

REPORT ON EXAMINATION
OF THE
ALLEGANY-CATTARAUGUS SCHOOLS
MEDICAL HEALTH PLAN
AS OF
JUNE 30, 2005

DATE OF REPORT
EXAMINER

JANUARY 12, 2007
BARBARA FINNERTY

TABLE OF CONTENTS

<u>ITEM NO</u>		<u>PAGE NO.</u>
1.	Scope of examination	2
2.	Executive summary	3
3.	Description of Plan	4
	A. Management	5
	B. Territory and plan of operation	11
	C. Reinsurance	12
	D. Accounts and records	13
4.	Financial Statements	14
	A. Balance sheet	14
	B. Statement of revenues and expenses	15
	C. Net worth	16
5.	Premiums receivable	17
6.	Claims payable	18
7.	Contingency reserves	18
8.	Market conduct activities	18
	A. Claims processing and payment practices	19
	B. Community rating	21
	C. Policy forms/benefits	22
	D. Utilization review	23
9.	Compliance with Report on Organization	24
10.	Summary of comments and recommendations	26



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

Eliot Spitzer
Governor

Eric R. Dinallo
Acting Superintendent

January 12, 2007

Honorable Eric R. Dinallo
Acting Superintendent of Insurance
Albany, NY 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22471 dated March 3, 2006, attached hereto, I have made an examination into the condition and affairs of Allegany-Cattaraugus Schools Medical Health Plan, as of June 30, 2005, a not-for-profit municipal cooperative health benefit plan licensed pursuant to the provisions of Article 47 of the New York Insurance Law. The following report is respectfully submitted.

The examination was conducted at the Plan's home office located at 1825 Windfall Road, Olean, New York.

Whenever the designation the "Plan" appears herein without qualification, it should be understood to refer to Allegany-Cattaraugus Schools Medical Health Plan.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of March 31, 2001. This examination covered the four year and three month period from April 1, 2001 through June 30, 2005. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of June 30, 2005, in accordance with Statutory Accounting Principles, as adopted by the New York Insurance Department, 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 accountant. 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 the Plan
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Territory and plan of operation
- Growth of Company
- Business in force
- Loss experience
- Accounts and records
- Treatment of policyholders and claimants

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on organization.

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

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that directly impacted the Plan's compliance with the New York Insurance Laws and Regulations. Significant findings relative to this examination are as follows:

- That the Plan did not have formalized third party claims administrative agreements with Nova Healthcare Administrators, Inc. (“NOVA”) and Express Scripts, in accordance with Section 4705(d)(2)(A) of the New York Insurance Law.
- The Plan did not have in place a written administrative service agreement between Allegany-Cattaraugus BOCES and the Plan in accordance with Sections 4705(d)(2)(A) of the New York Insurance Law and Department Regulation 33 (11 NYCRR 91.4).
- The Plan did not obtain a waiver from the New York Insurance Department relative to the non-maintenance of aggregate and specific stop-loss insurance coverage as required by Sections 4707(a)(1)&(2) of the New York Insurance Law.
- The Plan’s third party claims administrator, NOVA, and employees of that entity assigned to process claims on behalf of the Plan did not maintain claims adjusters licenses as required by Section 2102(a)(1) and 2108(a)(3) of the New York Insurance Law.

- The Plan did not obtain approval from the New York State Insurance Department prior to offering the Plan and Summary Plan Description amendments to those documents relative to mandated benefits in accordance with Section 4709(b) of the New York Insurance Law.
- The Plan has not submitted the required reports to the New York Insurance Department in accordance with Section 4704(a)(8) of the New York Insurance Law.

3. **DESCRIPTION OF THE PLAN**

The Board of Cooperative Educational Services Sole Supervisory District of Cattaraugus, Allegany, Erie and Wyoming Counties (BOCES) and its twenty-two member school districts (plan participants) commenced business on February 2, 1982. The Plan is a Municipal Cooperative Health Benefit Plan licensed under Article 47 of the New York Insurance Law. In accordance with the Municipal Cooperative Agreement, each of the participants have agreed to share the costs and assume the liabilities for hospital, surgical, prescription drug, and major medical benefits provided under the Plan. Administration for the Plan is provided by Cattaraugus-Allegany BOCES, one of the Plan's members.

