000. Where deemed appropriate, transactions subsequent to this period were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2000, a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners' Handbook of the National Association of Insurance Commissioners:

- History of Plan
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of Plan
- Business in force
- Claims experience
- Reinsurance
- Accounts and records
- Financial statements
- Treatment of policyholders and claimants

This report contains the significant findings of the examination and is confined to the financial statements and comments on those matters, which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

2. DESCRIPTION OF PLAN

The Plan is a wholly-owned subsidiary of AmeriChoice Corporation, a Delaware Corporation. AmeriChoice of New York, Inc. was originally incorporated as a for-profit business corporation under New York State Law on July 24, 1992. It commenced business on January 1, 1994, and was certified as a health maintenance organization (“HMO”) on October 14, 1995, as defined in Article 44 of the New York State Public Health Law. The Certificate of Authority to operate pursuant to Article 44 of the New York State Public Health Law was reissued by the New York State Department of Health on June 6, 2000, to reflect the name change from Managed HealthCare Systems of New York, Inc. to AmeriChoice of New York, Inc.

A. **Management**

The Plan’s amended by-laws as of April 1, 1997, provides that the corporate powers of the Plan be exercised by a board of directors consisting of not less than 5, nor more than 11 members, and by committees thereof, which exercise delegated powers when the board is not in session.

At December 31, 2000, the board of directors consisted of the following seven members:

Name and Residence

Principal Business Affiliation

Enrollees

Rev. Arlee Griffin
Brooklyn, New York

Pastor,
Berean Baptist Church, Brooklyn, NY

Name and ResidencePrincipal Business AffiliationCommunity Representatives

Arthur Hill
Hollis, New York

Retired, Represents the Brooklyn
Community on the Board

Dr. Thomas Morales
New Paltz, New York

Served as a community representative on the
Board,
Dean of Student Affairs at the City
University of New York
After December 2000, joined California
Polytechnic University, but was still a board
member at December 31, 2001

Other Members

Andre Vincent Duggin
Wayne, Pennsylvania

Principal in AV International, an insurance
brokerage concern,
A Shareholder of AmeriChoice Corporation

Edgar Gonzalo Rios
Vienna, Virginia

Executive Vice President and
General Counsel,
AmeriChoice Corporation

Jess Elmer Sweely
Vienna, Virginia

Vice Chairman and Chief Operating Officer,
AmeriChoice Corporation

Anthony Welters
Vienna, Virginia

Chairman and Chief Executive Officer,
AmeriChoice Corporation

The composition of the seven board members at December 31, 2000, includes three New York residents and four out of state residents.

Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department requires that twenty percent of the board of directors be comprised of enrollee representatives. In a March 13, 1996 letter, the New York State Department of Health authorized the use of one representative of enrollee advocacy organizations (Community Representative) as a source for enrollee representation on the Plan's board for purposes of meeting the 20% requirement. As a

result, the board of directors complies with Section 98-1.11(f) of the Administrative Rules and Regulations of the Health Department.

The minutes for the board of directors' meeting for the first quarter of 1997 were not provided to the examiners. Section 98-1.17(d) of the Administrative Rules and Regulations of the Health Department requires:

“All fiscal and statistical records and reports of the Plan shall be subject to audit for a period of six years from the date of their filing with the department [DOH]...”

It is recommended that ACNY maintain all minutes of the board of directors' meetings for a period of at least six years as required by Section 98-1.17(d) of the Administrative Rules and Regulations of the Health Department.

§1411(a) of the New York Insurance Law states:

“(a) No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting.”

Further, Part 98-1.11(g)(5) of the Administrative Rules and Regulations of the Health Department requires that the authority over the disposition of assets and incurring of liabilities on behalf of the Plan shall be the responsibility of the governing authority of the Plan.

Article V, Section 5 of the Plan's amended by-laws states in part:

"The Board of Directors of MHSNY [amended in August 1, 2000 to AmeriChoice of New York, Inc.] is responsible for and must approve all financial transactions undertaken by MHSNY, including the disposition of assets and incurring of liabilities..."

The board of directors' minutes of April 5, 2000 reads: "The AmeriChoice Corporate Investment Policy was distributed to the board for review and approval. Mr. Sweely explained that the AmeriChoice subsidiaries are required to adopt this policy, which has been approved by the AmeriChoice Corporation Board of Directors. After review and discussion, a motion to adopt the Corporate Investment Policy was made, seconded and unanimously adopted."

However, the board of directors for the Plan should adopt a specific investment policy for the Plan so that it ensures compliance with its statutory investment requirements. The annual statement for year-end 2000 shows bond assets of over \$21 million. During the same year, ACNY acquired approximately \$15 million worth of securities and sold over \$14 million. The board of directors' minutes made no mention of being aware of the Plan's investment transactions during or subsequent to the examination period.

It is recommended that the Plan's investments be approved by the board of directors or a committee thereof to comply with the requirements of Section 1411(a) of the New York Insurance Law.

It is recommended that ACNY's board of directors create policies that will enable it to approve the sale and purchase of its investments in compliance with Part 98-1.11(g)(5) of the

Administrative Rules and Regulations of the Health Department. It is also recommended that the Plan's board adopt an investment policy for ACNY.

The principal officers of the Plan as of December 31, 2000 were as follows:

<u>Name</u>	<u>Title</u>
Thelma Duggin	President
Pat Celli	Vice President, Fiscal Operations
Edgar Gonzalo Rios	Secretary

B. Territory and Plan of Operation

AmeriChoice has a contract with the City of New York, Office of Medicaid Managed Care, to act as an agent for the State, to provide health care services to Medicaid recipients in the City of New York. During calendar year 2000, ninety-nine percent (99%) of the Plan's writings was Medicaid business. The remainder of the Plan's writings was Medicare, Child Health Plus, Healthy NY, NY Family Health Plus, and statutorily required individual and small group commercial business.

