REPORT ON EXAMINATION

OF

MVP HEALTH SERVICES CORPORATION

AS OF

DECEMBER 31, 2003

DATE OF REPORT **MARCH 27, 2006**

EXAMINER **ELSAID ELBIALLY, CFE**

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

George E. Pataki
Governor

Howard Mills
Superintendent

March 27, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and in accordance with the instructions contained in Appointment Number 22143 dated January 30, 2004, attached hereto, I have made an examination into the condition and affairs of MVP Health Services Corporation (MVPHSC), a not-for-profit corporation licensed pursuant to Article 43 of the New York Insurance law. The following report is respectfully submitted.

The examination was conducted at the Plan's home office located at 625 State Street, Schenectady, New York.

Whenever the designations “the Plan” or “MVPHSC” appears herein without qualification, they should be understood to indicate the MVP Health Services Corporation.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1999. This examination covers the period from January 1, 2000 through December 31, 2003. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2003, in accordance with statutory accounting principles, as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was 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 of the Plan
Corporate records
Fidelity bonds and other insurance
Officers' and employees' welfare and pension funds
Territory and plan of operations
Growth of the Plan
Accounts and records
Loss experience
Treatment of subscribers

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

- The Plan failed to comply with the requirements of Section 4301 (k)(1)(A)&(B) of the New York Insurance Law with regard to the composition of its Board of Directors.

- The Plan failed to adhere to the requirements of its by-laws with regard to holding its membership annual meeting, board of directors' annual meeting and establishment of an executive committee. Include a sentence on failure to maintain records of specified meetings.

- The Plan failed to submit its administrative service agreement with its affiliate, MVP Service Corporation, to the New York Insurance Department.

- The Plan understated claims adjustment expenses and its reserve for unpaid claims adjustment expenses, by failing to allocate administrative costs properly within expense categories on the Underwriting and Investment Exhibit, "Part 3-Analysis of Expense" schedule of the Plan's annual statement.

- The Plan failed to adhere to the requirements of Statement of Statutory Accounting Principles (SSAP) No. 6 with regard to the reporting of its uncollected premium on various schedules of its 2003 annual statement.

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

3. DESCRIPTION OF THE PLAN

MVP Health Services Corporation was incorporated on October 8, 1992 and filed its Certificate of Incorporation with the New York Department of State on October 16, 1992.

The Plan was incorporated under Section 402 of the Not-for-Profit Corporation Law and licensed under Article 43 of the New York Insurance Law as a not-for-profit health services corporation. The Plan provides health insurance to indemnify subscribers for the cost of hospital and medical services provided to them.

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

A. Management and Control

Pursuant to the Plan's charter and by-laws, management of the Plan is vested in a board of directors consists of not less than three nor more than nineteen directors. As of the examination date, the board of directors was comprised of nine members.

The members of the Plan's board of directors as of December 31, 2003, were as follows:

Name and Residence	Principal Business Affiliation
Provider Representative	
Herschel Lessin, M.D. Poughkeepsie, New York	Vice President, Hudson Valley Pediatric Group, PC
Community Representatives	
Karen B. Johnson Schenectady, New York	Director of Development, Proctor's Theatre
Jon Rich Alplaus, New York	Retired
Subscriber Representatives	
Samuel Larry Feldman, CLU Latham, New York	President, CFK Life Plans, Inc.
Murray M. Jaros, Esq. Albany, New York	Attorney, New York State Association Of Towns
Leland C.Tupper Schenectady, New York	Treasurer, MVP Health Services, Inc.
Mary Cosgrove Militano, Esq. Scotia, New York	Attorney
David W. Oliker Schenectady, New York	President, MVP Health Plan, 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 following was noted:

(a) Composition of the Board of Directors

Sections 4301(k)(1) A and 4301(k)(1) B of the New York Insurance Law States, in part,

> "…Of the directors not included in the classifications set forth in the preceding sentences, (A) one-half in number, as nearly as possible, shall be persons covered under a contract or contracts issued by such health service, hospital service or medical expense indemnity corporation, and who are generally representative of broad segments of such covered persons, and (B) one-half in number, as nearly as possible, shall be persons whose background and experience indicate that they are qualified to act in the broad public interest, whether or not they are persons covered under contract or contracts issued by such health service, hospital service or medical expense indemnity corporation…"

A review of the membership of the Board of Directors of MVP Health Services Corporation was conducted during the four years period under this examination. This review revealed that the composition of the Board of Directors did not comply with the requirements of Section 4301 (k)(1) (A) and (B) of the New York Insurance Law.

