REPORT ON EXAMINATION

OF

VYTRA HEALTH SERVICES, INC.

AS OF

DECEMBER 31, 2001

DATE OF REPORT	**FEBRUARY 13, 2004**
AMENDED DATE	**NOVEMBER 8, 2004**
EXAMINER	**WAI WONG**

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

November 8, 2004

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with instructions contained in Appointment Number 21871 dated May 15, 2002, annexed hereto, I have made an examination into the financial condition and affairs of Vytra Health Services, Inc. as of December 31, 2001. The financial condition examination was conducted at the Company's home office located at Corporate Center, 395 North Service Road, Melville, New York 11747. The following report is respectfully submitted.

Wherever the terms "the Company", or "VHS" appear herein without qualification, they should be understood to indicate Vytra Health Services, Inc.

1. SCOPE OF EXAMINATION

Vytra Health Services, Inc. was previously examined as of December 31, 1998. The current examination covered the period from January 1, 1999 through December 31, 2001. Transactions occurring subsequent to this period were reviewed where deemed appropriate.

The examination comprised a verification of assets and liabilities as of December 31, 2001, and a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by VHS'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:

A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Company
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Loss experience
Reinsurance
Accounts and records
Market Conduct Review
Treatment of policyholders

A review was also made to determine whether the Company performed any actions regarding the comments and recommendations contained in the prior report on examination.

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

2. DESCRIPTION OF THE COMPANY

Vytra Health Services, Inc. (formerly CCLI Health Services Corporation) is a not-for-profit health service corporation that provides health insurance to indemnify subscribers for the cost of hospital and medical services rendered to them. The Company was incorporated on September 19, 1989 and commenced business October 1, 1995. The Company was licensed under Article 43 of the Insurance Law as a not-for-profit health service corporation. CCLI Health Services Corporation was renamed Vytra Health Services, Inc. effective July 31, 1996.

The Company is a Type B Corporation defined under Section 102(a)(5) of the Not-for-Profit Corporation Law, whose sole member is Vytra Health Plans Long Island, Inc. a not-for-profit corporation operating as a health maintenance organization ("HMO") as defined in Article 44 of the Public Health Law. Initial donated capital consisted of $1,500,000, which was obtained through a Section 1307 loan from the sole member, Vytra Health Plans Long Island, Inc.

In November of 2001 Vytra Health Plans Long Island, Inc. and its subsidiary Vytra Health Services, Inc. were purchased by the Health Insurance Plan of Greater New York ("HIP").

A. Management

The by-laws of the Company provide that its affairs are to be managed by a board of directors consisting of thirteen persons.

At December 31, 2001 the board of directors was comprised of the following thirteen members:

Name and Residence	Principal Business Affiliation
	Subscriber Category
Robert Brokaw Garden City, NY	Retired Formerly Senior Vice President and Director of Human Resources ITT Sheraton Corporation
Donald Cowdell Commack, NY	Principal/Executive VP Klein & Eversoll, Inc.
Arthur Dromerhauser Bay Shore, NY	Executive Director The Long Island Aquarium
Joseph Gergela, III Calverton, NY	Executive Director Long Island Farm Bureau
Bruno Laspina Brentwood, NY	Chief Executive Officer Transitional Services of New York for Long Island
	Provider Category
David Maurice Weiss PH.D Northport, NY	Associate Professor Hostra University
	Public Category
Christina Reimann Smithtown, NY	Member Suffolk County Legislature

Name and Residence	Principal Business Affiliation
	Public Category
Daniel McGowan New York, NY	President & COO Health Insurance Plan of Greater New York
Vera Payne Rivers Hempstead, NY	Retired Cornell University Field Faculty
Robert Pierce Brightwaters, NY	President RLP Management Consultant
Ralph Frederick Ranghelli Hauppauge, NY	Business Manager IBEW Local 1049
	Employee-Officer Category
Anthony Watson New York, N.Y.	Chairman & CEO Health Insurance Plan of Greater New York
Thomas James McAteer, Jr. Melville, NY	President and CEO Vytra Health Plans

During the period under examination, the board of directors held six meetings. Meetings were generally well attended.

§ 4301 (k)(1) of the New York State Insurance Law states in part:

> "The board of directors of each health service, hospital service or medical expense indemnity corporation subject to this article shall be composed of persons who are representatives of the member hospitals or licensed medical professionals of such corporation, persons covered under its contracts and the general public. The board of directors of such corporations may also include persons who are employees of such corporations and who also serve as officers of such corporations. Not more than one-eighth of the directors of any such corporation shall be persons who are employees of such corporation and who also serve as officers of such corporation."

As of December 31, 2001 Daniel McGowan President & COO of the Health Insurance Plan of Greater New York served on the board of Vytra Health Services, Inc. in the public

director category. In the opinion of the Department Daniel McGowan as an officer/employee of VHS's ultimate parent, The Health Insurance Plan of Greater New York cannot adequately represent the public director category on the board.

Daniel McGowan resigned from the board on April 30, 2002 and was replaced in the public director category by Peter Scarlatos.

The principal officers of the Company as of the date of examination were as follows:

Name	Title
Thomas James McAteer, Jr.	President
Michael Fullwood, Esq.	Secretary
Philip Gandolfo	Treasurer

B. Territory and Plan of Operation

The Company provides health coverage for residents of Nassau, Queens and Suffolk counties in the State of New York. The Company offers point-of-service (POS) contracts where the in-network portion of the product is underwritten by Vytra Health Plans Long Island, Inc., an affiliated HMO, and the out-of-network portion is underwritten by VHS. The subscriber can choose to receive in-network benefits from the HMO's network of providers subject to co-payment for most services, or a subscriber can choose to access out-of-network benefits through the POS option. When the subscriber accesses out-of-network benefits through the POS contract, the subscriber is subject to coinsurance and deductibles, and is reimbursed based upon a Usual, Customary and Reasonable ("UCR") fee schedule.