It is noted that while the Plan accepts non-Medicaid business, it does not actively market this business.

The Certificate of Authority limits the Plan's service area for the commercial population to Kings and Queens County. It also limits the service area for the Medicaid population to the Bronx, Queens, Kings, and Richmond counties. Currently, ACNY does not write business in Richmond County.

During the period January 1, 1996 through December 31, 2000, the Plan experienced a net increase in enrollment of 16,337 enrollees. An analysis of the increase in enrollment is set forth below:

	1996	1997	1998	1999	2000
Enrollment, January 1	43,111	37,944	32,892	31,909	57,662
Net Gain/(loss)	(5,167)	(5,052)	(983)	*25,753	1,786
Enrollment, December 31	37,944	32,892	31,909	57,662	59,448

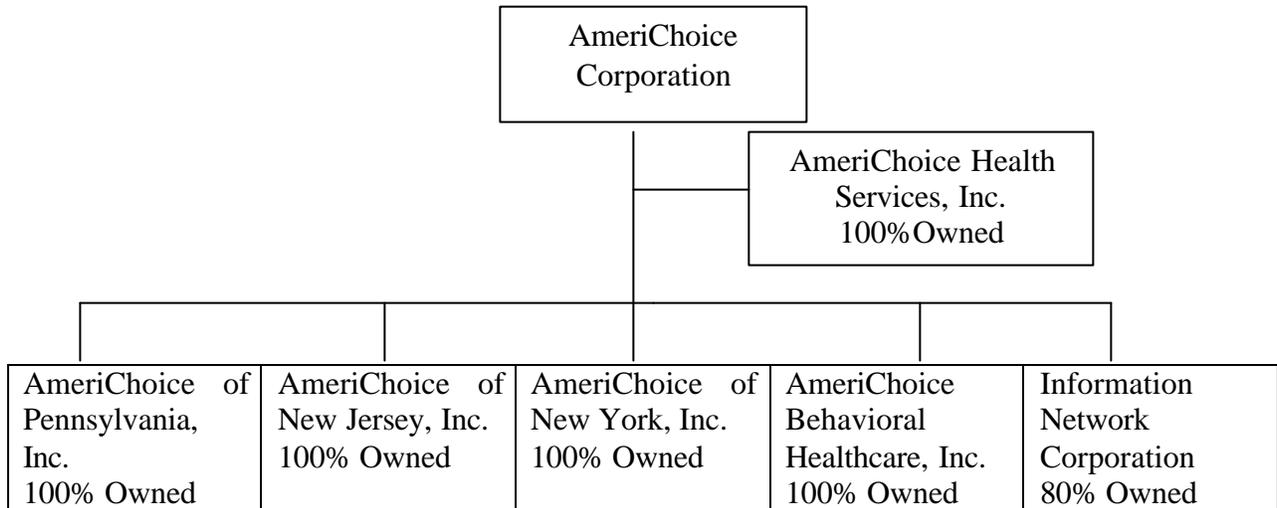
* Denotes acquisition of Oxford Health Plans (NY), Inc.'s Medicaid members in January 1999.

C. Holding Company System

As of the examination date, AmeriChoice was a wholly owned subsidiary of AmeriChoice Corporation, Inc ("ACI" or "Parent"), a Delaware corporation.

ACI controlled one hundred percent of the outstanding shares of AmeriChoice of New Jersey, Inc., ("ACNJ") (previously known as Managed Healthcare Systems of New Jersey, Inc.), AmeriChoice of Pennsylvania, Inc. ("API") (previously known as Healthcare Management Alternatives, Inc.), and AmeriChoice Behavioral Healthcare, Inc. ("ABHI"). ACI similarly controls 80% of the outstanding common stock of Information Network Corporation ("INC"). The Holding Company System also contained various non-active shell companies and dormant corporations.

The following shows the Plan’s holding company system as presented in Schedule Y of the Plan’s filed 2000 Annual Statement:



Subsequent to the examination date, effective close of business on September 30, 2002, UnitedHealth Group, Inc. (“United”) acquired ACI, the sole shareholder of ACNY. The Departments of Health and Insurance approved the transaction subject to the following conditions:

1. UnitedHealth Group, Inc. commits to continue AmeriChoice Corporation’s current focus of marketing government sponsored programs, including Medicaid, Child Health Plus, Family Health Plus, and Healthy New York. UnitedHealth Group further agrees that it must address the concerns of the New York State Departments of Health and Insurance before undertaking any change to AmeriChoice’s current focus.
2. All inter-company agreements that were revised based upon the review and comments by the Departments of Health and Insurance will be executed and that such copies be forwarded to the New York State Health and Insurance Departments.

The Plan made its Holding Company filing in compliance with Part 98-1.16(e) of the Administrative Rules and Regulations of the Health Department. The filing agrees with

Schedule Y of the Annual Statement. However, as is detailed below, the examiners were unable to obtain information necessary to verify the accuracy and completeness of the filings.

i. Shell and Dormant Corporations

While reviewing corporate insurance coverage, contracts, and trial balance entries, the examiners noted names of entities owned by ACI, which were not accounted for in the Plan's Schedule Ys. Many oral and e-mail inquiries by the examiners resulted in only a partial explanation from Plan personnel, as follows:

ACI, AmeriChoice of New York, Inc.'s Ultimate Parent, incorporated or otherwise formed several entities throughout the years that are no longer active, or which were never capitalized. Affiliates with discontinued operations include: Ameriworks, AmeriChoice Behavioral Healthcare, Inc. and Main Line MSO, Ltd.

