

REPORT ON EXAMINATION
OF THE
CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
AS OF
DECEMBER 31, 2000

DATE OF REPORT

APRIL 12, 2002
Revised **NOVEMBER 6, 2002**

EXAMINER

ELSAID ELBIALLY, CFE

TABLE OF CONTENTS

<u>ITEM NO.</u>	<u>PAGE NO.</u>
1. Scope of examination	2
2. Description of HMO	3
A. Management and control	4
B. Territory and plan of operation	7
C. Reinsurance	10
D. Holding company system	14
E. Furniture and equipment	17
F. Custodian and investment agreements	18
G. Significant operating ratios	19
3. Financial statements	20
A. Balance sheet	20
B. Statement of revenue and expenses	22
C. Changes in net worth	23
4. Claims payable	23
5. Impact of statutory accounting principles	23
6. Market conduct	25
7. Compliance with prior report on examination	37
8. Summary of comments and recommendations	39



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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

April 12, 2002
Revised November 6, 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 the instructions contained in Appointment Number 21722, dated April 10, 2001, attached hereto, I have made an examination into the condition and affairs of Capital District Physicians' Health Plan, Inc., as of December 31, 2000, and respectfully submit the following report thereon.

The examination was conducted at the Company's home office located at 1223 Washington Avenue, Albany, New York.

Wherever the term "the HMO" or "CDPHP" appear herein without qualification, they should be understood to indicate Capital District Physicians' Health Plan, Inc.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1995. This examination covers the five-year period from January 1, 1996, through December 31, 2000. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

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

- History of the HMO
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Officers' and employees' welfare and pension plan
- Territory and plan of operation
- Growth of the HMO
- Accounts and records
- Loss experience
- Treatment of policyholders and claimants

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

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

2. DESCRIPTION OF HMO

The HMO was formed as a membership corporation on February 27, 1984 under Section 402 of the Not-for-Profit Corporation Law, and incorporated within the State of New York, Department of State on April 13, 1984. The members consist of physicians licensed by the State of New York. The HMO was licensed as a Health Maintenance Organization (HMO) pursuant to Article 44 of the Public Health Law of the State of New York and obtained its certificate of authority to operate as an individual practice association (IPA) model HMO, effective April 30, 1984.

As of December 31, 2000, membership in the HMO was opened to physicians licensed by the State of New York, who apply for membership and meet the criteria required by the HMO's by-laws, and are accepted as, member physicians.

The HMO is exempt from income taxes under the provisions of Section 501 (c)(4) of the Internal Revenue Code.

A. Management and Controls

The HMO is a physician-controlled corporation. The participating physicians, who are members in good standing of the corporation, constitute a majority of the corporation's board of directors.

Pursuant to the HMO's by-laws, management of the HMO is vested in a board of directors consisting of fifteen members. Eight of the fifteen directors shall be members of the corporation. The remaining seven directors shall not be members of the corporation. At least three of such non-member directors shall be enrollees of the HMO.

As of the examination date, the board of directors was comprised of fifteen members. The composition of the board was in compliance with the HMO's by-laws and Part 98-1.11 (f) of the Administrative Rules and Regulations of the State of New York, Health Department (10 NYCRR 98.11).

The directors of the HMO as of December 31, 2000 were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Joseph W. Monahan, M.D., Troy, New York	Chairman of the Board of Directors, CDPHP Internist, Seton Health Systems
John D. Bennett, M.D. Albany, New York	Cardiologist, Albany Associates in Cardiology
Teresa S. Briggs, M.D. Albany, New York	Infectious Disease Specialist
Peter T. Burkart, M.D. Albany, New York	Hematologist, Capital District Hematology/Oncology
Thomas P. Collins Albany, New York	President, Preferred Group Plans, Inc

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Cathy B. Connors Voorheesville, New York	Deputy Commissioner of Human- Resources, Albany County
Richard B. Cunningham Watervliet, New York	President, Passonno Paints
Douglas P. Larsen, M.D.. Albany, New York	Pediatrician
Charles M. Liddle, III Albany, New York	President, Austin and Co., Inc.
William M. Notis, M.D. Albany, New York	Gastroenterologist, Albany Gastroenterology Consultants
William A. O'Dwyer, M.D. Latham, New York	Pediatrician, Shaker Pediatric
Valmore A. Pelletier, M.D. Albany, New York	Neurologist, Albany Troy Neurosurgical Associates
Richard P. Sherwin Albany, New York	Senior Vice-President, Key Structured Finances
Stephen C. Simmons Albany, New York	President, Simmons Computing Service, Inc.
Bettye J. Zeringue Albany, New York	Associate Information Representative, New York State Higher Education Services Corp.

The minutes of all meetings of the board of directors' and committees thereof held during the examination period were reviewed. All meetings were well attended.

However, the following are the examiners' observations in regard to the process of electing or re-electing the directors of the HMO's board of directors:

(i) The HMO did not maintain minutes of the meetings of its Nominating Committee for the period from August 6, 1996, the effective date of the HMO's amended by-laws to the date of this examination report.

It is recommended that the HMO maintain minutes of its Nominating Committee meetings.

(ii) Section 4.04(a) of the HMO's new amended by-laws states in part:

“...No director may serve more than three full, consecutive, three year terms, except upon a finding by the board that unusual circumstances exist which make additional service by a particular director in the best interests of the corporation.”

During the period covered by this examination, three directors were nominated and re-elected to serve more than three full, consecutive, three year terms. Two of the three directors are currently serving their fifth three full year term and the third is currently serving his fourth three full year term.

