REPORT ON EXAMINATION

OF

UNITED CONCORDIA INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 2005

DATE OF REPORT	MAY 3, 2007
EXAMINER	JEFFREY L. USHER

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

Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent of Insurance

May 3, 2007

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

Sir:

Pursuant to the provisions of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22485 dated March 10, 2006, attached hereto, I have made an examination into the condition and affairs of United Concordia Insurance Company of New York, an accident and health insurance company licensed under Article 42 of the New York Insurance Law. The following report is respectfully submitted.

The examination was conducted at the Company's home office located at 4401 Deer Path Road, Harrisburg, PA 17110.

Wherever the designations "the Company" or "UCICNY" appear herein without qualification, they should be understood to indicate the United Concordia Insurance Company of New York.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 2001. This examination covered the four year period from January 1, 2002 to December 31, 2005. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised of a complete verification of assets, liabilities and surplus as of December 31, 2005, in accordance with statutory accounting principles as adopted by this Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized to the extent considered appropriate, work performed by the Company's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners (NAIC):

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

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

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

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that directly impacted the Company's compliance with the New York Insurance Law. Significant findings relative to this examination are as follows:

- The Company did not execute proper custodian agreement with its investment custodial bank which included the prudent protective covenants and provisions as set forth in the Department's guidelines.

- The Company did not properly allocate expenses between cost containment, claim adjustment expense and general administrative expenses on its annual statement exhibit of "Part 3-Analysis of Expenses".,

- The Company did not comply with Regulation 62, Part 52, Section 53.40(e) by discounting and deviating from its filed rates with the New York Insurance Department.

- The Company did not issue proper Explanation of Benefits statements (EOBs) to its members.

- The Company did not fully comply with the requirements of the Prompt Pay Law.

- The Company's utilization review agent did not fully comply with the requirements of Article 49 of the New York Insurance Law with regard to notices to members of first adverse and final adverse determinations.

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

3. DESCRIPTION OF COMPANY

The Company was incorporated January 10, 1990 as the "Citadel Insurance Company," under the laws of the State of New York. It commenced business on September 25, 1990. On December 31, 1996, United Concordia Companies, Inc. (UCCI) acquired 100% of the outstanding common stock of Citadel Insurance Company. On January 8, 1997, Citadel Insurance Company's name was changed to United Concordia Insurance Company of New York (UCICNY). UCICNY is a for-profit corporation authorized to write accident and health insurance in the State of New York. The Company is a wholly owned subsidiary of UCCI. On July 11, 1997, the New York State Insurance Department approved the Company's license change from a property casualty insurer to an Article 42 accident and health insurer.

On December 6, 1996, UCCI's parent corporation, Medical Service Association of Pennsylvania (d/b/a Pennsylvania Blue Shield), combined with Veritus Inc. (d/b/a Blue Cross of Western Pennsylvania) to form Highmark Inc. (Highmark). As a result, UCCI became a wholly owned subsidiary of Highmark.

A. Management

Pursuant to UCICNY's charter and by-laws, management of the Company is vested in a board of directors consisting of thirteen members. As of December 31, 2005, the directors of the Company were as follows:

Name and Residence	Principal Business Affiliation
Thomas A. Dzuryachko Harrisburg, PA	Chairman of Board, President and CEO, United Concordia Companies, Inc.

Name and Residence	Principal Business Affiliation
Frederick G. Merkel Harrisburg, PA	Senior Vice President, Eastern Division United Concordia Companies, Inc.
Daniel J. Wright Harrisburg, PA	Senior Vice President, Finance and Treasurer, United Concordia Companies, Inc.
Nathan C. Kleinberg Phoenix, AZ	Senior Vice President, Marketing, United Concordia Companies, Inc.
Jon K. Seltenheim Lemoyne, PA	Senior Vice President, Customer Service Operations, United Concordia Companies, Inc.
Nanette P. DeTurk Lancaster, NH	Executive Vice President, Treasurer and Chief Financial Officer, Highmark Inc.
Karen L. Hanlon Cranberry Township, PA	Vice President, Financial Planning and Analysis, Highmark Inc.
Todd B.Vanerstrom Pittsburgh, PA	Vice President, Investor Relations, Highmark Inc.
Russell Rubin Pittsburgh, PA	Regional Vice President, Sales, United Concordia Companies, Inc.
Joseph Carlomusto Old Brookville, NY	Chief Operating Officer, Davis Vision, Inc.
Lawrence M. Gabel Franklin Square, NY	Executive Vice President, CFO, Treasurer and Assistant Secretary, Davis Vision, Inc.
Carl Moroff, O.D. Commack, NY	Executive Vice President, COO, Vision Care and Chief Quality Officer, Davis Vision, Inc.
Thomas A. Harbold East Berlin, PA	Senior Vice President, TDP, United Concordia Companies, Inc.

