REPORT ON EXAMINATION

OF

JEFFERSON-LEWIS ET. AL. SCHOOL EMPLOYEES'

HEALTHCARE PLAN

AS OF

JUNE 30, 2005

DATE OF REPORT	MARCH 20, 2007
EXAMINER	JEFFREY L. USHER

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

ELIOT SPITZER
Governor

ERIC R. DINALLO
Acting Superintendent of Insurance

March 20, 2007

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

Sir:

Pursuant to the provisions of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22470 dated March 3, 2006, attached hereto, I have made an examination into the condition and affairs of Jefferson-Lewis et. al. School Employees' Healthcare 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 853 James Street, Clayton, New York.

Wherever the designations "Plan" or "J-LSEHP" appear herein without qualification, they should be understood to indicate the Jefferson-Lewis et.al. School Employees' Healthcare Plan.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of September 30, 2000. This examination covered the four years and nine months period from October 1, 2000 to June 30, 2005. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised of a complete verification of assets, liabilities and surplus as of June 30, 2005, in accordance with statutory accounting principles as adopted by this 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 accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners (NAIC):

History of the Plan
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
Loss experience
Accounts and records
Market conduct activities

A review was also made to ascertain the action that was taken by the Plan with regard to comments and recommendations 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 which 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 and New York Public Health Laws. Significant findings relative to this examination are as follows:

- The Plan did not execute a proper custodian agreement with Key Bank which included prudent protective covenants and provisions as set forth in the Department's guidelines.
- The Plan's policy forms and riders were not approved for use by the New York Insurance Department prior to or during the examination period.
- POMCO, Inc. and each of its employees who perform claim adjusting services for the plan were not licensed as independent adjusters.
- The Plan overstated its claim expenses and understated its claim adjustment expenses due to assigning claims numbers to third party administrative fee invoices.
- The Plan did not issue proper Explanation of Benefits statements (EOBs) to its members.
- The Plan did not fully comply with the requirements of Article 49 of the New York Insurance Law with regard to notices to members of first adverse and final adverse determinations.

The examination findings are described in greater detail in the remainder of this report.

3. DESCRIPTION OF PLAN

Jefferson-Lewis Board of Cooperative Educational Services (J-LBOCES) and its fifteen original member school districts (participants) formed a Consortium in 1979. The purpose of the Consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance (the Plan). The Plan provides benefits to covered employees and their eligible dependents as defined in the plan booklet.

On June 1, 2001, the Plan was issued a certificate of authority by the Superintendent of Insurance under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority, the participants have agreed to share the costs and assume the liabilities for medical, surgical, prescription drugs, and hospital benefits provided to covered employees (including retirees) and their dependents.

There are fifteen school districts and one Board of Cooperative Educational Services participating in the Plan as follows:

Alexandria Bay Central	Beaver River Central School
Belleville-Henderson Central School	Carthage Central School
Copenhagen Central School	General Brown Central School
Indian River Central School	La.Fargeville Central School
Lyme Central School	Watertown City School District
South Lewis Central School	Jefferson Community College
Thousand Islands Central School	Sackets Harbor Central School
Jefferson-Lewis B.O.C.E.S.	Lowville Central School

A. Management

Pursuant to the Municipal Cooperative Agreement, management of the Plan is vested in the governing board comprised of one representative from each participating school district including BOCES as a participant. As of the examination date, the governing board was comprised of fifteen members. The board meets at least once during each calendar year. The members of the governing board of the Plan as of June 30, 2005 were as follows:

Name	Municipality
Wally Keeler	Alexandria Bay Central School District
Larry Strife	Beaver River Central School District
Unassigned	Belleville-Henderson Central School District
Michael Powers	Carthage Central School District
Marcia Mundy	Copenhagen Central School District
Terry Remington	General Brown Central School District
Valerie Borland	Indian River Central School District
Michelle Denny	LaFargeville Central School District
Sandra Dudley-Rooney	Lyme Central School District
Connie Timmerman	Watertown City School District
Frank House	South Lewis Central School District
James Bliss	Jefferson Community College
Sally Switzer	Thousand Islands Central School District
Anne Spanziani	Sackets Harbor Central School District
Barbara Greene	Jefferson-Lewis B.O.C.E.S.
Kenneth J. McAuliffe	Lowville Central School

The above school districts cover the geographic areas of Jefferson and Lewis counties.

