REPORT ON EXAMINATION

OF

CDPHP UNIVERSAL BENEFITS, INC.

AS OF

DECEMBER 31, 2004

DATE OF REPORT **JANUARY 29, 2007**

EXAMINER **BRUCE BOROFSKY, CPA, CFE**

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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

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

Date: January 29, 2007

Sir:

Pursuant to the provisions of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22344, dated March 11, 2005 attached hereto, I have made an examination into the condition and affairs of CDPHP Universal Benefits, Inc., a Medical and Hospital Indemnity corporation licensed pursuant to Article 43 of the New York Insurance Law. The following report as of December 31, 2004, is respectfully submitted.

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

Wherever the designations "the Plan" or "UBI" appear herein without qualification, they should be understood to indicate CDPHP Universal Benefits, Inc. Whenever the designations "CDPHP" or "the Parent" appears herein, without qualification, they should be understood to refer to Capital District Physicians' Health Plan, Inc., the parent of UBI.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 2000. This examination covered the four year period from January 1, 2001 through December 31, 2004. 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 December 31, 2004, in accordance with Statutory Accounting Principles, as adopted by the Department, 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 Plan'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 Plan
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 Plan
Accounts and records
Loss experience
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 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. 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 New York Public Health Laws. Significant findings relative to this examination are as follows:

- CDPHP made two loans to its subsidiary CDPHP Universal Benefits, Inc. without the approval of the Superintendent as required by Section 1307(d) of the New York Insurance Law.

- The Plan violated New York Insurance Law §1409(a) by investing more that 10% of its admitted assets in the securities of a single institution.

- The Plan failed to include all required wording within its Explanation of Benefit statements (EOBs) issued with regard to member paid claims and claims from non-participating providers required by Section 3234(b) of the New York Insurance Law. .

- The Plan failed to issue EOBs to members and non-participating providers for certain denial codes in violation of Section 3234(a) of the New York Insurance Law.

- The Plan failed to issue EOBs relative to non-participating provider claims, member claims and claims submitted by participating providers in instances when the Plan's member was financially liable for payment of a portion of the claim in compliance with Department of Labor Regulation, Part 2560. The above instances occurred when a claim was denied in a request for missing information and that information was never received.

- The Plan failed to issue a notice of first adverse determination relative to instances of concurrent reviews in violation of Section 4903(c) of the New York Insurance Law.

- It is the Plan's policy to resolve any dispute with participating providers according to the dispute resolution language in the participating provider contract. As a result, claims where there was no member liability and that were denied retrospectively as not medically necessary had no notice of the first adverse determination issued to the participating provider in violation of Sections 4903(d), 4903(e) and 4904(a) of the New York Insurance Law.

- The Plan did not comply with Section 4903(e)(3) of the New York Insurance Law relative to wording included within its acknowledgement letters of an appeal of first adverse determination.

- In those cases where UBI had denied claims received from non-participating providers and members for missing medical information, the Plan failed to comply with Sections 4903(d) and 4903(e) of the New York Insurance Law by failing to issue a notice of first adverse determination to its members/providers relative to a retrospective review of claims when such claims involved medical necessity.

- The Plan failed to comply with Section 2108(a)(1) of the New York Insurance Law by utilizing an unlicensed claims adjuster to negotiate discounts for medical bills from non-participating providers.

- The Plan violated New York Insurance Department Regulation 34 (11 NYCRR 215.3(a)(1-3)) as some of its media and communications did not clearly specify which entity, UBI or CDPHP, was providing the coverage for the specific product(s) being offered.

3. DESCRIPTION OF THE PLAN

The Plan was formed on January 2, 1997 and incorporated on February 28, 1997 pursuant to Section 402 of the New York State Not For-Profit Corporation Law. It was then licensed on August 14, 1997 pursuant to Article 43 of the New York Insurance Law for the purpose of providing indemnity based, prepaid comprehensive health care service through arrangements with physicians, hospitals, and other providers.

The Plan is a type D Corporation, as defined in Section 201 of the Not-for-Profit Corporation Law. The sole member of the Plan is the Capital District Physicians' Health Plan, Inc.; a not-for-profit corporation operating as a health maintenance organization (HMO), pursuant to Article 44 of the New York Public Health Law.

UBI was capitalized by means of a $1,250,000 loan from its parent and sole member, CDPHP. Further details regarding the financing of UBI are contained within the Holding Company section of this report.

A. Management and controls

Pursuant to the Plan's by-laws, management of the Plan is vested in a board of directors consisting of not less than thirteen nor more than nineteen members, the exact number to be determined by the sole member of the Plan. As of the examination date, the board of directors was comprised of thirteen members. The composition of the board was in compliance with Section 4301 of the New York Insurance Law.

Pursuant to the Plan's by-laws, the board of directors meetings shall be held at least quarterly, in addition to its annual meeting.

