REPORT ON EXAMINATION

OF

VYTRA HEALTH PLANS LONG ISLAND, INC.

AS OF

DECEMBER 31, 2001

DATE OF REPORT **FEBRUARY 13, 2004**

EXAMINER **WAI WONG**

TABLE OF CONTENTS

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

February 13, 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 21870 dated May 15, 2001, annexed hereto, I have made an examination into the financial condition and affairs of Vytra Health Plans Long Island, 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 thereon is respectfully submitted.

Wherever the terms "Vytra" or "HMO" appear herein without qualification, they should be understood to indicate Vytra Health Plans Long Island, Inc.

1. SCOPE OF EXAMINATION

Vytra Health Plans Long Island, 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 Empire'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 HMO
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 ascertain what action was taken by the HMO with regard to comments 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 HMO

Vytra Health Plans Long Island, Inc. (formerly ChoiceCare Long Island, Inc.) is a health maintenance organization ("HMO") that provides health care services in exchange for premiums charged. The HMO was incorporated on September 13, 1985, certified as an HMO on October 1, 1985, and began operations on January 1, 1986. Organized under the provisions of Article 44 of the New York Public Health Law, the HMO was licensed as a not-for-profit, independent practice association ("IPA") model HMO. An IPA is a group of independent medical practitioners that contract with an HMO to provide services to its members. ChoiceCare Long Island, Inc. was renamed Vytra Healthcare Long Island, Inc. effective November 18, 1996. Vytra Healthcare Long Island, Inc. was subsequently renamed Vytra Health Plans Long Island, Inc. effective November 20, 1999.

Initial donated capital consisted of $1,550,000 by the HMO's Class A member, Winthrop-University Hospital and $550,000 by the HMO's Class B Member, Health Care Plan. Additional contributions by both members increased the donated capital to $3,666,000 that includes $2,333,000 from Winthrop University Hospital and $1,333,000 from Health Care Plan, Inc. On September 17, 1998, and September 30, 1998, the HMO's members, Winthrop University Hospital and Health Care Plan, Inc. each respectively contributed additional capital of $4,500,000 via New York Insurance Law Section 1307 loans. On May 25, 1999, the New York

State Insurance Department approved two transactions that resulted in $2 million of each of the 1307 loans from Health Care Plan and Winthrop-University Hospital to Vytra being converted to contributed capital. The Department approved these transactions subject to the condition that no contributed capital will be returned by Vytra to Health Care Plan or Winthrop-University Hospital or any other entity without the prior approval of the Superintendent of Insurance. The effect of these two transactions was that Vytra, since inception received $7,666,000 in capital contributions and $5,000,000 in subordinate loans.

The HMO formed a wholly owned subsidiary CCLI Health Service Corporation (renamed Vytra Health Services, Inc.) for the purpose of providing health services under Article 43 of the New York Insurance Law. Vytra Health Services, Inc. ("Company") is licensed as a not-for-profit health service corporation under Article 43 of the New York Insurance Law. The Company was incorporated on September 19, 1989 and commenced business on October 1, 1995. The Company provides health insurance that indemnifies members for the cost of hospital and medical services rendered to them. The Company is organized as a membership corporation defined in Section 102(a)(5) of the Not-For-Profit Corporation Law. The sole member of the Company is ChoiceCare Long Island, Inc. (renamed Vytra Health Plans Long Island, Inc.). The initial capital of $1,500,000 was obtained through a New York Insurance Law Section 1307 loan agreement entered into on April 20, 1995. Pursuant to section 1307 of the New York Insurance Law, the repayment of principal and interest shall only be made out of free and divisible surplus, subject to the approval of the Superintendent of Insurance.

In November 2001 Health Insurance Plan of Greater New York (HIP) purchased control of Vytra from Winthrop-University Hospital, Mineola, NY and Health Care Plan, Inc. Buffalo,

NY for $31,000,000 each, for a total of $62,000,000. Notwithstanding the fact that Vytra Health Plans Long Island, Inc. and it's subsidiary Vytra Health Services, Inc. are now controlled by HIP, they continue to function as independent companies and there are currently no plans to merge the Vytra companies with HIP.