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

The Plan entered into contractual agreements with the following vendors to provide various administrative services to the Plan:

- Progressive Management Consulting, LLC (PMC), is the general manager and Comptroller of the Plan. As Plan general manager, PMC defines a strategic plan of action for the future of the Plan. PMC works with POMCO, Inc (POMCO), which provides services to the Plan as described below, to ensure accurate and prompt payment of claims. PMC meets with the Board of Trustees as deemed necessary to conduct the business of the Plan. PMC provides mandated reports and documentation to regulators and others as required to keep Plan participants informed of benefit issues, and assists in the review and revision of plan benefit structure and design.

- POMCO, Inc. provides a computerized on-line system for developing and maintaining comprehensive employee benefit records, POMCO provides administrative and third party claims processing services relative to the payment of claims. POMCO, provides the Plan with access to its provider network as well as access to the provider network of its contractual partner, Multi Plan Inc. (Multi Plan). The Multi Plan provider network is available in all 50 states of the United States. POMCO also utilizes Preferred Medical Claim Solutions (PMCS) as a claim payment re-pricer (for discounts) for outpatient claims when the provider is not in the POMCO or Multi Plan network.

- Pharmacare provides a prescription drug plan for eligible covered persons of the Plan. This includes a nationwide network of retail and mail service pharmacies, remote electronic claims adjudication and processing system for adjudicating and processing pharmacy claims. Pharmacare provides a drug utilization review service by which the cost effectiveness, interaction and resulting therapeutic effect of various drugs are reviewed and monitored electronically. Pharmacare also provides a prescription drug benefit management service for designing and managing prescription drug benefit plans.

- Davis Vision provides administrative and information services to members of the plan relating to its Vision Plan benefits. Davis Vision

provides laboratory services, processing of claims, data entry and clerical processing. Davis Vision provides management reporting of billing statements quality care reports and/or other reports as required. Davis Vision provides a panel of private offices for eye exams and dispensing services to the members. Davis Vision also has a comprehensive program for quality assurance.

- KBM Management Inc. (KBM), provides consulting services to the Plan's Trustees as required on matters regarding negotiations with employee groups. KBM also provides actuarial services and assists in obtaining alternative markets for stop-loss coverage as well as reviews and investigates claims which affect stop-loss coverage. KBM assists in the negotiations of administrative agreements of the Plan.

- Poulsen & Podvin, CPA, LLC provides accounting services to the Plan.

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

Officers	Title
Kenneth McAuliffe	Chairperson
Penny Sweredoski	Vice Chairperson
Sally Switzer	Chief Financial Officer
Diane Wright	Secretary
Edgar Higgins	Plan Manager

B. Territory and Plan of Operation

The Plan provides health benefits in the Jefferson and Lewis counties of New York State. The Plan provides its members with medical, including hospital coverage, prescription drug coverage and vision benefits. The Plan had an annual premiums written of $35,259,011 as June 30, 2005. There has not been any significant change in membership during the examination period. The plan has represented the same school districts during the exam period. The Plan has not had any significant changes subsequent to the exam period.

C. Reinsurance

As required by Section 4707 (a) of the New York Insurance Law, the Plan maintains both specific and aggregate stop loss insurance policy issued by a licensed insurer in order to limit its exposure to losses from medical and prescription drugs. The following is a summary of the Plan's stop loss insurance policy at June 30, 2005:

Specific excess stop-loss coverage

Excess of LossCoverage: medical and prescription drugs

100% of $700,000 in excess of $300,000 per member, per contract year

Aggregate excess stop-loss coverage

Excess of Loss:	Coverage: medical and prescription drugs 100% of paid aggregate losses in excess of $42,566,665 to a maximum limit of $1,000,000 and a maximum limit per covered person of $300,000 per contract year.

D. Investment Activities

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

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

A review of the minutes of meetings of the Plan's board of trustees and finance committee held during the examination period revealed that the Plan did not comply with the requirement of Section 1411(a) of the New York Insurance Law. Investment reports were provided to the board of trustees on a periodic basis, however, specific investments were neither approved by the board nor by any committee thereof.

It is recommended that the Plan comply with the requirements of Section 1411(a) of the New York Insurance Law.

E. Custodian agreement

A review of the Plan's custodial agreement with its custodian bank revealed that such custodial agreement did not include the following prudent protective covenants and provisions as described in the Insurance Department's guidelines:

1. Bank shall have in force Bankers Blanket Bond Insurance.

2. Give the securities held same care given own property of similar nature.

3. Furnish insurer with a list of such securities showing complete description of each issue.

4. Maintain records sufficient to verify information required to report in schedule D of annual Statement.

5. Furnish the appropriate affidavits in the form acceptable to bank and NYSID in order for securities to be recognized as admitted assets of the company.