The directors of the Plan as of December 31, 2004 were as follows:

Name and Residence	Principal Business Affiliation
Provider Representatives:	
John D. Bennett, M.D.	Chairman of the Board, UBI

Menands, New York	Cardiologist, Albany Associates in Cardiology
Peter T. Burkart, M.D. Averill Park, New York	Hematologist, Capital District Hematology/Oncology
William M. Notis, M.D. Delmar, New York	Gastroenterologist, Albany Gastroenterology Consultants
Subscriber Representatives:	
Sheree Britten Albany, New York	Benefits Administrator, State Employee Federal Credit Union
Thomas J. Kane Glenmont, New York	Principal, St. Thomas School
Suellen Mallette Duanesburg, New York	Manager, Intermagnetics General Corporation
Jorge L. Valero Niskayuna, New York	Business Manager, McNamee, Lochner, Titus & Williams, P.C
General Public Representatives:	
James Michael Brennan Slingerlands, New York	President, Albany Truck Sales
M. Bruce Cohen Albany, New York	Retired
Daniel Frasca Valatie, New York	Executive Director, Finance and Administration, New York State United Teachers
Stephen C. Simmons Albany, New York	President, Simmons Computing Service, Inc.
Employee/Officer:	
William J. Cromie, M.D. Albany, New York	President and CEO, CDPHP Universal Benefits, Inc
Stephen R. Sloan, Esq. Albany, New York	Executive VP and Chief Counsel of both Capital District Physicians' Health Plan, Inc. and CDPHP universal Benefits. Inc.

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.

The principal officers of the Plan, as of December 31, 2004, were as follows:

Name	Title
John D. Bennett, M.D.	Chairman of the Board of Directors
William J. Cromie, M.D.	President and Chief Executive Officer
Stephen R. Sloan, Esq	Executive Vice President and Chief Counsel
M. Bruce Cohen	Treasurer
Stephen C. Simmons	Secretary

B. Territory and plan of operation

The Plan is licensed to do business as a not-for-profit health service corporation within the State of New York pursuant to Article 43 of the New York Insurance Law. The Plan started operations on January 1, 1998.

Members are able to select from various lines of business including a Preferred Provider Organization (PPO), an Exclusive Provider Organization (EPO) and a Point of Service Plan (POS). Subsequent to the examination, the Plan also began offering a high deductible PPO. Dependent upon the limitations within each contract, members are permitted to see providers participating in the Plan's network, or providers outside of the network. In some cases, a co-pay, co-insurance or deductible may apply.

The Plan pays hospital charges through direct hospital billing. Out-of-area emergency care benefits are also provided within the subscriber contracts.

The Plan's member enrollment as of December 31 for the years under examination was as follows:

	2001	2002	2003	2004
Members	1,379	1,698	1,883	3,846
% change	(40.2%)	+23.1%	+10.9%	+204.2%

At the end of calendar year 2005, the membership for UBI increased to 27,516, a 715% increase over calendar year 2004. A significant reason for this increase, and that of the prior years, is member migration from the Parent's HMO line of business coverages to UBI's various indemnity plans.

The Plan does business through the use of an internal sales force as well as through the utilization of independent agents and brokers.

C. Reinsurance

The Plan entered into the following two excess risk reinsurance agreements in order to limit its exposure to losses from catastrophic inpatient claims. At December 31, 2004, these reinsurance agreements were as follows:

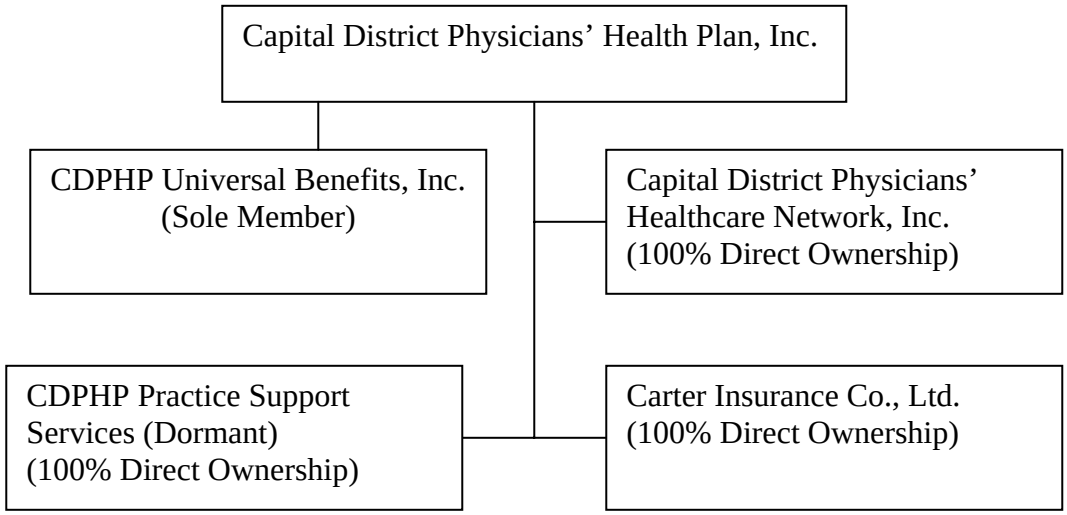
(i) Excess of loss reinsurance agreement with Carter Insurance Company, LTD (Carter), a 100% wholly owned subsidiary of Capital District Physicians' Health Plan, Inc. (CDPHP). Carter, which is not licensed as a reinsurer in the State of New York, was organized for the purpose of providing reinsurance services for the Plan and began operations January 1, 2004. Carter reimburses the Plan for 85% of inpatient hospital services in excess of a $175,000 deductible up to the limit of $350,000 per member.