There are currently 22 school districts and one BOCES participating in the Plan. The Plan participants are as follows:

Allegany-Limestone Central CSD	Hinsdale CSD
Andover Central CSD	Olean City CSD
Belfast Central CSD	Pioneer CSD
Bolivar-Richburg CSD	Portville CSD
Cattaraugus-Allegany BOCES	Randolph Academy Union Free SD

Cattaraugus-Little Valley CSD	Randolph CSD
Cuba-Rushford Central CSD	Salamanca City CSD
Ellicottville CSD	Scio CSD
Fillmore CSD	Wellsville CSD
Franklinville CSD	West Valley CSD
Friendship CSD	Whitesville CSD
Genesee Valley Central CSD	

A. Management

Pursuant to the Municipal Cooperative Agreement and its by-laws, management of the Plan is vested in the Governing Board comprised of one representative from each participating school district, including BOCES. The governing board of the Plan as of June 30, 2005 was as follows:

Governing Board

<u>Name</u>	<u>Municipality</u>
Stephen Troskosky	Allegheny-Limestone Central SD
William Berg	Andover Central SD
Robert D'Angelo	Belfast Central SD
Joseph DeCerbo	Bolivar-Richburg Central SD
Thomas Nickle	Cattaraugus-Allegany BOCES
Louis McIntosh	Cattaraugus-Little Valley Central SD
Anne Brungard	Cuba-Rushford Central SD
Patricia Haynes	Ellicottville Central SD
David Hanks	Fillmore Central SD
Terence Dolan	Franklinville Central SD
Robert Mountain (Interim)	Friendship Central SD
Michael Taylor	Genesee Valley Central SD
Dennis Senn	Hinsdale Central SD

Mark Ward	Olean City SD
Jeffrey Bowen	Pioneer Central SD
Peter Tigh	Portville Central SD
John Hogan	Randolph Academy Union Free SD
Sandra Craft	Randolph Central SD
Raymond Cenni (Interim)	Salamanca City SD
Michael McArdle	Scio Central SD
Dr. Byron Chandler	Wellsville Central SD
Edward Ahrens	West Valley Central SD
Charles Cutler (Interim)	Whitesville Central SD

According to the By-Laws, the Governing Board shall meet quarterly and call special meetings at any time upon 72 hours written notice. The governing board scheduled regular quarterly meetings during the period under examination. The minutes of all meetings of the governing board were reviewed. All such meetings were well attended.

Each of the Participants appointed both the school district superintendent and a designee. In practice either one or the other appointee of the Participant attended the Board meeting. However, the provision within the Municipal Cooperative Agreement that describes the procedures under which governing board members are chosen is located on page 2, item 2 of that Agreement. Item 2 of the Municipal Cooperative Agreement states in part as follows;

“The governing body of the Plan shall be a Board of Directors comprised of the chief executive officer or other designated officer of each Participant...”

In addition, Article I, Item B of the Plan’s by-laws states in part as follows:

“The Board of Directors of the Plan shall be comprised of one representative from each Participant, which shall be the chief executive officer or other designated officer of the Participant...”

It is recommended that the Plan amend its Municipal Cooperative Agreement and by-laws to reflect the current practice of allowing either the Superintendent or Superintendent’s designee to attend Board of Director meetings.

The principal officers of the Plan as of June 30, 2005 are as follows:

<u>Officers</u>	<u>Title</u>
Dennis Senn	President
Stephen Troskosky	Secretary
Thomas C. Potter	Chief Financial Officer

The Board of Governors has designated Linda Quick as the Attorney-in-Fact and custodian for all Plan reports, records, and statements.

The Plan provides medical coverage through self-insurance administered by a third party administrator in accordance with the Summary Plan Description to covered employees, retirees and their eligible dependents as defined in the plan booklet. The Plan has purchased a hospital (only) insurance policy from Blue Cross and Blue Shield of Western New York for the benefit of its participants’ members.

As of June 30, 2005, the Plan had entered into the following agreements for services.