The HMO's by-laws require the board of directors to present supporting rationale for nomination when directors are nominated for more than three full, consecutive, three year terms.

The minutes of the Board of Directors did not contain any documentation to support a position that the nominations were in the best interest of the HMO. In fact, the minutes of the board of directors meeting on February 28, 2000, stated “There being no discussion”.

In addition, neither the proxy notices to the HMO Corporate Members for the annual members meetings nor the minutes of these meetings contained any documentation that revealed and/or substantiated to the members that nominating such directors to serve beyond the term limitation was in the best interest of the HMO.

Therefore, it is recommended that when a director is considered for re-election for more than three full, consecutive, three year terms, the minutes of the board of directors should describe the unusual circumstances that exist which make the additional service by a particular director in the best interest of the HMO.

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

<u>Name</u>	<u>Title</u>
Joseph W. Monahan, M.D.,	Chairman
John D. Bennett, M.D.	Vice Chairman
Thomas P. Collins,	Treasurer
Diane E. Bergman,	Executive Director
Cathy B. Connors	Secretary
Mary E. Connolly	Executive Vice President, Finance
Stephen R. Sloan, Esq.	General Counsel, Executive Vice President, Legal Affairs and Counsel to the Board of Directors

B. Territory and Plan of Operation

As of the last examination date, the HMO had a service area of eleven counties, however, in 1999, the HMO acquired the New York HMO book of business of Community Health Plan (“CHP”). As a result of this acquisition, the HMO’s service area expanded to include an additional fourteen counties.

The HMO's service area as stated in its Certificate of Authority dated November 15, 1999, includes the following counties in New York:

Albany	Fulton	Orange	Ulster
Broome	Greene	Otsego	Warren
Chenango	Hamilton	Rensselaer	Washington
Columbia	Herkimer	Saratoga	Westchester
Delaware	Madison	Schenectady	
Dutchess	Montgomery	Schoharie	
Essex	Oneida	Tioga	

The HMO also received a license from the State of Vermont, Department of Banking, Insurance and Securities to provide benefits for (transact insurance business authorized by its charter) comprehensive health service. The HMO did not cover any members in Vermont as of the examination date.

The HMO provides a comprehensive prepaid health program by means of a network of participating physicians. Subscribers to the HMO select a participating physician who acts as the primary care physician. This physician refers subscribers to other participating HMO physicians when particular medical specialties are required. Except for services specifically excluded or limited in the HMO's contracts or riders, there is no limit to duration, frequency or type of health care provided as long as the care is directly provided or pre-authorized by the HMO medical director and/or the participating physician. In certain cases, such as out-of-area emergency care, the pre-authorization requirements may be waived if medical necessity is established.

Physicians contract individually with the HMO by means of participating agreements that authorize the HMO to withhold from any fees payable to the physicians such amounts as are deemed necessary by the HMO to fund any operating deficits incurred, or to meet other financial requirements of the HMO. The HMO shall determine in its sole discretion, whether to distribute the amounts withheld or some portion of that amount based upon the HMO's overall financial condition and anticipated future financial requirements.

During the period under this examination, the participating physicians were paid on a fee for service basis. The participating provider agreements authorize the HMO to withhold up to 20% from fees paid to the physicians for the purpose of retaining the funds to offset operating deficits, to establish operating reserves, or to meet other financial needs of the HMO. In the years under examination, however, the amount of the physician withhold was 13%. For each year during the examination period, the amounts withheld were returned in full to the physicians in April of the following year except withhold on fees paid in 1996, 75% of which was returned in April 1997.

Inpatient hospital services are rendered as directed by HMO physicians. The HMO pays hospital charges through direct hospital billing. Out-of-area emergency care is provided for in the subscriber contracts.

The vast majority of the HMO's business is employer groups in both the public and private sector. The HMO's member enrollment was substantially increased from

203,357 in 1998 to 296,715 in 1999, through the acquisition in late 1999 of the New York State book of business of Community Health Plan.

At December 31, 2000, the HMO's total member enrollment was 316,322, with New York State agencies representing 16.3 % of the total.

The community rated premiums, as filed and/or approved by the Superintendent of Insurance, are applicable to all New York enrollees.

C. Reinsurance

To limit its exposure to losses from catastrophic inpatient claims, the HMO entered into the following two excess risk reinsurance agreements:

(i) Excess of loss reinsurance agreement with Mason Insurance Company, Ltd. (Mason), an unauthorized captive offshore reinsurance company. CDPHP and Independent Health Association, Inc. (IHA) each own 50% of Mason.

The HMO is reimbursed under this reinsurance agreement for all hospital inpatient services once the cost of eligible services exceeds the amount of \$125,000 per member per year. Once the deductible of \$125,000 has been reached in an agreement year, Mason shall reimburse the HMO 85% of eligible inpatient hospital services.

The reimbursement maximum is \$318,750 (85% of the total of \$375,000 in excess of the deductible) per member per contract year.

The reinsurance agreement with Mason Insurance Company, Ltd. did not contain the insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

Section 1308(a)(2)(A)(i) of the New York Insurance Law states in part:

“...reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts insured without diminution because of the insolvency of the ceding insurer...”

It is recommended that CDPHP amend its reinsurance agreement with Mason Insurance Company, Ltd. To include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

(ii) A second layer excess of loss reinsurance agreement with Reliastar Life Insurance Company, an accredited reinsurer.