(ii) A second layer excess of loss reinsurance agreement with Employers Reinsurance Corporation (ERC), an unrelated accredited reinsurance carrier. With certain exclusions and limitations, ERC reimburses the Plan for 85% of certain hospital services in excess of a $350,000 deductible up to a limit of $2,000,000 per member per lifetime.

Both reinsurance agreements contain the insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

D. Holding company system

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



Capital District Physicians' Health Plan, Inc.

The Parent was formed on February 27, 1984 under Section 402 of the Not–For-Profit Corporation Law and 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.

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

The Plan reimburses its parent on a monthly basis based on actual costs incurred. The Plan's premiums are collected by CDPHP and subsequently disbursed to UBI on a

monthly basis. As of December 31, 2004, the Plan had a net payable to CDPHP in the amount of $206,672.

Section 1307(d) of the New York Insurance Law states the following:

> "No …insurance company …shall directly or indirectly make any agreement for any advance or borrowing pursuant to this section unless such agreement is in writing and shall have been approved by the superintendent…"

UBI was capitalized by means of a $1,250,000 loan from its parent and sole member, CDPHP in November 1997. This transfer was one-half of a $2,500,000 Section 1307 loan that had been approved by the Superintendent in 1997. The remaining 1997 approved amount was not transferred at that time. On May 1, 2004, $1,250,000 was transferred from the Parent to UBI. While the Parent described this May 1, 2004 transfer as the second half of the originally approved amount, the Department's 1997 approval cannot be considered open-ended. When the Parent did not avail itself of the 1997 approval in full within a reasonable time thereafter, the approval for the un-remitted portion became null and void. As a result, the May 1, 2004 transfer is considered to be without the approval of the Superintendent and thus in violation of Section 1307(d) of the New York Insurance Law.

An additional transfer of $1,500,000 was made on December 30, 2004. Though considered by the Parent to be a loan, this transfer was also not approved by the Superintendent and, as a result, it is also in violation of Section 1307(d) of the New York Insurance Law.

It is recommended that the Plan comply with Section 1307(d) of the New York Insurance Law and obtain Superintendent approval for the two loans it received from its parent, CDPHP, during 2004. It is further recommended that the Plan desist from entering into further such loans until Superintendent approval has been obtained.

On January 5, 2005, the board of directors of CDPHP approved a motion to provide the Plan with an additional $6,000,000 in Section 1307 loans. Of this amount, the Department approved $4,500,000, which was distributed to UBI as follows:

Date	Amount
February 28, 2005	$2,000,000
March 25, 2005	$1,000,000
April 13, 2005	$1,500,000

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

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

CDPHP Practice Support Services (PSS)

PSS was incorporated on May 9, 1994 and 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.

Carter Insurance Company, LTD (Carter)

Carter, an unauthorized reinsurer, was incorporated November 2003 in Bermuda as a for-profit corporation and began operations on January 1, 2004. CDPHP made a capital contribution of $1,000,000 in this subsidiary during November 2003 and received in return 120,000 shares of stock, 100% of common stock issued.

As a member of a holding company system, the Plan is required to file registration statement IR pursuant to Article 15 of the New York Insurance Law and New York Insurance Regulation 115 (11 NYCRR 81-2.4). All pertinent filings made during the examination period, regarding the aforementioned statute and regulation, were reviewed and no problem areas were encountered.

E. Significant operating ratios

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

	Amount	Ratio
Medical expenses	11,244,795	85.2%
Claim adjustment expenses	1,300,265	9.9%
Administrative expenses	2,172,616	16.4%
Net underwriting gain/(loss)	(1,524,051)	(11.5%)
Premiums earned	13,193,625	100.0%

In addition, the Plan had the following ratios, which, during 2004, the year under examination, were above the benchmarks established by the National Association of Insurance Commissioners:

	2004	2005
Administrative Expense Ratio	17.6 %	8.3%
Profit Margin Ratio	-6.7 %	-.4%
Net Change in Capital & Surplus	-435.3%	-21.6%

These results reflected the movement of members from the lines of business offered by the Parent to the lines of business offered by the Plan. As noted in the above schedule, the ratios improved during 2005.

F. Investment Activities

The Plan's investments are managed by the Parent through the Parent's relationship with independent managers and advisors. This arrangement is formalized through an inter-company management agreement which stipulates that the Parent will provide "financial services" as required by the subsidiary. Such wording does not sufficiently include the provision of investment services and, as a result, it is recommended that the Plan establish independent contractual arrangements with its investment managers and advisors.