Enrollment

Enrollment is available to both groups and individuals. Enrollment activity during the examination was as follows:

Enrollment and Terminations:	1999	2000	2001
Number of members – beginning of the year	57,929	66,322	65,062
Net Gain (Loss)	8,393	(1,260)	(11,125)
Number of members – end of year	66,322	65,062	53,937

C. Statutory Reserve

A health service corporation subject to Article 43 of the New York Insurance law is required to maintain a statutory reserve fund pursuant to the requirements of New York Insurance Law section 4310(d). Vytra Health Services, Inc. was required to maintain a statutory reserve of $3,585,603 as of December 31, 2001.

D. Reinsurance

The examiner reviewed all reinsurance contracts in effect during 2001 and 2002. The Company has an excess of loss contract with an authorized reinsurer. The retention varies for the Medicare line of business and the commercial line of business. A summary of the reinsurance program is as follows:

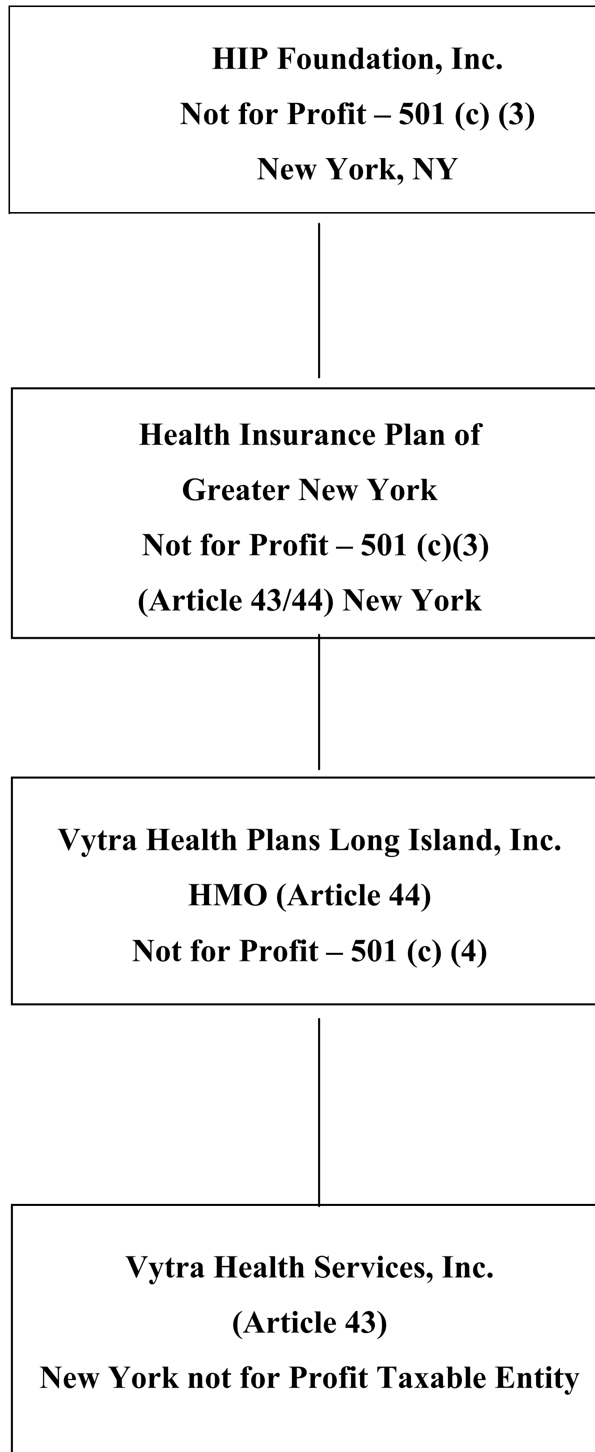
Term of Agreement (Incurral Period)	1/1/01 –12/31/01
Coverage	Inpatient Hospitalization & Transplant
Retention	Commercial PPO, POS - $125,000 of losses or losses incurred by each covered person(s) during the agreement year
Coinsurance	90%
Hospital in-patient services Out-of–Area, Referral and Emergency, in area	90% of eligible hospital expenses incurred by covered persons subject to the following limitation: $2,000 maximum average per day coverage per confinement.
Reporting Period	Within 18 months of beginning of agreement (up to 6/30/02)
Limits of Coverage	$1,000,000 per member per year
Insolvency	$5,000,000 aggregate maximum coverage
Carryover	31 days
Out of Area Conversion Coverage	Yes
Experience Refund	If the contract is renewed: 50% of (75% of premium paid minus claims paid)

The agreement includes continuation of benefits provision within its insolvency protection language. This provision requires that the reinsurer cover VHS members who are confined to an inpatient facility with certain limitations. It also requires prospective continuation of benefits, for up to thirty-one days, for all VHS members who have paid the contract premium.

A review of the reinsurance contract revealed the application of an aggregate limit of liability of $5,000,000 to the insolvency protection afforded under the continuation of coverage provision. Although the Insurance Department does not require the Company to obtain reinsurance coverage, the Department views reinsurance in general, and continuation of benefits provisions in particular, as an additional layer of protection for the Company's members against impairment and insolvency. In VHS's case the potential liability for covering members for up to thirty days beyond insolvency is far in excess of the $5 million limitation included in the reinsurance contract, in effect negating the continuation of coverage provision.

