REPORT ON EXAMINATION

OF

MVP HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2003

DATE OF REPORT	**MARCH 27, 2006**
EXAMINER	**ELSAID ELBIALLY, CFE**

TABLE OF CONTENTS

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

George E. Pataki
Governor

Howard Mills
Superintendent

March 27, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22142 dated January 30, 2004, attached hereto, I have made an examination into the condition and affairs of MVP Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law. The following report is respectfully submitted.

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

Wherever the designations “MVPHP” or “HMO” appear herein without qualification, they should be understood to refer to MVP Health Plan, Inc.

1. SCOPE OF EXAMINATION

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

The examination comprised a complete verification of assets and liabilities as of December 31, 2003, in accordance with statutory accounting principles, as adopted by the Department, a review of income and disbursements to the extent deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO'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 HMO
Management of the HMO
Corporate records
Fidelity bonds and other insurance
Officers' and employers' welfare and pension plans
Territory and plan of operations
Growth of the HMO
Accounts and records
Loss experience
Treatment of subscribers

A review was made to ascertain the action that was taken by the HMO 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 HMO's compliance with the New York Insurance and New York Public Health Laws. Significant findings relative to this examination are as follows:

- The HMO failed to submit its reinsurance agreement to the New York State Departments of Health and Insurance.
- The HMO understated claims adjustment expenses and its reserve for unpaid claims adjustment expenses by failing to allocate administrative costs properly within expense categories on the Underwriting and Investment Exhibit, "Part 3-Analysis of Expense" schedule of the HMO's annual statement.
- The HMO failed to investigate and reconcile its bank accounts in a timely manner.
- The HMO failed to adhere to the requirements of Statement of Statutory Accounting Principles (SSAP) No. 6 with regard to the reporting of its uncollected premiums on various schedules of its 2003 annual statement.
- The HMO failed to comply with the Abandoned Property Law which resulted in a delay of two years to send abandoned funds to the State of New York, Comptroller's Office.
- The HMO failed to report on its annual statement, an accurate breakdown of earned premiums and claims expenses by large groups, small groups and individuals.
- The HMO failed to adhere to its stated policy relative to group terminations.
- The HMO failed to fully comply with the requirements of the Prompt Pay Law.
- The HMO failed to issue Explanation of Benefits statements (EOBs) to some members.

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

3. DESCRIPTION OF HMO

MVP Health Plan, Inc. was incorporated on July 30, 1982 pursuant to Section 402 of the New York Not-For-Profit Corporation Law for the purpose of operating as a health maintenance organization as such term is defined in Article 44 of the New York Public Health Law. MVPHP is a federally qualified HMO. The HMO's incorporators were the board of directors of the Schenectady County Foundation for Medical Care, Inc., a non-profit physicians' association. Simultaneously with the incorporation of the HMO, the incorporators formed Mohawk Valley Medical Associates, Inc., a non-profit independent practice association (IPA), pursuant to the same section of the Not-For-Profit Corporation Law.

MVP Health Plan, Inc. is an IPA model HMO. On March 8, 1982, the HMO and Mohawk Valley Medical Associates, Inc. contracted, through an "IPA Service Agreement" to work together to provide for the administration of a comprehensive prepaid program of health care and for the delivery of health services. Subsequently, the HMO made similar arrangements with five other independent practice associations to achieve the same goal. This is discussed more fully in Item 3B of this report, "Territory and Plan of Operation."

A. Management and control

Pursuant to the HMO's charter and by-laws, management of the HMO is vested in a board of directors consisting of not be less than twelve nor more than twenty five directors. As of December 31, 2003 the board of directors consisted of eighteen members as set forth below:

Name and Residence	Principal Business Affiliation
Physicians Representatives	
Donald A. Bentrovato, M. D. Schenectady, New York	Urologist
Richard J. D'Ascoli, M. D. Schenectady, New York	Orthopedic Surgeon
Richard F. Gullott, M. D. Scotia, New York	Internal Medicine
John F. Houck Jr., M. D. New Hartford, New York	Physician
Stephen Lichtenberg, M. D. Poughkeepsie, New York	Cardiologist
Joseph J. Schwerman, M. D. Hyde Park, New York	Internal Medicine
Subscriber Representatives	
Burt Danovitz, Ph. D. Utica, New York	Executive Director, Resource Center for Independent Living
Joseph F. Heavey Poughkeepsie, New York	Associate Director, Veterans' Hospital
Karen B. Johnson Schenectady, New York	Director of Development, Proctors Theatre
Mary Cosgrove Militano, Esq. Scotia, New York	Attorney
Leland C. Tupper Schenectady, New York	Treasurer, MVP Health Plan, Inc

Name and Residence	Principal Business Affiliation
Timothy Wade Scotia, New York	President, Priority Financial Services, LLC
Herschel Lessin, M. D. Poughkeepsie, New York	Vice President, Hudson Valley Pediatric Group, PC
Ernest Levy, M. D. Oneonta, New York	Neurosciences & Radiology,
Community Representatives	
Samuel Larry Feldman, CLU Latham, New York	President, CFK Life Plans, Inc.
Murray M. Jaros, Esq. Albany, New York	Attorney, New York State Association of Towns
Jon Rich Alplaus, New York	Retired
Norma C. Westcott Rexford, New York	Consultant, Westcott Enterprises, Inc.

The minutes of all meetings of the Board of Directors, and committees thereof, held during the examination period, were reviewed. During the examination period, board meetings were generally well attended; all directors attended at least half of the meetings they were eligible to attend.

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

Name	Title
David W. Oliker	President and Chief Executive Officer
David Field	Executive Vice-President and Chief Operating Officer
Leland Tupper	Treasurer
Murray M. Jaros, Esq.	Secretary

B. Territory and plan of operation

The HMO's service area, as stated in its Certificate of Authority, as of December 31, 2003, included the following thirty two counties in New York:

Albany	Fulton	Oneida	Saratoga
Broome	Greene	Onondaga	Schenectady
Cayuga	Hamilton	Orange	Schoharie
Chenango	Herkimer	Oswego	Sullivan
Columbia	Jefferson	Otsego	Tioga
Cortland	Lewis	Putnam	Ulster
Delaware	Madison	Rensselaer	Warren
Dutchess	Montgomery	Rockland	Washington

The HMO contracted with various independent practice associations (IPAs), to provide, through their combined efforts, a comprehensive prepaid program of health care and the delivery of health services. All contracts are similar in nature. Each contract is entitled, "IPA Service Agreement" (hereinafter referred to as "the IPA agreement".