A. Management

Pursuant to the HMO's charter and by-laws, management of the HMO is vested in a board of directors consisting of not less than five but not more than nine members. As of the date of this exam the board consisted of seven members. Directors as of December 31, 2001 were as follows:

Name and Residence	Principal Business Affiliation
David Abernethy New York, NY	Senior VP Public Policy & Regulatory Affairs HIP
Robert W. Brokaw* Garden City, NY	Retired Formerly Senior Vice President Director of Human Resources ITT Sheraton Corporation
Michael Fullwood, Esq. New York, NY	Executive VP, CFO and General Counsel HIP
Thomas J. McAteer, Jr. Melville, NY	President and CEO Vytra
Daniel McGowan New York, NY	President and COO HIP
Francis Olsen New York, NY	Senior VP Coordination & Oversight HIP
Anthony Watson New York, NY	Chairman & CEO HIP

* HMO enrollee pursuant to Part 98.11(f) of the Health Department's Administrative Rules and Regulations {10 NYCRR 98}.

A new board of directors was created in November of 2001 after the purchase of Vytra by the Health Insurance Plan of Greater New York. Robert Brokaw and Thomas J. McAteer were the only directors who remained from the previous board. The previous board of directors held thirty-two meetings during the period under review. The meetings were generally well attended with the following exceptions. Robert R. Banta, John H. Krumpe and Frederick Yanni failed to attend at least 50% of the meetings in 2000 and Robert R. Banta failed to attend at least 50% of the meetings in 1999.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the insurer. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that the board may reach appropriate decisions. Individuals who fail to attend at least one-half of the regular meetings do not fulfill such criteria. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.

> Part 98-1.11(f) of the Department of Health Rules and Regulations {10 NYCRR 98} states in part:
>
> "…within one year of the HMO receiving a certificate of authority, no less than 20 percent of the members of the governing authority shall be enrollees of the HMO. Employees of the HMO or providers of health services may not serve as enrollee representatives…"

As of December 31, 2001 contrary to the aforementioned Regulation, the HMO had less than 20% (one out of seven members) of the Board designated as an enrollee representatives. Subsequent to the date of examination, Morris Lee was elected to the board on March 28, 2002

as a subscriber representative, satisfying the requirements of Part 98-1.11(f) of the Department of Health Rules and Regulations {10 NYCRR 98}.

The principal officers of the HMO as of December 31, 2001 were as follows:

Name	Title
Thomas McAteer	Chief Executive Officer & President
Philip Gandolfo	Executive Vice President and Chief Financial Officer
Michael Fullwood Esq.	Secretary

B. Territory and Plan of Operation

Vytra provides healthcare coverage for residents of Nassau, Queens and Suffolk counties in the State of New York. The HMO contracts with primary and specialty care physicians. The HMO also provides coverage for prescription drugs, vision care and hospitalization.

C. Contingency Reserve

A certified operating HMO is required to maintain a contingency reserve pursuant to the requirements of Part 98.11(d) of the Department of Health Rules and Regulations {10 NYCRR 98}.

Vytra Health Plans Long Island, Inc. was required to maintain a contingency reserve of $10,548,003 as of December 31, 2001. The contingency reserve is calculated by increasing the previous calendar year-end contingency reserve by 1% of the current year's premium income, with the maximum contingency reserve being 5% of the current year's premium. Vytra's premium income for the 2001 was $210,960,049; 5% of that amount yields the contingency reserve amount of $10,548,003.

D. Reinsurance

The examiner reviewed all reinsurance contracts in effect during 2001 and 2002. The HMO 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 HMO, 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.
Term of Agreement (Incurral Period)	1/1/01 –12/31/01
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 Vytra 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 Vytra 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 HMO 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 HMO's members against impairment and insolvency. In Vytra'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.