E. Holding Company System

The following chart depicts the relationship of the Company to its parent and affiliated companies as of the examination date:



F. Accounts and Records

In the course of the examination, the examiners reviewed the manner in which accounts were maintained and reported in its filed Annual and Quarterly statements. Deficiencies were noted in the following areas:

- The Company did not list any premiums received in advance on its 2001 annual statement filing. The amount for premiums received in advance as of December 31, 2001 amounted to $306,208 and was improperly included with trade payables in VHS's trial balance. The trade payables sub-account is part of the general expenses due and accrued account on the 2001 annual statement. The Company filed an amended 2001 statement with the Department, which listed premiums received in advance separately.

- The Company's general expenses due and accrued account included a non-admitted HealthCare Receivable amount of $171,274 that was over 90 days past due. This amount represents claim overpayments made by VHS that have not been repaid by providers. The Company's accounts payable aging schedule showed an additional amount of $50,917 on the 90 days past due balance; however, VHS admitted this amount as an accounts payable debit balance. The $50,917 overpayment was made to in network physicians and as such VHS believed the amount was more likely to be recovered despite the age of the receivable by offsetting the amount against any future claim made by the providers. No changes were made to the balance sheet because the amount was insignificant. The Company has stated that they will treat all receivables over 90 days as non-admitted assets in the future.

- The Company failed to list any claims adjustment expenses on its annual statement for the year 2001. It should be noted that VHS engaged the firm of Milliman USA to review its claims unpaid and file its actuarial certification with the Department. As part of the review Milliman USA noted that VHS did not include any explicit provision for the administrative expenses associated with processing unpaid claims. Accordingly, Milliman USA added 3% to VHS's outstanding claim liability for loss adjustment expense based upon its own experience with other health plans. Notwithstanding Milliman's recommendation, VHS did not report such a reserve in its filed annual statement. The Company subsequently filed an amended annual statement for 2001, which separately listed the unpaid claims adjustment expenses.

- The Company failed to reflect the appropriate footnote relating to its Section 1307 loan on its 2001 annual statement filing.

§1307(a) of the New York State Insurance Law states:

> "Any domestic stock, mutual or co-operative insurance company or reciprocal insurer may, without pledging any of its assets, receive advances or borrow funds to: (1) conduct its business, (2) enable it to comply with any surplus requirement or make good any impairment or deficiency or other requirement of this chapter, (3) defray the reasonable expenses of its organization, (4) provide any fund to be voluntarily contributed to surplus, or (5) organize, acquire or invest in any subsidiaries authorized by this chapter."

§1307(c) of the New York State Insurance Law states:

> "Any sum so advanced or borrowed shall not be part of the legal liabilities of such insurer and shall not be a basis of any set-off but until repaid all statements published by such insurer or filed with the superintendent shall show, as a footnote, the amount then remaining unpaid."

It is recommended that VHS include the footnote required by §1307(c) of the New York State Insurance Law in its annual and quarterly filings with the Department.

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, 2001. The examination reclassified certain assets and liabilities; however, there was no change to the total amount of assets and liabilities.

Assets	Assets	Not-Admitted Assets	Net-Admitted Assets	Examination Assets
Cash	$ 6,840,070	$ 0	$ 6,840,070	$ 739,610
Short-term investments	11,839,247		11,839,247	17,939,707
Accident and health premium due and unpaid	412,395		412,395	412,395
Health care receivable	171,274	171,274	0	0
Investment Income due and accrued	170,931		170,931	170,931
Amounts due from parents subsidiaries and affiliates	822,904		822,904	822,904
Deferred Income Tax	833,511	833,511	0	0
Total assets	$ 21,090,332	$ 1,004,785	$ 20,085,547	$ 20,085,547

Liabilities	Annual Statement	Examination
Claims unpaid	$ 14,765,568	$ 14,765,568
Premiums received in advance		306,208
General Expenses Due and Accrued	479,806	173,598
Amounts due to parent, subsidiaries & affiliates	901,059	901,059
Total liabilities	$ 16,146,433	$ 16,146,433
Surplus Notes*	5,500,000	5,500,000
Aggregate write-ins for other than special surplus funds	3,585,603	3,585,603
Unassigned funds (surplus)	(5,146,489)	(5,146,489)
Total capital and surplus	$ 3,939,114	$ 3,939,114
Total liabilities, capital and surplus	$ 20,085,547	$ 20,085,547

*No liability appears for the above loan in the amount of $5,500,000 and accrued interest thereon in the amount of $968,750. The loan was granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, 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. It should be noted that no note in regards to the 1307 loan appears on page 3 of the Company's annual statement.

It is recommended that a notation regarding the Company's outstanding 1307 loan be shown on page 3 of the Company's annual and quarterly statements filed with the Department.

Note: The Internal Revenue Service ("IRS") has not conducted any audits of the Company. Any potential exposure due to income tax assessments that may arise as a result of an IRS audit has not been established herein.