All investments are approved by the Board of Directors.

Section 1409(a) of the New York Insurance Law states:

> "Except as more specifically provided in this chapter, no domestic insurer shall have more than ten percent of its admitted assets as shown by its last statement on file with the Superintendent invested in, or loaned upon, the securities (including for this purpose certificates of deposit, partnership interests and other equity interests) of any one institution."

UBI was not in compliance with this restriction as it had more than 10% of its admitted assets invested in the securities of Victory Gradison Money Market Fund.

It is recommended that the Plan comply with Section 1409(a) of the New York Insurance Law and not invest more that 10% of its admitted assets in the securities of any one institution.

The Plan maintains a custodial agreement with Key Trust Company. That agreement complies with all recommended controls and safeguards.

G. Provider/TPA arrangements

The Plan maintains four Third Party Administration agreements with the following entities:

1. Labcorp: Labcorp provides laboratory services to the Plan's providers and is compensated on both a capitated basis and a fee-for-service basis, dependent on the location of the provider.
2. St. Peter's Addiction Recovery Center (SPARC): SPARC provides alcohol and substance abuse treatment services to Plan members on a capitated basis. SPARC also receives compensation for administrative services.
3. Value Options: This Independent Practice Association (IPA) provides psychological, psychiatric social services and other mental health services to Plan members on a capitated basis.
4. CaremarkPCS LP: This entity provides a network of pharmacies to the Plan for use by the Plan's members. CaremarkPCS is reimbursed for the cost of the drug dispensed on a prescription basis. CaremarkPCS also provides the Plan with rebates based on the contractual agreement.

H. Accounts and records

The Plan maintains administrative service agreements with its Parent whereby various services are provided to the subsidiaries by the Plan. These services include but are 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.

As established by the administrative service agreements, premiums for the subsidiaries are collected by CDPHP and disbursed to the subsidiaries on a monthly basis. The agreements also establish the requirement that the Plan be reimbursed monthly for actual costs incurred.

The Plan does not allocate any expenses to investments in its Annual Statement Underwriting and Expense Exhibit, Part 3, Analysis of Expenses, other than those fees paid specifically to investment consultants/managers/brokers/custodians. This is contrary to SSAP No. 70, Allocation of Expenses, which states the following:

> "Investment expenses - Expenses incurred in the investing of funds and pursuit of investment income. Such expenses, include those specifically identifiable and allocated costs related to activities such as ... support personnel, postage and supplies, office overhead, management and executive duties and all other functions reasonable associated with the investment of funds."

It is recommended that the Plan comply with SSAP No. 70 and properly allocate investment expenses within its Annual Statement, Underwriting and Expense Exhibit, Part 3, Analysis of Expenses.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as regards policyholders as determined by this examination as of December 31, 2000. This statement is the same as the balance sheet filed by the Plan.

Assets	Assets	Nonadmitted Assets	Net admitted Assets
Cash	$ 3,643,331	$	$ 3,643,331
Investment income due and accrued	610		610
Uncollected premiums	54,723		54,723
Health care receivables	85,310		85,310
Prepaid assets	133,815	133,815	
Total assets	$ 3,783,974	$ 133,815	$ 3,783,974

Liabilities	Covered	Uncovered	Total
Claims unpaid	$ 1,243,191		$ 1,243,191
Unpaid claims adjustment expenses	26,405		26,405
Premiums received in advance	13,174		13,174
General expenses due and unpaid	61,985		61,985
Amounts due to parent, subsidiary and affiliates	206,672		206,672
Total liabilities	$ 1,551,427		$ 1,551,427
Surplus notes			$ 4,000,000
NYS contingent reserve			165,248
Unassigned funds (surplus)			(1,932,701)
Total capital and surplus			$ 2,232,547
Total liabilities, capital and surplus			$ 3,783,974

Note 1: No liability appears in the above balance sheet for loans totaling $4,000,000 and interest accrued thereon in the amount $698,248. The loans were granted pursuant to the provision of Section 1307 of the New York Insurance Law. As provided in such section, repayment of principal and interest shall only be made out of free and divisible surplus, subject to the prior approval of the Superintendent of Insurance of the State of New York.

Note 2: The Internal Revenue Service did not audit the tax returns filed by the Plan since its inception. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to such contingency.

B. Statement of revenue and expenses:

Capital and surplus increased by $1,222,170 during the four year period under examination, January 1, 2001 through December 31, 2004, detailed as follows:

Net Premium Income		$ 13,193,625
Hospital and Medical:		
Hospital/medical benefits	$ 5,786,810	
Prescription drugs	2,248,761	
Outpatient	1,705,707	
Lab and X-ray	901,915	
Other write-ins	164,020	
Incentive pool, withhold adjustments and bonus amounts	382,426	
Subtotal	$ 11,189,639	
Net reinsurance recoveries	(55,156)	
Total hospital and medical		11,244,795
Claims adjustment expenses	1,300,265	
General administrative expenses	2,172,616	
Total underwriting deductions		3,472,881
Net underwriting gain/(loss)		(1,524,051)
Net investment income earned	96,119	
Net realized capital gains/(losses)	(251)	
Net investment income	95,868	
Net income (loss) before income taxes	(1,428,183)	
Federal income taxes incurred	(106,499)	
Net income (loss)		$(1,534,682)

