REPORT ON EXAMINATION

OF

DELTA DENTAL OF NEW YORK, INC.

AS OF

DECEMBER 31, 2002

DATE OF REPORT	**OCTOBER 14, 2003**
AMENDED DATE	**JUNE 4, 2004**
EXAMINER	**BRUCE BOROFSKY**

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

Date: October 14, 2003

Honorable Greg V. Serio
Superintendent of Insurance
Albany, NY 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the directions contained in Appointment Number 21984, dated January 17, 2003 and attached hereto, I have made an examination into the condition and affairs of Delta Dental of New York, Inc., a dental expense indemnity company licensed under Article 43 of the New York Insurance law. The statutory home office is located at 575 Madison Avenue, New York, NY 10022. The examination was conducted at the Plan's administrative offices located at One Delta Drive, Mechanicsburg, Pennsylvania 17055. The following report is respectfully submitted.

Wherever the designations "DDNY" or "the Plan" appear herein, without qualification, they should be understood to indicate Delta Dental of New York, Inc.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1996. This examination covers the six-year period from January 1, 1997 through December 31, 2002. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2002, in accordance with Statutory Accounting Principles, as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Plan
Management
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Reinsurance
Accounts and records
Financial statements
Market conduct activities

A review was also made to ascertain what action was taken by the Plan 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 indicate that during the examination period, Delta Dental of New York, Inc. management did not adequately monitor its compliance with certain provisions of New York Insurance Law and Department regulations. This conclusion is borne out, not by any one major violation, but by the number of smaller violations found throughout DDNY's operations.

The examination findings are described in greater detail in the remainder of this report. Action already taken by management in response to the findings is also described herein as applicable.

3. DESCRIPTION OF THE PLAN

The New York Dental Service Corporation, which was organized by the Dental Society of New York, was certified by New York State in 1963 and licensed by the Department at that time as a dental expense indemnity corporation under the provisions of New York Insurance Law Section 252, currently §4302. The Plan commenced business in 1963.

On March 30, 1994, the New York Dental Service Corporation changed its name to Delta Dental of New York, Inc.

The purpose of the Plan is to establish, maintain, and operate a non-profit dental service plan whereby dental care may be provided to groups whose members become subscribers. Such care is furnished by dentists, duly licensed to practice under the laws of the State of New York, who may have contracts with the Plan to provide dental care to its subscribers.

A. Management

Pursuant to the Plan's charter and by-laws, management of the Plan is vested in a board of directors consisting of not less than fourteen members. As of the examination date, the board of directors was comprised of fourteen members. The board meets four times during each calendar year. The directors as of December 31, 2002 were as follows:

Name and Address	Business Affiliation
Henry R. Amen, D.D.S. Brooklyn, NY 11209	Dentist
Herman L. Bosboom, D.D.S. New York, NY 10022	Dentist
Thomas D. Coiro Commack, NY 11725	Retired
Anthony L. Dimango, M.D. Brooklyn, NY 11209	Retired
Robert B. Elliott San Francisco, CA 94105	President, Delta Dental Insurance Company
Thomas M. Halton, D.M.D. Flushing, NY	Dentist
Roy M. Hilliard Mechanicsburg, PA	Senior Vice President, Delta Dental of Pennsylvania
Andrew S. Levine, D.D.S. Saratoga Springs, NY 12866	Dentist
Thomas J. McCartin New York, NY 10016	President, Warren Kremer Paino Advertising
Gerard E. McGuirk, D.D.S. Goshen, CT	Chairman of the Board, Delta Dental of New York, Dentist
Michael A. Pagliaro White Plains, NY 10601	Sr. Vice President, White Plains Hospital Center

Name and Address	Business Affiliation
John D. Semler Des Plaines, IL 60016	Retired
Jozef C. Verbraeken Rhinebeck, NY 12572	Retired
Thomas H. Wysmuller Saugerties, NY 12477	Advisor, Wysmuller Corporation

The minutes of all meetings of the Board of Directors and committees thereof held during the examination period were reviewed. The meetings were well attended generally. Although his absences were excused, one member, Dr. Halton, attended less than 50% of the meetings during the three-year period ending December 31, 2002.

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 appropriate decisions may be reached by the board. 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.

Between the period January 2000 and November 2001, and again between March 2002 and the examination date, the board was in violation of Article III, section 4 of its by-laws that states the following:

> "The number of Directors who are not dentists shall exceed the number of Directors who are dentists by one."

It is recommended that the board comply with its by-laws and maintain the proper number of dentist to non-dentist directors.

The Plan indicated that, as of May 2003, the board achieved the appropriate number of dentist to non-dentist directors and is now in compliance with its by-laws.