The IPA agreements were entered into with the following entities:

Name of IPA	Date of contract
Mohawk Valley Medical Associates, Inc. (MVMA),a not-for-profit corporation	January 1, 1994
Central New York Independent Practice Association, Inc. (CNYIPA), a not-for-profit corporation	December 9, 1985
Taconic I. P. A. , Inc. (TIPA), a for-profit corporation	July 1, 1998
Midstate Individual Practice Association, Inc. (Midstate), a not-for-profit corporation	October 1, 1997
South Central New York individual Practice Association (SCNYIPA), a not-for-profit corporation	May 6, 1987
Two Rivers Individual Practice Association (Two Rivers), a not-for-profit corporation	January 1, 1994

According to the IPA agreements, the HMO provides all administrative, marketing, enrollment, financial, accounting, claims processing, management information and other functions necessary, convenient or appropriate for the administration of a comprehensive prepaid health program. The IPA is responsible for establishing contractual relationships with physicians, health care professionals and other providers of health care and for arranging for and facilitating the availability and delivery of health services to members of the HMO. These IPA agreements require that such providers look solely to the IPA for compensation for covered services and at no time seek compensation from members except for nominal co-payments required under the subscribers' health service contracts.

As of January 1, 2000, all IPAs were under risk contacts with MVPHP. Every month, MVPHP calculates the capitation amounts due to the IPAs (based on a per member per month method), then makes a journal entry to debit claim expenses and credit accounts payable "Due to the IPAs". MVPHP invests the amounts due to the IPAs with its own funds in accordance with an investment pooling arrangement. Pursuant to the administrative duties specified in the IPA agreements, MVPHP processes and pays provider claims on behalf of IPAs. MVPHP issues checks to IPA physicians, who are paid on a fee-for-service basis. MVPHP then transfers funds to the IPA's bank accounts on a daily basis to cover the cost of all provider checks that are presented.

MVPHP also has risk sharing agreements with the IPAs to address the cost variance for certain medical costs. These risk-sharing agreements differ between the IPAs. The premise is that MVPHP and its IPAs are responsible for certain medical costs that affect each other. Under the agreements, the actual medical costs of certain services are compared to budget amounts with the differences being shared by MVPHP and the IPA.

Pursuant to agreements between the IPAs and their participating physicians, MVPHP withholds either 15 or 20 percent from provider payments when issuing checks. The amounts withheld are credited to an IPA withhold liability. Amounts to be returned to providers are reviewed on an annual basis. Any amounts not returned are recorded as reductions of medical expenses, with corresponding reductions to the related liability in

the physicians' risk withholding account. Effective January 1, 2001, the TIPA Participating Physician contract eliminated the withhold provision.

As of December 31, 2003, MVMA and TIPA, were the only remaining IPAs operating under capitation agreements. CYNIPA, Midstate, SCNYIPA, and Two Rivers changed to agreements wherein the HMO is liable for the payment of claims from its own funds under a fee-for-service arrangement and the participating physicians are not subject to a withhold provision.

As of December 31, 2003, the HMO's service area, within the State of New York, as authorized by the New York State Department of Health, covered six regions which are served by the following IPAs. The exception is Jefferson County where MVPHP directly contracted with medical and hospital providers:

Eastern region served by MVMA, covering the counties of Albany, Fulton, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

Central region served by CNYIPA, covering the counties of Herkimer, Lewis, Madison and Oneida.

Mid-Hudson region served by TIPA, covering the counties of Dutchess, Orange, Putnam, and Rockland, Sullivan, Ulster, and the southern portion of Greene and Columbia.

South Central region served by SCIPA, covering the counties of Chenango, Delaware and Otsego. Parties recognize that the independent practice association, Two Rivers IPA, Inc. and Basset Health Care may each continue to maintain a presence in the various counties within which they operate and not constitute a breach of the Agreement.

Southern Tier region served by Two Rivers, covering the counties of Broome, Tioga, and portions of Chenango, and Delaware counties. The parties recognize that Bassett Healthcare, South Central IPA, and Guthrie Clinic, P.C. and physicians associated with those entities, may continue a presence within those counties.

Southern Tier region served by Midstate IPA and covering the counties of Onondaga, Oswego, and Cayuga.

Cortland county is served by ECPO, Inc., which is an IPA (ECPO stands for Eight County Physician Organization, but the legal name is ECPO, Inc.)

In addition, on March 20, 1993, the HMO was issued a Certificate of Authority to transact the business of a Health Maintenance Organization in the State of Vermont. The HMO entered into capitation agreements with Vermont Managed Care/Fletcher Allen Health Care, Inc., ("VMC") and United Health Alliance ("UHA") to provide health care services to its members throughout the State of Vermont.

The HMO's enrollment grew by 15% during the examination period, MVPHP's enrollment as of December 31st for the years under examination was as follows:

	1999	2000	2001	2002	2003
New York	274,669	256,080	304,948	309,322	310,759
Vermont	25,808	60,218	64,527	38,549	34,972
Total members	300,477	316,298	369,475	347,871	345,731

It should be noted that the above enrollment numbers do not include self-insured groups. At December 31, 2003, there were approximately 119,979 self-insured participants. Under terms of these agreements, MVP Select Care, Inc., a wholly-owned subsidiary of the HMO, provided these groups administrative services that included, but was not limited to membership and claims processing operations, management information systems and utilization review services.