- North American Administrators, Inc. (“NAA”) provided third party claims administrative services for specified employee benefits in force through December 31, 2004 relative to Plan

members. NAA provided the Plan with access to its PPO network, North American Preferred as well as pharmacy administration for the Pharmacy Benefit Manager (“PBM”), Express Scripts. NAA also, provided utilization review services, intensive case management review services and consultation services regarding operations of the Plan.

- Effective January 1, 2005 Nova Healthcare Administrators, Inc. (“NOVA”), a wholly owned subsidiary of Independent Health Corporation, provides third party claim administrative services limited to Wrap Around Major Medical Services to participants of the Plan. In addition, NOVA provides the Plan with access to its provider network. NOVA, also establishes utilization management criteria for review of medical and pharmacy authorizations and claims; NOVA acts as the pharmacy administrator for the PBM, Express Scripts (i.e. Express Scripts provides access to their retail pharmacy network and mail order pharmacy services, and adjudicates all prescription claims at the pharmacy level in accordance with the Plan. Express Script invoices NOVA for the costs associated with the prescription claims).
- Effective July 1, 2004, BlueCross BlueShield of Western New York, a division of HealthNow New York Inc. (“Health Plan”), provides to the Plan a fully insured POS Group Plan with an endorsement that eliminates the requirement for referrals. Effective July 1, 2005, Health Plan provides two fully insured options: a POS Group Plan or a Hospital Benefits Contract. The POS Group Plan includes two endorsements, one that eliminates referral requirements for in-network benefits, and the other that eliminates the co-payment requirement for pediatric visits to PCP for dependents up to age 19. The Hospital Benefits Contract is endorsed to include inpatient treatment of alcoholism and substance abuse and out-of-area hospital benefits.
- Mercer Human Resource Consulting, Inc. (“Mercer”) provided the following services through June 30, 2005: development of premium rates and performance of actuarial certifications of reserves as required by NYIL Article 47; assistance with negotiating carrier administration fees and performance guarantees. In addition, Mercer consulted with the Plan relative to the Plan’s compliance with statutes, regulations and rules, and recommended plan design changes when needed. Mercer, also, assisted with the implementation of plan design

changes (i.e. negotiating the change with the current vendor or developing employee communication strategies).

- Effective July 1, 2005, Gilroy Kernan & Gilroy, Inc. (“GKG”) provides the following services: analysis of plan experience, utilization data, and recommendations; preparation of monthly financial summary reports to monitor plan costs and claim activity; and development and implementation of new plan options or plan design changes. GKG also, updates the Plan Documents and Summary Plan Description (“SPD’s”) booklets in accordance with new or changing regulations including recommendations in response to Medicare Part D legislation. Also, GKG provides financial support services, including but not limited to: calculating premium rates, reserve setting, and budgeting. In addition, GKG suggests cost control initiatives including the appropriateness of alternative health care strategies and programs, and negotiates renewal rates and service contracts with vendors.

As noted above, effective January 1, 2005, the Plan changed third party claims administrators. The Plan had contracted with North American Administrators (“NAA”) through June 30, 2005 to provide services for claims incurred prior to January 1, 2005. As of January 1, 2005, the Plan contracted with Nova Healthcare Administrators, Inc., (“NOVA”) an administrator of self-funded groups and subsidiary of Independent Health Corporation, Inc., to process the Plan’s medical and administer the prescription drug claims. The Plan also utilizes Express Scripts, Inc. to process the prescription claims which are administered through NOVA third party administrators. Effective July 1, 2005, the Plan contracted with Gilroy, Kernan, & Gilroy (GKG) to perform the services previously provided by Mercer.

The third party claim administrative agreement with NOVA, as of the date of the examination, was only in draft form and not signed by either party to the agreement. In addition, a provision within the draft agreement with NOVA states in part, “...where NOVA acts as an intermediary only, the administrative charges are determined by a “third party” (i.e. ...prescription drug companies, etc.) and not under NOVA’s control.” Therefore NOVA acts

as an administrator for Express Scripts. The draft agreement with NOVA must be formalized in accordance with Section 4705(d)(2)(A) of the New York Insurance Laws which states in part, :

(d) ...the governing board: (2) may enter into an agreement with a contract administrator or other service provider...to receive, investigate, recommend, audit, approve or make payment of claims under the municipal cooperative health benefit plan, provided that: (A) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts...