It is recommended that the MVPHSC change the composition of its Board of Directors to comply with Section 4301 (k)(1)(A) and (B) of the New York Insurance Law.

(b) Membership Meetings

Article II Section 2.02 of the by-laws of MVP Health Services Corporation states, in part,

> "… The annual meeting of the membership of the Corporation for the election of Directors and for the transaction of any other business which may be properly brought before the meeting shall be held on the first Monday in the month of November, unless otherwise ordered by the Board of Directors. The annual meeting shall be held at such time and places as the Board or Directors shall fix…"

Article II Section 2.06 of the by-laws of MVPHSC states, in part,

> "… Minutes shall be maintained of meetings of the membership and shall be signed by the secretary of the Corporation or the secretary's designee and retained by the Corporation as a permanent record…"

MVPHSC failed to hold the annual meeting of the membership as required by Article II Section 2.02 of its by-laws.

It is recommended that MVPHSC membership hold annual meetings as required by Article II Section 2.02 of its by-laws.

In addition, it is recommended that MVPHSC maintain all minutes of its membership meetings, signed by the Secretary of the Corporation or the Secretary's designee and retained by the Corporation as a permanent record, as required by Section 2.06 of the Plan's by-laws.

(c) Board of Directors Meetings

Article III Section 3.06 of the by-laws of MVPHSC, states, in part,

> "… (a) The annual meeting of the Board of Directors shall be held on the second Monday of December of each year, unless otherwise specified by resolution of the Board of Directors.

> (b) Regular meetings of the Board of Directors shall be held at such times and places as may be designated by resolution of the Board of Directors, but shall be held at least once every calendar quarter…"

A review of the minutes of the Board of Directors revealed that the Board did not meet in 2002 and 2003.

It is recommended that the Board of Directors of MVPHSC hold an annual meeting and at least one regular meeting every calendar quarter as required by Article III Section 3.06 (a) and (b) of its by-laws.

(d) Committees

Section 4301(k)(1)(D) of New York Insurance Law states, in part,

> "…Each such health service, hospital service or medical expense indemnity corporation shall have an executive committee the members of which shall be composed, as nearly as possible, of representatives of any member hospitals or corporation, persons covered under its contract and the general public in the same proportions as the membership of the board of directors…"

Article VI Section 6.01 of the by-laws of MVPHSC states, in part,

> "… The Board of Directors shall appoint from among its members an Executive Committee and such other standing committees as may from time to time be authorized by the Board of Directors. Standing committees must consist of three or more directors…"

The minutes of the Executive Committee were requested by the examiner; however, MVPHSC was not able to provide said minutes.

It is recommended that MVPHSC establish an Executive Committee, and such other standing or special committees as may from time to time be authorized by the Board of Directors, pursuant to Section 4301(k)(1)(D) of the New York Insurance Law and Article VI Section 6.01 of the Plan's by-laws.

The principal officers of the Plan, as of December 31, 2003, were as follows:

Name	Title
David W. Oliker	President
Murray M. Jaros, Esq.	Secretary
Leland C. Tupper	Treasurer

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. During the examination period the Plan provided Point of Service (POS) health insurance contracts until the creation of its affiliate MVP Health Insurance Company (MVPHIC) in 2001. All POS business was transferred to MVPHIC, and since then the Plan writes only stand-alone indemnity dental insurance.

As of December 31, 2003, the Plan had an enrollment of 9,077 subscribers with 17,111 members.