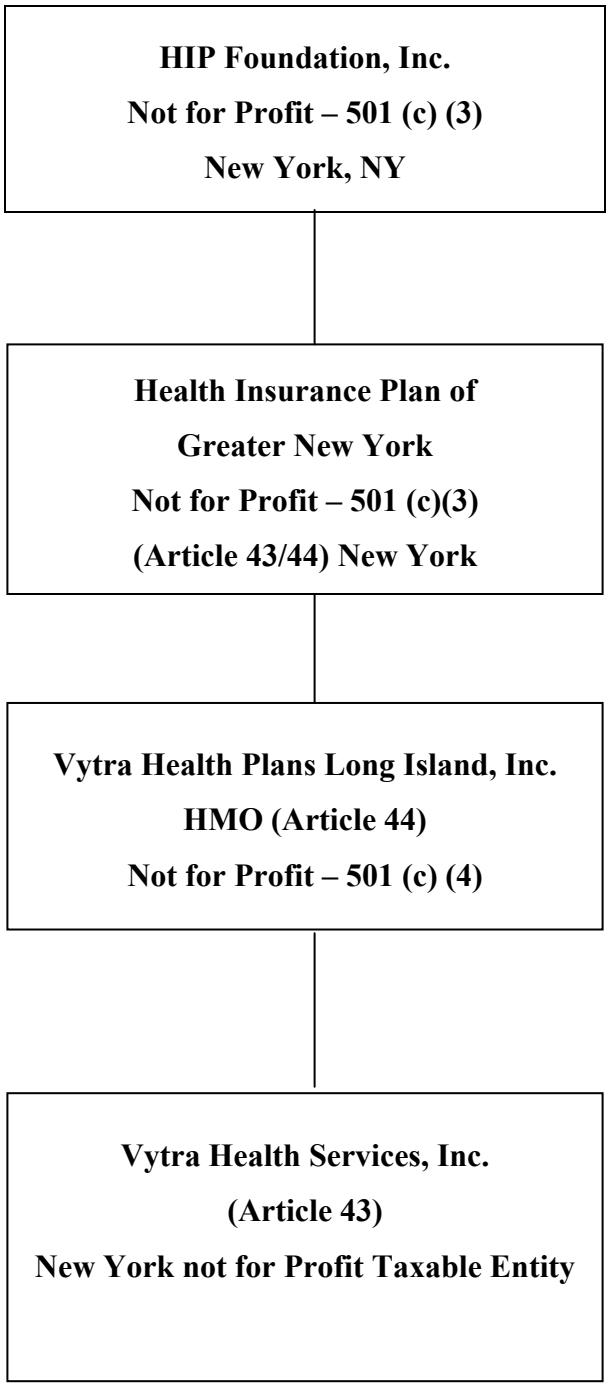
Reinsurance contracts are approved by the Department during the initial certification of an HMO pursuant to Part 98.5(b)(7) of the Department of Health Rules and Regulations {10 NYCRR 98.5(b)(7)} to assure that they contain required provisions relative to insolvency protection and continuation of coverage. Further, Part 98.8(b) requires the prior approval of the Superintendent and the Commissioner for changes in risk sharing with insurers (i.e. reinsurance contracts) as follows.

"(b) Any amendments to the risk-sharing arrangements contained in any contracts between the HMO and insurers shall not be entered into without prior approval of the Commissioner and the superintendent…"

It is recommended that the HMO submit the reinsurance agreement in effect to the Department for review and approval in accordance with Part 98-1.8(b) of the Department of Health Rules and Regulations {10 NYCRR 98}.

E. Holding Company System

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



Vytra Health Plans Long Island, Inc. is a health maintenance organization incorporated under the Not-For-Profit Corporation Law of New York and was a corporate joint venture by Winthrop University Hospital and Univera Healthcare. Vytra Health Plans Long Island, Inc. is the sole corporate member of its subsidiary Vytra Health Services, Inc., an insurer licensed under Article 43 of the New York Insurance Law. The HMO and its subsidiary were acquired by the Health Insurance Plan of Greater New York during November 2001.