C. Capital and surplus account

Capital and surplus as of December 31, 2000			$ 1,010,377
	Gains	Losses	
Net Income	$	$ 1,534,682	
Change in non-admitted assets	6,852		
Change in surplus notes	2,750,000		
Net change in surplus			1,222,170
Capital and surplus per examination as of December 31, 2004			$ 2,232,547

5. CLAIMS UNPAID

The examination liability of $1,243,191 is the same as the amount reported by the Plan as of December 31, 2004.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and utilized statistical information contained in the Plan's internal records and in its filed annual and quarterly statements, as well as additional information provided by the Plan.

6. MARKET CONDUCT

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

Claims processing
Prompt pay compliance
Explanation of benefit statements
Utilization review
Complaints and grievances
Underwriting and rating
Agents and brokers
Third party payment negotiator
Advertising

A. Claim Processing

This review was performed by using a statistical sampling methodology covering the examination period in order to evaluate the overall accuracy and compliance environment of CDPHP's claims processing. In order to achieve the goals of this review, claims were divided into hospital and medical claims segments and a random statistical sample was drawn from each group. It should be noted that for the purpose of this examination, those medical costs characterized as Medicare were excluded.

This statistical random sampling process, which was performed using the computer software program ACL, was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample.

The sample size for each of the populations described herein was comprised of 167 randomly selected claims. Additional random samples were also generated as "replacement items" when it was determined that particular claims within the sample should not be tested (i.e., Medicare claims that were inadvertently included). Accordingly, various replacement items were appropriately utilized. In total, 334 claims for the scope period were selected for review.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a "claim," which is defined by the Plan as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It is possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into

one line, which is the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by CDPHP for the period January 1, 2004 through December 31, 2004.

The examination review revealed that overall claims processing accuracy rates were 94.61% for medical claims and 94.01% for hospital claims. Overall claims processing financial accuracy levels were 98.8% for medical claims and 97.6% for hospital claims.

However, if the EOB errors were not taken into consideration, the Plan's overall claims processing accuracy rates would have been 97.6% for medical claims and 97.0% for hospital claims. Also, overall claims processing financial accuracy rates would have been 98.8% for medical claims and 97.6% for hospital claims. This is consistent with the Plan reported overall accuracy standard being at or above 98%.

Procedural accuracy is defined as the percentage of times a claim was processed in accordance with UBI's claim processing guidelines and/or Department regulations. A claim determined by the Plan to be in error and corrected by the Plan at a later date would still be found to be an error for the purposes of this review. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. An error in processing accuracy may or may not affect the financial accuracy.

B. Explanation of Benefit Statements

A detailed review of claims procedures was made during the previous examination that covered the period from January 1, 1996 to December 31, 2000. The prior Report on Examination findings included among other violations, that UBI violated Sections 3234(a) and (b) of the New York Insurance Law because it failed to send to its subscribers proper EOBs that include 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.

A follow up review performed during this examination revealed multiple violations exited relative to EOBs for the years 2004 through present.

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…"

Section 3234(c) of the New York Insurance Law creates an exception to the requirements for the issuance of an EOB established in Section 3234(a) of the New York Insurance Law 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 directly to the participating facility or provider."

Section 3234(b) of the New York Insurance Law 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 whey a request for clarification has been made".

The review revealed the following:

1. Explanation of Benefits (EOB) issued to subscribers by UBI during the major portion of year 2004 for fully/partially paid claims to members and non-participating providers, failed to contain all the language required by Section 3234(b) of the New York Insurance Law (including the appeal language). Such EOBs as presented to the examiners during the review, were issued in the form of payment vouchers/explanation of payment (EOP). Subscribers were neither properly informed of their appeal rights nor were they advised how their claims were processed. However, it should be noted that in the last quarter of 2004, UBI started to issue a proper form of EOB that contained all the language required by Section 3234(b) of the New York Insurance Law.

It is recommended that UBI issue EOB forms that contain all of the requisite information required by Section 3234(b) of the New York Insurance Law for claims involving payments to members and non-participating providers.

2. UBI's current procedures failed to include all situations that require UBI to issue EOBs. The following are three examples:
   a. UBI denied many participating provider's claims because of the providers' failure to submit original and/or adjusted claims in a timely manner in accordance with the time tables of their participating provider agreement with UBI.
   b. UBI denied many provider and member claims under Explanation-Codes that UBI considered as missing information, therefore, no EOBs were required, while in fact there was no missing information and claims were properly denied for good reasons, yet no EOBs were issued.
   c. UBI failed to issue EOBs to subscribers when claims submitted by providers and members were fully or partially denied as medically unnecessary under the following Explanation-Codes:

CK	Medically unnecessary days–don't bill member.
UI	Deny result of Utilization management decision.
UJ	Deny as result of Utilization management policy-don't bill member.
UK	Deny follow-up days-don't bill patient.
UM	Assistant surgeon not allowed-don't bill patient.
VB	Deny authorization request determined to be investigative/ experimental.
ZH	Deny contract exclusion
ZL	Deny for non-medical reasons

It is recommended that UBI issue EOBs in all situations that require UBI to issue an EOB. EOBs should include all of the requisite information required by Section 3234(b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

3. UBI's policy is to deny claims for missing information but does consider such claims not completely adjudicated until missing information is received. Therefore, no EOBs are issued to subscribers in such cases.