The HMO does not currently provide Medicare coverage. Medicaid, Family Health Plus, and Child Health Plus were offered starting in 2004. Healthy New York (HNY) started on January 1, 2001. The following is a breakdown of MVPHP's enrollment, showing member months by line of business for the period covered by this examination:

Year	HMO	POS	HNY	Total
2000	3,472,649	250,390	-0-	3,723,039
2001	3,972,228	356,723	34,178	4,363,129
2002	4,129,939	10,527	16,461	4,156,927
2003	3,692,761	446,753	39,565	4,179,079

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

C. Reinsurance

At December 31, 2003, the HMO had a reinsurance agreement with Employers Reinsurance Corporation, an accredited reinsurer, on a per member per contract year basis. The agreement requires the reinsurer to pay specified percentages of all eligible hospital and medical service claims paid by the HMO during the contract year in excess of a $250,000 deductible per case, except the separately underwritten three members named in the reinsurance agreement. The annual deductible for each of the three individual members ranged between $300,000 and $400,000.

The following chart depicts the percentage of loss the reinsurer will indemnify the HMO relative to all members with the exception of the separately underwritten three members, in excess of a specified deductible.

For all other Members:	For Losses between $250,001 - $499,999	For Losses of $500,000 & above
A. Hospital Service:		
(i) Inpatient Hospital Services:		
(a) Transplant services:		
Scheduled	60%	90%
Unscheduled	60%	Avg. Daily Charge $3,000 or less 90% Greater than $3,000, 60%
(ii) Other inpatient hospital services:	60%	90%
(iii) Sub-acute facility services; SNF services; Inpatient Rehab. Facility; Hospice Services; Home Health Care Agency Services	60%	90%
B. Medical Services	60%	90%

In addition, Amendment Number 1 to the reinsurance agreement, effective January 1, 2003, allows for a 10% reduction in the deductible from $250,000 to $225,000 if within 5 days of initial inpatient hospital admission Paradigm Health is providing clinical management services for the member. The amendment also provides for a 10% reduction in the coinsurance and commensurate increase in reinsurance for inpatient hospital services other than transplant services when Paradigm Health is used under the same condition specified above.

The reinsurance agreement applies to all of the HMO members with the exception of Vermont members who are only covered by the transplant provisions and outpatient prescription drugs. This is due to a full risk transfer arrangement that is in effect in Vermont. The HMO's reinsurance premium rate including conversion fee, if any, is $0.21 per Vermont Managed Care Member per month and $0.47 per month for all other members. There is a lifetime maximum reinsurance benefit of $2,000,000 per member.

The reinsurance agreement contained all the required standard clauses, including the insolvency clause, required by Section 1308 of the New York Insurance Law.

The agreement includes continuation of benefits provision within its insolvency protection language. This provision requires that the reinsurer cover MVPHP members who are confined to an inpatient facility with certain limitations. It also requires prospective continuation of benefits for all MVPHP members who have paid their contract premium. The language included in MVPHP's current reinsurance contract specifies a sixty (60) day time limit.

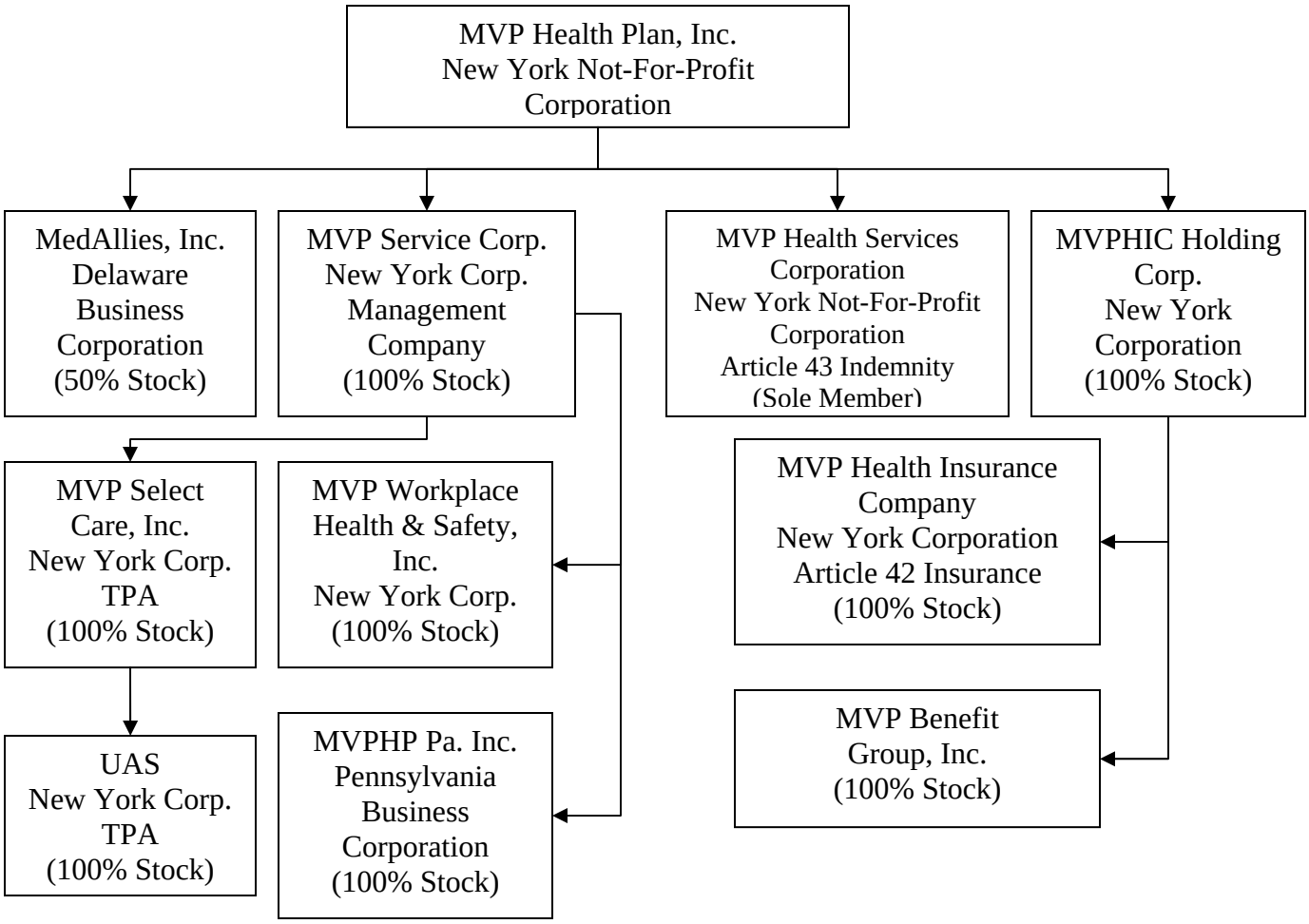
The HMO failed to submit its reinsurance agreement to the New York State Departments of Health and Insurance for approval as required by Section 98.1.8n(b) of the New York State Department of Health, Rules and Regulations (10 NYCRR 98) which states, in part,