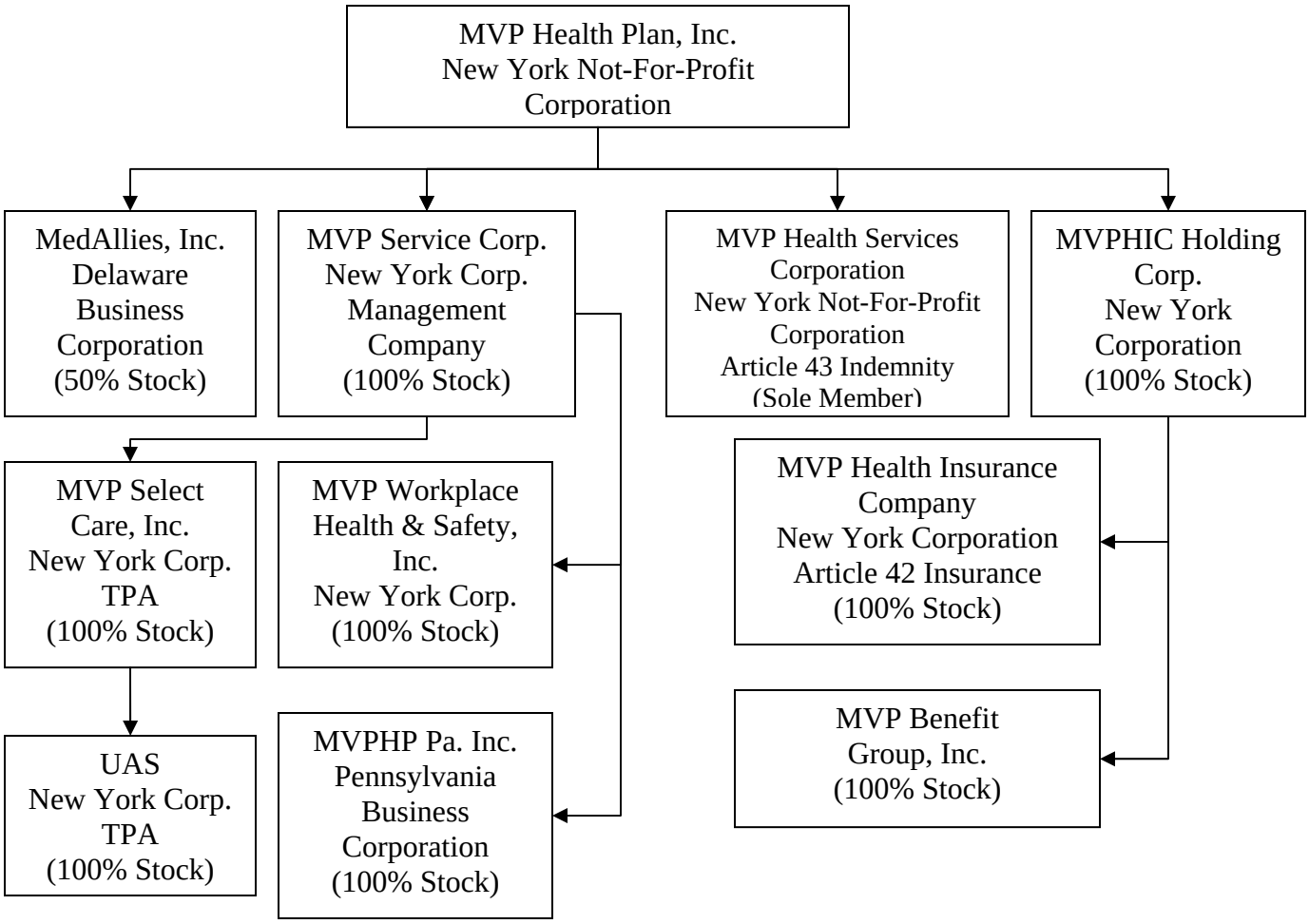
During the examination period, MVPHSC solicited business as a direct writer utilizing their own in-house licensed agents. MVPHSC also dealt with licensed brokers, for the production of business.