EOP forms are used to request missing information from providers and members; however, because no follow up procedures were instituted, claims and lines of service received in 2004 were noted as not being fully adjudicated as of the examination date.

It is recommended UBI issue an EOB for denied claims of non-participating providers and members relative to requests for missing information and change its policy by completing the adjudication process in a date certain in accordance with the requirement of Department of Labor (DOL), Part 2560 for non-participating provider/member claims.

4. UBI utilizes pre-established explanation of payment forms (EOPs) to pay, deny and also request missing information from providers and members. A review of UBI usage of EOP forms revealed the following:

a. The explanation in certain instances did not sufficiently explain the cause for denial. Examples of such insufficient explanations included following::
   - The claims do not contain sufficient information to allow processing.
   - The information that has been provided appears to be incorrect or inaccurate.

b. The EOPs reviewed, in certain cases, did not clearly indicate what information needs to be submitted in order to permit payment of the claim.

c. Although providers are familiar with EOP forms , it is not appropriate to use the form for requesting missing information from members, because the form lacks sufficient and clear message of what missing information is needed to complete the claim adjudication process.

d. The EOP forms frequently do not clearly indicate that there is no member liability for certain claims.

It is recommended that UBI review all of its explanation codes and ensure that the text utilized on the EOP and EOB forms for denials or requesting missing information clearly indicates the reason for denial and what information is missing. In addition, EOP forms should indicate the subscriber's additional claim payment liability.

Also, it is recommended that UBI cease using EOP forms to request missing information from its members.

5. It was noted during the review that UBI, in certain instances, requested the member to provide proof of his/her payment to the providers before completing its adjudication of the claim.

It is recommended that UBI cease the practice of requesting its members provide proof of payment during its adjudication of claims.

C. Utilization review

Article 49 of the New York Insurance Law sets forth the minimum utilization review program requirements including standards for: registration of utilization review

agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. The aforementioned Article establishes the enrollee's right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an enrollee's health care provider shall have the right to request standard appeal and an external appeal.

An examination review was made of UBI's utilization review files and denied claims under medically unnecessary, experimental or investigational for year 2004.

The review revealed the following:

1. Concurrent review:

Section 4903(c) of the New York State Insurance Law states in part;

> "A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date."

UBI did not comply with Sections 4903(c) of the New York State Insurance Law in that there were instances of concurrent reviews where UBI decided not to pay the provider for medical services to its members because such services were no longer medically necessary, but where UBI failed to issue a notice of first adverse determination to its members. UBI's policy is to issue denial letters of such coverage to the participating providers in accordance with dispute resolution language of their contracts. Thereafter, the providers submitted claims were denied retrospectively under Explanation-code CK (Medically unnecessary days–don't bill member).

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

It is recommended that UBI comply with Section 4903(c) of the New York State Insurance Law and issue a notice of the first adverse determination to its subscribers when UBI decides not to pay for medical services based on a concurrent review because medical services are no longer considered medically necessary.

2. Retrospective review:

Section 4903(d) of the New York State Insurance Law 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(e) of the New York State 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."

Section 4904(a) of the New York State Insurance Law states:

> "An insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, may appeal an adverse determination rendered by utilization review agent."

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

> "…The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal…."

A review of retrospective claims utilization review conducted in 2004 revealed the following:

a). UBI notification form of the first adverse determination was not in compliance with the requirement of Section 4903(e)(3) of the New York Insurance Law because the notice stated that "…We will notify you within five (5) days from the date your appeal was received if we require additional information to decide your appeal…", while Section 4903.5(e)(3) require UBI to "…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."

It is recommended that UBI revise its notice of first adverse determination to its subscribers/providers, when claims are denied retrospectively for medical reasons to fully comply with the requirement of Section 4903(e)(3) of the New York Insurance Law.

b.). UBI's policy is to treat any dispute with its participating providers as a contractual issue to be resolved based on the dispute resolution language in their contracts. Therefore, an undetermined number of participating provider claims were denied retrospectively in 2004 because the services rendered did not qualify as medically necessary and no notice of the first adverse determination was issued to the member/participating provider as required by Section, 4903(e) of New York Insurance Law. However, notices of the first adverse determination were issued to the member only when such members were financially liable for additional payment.

UBI failed to issue a notice of first adverse determination to enrollees when claims submitted by providers and members were fully or partially denied under medically unnecessary under the following Explanation-Codes:

U4	Deny authorization request determined to be not medically necessary.
UI	Deny result of Utilization management decision.
UK	Deny follow-up days-don't bill patient.