6. Access shall be during regular banking hours & specifying those who shall be entitled to examine on premises securities held and records regarding securities held.

7. Written instructions shall be signed by any two authorized officers specified which will be furnished to the bank from time to time signed by the treasurer or an assistant and certified by corporate seal.

8. In connection with any situation involving registration of securities in the name of a nominee bank of a bank custodian, the custodian agreement should empower the bank to take such action.

9. There should be a provision in the agreement that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls.

It is recommended that the Plan enter into a proper custodial agreement with its custodian bank for its investment account. The custodian agreement should include the prudent protective covenants and provisions as set forth in the Department's guidelines.

F. Uncashed checks

The Plan's current procedures with regard to uncashed checks are as follows:

Checks remain outstanding for up to six months. Those checks that are still outstanding at the end of six months from the date the check was issued are restored to cash by journal

entry and a claims expense accounts credited for the unclaimed checks. This journal entry is prepared at twice or four times each year.

It is recommended that the Plan establish a follow-up procedure and send an initial letter of inquiry to the payee for all checks which remain outstanding for three months from the date of issue.

G. Accounts and Records

A review of the Plan's service agreement with POMCO, Inc., related general ledger expense entries and the billing for administrative expenses from POMCO, Inc revealed that the Plan's practice is to prepay POMCO, Inc. for its services which include the administration of claims.

Section 4705 (d) (2) (B) of the New York Insurance Law states:

> "(d) The municipal cooperation agreement shall provide that the governing board:
> (2) may enter into an agreement with a administrator or other service provider, determined by the governing board to be qualified, to receive, investigate, recommend, audit, approve or make payment of claims under the municipal cooperative health benefit plan, provided that:
> (B) payment for contracted services shall be made only after such services are rendered;"

.

It is recommended that the Plan payment for contracted services be made only after such services are rendered in accordance with the requirements of Section 4705(d)(2)(B) of the New York Insurance Law.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of June 30, 2005. This statement is the same as the balance sheet filed by the Plan

Assets	
Cash and cash equivalents	$ 9,597,158
Short-term investments	1,297,045
Investment income receivable	126,499
Aggregate write-ins for current assets	130,711
Long-term investments	6,026,301
Total assets	$17,177,714
Liabilities	
Accounts payable	416,885
Claims payable	8,659,285
Unearned premiums	162,442
Total liabilities	$9,238,612
Net worth	
Contingency reserves	$ 1,784,424
Retained earnings/fund balance	6,154,678
Total net worth	$ 7,939,102
Total liabilities and net worth	$17,177,714

B. Statement of revenue and expenses:

Net worth decreased by $909,405 during the four years and nine months period under this examination, October 1, 2000 through June 30, 2005, detailed as follows:

Revenue			
Premiums and related revenue			$138,141,505
Expenses			
Hospital/medical benefits	$104,390,797		
Prescription drugs	28,380,868		
Reinsurance expenses	937,318		
Total medical and hospital		$133,708,983	
Administrative expenses			
Compensation	364,841		
Marketing	43,655		
Professional fees	114,294		
Administrative fees	5,690,382		
Consultant fees	175,264		
Office expense	55,011		
Insurance	42,907		
Summary of other write-ins	442,626		
Total administrative expenses		$6,928,980	
Total expenses			140,637,963
Net Underwriting gain			($2,496,458)
Investment income		1,693,567	
Unrealized loss on investments		(121,148)	
Investments and other income			$1,572,419
Net income or (loss)			($924,039)

C. Net worth

Net worth per examination on organization as of September 30, 2000			$ 8,848,507
	Gains in Surplus	Losses in Surplus	
Net loss		$ (924,039)	
Wellness benefits	14,634		
Total gains and losses	$ 14,634	$ (924,039)	
Net decrease in net worth			(909,405)
Net worth per this exam report June 30, 2005			$ 7,939,102

5. CLAIMS UNPAID

The examination liability of $8,659,285 is the same as the amount reported by the Plan as of June 30, 2005. 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.

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the generally more precise scope of a market conduct investigation.

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

A. Policy forms
B. Claims processing
C. Utilization review

A. Policy forms

It is noted during the examination review that Jefferson Lewis et. al. School Employees' Health Plan did not obtain Department approval for the forms which they have been using since attaining the Certificate of Authority.

During the examination, the Plan submitted all currently used forms for review by the Department.

A review by the Insurance Department indicated that there are many observations on the policy forms and riders in use by the plan during the period under examination.