F. Accounts and Records

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

- Vytra did not list any premiums received in advance on its 2001 annual statement filing. The amount for premiums received in advance was included with trade payables in Vytra's trial balance. The trade payables sub-account is part of the general expenses due and accrued account on the 2001 annual statement. Vytra's premium received in advance for the year 2001 amounted to $2,715,472. The HMO filed an amended 2001 statement with the Department, which listed premiums received in advance separately.

- Vytra failed to list any claims adjustment expenses on its annual statement for the year 2001. It should be noted that Vytra 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 Vytra did not include any explicit provision for the administrative expenses associated with processing unpaid claims. Accordingly,

Milliman USA added 3% to Vytra's outstanding claim liability for loss adjustment expense based upon its own experience with other health plans. Notwithstanding Milliman's recommendation, Vytra did not initially report such a reserve in its filed annual statement. Vytra subsequently filed an amended annual statement for 2001, which listed separately the unpaid claims adjustment expenses.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as regards policyholders as determined by this examination and as reported by the HMO in its December 31, 2001 filed annual statement:

	Company			Examination	
Assets	Assets	Not-Admitted Assets	Admitted Assets	Admitted Assets	Surplus Increase (Decrease)
Cash	$ 39,878,361	$ 0	$ 39,878,361	$ 1,657,609	$ (38,220,752)
Short-term investments	19,588,822		19,588,822	57,658,810	38,069,988
Investment in Vytra Health Services, Inc.	3,939,114		3,939,114	3,939,114	
Accident and health premiums due and unpaid	1,000,156		1,000,156	1,000,156	
Amounts recoverable from reinsurers	380,705		380,705	380,705	
Investment income due and accrued	300,565		300,565	300,565	
Amounts due from parent, subsidiaries and affiliates	1,615,004		1,615,004	1,615,004	
Furniture and equipment	1,446,366	1,446,366			
EDP equipment and software	2,236,124		2,236,124	2,236,124	
Prepaid expenses	552,042	552,042			
Aggregate write ins for other than invested assets	139,199		139,199	289,963	150,764
Goodwill from HIP	26,579,351	26,579,351			
Total assets	$ 97,655,809	$ 28,577,759	$ 69,078,050	$ 69,078,050	$ 0

Liabilities, Capital and Surplus	Company	Examination	Surplus Increase (Decrease)
Claims unpaid	$ 36,266,627	$ 30,641,600	$ (5,625,027)
Unpaid claims adjustment expenses	474,900	474,900	
Premiums received in advance	2,715,472	2,715,472	
General expenses due and accrued	3,294,599	3,294,599	
Amounts due to parents, subsidiaries and affiliates	822,904	822,904	
Salaries and Payroll taxes	2,964,412	2,964,412	
Total liabilities	$ 46,538,914	$ 40,913,887	$ (5,625,027)
Gross paid in and contributed surplus	41,470,351	41,470,351	
Aggregate write-ins for other than special surplus funds	10,548,003	10,548,003	
Unassigned funds (surplus)	$ (29,479,218)	$ (23,854,191)	$ 5,625,027
Total capital and surplus	$ 22,539,136	$ 28,164,163	$ 5,625,027
Total liabilities, capital and surplus	$ 69,078,050	$ 69,078,050	$ 0

B. Statement of Revenue and Expenses

Capital and surplus increased by $17,103,849 during the three-year examination period, January 1, 1999, through December 31, 2001, detailed as follows:

Statement of Income

Revenue:		
Net premium income	$ 687,320,672	
Net investment income earned	5,964,346	
Aggregate write-ins for other income or (expenses)	956,653	
Net reinsurance recoveries	2,186,545	
Total Revenue		$ 696,428,216
Medical and Hospital Expenses:		
Hospital/medical benefits	$ 366,658,904	
Outside referrals	87,709,955	
Emergency room, (out of area)	13,142,981	
Aggregate write-ins for other medical and hospital expenses	21,902,674	
Drug expense	87,795,511	
COB and subrogation	(18,432,798)	
Total medical and hospital expenses		$ 558,777,227
Total administrative expenses		$ 118,956,594
Net income (loss)		$ 18,694,395