The HMO is reimbursed under this reinsurance agreement for eligible inpatient hospital services; the deductible amount for such reinsurance coverage shall be as follows:

\$500,000 of the loss for each commercial member during each agreement year,
\$500,000 of the loss for each Medicaid member (insolvency coverage only),
\$50,000* of the loss for each in-network point of service member during each agreement year when combined with CDPHP Universal Benefits agreement with the same reinsurer and

\$75,000* of the loss for each Medicare member during each agreement year.

* Not covered under the first excess layer of coverage with Mason Insurance.

However, eligible inpatient hospital services shall be limited for each member to the lesser of:

- (a) \$2,500 per day for in-network point of service members, \$1,500 per day for Medicare members; or
- (b) 100% of billed charges; or
- (c) The amount paid by the HMO or
- (d) The contracted amount as approved and on file with the reinsurer.

Once the deductible has been reached in an agreement year, the reinsurer shall reimburse the HMO as follows:

- (a) 90% of eligible inpatient hospital services for each commercial member and Medicare member and
- (b) 85% of eligible inpatient hospital services for each in-network point of service member.

The maximum reinsurance coverage payable under the reinsurance agreement, during any agreement year, for eligible coverage for each member shall be \$1,000,000 when combined with CDPHP Universal Benefits agreement with the same reinsurer, and a lifetime maximum of \$2,000,000 when combined with CDPHP Universal Benefits agreement with the same reinsurer.

In the event the HMO becomes insolvent during the term of the Reliastar agreement, reinsurance will continue without the deductible or coinsurance limitation set forth above for eligible inpatient hospital services for non-Medicare and non-Medicaid

members who are receiving acute-care services while confined in a hospital on the date of insolvency. In addition, each member shall have the right to convert within thirty (30) days of the date of solvency, without evidence of insurability, to coverage then being offered or made available by the reinsurer to other individuals eligible for conversion under group insurance policies with the same benefits and at the same rates as offered to such other individuals in the state where the member resides.

Also, the Reliastar reinsurance agreement provides out of area conversion, in the event that a member moves outside the HMO's service area and coverage is terminated by the HMO. The reinsurer shall, pursuant to the member's certificate of coverage with the HMO, offer such member, without evidence of insurability, a conversion policy with substantially similar benefits and at such rates as then being offered through the reinsurer to others eligible for conversion.

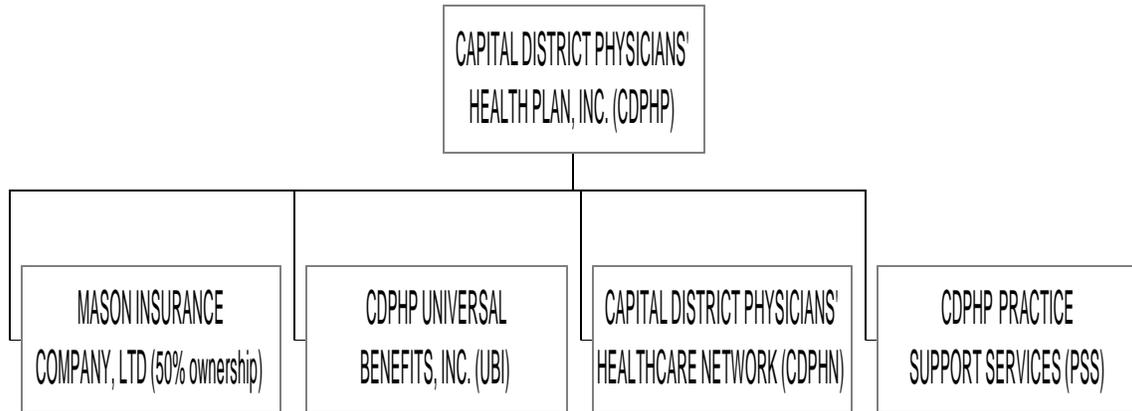
The HMO failed to submit its reinsurance agreements to New York State, Departments of Health and Insurance for approval as required by Section 98.1.8 (b) of 10 NYCRR 98, which states in part;

“Any amendment to the risk sharing arrangements contained in any contracts between the HMO and insurers shall not be entered into without prior approval of the commissioner and superintendent....”

It is recommended that the HMO submit its reinsurance agreements with Mason and Reliastar Life Insurance Company to the New York State Departments of Health and Insurance for approval.

D. Holding Company System

The following chart depicts the HMO and its relationship to its affiliates within the holding company system:



CDPHP Universal Benefits, Inc (UBI).

UBI is a not-for-profit corporation, incorporated under Section 402 of the Not-for-Profit Corporation Law on February 28, 1997. UBI was licensed on August 14, 1997 pursuant to the provision of Article 43 of New York Insurance Law, for the purpose of providing a prepaid comprehensive health care service through arrangement with physicians, hospitals, and other providers. UBI was capitalized by means of a \$1,250,000 Section 1307 surplus loan from its parent and sole member, CDPHP.

UBI has no employees. The HMO entered into an administrative service agreement with UBI, wherein various services are provided to UBI by the HMO, including, but not limited to financial, legal, internal operations, management information systems, marketing, consultation, utilization review services, claims administration, developing, revising, and refining new health care services products, systems, policies and overall administration.

UBI reimburses its parent monthly, based on actual costs incurred. UBI's premiums are collected by CDPHP and subsequently disbursed to UBI on a monthly basis. As of December 31, 2000, the HMO had payables to UBI in the amount of \$178,648.

The HMO did not report a carrying value for this not-for-profit subsidiary as of December 31, 2000, however, the HMO reported \$1,250,000 receivable due from UBI for its Section 1307 surplus loan.