The officers of the Plan as of December 31, 2002, were as follows:

Name	**Title**
Dr. Gerard E. McGuirk, D.D.S.	Chairman
Mr. Gary D. Radine	President, CEO
Mr. William B. McQuiggan	Sr. Vice President, COO

DDNY was acquired by Dentegra Group, Inc. in 2001 without the Department's prior approval. This was effectuated by DDNY changing its by-laws to transfer the membership voting rights of its directors to the directors of the Dentegra Group, Inc. Upon learning of this change, the Department asked DDNY to submit an application for change of control. Ultimately, DDNY withdrew its application and rescinded the resolutions. Therefore, DDNY is not considered to be a controlled insurer. However, DDNY has agreed to submit all agreements with companies that would have been in its holding company structure had it proceeded with its proposal to become a controlled insurer to the Superintendent of Insurance for review.

The Plan is managed through the operation of a General Agency Agreement (GAA or the agreement) between DDNY, Pennsylvania Dental Service Corp., d/b/a Delta Dental of Pennsylvania (DDP) and the Delta Dental Insurance Company (DDIC), a Delaware Corporation licensed to do accident and health insurance in several states, including New York. Through the agreement, DDP accepts responsibility to administer the Plan, in return for which, DDP receives an administration fee.

The provisions of the GAA relating to the Plan and DDIC give the Plan the responsibility for providing administrative services to DDIC. These responsibilities are passed along to DDP.

It should be noted that, under a separate agreement, all of DDP’s responsibilities are ultimately passed to PaCa Management, LLC (PaCa), a limited liability company, organized under the laws of the State of Delaware, with principal offices in Wilmington, Delaware. PaCa, which is owned jointly by Delta Dental of California (DDPC) and

DDP, was formed to administer and support DDNY. Such alternate arrangements should be clearly delineated in the Plan's own GAA.

It is recommended that the Plan rewrite its General Agency Agreement to reflect the responsibilities of all involved parties and submit that agreement to the Superintendent of Insurance for review.

One of the clauses within the GAA provides instructions on how to divide interest earned on the investment of funds other than funds in the Premium Accounts. The Plan has indicated the parties are not in compliance with this clause.

It is recommended that the parties to the General Agency Agreement review the agreement to ensure all relevant clauses are being enforced as written.

The Plan is also party to a separate agreement, the DeltaCare USA Administration Agreement (DAA), with PaCa, whereby PaCa administers the management of the DHMO. Under the DHMO, members can visit participating providers and pay only a fixed co-payment.

It is recommended that the Plan submit its DeltaCare USA Administration Agreement (DAA) to the Superintendent of Insurance for review.

It is noted that, under the DAA, the administrator sells capitated coverage to groups outside of New York State. In many cases, these groups have members within New York State. For these members, PaCa has been paying a fee to the Plan, in return for which, the Plan has been providing dental services to the New York members through its capitated network and performing certain administrative functions. The DeltaCare USA Administration Agreement does not discuss such services, but the Plan reported the income from this "leasing" of its provider panel as premium income. This income should have been reported as "Risk Revenue" on the Plan's Income Statement filed for 2001. The NAIC Annual Statement Instructions for Health Companies states:

> "Line 5 – Risk Revenue
> Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g. full professional, dental, radiology, etc.) provided to the policyholders or members of another insurer or reporting entity. Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually of a capitated basis) payment, made by another insurer or reporting entity to the reporting entity in exchange for services to be provided or offered by such organization."

It is recommended that the Plan report income generated from "leasing" its provider network to PaCa for NY residents who are enrolled through DeltaCare USA group contracts located outside of the State of New York as Risk Revenue in accordance with the NAIC Annual Statement Instructions.

It is recommended that DDNY submit a revised Annual Statement for 2002 and revised Quarterly Statements for 2003, that correctly report all risk revenue in the Statement of Revenue and Expenses and exclude all such revenue from premium income.

B. Territory and Plan of Operation

The Plan is licensed to sell dental insurance in all counties of New York. The Plan's direct premiums written for the previous six years are as follows:

Calendar Year	Direct Premiums Written
1997	$1,540,814
1998	2,880,951
1999	3,802,337
2000	6,152,337
2001	7,677,918
2002	7,651,094

Note: Direct Premiums Written for calendar 2002 have been reduced to reflect the reclassification of certain premiums to the account Risk Revenue. Further information on this transfer may be obtained on page 10 of this report.

It offers indemnity contracts and managed care contracts.

As mentioned earlier in this report, the Plan's managed care arrangement is offered under the DeltaCare USA program, a Dental Health Maintenance Organization. With this type of contract, DDNY pays a monthly capitation to contracted providers who provide service to enrolled members who pay a fixed copayment at the time of service. While the dentists who participate in this program accept some risk, the risk is mitigated through the Plan's "chair hour guarantee " program which guarantees providers will receive a certain income based upon the Relative Value Units of the procedures performed.