Other corporations (Atlantic Healthcare Systems, Inc., Management Alternatives, Inc., AmeriChoice Health Services Northeast Division, AmeriChoice of Georgia, Ameriworks Corporation, AmeriChoice Behavioral Healthcare, Inc. D/B/A Mustard Seed, Boston Medical Center Health Plan ("BMC"), and Revolution Health Systems, Inc. (RHS)) were not addressed in the e-mail reply. Additionally, an entity referred to as "Call Center" was not explained. Pat Celli, Vice-President for Fiscal Operations of the Plan, stated that Ameriworks, owned by ACI and listed as a party to the Plan's Consolidated Tax Allocation Agreement, is a dormant corporation. In addition, Main Line MSO Ltd., a Physicians management services company, was inactive in 2000, but active prior to 2000. Main Line MSO, Inc., is a general partner of MSO, Inc.

The Annual Statement instructions for Schedule Y, Part 1, Organizational Chart states:

“Attach a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and other affiliates... No non-insurer (excluding the parent company) need be shown if it does not have any activities reported in Schedule Y, Part 2, and its total assets are less than one-half of one percent of the total assets of the largest affiliated insurer. Only those companies that were a member of a holding company group at the end of the end of the reporting period should be shown on Schedule Y, Part 1, Organizational Chart.”

Since the Plan did not provide all requested information regarding its affiliates, the examiners were not able to determine if the non-disclosed entities met the criteria to exclude them from the organizational chart.

A review of the Holding Company filings with the Insurance Department disclosed a similar non-disclosure problem.

It is recommended that ACNY submit a listing to this Department and the Department of Health, where applicable, of all affiliates that are not shown on Schedule Y and the reason for their exclusion.

ii. AmeriChoice Health Services, Inc. ("AHS")

Managed Healthcare Systems of New York, Inc., entered into a five-year management agreement, ("Agreement") effective September 1, 1995, with AHS, a Delaware Corporation. The Agreement requires that AHS provide various administrative services, including: personnel, general administration, corporate support, accounting and finance, claim processing, and marketing. The Agreement was renewed under the new name of AmeriChoice of New York, Inc., effective September 1, 2000. The original and renewal Agreements were both approved by

the Commissioner of Health pursuant to Part 98-1.11(h) of the Department of Health Administrative Rules and Regulations. The renewal Agreement was not submitted to the Superintendent of Insurance.

It is recommended that the Plan submit a copy of the renewal management agreement, together with the Commissioner's approval, to the Superintendent of Insurance.

iii. Boston Medical Center Health Plan ("BMC")

AHS had a contract to provide support services to BMC. Some of the support services described in this agreement, specifically accounting, were actually provided by ACNY to BMC. The Plan would charge BMC directly for these services. The Plan states that they had no agreement with BMC. The services are provided under the Plan's management agreement with AHS. The management agreement encompasses services to be provided by AHS to the Plan, including accounting services, but the Agreement is silent as to BMC's involvement.

Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department requires transactions within a Holding Company System to which a controlled HMO is a part be subject to the following guidelines:

- (1) the terms of the financial transaction shall be fair and equitable to the HMO at the time of the transaction;
- (2) charges or fees for services performed shall be reasonable; and
- (3) expenses incurred and payments received shall be allocated to the HMO on an equitable basis in conformity with customary accounting practices consistently applied.

Part 98-1.10(b) of the Administrative Rules and Regulations of the Health Department states:

“The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.”

Further, Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department states:

“The commissioner’s and superintendent’s prior approval shall be required for the following transactions between a controlled HMO and any person in its holding company system: sales, purchases, exchanges, investments or rendering of services on a regular or systematic basis the aggregate of which involves 10 percent or more of the HMO’s admitted assets at last year-end. Notice shall be required for such transactions of five percent or more.”

Finally, Part 98-1.10(d) of the Administrative Rules and Regulations of the Department of Health states:

“The commissioner, in reviewing transactions pursuant to subdivision (c) of this section, shall consider whether they comply with the standards set forth in subdivision (a) of this section, and whether they may adversely affect the interests of enrollees.

It is recommended that the Plan submit the Agreement to the Superintendent of Insurance and the State of New York Department of Health for approval (if it meets the above criteria) and that the list of services to be provided by the Plan to third parties complies with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department.

iv. Tax Allocation Agreement

Effective January 1, 1997, the Parent entered into a tax allocation agreement with the Plan, formerly known as Managed Health Care Systems of New York, Inc. and various subsidiaries, including Ameriworks. Based on statements made by the Plan, Ameriworks is a dormant corporation.

It is recommended that the Plan update its Tax Allocation Agreement and list only the affiliates that are participating in the agreement and the Plan's new corporate name.

It is also recommended that the Plan submit the agreement to the New York Insurance Department and to the New York Department of Health for their approval in compliance with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department.

Subsequent to the examination period, on October 22, 2002, the Plan submitted to the Insurance Department a new Tax Allocation Agreement between its new ultimate parent United Health Group Incorporated, AmeriChoice of New York, Inc., and its parent AmeriChoice Corporation.

v. Intercompany Subordination Agreements/Credit Agreement

AmeriChoice Corporation entered into two different "Intercompany Subordination Agreements" that were not submitted to the Department of Insurance or the Department of Health for approval. The first contract dated June 28th, 1996 and amended on June 30th, 1998, refers to another agreement addressed as the "Loan Agreement" with the Banks parties thereto (the "Banks") and NationsBank, N.A., as agent for such Banks. The Plan's response to an

examiner query was that the Intercompany Subordination Agreement stated: "...if AmeriChoice Health Services owes money to both the plans and the Banks, the plans agree that the Banks may be paid first. This agreement has had no impact on AmeriChoice of New York. You will note that the auditors [CPAs] do not require us to note it as a contingency in our financial statements."