It is recommended that the Plan formalize and cause to be executed by all subject parties third party claims administrative agreement(s) with NOVA and Express Scripts in accordance with Section 4705(d)(2)(A) of the New York Insurance Law.

Mercer performed the actuarial certification of the loss reserves during the examination until June 30, 2005. Gilroy, Kernan, & Gilroy did not provide this service. It was not known by the Plan, when it entered into a contract for specified services with Gilroy, Kernon & Gilroy (GKG) that GKG did not provide actuarial services which resulted in a delay in the submission to this Department of the Plan's actuarial certification of reserves as of December 31, 2005. EBS Benefit Solutions, Inc. ("EBS") was subsequently retained by the Plan to provide the annual actuarial certification of compliance regarding the Plan's reserves for fiscal year June 30, 2005.

Cattaraugus-Allegany BOCES provides administrative services for the Plan however, does not have a formal written service agreement or cost allocation basis. New York State Insurance Department Regulation 33 (11 NYCRR 91.4) may be used as a guideline to allocate expenses incurred to the Plan. Department Regulation 33 (11 NYCRR 91.4) states in part,

(a)...(1)...an insurer may use only such methods of allocation in its distribution of ...expenses...(2) ... maintain records with sufficient detail to show fully:(i) the system actually used for allocation of income and expenses;(ii) the actual bases of allocation;(iii) the actual monetary distribution of the respective items of income, salaries, wages, expenses, and taxes to:(a) units of activity or functions, if any distribution is made on such basis,...(c) annual statement lines of business,(d) companies, and (e) a recapitulation and reconciliation of items (a) .., (c) and (d) with the insurer's books of account and annual statement.

It is recommended the Plan formulate a written administrative services agreement with Allegany-Cattaraugus BOCES that contains provisions relative to services provided, fees charged to Plan for such services and a shared cost allocation basis in accordance with Section 4705(d)(2)(A) of the New York Insurance Law and Department Regulation 33 (11 NYCRR 91.4).

On November 1, 2001, the Plan was issued a Certificate of Authority pursuant to Article 47 of the New York State Insurance Law. The Certificate of Authority authorizes the Plan to conduct the business of a municipal cooperative health benefit plan in the counties of Cattaraugus, Allegany, Erie and Wyoming of this state.

B. Territory and Plan of Operation

The Plan provides health benefits in the counties of Cattaraugus, Allegany, Erie and Wyoming within New York State. The Plan's enrollment as of June 30, 2005 was 3,868. The Plan's enrollment during fiscal years 2002-2005 was as follows:

<u>Year</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>
Enrollment	2,819	2,678	3,408	3,863
Disenrollment Ratio		(5.00)%	27.26%	13.35%

The Plan has recently experienced an increase in enrollment as a result of including contracts that are fully-insured, experienced-rated POS plan products that contain prescription coverage that is self-funded through Express Scripts.

C. Reinsurance

The Plan does not purchase stop-loss insurance coverage as required by Section 4707 of the New York Insurance Law. The Plan has requested a waiver from the stop-loss requirement for the self-funded portion of the Plan, to the New York State Insurance Department. New York Insurance Law section 4707 states in part as follows:

“(a) The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:

(1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year; and

(2) specific stop-loss coverage with a specific retention amount or attachment point not greater than four percent of the amount certified by a qualified actuary to represent the plan's expected claims for the current fiscal year.”

It is recommended the Plan obtain stop-loss insurance coverage as required by New York Insurance Law Section 4707(a)(1) and Section 4707(a)(2) or formally apply to this Department for a waiver of such stop-loss insurance policy coverage.

D. Accounts and Records

A review of the annual statements filed during the period under examination revealed the Plan incorrectly completed NY Schedule F – Claims Payable Analysis for all years under examination. The Plan reported amounts in Column C and Column D of NY Schedule F – Claims Payable Analysis, Section 1 based upon actual projected paid claims.

However, these amounts should reconcile to the amounts reported on line 2 of Report # 1 – Part B: Liabilities and Net Worth of the annual statement.