The Plan does not offer government programs and is not involved in the Healthy New York program. Further, the Plan does not offer individual coverage. Small group indemnity coverage is limited to those with at least ten members, while the DeltaCare USA program is available to groups with at least five members.

The Plan acts as a Third Party Administrator (TPA) for Cost Plus Contracts wherein purchasers are billed for all of the claims that are paid plus an adminstrative fee, which is either a percentage of claims paid or a fee per eligible enrollee.

The following chart shows the change in enrollment by year during the examination period:

Date	Enrollment
December 31, 1997	41,308
December 31, 1998	72,102
December 31, 1999	79,456
December 31, 2000	136,724
December 31, 2001	166,730
December 31, 2002	158,822

The Plan sells its policies using an internal sales force as well as independent agents and brokers.

C. Reinsurance

The Plan maintains two reinsurance treaties with Delta Reinsurance Company Inc. (DRC). Those agreements call for DDNY to cede 90% of the risk associated with its prospective contracts and 95% of the risk associated with its managed care contracts.

The treaties contain an insolvency clause conforming to the requirements of New York Insurance Law §1308. With DRC as the applicant, the Plan is provided with a clean and irrevocable letter of credit issued by a qualified Pennsylvania bank. The value of the letter of credit as of the examination date was $50,000. The letter, originally issued on April 7, 1988, is renewed annually. The most recent renewal date was March 26, 2003. A trust agreement in the prescribed form is incorporated in the reinsurance treaty to define the terms and conditions under which the credit may be drawn.

The offset clause in the reinsurance treaties contains the following language:

> DDNY or DRC may offset any balance, whether on account of premium, commission, claims, adjustment expenses, or otherwise, due from one party to the other under this Treaty or any other agreement between them. In the event of the insolvency of either party to this Treaty then offsets shall only be allowed to the extent permitted by the provisions of New York Insurance Law §7427(a)."

This offset clause does not establish appropriate treatment for funds held by the insurer and owed to DRC. Such treatment is necessary because DRC is unauthorized to conduct the business of insurance in the state of New York. As a result, unless the language is changed and additional language added, the Plan may be required to establish a liability for unauthorized reinsurance as required by New York Insurance Law §1308(b).

It is noted that the Plan has submitted its reinsurance treaties to the Department for approval. Discussions are under way to ensure appropriate language is included.

It is recommended that the Plan include language required by the Department within its reinsurance contracts or establish a penalty for unauthorized reinsurance as required by New York Insurance Law §1301(a)(14).

It should be noted that unless the appropriate language is inserted into the agreements, the Plan must establish a liability for unauthorized reinsurance as described above.

D. Significant Operating Ratios

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

	Amounts	Ratios
Claims	$11,857,219	40.12%
Claim adjustment expenses	$6,742,446	22.82%
General administrative expenses	$11,468,228	38.81%
Net underwriting and risk revenue gain /(loss)	$(519,990)	(1.75%)
Premium and Risk Revenue	$29,547,902	100.00%

E. Investment Activities

The Plan invests only in short-term obligations guaranteed as to interest and principal by the government of the United States. Such transactions have been approved by the Board of Directors.

There have been no internal audit reports related to investments.

The Plan maintains a custodial agreement with its financial institution, PNC Bank. That agreement does not include the following covenants suggested by the Department as a prudent business practice:

- The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank shall give the Company 60 days written notice of any material change in the form or amount of insurance or termination of such coverage.

- The bank will give the securities held by it hereunder the same care it gives its own property of a similar nature.

- Access to securities held by the bank shall be during regular banking hours and specify those persons who shall be entitled to examine on the premises securities held and the records regarding those securities, but only upon furnishing the bank with written instructions to that effect from any specified authorized officer.

- Written instructions hereunder shall be signed by any two of the Company's Authorized Officers, specified in a separate list for this purpose, which will be furnished to the bank from time to time, signed by the treasurer or an assistant treasurer, and certified under the corporate seal by the secretary or an assistant secretary.

- An opportunity for the insurer to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors.

It is recommended that the custodial agreement be amended to include all of the covenants suggested by the Department.

It is noted that, as of the examination date, that agreement had been amended to include all of the suggested covenants and was in the final stages of approval.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and reserves and other funds as determined by this examination as of December 31, 2002.