> "(b) Any amendments to the risk-sharing arrangements contained in any contracts between, the HMO and insurer shall not be entered into without prior approval of the Commissioner and the Superintendent. All new contracts with new types of health service providers, and material amendments to existing contracts between the HMO and health service providers, shall require prior approval and be submitted to the commissioner at least 30 days in advance of their anticipated execution."

It is recommended that the HMO comply with Section 98.1.8n(b) of the New York State Department of Health, Rules and Regulations (10 NYCRR 98) and submit its reinsurance agreement in effect with Employers Reinsurance Corporation to the New York State Departments of Health and Insurance for approval.

D. Holding company system

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



MVPHP has no employees. The HMO has entered into an administrative service agreement with its subsidiary MVP Service Corporation. (MVPSC), wherein various services are provided to MVPHP by MVPSC, including, but not limited to financial,

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

The HMO valued its investment in MVPSC and all MVPSC subsidiaries in the amount of $13,484,660 as of December 31, 2003. This amount represented the net equity of MVPSC and all its subsidiaries on a consolidated basis as per an audit conducted by the HMO's CPA firm using generally accepted accounting principles.

MedAllies, Inc.

MedAllies, Inc. was incorporated on February 2, 2001 as a Delaware Business Corporation. It is a joint venture with Taconic IPA. MVP Health Plan, Inc. owns 50% of the stock of MedAllies, Inc. The purpose of the joint venture was to integrate clinical labs and payors to improve care by providers. This is a start-up company that has not earned any profit yet.

MVP Service Corporation

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

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

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

MVP Select Care, Inc.

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

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

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

MVP Workplace Health & Safety, Inc.

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

MVPHP Pa, Inc.

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

MVP Health Services Corporation

MVP Health Services Corporation (MVPHSC) is a not-for-profit corporation whose sole member is MVPHP. MVPHSC was incorporated on October 8, 1992, and is licensed under Article 43 of the New York Insurance Law. In the past, MVPHSC offered point-of-service (POS) health insurance products. Currently, MVPHSC issues only indemnity dental insurance products.

MVPHIC Holding Corp.

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

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

The HMO valued its investment in MVPHIC Holding Corp. in the amount of $1,613,598 as of December 31, 2003. The examiners did not accept this as an admitted asset due to the insolvency of its subsidiary MVPHIC as of December 31, 2003. Therefore, the value of MVPHIC Holding Corp., as per this examination was zero.

MVP Health Insurance Company

MVP Health Insurance Company, (MVPHIC) is a for-profit New York corporation, wholly-owned by MVPHIC Holding Corp., which is a wholly-owned subsidiary of MVP Health Plan, Inc. MVPHIC was incorporated on April 24,

2000. MVPHIC received its license, as an accident and health insurance company under Article 42 of the New York Insurance Law in June, 2001.

MVP Benefit Group, Inc.

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

E. Significant operating ratios

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

	Amounts	Ratios
Claims	$2,741,039,965	86.5%
Claims adjustment expenses	108,052,431	3.4%
General administrative expenses	254,911,831	8.0%
Net underwriting gain	65,296,002	2.1%
Premium earned	$3,169,310,229	100.0%

F. Allocation of expenses

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

The examiners used New York State Insurance Department Regulations 30 (11NYCRR 20) and 33 (11NYCRR 91) as guidelines, allocating the expenses to expense categories based on the guidelines provided within those regulations. The examiners calculated incurred expenses attributable to the CAE category at $29,489,454 compared with $3,207,895 reported by the HMO. The HMO's understatement of its CAE expense allocation resulted in the following:

(a) An examination increase in the HMO's unpaid claims adjustment expense reserve to $4,496,770 as of December 31, 2003. The HMO's reported unpaid claims adjustment expense component of its reserve as of such date in the amount of $1,771,000 was understated by $2,725,770.

(b) An increase of $98,157,169 to claims adjustment expenses over the four year period under examination from $9,255,262 reported on MVPHP annual statements to $107,412,431 was made per this examination.

(c) A decrease in the HMO's administrative expenses by $96,081,399 from $350,993,230 reported on MVPHP's filed annual statements during the four year examination period to $254,911,831 per this examination.

The difference between the increase of claims adjustment expenses and the decrease of administrative expenses is $2,075,770 which represents the increase in unpaid claim adjustment expenses liability per the examination as of December 31, 2003.

It is recommended that the HMO apply the guidelines in New York Insurance Department Regulations No. 30 (11 NYCRR 20) and No.33 (11 NYCRR 91) to revise and update its expense allocation methodology in order to reflect an appropriate allocation among the three expense groupings (i.e. claim adjustment expense, general and administrative expense and investment expense) on U & I, Part 3 of the HMO's annual statement.

(2) The expense classification, “Salaries, wages and other benefits”, reported by MVP Health Plan, Inc., Underwriting and Investment Exhibit, “Part 3 -Analysis of Expenses” in its 2003 annual statement, was understated, since the MVP entities reimburse MVP Health Plan, Inc. by a credit entry to “Salaries, wages, and other benefits”.

It is recommended that the HMO apply the guidelines in New York State Insurance Department, Regulations No. 30 and No. 33, by crediting reimbursement to all appropriate expense classifications.