C. Reinsurance

The plan did not assume or cede any reinsurance during the four year period covered by this examination.

D. Holding company system

The following chart depicts the Plan in relationship to its affiliates within the holding company system. The percentages included in the chart indicate percentage of ownership.



The Plan has no employees. Therefore, it entered into an administrative service agreement with its affiliate, MVP Service Corporation. (MVPSC) on May 5, 1993. Pursuant to the agreement various services are provided to MVPHSC by MVPSC, including, but not limited to financial, legal, internal operations, management information

systems, marketing, consultation, utilization review services, claims administration, developing, revising and refining new health care service products, systems, policies and overall administration.

The Plan failed to notify the superintendent, 30 days prior to the effective date of its administrative service agreement with MVPSC as required by Section 1505(d)(3) of the New York State Insurance Law.

It is recommended that the administrative service agreement between the Plan and MVPSC be submitted to the Superintendent of Insurance for review as required by Section 1505(d)(3) of the New York State Insurance Law.

MVP Health Plan, Inc.

MVP Health Plan Inc. (MVPHP), the Plan's ultimate parent, was incorporated on July 30, 1982, pursuant to Section 402 of the Not-for-Profit Corporation Law. MVPHP is a Type B Corporation under Section 201 of the Not-for-Profit Corporation Law. MVPHP 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 June 1, 1983.

MedAllies, Inc.

MedAllies, Inc. was incorporated on February 2, 2001 as a Delaware Business Corporation. It is a joint venture with Taconic IPA. MVP Health Plan, Inc. owns 50% of

the stock of MedAllies, Inc. The purpose of the joint venture was to integrate clinical labs and payors to improve care by providers. This is a start-up company that has not earned any profit yet.

MVP Service Corporation

MVP Service Corporation (MVPSC) was incorporated in 1990, as a New York corporation that performs management services for the corporations affiliated with it (the Plan, MVPHP, MVPHICHC, MVPHIC, and MVP Select Care). MVP Health Plan, Inc. owns 100% of the stock of MVPSC.

MVP Service Corporation also holds 100% of the stock of MVP Select Care, Inc., a New York corporation that is a third party administrator (TPA); 100% of the stock of MVPHP Pa, Inc., a Pennsylvania business corporation (incorporated May 1, 1996); and 100% of the stock of MVP Workplace Health & Safety, Inc., a New York corporation (incorporated August 4, 1994 as MVP Corporatecare, Inc.; renamed on September 13, 1996 to MVP Workplace Health and Safety, Inc.).

In addition, MVP Service Corporation owns 50% of Comprehensive Health Solutions, Inc. (CHS) and CHS Pharmacy, Inc. (CHS Rx). These entities are accounted for on MVP Health Plan, Inc.'s balance sheet by the equity method. CHS was formed to provide management services for an ambulatory infusion center. CHS Rx was formed to provide pharmaceutical supplies to the ambulatory infusion center.

MVP Select Care, Inc.

MVP Select Care, Inc. (Select Care) is a for-profit New York corporation wholly-owned by MVP Service Corporation. Select Care was incorporated in 1987 to provide administrative services to companies that self insure health care benefits.

MVP Select Care, Inc. owns 100% of Upstate Administrative Services (UAS) a New York corporation licensed as a TPA. UAS business was fully integrated into Select Care to achieve administrative service efficiencies.

On November 16, 1992, Select Care entered into an administrative service agreement with MVPSC whereby MVPSC provides for all the day-to-day operations of Select Care.

MVP Workplace Health & Safety, Inc.

MVP Workplace Health & Safety, Inc. (MVPWHS) is a for-profit corporation wholly-owned by MVPSC. MVPWHS was incorporated in 1994 to provide occupational health services. It is in the process of being dissolved.

MVPHP Pa, Inc.

MVPHP Pa, Inc. was formed to hold stock of insurance companies/HMOs to be licensed in the Commonwealth of Pennsylvania. However, to date, this Company remains dormant since licenses to write insurance business or conduct an HMO business in the Commonwealth of Pennsylvania were not pursued.