	EXAMINATION			COMPANY	
Assets	Ledger Assets	Assets Not Admitted	Net Admitted Assets	Admitted Assets	Surplus Increase (Decrease)
Cash	$ 4,483,606	$	$ 4,483,606	$ 4,483,606	$
Premiums due and unpaid	137,793	20,748	117,045	1,615,313	(1,498,268)
Amounts recoverable from reinsurers	5,241,284		5,241,284	5,272,901	(31,617)
Amounts receivable relating to uninsured health plans	1,869,617		1,869,617	1,869,617	
Miscellaneous account receivable	202,149		202,149	3,792	198,357
Total asset	$ 11,934,449	$ 20,748	$ 11,913,701	$ 13,245,229	$ (1,331,528)
Liabilities			Liabilities	Liabilities	
Claims unpaid			$ 320,541	$ 320,541	
Unpaid claims adjustment expenses			631,018	631,018	
Premiums received in advance			335,614	335,614	
General expenses due and accrued			1,690,818	1,690,818	
Amounts withheld or retained for account of others			119,483	119,483	
Funds held under reinsurance treaties			6,722,841	8,054,369	1,331,528
Liability for amounts held under uninsured accident and health plans			456,627	456,627	
Amount due retention group			589,406	589,406	
Total liabilities			$ 10,866,348	$ 12,197,876	$ 1,331,528
Reserves and other funds					
Surplus notes			$ 200,000	$ 664,700	$ (464,700)
Statutory reserve			956,387	992,886	(36,499)
Unassigned funds			(109,034)	(610,233)	501,199
Total reserves and other funds			$ 1,047,353	$ 1,047,353	
Total liabilities, reserves and other funds			$ 11,913,701	$ 13,245,229	

Note 1: The Internal Revenue Service has not made any audits of the Plan's federal income tax returns through tax year 2002. Except for any impact, which may result from the examination changes contained in this report, the examiner is unaware of any potential exposure of the Plan to any further tax assessment and no liability has been established herein relative to such contingency.

Note 2: No liability appears on the above statement for loans in the amount of $200,000 and no interest has been accrued. The loans were granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to the prior approval of the Superintendent of Insurance of the State of New York.

B. Underwriting and Investment Exhibit

Reserves and unassigned funds increased $576,773 during the six (6) year examination period, January 1, 1997 through December 31, 2002, detailed as follows:

Statement of revenues and expenses

Revenue		
Premiums earned (net of reinsurance)	$29,255,902	
Risk revenue	292,000	
Net investment income	1,096,615	
Total		$30,644,517
Deductions		
Claims incurred	$120,780,996	
Claim adjustment expense	6,742,446	
Solicitation expense	3,154,766	
Administrative expense	8,313,462	
Aggregate write-ins	(211,397)	
Reinsurance recoverables	(108,923,777)	
Total		29,856,496
Net gain (or loss) from operations		788,021
Change in non-admitted assets		(20,748)
Surplus loans repaid		(190,500)
Change in reserve and unassigned funds		$ 576,773

Reserves and unassigned funds

Reserves and unassigned funds, per report on examination as of December 31, 1996			$470,580
	Gain in Reserves	Losses in Reserves	
Net gain from operations	$788,021		
Change in non-admitted assets	(20,748)		
Change in surplus loans	(685,700)		
Surplus notes forgiven	495,200		
Net increase in reserves and unassigned funds			576,773
Reserves and unassigned funds, per report on examination as of December 31, 2002			$1,047,353

5. PREMIUMS DUE AND UNPAID

The examination admitted asset of $117,045 is $1,498,268 less than the $1,615,313 reported by the Plan as of December 31, 2002.

The Plan recorded fees owed to it under the DAA agreement as premiums due and unpaid, when such amounts should more properly have been accounted for as miscellaneous receivables. As a result, $166,740 was transferred to the account, "Miscellaneous receivables" within the foregoing Balance Sheet.

The Plan does not conform to Statutory Accounting Principle (SAP) No. 61, paragraph 25, which states the following:

> "[For all reinsurance arrangements,] the ceding entity shall reduce its deferred and uncollected premiums reported as an asset by the corresponding proportionate amount of any deferred and uncollected premium attributable to those insurance policies reinsured."

This breach is the result of the Plan's having recorded premiums receivable on a gross basis in its annual statement instead of having recorded such amounts net of reinsurance, as required by the cited accounting principle.

DDNY is recording the ceded portion of its premiums due and unpaid in the liability account "Funds held under reinsurance treaties." This is done to avoid having to establish a liability for unauthorized reinsurance as described in Section 3C herein. However, such funds did not qualify as funds held in that they were not being set aside and held for the purpose of offsetting. Instead, the amounts ceded were simply set aside in a normal operating account. Therefore, the Plan is required to record its premiums receivable on a net basis as required by the SAP No. 61

This examination corrected the foregoing Balance Sheet to properly reflect the amounts ceded. As a result, $1,331,528 was deducted from the asset value per this

examination. This amount was also used to reduce the liability account, "Funds held under reinsurance treaties", to reflect that such amounts were not owed to DRC.