Article II, Section 2 of UCICNY's by-laws states that there shall be not less than two regular meetings of the board of directors held each year. Our review indicated that the board of directors has held meetings at least twice each year. The minutes of all meetings of the board of directors were reviewed. All such meetings were well attended.

The Company's principal officers, as of December 31, 2005, were as follows:

Name	Title
Thomas A. Dzuryachko	Chairman of the Board
Frederick G. Merkel	President and Chief Executive Officer
Richard J. Enterline, Esq.	Secretary
Daniel J. Wright	Vice President and Treasurer
Timothy D. Billow	Assistant Treasurer

B. Territory and Plan of Operation

UCICNY was licensed, as of December 31, 2005, to transact accident and health insurance business as defined by Section 1113(a)(3)(i) of the New York Insurance Law. The Company writes business in New York State only. In 2005, the Company wrote total direct premiums in the amount of $7,859,788.

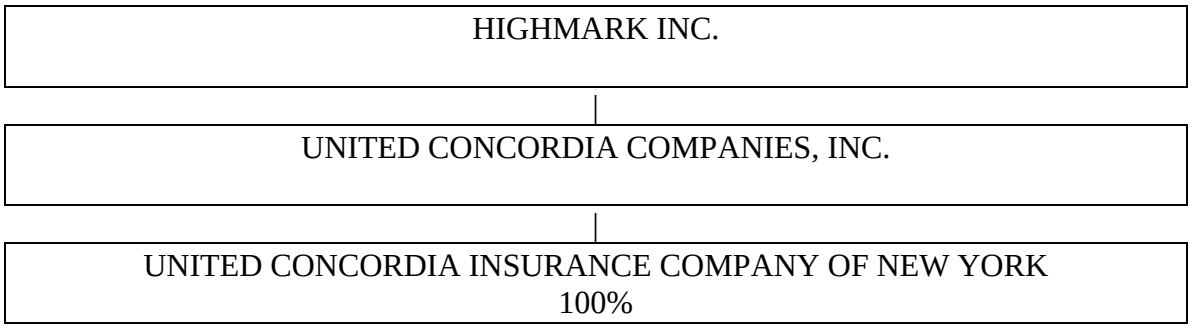
The following chart depicts UCICNY's membership at each year-end:

2002	2003	2004	2005
11,904	19,444	19,929	23,022

C. Reinsurance

On July 1, 2004, the Company entered into a Quota Reinsurance Agreement with an authorized reinsurance company. Such reinsurance agreement provided for 50% quota share indemnity reinsurance that covers all policies issued by the Company in connection with the Marketing and Services agreement between the Company and the reinsurer. The reinsurer shares equally in premiums, claims expense, producer payments and taxes in each case as set forth in the agreement. The reinsurance agreement contained all the required standard clauses, including the insolvency clause required by Section 1308 of the New York Insurance Law.

D. Holding Company System



It should be noted that at December 31, 2005, United Concordia Companies, Inc. owned and controlled directly or indirectly a total of fifteen (15) subsidiaries consisting of fourteen (14) dental plans and one (1) customer service only subsidiary.

As detailed in Section 3 of this report, on December 31, 1996, United Concordia Companies, Inc. (UCCI) acquired 100% of the outstanding common stock of Citadel Insurance Company. On January 8, 1997, Citadel Insurance Company's name was

changed to United Concordia Insurance Company of New York (UCICNY). UCICNY is a for-profit corporation authorized to write accident and health insurance in the State of New York. The Company is a wholly owned subsidiary of UCCI.

On December 6, 1996, UCCI's parent corporation, Medical Service Association of Pennsylvania (d/b/a Pennsylvania Blue Shield), combined with Veritus Inc. (d/b/a Blue Cross of Western Pennsylvania) to form Highmark Inc. (Highmark). As a result UCCI became a wholly owned subsidiary of Highmark.