B. Underwriting and Investment Exhibit

Capital and surplus increased by $2,415,633 during the three-year examination period, January 1, 1999 through December 31, 2001, detailed as follows:

Statement of Income

Underwriting Income		
Net premium income		$ 235,465,167
Deductions:		
Claims incurred	$ (210,583,399)	
Administrative expenses	(28,209,305)	
Total underwriting deductions		(238,792,704)
Net underwriting loss		(3,327,537)
Investment Income		
Net investment income earned	1,659,710	
Net realized capital gains	0	
Net investment gain		1,659,710
Aggregate write in for other income or expense		20,645
Net income (loss) before federal income taxes		(1,647,182)
Federal and foreign income taxes incurred		(499,174)
Net income (loss)		$ (1,148,008)

Capital and Surplus Account

	Gains in Surplus	Losses in Surplus	
Capital and surplus per report on Examination as of December 31, 1998			$ 1,523,480
Net loss		$ (1,148,008)	
Aggregate write-ins for gains or (losses) in surplus	$ 568,427		
Change in nonadmitted assets		$ (1,004,785)	
Cumulative effect of changes in accounting principal	$ 4,000,000		
Total gains and losses	$ 4,568,427	$ (2,152,793)	
Change in capital and surplus			$ 2,415,634
Capital and surplus per report on Examination as of December 31, 2001			$ 3,939,114

4. CASH AND SHORT TERM INVESTMENTS

A. Cash

The examination asset of $739,610 is $6,100,460 less than the $6,840,070 reported by the company in its 2001 filed annual statement. The decrease resulted from a reclassification of certain items from cash to short-term investments as follows:

- Investments in commercial paper amounting to $1,100,232 with maturity dates of three months or less were reclassified from cash to short-term investments.
- A money market fund, amounting to $5,000,228, which invests in government obligations, was reclassified from cash to short-term investments.

It is recommended that VHS take steps to ensure that short-term investments are properly reflected as such in its annual statement filings with the Department.

Section 1316 of the New York Abandoned Property Law requires that certain unclaimed insurance proceeds which are unclaimed over three years should be reported to the Office of the State Comptroller of the State of New York by April 1 of each year. Such reports comprise all abandoned property held by the Company at the close of business on January 1 each year.

Section 1315 of the New York Abandoned Property Law requires that certain unclaimed vendor payments, outstanding checks and escrow amounts, or gift certificates which are unclaimed over five years be reported to the Office of the State Comptroller of the State of New York by March 10 of each year. Such reports comprise all abandoned property held by the Company at the close of business on December 31 each year.

During the review, it was noted that VHS was filing abandoned property reports for unclaimed checks issued to providers pursuant to Section 1315 of the Abandoned Property Law. The abandoned property however, consisted of unclaimed checks owed to providers, which make those items insurance proceeds. Accordingly, the Company should have filed its Abandoned Property Reports pursuant to Section 1316 of the Abandoned Property Law, which refers to unclaimed insurance proceeds other than life insurance. This section of the law also requires that the Company publish a listing of all unclaimed checks within thirty days of the filing of the report, which VHS failed to do.

It is recommended that VHS files abandoned property reports according to Section 1316 of the Abandoned Property Law and publish a list of unclaimed checks as required by this section.

B. Short Term Investments

A review of the VHS's investment transactions and the minutes of meetings of its board of directors indicated that investment transactions effected by management were not authorized or approved by the board of directors. Section 1411(a) of the New York Insurance Law states in part:

> "No domestic insurer shall make any loan or investment... 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."

It is recommended that the board of directors authorize and approve the Company's investment transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law and that such transactions be appended to the minutes thereof.

During the examination review of investment activity, the examiner noted that VHS utilized the services of J.P. Morgan Chase and J.P. Morgan Investment Management, Inc. (collectively known as J.P. Morgan Chase) for its investment transactions. It appears that VHS did not maintain custodial accounts for its investments, but instead, used J.P. Morgan Chase's self initiated online banking services for these transactions.

The guidelines set forth in the NAIC Examiners Handbook require that securities held under custodial or safekeeping arrangements by a bank or trust company need not be counted, at the discretion of the examiner-in-charge, if such deposits meet the following requirements:

- Examiners are furnished a copy of the custodial or safekeeping agreements and they are satisfied such agreement have the necessary safeguards and controls;
- The securities are held by a bank or trust company licensed by the United States or any state thereof, and such bank or trust company is regularly examined by the licensing authority;
- The securities so deposited are at all times kept separate and apart from other deposits with the custodian, so that at all times they may be identified as belonging solely to the company for which they are held;
- If such a deposit is not counted, a notarized custodial affidavit and a verification certificate signed by an authorized signatory of the bank or trust company holding the deposit, including sufficient detail to permit adequate identification of the securities, shall be secured by the examiners directly;

The Company did not maintain a custodial agreement with JP Morgan Chase and could not document whether securities held by JP Morgan Chase on its behalf were registered in the name Vytra Health Services, Inc. or held in “street name”. In addition, J.P. Morgan Chase did not provide the examiners with the requisite affidavit and a verification certificate in accordance with the Insurance Department’s guidelines.

The CPA workpapers for VHS’s short-term investments were reviewed and based upon the findings contained therein it was determined that reliance could be placed upon the workpapers for verification of VHS’s assets. In addition the monthly bank statements from J.P. Morgan Chase were analyzed and tested to ensure the accuracy of the account.

In September of 2002 VHS moved its long-term investments into Deutsche Bank Trust Company Americas and entered into a custodial agreement with the bank. However all short-term investments remains with J.P. Morgan Chase and their remains no custodial agreement for these assets.

It is recommended that VHS instruct such bank or trust company with which it executes any custodial or safekeeping agreements to provide the Insurance Department examiners with the requisite affidavit(s) and verification certificate(s) of investments held under custodial or safekeeping arrangements in accordance with the Department's guidelines.

The examination review also determined that VHS failed to complete Schedule D of its filed Annual Statements in accordance with the annual statement instructions of the National Association of Insurance Commissioners (NAIC), and in accordance with the provisions of Section 308(b) of the New York Insurance Law. Section 308(b) of the New York Insurance Law states in part that:

> "…The superintendent may also require the filing of quarterly or other statements, which shall be in such form and shall contain such matters as the superintendent shall prescribe."