The second contract, dated November 13th, 1998, refers to another agreement described as the "Credit Agreement" (for advances and letters of credit), with the Lender Parties thereto, and NationsBank, N.A., as collateral agent and as administrative agent for the Lender Parties. The agreement states that each AmeriChoice Party's extension of credit now or hereafter existing (whether created directly or acquired by assignment or otherwise and whether evidenced by a note, instrument, book entry, oral understanding or otherwise) to any Loan Party, along with interest and premiums, if any, thereon and other amounts payable in respect thereof, are herein referred to as "Subordinated Debt".

In a letter to the Plan dated May 6, 2002, the Insurance Department disapproved the Intercompany subordination agreement, and took the position that the Intercompany Subordination Agreement is subject to Parts 98-1.10(c) and 98-1.11(b) the Administrative Rules and Regulations of the Department of Health which state:

Part 98-1.10(c) states that:

"The commissioner's and superintendent's prior approval shall be required for the following transactions between a controlled HMO and any person in its holding company system: sales, purchases, exchanges, investments or rendering of services on a regular or systematic basis the aggregate of which involves 10 percent or more of the HMO's admitted assets at last year end. Notice shall be required for those transactions of five percent or more."

Part 98-1.11(b) states that:

“No funds the aggregate of which involves 10 percent of the HMO’s admitted assets at last year-end shall be transferred or loaned from the HMO line of business to any other line of business, function or contractor of the HMO, or within a holding company system, without the prior approval of the superintendent and commissioner; and notice shall be required for transfers or loans involving five percent or more of the HMO’s admitted assets at last year-end. Repayment of any such approved loans shall be made in accordance with schedules approved by the superintendent and commissioner.”

ACNY, per an Insurance Department request dated April 5, 2002, forwarded the “Intercompany Subordination Agreement”, but failed to submit a related “Credit Agreement”-LOCs.

It is recommended that the Plan complies with Parts 98-1.10(c) and 98-1.11(b) of the Administrative Rules and Regulations of the Department of Health and forward the remaining agreement to the Superintendent and the Commissioner for their review.

Subsequent to the examination period, on January 9, 2003, the Plan provided documentation from Bank of America, N.A., as Administrative Agent, confirming that the Credit Agreement has been terminated and all amounts due pursuant to the Agreement have been paid in full.

D. **Intercompany Balances and Records**

Mr. Alan Schefing, Director of Special Projects of the Plan, provided the examiners with all the Intercompany billings received during 2000. He also provided a computer run with all payments received during the same year and the run included Intercompany payments.

However, the payments were very numerous and neither the examiners nor Mr. Schefing could determine if a specific payment was a fee for a service or if it was a reimbursement for an expense incurred and billed by the affiliate. The Intercompany payments are independent of the invoices and no reconciliations are made by the Plan. Supporting documentation shows transfers or payments of money, but does not explain the reason for the payment other than it is an Intercompany balancing entry. Payments are not readily traceable to invoices since they have running balances. The Plan accumulated an asset net of liabilities for "Amounts due from affiliates" in the amount of \$6,839,963 (25.9% of net worth) for the year ended December 31, 2000. The Parent is aware of those balances and notifies each affiliate how much to pay.

Part 98-1.10(b) of the Administrative Rules and Regulations of the Department of Health states:

The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

It is recommended that the Plan add such ledger accounts as may be deemed necessary to segregate and identify the numerous types of payments into various categories to determine the reason for the payments.

It is also recommended that if the Plan provides services to an affiliate or to other third party on its own behalf or on behalf of an affiliate, that the services and applicable fees to be charged be enumerated in a formal agreement .

It is further recommended that the Plan settle balances within the holding company system at least quarterly, and that the underlying transactions meet the requirements of Part 98-1.10(a) of the Administrative Rules and Regulations of the Department of Health, and that any receivable balances meet the definitions of an admitted asset as established in Statements of Statutory Accounting Principles (SSAP) No. 4 for Assets and Nonadmitted Assets.

E. **Conduct of Examination**

Sections 310(a)(2) & (3) of the New York Insurance Law state:

(2) “Any examiner authorized by the superintendent shall be given convenient access at all reasonable hours to the books, records, files, securities and other documents of such insurer or other person, including those of any affiliated or subsidiary companies thereof, which are relevant to the examination...”

(3) “The officers and agents of such insurer or such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so.”

ACNY leases its office in New York City, but its Parent maintains locations in Albany, New York, and in Arizona and Virginia. Many of the supporting documents needed to complete the examination were not located in the New York City office. Some of these documents were required in original form for examination purposes. The Plan did not provide, in a timely manner, certain requested documents that should be readily available. In other cases, documents that were received were incomplete and/or missing signatures, dates, names of parties, or a combination of each.

Various meetings with the Plan yielded only limited improvement in providing requested documentation in the time frame requested by the examiners. The resulting delays impacted the overall length of the examination.

It is recommended that in future examinations, ACNY act in compliance with Sections 310(a)(2) and (3) of the New York Insurance Law, and improve its procedures to facilitate the examination and provide requested documentation on a timely basis.

It is recommended that ACNY provide sufficient access to its books of accounts at its New York office in compliance with Part 98-1.11(a) of the Administrative Rules and Regulations of the Department of Health in order to facilitate future examinations.

3. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2000. This statement is the same as the balance sheet filed by the Plan in its December 31, 2000 Annual Statement.

<u>Current Assets</u>	<u>Ledger</u>	<u>Not Admitted</u>	<u>Net Admitted</u>
Cash	\$ 4,708,088	\$ 0	\$ 4,708,088
Short-term investments	12,234,954	0	12,234,954
Premiums receivable	681,635		681,635
Investment income Receivables	441,771	0	441,771
Amounts due from affiliates	6,839,963	0	6,839,963
Reinsurance recoverable on paid losses	520		520
Prepaid expenses	234,130	234,130	0
Deferred taxes – current	177,814	177,814	0
Exchange	<u>23,696</u>	<u>23,696</u>	<u>0</u>
Total current assets	<u>\$25,342,572</u>	<u>\$435,640</u>	<u>\$24,906,931</u>
<u>Other Assets</u>			
Bonds	\$21,249,389	\$ 0	\$21,249,389
Security deposit	8,100	8,100	0
Deferred taxes	541,115	541,115	0
Goodwill	<u>10,895,358</u>	<u>10,895,358</u>	<u>0</u>
Total other assets	<u>\$32,693,962</u>	<u>\$11,444,573</u>	<u>\$21,249,389</u>
<u>Property and Equipment</u>			
Furniture and equipment	\$ 153,968	\$ 153,968	\$ 0
Leasehold improvements	495,379	495,379	0
EDP equipment	495,888	495,888	0
Other property and equipment	<u>141,412</u>	<u>141,412</u>	<u>0</u>
Total property and equipment	<u>\$1,286,647</u>	<u>\$1,286,647</u>	<u>\$ 0</u>
Total assets	<u>\$59,323,181</u>	<u>\$13,166,861</u>	<u>\$46,156,320</u>

LiabilitiesCurrent Liabilities

Accounts payable	\$ 365,393
Claims payable	16,154,693
Accrued expenses	2,402,040
Unearned premiums	293,261
Amounts due to affiliates	31,640
Capital lease obligation – current	<u>22,577</u>

Total current liabilities \$19,269,604

Other liabilities

Deferred rent abatement \$ 444,682

Total liabilities \$ 19,714,286

Net Worth

Common stock	\$ 9,636,596
Contingency reserves	4,639,590
Retained earnings	<u>12,165,848</u>

Total net worth \$26,442,034

Total liabilities and net worth \$46,156,320

Note - Since the inception of the Plan, the Internal Revenue Service has not made any audits of the Plan. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of revenue, expenses and net worth

Reserves and unassigned funds increased \$17,071,974 during the examination period, January 1, 1996 through December 31, 2000, detailed as follows:

Revenue

Premiums	\$377,837,342	
Investments	6,881,080	
Other revenues	<u>6,646</u>	
Total Revenue		\$384,725,068

Expenses

Claims incurred	\$229,935,804	
Administrative expenses incurred	<u>92,362,369</u>	
Total expenses		<u>\$322,298,173</u>

Net operating income \$ 62,426,895

Provision for federal income taxes (29,720,939)
 Net income \$ 32,705,956

Changes in Net Worth

Net worth as of December 31, 1995 \$ 9,370,059

Gains (Losses)
in Net Worth

Net income	\$32,705,956	
Dividends to stockholders	(2,400,000)	
Change in non-admitted asset	(13,166,856)	
Unrealized capital losses	<u>(67,125)</u>	
Net increase in net worth		<u>17,071,975</u>

Net worth per examination as of
 December 31, 2000 \$26,442,034

4. CLAIMS PAYABLE

The examination liability of \$16,154,693 is the same as that reported by the Plan in its filed Annual Statement. The examination reserve was determined by a Department actuary and was based upon actual payments made through September 30, 2001, plus an estimate of claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2000, that was still outstanding at September 30, 2001.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. Following are the examiners' findings:

A. Claims

The examination review population consisted of all claims adjudicated in 2001. The claims population provided by the Plan was downloaded from the SQL Data Warehouse accessed at the Plan's office. The mainframe located at Information Network Corporation ("INC") in Arizona supplied the data concerning the population. The information maintained at the SQL Data Warehouse ("Warehouse") was not complete and required frequent updates to match the population data at INC. For example, when a claim transaction is reversed, fields such as "amount billed" appear with a positive amount while the field "amount paid" contains a negative number. The contradicting signs appear when a claim is reversed and create an

appearance of an erroneous procedure in claims processing. The Plan informed the examiners that the data warehouse is synchronized to the mainframe every month based upon matching the total amount paid for claims. As data is updated in the Warehouse, the fields will reflect the data stored at INC, and the differences in the system are eliminated.

It is recommended that in future examinations the Plan download the data from the INC database at Arizona rather than the SQL Data Warehouse.

The Plan tracks claims denied and resubmitted by using two fields to store the initial claim number and the subsequent claim number, if any. Also, the Plan substitutes the first digit of a five digit sequence number that follows the Julian date and replaces it with a 9 to identify a claim adjustment. The Plan correctly maintains the original claim receipt date on all resubmitted and/or adjusted claims. However, the date an originally denied claim is resubmitted does not appear on the resubmitted claim and was not provided to the examiners. Based on a review of the record layout provided by ACNY it did not appear to include the resubmitted claim receipt date. The lack of a resubmitted receipt date made the aging of claims function very difficult. For example, a claim received on October 1, 2000 and denied on October 20, 2000, that is resubmitted on January 5, 2001 and reversed and/or paid on March 1, 2001, was aged by the examiners at 151 days from the date of receipt to the date of payment since the date of resubmission is not available.