It is recommended that the Plan complete NY Schedule F – Claims Payable Analysis by including a reconciliation footnote that reflects the statutory reserve that exceeds the actuarially determined unpaid claims in order to provide a reconciliation of Columns C and D of Section 1 of Schedule F to the claims payable amount reported on line 2 of Report # 1 – Part B: Liabilities and Net Worth of its annual statement for both the current and prior year.

4. FINANCIAL STATEMENTS

A. BALANCE SHEET

The following shows the assets, liabilities and net worth as determined by this examination and as reported by the Plan as of June 30, 2004.

<u>Assets</u>	<u>EXAMINATION</u>		<u>PLAN</u>		<u>Surplus Increase (Decrease)</u>
	<u>Ledger Assets</u>	<u>Not Admitted Assets</u>	<u>Admitted Assets</u>	<u>Admitted Assets</u>	
Cash and Equivalents	\$11,916,120		\$11,916,120	\$11,916,120	
Premiums receivable	<u>224,831</u>		<u>224,831</u>	<u>224,831</u>	
Total Assets	<u>\$ 12,140,951</u>		<u>\$ 12,140,951</u>	<u>\$ 12,140,951</u>	
<u>Liabilities</u>					
Accounts payable			\$698,345	\$ 698,345	
Claims payable			4,525,000	7,039,521	<u>\$ 2,514,521</u>
Unearned premiums			<u>203,912</u>	<u>203,912</u>	
Total Liabilities			<u>\$5,427,257</u>	<u>\$7,941,778</u>	<u>\$ 2,514,521</u>
<u>Net Worth</u>					
Contingency reserves			\$ 865,983	\$ 1,423,070	\$ (557,087)
Retained earnings/Fund balance			<u>5,847,711</u>	<u>2,776,103</u>	<u>3,071,608</u>
Total net worth			<u>\$6,713,694</u>	<u>\$4,199,173</u>	<u>\$2,514,521</u>
Total liabilities and net worth			<u>\$12,140,951</u>	<u>\$12,140,951</u>	

B. Statement of revenues and expenses

Net worth increased \$4,329,829 during the period from April 1, 2001 to June 30, 2005, detailed as follows:

Revenues:

Premiums (basic) community rated	\$71,423,999
Investment	1,222,912
Aggregate write-ins for other revenue	<u>1,953,611</u>
Total revenues	\$74,600,522

Expenses:

Hospital and medical	\$45,210,297
Drug	<u>23,863,701</u>
Subtotal	\$69,073,998
Reinsurance expenses net of recoveries	<u>0</u>
Total Medical and Hospital	<u>\$69,073,998</u>
Revenues less Medical and Hospital	\$ 5,526,524

Administration:

Compensation	349,516
Occupancy, Depreciation, and Amortization	23,620
Aggregate write-ins for other administrative expense	1,699,418
Total administration	<u>\$ 2,042,554</u>
Total expenses	<u>\$71,116,552</u>
Net income	<u>\$ 3,483,970</u>

C. Net Worth

Net worth per Examination On-Organization as of March 31, 2001			\$2,383,865
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	<u>Increases</u>	<u>Decreases</u>	
Net income	\$3,483,970		
Aggregate write-ins for changes in retained earnings	994,992		
Rounding	1		
Change in Contingency Reserve	\$149,134	
	<u>4,478,963</u>	<u>\$149,134</u>	
Net increase in net worth			<u>\$4,329,829</u>
Net worth, per examination, as of June 30, 2005			<u>\$6,713,694</u>

5. PREMIUMS RECEIVABLE

Although no examination change was made relative to this item, during the course of the examination, a premium receivable balance due in excess of ninety days from one of the Plan's participants was maintained on the books of the Plan. During June 2005, the delinquent premiums were paid.

The Municipal Cooperation Agreement (page 9, item 6) states the following:

“A late payment charge equal to 1% of the monthly installment due shall be charged for any payment not received by the 15th day of each month, or the next business day if the 15th falls on a Saturday, Sunday or legal holiday. If payment is not received within thirty (30) days of the due date, a late payment charge equal to five percent (5%) of the monthly installment due shall be charged. If payment is not received within ninety (90) days of the due date, the Participant's membership in the Plan will be automatically terminated unless the Board of Directors finds good cause for the delay...”