(3) MVP Health Insurance Company (MVPHIC) reimburses MVPHP and MVPSC for its share of joint administrative expenses based upon 8.25% of its premiums

written. The 8.25% was referred to as estimated administrative costs in the initial capitalization plan of MVPHIC submitted to the New York State Insurance Department. Thereafter, the agreement between MVPHIC and its affiliate stated the following:

> "…The Company (MVPSC) shall use an allocation method for shared expenses consistent with provisions of New York Regulation No. 33."

Part 91.4(f)(vii)(5) of New York Insurance Department Regulation No. 33, (11NYCRR 91) states, in part,

> "General indexes such as premium volume, number of policies, and insurance in force shall not be used as basis for distributing costs among major annual statement lines of business, except where the incidence of cost is closely related to such general indexes, or except where there is no more appropriate basis for measurement"

It is recommended that the HMO comply with Part 91.4(f)(vii)(5) of New York Insurance Department Regulation No. 33 (11 NYCRR 91) relative to reimbursement from MVPHIC for its share of joint administrative expenses as required by their administrative service agreement.

G. Cash

A review of the HMO's cash policy, procedures and system control, with regard to its bank account reconciliations and un-cashed checks, revealed the following:

(1) There is no follow-up on outstanding checks that remained on the bank reconciliation until deemed to be abandoned property.

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

(2) During the four year period under this examination, MVPHP, opened two bank accounts in relation to one general ledger account. The bank reconciliations of these accounts contained unidentified differences which were not fully investigated and reconciled in a timely manner.

It is recommended that the HMO change its policy and open/reconcile one bank account instead of two associated with each general ledger account. Furthermore, it is recommended that the HMO investigate any un-reconciled differences on bank reconciliations and correct them in a timely manner.

H. Uncollected premiums

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

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

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

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

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

(2) The HMO reported on page 2 of its annual statements for all years during the examination period, premium receivables net of non-admitted amounts without showing the gross receivables. The annual statement instructions provide for the reporting of gross receivable, the non-admitted asset portion and the net admitted asset portion as per the following comparative chart:

	Admitted Assets	Not-admitted Assets	Net admitted Assets
Company	$39,518,679	-0-	$39,518,679
Examination	49,293,215	$19,398,969	$29,894,246

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

(3) The HMO reported $ 0 premiums outstanding over 60 days due, on its filed December 31, 2003 annual statement in Exhibit 3 - Accident and Health Premiums Due and Unpaid. The examination review revealed that premiums due were outstanding over six months. Therefore, the reporting on this exhibit was not an accurate representation of the HMO's aged premiums as of December 31, 2003.

It is recommended that the HMO report the proper aging of its premium receivable on its annual statement Exhibit 3-Accident and Health Premiums Due and Unpaid.

(4) The HMO did not reconcile its New York State Employees group's premiums or membership data with the State of New York for the period under examination. The HMO's practice is to bill such group, on a monthly basis, using the HMO's current enrollment data for such group. The monthly bills generated by the HMO are for internal purposes only as it is the New York State Civil Service Department's practice to remit payments based on its own enrollment data. Payments are received from the New York State Civil Service Department on a bi-weekly basis; however, information as to which employees' premiums are paid for, is not provided to the HMO.

A review of the HMO's premium receivable records revealed that the HMO up-dates the group's membership data by deleting and/or adding members through its access to the New York Benefits and Eligibility Accounting System (NYBEAS), however, there is no overall reconciliation of membership data. Therefore, there is always a difference between the premiums billed and the payment received.

The HMO accepts as payment in full, funds received from the State of New York and writes-off the difference without investigation (i.e. $820,031 in year 2003).

It appears that the difference between the HMO billing and payments received from the State of New York is due to the following:

- Differences in enrollment data of the HMO and the State of New York.
- Differences in the period covered by the HMO billing (i.e. twelve month billing for year 2003) and the State of New York payment on a bi-weekly basis that may add up to 50, 52 or 54 weeks for the same year.

It is recommended that the HMO request the New York State group's enrollment information from the State Department of Civil Service or through the New York Benefits and Eligibility Accounting System so that the HMO can reconcile the membership data at various cut-off dates throughout the year in and reduce future write-offs to a minimal amount.

I. Abandoned property

The HMO filed its abandoned property reports for each year within the examination period with the State of New York Comptroller's Office in accordance with the New York Abandoned Property Law. However, the HMO failed to follow the requirement of Section 1316 of the Abandoned Property Law, to remit checks which are deemed to be abandoned property after three years.

The HMO remitted checks deemed abandoned property after five years instead of three years in violation of Section 1316 of Abandoned Property Law which states, in part,

> "Any amount issued and payable on or after July 1, 1974, to a resident of this state on or because of a policy of insurance other than life insurance, which is held or owing by a domestic insurer… shall be deemed abandoned property if unclaimed for three years by the person entitled there to…"

The examination review revealed that the HMO failed to make abandoned property payments in the approximate amount of $200,000 to the Office of the State Comptroller relative to checks over three (3) years outstanding.

It is recommended that the HMO report to the New York State Comptroller's Office all checks that remain unclaimed for three years, including abandoned property amounts for checks issued prior to 2001 (approximately $200,000) as required by Section 1316 of the Abandoned Property Law.

4. FINANCIAL STATEMENT

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination and as reported by the HMO as of December 31, 2003:

	Examination			MVPH	
Assets	Assets	Not-Admitted Assets	Net-Admitted Assets	Net-Admitted Assets	Surplus Increase (Decrease)
Bonds	$107,089,457	$	$107,089,458	$107,089,458	$
Common stocks	13,484,660	1,613,598	11,871,062	13,484,660	(1,613,598)
Cash and short-term investments	83,972,848		83,972,848	83,972,848	
Surplus notes-MVPHSC	$1,070,000		$1,070,000	$1,070,000	
Investment-MVPHSC	2,731,457	0	2,731,457	2,731,457	0
Subtotals, cash and invested assets	$208,348,422	$1,613,598	$206,734,825	$208,348,423	($1,613,598)
Investment income due and accrued	1,580,926		1,580,926	1,580,926	
Uncollected premiums	39,518,679	9,624,433	29,894,246	39,518,679	(9,624,433)
Amounts recoverable from reinsurers	2,413,706		2,413,706	2,413,706	
Electronics data processing equipment and software	16,147,484	12,436,903	3,710,581	3,710,581	
Furniture and equipment	1,254000	1,254,000	0	0	
Receivable from subsidiaries/affiliates	10,245,869		10,245,869	10,245,869	
Health care receivable	11,395,590		11,395,590	11,395,590	
Aggregate write-ins for other than invested assets	8,409,307	6,371,587	2,037,720	2,037,720	0
Total assets	$299,313,983	$31,300,521	$268,013,463	$279,251,494	$(11,238,031)