Change in Net Worth

Capital and surplus as of December 31, 1998, per report on examination				$ 5,435,285
	Gains in Surplus		Losses in Surplus	
Net income	$ 18,694,395			
Change in non admitted asset		($	28,577,760)	
Change in surplus notes		($	9,000,000)	
Increase (decrease) in contributed capital	$ 4,000,000			
Increase (decrease) in contingency reserve fund	$ 1,929,437			
Paid in capital	$ 34,629,351			
Aggregate write-ins for gains or (losses) in surplus		($	4,571,572)	
Total gains and losses	$ 59,253,183	($	42,149,332)	
Net increase to Capital and surplus.				$ 17,103,851
Capital and surplus as of December 31, 2001, per report on examination				$ 22,539,136

4. CASH AND SHORT TERM INVESTMENTS

A. Cash

The examination asset of $1,657,609 is $38,220,752 less than the $39,878,361 reported by the HMO in its 2001 filed annual statement. The decrease resulted from a reclassification of the following assets:

- Investments in commercial paper which matured within 3 three months were reclassified from cash to short-term investments. The account was decreased by $7,574,595.45.

- A money market fund, which invests in government obligations, was reclassified as short-term investments from cash. The account was decreased by $30,495,392.20.
- A security deposit by American Home Mortgage Corporation for property leased from Vytra was reclassified as other assets from cash. The account was decreased by $150,764.28.

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

It is recommended that Vytra reclassify its security deposit by American Home Mortgage Corporation under the caption “Other Assets”.

Section 1316 of the New York Abandoned Property Law requires that certain unclaimed insurance proceeds which is 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 HMO 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 HMO at the close of business on December 31 each year.

During the review, it was noted that Vytra 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 makes those items insurance proceeds. Accordingly, the HMO 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 HMO publish a listing of all unclaimed checks within thirty days of the filing of the report, which Vytra failed to do.

It is recommended that Vytra file abandoned property reports pursuant to Section 1316 of the Abandoned Property Law and publish a list of unclaimed checks as required.

B. Short term investments

A review of the Vytra'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 Vytra ensure that the HMO's investment transactions are authorized and approved by it's board of directors pursuant to 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 Vytra 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 Vytra 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 HMO 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 HMO 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 Plans Long Island, 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 on Vytra'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 Vytra'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 Vytra 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 still remain with J.P. Morgan Chase.

It is recommended that Vytra instruct any bank or trust company with which it executes any custodial or safekeeping agreements to provide the Insurance Department 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 Vytra 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."

Vytra's failure to complete Schedule D hindered the Department's analysis of the statutory admissibility of its investments. Technically, any of Vytra'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.

Vytra 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 $30,641,600 is $5,625,027 less than the $36,266,627 reported by the HMO 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. Vytra has acknowledged that the HMO was over reserved and has stated it will reduce its claims unpaid liability.

6. AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

Vytra Health Plans Long Island, Inc. had the following inter-company accounts for 2001: Two inter-company accounts with Vytra Health Services, Inc one for its standard Point of Service business and one for the solutions point of service business. The solutions contract allows its members to see any provider within Vytra's network without a referral from their primary care physician. Vytra Health Plans Long Island, Inc. also has inter-company balances with Vytra Health Management Systems a subsidiary of Health Insurance Plan of Greater New York (HIP) incorporated for the purposes of engaging in the business of providing managed health care Administrative Services for the HMO. 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 Plans Long Island, Inc. receives an administrative fee of 2.8% of the monthly premium from Vytra Health Services, Inc. for the point of service product. For the solutions product the HMO receives an administrative fee of 13% of the monthly premium from Vytra Health Service, Inc. The administration fee paid to the HMO by Vytra Health Management Systems for self-insured business is based upon the member months multiplied by a factor of 9.85.