MVPHIC Holding Corp.

MVPHIC Holding Corp. was incorporated on November 22, 2000, pursuant to Section 402 of New York Business Corporation Law. It was specifically formed to hold the stock of MVP Health Insurance Company (MVPHIC). MVPHIC is an Article 42 for-profit accident and health insurance company licensed in the State of New York. MVPHIC Holding Corp. holds and controls 100% of the stock issued by MVPHIC. MVP Health Plan, Inc., in turn, owns and controls 100% of the stock of MVPHIC Holding Corp.

MVPHIC Holding Corp. currently has two licensing applications pending with the State of New Hampshire. One application is to form a domestic accident and health insurance company and the other application is to form a domestic health maintenance organization.

MVP Health Insurance Company

MVP Health Insurance Company, (MVPHIC) is a for-profit New York corporation, wholly-owned by MVPHIC Holding Corp., which is a wholly-owned subsidiary of MVP Health Plan, Inc. MVPHIC was incorporated on April 24, 2000. MVPHIC received its license as an accident and health insurance company under Article 42 of the New York Insurance Law in June, 2001.

MVP Benefit Group, Inc.

MVP Benefit Group, Inc. a New York business corporation was incorporated on March 12, 2003. MVP Benefit Group, Inc. is licensed as an insurance agent pursuant to Section 2103 of the New York Insurance Law and as insurance agent and insurance broker in the State of Vermont. It was formed for the purpose of transacting a brokerage business for the stop loss insurance offered to MVP Select Care groups. All other affiliated entities have separate reinsurance policies that are not brokered through MVP Benefit Group, Inc. MVPHIC Holding Corp. owns 100% of the stock of MVP Benefit Group, Inc.

E. Significant operating ratios

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

	Amounts	Ratios
Claims	$11,907,313	82.5%
Claims adjustment expenses	730,399	5.0%
General administrative expenses	1,053,791	7.3%
Net underwriting gain	745,119	5.2%
Premium earned	$14,436,622	100.0%

The following ratio has been computed, as of December 31, 2003, based upon the results of this examination:

Premium receivable to premium revenue	12.1%

The above ratio falls outside the NAIC benchmark of 8%.

F. Allocation of expenses

The expense group “Claim Adjustment Expense” (CAE) reported in Underwriting and Investment Exhibit, ”Part 3-Analysis of Expense” schedule of the Plan's filed December 31, 2003 annual statement was calculated by applying a flat percentage to all expense categorizes. The Plan was unable to provide the examiners with any supporting documentation or the rationale of the use of this flat percentage.

It is recommended that MVPHSC apply the guidelines in New York Insurance Department Regulations 30 (11 NYCRR 20) and 33 (11 NYCRR 91) to revise and update its expense allocation methodology in order to reflect an appropriate allocation among the three expense groupings (i.e. claim adjustment expense, general and administrative expense and investment expense) on U & I, Part 3 of its annual statement.

G. Cash

A review of the Plan's current procedures with regard to uncashed checks revealed that there is no follow-up on outstanding checks that remained on the bank reconciliation until deemed to be abandoned property.

It is recommended that the Plan establish a follow-up procedure applicable to all checks which remain outstanding for six months from the date of issue.

H. Uncollected premiums

A review of the Plan's procedures in regard to uncollected premiums revealed the following:

(a) Statement of Statutory Accounting Principles (SSAP) No. 6 paragraph 10 states, in part,

> "…any uncollectible receivable shall be written off and charged to income in the period the determination is made."

It is noted that the Plan's practice is to charge the expense account of bad debt instead of charging the bad debt to income as required by SSAP No. 6.

It is recommended that the Plan comply with the requirement of SSAP No. 6 paragraph 10 and charge bad debt to income.