Capital District Physicians' Healthcare Network, Inc. (CDPHN)

CDPHN, a wholly owned subsidiary of CDPHP, was incorporated on June 14, 1991. CDPHN was organized for the purpose of providing managed care and administrative support services to self-insured employers.

CDPHN has no employees. The HMO provides various administrative services to CDPHN including, but not limited to, financial, legal, internal operations, management information systems, marketing, consultation, utilization review services, claims administration, developing, revising, and refining new health care services products, systems, policies and overall administration.

It is recommended that the HMO formalize its business relationship with its affiliate CDPHN by entering into a written administrative service agreement which specifies the services and obligations of each entity to the other.

The total investment of the HMO in its CDPHN subsidiary was \$1,265,000 as of December 31, 2000.

The HMO valued its investment in CDPHN in the amount of \$263,214 as of December 31, 2000. This amount represented the net equity of the subsidiary as per an audit done by the HMO's CPA firm using generally accepted accounting principles.

Mason Insurance Company, Ltd. (Mason)

On January 2, 1992, Mason was formed pursuant to the Companies Act of 1981 of Bermuda. CDPHP and Independent Health Association, Inc. (IHA) each contributed \$250,000 in capital and surplus relative to the formation of Mason and share equally in the ownership of said company.

At December 31, 2000, Mason's sole function was the reinsurance of hospital inpatient services relative to members of CDPHP and IHA.

The HMO valued its investment in Mason in the amount of \$2,286,132 as of December 31, 2000. This amount represented the HMO's 50% interest in the net equity of the subsidiary as per an audit by a CPA firm using generally accepted accounting principles.

CDPHP Practice Support Services (PSS)

PSS is a wholly owned subsidiary of CDPHP, incorporated on May 9, 1994. PSS was organized for the purpose of providing management support services to participating providers. PSS became dormant during 1997; therefore, it is not currently conducting business.

The total investment of the HMO in its DSS subsidiary was \$593,000 for the period of 1994-1997.

The HMO did not report a carrying value for this subsidiary as of December 31, 2000.

E. Furniture and Equipment

A sample physical inspection of electronic data processing (EDP) equipment revealed the following:

(i) The HMO did not fully comply with the previous examination's recommendation for the complete permanent tagging of its furniture and equipment.

(ii) The HMO failed to account for some of the EDP equipment that was selected by the examiner for physical inspection.

(iii) The HMO allows some of its employees to work from their homes and provides them with computers, printers, pagers and office furniture. The HMO's internal control procedures over these assets should be improved to require employees' signatures

for the custody of these assets. The HMO should conduct periodic inspections on a sample basis.

It is recommended that the HMO complete permanent tagging of its equipment.

Also, it is recommended that the HMO's internal control procedures over its assets located at some employees' homes should be improved by requiring employee's signatures, instead of a manager's signature for the custody of these assets. In addition, the HMO should conduct periodic inspections on a sample basis.

F. Custodian and Investment Agreements

The HMO entered into four custodian agreements with Key Trust Company and utilized the services of four investment advisors. The following observations were noted:

(i) The HMO failed to execute proper custodian agreements with Key Bank National Association for the McDonald investment sweep account.

(ii) HMO failed to update the authorized signatures of its officers in relation to its custodian agreements.

(iii) Two investment advisors, Smith Barney and McDonald Investment, Inc., did not sign their respective investment agreements. Also, the agreements were found to contain unacceptable terms, such as the right to keep securities owned by CDPHP at Smith Barney.

It is recommended that the HMO execute a proper custodian agreement with Key Bank National Association for the McDonald investment sweep account. The custodian agreement should include the prudent protective provisions as set forth in the Department's guidelines.

It is recommended that the HMO's custodian agreements should be updated for current authorized signatures.

It is recommended that the HMO execute a new investment agreement with Smith Barney. The new agreement should not contain unacceptable terms such as the right to keep securities owned by CDPHP at Smith Barney.

G. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the period covered by this examination:

	<u>Amounts</u>	<u>Ratios</u>
Medical expenses	\$1,728,127,565	91.8 %
Administrative expenses	183,034,899	9.7
Net underwriting loss	(28,406,296)	(1.5)
Premium earned	<u>\$1,882,756,168</u>	<u>100.0 %</u>

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 HMO.

<u>Assets:</u>	<u>Amount</u>
<u>Current assets</u>	
Cash and short-term investments	\$95,955,448
Premiums receivable	22,828,636
Investment income receivables	2,541,162
Health care receivables	4,623,758
Amount due from affiliates	1,657,188
Reinsurance recoverable on paid losses	780,254
Prepaid expenses	<u>1,725,597</u>
Total current assets	<u>\$130,112,043</u>
<u>Other assets</u>	
Bonds	\$48,379,951
Common stocks	2,549,346
Loan receivable	1,250,000
Goodwill	<u>6,462,772</u>
Total other assets	<u>\$58,642,069</u>
<u>Property and equipment</u>	
Furniture and equipment	\$ 186,858
EDP equipment	<u>6,111,554</u>
Total property and equipment	<u>\$ 6,298,412</u>
Total assets	<u>\$195,052,524</u>

<u>Liabilities:</u>	<u>Amount</u>
<u>Current liabilities</u>	
Accounts payable	\$ 1,250,719
Claims payable	106,308,489
Accrued medical incentive pool	2,803,135
Unearned premiums	6,175,884
Amounts due to affiliates	178,648
Accrued salaries and benefits	4,514,369
Accrued expenses	1,625,197
Accrued general administrative expenses	7,219,260
Accrued hospital rate liability	<u>857,944</u>
Total current liabilities	<u>\$130,933,645</u>
<u>Other Liabilities</u>	-0-
Total Liabilities	<u>\$130,933,645</u>
<u>Net worth:</u>	
Contingent reserves	\$33,515,840
Retained earnings/fund balance	<u>30,603,039</u>
Total net worth	<u>\$64,118,879</u>
Total liabilities and net worth	<u>\$195,052,524</u>

Note 1:

The Internal Revenue Service did not audit the tax returns filed by the HMO since its inception. The examiner is unaware of any potential exposure of the HMO to any further tax assessment and no liability has been established herein relative to such contingency.