It is recommended that a field containing the resubmitted date of a claim be created and maintained in the system.

i. Claims Processing Accuracy

From a population of 358,743 medical and 77,221 hospital Medicaid claims adjudicated in 2001, the examiners selected medical and hospital claim samples of 167 each to test various financial and procedural attributes. Two statistical samples of 167 Medicaid claims each (medical and hospital) were pulled from the extracted population using the ACL software. The review was limited due to systemic problems in reviewing the detail provided for selected claims and the concentration of business in the Medicaid line. The problems encountered are described in more detail below.

The Plan contracts with providers under varying payment schedules and methodologies: Medicaid (Medicaid Fee Rate), Resource Based Relative Value Scale (“RBRVS”), Resource Based Relative Value Scale Plus (“RBRVS+”), Oxford (“OXFD”), Contract Based (other method of payment based on an agreement with the provider), and the capitation fee schedule (some claims could have a diagnosis code fall under a fee-for-service payment and other diagnosis code falling under capitation). When the claim is scanned into the system, the software program identifies the payment schedule that applies to the provider of services. If the program cannot determine the payment mode, the claim examiner manually inputs the payment amount into the system.

On reviewing selected claims it was determined that the Plan did not maintain, or did not provide, adequate detail to support the accurate and proper adjudication of its claims. Specifically, the following was noted:

1. A number of claims payments could not be traced to specific provider payment schedules.
2. In certain cases, the contracts were provided without a rate schedule to verify the amount paid. In other cases, where the contract sets forth the rate to be charged, the payment fee schedule was missing.
3. One claim under Products of Ambulatory Surgery also known by claim personnel as Professional Ambulatory Services (PAS) could not be traced or explained by the Plan. The Plan did not provide the necessary documentation to enable the examiners to reconstruct the amount paid on the claim.
4. The examiners did not receive the actual manual of the Medicaid fee schedule since the manual was deemed “too big” by Plan personnel. It is located in New Jersey, and, if it is lost, it is difficult to get a replacement from the State. When the examiners asked for the Medicaid fee schedule, the Plan requested that we notify them of the codes we need to verify, and they sent the applicable two sided copies of the Medicaid rates. These copies are revisions of Medicaid Fees for 4/93, 4/97, 7/00, and 4/01.
5. Four hospital rates from the claims database did not agree with the Medicaid schedule provided to the examiner. This is a procedural system error that could affect all claims containing the same procedures. The Plan responded that the affected procedure codes’ rates need to be updated.

It is recommended that the Plan formalize its understanding with its providers, including rates to be charged and the effective date of the charges, to allow third parties to follow an audit trail of the claim charges.

It is further recommended that the Plan update all payment rates in a timely manner to avoid making erroneous payments on the affected codes.

Department Regulation 64 {11 NYCRR 216.11} states in part:

“...To enable department personnel to reconstruct an insurer’s activities, all insurers subject to the provision of this part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to the claim can be reconstructed by the Insurance Department examiners. Insurers shall make a notation in the file or retain a copy of all forms mailed to claimants.”

Department Regulation 152{11 NYCRR 243.2(b)(4)}states:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain:

“(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.”

It is recommended that the Plan comply with Department Regulation 64 {11 NYCRR 216.11} and Department Regulation 152 {11 NYCRR 243.2(b)(4)}, which require that all insurers maintain all data within the claim files so that the Insurance Department examiners can reconstruct the claim.

Part 98-1.11(a) of the Administrative Rules and Regulations of the Health Department states:

“...All records pertaining to the article 44 certified HMO shall be maintained in New York State.”

It is recommended that ACNY provide access to its Medicaid Fee manual or reasonable facsimile at its New York office to comply with Part 98-1.11(a) of the Administrative Rules and Regulations of the Department of Health.

Based upon all of the above, the examiner could not draw a conclusion about the overall financial and procedural accuracy of claims processed by the Plan. A follow-up examination will be scheduled based upon the action plan submitted by the Plan in response to the criticisms contained this report.

B. Prompt Pay

§3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” requires all insurers to pay undisputed claims within forty-five days of receipt.

§3224-a(a) of the New York Insurance Law states that:

“(a) Except in a case where the obligation of an insurer to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered.”

§3224-a(b) of the New York Insurance Law states that:

“(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to ...article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine

liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

§3224-a(c) of the New York Insurance Law states that:

“any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such a claim.”

Examination objectives included extracting all Medicaid claims that were paid more than forty-five days from the date of receipt by the Plan to verify compliance with Section 3224-a of the New York Insurance Law. From the same population used for the claims processing review (358,743 medical and 77,221 hospital), the examiners extracted 6,136 medical and 1,933 hospital claims that met the forty-five day threshold referred to in §3224-a(a). Two samples of 167 (medical and hospital) claims each were selected from this reduced population and provided to the Plan for their review. For every claim in the sample, the Plan stated that they complied with Section 3224-a(a) and provided an explanation supporting such compliance. After the examiners reviewed the Plan’s documentation and discussed certain items with the Plan’s management, it was determined by the examiners that 142 of the sampled medical claims, and 93 of the sampled hospital claims, contained one or more prompt pay violation.

The Plan’s documentation centered on explaining the entries in the claims database and providing a screen printout of various portions of the claim. The printout, in most cases, included a memo that contained a code and a date, or an entry such as: Per Pat Hepatitis B

Immunization S/B Paid FFS –JT – 03/31/1999 – 15:44 JB. In some cases the examiner concluded that the memo entry was sufficient documentation. However, in most cases only the Plan could read and understand the memo, or it did not appear to support the Plan's conclusions. For example, if the Plan denied a claim for late submission and subsequently paid the claim, no documentation was provided to show that the claim was properly denied in the first place, nor the type of data relied on to reprocess the claim. As a result, some claims that might not be violations are considered violations due to lack of documentation.