(b) The Plan reported on page 2 of its annual statements for all years during the examination period, premium receivables net of non-admitted amounts without

showing the gross receivables. The annual statement instructions provide for the reporting of gross receivable, the non-admitted asset portion and the net admitted asset portion as per the following comparative chart:

	Admitted Assets	Not-admitted Assets	Net admitted Assets
Company	$531,372	-0-	$531,372
Examination	625,182	$93,810	$531,372

It is recommended that the Plan comply with the annual statement instructions and appropriately report its gross premium receivables and non-admitted asset premium receivable on the annual statement.

4. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the assets, liabilities and capital and surplus account as determined by this examination as of December 31, 2003. This statement is the same as the balance sheet filed by the Plan.

Assets	Assets	Non-Admitted Assets	Net Admitted Assets
Cash and short term investment	$4,211,791	$	$4,211,791
Investment income accrued	15,194		15,194
Uncollected premiums	625,183	93,810	531,373
Federal income tax recoverable	68,387		68,387
Net deferred tax asset	56,853	56,853	
Prepaid expense	39,903	39,903	
Miscellaneous receivable	6,293	0	6,293
Total assets	$5,023,604	$190,566	$4,833,038

Liabilities	Amount
Claims unpaid	$558,548
Unpaid claims adjustment expense	12,763
General expenses due and accrued	20,766
Amount due to parent, and affiliates	439,504
Total liabilities	$1,031,581
Reserves and other funds	
Surplus notes	$1,070,000
New statutory reserve	294,815
Unassigned fund-surplus	2,436,642
Total capital and surplus	$3,801,457
Total liabilities, capital and surplus	$4,833,038

Note:
The Internal Revenue Service did not audit the tax returns filed by the Plan during the period under this examination. The examiner is unaware of any potential exposure of the Plan to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of revenue and expenses

Capital and surplus increased by $1,163,666 during the four year period under examination, January 1, 2000 through December 31, 2003, detailed as follows:

Revenue			
Net premium income			$14,436,622
Total revenues			$14,436,622
Expenses			
Medical and hospital			
Hospital and medical benefit	$8,277,687		
Other professional services	3,627,645		
Emergency room	1,075		
Prescription drugs	72,906		
Sub-total	$11,979,313		
Less reinsurance recoveries	(72,000)		
Total hospital and medical		$11,907,313	
Administrative expenses			
Claims adjustment expenses	$ 730,399		
General administrative expenses	1,053,791		
Total administrative expenses		$1,784,190	
Total underwriting deductions			($13,691,503)
Net underwriting gain			$745,119
Net investment income earned		569,037	
Net realized capital gain		1,976	
Net investment gain			$571,013
Net income before federal income tax			1,316,132
Federal income tax incurred			204,461
Net income(loss)			$1,111,671

C. Capital and surplus account

	Gains in Surplus	Losses in Surplus	
Capital and surplus per report on examination as of December 31, 1999			$2,637,791
Net income from operation	$1,111,671	$	
Net unrealized capital gain	76,788		
Change in net deferred income tax	54,999		
Change in non-admitted assets	0	79,792	
Total gains and losses	$1,243,458	$79,792	
Net increase in capital and surplus			1,163,666
Capital and surplus per report on examination as of December 31, 2003			$3,801,457

5. CLAIMS UNPAID

The examination liability of $558,548 is the same as the amount reported by the Plan as of the examination date. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and its filed annual statements.

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 policyholders and claimants. The review was general in nature and was directed at practices of the Plan in the following major areas:

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

The examiners' review revealed the following:

A. Claims Processing

A claims review was performed by using a statistical sampling methodology covering dental claims processed in 2003, in order to evaluate the overall accuracy and compliance environment of MVP Health Services Corporation's (MVPHSC) claims processing.

The statistical random sampling process, which was performed using ACL auditing software program, was devised to test various attributes deemed to be necessary for the successful processing of claims. The objective of the 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 drawn for each item in the sample. The review incorporated processing attributes used by MVPHSC in their own "Quality

Analysis" of claims processing. The sample size was comprised of 167 randomly selected claims.