Note 2:

The "Claims Payable" shown above includes the following:

\$767,130	An estimated liability for years 1999 and 2000 to the SMC Pool.
\$922,154	An estimated liability for years 1998-2000 net of an estimated refunds of \$514,343 for years 1996 and 1997.

In addition, the HMO incorrectly reported \$1,194,641 in Health Care Receivables of \$4,623,758 which represents a distribution from the Specified Medical Condition (SMC) Pool that was received in January 2001 for years 1997 and 1998

B. Statement of Revenue and Expenses:

Net worth increased by \$223,392 during the five (5) year period under examination,

January 1, 1996 through December 31,2000, detailed as follows:

Revenue:

Premiums	\$1,882,756,168
Investment income	<u>29,013,688</u>
Total revenue	<u>\$1,911,769,856</u>

Expenses:

Medical and hospital

Physician services	\$661,573,060
Inpatient	312,691,837
Outpatient	227,570,072
Laboratory and x-ray	125,650,680
Drugs	259,251,024
Dental	11,578,839
Substance abuse	11,410,670
Other medical and hospital	67,399,000
Home health, prosthetics and durable medical equipment	32,687,691
Incentive pool adjustment	9,511,028
Demographic and SMC pools	8,281,690
Reinsurance expenses net of recoveries	<u>521,974</u>

Total medical and hospital expenses	<u>\$1,728,127,565</u>
-------------------------------------	------------------------

Administration

Compensation	\$93,141,964
Occupancy and depreciation	23,068,388
Marketing	27,206,461
Commissions	845,393
Other expenses	<u>38,772,693</u>

Total administration expenses	<u>\$183,034,899</u>
-------------------------------	----------------------

Total expenses	<u>\$1,911,162,464</u>
----------------	------------------------

Net income from operations	<u>\$ 607,392</u>
----------------------------	-------------------

C. Changes in Net Worth

Net worth per report on examination as of December 31, 1995	\$63,895,487
Reduction in surplus notes (Subvention Certificates)	(384,000)
Net income from operations	<u>607,392</u>
Net worth per report on examination as of December 31, 2000	<u>\$64,118,879</u>

4. CLAIMS PAYABLE

The examination liability of \$106,308,489 is the same as the amount reported by the HMO as of the examination date. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and its filed annual statements.

5. IMPACT OF STATUTORY ACCOUNTING PRINCIPLES

Effective January 1, 2001, the HMO is required to comply with new statutory accounting principles (SAP) established by the National Association of Insurance Commissioners (NAIC), except where modified by Department Regulation 172, to allow certain prescribed practices. These new accounting rules may result in changes in the reported value for certain assets and liabilities.

This examination included an analysis to determine the effect of the new accounting rules on the HMO's December 31, 2000 net worth. The analysis concluded that, had the new rules been in place as of the examination date, the HMO's net worth would have decreased \$5,343,891. This decrease would have been the result of the following changes:

Non-admission of EDP equipment and computer software	\$3,431,436
Non-admission of furniture and fixture	186,858
Non-admission of prepaid expenses	1,725,597
Total	<u>\$5,343,891</u>

Based on a limited review of the year 2001 annual Statement filed with the Department on March 30, 2002, it appears that the HMO is properly recognizing the impact of Statutory Accounting Principles in such statement. However, such Annual Statement has not been subjected to examination.

6. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the HMO conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and was directed at practices of the HMO in the following major areas:

- A) Underwriting
- B) Claims
- C) Rating
- D) Sales and advertising

The examiners' review revealed the following:

A. Underwriting

(i) Termination of Coverage

CDPHP's policy is to accept terminations submitted from group and non-group customers and process them in accordance with the customer's requested termination date, provided the date falls within normal processing timeframes. Normal processing timeframes for non-group customers is 30 days and for group customers is 30 or 60 days depending on the size of the group.

With regard to terminations for non-payment of premiums, CDPHP differentiates between direct pay, small group and large group. For direct pay subscribers, CDPHP sends termination notice upon the passing of the due date and grace period contained in the contract. For small groups, CDPHP sends notices after 20 days from the end of the grace period and for large groups, CDPHP sends the notice after 35 days from the end of the grace period. The grace period stated in CDPHP contracts is 10 days.

Reinstatement is allowed, if payment in full is received within 5 days from the date of sending the termination notice.

CDPHP continues to pay claims until it sends the notice of termination, then suspends payment of claims until the premiums are received.

When coverage is retrospectively terminated, CDPHP recoups the amounts of claims that were paid after the termination date, from its providers.

(ii) Complete Benefit Connection

The HMO markets, through the use of a licensed general agent, Niagara Benefits Group (Niagara), and the HMO's own in-house licensed agents, a combined benefit package known as Complete Benefit Connection (CBC).