It is recommended that the Plan comply with SAP No. 61 and record its premium receivables net of reinsurance in its financial statement.

6. AMOUNTS RECOVERABLE FROM REINSURERS

The examination admitted asset of $5,241,284 is $31,617 less than the $5,272,901 reported by the Plan as of December 31, 2002.

As noted herein under item 3D, the Plan improperly deemed administrative fees owed to it under the DeltaCare USA Administrative Agreement to be premiums rather than risk revenue. As part of that Agreement, the Plan receives in turn, a portion of funds paid out by DRC under its obligations. At December 31, 2002, certain amounts were owed to the Plan under this arrangement. The Plan accounted for this asset as "Amounts recoverable from reinsurers", when such amounts should more properly have been reflected as "Miscellaneous receivables". As a result, $31,617 was transferred from the captioned account to its proper location, Miscellaneous receivables.

7. MISCELLANEOUS RECEIVABLES

The examination admitted asset of $202,149 is $198,357 greater than the $3,792 reported by the Plan as of December 31, 2002.

As noted in section 5 of this report, this examination increased the account, "Miscellaneous receivables" by $166,740 to reflect amounts owed to it by PaCa for the performance of administrative services under the DAA. Additionally, as noted in Section 6 of this report, the examination transferred $31,617 to this account from the account,

"Amounts recoverable from reinsurers" to reflect amounts owed to it by DRC as a reduction in the amount of expenses owed under the DAA.

8. CLAIMS UNPAID

The examination liability of $320,541 is the same as the amount reported by the Plan as of December 31, 2002.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements.

9. FUNDS HELD UNDER REINSURANCE TREATIES

The examination liability of $6,722,841 is $1,331,528 less than the $8,054,369 reported by the Plan as of December 31, 2002.

As noted within Section 5 of the report, this account has been reduced by $1,331,528 to reflect the amount of reinsurance premiums not considered to be a liability of the Plan as per this examination.

10. SURPLUS NOTES

The examination amount of $200,000 is $464,700 less than the $664,700 reported by the Plan as of December 31, 2002.

The account, "Surplus notes" was reduced by $464,700 to reflect the write-off of New York Insurance Law §1307 surplus notes owed by the Plan to the Delta Dental

Plans Association. As a result of this write-off, the account, "Unassigned Funds" was increased by such amount.

11. NET PREMIUM INCOME

This account has been reduced by $292,000 to reflect income received by the Plan under the DAA, as discussed in Section 5 of this report. Such amounts have been moved to the account Risk revenue within the Statement of Revenue and Expenses. This change does not impact the Plan's net income(loss) for the calendar year.

12. MARKET CONDUCT ACTIVITIES

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

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

A. Claims Processing
B. Prompt Pay Compliance
C. Complaints/Grievances
D. Policy Forms
E. Rating
F. Contract Period – Non-Payment of Premium
G. Participating Provider Agreement
H. Explanation of Benefits Forms
I. Record Retention
J. Fraud Prevention
K. New York State United Teachers
L. Third Party Administration Agreements

A. Claims processing

A review of Delta Dental of NY, Inc.'s claims practices and procedures was performed. This review was performed by using a statistical sampling methodology in order to evaluate DDNY's overall claims processing accuracy and level of regulatory compliance. In order to achieve the goals of this review, a random statistical sample was drawn from all of the paid claims for calendar year 2002. For the purpose of this review, those medical costs characterized as capitation, or self-insured were excluded.

This statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for accurate 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 concluded for each item in the sample.

The sample size was comprised of 167 randomly selected claims.

For the purpose of this report, a "claim" as defined by DDNY, is the total number of items submitted by a single provider with a single claim form, as reviewed and entered into the claims processing system. This claim may consist of various lines, procedures or service dates. It was possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by DDNY for calendar year 2002.

The examination review revealed that the overall claims processing financial accuracy level was 99.4%. The overall claims processing procedural accuracy level was 92.2%. 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 DDNY's claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. These results correspond closely to the results of the Plan's claim testing.

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

Summary of Claims Processing Accuracy

	Financial Accuracy	Procedural Accuracy
Claim Population	225,304	225,304
Sample Size	167	167
Number of claims with Errors	1	13
Calculated Error Rate	.6%	7.8%
Upper Error limit	1.8%	11.9%
Lower Error limit	0%	3.7%
Upper limit Claims in error	3,988	26,811
Lower limit Claims in error	0	8,381

Note 1: 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.)

As a result of the testing, the following errors were noted:

- Violations of New York Insurance Law §3234(b), which states the following:

  "The explanation of benefits form (EOB) must include at least… …(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..."