UL	Visit not covered-surgery day.
UJ	Deny as result of Utilization management policy-don't bill member.

It is recommended that UBI comply with Section 4903(e) of the New York Insurance Law and issue a notice of the first adverse determination letter to members and participating providers, when claims are denied retrospectively for medical reasons.

c.) UBI's practice with regard to its acknowledgement letter of an appeal of first adverse determination was noted to indicate to the members and providers that UBI would notify such member or provider within 5 days from the date such appeal was received if any additional information was required to decide the appeal.

The review indicated that in 2004, UBI's acknowledgement letters of first adverse determination appeals by providers and members violated Sections 4903(e) and 4904(c) of the New York Insurance Law.

It is recommended that UBI comply with Sections 4903(e) and 4904(c) of the New York Insurance Law and cease the practice of requesting additional medical information in the acknowledgement letter of an appeal of medical adverse determination from its providers/members.

D. Third party claim negotiator

The Plan utilizes a third party, Medcal, Inc. ("Medcal"), to negotiate discounts with non-participating providers for medical bills from non-participating providers.

Medcal provides these discounts to UBI through two processes; its own independent network of hospitals and doctors, and negotiation with non-participating providers. In return, Medcal receives 20% of the monies that are saved by the Plan.

Roughly 30% of the claims for which Medcal is compensated are discounts negotiated outside the Medcal network.

Medcal negotiates with non-participating providers through the use of a letter that makes an offer of a negotiated payment and promises, in return, to expedite the claim payment. According to Medcal, it establishes its negotiation rate "using "HIIA data by cpt code and our IDB (Integrated Data Base) based on prior procedures by similar percentiles of medical fee schedules." This method of establishing the value of claims establishes Medcal as a claim adjuster under Section 2108(a) of the New York Insurance Law which defines a claim adjuster as follows:

> "Any person, firm, association or corporation who, or which, for money, commission or any other thing of value acts in the state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer…."

It is noted that Medcal does not have a New York license to adjust claims.

Section 2108(a)(1) of the New York Insurance Law states,

"Adjusters shall be licensed as independent adjusters or as public adjusters."

It is recommended that the Plan take steps to ensure that its third party claim negotiator, Medcal, Inc., maintains a New York license to adjust claims in compliance with Section 2108(a)(1) of the New York Insurance Law if it is the intent of the Plan to continue to use the claims adjustment services of Medcal, Inc.

It is noted also that there is no HIPAA compliant Business Associate Agreement between the two entities. This critical document ensures that the Plan's business partners agree to comply with federally required confidentiality laws and reduce the Plan's liability in the event the partner fails to do so.

It is recommended that the Plan establish a HIPAA compliant Business Associate Agreement with its third party claims negotiator, Medcal, Inc.

The text of the letter utilized by Medcal contains the following statement:

> "We have been requested by the payor to negotiate with your office in order that we may reduce the out-of-network costs for the patient and expedite payment to your office."

This statement is misleading for two reasons. First, a review of Medcal negotiated claims reveals that the vast majority of the claims only involved a co-payment on the part of the member. In this circumstance, the member's costs are not being reduced. Second, prior to the negotiation, the Plan's liability is asserted because UBI has already been billed by the provider for the amount the provider charges for the services that were rendered to the UBI member. The negotiation is simply an attempt to reduce that liability.

It is recommended that the Plan preclude its third-party negotiator from using prompt payment of claims as justification for the negotiation of discounted rates. Additionally, the implication that a reduced liability will occur if a negotiated settlement is agreed upon should be stated in the text of the letter only in those cases where an actual savings will occur.

The letter also includes the following:

> "With this in mind, we would propose a [contract type] payment of $._____. In addition, late charges will not be billed."

The statement regarding late charges is unclear as it does not specify what late charges are involved or who will charge them.

It is recommended that the negotiated agreement between the third party negotiator and the provider clearly indicate what charges may be billed and by whom.

Finally, much of the letter is ambiguous as to commitment. Examples are the words noted above "we *would propose* a [contract type] payment of…" and "…the patient *should not* be billed the difference…" (italics added). Additionally, the letter does not clearly indicate that a signature on the letter is an acceptance of the terms of the agreement.

It is recommended that the negotiated agreement between the third party negotiator and the provider clearly spell out the terms of the agreement and indicate the purpose that a signature on the letter serves.

To date, the Plan has not audited the performance of its third-party negotiators. As such, there is no certainty that the program is working according to the Plan's understanding.

It is recommended that the Plan conduct an audit of its third party negotiator, Medcal.

As regards the use of Medcal, the Plan does not maintain a copy of the signed agreements under which the extent of its liability is established. This agreement serves to document the disposition of the Plan's claims.

The Plan's failure to obtain and retain the negotiated discount agreement is a violation of New York Regulation 152 (11 NYCRR 243.2 (b)), which states:

> **"**(b)Except as otherwise required by law or regulation, an insurer shall maintain…"(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed. …A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.