CBC offers small groups the option of obtaining life, disability and dental insurance products covered by US Life Insurance Company (US Life), in addition to the HMO's health insurance coverage. Niagara and the HMO's in-house agents are licensed to sell the US Life products.

The marketing of these insurance policies is outlined below:

1. Niagara Benefits Group, a licensed general agent, or a CDPHP in-house agent solicits a current CDPHP covered employer or a prospective CDPHP covered employer to offer them the CBC option. In order for the employer to choose any of the insurance

products offered by US Life, they must first purchase, or be covered by, a CDPHP insurance product. The interdependent sales of life, accident and health insurance products with any good or service is prohibited by Section 4224 (d)(1) of the New York Insurance Law, which states in part;

“...No insurer...shall directly or indirectly, or by any of its agents or representatives, participate in any plan to offer or effect any kind or kinds of such insurance business in this state as an inducement to, or interdependent with, the purchase by the public of any goods, securities, commodities, housing, services or subscriptions to periodicals,...”

Therefore, the manner in which this program is administered appears to conflict with the provisions of Section 4224 (d)(1) of the New York Insurance Law, which prohibits the interdependency of an insurance product with any good or service. The HMO limits the eligibility to select US Life products to those who are CDPHP subscribers or members.

2. When a CBC package is sold to an employer, the applications are sent out to the respective companies, CDPHP and US Life. CDPHP then sends a bill for their portion of the coverage to a third party billing agent, Fringe Benefit Analysts, who in turn, after receiving billing information from US Life, combines the two bills into one invoice, payable to Fringe Benefit Analysts and mails an invoice to the employer. The employer would then remit payment to Fringe Benefit Analysts, who in turn would apportion the payment to the proper insurers.

It is noted that there is no written agreement between the HMO and Fringe Benefits Analysts. However, the following agreements do exist:

- a) An Agency/Broker agreement between CDPHP and Niagara, and
- b) An agency sponsorship between US Life and Niagara and US Life and CDPHP's in house producers. Forty-three in-house producers who market insurance products are licensed to sell life insurance as well as accident and health insurance.

On July 1, 2002, the HMO terminated its agreement with Fringe Benefit Analysts. In addition, CBC program is not currently being marketed by CDPHP.

All commissions on US Life insurance products are paid directly from US Life to the agent, whether such agent is an agent of Niagara Benefit Group or is a CDPHP in-house producer.

B. Claims

(i) Schedule H Reporting

A review of the HMO's filed Schedule H revealed that the claim counts for Section 3 represented number of service lines not claims (i.e. A claim may include more than one service line). Therefore, the "claim count" information reported on section 3 of schedule H during the period under examination was inflated. This was amended in the second quarter 2001, to convert the service lines to claim counts.

In addition, the HMO reported paid claim count on section 3 of schedule H based on an estimate instead of utilizing the actual claim counts available from its claim system.

It is recommended that for schedule H purposes, the HMO should use an actual count of paid claims available from its claim system and estimates the remainder instead of using an estimate for all paid claims.

(ii) Prompt Payment of Claims

The examiner's review of the prompt payment of claims revealed violations of the New York Insurance Law-Sections 3224-a (a), (b) and (c).

Section 3224-a (a) states in part;

"...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 forth-five days of receipt of a claim or bill for service rendered."

Section 3224-a (b) states in part;

"...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..."

Section 3224-a (c), which requires that interest be paid if it amounts to \$2 or more, states in part;

"... 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...”

A review was made of year 2000 claims, other than Medicare, using ACL audit software, for compliance with Section 3224-a.

A claim was defined as the total number of items submitted on a single claim form to which the HMO assigns a unique claim number. This definition was agreed to by both the examiners and CDPHP.

The review was performed using a statistical sampling methodology. The population of claims from which a sample was selected consisted of claims that exceeded the thresholds established in Section 3224-a.

CDPHP paid 2,449,017 claims and denied 487,087 claims in the year 2000. Of these claims, 39,666 were paid more than 45 days after the receipt date and 32,330 were denied more than 30 days after the receipt date.

From each of the populations described above which may have been in violation of Section 3224-a, a sample of 167 claims was randomly selected for review to determine whether the claims were processed in compliance with Section 3224-a of the New York Insurance Law.

The following is a summary of prompt pay review findings:

Description	Paid claims over 45 days	Denied claims over 30 days
Claim population	39,666	32,330
Sample size	167	167
Number of claims with errors	57*	138
Calculated Error Rate	<u>34.13%</u>	<u>82.63%</u>
Upper Error limit	41.32%	88.38%
Lower Error limit	26.94%	76.89%
Upper limit Claims in error	<u>16,391</u>	<u>28,573</u>
Lower limit Claims in error	<u>10,686</u>	<u>24,858</u>

Note 1: 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.)

*Note 2: Of the 57 claims found to be in violation of Section 3224-a(a), 13 also violated Section 3224-a(c) because interest due of \$2 or more was not paid.

It is recommended that the HMO improve its internal claim procedures in order to ensure full compliance with Section 3224-a of the New York Insurance Law.

It is important to note that the populations of claims which were paid more than 45 days, or which were denied more than 30 days after the date of receipt may be understated because of the following:

- a) The HMO created claims due to a change in "Header Information" of a claim that indicate when the claim is received. These claims will reflect a new date of receipt, depending on when the claims examiner creates the new claim. This means that the claims may show that they were paid within 45 days or denied within 30 days, when in fact they may not have been.