Part 98.10 (c) of the Department of Health Rules and Regulations {10 NYCRR 98} states:

> "The commissioner's and superintendent's prior approval shall be required for the following transactions between a controlled HMO and any person in its holding company system: sales, purchases, exchanges, investments or rendering of services on a regular or systematic basis the aggregate of which involves 10 percent or more of the HMO's admitted assets at last year-end. Notice shall be required for such transactions of five percent or more."

Vytra was unable to produce inter-company agreements between Vytra Health Plans Long Island, Inc. and Vytra Health Services, Inc. for the 2.8% fee paid on the point of service product or for the administrative fees paid by Vytra Health Management Systems on the self insured product. Though Vytra had an inter-company agreement for the solutions contract between Vytra Health Plans Long Island, Inc. and Vytra Health Services, Inc. dated as of April 10, 1995, the contract was effective for only five years and expired in the year 2000.

It is recommended that Vytra Health Plans of Long Island, Inc. develop and file with the Department inter-company agreements for its Point of Service, solutions and self-insured products in accordance with Part 98.10 (b) of the Department of Health Rules and Regulations {10 NYCRR 98}.

7. MARKET CONDUCT EXAMINATION

As part of the Department's examination of Vytra Health Plans Long Island, Inc., a review of the manner in which the HMO 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 the HMO 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. Agents and Brokers

A review was done of Vytra's contracts with agents and brokers for licensing, appointment letters and compensation.

Vytra provided the examiners with a listing of 1,134 external producers, both active and terminated, which consisted of 58 brokers and 1,076 agents. This listing was reviewed against

the Department listing received from the Department's Licensing Bureau of active and terminated producers for Vytra.

The examiner found 547 producers either active or terminated, who appeared on Vytra's listing but not the Department's. From this group 25 active and 10 terminated producers were selected for review.

Twenty-two of the twenty-five active producers sampled were agents. Vytra failed to file certificate of appointments for ten of the agents in violation of this section.

§ 2112(a) of the New York State Insurance Law states:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

It is recommended that Vytra file appointment letters for all agents with the Department's Licensing Bureau to comply with § 2112(a) of the New York State Insurance Law.

Vytra was unable to produce current licenses for fourteen of the agents sampled. In addition the licensing bureau did not have any record that the fourteen agents had current licenses.

§ 2102(a)(1) of the New York State Insurance Law states:

> "No person, firm association or corporation shall act as an insurance agent, insurance broker, reinsurance intermediary or insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

It is recommended that Vytra ensure that all their producers have valid licenses as required by § 2102(a)(1) of the New York State Insurance Law.

Vytra failed to provide notices of termination for seven of the ten terminated agents sampled in violation of this section.

§ 2112(d) of the New York State Insurance Law states:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall, upon termination of the certificate of appointment of any insurance agent licensed in this state, forthwith file with the superintendent a statement, in such form as the superintendent may prescribe, of the facts relative to such termination and the cause thereof. Every statement made pursuant to this section shall be deemed a privileged communication."

It is recommended that Vytra file notices of termination with the department for all terminated agents as required by § 2112(d) of the New York State Insurance Law.

B. Grievances and Appeals

The examiners reviewed a sample of thirteen grievance cases for compliance with Article 44 of the Public Health Law. Three of the thirteen grievance cases went to a second level appeal. The second level appeal for these three cases were also reviewed.

There were no violations noted on the review of the initial grievances.

The review of the second level appeal found that the HMO failed to provide a specific reason for its appeals decision on the determination notices sent to the subscriber. 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.

C. Utilization Review – Appeals of Adverse Determination

A sample of fifteen appeals of adverse determinations by utilization review agents were selected for review for compliance with Article 49 of the Public Health Law.

§ 4904 (3) of the Public Health Law states:

> "...The utilization review agent shall notify the enrollee, the enrollee's designee and, where appropriate, the enrollee's health care provider, in writing, of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include..."