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 MVPHSC as the total number of items submitted by a single provider within a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines or procedures. It was 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.

A paid claim was defined as any claim for which MVPHSC was obligated to pay the claim; a denied claim was one for which the Plan was not obligated to pay the claim.

To ensure the completeness of the claims population being tested, the total claim amounts paid were accumulated and reconciled to the financial data reported by MVPHSC for calendar year 2003.

The examiner's review indicated there were no claims that were "processed" incorrectly, according to the criteria used by both MVPHSC and the New York State Insurance Department. As such, the accuracy rate was at 100%.

B. Prompt Payment of Claims

Section 3224-a of the New York Insurance Law "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay") 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.

Section 3224-a(a) of the New York Insurance Law states, in part,

> "…such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a healthcare provider within forth-five days of receipt of a claim or bill for service rendered."

Section 3224-a(b) of the New York Insurance Law states, in part,

> "…an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or to request all additional information needed to determine liability to pay the claim or make the health care payment…"

Section 3224-a (c) of the New York Insurance Law states, in part,

> "… any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest…"

A review was made of year 2003 claims, using ACL audit software, for compliance with Section 3224-a. Also, to determine whether or not interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law, to

those claimants not receiving payment within the timeframes required by Section 3224-a (a) of the New York Insurance Law.

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

MVPHSC paid 22,217 claims and wholly denied 1,408 claims for its New York State groups and providers / subscribers in year 2003. Of these claims, a population of 36 claims was identified where the payment date was more than 45 days after the receipt date. The review of all 36 claims revealed that 26 claims were in violation of Section 3224-a (a) of the New York Insurance Law. Furthermore, of the 26 claims found to be in violation of Section 3224-a (a), three claims were also found to be in violation of Section 3224-a (c), because interest due of $2 or more was not paid.

A second population of 6 claims was identified where the claim was denied more than 30 days from the date that MVPHSC had all the necessary information to adjudicate the claim or; took longer than 30 days to request further information, from the date that the claim was received. The review of all 6 claims revealed that 4 claims were in violation of Section 3224-a (b) of the New York Insurance Law.

7. FRAUD PREVENTION AND DETECTION

A review was performed of the organization and structure of MVPHSC’s special investigations unit (SIU), and their compliance with Article 4 of the New York Insurance Law, and New York Insurance Department Regulation 95 (11NYCRR 86). The examination review indicated MVPHSC's compliance with Article 4 of the New York Insurance Law and New York Insurance Department Regulation 95 (11 NYCRR 86).

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 1999, contained one recommendation. In addition, the Insurance Department conducted a detailed review of claims as of September 30, 2001. The comments and recommendations of both examinations are detailed as follows (page numbers refer to the prior reports):

ITEM		PAGE NO.
A.	It is recommended that the number of directors on the Plan's board representative of subscribers and the number of directors representative of the public be as equal as possible in compliance with Section 4301(k)(1)(A)and(B) of the New York Insurance Law. The Plan did not comply with this recommendation. A similar recommendation is included in this report under item A.	5
A.	MVP Health Care provided the examiners with reconciled claims data. However, MVP Health Care did not provide the reconciled claims data in a timely manner. MVP Health Care's inability to provide reconciled data during the prior examination was cited in this report as a reason for this examination. The inability of MVP Health Care to provide reconciled data in a timely manner caused a delay in the conclusion of this examination. The Plan provided reconciled claims data in a timely manner during this examination.	6
B.	It is recommended that MVP report all capitation payments to its Vermont IPAs in Exhibit 8-Parts 1 and 2 of its filed financial statement. The Plan has complied with this recommendation.	6
C.	It is recommended that MVPHSC comply with New York Insurance Department Regulation Number 64, {11 NYCRR 216.0(e)(6)), and distribute such regulation to all persons responsible for the supervision, handling and settlement of claims. The Plan has complied with this recommendation.	7