Liabilities	Examination	MVPHP	Surplus Increase (Decreases)
Claims unpaid	$139,995,299	$125,298,060	$(14,697,239)
Accrued medical incentive pool	($319,541)	($319,541)	
Unpaid claim adjustment expenses	4,496,770	2,421,000	(2,075,770)
Aggregate health policy reserves	650,000		(650,000)
Premiums received in advance	510,055	510,055	
General expenses due and accrued	21,782,986	42,100,836	20,317,850
Amounts due to affiliates	6,506,031	335,301	(6,170,730)
Total liabilities	$173,621,600	$170,345,711	$(3,275,889)
Capital and surplus			
New York contingency reserves	$45,457,242	$45,457,242	
Vermont statutory reserves	1,275,098	1,275,098	
Unassigned funds (surplus)	47,659,523	62,173,443	$(14,513,920)
Total capital and surplus	$94,391,863	$108,905,783	$(14,513,920)
Total liabilities, capital and surplus	$268,013,463	$279,251,494	$(11,238,031)

Note:

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

B. Statement of Revenue and Expenses:

Capital and surplus increased by $74,381,070 during the four year period under examination, January 1, 2000 through December 31, 2003, detailed as follows:

Revenue			
Premiums earned			$3,169,310,229
Expenses			
Hospital and medical			
Hospital/medical benefits	$1,848,652,120		
Emergency room and out of area	210,832,573		
Prescription drugs	225,101,574		
Professional services	53,046,161		
Other hospital and medical	393,262,799		
Incentive pool, withhold adjustments and bonus amount	16,036,295		
Less reinsurance recoveries	(5,891,557)		
Total medical and hospital		$2,741,039,965	
Administrative expenses			
Claims adjustments expense	$107,412,431		
General administrative expenses	254,911,831		
Increase in reserves for health contracts	650,000		
Total administrative expenses		$362,974,262	
Total expenses			3,104,014,227
Net underwriting gain			$65,296,002
Investment income		17,562,105	
Other income		22,008,441	
Investment and other income			$39,570,546
Net income			$104,866,548

C. Capital and surplus account

Capital and surplus per report on examination as of December 31, 1999			$20,010,793
	Gains in Surplus	Losses in Surplus	
Net income	$104,866,548	$	
Change in non-admitted assets		31,300,521	
Unrealized capital gain	1,101,486		
Secured loans	794,002		
Cumulative effect of changes in accounting principals	0	1,080,445	
Total gains and losses	$106,762,036	$32,380,966	
Net increase in capital and surplus			74,381,070
Capital and surplus per report on examination as of December 31, 2003			$94,391,863

5. COMMON STOCKS

The examination asset of $11,871,062 is $1,613,598 less than the $13,484,660 reported by the HMO in its December 31, 2003 annual statement. The examination change is due to the reduction of the value of the MVPHIC Holding Corp. stock from $1,613,598 to zero. The Holding Corp. was specifically formed to hold the stock of MVP Health Insurance Company (MVPHIC). MVPHIC was insolvent as of December 31, 2003.

6. UNCOLLECTED PREMIUMS

The examination asset of $29,894,246 is $9,624,433 less than the $39,518,679 reported by the HMO in its December 31, 2003 annual statement. The examination change is due to the non-admitting of uncollected premiums that were due more than 90 days in accordance with SSAP No. 6 paragraph 9 a, that states, in part,

> "…,If an installment premium is over ninety days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be non-admitted,"

7. CLAIMS UNPAID

The examination liability of $139,995,299 is $14,697,239 more than the $125,298,060 reported by the HMO in its December 31, 2003 annual statement. The examination change is due to the following:

($1,664,898)	Decrease in incurred but not reported claims reserve (IBNR) The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and its filed annual and quarterly statements.
20,317,850	Reclassification of liability due to Specified Medical Condition Pool from general expenses due and accrued to unpaid claims.
2,215,017	An additional increase per this examination to due to Specified Medical Condition (SMC) Pool liability from $20,317,850 to $22,532.867.
(6,170,730)	Reclassification of due to an affiliate, Select Care liability from claims unpaid to amounts due to affiliates.
$14,697,239	Total

8. UNPAID CLAIM ADJUSTMENT EXPENSES

The examination liability of $4,496,770 is $2,075,770 more than the $2,421,000 reported by the HMO in its December 31, 2003 annual statement. The examination change is due to the following:

$2,725,770	Substantial increase in allocation of expenses to claims adjustment expenses using New York State Insurance Department Regulations 30 (11NYCRR 20) and 33 (11NYCRR 91) as guidelines, allocating the expenses to expense categories based on the guidelines provided within those regulations.
(650,000)	Reclassification of premium deficiency reserve liability from unpaid claims adjustment expenses to aggregate health policy reserve in accordance with annual statement instructions.

9. AGGREGATE HEALTH POLICY RESERVES

The examination liability of $650,000 is $650,000 more than the $0 amount reported by the HMO in its December 31, 2003 annual statement. The examination change is due to the reclassification of the HMO's premium deficiency reserve from unpaid claim adjustment expenses to aggregate health policy reserve in accordance with SSAP No. 54.

10. GENERAL EXPENSES DUE AND ACCRUED

The examination liability of $21,782,986 is $20,317,850 less than the $42,100,836 reported by the HMO in its December 31, 2003 annual statement. The

examination change is due to a reclassification of liability amounts due to Specified Medical Condition (SMC) Pool from general expenses due and accrued to unpaid claims .