The Company's failure to complete Schedule D hindered the Department's analysis of the statutory admissibility of its investments. Technically, any of VHS's investments that did not satisfy the quality standard of the NAIC's Securities Valuation Office could have been not admitted to the extent that the investment was overvalued.

The Company has agreed to complete Schedule D of its filed Annual Statements in accordance with the annual statement instructions of the National Association of Insurance Commissioners.

5. CLAIMS UNPAID

The examination liability of $14,692,000 is the same as the $14,692,000 reported by VHS in the filed annual statement as of December 31, 2001. The examination liability was determined through a review of a six-month claim runoff and financial statements and supplements through September 30, 2002.

6. AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

Vytra Health Services, Inc. had two inter-company accounts with Vytra Health Plans Long Island, Inc during 2001. One account was for its standard point of service business and the other for the solutions point of service business. The solutions contract provides Vytra Health Plan members the option of seeing any provider within Vytra's network without a referral from their primary care physician. Vytra Health Plans Long Island, Inc. is responsible for the administration of the point of service programs including billing and collecting premiums on behalf of VHS, designing and maintaining the claims processing system and providing assistance to VHS in the preparation of and provision of statistical and other informational reports.

Vytra Health Services, Inc. pays Vytra Health Plans Long Island, Inc. an administrative fee of 2.8% of the monthly premium for the standard point of service product. For the solutions product Vytra Health Services, Inc. pays Vytra Health Plans Long Island, Inc an administrative fee of 13% of the monthly premium.

§ 1505 (d)(3) of the New York State Insurance Law states:

> "The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period:"
>
> "rendering of services on a regular or systematic basis; or"

The Company was unable to produce any inter-company agreements between Vytra Health Services, Inc. and Vytra Health Plans Long Island, Inc for the 2.8% fee paid on the point of service product. There was an inter-company agreement for the solutions contract between Vytra Health Services, Inc. and Vytra Health Plans Long Island, Inc. dated as of April 10, 1995, but the contract was effective for only five years and expired in the year 2000.

It is recommended that VHS develop and file with the Department inter-company agreements for its Point of Service and solutions products in accordance with § 1505 (b) of the New York State Insurance Law.

MARKET CONDUCT EXAMINATION

As part of the Department's examination of Vytra Health Services, Inc., a review of the manner in which VHS conducts its business practices and fulfills its contractual obligations to policyholders and claimants has been performed. This review contains significant findings and covers transactions occurring through December 31, 2001.

The purpose of this review is to assist VHS in addressing problems that are of such a nature that corrective action is required. Accordingly, this report is confined to comments on those matters that involves departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A. Grievances and Appeals

The examiners reviewed a sample of seven grievance cases and the corresponding contracts for compliance with Article 48 of the New York State Insurance Law. Two of the seven grievance cases went to a second level appeal. The second level appeal for these two cases were also reviewed.

It was noted that the Company did not provide a specific reason for its appeals decision on the determination notices on both of the appeal files reviewed. The appeal notice only states that the original determination was upheld. It is Vytra's position that the appeal notices in conjunction with the original grievance letter satisfied the requirements of the Insurance Law. Notwithstanding the foregoing, Vytra has revised its appeal letters to include the specific reasons for the determination.

B. Underwriting and Rating

A review of VHS's experience rating practices and policies was performed to determine compliance with Section 4308(b) of the Insurance Law and Department Regulation 62 {11 NYCRR 52}.

The Department's Circular Letter #26 of 2000 specifically states that such a formula shall be in keeping with the provisions of Insurance Law Section 4308 (b), 10 NYCRR Part 98.5 and 11 NYCRR Part 52.40; and must be filed by the HMO and approved by the Superintendent pursuant to Section 4308(b) and Part 98.5.

§ 4308 (b) of the New York State Insurance Law states:

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof. The superintendent may refuse such approval if he finds that such premiums, or the premiums derived from the rating formula, are excessive, inadequate or unfairly discriminatory, provided, however, the superintendent may also consider the financial condition of such corporation in approving or disapproving any premium or rating formula. Any premium or formula approved by the superintendent shall make provision for such increase as may be necessary to meet the requirements of a plan approved by the superintendent in the manner prescribed in section four thousand three hundred ten of this article for restoration of the statutory reserve fund required by such section. Notwithstanding any other provision of law, the superintendent, as part of the rate increase approval process, may defer, reduce or reject a rate increase if, in the judgment of the superintendent, the salary increases for senior level management executives employed at corporations subject to the provisions of this article are excessive or unwarranted given the financial condition or overall performance of such corporation. The superintendent is authorized to promulgate rules and regulations which the superintendent deems necessary to carry out such deferral, reduction or rejection."

VHS initially submitted an experience-rating formula for an HMO / POS product to the Department on May 22, 2001. Premiums and claims for this product are shared between VHS and its immediate Parent Vytra Health Plans, Long Island, Inc., an HMO. The Department requested some modifications, and a final submission was made on September 27, 2001. On

October 17, 2001, the Department formally approved VHS's formula subject to the following conditions that were specifically stated in the approval letter:

> (a) All rules and factors used shall be based on the experience rating formula on file with the Department; and
>
> (b) Any change or revision in the procedure and/or factors of the experience rating formula shall be submitted to the Department for its review and approval, before any such changes or revisions are put in effect.

Notwithstanding the conditions set forth in the aforementioned approval, it was noted that the trend factors used in the calculation of the rates did not correspond to those on file with the Department. The Company increased its trend factors three times since their last filing with the Department. The trend factors were increased by 12% in November 2002, 13% in December 2002 and 15% in January 2003.