Vytra did not provide the enrollee notice of the appeal determination within 2 business days of the rendering such notice on two occasions, in violation of this section.

It is recommended that Vytra put in place procedures to ensure that it notifies its enrollees of the results of appeal determinations within two business days of the rendering of such determination as required by § 4904 (3) of the Public Health Law.

D. 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 Vytra's claim's processing.

Vytra'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 92.22% for medical claims and 92.81% for hospital claims. Overall claims processing procedural accuracy levels were 65.27% for medical claims and 79.64% 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 Vytra'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	1,434,753	94,371
Sample Size	167	167
Number of claims with Errors	12	12
Calculated Error Rate	7.78%	7.19%
Upper Error limit	11.85%	11.10%
Lower Error limit	3.72%	3.27%
Calculated claims in error	111,624	6,785
Upper limit Claims in error	170,018	10,475
Lower limit Claims in error	53,373	3,086

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	1,434,753	94,371
Sample Size	167	167
Number of claims with Errors	58	34
Calculated Error Rate	34.73%	20.36%
Upper Error limit	41.95%	26.47%
Lower Error limit	27.51%	14.25%
Calculated claims in error	498,290	19,214
Upper limit Claims in error	601,879	24,980
Lower limit Claims in error	394,701	13,448

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 Vytra reimbursed non-participating providers for services performed at in-network facilities according to Vytra's contracted fee schedule. These non-participating providers should have been reimbursed based upon the usual, customary and reasonable rate. As non-participating providers do not have to accept Vytra's contracted rate as payment in full they would be entitled to balance bill the member for any outstanding fee. Vytra discovered the problem and has taken steps to identify and reimburse the affected providers.

- Many of Vytra'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.

E. 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. Further, a separate sample for each company was selected for hospital and medical claims. 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	1,434,753	94,371
Claim Population unpaid over 45 days	18,185	2,516
Sample Size	167	167
Number of claims with Errors	161	166
Calculated Error Rate	96.41%	99.40%
Upper Error limit	99.23%	100%
Lower Error limit	93.58%	98.23%
Calculated claims in error	17,532	2,501
Upper limit Claims in error	18,045	2,515
Lower limit Claims in error	17,018	2,471

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	1,434,753	94,371
Claim Population unpaid over 45 days	18,185	2,516
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% (1.35%) of the 1,529,124 medical and hospital claims processed during the period.

It is the policy of the HMO to pay all claims within 45 days where Vytra'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 161 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.

F. Claim 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 with zero payments made past 30 days was reviewed to determine Vytra's compliance with the above statue.

The examiners found that 27 of the 30 claims reviewed were in violation of the aforementioned 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 Vytra put in place procedures to ensure that denial notices are sent out on a timely basis as required by §3224-a (b) of the New York Insurance Law.

G. 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."

Vytra'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 Vytra 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 7 out of 167 of Vytra's medical claims and 10 out of 167 of Vytra's hospital claims failed to send an explanation of benefit form to the member in violation § 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 Vytra'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 Vytra's Explanation of Benefits statements show the discounted payments made when applicable.

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

ITEM NO.		PAGE NO.
A.	Management	
	It is recommended, that the HMO comply with Section 621(a) of the New York Not-for-Profit Corporate law, and its by-laws by keeping at its office, minutes of proceedings of its members, board and executive Committee.	6
	The HMO has complied with this recommendation.	
D.	Reinsurance	
	It is recommended that the HMO submit the reinsurance agreement in effect to the New York State Insurance Department for review and approval in accordance with Public Health Law, Part 98-1.8(b) of the Health Department Regulations {10 NYCRR 98}.	10
	The HMO has not complied with this recommendation and it is repeated herein.	
	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.	11
	The HMO has not complied with this recommendation and it is repeated herein.	

ITEM NO. **PAGE NO.**

F. Custodial Agreement

It is recommended that the HMO enter into a formal custodial agreement with the bank that contains at a minimum, protective covenants and provisions suggested by this Department. 13

The HMO has not complied with this recommendation and it is repeated herein.