This violation is the result of certain claims that had procedure codes changed or reduced, but did not provide any explanation or reason for such changes or reductions.

- Amounts that were billed on claim forms were transposed as they were entered into the claim system. While in each of these cases, the payment remunerated to the provider was not affected, the error did affect the data used by the Plan to calculate and review its Usual, Customary and Reasonable (UCR) amounts.

- Claims that were submitted for pulpotomies on permanent teeth were denied because the Delta Dental Processing Guidelines exclude the procedure from coverage. The exclusion, however, is not explained in either the Provider Manual or in the Member Contracts.

It is recommended that the Plan comply with New York Insurance Law §3234(b) and specifically explain on its EOBs why it has reduced procedures and payments from those claimed.

It is recommended that the Plan audit its processing systems to ensure that amounts billed are properly entered into the claim system.

It is recommended that the Plan fully explain its contractual exclusions to its members and to its participating providers.

B. Prompt Pay Compliance

New York Insurance Law §3224-a, "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.

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

> "Except in a case where the obligation of an insurer 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 policyholder 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(b) of the New York Insurance Law states that:

> "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…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."

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

> "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."

The examiner performed testing to establish DDNY's compliance with the Prompt Pay law. In order to accomplish this, a population consisting of all claims submitted by NY providers on behalf of New York subscribers between January 1, 2002 and December 31, 2002 that were not paid within 45 days was identified. The results of this process revealed that, from the total population of 225,304 claims, only 344 claims took longer than 45 days to pay. A small sample of claims was then randomly selected to establish whether there was a reasonable explanation for the delay and if there was not, whether interest was properly calculated and if due, was paid as required by statute.

When the sample was reviewed, only a small number of violations were noted. The only significant cause for such violations resulted from the Plan's suspension and late payment of claims from groups whose premiums were more than thirty days overdue. This is a violation of the Plan's contracts, which require such claims be denied for lack of coverage. Further discussion and recommendations regarding this issue are included herein under item 13F.

Of the 344 claims that took greater than 45 days to pay, 86 claims were paid late enough and were of a high enough value that, had there been insufficient cause for the delay, interest would have been due. When a sample of these claims was reviewed, only a small percentage of violations was found. It is noted, however, that, during the period in question, the Plan paid no interest on any claims.

It is recommended that the Plan review all claims not paid within 45 days to determine whether any applicable interest is due and pay such interest.

It is noted that, as of the examination date, the Company has undertaken such a review.

Possible Prompt Pay, Section 3224-a(b) of the New York Insurance law violations were established through the isolation of all claims that were not paid within 45 days and took more than thirty (30) days to either deny or for the Plan to seek additional

information. The results of this extraction revealed 192 possible violations. When a sample of these claims was reviewed, the Plan was not able to provide documentation to support its contention that it had distributed the appropriate communications. The Plan indicated this was so because it did not keep copies of such documents. Therefore, compliance with Section 3224-a(b) could not be determined. This finding is documented further in the Record Retention section of this report.

C. Complaints/Grievances

Part 216(4)(e) of New York Insurance Department Regulation 64 (11 NYCRR 216.4(e)) states the following:

> "As part of its complaint handling function, an insurer's consumer services department shall maintain an ongoing central log to register and monitor all complaint activity."

The Plan does not keep individual records of subscriber complaints for its indemnity product. Instead, the Plan simply attaches notes and records to the electronic claims records by Member Identification Number. This procedure is not only a violation of the referenced regulation, it also removes an effective management tool for the oversight of policyholder treatment. Maintaining such records would enable the Plan to discern trends that negatively impact customer service. Further, they would enable the Plan to measure the timeliness of responses.

It is recommended that the Plan comply with Part 216(4)(e) of New York Insurance Department Regulation 64 (11 NYCRR 216.4(e)) and maintain a log of all complaints and grievances received.

It is noted that the Company has agreed to comply with this recommendation.

D. Policy Forms

New York Insurance Law §4308(a) states the following:

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a copy of the contract or certificate …to be approved by him."

Several contracts distributed by the Plan contained language that differed from that which had been approved by the Department in violation of New York Insurance Law §4308(a). The effect of this change was that important benefits relating to continuing coverage were removed. When the discrepancy was pointed out to the Plan, they acknowledged the error and indicated that, although up to 175 groups may have been affected, no policyholders had been negatively impacted.

It is recommended that the Plan comply with New York Insurance Law §4308(a) and issue only contracts that have been approved by the Superintendent of Insurance.