It is recommended that the plan revise it's policy forms and riders as directed by the Insurance Department in order to be in compliance with Section 4303 and 4308(a) of the New York Insurance Law.

B. Claims processing

1. Third party claims administrator

The Plan has an agreement, dated May 1, 1997, with POMCO, Inc. to administer claims on the Plan's behalf.

A review of the claim adjudicating process revealed that neither POMCO, Inc. nor any of it's employees assigned to process the Jefferson Lewis et al Schools Health Plan claims possess a New York claims adjuster license which is in violation of section 2102(a)(1) of the New York Insurance Law, which states:

> "(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 2101(g)(1) of the New York state Insurance Law states in part:

> "(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 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 POMCO, Inc. and each of its employees who perform claim adjusting services in New York for the plan be licensed as independent adjusters in accordance with Sections 2101(g)(1) and 2108(a)(3) of New York Insurance Law.

2. Claim attribute sample

A review of claims processed during the July 1, 2004 through June 30, 2005 fiscal year was performed by using a statistical sampling methodology covering the claims processed during the aforementioned period in order to evaluate the overall accuracy and compliance environment of the Plan's claims processing.

This statistical random sampling process was performed using ACL, an auditing software program. The sampling methodology, was devised to test various attributes deemed necessary for successful processing of claims and to test and reach conclusions about all predetermined attributes, individually or on a combined basis. The review incorporated processing attributes used by the POMCO in its own "Quality Analysis" of claims processing. The sample size was comprised of 167 randomly selected claims.

The review indicated that two claims were "processed" incorrectly, according to the criteria used by both the Plan and the Insurance Department examiners, not including

any claims for which the Plan issued Explanation of Benefits forms (EOBs) which were not in compliance with Section 3234 of the New York Insurance Law.

EOBS which contained wording not in compliance with Section 3234 of the New York Insurance Law were issued with regard to an additional 144 claims producing an overall accuracy rate of 13%.

If the EOB errors were not taken into consideration, the Plan's claims processing accuracy rate would have been 99%. This is consistent with the Plan's reported overall accuracy standard being above 98%.

3. Claim adjustment expense

In addition, Claim numbers were assigned to bills received from consultants, Multiplan and PMCS for their services. The services were reported as claims expenses in the general ledger and annual statement. These expenses should be treated as claims adjustment expenses instead of being treated as claims expenses.

It is recommended that the Plan stop the practice of assigning a claim number to third party administrative fee invoices. Such fees should be reported as claims adjustment expenses.

4. Explanation of Benefits Statements:

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

Section 3234(a) of the New York Insurance Law states in part:

> "Every insurer, including health maintenance organizations … is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy…"

The New York Insurance Law Section 3234(c) creates an exception to the requirements for the issuance of an EOB established in New York Insurance Law Section 3234(a) as follows:

> "…insurers…shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer directly to the participating facility or provider."

In addition, Section 3234(b) of the New York Insurance Law sets forth, minimum standards for content of an EOB as follows:

> "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".

A review of a sample of the Plan's paid and denied claims for members/providers residing or located in New York during the period from July 1, 2004 to June 30. 2005 was performed. The review revealed that all EOBs issued by the Plan failed to contain all the language required by Section 3234(b) of the New York Insurance Law (including the appeal language). The Plan's EOBs, in the form as presented to the examiners would not be sufficient to serve as a proper EOB. The subscribers were neither properly informed of their appeal rights nor were they advised how their claims were processed. Therefore, all claims processed either paid or wholly/partially denied to New York subscribers and/or providers were in violation of Section 3234(b) of the New York Insurance Law.

It is recommended that the Plan issue EOBs that include all of the requisite information required by Sections 3234(a) and (b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

C. Utilization review

As a condition to the issuance and continuance of the certificate of authority to operate as a municipal cooperative health benefits plans under Article 47 of the Insurance Law, the Plan must demonstrate to the Superintendent's satisfaction that it has established a fair and equitable process for claims review, dispute resolution and appeal procedures. Under New York statutes, health care claims involving a coverage determination as to whether services are medically necessary or experimental or investigational constitute utilization review and are to be adjudicated consistent with the requirements of either Article 49 of the Insurance Law or Article 49 of the Public Health Law. Article 49 of the Insurance Law is applicable to any insurer subject to Article 32 or Article 43 of the Insurance Law and their contracted utilization review agents. Article 49 of the Public Health Law applies to any other entity performing utilization review except, inter alia, an insurer subject to Article 32 or 43 of the Insurance Law.