A review was conducted of the Company filings required by Article 15 of the New York Insurance Law and Part 80-1.4 of Department Regulation 52 (11 NYCRR 80-1.4). It was determined that the Company was in compliance with those requirements.

The following is a description of the inter-company agreements in effect as of the examination date:

1. Management Agreement

As of December 31, 2005, UCICNY maintained a management agreement with UCCI which was approved by the New York State Insurance Department. This agreement automatically renews for successive one-year terms commencing on December 31, 1996, unless either party gives the other written notice of termination at least sixty (60) days prior to the end of the then-current term or if terminated immediately upon mutual consent. The management agreement

provides for UCCI to render certain services to UCICNY. These services include management information systems, utilization review services, claims administration, marketing, collection of premiums, review of staffing and scheduling, and other related services.

2. Consolidated Tax Allocation Agreement

On April 29, 1999, UCICNY entered into a consolidated tax allocation agreement with its ultimate parent company, Highmark Inc. The April 29, 1999 agreement superseded a prior agreement to which the Company was a party with Highmark Inc. dated December 31, 1996. The new agreement provides for apportionment calculations to be performed on a biannual basis. This agreement was approved by the New York Insurance Department.

3. Investment Management Agreement

On April 21, 2003, UCICNY entered into an investment management agreement with its ultimate parent company, Highmark Inc. This agreement automatically renews for successive one-year terms commencing on April 21, 2003, unless either party gives the other written notice of termination at least sixty (60) days prior to the end of the then-current term or if terminated immediately upon mutual consent. The agreement provides for Highmark Inc. to provide services which include the supervision and direction of investment of cash and other assets of the company including the purchase and sale of securities, pursuant to the Company's written criteria, standards and guidelines and in

accordance with all appropriate sections of the New York Insurance Law pertaining to investments.

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	$18,524,923	87.3 %
Claim adjustment expenses	1,181,373	5.6 %
General administrative expenses	3,580,546	16.9 %
Net underwriting gain (loss)	(2,067,169)	(9.7 %)
Premium Revenue	$21,219,673	100.00%

F. Investment Custodian Agreement

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

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

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

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

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

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

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

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

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

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

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

b. The company did not submit appropriate custodian affidavits to accompany the inventory of securities held by the Fiduciary Trust Company.

It is recommended that the Company's custodian of the securities complete the appropriate custodian affidavits to accompany the certified inventory of the securities as of December 31, 2005.

G. Allocation of Expenses

UCICNY used its parent company's functional group expenses as a basis to calculate the percentage applicable to the cost containment, claim adjustment expense

and general administrative expenses, reported in the Company's Underwriting and Investment Exhibit, "Part 3-Analysis of Expense" annual statement for 2005. The parent Company's percentage of allocation between functional groups expenses was noted in an exhibit entitled, "UCCI Profit and Loss Statement Including Subscriber Data for December 2005".

Within the calculation of the claims adjustment expense percentage, the Company included an expense for Members/Group Administrative expenses of $14,930,800 which should have been included in the General Administrative expense percentage calculation. Therefore, the calculation of the claims adjustment expenses percentage was overstated by approximately 11% and the general administrative expense percentage was understated by the same percentage of 11%.

It is recommended that the Company properly allocate expenses between cost containment, claim adjustment expense and general administrative expenses on its Annual Statement exhibit, "Part 3-Analysis of Expenses".

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus as determined by this examination as of December 31, 2005. This statement is the same as the balance sheet filed by the Company.

Assets	Assets	Non Admitted Assets	Net Admitted Assets
Bonds	$ 2,126,255	$ 0	$ 2,126,225
Cash and Short-term investments	1,194,135		1,194,135
Accident and Health Premiums Due and Unpaid	217,850	16,626	201,224
Investment Income due and accrued	13,710		13,710
Net Deferred Tax Asset	38,652		38,652
Total assets	$ 3,573,976		$ 3,573,976

Liabilities, Reserves & Other Funds	
Claims Unpaid	$ 627,482
Unpaid Claim adjustment Expense	47,061
Premiums Received in Advance	351,473
General Expenses Due and Accrued	56,836
Federal and Foreign Income Taxes	82,174
Remittance and Items not allocated	4,256
Amounts Due to Parent, Subsidiaries and Affiliates	106,363
Escheated Check Liability	40,275
Total liabilities	$1,315,920