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO.		PAGE NO.
	Management	
A.	As of December 31, 2001 contrary to the aforementioned Regulation, the HMO had less than 20% (one out of seven members) of the Board designated as an enrollee representatives. Subsequent to the date of examination, Morris Lee was elected to the board on March 28, 2002 as a subscriber representative, satisfying the requirements of Part 98-1.11(f) of the Department of Health Rules and Regulations {10 NYCRR 98}.	6
	Reinsurance	
B.	It is recommended that the HMO submit the reinsurance agreement in effect to the Department for review and approval in accordance with Part 98-1.8(b) of the Department of Health Rules and Regulations {10 NYCRR 98}.	9
	Accounts and Records	
C.	Vytra did not list any premiums received in advance on its 2001 annual statement filing. The amount for premiums received in advance was included with trade payables in Vytra's trial balance. The trade payables sub-account is part of the general expenses due and accrued account on the 2001 annual statement. Vytra's premium received in advance for the year 2001 amounted to $2,715,472. The HMO filed an amended 2001 statement with the Department, which listed premiums received in advance separately.	11

ITEM NO.		PAGE NO.
	Short Term Investments	
H.	It is recommended that Vytra ensure that the HMO's investment transactions are authorized and approved by it's board of directors pursuant to the provisions of Section 1411(a) of the New York Insurance Law and that such transactions be appended to the minutes thereof.	20
I.	It is recommended that Vytra instruct any bank or trust company with which it executes any custodial or safekeeping agreements to provide the Insurance Department 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 Vytra Health Plans of Long Island, Inc. develop and file with the Department inter-company agreements for its Point of Service, solutions and self-insured products in accordance with Part 98.10 (b) of the Department of Health Rules and Regulations {10 NYCRR 98}.	23
	Agents and Brokers	
K.	It is recommended that Vytra file appointment letters for all agents with the Department's Licensing Bureau to comply with § 2112(a) of the New York State Insurance Law.	24
L.	It is recommended that Vytra ensure that all their producers have valid licenses as required by § 2102(a)(1) of the New York State Insurance Law.	24

ITEM NO.		PAGE NO.
	Agents and Brokers	
M.	It is recommended that Vytra file notices of termination with the department for all terminated agents as required by § 2112(d) of the New York State Insurance Law.	25
	Grievances and Appeals	
N.	The review of the second level appeal found that the HMO failed to provide a specific reason for its appeals decision on the determination notices sent to the subscriber. The appeal notice only stated that the original determination was upheld. It was Vytra's position that the appeal notice in conjunction with the original grievance letter satisfied the requirement of the Law. Notwithstanding the foregoing, Vytra has revised its appeal letters to include the specific reasons for the determination.	25
	Utilization Review – Appeals of Adverse Determination	
O.	It is recommended that Vytra put in place procedures to ensure that it notifies its enrollees of the results of appeal determinations within two business days of the rendering of such determination as required by § 4904 (3) of the Public Health Law.	26

ITEM NO.		PAGE NO.
	Claims Processing	
P.	During the period November 1, 2001 through February 28, 2002 Vytra reimbursed non-participating providers for services performed at in-network facilities according to Vytra's contracted fee schedule. These non-participating providers should have been reimbursed based upon the usual, customary and reasonable rate. As non-participating providers do not have to accept Vytra's contracted rate as payment in full they would be entitled to balance bill the member for any outstanding fee. Vytra discovered the problem and has taken steps to identify and reimburse the affected providers.	29
Q.	Many of Vytra'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.	29
	Prompt Pay	
R.	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.	32
	Claim Denials	
S.	It is recommended that Vytra put in place procedures to ensure that denial notices are sent out on a timely basis as required by §3224-a (b) of the New York Insurance Law.	33

ITEM NO.		PAGE NO.
	Explanation of Benefits	
T.	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.	34
U.	It is recommended that Vytra's explanation of benefits statements show the discounted payments made when applicable.	34

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. **21870**

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 Plans Long Island, 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