It is noted that, when the delinquent premiums were paid, no interest penalty was applied, or collected, in violation of the Municipal Cooperation Agreement. Additionally, the minutes of the Board of Directors indicate a discussion was held in regard to the delinquent member's participation. It appears the Board of Directors finds good reason for the delay, as required by the Municipal Cooperative Agreement inasmuch as they continued the member as a participant in the Plan. If the board intends to waive the interest required to be paid by its Municipal Cooperation agreement, the Plan should file an amended agreement including a waiver provision to this Department for approval consideration.

It is recommended that the Plan file for approval consideration with this Department, an amended Municipal Cooperative Agreement which

provides for the waiver of required interest if it is the intention of the board, in certain circumstances, to waive interest on delinquent payment of premiums.

6. CLAIMS PAYABLE

The examination liability of \$4,525,000 is \$2,514,521 less than the \$7,039,521 reported by the Plan as of June 30, 2005. The decrease in the reserve resulted from deducting the fully insured hospital premium from the calculation of this liability as prescribed by Section 4706(a)(1) of the New York Insurance Law.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements.

7. CONTINGENCY RESERVES

The examination reserve of \$865,983 is \$557,087 less than the \$1,423,070 reported by the Plan as of June 30, 2005. The decrease in this reserve resulted, as noted above, from deducting annual premium collected relative to the fully insured hospital premium from the calculation prescribed by Section 4706(a)(5) of the New York Insurance Law.

8. 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 subscribers and claimants. The review was general in nature

and is not to be construed to encompass the more precise scope of a market conduct examination.

The general review was directed at practices of the Plan in the following areas:

- (A) Claims processing
- (B) Rating
- (C) Policy Forms and Benefits
- (D) Utilization review

A. Claims Processing and payment practices

The Plan has contracted with Nova Healthcare Administrators, Inc., (“NOVA”) a third party claims administrator and member of the Independent Health Association, Inc. holding company, to process medical and administer prescription drug claims on behalf of the PBM, Express Scripts. Blue Cross & Blue Shield of Western New York, a dba of HealthNow New York, Inc. fully insures the hospital portion of the Plan’s benefits provided to its participants’ members.

1. Claim Attribute Sample

A review of claims processed by Nova Healthcare Administrators, Inc. during January 1, 2005 through June 30, 2005 was conducted. The claims review was performed using a statistical sampling methodology covering the claims processed during the aforementioned period to evaluate the overall accuracy and compliance environment of the Plan’s claims processing.

A statistical random sampling process was performed using ACL for Windows© an auditing software program. The sampling methodology was devised to test various attributes deemed to be necessary for the successful processing of claims and to reach conclusions about all predetermined attributes, individually or on a combined basis. The review incorporated processing attributes used by Nova in its own quality analysis of claims

processing. The sample size was 167 randomly selected claims comprised of 27 denied claims and 140 paid claims.

For purposes of this analysis, a claim is defined by NOVA as the total number of items submitted by a single provider within a single claim form that is reviewed and entered into the claim processing system. The basis of the Department's statistical sample of claims is the summary of all lines on a claim into a one line roll-up. During the review of claims processing it was determined that 14 errors existed in the sample. This represents an accuracy rate of 91.6%. However, 8 of the errors were related to Medicare claims containing incorrect explanations on the EOB form. If these errors are excluded from the population the accuracy rate increases to 96.4%.

2. Payment practices

A review of claim payment practices that involved 167 sampled claims was performed. This review resulted in no prompt payment issues.

As noted previously in this report within section three entitled, Description of the Plan, the agreement with NOVA is in draft form and has not been formalized. In addition, neither NOVA nor any of its employees assigned to process claims on the Plan's behalf are licensed claims adjusters in accordance with Section 2102(a)(1) of the New York Insurance Law. Section 2101(g)(1) of the New York Insurance Law defines an adjuster as follows:

“(g) In this article “adjuster” means any “independent adjuster”...as defined below:

(1) the term “independent adjuster” means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer as are

incidental to such claims and also includes any person who for compensation or anything of value investigates and adjusts claims on behalf of any independent adjuster...”

Section 2102(a)(1) of the New York Insurance Law states in part:

“(a)(1) No person, firm, association or corporation shall act as an...insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter.”