It is recommended that the HMO use the original date of receipt of the original claim number, for prompt pay purposes, unless the change in header information was due to the receipt of additional information requested from the provider/subscriber, and that the information requested was necessary to process the claim.

- b) When the HMO processed claims for which additional information was requested and received or where information was received without being requested, in certain instances such claims were not adjusted until a Contact Service Form (CSF) or Internal Service Form (ISF) was created. It was found that sometimes it took few days to scan in the information received, with the date of the scan appearing on the image. The HMO uses the date that the CSF or ISF was created for the starting date in determining compliance with Section 3224-a, instead of the date that the information was received.

It is recommended that the HMO consistently follow its policy of recognizing the date of receipt of information, and not the date it was scanned into the claim system, or the date that a CSF or ISF is created for the starting date in determining compliance with Section 3224-a of the New York Insurance Law.

(iii) Explanation of Benefits Statements

During the examination period (1996-2000), the HMO did not use Explanation of Benefits (EOB) forms. Rather, for claims denied wholly or in part, payable to subscribers/contract-holders the HMO sent denial letters. In addition, the HMO used a number of adjudication (denial) codes for claims submitted by participating providers

that indicate the subscribers/contract-holders may be liable for payment of all or part of the billed charges. In such instances, denial letters were also used in lieu of EOBs.

The examiner was not provided with documentation, nor was there any notation of the mailing of denial letters, for claims processed prior to March 2001. The claim files that were reviewed did not contain any correspondence that would serve as an EOB.

EOBs are an integral part of the link between the subscriber/contract-holder and their insurer, providing vital information as to how the claim was processed.

Under Section 3234 of the New York Insurance Law, an HMO is not required to provide an EOB if the claim is paid in full to a participating provider. However, regardless of who the claim is payable to, EOBs are required when there is a reduction in benefits, when a claim is denied wholly or in part; or when a claim is paid to anyone other than a participating provider.

The review indicated that the HMO does not send out EOBs, as required by Section 3234 of the New York Insurance Law, and that the denial letter, in the form presented to the examiners, would not be sufficient to serve as an EOB, because it failed to contain all of the provisions required by the aforementioned Section 3234 of the New York Insurance Law.

Section 3234(b), states,

“The explanation of benefits form must include at least the following:

- (1) the name of the provider of service the admission or financial control number, if applicable;
- (2) the date of service;
- (3) an identification of the service for which the claim is made;
- (4) the provider’s charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
- (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as 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 consumer’s right to challenge a denial or rejection, even when a request for clarification has been made”.

The denied claims review for year 2000 yielded more than 400,000 claims wholly denied and an undetermined number of claims partially denied. The HMO violated Section 3234(a) and (b), of the New York Insurance Law because it failed to send to its subscribers a proper EOB that includes all of the requisite information required by the New York Insurance Law. Therefore, the subscribers were not properly informed of their appeal rights and how their claims were processed.

It is recommended that the HMO issue an EOB that includes all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law.

In addition, the HMO denied 915 claims retrospectively during year 2000 because the services did not qualify as medical emergency, a sample of 167 claims was randomly

selected for review to determine compliance with Section 4903(4) and (5) of the New York Public Health Law.

Section 4903(4) states:

“A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information”.

Section 4903(5) states:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

- (a) the reasons for the determination including the clinical rationale, if any;
- (b) instructions on how to initiate standard and expedited appeals pursuant to section forty nine hundred four and an external appeal pursuant to section forty nine hundred fourteen of this article; and
- (c) notice of the availability, upon request of the enrollee, or the enrollee’s designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal”.

The review revealed that in all cases, the HMO either failed to send a notice of adverse determination to its subscribers and/or providers as required by Section 4903(4) and (5) of the New York Public Health Law or did not fully comply with Section 4903(5). The HMO retrospective review denial letter did not contain instructions on how to initiate standard and expedited appeal. Instead, the HMO directs the member, member’s designee or member’s health care provider to write to the Member Service Department or call the HMO. Directing the member to write or to call the HMO is insufficient to satisfy the requirement. The notice of adverse determination should set

forth the time, place and manner in which an appeal is initiated, including a discussion of standard, expedited and external appeals.

It is recommended that the HMO send proper notice of adverse determination to subscribers and/or providers, when claims are denied retrospectively for medical reasons as required by Section 4903(5) of the New York Public Health Law.

(iv) Overall Claim Processing

A review of the HMO's claims' processing accuracy during calendar year 2000 was performed using the previously described sampling methodology. The review incorporated processing attributes used by the HMO in their own "Quality Analysis" of claims processing, as agreed to by the examiners. Based upon a sample of 167 Medical claims the projected accuracy rate range between 93.6% and 99.2% of all claims processed. A review of 167 Hospital claims yielded a projected accuracy rate between 91.2% and 98.0%. The HMO purports to maintain an accuracy standard of above 97%.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report contained nine comments and recommendations detailed as follows (page numbers refer to the prior report):