11. AMOUNTS DUE TO AFFILIATES

The examination liability of $6,506,031 is $6,170,730 more than the $335,301 reported by the HMO in its December 31, 2003 annual statement. The examination change is due to a reclassification of liability amounts due to an affiliate, Select Care from "Claims unpaid" to "Amounts due to affiliates".

12. MARKET CONDUCT

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

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

The examiners' review revealed the following:

A. Underwriting

(1) Experience rated groups

A review of the national account groups marketing files revealed that most of the contracts were not signed by the groups.

It is recommended that the HMO require all national account groups to sign, on their anniversary dates, the current form of contracts which reflects the group's current provided coverage.

In breaking down the revenues and expenses by group size and line of business, MVPHP failed to accurately fill out “Statement of Revenue and Expenses by Line of Business, Part 1 & Part 2”, of the December 31, 2003 New York annual statement supplement.

The HMO used an improper methodology in filling out the schedule, combining the large and small groups into one group, and reporting the combined revenues and combined expenses under the large group heading, instead of separately.

It is recommended that the HMO report on its annual statement, the earned premium and claims expenses broken down into large groups, small groups and individuals in accordance with the New York State, annual statement supplement instructions.

In addition, the HMO has introduced some changes in its experience rating formula to update the quarterly trend and IBNR factor tables without securing an advance approval of the New York State Insurance Department as required by Section 4308(b) of the New York Insurance Law, which states, in part,

> "No corporation subject to the provision of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or , if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall obtained the superintendent's approval thereof…."

It is recommended that, the HMO seek advance approval of the Superintendent of Insurance before making any changes to its experience rating formula in accordance with Section 4308(b) of the New York Insurance Law.

(2) Termination of coverage

MVPHP's policy, in terminating group coverage for failure to pay premiums due, is as follows:

Any group with an outstanding balance from 30-60 days past due is sent a premium reminder letter along with a reconciliation to be due 10 business days from the date the letter is sent. Any group with an outstanding balance from 61-90 days past due is sent a letter by certified mail, along with a reconciliation to be due 10 business days from the date the letter is sent.

If the groups fails to pay after the two above letters are sent, the group is then sent a group termination by certified mail. The subscribers under the group policy are also sent a termination letter. All subscribers that were active under the group receive the subscriber termination letter offering them MVPHP's direct pay HMO or point of service policy.

A review revealed that MVPHP does not consistently adhere to its stated policy. Of the five sampled groups, it was determined that one group was terminated after eight months of non-payment of premium. Another two groups were terminated after five and seven months, respectively. Of the five groups reviewed, only one was terminated after 90 days.

It is recommended that the HMO adhere to its stated policy for non payment of premium terminations for all groups.

(3) Retention of records

A sample review of terminated direct pay individual contracts revealed that MVPHP was unable to submit accounts receivable correspondence, in support of the coverage termination of individuals.

Part 243.2(a) of New York Insurance Department Regulation No. 152 (11 NYCRR 243) states, in part,

> "…every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent..."

Part 243.2(b) (7) of New York Insurance Department Regulation No, 152 (11 NYCRR 243) states, in part,

> "...., A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset ownership, and source documents, for six calendar years from its creation or until after the filing of

> the report on examination in which the record was subject to review, whichever is longer."

It is recommended that the HMO keep supporting documentation of terminated individual accounts as required by New York State Insurance Department Regulation No. 152 (11 NYCRR 243).

B. Claims

(1) Claims processing

A review was performed by using a statistical sampling methodology covering the examination period in order to evaluate the overall accuracy and compliance environment of MVPHP's claims processing.

This statistical random sampling process, which was performed using the computer software program ACL, was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually or on a collective basis could be drawn for each item in the sample. The review incorporated processing attributes used by MVPHP in its own "Quality Analysis" of claims processing. The sample size was comprised of 167 randomly selected claims.

The sample of 167 claims was comprised of 20 denied claims and 147 paid claims.

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

A paid claim was defined as any claim for which MVPHP was obligated to pay the claim or make the medical payment; a denied claim was one for which MVPHP was not obligated to pay the claim or make the medical payment. Any claim which contains at least one service line for which MVPHP is not obligated to pay for the service was considered to be a denied claim, even if other service lines were paid (partially denied). There were seven claims in the sample that were partially denied.

The examiners and MVPHP determined that there existed three claims which were “processed” incorrectly, according to the criteria used by both MVPHP and the Insurance Department examiners, not including any claims for which MVPHP failed to

issue an Explanation of Benefits (EOB) when required or; if an EOB was issued, its content was not in compliance with Section 3234 of the New York Insurance Law.

It was further agreed upon that MVPHP was required to issue EOBs for all denied claims (wholly or partially denied) but in fact, either-: (1.) Failed to do so or (2.) the EOBs' content was not in compliance with Section 3234 of the New York Insurance Law. There were 25 additional claims found to be in error, producing an accuracy rate of 83.2%.

If the EOB errors were not taken into consideration, the HMO's claims processing accuracy rate would have been 98.2%. This is consistent with MVPHP's reported overall accuracy standard being above 98%.

(2) Prompt Pay 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 states, in part,

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

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

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

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

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

A review was made of year 2003 claims, using ACL audit software, for compliance with Section 3224-a 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 MVPHP assigned a unique claim number. This definition was agreed to by both the examiners and MVPHP.

MVPHP paid 2,475,076 claims and wholly denied 324,553 claims for its New York State groups and providers/subscribers in calendar year 2003. Of these claims, a population of 15,425 claims was identified where the payment date was more than 45 days after the receipt date. A second population of 29,721 claims was identified where the claim was denied more than 30 days after the receipt date. A sample of 167 claims was drawn from each of the populations described above.

The examiner's review of the sampled claims revealed violations of Sections 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
Claim population	15,425	29,721
Sample size	167	167
Number of claims with errors	142*	85
Calculated Error Rate	85.03%	50.80%
Upper Error limit	90.44%	58.48%
Lower Error limit	79.62%	43.32%
Upper limit Claims in error	13,951	17,381
Lower limit Claims in error	12,281	12,874

Of the 142 claims found to be in violation of Section 3224-a(a), 5 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 HMO improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.