It is recommended that that the Plan comply with New York Insurance Department Regulation 152 (11 NYCRR 243.2(b)) and maintain a copy of its agreements with the third party negotiator, Medcal, Inc.

The letter used by Medcal in order to negotiate a discount on claims from non-participating providers does not indicate that the claim relates to UBI. Instead, it references only the Parent, CDPHP.

It is recommended that the Plan ensure that the letters used by Medcal clearly indicate for which corporate entity Medcal is negotiating.

E. Rating

Experience rates are constructed by Company underwriters through entry of relevant factors into a computer program. As an internal control over the manual entry of those factors, a fellow underwriter reviews the documentation and according to procedure, initials the documents to indicate such review has taken place. Such review is documented solely by that initialization and does not provide sufficient support that a thorough review was performed or that critical areas of the calculation were examined.

It is recommended that a checklist be utilized with separate check off areas for review of specific critical areas such as the construction of age/sex factors and underwriting discretion.

Review of experience rate construction reveals that one factor, the age/sex ratio, has the ability to increase or decrease the final rate by as much as 8%, if not more. For new groups, it is the group itself that provides the data needed to construct the age/sex ratio. As a result, there is a risk that incorrect data will provide an inaccurate rate. Once the rate is constructed, and the group enrolls, the Company performs no testing to confirm the accuracy of the data that was provided, until the following year when the new rates are calculated.

It is recommended the Company institute procedures to confirm the accuracy of the age/sex data provided by new groups.

In the construction of experience rates, underwriters apply credibility weights to each group's medical history for the two most recent years. As an example, the underwriter may conclude that the group's medical history is consistent and representative and thus, apply a 50/50 weight to each year. However, if the group had an unusual event that is not expected to be repeated, the underwriter may apply a larger or smaller weight to a particular year. Thus, the weight applied to a given year could have a significant effect on the final rate derivation. At the time of the examination, there was no documentation created for the rationale of why a particular weight was used.

It is recommended that Plan's underwriters prepare a short summary for the rationale behind the weight applied to each year in a group's medical history.

F. Contract period – Non-payment of Premium

During the examination period, the Plan maintained a policy wherein they allowed groups to maintain coverage beyond the permitted grace period. In those cases where the groups did not pay overdue premiums, the Plan reversed the claims that had been paid, taking the funds back from the providers.

It is the position of the Department that when the Plan failed to cancel delinquent groups in a timely manner, it was in essence extending a credit to those groups for the premiums involved. In this sense, providers who accepted Plan members were acting in good faith that such coverage was in force. As a result, it is inappropriate for the Plan to pass the financial responsibility for those delinquencies onto the providers.

It is recommended that the Plan refrain from reversing claims for delinquent members when the Plan maintains the coverage beyond the grace period. It is further recommended that the Plan repay providers for those claims it inappropriately reversed and pay prompt pay interest where due.

It is noted that the Plan subsequently discontinued this practice and on December 7, 2005, the Plan repaid the claims which had been reversed under its former policy.

G. Advertising

New York Insurance Department Regulation 34 (11 NYCRR 215.5(a)) states the following:

> "The format and content of an advertisement of an accident and health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive."

Much of the Plan's advertising as well as the Plan's website fail to distinguish how available products are segregated by entity. In other words, various advertisements for the Plan discuss the lines of business that are available (HMO, PPO, EPO and ASO), but they do not clarify that those products are offered by different Plan subsidiaries. As a result, the advertising implies that all lines of business are written under the CDPHP corporate name.

It is recommended that the Plan comply with New York Insurance Department Regulation 34 (11 NYCRR 215.5(a)) by ensuring that all media and communications containing any information about the various products offered by the Plan or any of its subsidiaries clearly specify the product(s) each particular company is offering.

It is noted that the Plan has changed its website to bring it into compliance with New York Insurance Department Regulation 34 (11 NYCRR 215.5(a)).

7. FRAUD PREVENTION AND DETECTION

A review was performed of the organization and structure of Plan's special investigations unit (SIU), and their compliance with Article 4 of the New York Insurance Law, and New York Insurance Department Regulation 95 (11 NYCRR 86). The examination review indicated the Plan's compliance with Article 4 of the New York Insurance Law and New York Insurance Department Regulation No. 95 (11 NYCRR 86).

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

ITEM		PAGE NO.
A.	It is recommended that the Plan apply to the IRS for tax-exempt status in order to benefit from being incorporated as a not-for profit corporation. The Plan has complied with this recommendation.	5
B.	It is recommended that the Plan issue EOBs that include all of the requisite information required by Sections 3234(a) & (b), of the New York Insurance Law. The Plan did not fully comply with this recommendation. A similar recommendation is included under Section 6C of this report.	16

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. ***22344***

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Bruce Borofsky

as a proper person to examine into the affairs of the

CDPHP Universal Benefits, Inc.

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

Company

with such information as he shall deem requisite.

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

this 11 day of *March* *2005*

Howard Mills
Acting Superintendent of Insurance