Section 2108(a)(3) of the New York Insurance Law states in part:

“(a)(3) No adjusters shall act on behalf of an insurer unless licensed as an independent adjuster....”

It is recommended that, if it is the intention of the Plan to continue to have Nova Healthcare Administrators, Inc. adjust claims on the Plan’s behalf, that NOVA and its employees, who perform claim adjusting services on behalf of the Plan, be licensed as independent adjusters in accordance with Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law.

B. Community Rating

The Plan receives contributions from its plan participants on behalf of covered employees, retirees and dependents. This contribution is based on employee classification (single or family) multiplied by a predetermined rate per month, such rate being determined by an actuarial consultant. For the five year period covered by the examination, the Plan’s CPA firm made the following substantive comment within its annual report:

“Plan participants calculate revenue owed to the Plan based on a census report received from NOVA. The revenue received from the participants does not indicate the premium based on the type of health services provided, therefore, the Plan is unable to determine if the

participants are paying the required amounts. In addition, a reconciliation to the census report was not performed to determine that the premiums were accurate.”

It is recommended the Plan obtain a copy of the census report of covered Plan membership and prepare the necessary reconciliation of premiums by type of health services provided in order to determine that the premiums paid by the participants are accurate to meet the expenditures of the Plan.

It is recommended the Plan implement substantive management letter comments without necessitating the Independent CPA to repeat meritorious recommendations in subsequent audit years.

C. Policy Forms / Benefits

During the review of sales practice it was determined the Plan did not obtain necessary approval of the Summary Plan Description from the New York State Insurance Department to market mandated benefits as required by Section 4709(b) of the New York Insurance Law.

Section 4709(b) of the New York Insurance Law states in part,

“...b) The summary plan description shall be subject to regulation as if it were a health insurance subscriber certificate...”

It is recommended that the Plan obtain New York State Insurance Department approval prior to marketing any new products including any amended policy forms or riders relative to mandated benefits in accordance with Section 4709(b) of the New York Insurance Law.

D. Utilization review

The Plan, during the examination period, did not have any consumer complaints made to the New York State Insurance Department. A procedure has been established in the event that any complaints are submitted.

Nova is deemed to be a utilization review agent of the Plan since it performs utilization review services for the Plan. However, neither the Plan nor any of its' third party administrators filed its utilization review procedures with the Department in accordance with New York Insurance Law section 4704(a)(8) that states as follows:

“the municipal cooperative health benefit plan ...established a fair and equitable process of claims review, dispute resolution and appeal procedures including arbitration of rejected claims...which are satisfactory to the superintendent.

It is recommended the Plan file its utilization review procedures with the New York State Insurance Department in accordance with Section 4704(a)(8) of the New York Insurance Law.

Grievance and appeal procedures are summarized in the plan booklets that are issued to the plan members.

9. COMPLIANCE WITH REPORT ON ORGANIZATION

The report on organization included seven recommendations detailed as follows (page number refers to the report on organization):

<u>ITEM.</u>	<u>PAGE NO.</u>
1. It is recommended that the Plan maintain its cash reserves in a segregated account in its own name.	8
The Plan has complied with this recommendation.	
2. It is recommended that the Plan require the delinquent member to pay late fees accrued as a result of the member's failure to pay premiums on a timely basis.	8
The Plan did not comply with this recommendation. The recommendation is again repeated within this report on examination.	
3. It is recommended that the Plan consistently charge and collect interest for late premiums, as required by the Municipal Cooperative Agreement.	8
The Plan did not comply with this recommendation. The recommendation is again repeated within this report on examination.	
4. It is recommended that Participant's whose premiums are overdue greater than 90 days be automatically terminated from the Plan unless the Board of Directors finds good reason for the delay as required by the Municipal Cooperative Agreement.	8
The Plan has complied with this recommendation.	