<u>ITEM</u>		<u>PAGE NO.</u>
A	<p>Comment that the HMO agreed that in the future the Finance Committee will consistently approve all investment transactions as required by Section 1411(a) of New York Insurance Law.</p> <p>The HMO complied and the finance committee approved all investment transactions as recommended.</p>	6
B	<p>Comment that the HMO failed to notify the Superintendent within 5 days of acquiring 50% interest of Mason Insurance Company as required by Section 81-2.5 of Regulation 115. However, the HMO did file Form IR every year.</p> <p>The HMO complied and filed Form IR every year for the period under this examination.</p>	10
C	<p>Comment that the HMO failed to notify the Superintendent within 5 days of acquiring CDPHPN and PSS as required by Section 1701(b) of New York Insurance Law. However, the HMO did file Form IR every year.</p> <p>The HMO complied and filed Form IR every year for the period under this examination.</p>	10
D	<p>Comment that the HMO failed to submit Form PIR within 30 days after acquisition of a non insurer subsidiary as required by Section 78.4(b) of Regulation 59. However, the HMO did file Form IR every year.</p> <p>The HMO complied and filed Form IR every year for the period under this examination.</p>	11
E	<p>It is recommended that the reinsurance agreements should provide for at least thirty days notice for termination after insolvency of the HMO.</p>	13

<u>ITEM</u>		<u>PAGE NO.</u>
	The HMO complied and entered into a new reinsurance agreement with another reinsurer.	
F	Comment that the HMO agreed to obtain a market value for Mason from SVO.	14
	The HMO complied and followed SVO instructions to report market value for Mason.	
G	It is recommended that the HMO should maintain a schedule that cross references the asset number per the depreciation schedule to the furniture and equipment tag/serial number.	14
	The HMO partially complied with this recommendation. A similar recommendation is included in this report under item F.	
H	Violation of Section 4310(f) of New York Insurance Law. The HMO failed to secure the advance approval of the Superintendent for its capitalized leasehold improvements in 1995. However, the HMO requested from the Insurance Department on October 15, 1997 a retroactive approval for prior leasehold improvements.	14
	The HMO complied with Section 4310(f) of New York Insurance Law during the period under this examination.	
I	Violation of New York State Regulation number 34, Part 215.9(c). There was no reference to the source of statistics used in some of the HMO's advertisements. However, the HMO agreed to ensure that all future advertisements will include a reference to sources of all statistics.	21
	The HMO complied with the requirements of New York State Regulation number 34, Part 215.9(c) during the period under this examination.	

8. SUMMARY OF COMMENTS AND RECOMMENDATION

<u>ITEM</u>		<u>PAGE NO.</u>
A	It is recommended that the HMO maintains minutes of its Nominating Committee meetings.	6
B	It is recommended that when a director is considered for re-election for more than three full, consecutive, three year terms, the minutes of the board of directors should describe the unusual circumstances that exist which make the additional service by a particular director in the best interest of the HMO.	7
C	It is recommended that CDPHP amend its reinsurance agreement with Mason Insurance Company, Ltd. to include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.	11
D	It is recommended that the HMO submit its reinsurance agreements with Mason and Reliastar Life Insurance Company to the New York State, Departments of Health and Insurance for approval.	13
E	It is recommended that the HMO formalize its business relationship with its affiliate CDPHN by entering into a written administrative service agreement which specifies the services and the obligations of each entity to the other.	15
F	It is recommended that the HMO complete permanent tagging of its equipment.	18
G	It is recommended that the HMO's internal control procedures over its assets located at some employees' homes should be improved by requiring employee's signatures, instead of a manager's signature for the custody of these assets. In addition, the HMO should conduct periodic inspections on a sample basis.	18
H	It is recommended that the HMO execute a proper custodian agreement with Key Bank National Association for the McDonald investment sweep account. The custodian agreement should include the prudent protective provisions as set forth in Department's guideline.	19

<u>ITEM</u>		<u>PAGE NO.</u>
I	It is recommended that the HMO's custodian agreements should be updated for current authorized signatures.	19
J	It is recommended that the HMO should execute a new investment agreement with Smith Barney. The new agreement should not contain unacceptable terms such as the right to keep securities owned by CDPHP at Smith Barney.	19
K	The manner in which the Complete Benefit Connection program is administered appears to conflict with the provisions of Section 4224 (d)(1) of the New York Insurance Law which prohibits the interdependency of an insurance product with any good or service. The HMO limits the eligibility to select US Life products to those who are CDPHP subscribers or members.	27
L	It is recommended that for schedule H purposes, the HMO should use an actual count of paid claims available from its claim system and estimates the remainder instead of using an estimate for all paid claims.	29
M	It is recommended that the HMO improve its internal claim procedures in order to ensure full compliance with Section 3224-a of the New York Insurance Law.	31
N	It is recommended that the HMO use the original date of receipt of the original claim number, for prompt pay purposes, unless the change in header information was due to the receipt of additional information requested from the provider/subscriber, and that the information requested was necessary to process the claim.	32
O	It is recommended that the HMO consistently follow its policy of recognizing the date of receipt of information, and not the date it was scanned into the claim system, or the date that a CSF or ISF is created for the starting date in determining compliance with Section 3224-a of the New York Insurance Law.	32

<u>ITEM</u>		<u>PAGE NO.</u>
P	It is recommended that the HMO issue an EOB that includes all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law.	34
Q	It is recommended that the HMO send proper notice of adverse determination to subscribers and/or providers, when claims are denied retrospectively for medical reasons as required by Section 4903(5) of the New York Public Health Law.	36

Appointment No. 21722

STATE OF NEW YORK_{ORK}
INSURANCE DEPARTMENT

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

Elsaid ElBially

as a proper person to examine into the affairs of the

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN

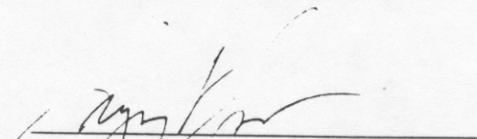
and to make a report to me in writing of the said

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 10th day of April 2001



(by) Gregory Serio
Acting Superintendent