Surplus and Other Funds	
Common Capital Stock	$ 1,000,000
Gross Paid In and Contributed Surplus	1,512,135
Unassigned Funds	(254,079)
Total Capital and Surplus	$ 2,258,056
Total Liabilities, Surplus and other Funds	$ 3,573,976

The Internal Revenue Service has completed its audits of the consolidated federal income tax returns filed on behalf of the Company through tax year 2003. An audit covering tax years 2004/2005 is currently ongoing at this time. The examiner is unaware of any potential exposure of the Company to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of revenue and expenses:

Net worth decreased by $189,761 during the four years under examination, January 1, 2002 through December 31, 2005 detailed as follows:

Revenue			
Net Premium Income			$21,219,673
Net Investment Income			290,169
Expenses			
Hospital/medical benefits	$18,537,173		
Net Reinsurance Recoveries	(12,250)		
Total Hospital/Medical		$18,524,923	
Administrative expenses			
Claim Adjustment Expenses	1,181,373		
General Administrative Exp.	3,580,546		
Total administrative expenses		$4,761,920	
Total expenses			23,286,843
Net Income (Loss) before Fed. Tax			($1,777,001)
Federal Tax Incurred			($588,491)
Net Income			($1,188,510)

C. Net worth

Capital and Surplus per report on examination as of December 31, 2001			$2,447,817
	Gains in Surplus	Losses in Surplus	
Net loss		$ (1,188,510)	
Deferred Income Tax	$25,268		
Non Admitted Assets and Related Items		(18,831)	
Asset Valuation Reserve		(1,406)	
Changes in Accounting Principles	28,031		
Paid in Surplus	962,135		
Aggregate Write Ins for gains	3,552		
Total gains and losses	$ 1,018,986	$ (1,208,747)	
Net decrease in net worth			(189,761)
Total capital and surplus per this examination report as of December 31, 2005			$2,258,056

5. CLAIMS UNPAID

The examination liability of $627,482 is the same as the amount reported by the Company as of December 31, 2005. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements.

6. MARKET CONDUCT ACTIVITIES

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

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

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

A. Policy forms/rates

The examiners' review of a sample of 5 of the Company's employer group's premium invoice billings revealed that the rates included within such invoices differed from the rates filed with and/or approved by this Department.

The rates were discounted during the four year period of this examination within a range of 6.55 to 10.3%. Such discounting was used with regard to at least 50% of the Company's total number of community rated groups, as indicated within the chart below.

Year	2002	2003	2004	2005
Total # of community rated groups	252	762	957	983
50% of total # of groups above	126	381	479	492

The approximate average of the discounts allowed during each of the four years under examination per projection based on the discounted rates of the sample of 5 groups being reviewed were as follows:

Year	2002	2003	2004	2005
Single coverage	7.7%	6.5%	10.2%	10.3%
Family coverage	7.3%	6.5%	10.1%	10.1%

The total premiums for the community rated groups during the examination period was as follows:

Year	**Community Rated Premium**	Premiums of 50%of all groups being discounted	Total discounted premiums with average discount rate shown in parenthesis :
2002	$627,648	$313,824	$22, 806 (7.3%)
2003	$3,153,919	$1,576,959	$101, 603 (6.5)
2004	$5,235,297	$2,617.648	$261, 765 (10%)
2005	$6,742,368	$3,371,184	$337, 118 (10%)

New York Insurance Department Regulation 62, (11 NYCRR 52.40(e)) states in part:.

> ”(e)(1) A rate filing shall accompany every policy, and rider or endorsement affecting benefits submitted to the Department for approval unless schedules of rates shall be identified by reference to specific page number(s) of the manual, formulas or schedules on file.”

In accordance with the New York Insurance Department Regulation 62, (11 NYCRR 52.2(1)) group insurance is defined as follows:

> “…(l) Group insurance means insurance written under the provisions of Section 4235 or 4305 of the New York Insurance Law.”

Section 4235(f)(4)(D) of the New York Insurance Law references dental services and states the following:

> "(4) Notwithstanding any provisions of a policy of group accident, group health or group accident and health insurance, whenever such policy provides for reimbursement for:
>
> (D) any dental service which is within the lawful scope of practice of a licensed dentist, a subscriber to such policy shall be entitled to reimbursement for such service whether the said service is performed by a physician or licensed dentist and when such policy or any certificate issued there under or delivered or issued for delivery without the state by an authorized insurer so provides, covered persons residing in this state shall be entitled to reimbursement for dental services as herein provided;"

The Company's use of a discounted community rating methodology which was not filed or approved by this Department is noted as a violation of the New York Insurance Department Regulation 62, (11 NYCRR 52.40(e)).