VHS utilizes an experience rating formula that blends experience-based rates with adjusted community rates. An issue was noted wherein on the last page of VHS's experience rated formula, the following is stated:

> "For renewing accounts with fewer than 100 subscribers, it is VHS's policy not to allow rate decreases under 10% or rate increases above 20%. The company reviews the total dollars needed for each month's renewals to assure that groups stay within these limits. For renewing accounts with 100 to 200 subscribers, there is a blend of 50% of the rates required based on accounts experience and 50% of the rate calculated according to the pooling process described above. For the larger accounts within this size band, the rates are based on a blend of 75% experience-based rates and 25% pooled rates."

Based on VHS's interpretation of the above, their renewal strategy was to be implemented as follows:

a. An initial calculation is done using the rules and factors outlined in the POS experience rating formula on file with the Department, including a "margin" provision for profit, as specified in the formula, for all groups to be renewed in a given month. [Premium calculation #1].

b. All renewal actions for all groups in that month are aggregated to determine the total rate increase or the total dollars needed for that month's renewals.

c. For renewals with fewer than 100 subscribers, which include most of VHS renewals, the POS formula specifies that renewal increases would be set within the range of -10% to +20%, meaning that decreases below -10% in (a) above will be raised to -10%, while increases in excess of +20% in (a) above would be lowered to +20%. [Premium calculation #2].

d. For renewals with 100 to 200 subscribers, the POS formula calls for a blend of increases in (a) and (b), using weights of 50% and 50% respectively. [Premium calculation #2].

e. For renewals with 200 or more subscribers, the POS formula calls for a blend of increases in (a) and (b), using weights of 75% and 25% respectively. [Premium calculation #2].

A review of actual groups indicates that the rules specified at step (c), (d) and (e) were not adhered to. Furthermore, the renewal increases actually implemented were again at variance with the premium calculation #2.

The exhibit below shows the results of the review of a sample of three VHS's experience rated policies. The differences in the target calculation from the initial calculation are the results of revisions in certain rating components.

Policy	Premium Calculation #1	% increase	Premium Calculation #2	% increase	Difference (2-1)	Actual Premium Charged	% increase	Difference (Actual–2)
1	$ 924,048	10.07%	$ 943,624	12.40%	$ 19,576	$ 931,865	11.00%	$ (11,759)
2	1,234,061	23.74%	1,166,841	17.00%	(67,220)	1,136,925	14.00%	$ (29,916)
3	2,334,234	25.56%	2,268,084	22.00%	(66,150)	2,090,657	12.46%	$ (177,427)

Note: **Premium calculation #1 includes a factor for margin.**
Premium calculation #2 excludes the factor for margin.

The process utilized by VHS to determine the premium for its the experience-rated business is in violation of Section 4308(b) and is discriminatory, as two groups getting the same increases in pursuant to the approved experience rating formula may end up with significantly different rate increases from the target rate calculation. Additionally, it is noted that VHS eliminates all references for the margin components utilized by VHS in the documents provided to the group. VHS simply adjusts other components for trends, stop loss, GME expenses, etc. Additionally, a component not reflected in premium calculation #1, is a component labeled "credibility", which VHS has stated is a plugged factor, to achieve the desired target increase.

It is recommended that VHS determine its premium rates pursuant to the experience rating formula on file with the Department.

It is recommended that VHS file any modifications to its rating plans with the Department pursuant to § 4308 (b) of the New York State Insurance Law.

It is recommended that VHS apply it's approved experience-rated formula to all of its new and renewal experience contracts in-force during the period January 1, 2003 through present and take the necessary steps to refund any overcharges.

C. Claims Processing

This review was performed by using a statistical sampling methodology covering the period January 1, 2001 through June 30, 2002 in order to evaluate the overall accuracy and compliance environment of VHS's claim's processing.

The Company's population of claims was divided into medical and hospital claims segments. A random statistical sample was drawn from each group. It should be noted for the purpose of this project, those medical costs characterized as Pharmacy, Medicare/Medicaid, Dental, Capitated Payments, and HCRA bulk payments were excluded.

The sample size for each population was comprised of 167 randomly selected unique claims. A second random sample of 50 items from each of the groups was also generated as "replacement items" in the event it was determined a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized. In total 334 claims were selected for this review.

The examination review revealed that overall claims processing financial accuracy levels were 81.44% for Medical Claims and 80.84% for Hospital Claims. Overall claims processing procedural accuracy levels were 59.88% for Medical Claims and 50.30% for Hospital Claims. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with VHS's claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy.

The following charts illustrate the financial and procedural claims accuracy findings summarized above.

Summary of Financial Claims Accuracy

	Medical Claims	Hospital Claims
Claim Population	399,296	24,759
Sample Size	167	167
Number of claims with Errors	32	31
Calculated Error Rate	18.56%	19.16%
Upper Error limit	24.46%	25.13%
Lower Error limit	12.67%	13.19%
Calculated claims in error	74,109	4,744
Upper limit Claims in error	97,668	6,222
Lower limit Claims in error	50,591	3,266

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

Summary of Procedural Accuracy

	Medical Claims	Hospital Claims
Claim Population	399,296	24,759
Sample Size	167	167
Number of claims with Errors	67	83
Calculated Error Rate	40.12%	49.70%
Upper Error limit	47.55%	57.28%
Lower Error limit	32.69%	42.12%
Calculated claims in error	160,198	12,305
Upper limit Claims in error	189,865	14,182
Lower limit Claims in error	130,530	10,428

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

During the process of examining the claims within the various claim adjudication samples, the following was noted:

- During the period November 1, 2001 through February 28, 2002 VHS reimbursed non-participating providers for services performed at in-network facilities according to VHS's contracted fee schedule. These non-participating providers should have been reimbursed based upon the usual, customary and reasonable rate. The Company discovered the problem and has taken steps to identify and reimburse the affected providers.