It is recommended that the Plan adopt procedures that better document the explanation of why and when a claim is denied, pended, or partially paid.

It is again recommended that the Plan comply with Department Regulation 64 and properly maintains claim files so that all events relating to the claim can be reconstructed.

The examination findings are summarized as follows:

i. Medical Claims

The findings include seventy-six claims that were classified by the Plan as being originally denied for late submission, tax ID mismatch, no authorization, or other reasons. The Plan was able to adequately establish that twenty-three of the seventy-six claims were not violations. The examiners therefore concluded that fifty-three claims were in violation of §3224-a(a).

Thirty claims were originally paid using the wrong rates and reprocessed to correct the payments. The result was an additional payment made on the claim. The thirty claims were violations of Section 3224-a(a) for the additional payment.

The remaining sixty-one claims were reviewed by the examiner and Plan personnel. The Plan proved that two claims were not violations of Section 3224-a(a). The remaining fifty-nine claims were violations of Section 3224-a(a).

ii. Hospital Claims

Forty-nine claims were pended due to the following: incorrect referrals, having no price loaded in the Plan's system, for other stated reasons, or for reasons not provided. Forty claims were violations of §3224-a(a) since the referral authorizations were in the system waiting to be reviewed by the Plan. The pricing not being loaded in the system cannot be used to excuse the Plan from adhering to the requirements of §3224-a(a)

Thirty-three claims were adjusted for administrative reasons, for clinical reasons, or to correct underpayments. Twenty-four claims that were underpaid are subject to the Prompt Pay Law for the amount underpaid.

Thirty-three claims were denied for no authorization or for medical review or invalid coding and were then adjusted since the authorization was on file or had been updated, or because the claims that were denied for invalid coding were incorrectly denied or had corrected coding. Twenty-nine claims were violations.

The remaining fifty-two claims are not violations of Section 3224-a(a).

The following chart summarizes the Prompt Pay Law findings of the examination:

Type of Claims	Medical	Hospital
Claim Population	6,136	1,933
Sample Size	167	167
Number of Claims with Errors	142	93
Calculated Error Rate	85.03%	55.69%
Upper Error Limit	90.44%	63.22%
Lower Error Limit	79.62%	48.15%
Upper Limit Claims in Error	5,549	1,222
Lower Limit Claims in Error	4,885	931

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Additionally, Section 3224-a(c) of the New York Insurance Law requires that calculated interest in amounts of \$2 or more should be paid in addition to the amount of the claim.

The Plan stated that its system began calculating interest during the month of November 2001. Prior to that month, the Plan performed the calculations outside the system. The examiner provided the Plan with two files containing 40 Prompt Pay Law violations (23 medical + 17 hospital claims) where interest due was \$2 or greater. The Plan did not respond to the examiner's request that they provide the checks showing the payment of interest to comply with §3224-a(c), and therefore, all of these are considered violations of §3224-a(c) of the New York Insurance Law.

Below is a chart analyzing all violations of the Prompt Pay Law as determined by the examination:

Section 3224-a Violations	Medical Claims	Hospital Claims	Total Violations
Section 3224-a(a)	142	93	235
Section 3224-a(b)	0	0	0
Total Sections 3224-a (a)& (b)	142	93	235
Section 3224-a(c)	17	23	40
Total	159	116	275

It is recommended that the Plan complies with Section 3224-a(a) and pay all clean claims within 45 days of receipt.

It is also recommended that the Plan pays the applicable interest on claims that are paid after 45 days as required by Section 3224-a(c) of the New York Insurance Law.

C. **Explanation of Benefits Statements**

§3234(a) of the New York Insurance Law states:

“(a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits.”

A review of the Plan’s Explanation of Benefits statements (“EOB”) sent to subscribers and remittance advices sent to providers was performed. All claims reviewed involved Medicaid members. An EOB is not issued to Medicaid members since, according to the Plan, the member is not responsible for payment of service to the provider. An EOB is issued to the member in

those instances when the Plan denies a service to be provided, and the service is provided despite the denial. In all cases, the Plan forwards a remittance advice to the provider with those claims that have been adjudicated and paid in full, partially paid, or denied. The “Provider’s Remittance Advice” contains those items specified in Sections 3234(b)(1), (b)(2), (b)(3), (b)(4), (b)(5), and (b)(6) of the New York Insurance Law. ACNY uses the remittance advice to operate as an EOB. However, it does not contain the appeal rights described in §3234(b)(7) of the New York Insurance Law as follows:

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

“(7) ...a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumers right to challenge a denial or rejection, even when a request for clarification has been made.”

ACNY indicated that Medicaid members are advised of their grievance and appeal rights via their member handbook.

D. Fraud Detection and Prevention

During the examination, a review was performed of the Plan’s compliance with New York Insurance Law Sections 405, 409, and Department Regulation 95 {11 NYCRR 86}. The reporting of fraud cases to the Department was also reviewed. It is noted that as of the exam date the Plan did not have the 60,000 enrollees required to file a plan for the detection, investigation and prevention of fraudulent insurance activities in this State as required by Section 409(a) of the New York Insurance Law and was therefore exempt from its requirements. Subsequent to the

period under examination (during year 2002) the Plan reached the basic level of enrollees and is in the process of creating such plan.

Subsequent to the examination period, the Plan submitted a Fraud Prevention Plan to the Insurance Department that was approved on December 11, 2002, effective January 31, 2002, as revised.

5. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management</u>	
i. It is recommended that ACNY maintain all minutes of the board of directors meetings for a period of at least six years as required by Part 98-1.17(d) of the Administrative Rules and Regulations of the Health Department.	5
ii. It is recommended that the Plan's investments be approved by the board of directors or a committee thereof to comply with the requirements of Section 1411(a) of the New York Insurance Law.	6
iii. It is recommended that ACNY's board of directors create policies that will enable it to approve the sale and purchase of its investments in compliance with Part 98-1.11(g)(5) of the Administrative Rules and Regulations of the Health Department.	6
iv. It is also recommended that the Plan's board adopt an investment policy for ACNY.	7
B. <u>Holding Company System</u>	
i. It is recommended that ACNY submit a listing to this Department and the Department of Health, where applicable, of all affiliates that are not shown on Schedule Y and the reason for their exclusion therefor.	11
ii. It is recommended that the Plan submit a copy of the renewal management agreement, together with the Commissioner's approval, to the Superintendent of Insurance.	12
iii. It is recommended that the Plan submit the agreement to the Superintendent of Insurance and the State of New York Department of Health for approval (if it meets the above criteria) and that the list of services to be provided by the Plan to third parties complies with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department.	13

<u>ITEM</u>	<u>PAGE NO.</u>
iv. It is recommended that the Plan update its Tax Allocation Agreement and list only the affiliates that are participating in the agreement and the Plan's new corporate name.	14
v. It is also recommended that the Plan submit the agreement to the New York Insurance Department and to the New York Department of Health for their approval in compliance with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department.	14
<p>Subsequent to the examination period, on October 22, 2002, the Plan submitted to the Insurance Department a new Tax Allocation Agreement between its new ultimate parent United Health Group Incorporated, AmeriChoice of New York, Inc., and its parent AmeriChoice Corporation.</p>	
vi. It is recommended that the Plan complies with Part 98-1.10(c) and Part 98-1.11(b) of the Administrative Rules and Regulations of the Department of Health, and forward the remaining agreement to the Superintendent and the Commissioner for their review.	16
<p>Subsequent to the examination period, on January 9, 2003, the Plan provided documentation confirming that the Credit Agreement has been terminated and all amounts due pursuant to the Agreement have been paid in full.</p>	
vii. It is recommended that the Plan add such ledger accounts as may be deemed necessary to segregate and identify the numerous types of payments into various categories to determine the reason for the payments.	17
viii. It is also recommended that if the Plan provides services to an affiliate or to other third party on its own behalf or on behalf of an affiliate, that the services and applicable fees to be charged be enumerated in a formal agreement.	17
ix. It is further recommended that the Plan settle balances within the holding company system at least quarterly, and that the underlying transactions meet the requirements of Part 98-1.10(a) of the Administrative Rules and Regulations of the Department of Health, and that any receivable balances meet the definitions of an admitted asset as established in Statements of Statutory Accounting Principles (SSAP) No. 4 for Assets and Non admitted Assets.	18

<u>ITEM</u>	<u>PAGE NO.</u>
C. <u>Conduct of Examination</u>	
i. It is recommended that in future examinations ACNY act in compliance with Sections 310(a)(2) and (3) of the New York Insurance Law, and improve its cooperation with the examiners and provide requested documentation on a timely basis	19
ii. It is recommended that ACNY provide sufficient access to its books of accounts at its New York office in compliance with Part 98-1.11(a) of the Administrative Rules and Regulations of the Department of Health in order to facilitate future examinations.	19
D. <u>Claims</u>	
i. It is recommended that in future examinations the Plan download the data from the INC database at Arizona rather than the SQL Data Warehouse.	24
ii. It is recommended that a field containing the resubmitted date of a claim be created and maintained in the system.	24
iii. It is recommended that the Plan formalize its understanding with its providers, including rates to be charged and the effective date of the charges, to allow third parties to follow an audit trail of the claim charges.	26
iv. It is further recommended that the Plan update all rates in a timely manner to avoid making erroneous payments on the affected codes.	27
v. It is recommended that the Plan comply with Department Regulation 64 {11 NYCRR 216.11} and Department Regulation 152 {11 NYCRR 243.2(b)(4)}, which require that all insurers maintain all data within the claim files so that the Insurance Department examiners can reconstruct the claim.	27
vi. It is recommended that ACNY provide access to its Medicaid Fee manual or reasonable facsimile at its New York office to comply with Part 98-1.1(a) of the Administrative Rules and Regulations of the Department of Health.	28

ITEMPAGE NO.E. Prompt Pay

- i. It is recommended that the Plan adopt procedures that better document the explanation why a claim is denied, pended, or partially paid. 30
- ii. It is again recommended that the Plan comply with Department Regulation 64 and properly maintains claim files so that all events relating to the claim can be reconstructed. 30
- iii. It is recommended that the Plan complies with Section 3224-a(a) and pay all clean claims within 45 days of receipt. 33
- iv. It is also recommended that the Plan pays the applicable interest on claims that are paid after 45 days as required by Section 3224-a(c) of the New York Insurance Law. 33

Appointment No. 21748

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Arcelio Vega
as a proper person to examine into the affairs of the

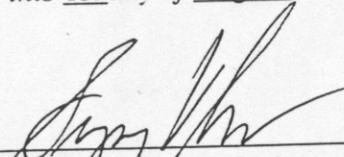
AMERICHoice OF NEW YORK, INC.
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal
of this Department, at the City of New York.

this 1st day of August 2001



Gregory V. Serio
Superintendent of Insurance