<u>ITEM</u>	<u>PAGE NO.</u>
5.	8
<p>It is recommended that the Plan accurately report its Quarterly Claims Development Schedule.</p> <p>The Plan did not comply with this recommendation. The recommendation is again repeated within this report on examination.</p>	
6.	9
<p>It is recommended that the Plan change its third party Administrator agreement to ensure that claim records are maintained for a minimum of six years.</p> <p>The draft agreement with NOVA the third party claim agreement contained a record retention provision and in this regard is in compliance with this recommendation.</p>	
7.	9
<p>It is recommended that the Plan ensure its third party administrator is in compliance with New York Insurance Law §3224-a Standards for prompt, fair and equitable settlement of claims for health care and Payments for health care services.</p> <p>The Plan has complied with this recommendation.</p>	

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE</u>
	<u>NO.</u>
A. <u>Management</u>	
It is recommended that the Plan amend its Municipal Cooperative Agreement and by-laws to reflect the current practice of allowing either the Superintendent or Superintendent's designee to attend Board of Director meetings.	7
It is recommended that the Plan formalize and cause to be executed by all subject parties third party claims administrative agreement(s) with NOVA and Express Scripts in accordance with Section 4705(d)(2)(A) of the New York Insurance Law.	10
It is recommended the Plan formulate a written administrative services agreement with Allegany-Cattaraugus BOCES that contains provisions relative to services provided, fees charged to Plan for such services and a shared cost allocation basis in accordance with Section 4705(d)(2)(A) of the New York Insurance Law and Department Regulation 33 (11 NYCRR 91.4).	11
B. <u>Reinsurance</u>	
It is recommended the Plan obtain stop-loss insurance coverage as required by New York Insurance Law Section 4707(a)(1) and Section 4707(a)(2) or formally apply to this Department for a waiver of such stop-loss insurance policy coverage.	12
D. <u>Accounts and Records</u>	13
It is recommended that the Plan complete NY Schedule F – Claims Payable Analysis by including a reconciliation footnote that reflects the statutory reserve that exceeds the actuarially determined unpaid claims in order to provide a reconciliation of Columns C and D of Section 1 of Schedule F to the claims payable amount reported on line 2 of Report # 1 – Part B: Liabilities and Net Worth of its annual statement for both the current and prior year.	

ITEM	<u>PAGE</u> <u>NO.</u>
<p>E. <u>Premium Receivable</u></p> <p>It is recommended that the Plan file for approval consideration an amended Municipal Cooperative Agreement which provides for the waiver of required interest if it is the intention the board, in certain circumstances, to waive the interest on delinquent payment of premiums.</p>	<p>18</p>
<u>Market Conduct Activities</u>	
<p>F. <u>Payment practices</u></p> <p>It is recommended that, if it is the intention of the Plan to have Nova Healthcare Administrators, Inc. adjust claims on its behalf,, that NOVA and its employees, who perform claim adjusting services on behalf of the Plan, be licensed as independent adjusters in accordance with New York Insurance Law sections 2102(a)(1) and 2108(a)(3).</p>	<p>21</p>
<p>G. <u>Community rating</u></p> <p>It is recommended the Plan obtain a copy of the census report of covered Plan membership and prepare the necessary reconciliation of premiums by type of health services provided in order to determine that the premiums paid by the participants are accurate to meet the expenditures of the Plan.</p> <p>It is recommended the Plan implement substantive management letter comments without necessitating the Independent CPA to repeat meritorious recommendations in subsequent audit years.</p>	<p>22</p> <p>22</p>
<p>H. <u>Policy forms/Benefits</u></p> <p>It is recommended the Plan obtain New York State Insurance Department approval prior to marketing any new products including any amended policy forms or riders relative to mandated benefits in accordance with Section 4709(b) of the New York Insurance Law.</p>	<p>22</p>
<p>I. <u>Utilization Review</u></p> <p>It is recommended the Plan file its utilization review procedures with the New York State Insurance Department</p>	<p>23</p>

in accordance with Section 4704(a)(8) of the New York Insurance Law.

Appointment No. 22471

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Barbara Finnerty

as a proper person to examine into the affairs of the

Allegany-Cattaraugus Schools Medical Health Plan

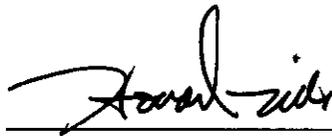
and to make a report to me in writing of the said

Municipal Cooperative Health Benefit Plan

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 3rd day of March 2006



Howard Mills
Superintendent of Insurance