- Many of VHS's contracts with hospitals included discounts on the amount charged. The average discount taken was 20% of the billed amount before application of the co-payment. The examiners found multiple instances where this discount was taken after the co-payment was deducted. In addition the actual payment after the discount was deducted was not shown as the amount paid amount on the claim data file provided to the examiners.

D. Prompt Pay

§3224-a of the New York State Insurance Law "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a

health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policy-holder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

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

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

A statistical sample of claims not paid within 45 days of submission to the HMO was reviewed to determine whether the payment was in violation of the timeframe requirements of §3224-a (a) of the New York State Insurance Law and if interest was appropriately paid pursuant to §3224-a (c) of the New York State Insurance Law. Accordingly, all claims that were not paid within 45 days during the period January 1, 2001 through June 30, 2002 was segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:

Summary of Violations of Section 3224-a(a)

	Medical Claims	Hospital Claims
Total Population	399,296	24,759
Claim Population unpaid over 45 days	2,046	238
Sample Size	167	167
Number of claims with Errors	167	166
Calculated Error Rate	100%	99.40%
Upper Error limit	100%	100%
Lower Error limit	100%	98.23%
Calculated claims in error	2,046	237
Upper limit Claims in error	2,046	238
Lower limit Claims in error	2,046	234

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

Summary of Violations of Section 3224-a (c)

	Medical Claims	Hospital Claims
Total Population	399,296	24,759
Claim Population unpaid over 45 days	2,046	238
Sample Size	167	167
Number of claims with Errors	5	5
Calculated Error Rate	2.99%	2.99%
Upper Error limit	5.58%	5.58%
Lower Error limit	.41%	.41%
Calculated claims in error	544	75
Upper limit Claims in error	1,015	140
Lower limit Claims in error	75	10

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

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims paid over forty-five days from receipt during the period January 1, 2001 through June 30, 2002, or just over 1% (.54%) of the 2,284 claims processed during the period.

It is the policy of the Company to pay all claims within 45 days where VHS's obligation to pay is clear while issuing denial notices within 30 days in all cases where the obligation to pay is not. The review found that 166 out of 167 hospital claims and 167 out of 167 medical claims were in violation of §3224-a (a) of the New York State Insurance Law.

It is recommended that the Company take steps to ensure that the provisions of §3224-a (a) of the New York State Insurance Law regarding the prompt payment of claims fully implemented and complied with.

E. Denials

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

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

A sample of 30 claims that were adjudicated past 30 days of the date of receipt where no payment was made were reviewed to determine compliance with §3224-a (b) of the New York Insurance Law.

The review discovered that 26 of the 30 claims reviewed were in violation of the statue. Most the claims reviewed were denied and released by the claims processor within 30 days and sent to the account payable unit. However by the time the accounts payable unit released the claim and a denial notice was sent the 30-day time frame had been exceeded.

It is recommended that VHS comply with §3224-a (b) of the New York Insurance Law and issue denial notices on a timely basis.

F. Explanation of Benefits

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

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

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

> "Except on demand by the insured or subscriber, insurers, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, 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."

The Company's policy when participating providers are used is to send an explanation of benefit form to the member only in cases where the member incurs some responsibility for payment. In instances where portions of the providers bill is denied but the provider cannot balance bill the member VHS will not send an explanation of benefit form. Section 3234 (c) of the Insurance Law states that explanation of benefit are not required only when full reimbursement is made for the claim other than a co-payment.

The examiners found that in 12 out of 167 medical claims reviewed and 16 out of 167 hospital claims reviewed VHS failed to send an explanation of benefit form to the member. This is contrary to § 3234 (a) of the New York State Insurance Law.

It is recommended that Explanation of Benefit statements be sent to policyholders in those cases 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. pursuant to § 3234 (a) of the New York State Insurance Law.

During the claims review it was also found that VHS's explanation of benefits issued to the member did not show the correct amount paid on the claim. The contract discounts applied to certain providers were not reflected in the explanation of benefits statement.

It is recommended that VHS's Explanation of Benefits Statements show the discounted payments made when applicable.

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

ITEM		PAGE NO.
A.	Management	
	It is recommended that the Company comply with New York Insurance Law section 1201(a)(5)(B)(v) and maintain the number of board members at no less than thirteen.	3
	The Company has complied with this recommendation.	
B.	Reinsurance	
	It is recommended that the reinsurance contract be amended to conform to the requirements of Section 1308(a)(2)(A)(i) of the New York Insurance Law.	8
	VHS has not complied with this recommendation and it is repeated herein.	
C.	Custodial Agreement	
	It is recommended that the Company enter into a formal custodial agreement with the bank that contains, at a minimum, protective covenants and provisions suggested by this Department.	10
	VHS has not complied with this recommendation and it is repeated herein.	10

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO.		PAGE NO.
	Management	
A.	As of December 31, 2001 Daniel McGowan President & COO of the Health Insurance Plan of Greater New York served on the board of Vytra Health Services, Inc. in the public director category. In the opinion of the Department Daniel McGowan as an officer/employee of VHS's ultimate parent, The Health Insurance Plan of Greater New York cannot adequately represent the public director category on the board. Daniel McGowan resigned from the board on April 30, 2002 and was replaced in the public director category by Peter Scarlatos.	5-6
	Accounts and Records	
B.	The Company did not list any premiums received in advance on its 2001 annual statement filing. The amount for premiums received in advance as of December 31, 2001 amounted to $306,208 and was improperly included with trade payables in VHS's trial balance. The trade payables sub-account is part of the general expenses due and accrued account on the 2001 annual statement. The Company filed an amended 2001 statement with the Department, which listed premiums received in advance separately.	11
C.	The Company's general expenses due and accrued account included a non-admitted HealthCare Receivable amount of $171,274 that was over 90 days past due. This amount represents claim overpayments made by VHS that have not been repaid by providers. The Company's accounts payable aging schedule showed an additional amount of $50,917 on the 90 days past due balance; however, VHS admitted this amount as an accounts payable debit balance. The $50,917 overpayment was made to in network physicians and as such VHS believed the amount was more likely to be recovered despite the age of the receivable by offsetting the amount against any future claim made by the providers. No changes were made to the balance sheet because the amount was insignificant. The Company has stated that they will treat all receivables over 90 days as non-admitted assets in the future.	11