ITEM		PAGE NO.
D.	It is recommended that MVP Health Care properly classify paid claims and report its paid outsourced claims data in Section 3 of Schedule H in both the annual and quarterly statements filed with the Department. The Plan has complied with this recommendation.	8
E.	It is recommended that MVP Health Care improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law. The Plan has complied with this recommendation.	10
F.	It is recommended that MVP Health Care issue EOBs that include all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed. The Plan has complied with this recommendation.	12
G.	It is recommended that MVP providewritten notice of the grievance procedures in accordance with Section 4408-a 2(a) of the New York Public Health Law. The Plan has complied with this recommendation.	12
H.	It is recommended that MVP revise its acknowledgement letter to comply with the requirements of Section 4408-a.9 of the New York Public Health Law. The Plan has complied with this recommendation.	13
I.	It is recommended that MVP Health Care maintain a central log for monitoring all complaint activity that contains all information required by New York Insurance Department, Circular Letter Number 11 of 1978. The Plan has complied with this recommendation.	14
J.	MVPHSC failed to file its utilization management documentation with the New York Insurance Department as required by Section 4901(a) of the New York Insurance Law. This was corrected in 2002. The Plan has complied with this recommendation.	14

ITEM		PAGE NO.
K.	It is recommended that MVP fully comply with Section 4903.5 of the New York Public Health Law and include all required information in its notice of adverse determination, when prospective utilization review of pre-authorization is requested. Subsequent to the examination period MVP Health Care revised the wording of the attachment to fully comply with the requirements of Section 4903.5 of the New York Public Health Law. In year 2002, MVP Health Care submitted the new attachment with its utilization management documentation to the New York Insurance Department as required by Section 4901(a) of the New York Insurance Law.	15
L.	It is recommended that MVP Health Care send proper notice of adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law as applicable. The Plan has complied with this recommendation.	17
M.	It is recommended that MVP Health Care revise its policy concerning provider appeals and comply with Section 4904(d) of the New York Insurance Law or Section 4904.4 of the New York Public Health Law as applicable, when conducting provider appeals. The Plan has complied with this recommendation.	17
N.	It is recommended that MVP Health Care comply with Section 4904(c) of the New York Insurance Law or Section 4904.3 of the New York Public Health Law by sending letters to acknowledge receipt of an appeal of medical adverse determination from its participating providers. The Plan has complied with this recommendation.	18
O.	It is recommended that MVP send proper notice of final adverse determination of expedited or standard utilization review appeals in accordance with Sections 4904(c) and 4910(b) of the New York Insurance Law or Sections 4904(3) and 4910.2 of the New York Public Health Law and/or Part 98-2.9 (e) {10 NYCRR98-2.9 (e)}as applicable. The Plan has complied with this recommendation.	19

ITEM		PAGE NO.
P.	It is recommended that MVP Health Care report retrospective utilization review appeals by providers on Schedule M of their annual statement along with all other utilization review appeals. The Plan has complied with this recommendation.	20

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
	Cash	
G.	It is recommended that the Plan establish a follow-up procedure applicable to all checks which remain outstanding for six months from the date of issue.	18
	Uncollected premiums	
H.	It is recommended that the Plan comply with the requirement of SSAP No. 6 paragraph 10 and charge bad debt to income.	18
I.	It is recommended that the Plan comply with the annual statement instructions and appropriately report its gross premium receivables and non-admitted asset premium receivable on the annual statement.	19

Respectfully submitted,

Elsaid E. Elbially
Principal Insurance Examiner, CFE

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

Elsaid E. Elbially being duly sworn, deposes and says that the foregoing report submitted By him is true to the best of his knowledge and belief.

Elsaid E Elbially

Subscribed and sworn to before me
this 23rd day of March, 2006.

Charles T. Lovejoy
Notary Public, State of New York
No. 31-4798952
Qualified in New York County
Commission Expires 1-26-10

Appointment No. ***22143***

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:

ELSAID ELBIALLY

as a proper person to examine into the affairs of the

MVP HEALTH SERVICES CORPORATION

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 *30th* day of *January 2004*

Gregory V. Serio
Superintendent of Insurance