It is recommended that the Company comply with New York Insurance Department Regulation 62, (11 NYCRR 52.40(e)) and discontinue the unapproved discounting and deviation of its filed rates with this Department.

B. Claims processing

1. Suspension of Claims

In our review of the claims procedures, it was revealed that UCICNY has in place a system generated procedure which automatically suspends payment of claims if the premium on such policy is in arrears.

The Company has a procedure listed in the United Concordia Delinquency and Collections Policy which causes an “intent to terminate coverage” letter to be sent to the group in the situation described above. Such procedure also provides for all future claims from the affected group to be suspended (not paid until the group’s premiums are current). The provision states the following:

Concurrent with the generation of the “Intent to term” letter, a delinquency indicator will be systematically placed on the group - effective the first of the month of the oldest delinquent invoice that meets the delinquency criteria. Any future claim(s) submitted with a date of service after this date, are suspended. If premium payment is subsequently received, the delinquency indicator will be systematically removed from the group on a nightly basis.

It is recommended that the Company discontinue its policy to link a group’s premiums being in arrears to suspension of the payment of claims.

2. Claim attribute sample

A review of claims processed during the period January 1, 2005 through December 31, 2005 was performed by using a statistical sampling methodology covering the claims processed during the aforementioned period in order to evaluate the overall accuracy and compliance environment of the Company’s claims processing.

This statistical random sampling process was performed using ACL, an auditing software program. The sampling methodology was devised to test various attributes

deemed necessary for successful processing of claims and to test and reach conclusions about all predetermined attributes, individually or on a combined basis. The review incorporated processing attributes used by the Company in its own "Quality Analysis" of claims processing. The sample size was comprised of 167 randomly selected claims.

The review indicated that three claims were "processed" incorrectly, according to the criteria used by both the Company and the Insurance Department examiners, not including any claims for which the Company issued Explanation of Benefits forms (EOBs) which were not in compliance with Section 3234 of the New York Insurance Law.

EOBs which contained wording not in compliance with Section 3234 of the New York Insurance Law were issued with regard to an additional 85 claims producing an overall accuracy rate of 47.31%.

If the EOB errors were not taken into consideration, the Company's claims processing accuracy rate would have been 98.20%.

3. Prompt Payment Law

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, which states, in part,

> "(a) Except in a case where the obligation of an insurer…to pay a claim…is not reasonably clear, …such insurer…shall pay the claim…within 45 days of receipt of a claim or bill for services 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: 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 2005 claims, using ACL audit software, for compliance with Section 3224-a of the New York Insurance Law. The review also determined 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) and (b) of the New York Insurance Law.

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

A population of 238 claims was identified as claims in which the payment dates were more than 45 days after the receipt date. All of the 238 claims were reviewed. A second population of 553 claims was identified as claims which were denied more than 30 days after the receipt date. A sample of 167 claims were taken and reviewed.

The examiners' review of the sampled claims revealed violations of Section 3224-a (a), (b) and (c) of the New York Insurance Law as shown in the following chart:

Description	Paid claims over 45 days	Denied claims over 30 days
Population	238	553
Sample Size	238	167
Errors	22	22
Calculated Error Rate	9.20%	13.17%
Upper Error Limit	N/A	18.30%
Lower Error Limit	N/A	8.04%
Lower Limit in Error	22	44
Upper Limit in Error	22	101

Of the 22 claims found to be in violation of Section 3224-a (a), 13 claims were also found to be in violation of Section 3224-a(c) because interest due of $2 or more was not paid.

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 recommended that the Company improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.

4. Explanation of Benefits Statements:

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

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

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

Section 3234(c) of the New York Insurance Law creates an exception to the requirements for the issuance of an EOB established in Section 3232(a) of the New York Insurance Law as follows:

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

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

> "The explanation of benefits form must include at least the following:
> (1) the name of the provider of service the admission or financial control number, if applicable;
> (2) the date of service;
> (3) an identification of the service for which the claim is made;
> (4) the provider's charge or rate;
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

A review of a sample of the Company's paid and denied claims for members/providers residing or located in New York during the period from January 1, 2005 to December 31, 2005 was performed. The review revealed that all EOBs issued by the Company failed to contain all the language required by Section 3234(b) of the New York Insurance Law (including the appeal language). The Company's EOBs, in the form as presented to the examiners would not be sufficient to serve as a proper EOB. The subscribers were neither properly informed of their appeal rights nor were they advised how their claims were processed. Therefore, all claims processed either paid or wholly/partially denied to New York subscribers and/or providers were in violation of Section 3234(b) of the New York Insurance Law.