ITEM NO.		PAGE NO.
	Accounts and Records	
D.	The Company failed to list any claims adjustment expenses on its annual statement for the year 2001. It should be noted that VHS engaged the firm of Milliman USA to review its claims unpaid and file its actuarial certification with the Department. As part of the review Milliman USA noted that VHS did not include any explicit provision for the administrative expenses associated with processing unpaid claims. Accordingly, Milliman USA added 3% to VHS's outstanding claim liability for loss adjustment expense based upon its own experience with other health plans. Notwithstanding Milliman's recommendation, VHS did not report such a reserve in its filed annual statement. The Company subsequently filed an amended annual statement for 2001, which separately listed the unpaid claims adjustment expenses.	12
E.	It is recommended that VHS insert the footnote required by §1307(c) of the New York State Insurance Law in its annual and quarterly filings with the Department.	12
	Cash	
F.	It is recommended that VHS take steps to ensure that short-term investments are properly reflected as such in its annual statement filings with the Department.	17
G.	It is recommended that VHS files abandoned property reports according to Section 1316 of the Abandoned Property Law and publish a list of unclaimed checks as required by this section.	17
	Short Term Investments	
H.	It is recommended that the board of directors authorize and approve the Company's investment transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law and that such transactions be appended to the minutes thereof.	18

ITEM NO.		PAGE NO.
	Short Term Investments	
I.	It is recommended that VHS instruct such bank or trust company with which it executes any custodial or safekeeping agreements to provide the Insurance Department examiners with the requisite affidavit(s) and verification certificate(s) of investments held under custodial or safekeeping arrangements in accordance with the Department's guidelines.	20
	Amounts Due to Parent, Subsidiaries and Affiliates	
J.	It is recommended that VHS develop and file with the Department inter-company agreements for its Point of Service and solutions products in accordance with § 1505 (b) of the New York State Insurance Law.	22
	Grievances and Appeals	
K.	It was noted that the Company did not provide a specific reason for its appeals decision on the determination notices on both of the appeal files reviewed. The appeal notice only states that the original determination was upheld. It is Vytra's position that the appeal notice in conjunction with the original grievance letter satisfied the requirements of the Law. Notwithstanding the foregoing, Vytra has revised its appeal letters to include the specific reasons for the determination.	23
	Underwriting and Rating	
L.	It is recommended that VHS determine its premium rates pursuant to the experience rating formula filed with the Department.	27
M.	It is recommended that VHS file any modifications to its rating plans with the Department pursuant to § 4308 (b) of the New York State Insurance Law.	27

ITEM NO.		PAGE NO.
N.	It is recommended that VHS apply it's approved experience-rated formula to all of its new and renewal experience contracts in-force during the period 2001 through present and take the necessary steps to refund any overcharges or collect any undercharges.	27
	Claims Processing	
O.	During the period November 1, 2001 through February 28, 2002 VHS reimbursed non-participating providers for services performed at in-network facilities according to VHS's contracted fee schedule. These non-participating providers should have been reimbursed based upon the usual, customary and reasonable rate. The Company discovered the problem and has taken steps to identify and reimburse the affected providers.	30.
P.	Many of VHS's contracts with hospitals included discounts on the amount charged. The average discount taken was 20% of the billed amount before application of the co-payment. The examiners found multiple instances where this discount was taken after the co-payment was deducted. In addition the actual payment after the discount was deducted was not shown as the amount paid amount on the claim data file provided to the examiners.	30
	Prompt Pay	
Q.	It is recommended that the Company take steps to ensure that the provisions of §3224-a (a) of the New York State Insurance Law regarding the prompt payment of claims fully implemented and complied with.	33
	Claim Denials	
R.	It is recommended that VHS comply with §3224-a (b) of the New York Insurance Law and issue denial notices on a timely basis.	34

ITEM NO.		PAGE NO.
	Explanation of Benefits	
S.	It is recommended that Explanation of Benefit statements be sent to policyholders in those cases where there is potential for subscriber liability pursuant to § 3234 (a) of the New York State Insurance Law.	35
	Explanation of Benefits	
T.	It is recommended that VHS's Explanation of Benefits Statements show the discounted payments made when applicable.	35

Respectfully submitted,

____

Wai Wong

Associate Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

WAI WONG, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

____

Wai Wong

Subscribed and sworn to before me

this ______ day of _______ 2003.

Appointment No. 21871

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Wai Wong

as a proper person to examine into the affairs of the

Vytra Health Services, Inc.

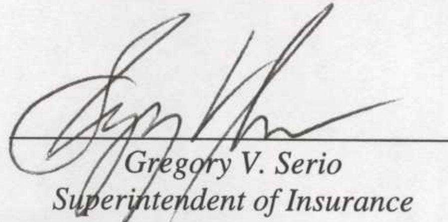
and to make a report to me in writing of the said

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 15th *day of* May 2002



Gregory V. Serio
Superintendent of Insurance