3. 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 3234(a) of the New York Insurance Law as follows:

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

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".

It should be noted that, the Insurance Department conducted a detailed review of claims as of September 30, 2001. The examination report of the claims review included among other violations that the HMO failed to issue proper EOBs or issued faulty EOBs that did not contain all the requisite information required by Section 3234 (a) and (b) of the New York Insurance Law. On November 25, 2003, the HMO signed a stipulation with the Insurance Department that required the HMO to take actions to remedy the violation of Section 3234 (a) (b) of the New York Insurance Law.

Item 4 (d) of the stipulation stated the following:

"Respondents (the HMO) shall identify all member and nonparticipating provider claims from January 1, 2001 through present that were denied in

> whole or in part, where the member received no. EOB or a faulty EOB. Also, Respondents shall identify all HMO participating provider claims that were denied in whole or in part and where the received a faulty EOB. Respondents shall contact and advice affected members of the right to have any claim reprocessed to the extent that a processing error, or lack of opportunity to exercise appeal rights caused financial harm to the member. Any claims presented by the member will be reprocessed in accordance with standards established by the Company and approved by the Department and any resulting payments shall include applicable interest pursuant to Section 3224-a(c) accrued from the date of the original denial;"

A follow up review of the HMO actions to remedy the EOBs violations revealed that the HMO did not fully comply with the stipulation set forth for remediation of sending out proper EOBs for the years 2001 through present. The HMO's current procedures failed to include all situations that require the HMO to issue an EOB because of its interpretation of the requirements of Section 3234 (a) and (b) of the New York Insurance Law. Therefore, the HMO and its subsidiary, MVP Health Insurance Company failed to issue approximately 40,000 EOBs as required by Section 3234 (a) and (b) during the period from January 1, 2001 to December 31, 2003.

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

13. FRAUD PREVENTION AND DETECTION

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

14 COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior report on examination as of December 31, 1999, contained five comments and recommendations, including a recommendation that the Department will conduct a more detailed review of claims adjudication in general, and compliance with Section 3224-a ("Prompt Pay Law") specifically, at a future date. The Department conducted a detailed review of claims as of September 30, 2001. The comments and recommendations of both examinations are detailed as follows (page numbers refer to the prior reports):

ITEM.		PAGE NO.
A.	It is recommended that the HMO revise its agreement with its reinsurer so as to allow for full effect of the continuation of benefits provision contained within the insolvency language of such agreement. The HMO did not comply with this recommendation. A similar recommendation is included in this report under item M.	11
B.	It is recommended that the Plan 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. The HMO did not comply with this recommendation. A similar recommendation is included in this report under item N.	12
C.	It is recommended that the HMO take steps to identify any exposure to potential additional liability resulting from VMC's insolvent condition by either: re-evaluating the adequacy of its capitation payment and VMC's financial resources; restructuring the contract to change the extent of risk transfer; or working with VMC to attain great administrative expense efficiency. VMC is solvent as of this examination date.	15

ITEM		PAGE NO.
F.	It is recommended that MVP Health Care improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law. The HMO did not comply with this recommendation. A similar recommendation is included in this report under item T.	10
G.	It is recommended that MVP Health Care issue EOBs that include all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed. The HMO did not comply with this recommendation. A similar recommendation is included in this report under item V.	12
H.	It is recommended that MVP provide written notice of the grievance procedures in accordance with Section 4408-a 2(a) of the New York Public Health Law. The HMO has complied with this recommendation.	12
I.	It is recommended that MVP revise its acknowledgement letter to comply with the requirements of Section 4408-a.9 of the New York Public Health Law. The HMO has complied with this recommendation.	13
J.	It is recommended that MVP Health Care maintain a central log for monitoring all complaint activity that contains all information required by New York Insurance Department, Circular Letter Number 11 of 1978. The HMO has complied with this recommendation.	14
K.	MVPHS failed to file its utilization management documentation with the New York Insurance Department as required by Section 4901(a) of the New York Insurance Law. This was corrected in 2002. MVPHS has complied with this recommendation.	14
L.	It is recommended that MVP Health Care send proper notice of adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law as applicable. The HMO has complied with this recommendation.	17

15. SUMMARY OF COMMENTS AND RECOMMENDATIONS

APPENDIX A

INFORMATION SYSTEMS REVIEW

INFORMATION SYSTEMS REVIEW

Information technology (IT) at MVP Health Plan, Inc. is used to support the delivery of services and products and to provide support for all management processes. The objective of the IT control evaluation is to assure the Examiner-In-Charge that MVPHP has the appropriate controls in place to maintain an acceptable level of security, data integrity, and reliability with regards to the processing of financial data via their information system network. Additionally, MVPHP's present information systems have an adequate level of capacity as well as functionality necessary to manage the organization financial information technology and provide the New York State Insurance Department with the necessary reporting documentation and reports.

In order to accomplish this objective, CMA Consulting, of Latham, New York was contracted to review the general controls regarding MVPHP's processing environment as identified through discussions with IT management and a review of control documentation. The general controls reviewed during this examination included the following risk areas:

- Management risks, (associated with supporting IT management processes)
- Transaction risks, (associated with service or product delivery)
- Infrastructure risks, (associated with the IT hardware and software supporting business processes)

The review and the audit testing revealed several areas where the HMO should take steps to improve the operation of the IT environment within the organization. These areas include documentation of system changes and issue

remediation, establishment of formal policy and procedures, monitoring and auditing of systems, training of personnel and establishment of formal oversight committees.

It is recommended that the HMO establish written procedures to ensure that the efforts of the IT department staff are clearly documented and archived.

It is also recommended that the IT department develop standard policy and procedures and implement a uniform monitoring and auditing policy that is followed by all throughout the department.

15. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

Elsaid E. Elbially
Principal Insurance Examiner, CFE

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

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

Elsaid E Elbially

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

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

Appointment No. *22142*

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

ELSAID ELBIALLY

as a proper person to examine into the affairs of the

MVP HEALTH PLAN 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 *30th* day of *January 2004*

Gregory V. Serio
Superintendent of Insurance