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

5. Utilization review

Article 49 of the New York Insurance Law sets forth the minimum utilization review program requirements including standards for: registration of utilization review agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. Article 49 of the New York Insurance Law also establishes the insured's right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an insured's health care provider shall have the right to request an external appeal.

A. Section 4903(b) of the New York Insurance Law states:

> A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information.

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

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

A review was made of the Company's utilization review files for the period from January 1, 2005 to December 31, 2005. The review revealed the following:

The Company did not fully comply with Sections 4903(b) and (d) of the New York Insurance Law in that the Company's pre-authorization and retrospective review denial notices of first adverse determination were not sent to the subscribers.

It is recommended that the Company fully comply with Sections 4903(b) and (d) of the New York Insurance Law and send a notice of adverse determination to subscribers as well as to the providers when a pre-authorization or a retrospective utilization review is conducted.

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

> "Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
> (1) the reasons for the determination including the clinical rationale, if any;
> (2) instructions on how to initiate standard and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and
> (3) notice of the availability, upon request of the enrollee, or the enrollee's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal".

The Company did not fully comply with Section 4903(e) of the New York Insurance Law in that the Company's pre-authorization and retrospective review denial

notices of first adverse determination did not contain instructions on how to initiate standard appeals pursuant to Section 4904 and an external appeal pursuant to Section 4914 of the New York Insurance Law. Referring the subscriber to their contract or hand book is insufficient to satisfy the requirements of Section 4903 (e) of the New York Insurance Law. A notice of adverse determination should set forth the time, place and manner in which an appeal is initiated, including a description of standard and external appeals.

It is recommended that the Company comply with Section 4903(e) of the New York Insurance Law and include all required information in its notice of adverse determination when a pre-authorization or a retrospective utilization review is conducted.

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

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

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

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

The examiners' review of the Company's notices of final adverse determination revealed the following:

1. The Company failed to send a notice of final adverse determination to the subscribers as required by the New York Insurance Law.

2. The Company's final adverse determination notice sent to the providers failed to include mandated information regarding the availability of the external appeals process, along with the associated time frames for requesting such an appeal.

It is recommended that the Company send proper notice of final adverse determination of standard or external utilization review appeals in accordance with Sections 4904(c) and 4910(b) of the New York Insurance Law to its subscribers and, in connection with retrospective adverse determinations, to the providers.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

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

SUMMARY OF COMMENTS AND RECOMMENDATIONS

The following is a summary of the comments and recommendations included within the body of this report on examination.

ITEM		PAGE NO
A.	It is recommended that the Company enter into a proper custodian agreement with its custodian bank for its investment account. The custodian agreement should include the prudent protective covenants and provisions as set forth in the Department's guidelines.	11
B.	It is recommended that the Company's custodian of the securities complete the appropriate custodian affidavits to accompany the certified inventory of the securities as of December 31, 2005.	11
C.	It is recommended that the Company properly allocate expenses between cost containment, claim adjustment expense and general administrative expenses on its annual statement exhibit of "Part 3-Analysis of Expenses".	12
D.	It is recommended that the Company comply with Regulation 62, (11 NYCRR 52.40(e)), and discontinue the unapproved discounting and deviation of its filed rates with this Department.	19
E.	It is recommended that the Company discontinue its policy to link a group's premiums being in arrears to suspension of the payment of claims.	20
F.	It is recommended that the Company improve its internal claim procedures to ensure full compliance with Section 3224-a (a),(b) and (c) of the New York Insurance Law.	24
G.	It is recommended that the Company issue proper EOBs that include all of the requisite information required by Sections 3234 (a) and (b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.	26

Appointment No. 22485

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Jeffrey Usher

as a proper person to examine into the affairs of the

United Concordia Insurance Company of New York

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

Company

with such information as he shall deem requisite.

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

this 10th day of March 2006

Howard Mills
Superintendent of Insurance