POMCO 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 POMCO has a utilization review report currently on file with the Department, in accordance with New York Insurance Law Section 4704(a)(8) and Article 49 of the Insurance Law or are currently registered as a utilization review agent with the Department of Health under Article 49 of the Public Health Law.

POMCO did file a utilization review report with the Superintendent of Insurance pursuant to Section 4901 (a) of the New York State Insurance Law, however, it did not file thereafter a biennial report to the Superintendent of Insurance as required by that Section.

In order for POMCO to continue to perform utilization review under contract to the Plan, it is recommended that the Plan or POMCO on behalf of the Plan file a current utilization review report with the New York State Insurance Department in accordance with Section 4704(a)(8) and Article 49 of the New York Insurance Law or, in the alternative, register as a utilization review agent with the New York Department of Health.

Section 4903(e) of the New York Insurance Law states:

> "Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
> (1) the reasons for the determination including the clinical rationale, if any;
> (2) instructions on how to initiate standard and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and
> (3) notice of the availability, upon request of the insured, or the insured'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 Plan did not fully comply with Section 4903(e) of the New York Insurance Law in that the Plan's prospective and concurrent review denial notices of first adverse determination did not contain instructions on how to initiate standard and expedited appeals pursuant to Section 4904 and an external appeal pursuant to Section 4914 of the New York Insurance Law. A notice of adverse determination should set forth the time, place and manner in which an appeal is initiated, including a description of standard, expedited and external appeals.

It is recommended that the Plan fully comply with Section 4903(e) of the New York Insurance Law and include all required information in its notice of adverse determination when prospective or concurrent utilization review is conducted.

Section 4904(c) of the New York Insurance Law states, in part:

> "…The notice of the appeal determination shall include:..
> (2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health…"

Section 4910(b) of the New York Insurance Law states, in part:

> "An insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, shall have the right to request an external appeal…"

The examiners review of the Plan notices of final adverse determination revealed that the Plan failed to include mandated information regarding the availability of the external appeals process along with the associated time frames for requesting such an appeal.

It is recommended that the Plan send proper notice of final adverse determination of expedited or standard utilization review appeals in accordance with Sections 4904(c) and 4910(b) of the New York Insurance Law.

The Plan denied claims received from non participating providers and members that were missing medical information which was needed to fully adjudicate these claims. However, the company failed to issue notice of first adverse determination letters to members/providers relative to its retrospective review of claims involving medical necessity as required by section 4903(d) of the New York Insurance Law. Section 4903(d) of the New York Insurance Law does not provide an exception to the utilization review procedure in cases where information to demonstrate medical necessity is not provided. Therefore, the company must make a utilization review determination regardless of whether the medical necessity information is received. The review of the number of notices of first adverse determinations that were not issued in the period from July 1, 2004 to June 30, 2005, yielded a limited number of violations of sections 4903 (d) and (e) of the New York Ins. Law.

In addition, and as a consequence of it 's failure to issue a notice of first adverse determination, the members did not receive their rights relative to full due process of appeals of a first adverse determination and notice of external review.

It is recommended that the Plan issue a notice of first adverse determination to its members for retrospective review of non participating provider/member submitted claims

and also, claims of participating providers in cases where the member is financially liable, when missing medical necessity information is not received.

7. COMPLIANCE WITH PRIOR REPORT ON ORGANIZATION

The examiner reviewed the Plan's compliance with the following recommendation from the prior report on organization. The page numbers refer to the prior report:

ITEM		PAGE NO.
A.	It is recommended that the Plan include all the required data in all future statement filings. The Plan complied with this recommendation.	6

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
I.	It is recommended that the Plan or POMCO, on behalf of the Plan, file a current utilization review report with the New York Insurance Department in accordance with Section 4704(a)(8) and Article 49 of the New York Insurance Law, or, in the alternative, register as a utilization review agent with the New York Department of Health.	23
J.	It is recommended that the Plan fully comply with Section 4903(e) of the New York Insurance Law and include all required information in its notice of adverse determination when prospective or concurrent utilization review is conducted.	24
K.	It is recommended that the Plan send proper notice of final adverse determination of expedited or standard utilization review appeals in accordance with Sections 4904(c) and 4910(b) of the New York Insurance Law.	24
L.	It is recommended that the Plan issue a notice of first adverse determination to its members for retrospective review of non participating provider/member submitted claims and also, claims of par providers in cases where the member is financially liable, when missing medical necessity information is not received.	25

Appointment No. **22470**

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:

Jeffrey Usher

as a proper person to examine into the affairs of the

Jefferson-Lewis et. al. Schools Healthcare 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