DDNY policies cover "palliative" procedures, which can range from a consultation/examination to any number of services required as a result of pain or discomfort. The Plan pays such procedures using the same benefits as those provided under the benefit description "diagnostic". Frequently, this treatment results in the application of co-insurance to the billed amount, and in some cases, the member is responsible for the balance. The benefit lists attached to the contracts used by the Plan, however, do not specify how such procedures will be paid. As a result, members are not advised that they may have liability for some portion of the bill.

It is recommended that the benefit lists attached to group contracts be rewritten to clarify the amount of reimbursement that will be made for palliative procedures.

E. Rating

A review was conducted of the Plan's rating procedures to determine compliance with applicable New York State Insurance Laws and Regulations. This review revealed that the Plan violated New York Insurance Law §4308(b), which states:

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

This violation is due to the fact that when groups are renewed, strategic factors, such as the effect of competition, may be used to derive new rates. These factors are not described within the rate formula on file with the Insurance Department.

It is recommended that DDNY comply with New York Insurance Law §4308(b) and calculate rates utilizing only those factors noted in the filed rate formula.

DDNY has indicated it intends to file a new rate formula.

F. Contract Period –Non-Payment of Premium

The contracts between DDNY and its member groups contain a grace period for the payment of premiums. If premiums are not paid within thirty days of the effective date, coverage will be terminated and claims incurred after the expiration date will be denied for lack of coverage.

As noted in the Prompt Pay section of this report, the Plan did not consistently enforce this requirement. Instead, the Plan suspended the claims until such payment was received. This practice places an undue burden on providers in that they are not advised that the members may no longer be covered. Further, should such groups be terminated retroactively, the providers may not be remunerated for treatment they provided in good faith. If the Plan fails to enforce its own Grace Period, the Plan is, in effect, accepting the

risk of nonpayment. When asked to justify the procedure, the Plan explained that the practice had been discontinued. As of the examination date, the Plan's policy is to deny such claims, and cancel the group, as is appropriate.

As of the examination date, a significant portion of the premiums due under the DHMO contract were delinquent greater than 90 days. In some cases, the accounts were delinquent by up to eleven months. This delay in the enforcement of the grace period requirements has resulted in the impairment of the Plan.

It is recommended that, in the event the Plan elects not to terminate delinquent groups, even after the contractual grace period, the Plan accept the risk for such groups and process all claims within the time parameters required under New York Insurance Law 3224-a.

It is recommended that the Plan take steps to actively enforce its grace period requirements.

G. Participating Provider Agreement

The Plan is not in compliance with its Participating Provider Agreement because, in certain cases, the amount it pays to participating providers is not the amount required by that agreement.

Section 5 of the Participating Dentist Agreement used for DDNY providers states the following:

> "Dentist shall submit to Delta an initial Confidential Fee Listing and may file additional Confidential Fee Listings whenever he/she makes a general revision of fees, certified by Dentist to be current and consistent with charges generally made by Dentist in his/her practice. This provision may be waived by Delta. This filing or the Dentist's charges shall be used periodically by Delta to calculate the Usual, Customary and Reasonable Fee of the Dentist."

Section 10 of that same agreement states the following:

> "Dentist shall accept as full payment for services provided to Delta subscribers his/her charged fee, not to exceed Dentist's Usual, Customary and Reasonable fee as calculated by Delta from his/her filed fees and those of other Participating Dentists of Delta."

Delta's practice is to pay providers from their filed fee schedule without reference to the calculated UCR and regardless of the amount the provider charges on submitted claims unless the amount billed is lower than the filed fee schedule. This is contrary to Section 10 of that agreement in that the clause specifies the filed fees of other Participating Providers will also be used to establish the upper value of paid amounts.

It is recommended that the Plan ensure the methods by which it establishes participating provider reimbursement amounts comply with the agreements with such providers.

H. Explanation of Benefits Forms

New York Insurance Law §3234(b)(7), states the following:

> "the [explanation of benefits form] must include at least the following… 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."

The Plan is in violation of the cited law because the explanation of benefits form sent to subscribers do not include the notification that failure to comply with the requirements of the appeal may lead to forfeiture of a consumer's right to challenge the denial or rejection.

It is recommended that the Plan comply with New York Insurance Law §3234(b)(7) and include all requisite language on its EOB forms.

It is noted that the referenced language refers specifically to the rights granted to subscribers for an external appeal. This right is granted under New York Insurance Law Article 49 concerning denials made based upon medical necessity. Due to the limited nature of the benefits offered by a Dental Indemnity Insurer, such denials are not common.

I. Record Retention

New York Insurance Department Regulation 152 (11 NYCRR 243) establishes the requirement that the Plan maintain claim files for six years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject. The Plan is in violation of this requirement in that it does not maintain Explanation of Benefit Statements that were sent to subscribers or providers. Additionally, the Plan was not able to provide copies of letters sent to subscribers and providers in response to claims that may have been missing information critical to the processing of those claims.

It is recommended that the Plan comply with Part 243.2(b)(4) of New York Regulation 152 (11 NYCRR 243.2(b)(4)) and maintain all claim records for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer.

J. Fraud Prevention

New York Insurance Law §403(d) states the following:

> "All ...claim forms... shall contain a notice in a form approved by the superintendent that clearly states in substance the following:
>
> "Any person who knowingly and with intent to defraud any insurance Plan or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance

act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation." "

It was noted that the claim forms attached to the Plan's website that are downloadable for use by subscribers and providers, do not have the required warning.

It is recommended that the Plan comply with New York Insurance Law §403(d) and place a fraud warning on all of its claim forms.

K. New York State United Teachers

The Plan maintains a relationship with the New York State United Teachers (NYSUT), in which the Plan pays monies to NYSUT in return for its administration of certain dental contracts with various school districts. Under this agreement, the school groups pay a rate per eligible employee that is determined at the inception and renewal of the contract. A two-percent administrative fee is also charged by NYSUT. At the end of a contract period, the Plan determines the experience on each contract. If the total of premiums received exceeds the total of claims incurred and a fifteen percent administrative fee added to the calculated premium to compensate the Plan for its administration of the contracts, the excess amount is refunded to NYSUT as additional administrative fees. If the claims incurred plus the administrative fee exceeds the premiums received, the Plan absorbs the excess amount of claims incurred. NYSUT was compensated $188,443 during 2002 through this arrangement.

As each policy year draws to a close, DDNY calculates new rates for the various school districts, utilizing the specific claims experience of each district. Once calculated, as noted above, DDNY adds its own fifteen percent administrative fee and the two-percent NYSUT administration fee, which it calls a retention rate to reflect its risk in the event the groups' experience is higher than anticipated. As noted above, if the premiums received exceed the claims incurred plus the administrative fee, the excess amount is refunded to NYSUT. As a result, the retention rate amounts to an improper subsidy between the insured groups and NYSUT, is not permitted under the approved experience-

rated formula and is a violation of New York Insurance Law §4308(b), as detailed elsewhere within this report.

DDNY gives the final rates to NYSUT, who recommends adjustments to the calculated rates, increasing the rate in some districts and decreasing the rate in others. The net effect of the recommended changes is revenue neutral. The Plan maintains the changes are made in order to smooth out the increases or decreases in premium for the separate school districts. Since the contracts are directly between DDNY and the school districts, and not with NYSUT, this is not permitted under the approved experience-rated formula and as such is also a violation of New York Insurance Law §4308(b), as detailed elsewhere within this report.

It is recommended that DDNY comply with New York Insurance Law §4308(b) and discontinue adding a retention rate to the rates charged to its school groups.

It is recommended that DDNY comply with New York Insurance Law §4308(b) and take steps to prevent NYSUT from recommending changes to the rates from those calculated using the rate formula.

L. Third Party Administration Agreements

The Plan utilizes Wolfpack Insurance Services, Inc. to administer certain indemnity contracts, although there is no formal agreement between the two companies.

It is recommended that the Plan implement a signed agreement outlining the administrative services that Wolfpack Insurance Services, Inc. is to provide on behalf of the Plan.

13. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

ITEM		PAGE NO.
A.	It is recommended that the Plan use its true and complete name "Delta Dental of New York, Inc. on all filings with the Department. The Plan has complied with this recommendation.	4
B	It is recommended that the Plan revise its by-laws to provide for an annual meeting of the Board of Directors that closely corresponds to the filing of the respective quarterly statement. The Plan has complied with this recommendation.	8
C.	It is recommended that the Plan schedule its three additional meetings to closely correspond to the filing of the respective quarterly statement. The Plan has complied with this recommendation.	8
D.	It is recommended that the Plan comply with Insurance Law Section 312(b) by obtaining signed statements from each board member that they received and read the report on examination. The Plan has complied with this recommendation.	8
E.	It is recommended that the Plan comply with Section 715(f) of the Not-for-profit law by fixing the salaries of officers pursuant to the by-laws or an affirmative vote of the entire board. The Plan has complied with this recommendation.	9

ITEM		PAGE NO.
F.	It is recommended that management exhibit due diligence by having an accounting rendered of the actual cost of the services performed under the GAA. Thereafter, the Board should review the accounting to satisfy itself that there is a reasonable correlation between the cost of the services performed to the percentage of the claims charged under the GAA. The Plan has complied with this recommendation.	13
G.	It is recommended that the right granted to DRC to make binding recommendations to the plan on rating dental service contracts which the Plan offers to DRC be deleted from the reinsurance treaty. The Plan has complied with this recommendation.	17
H.	It is recommended that the Plan file the 90% quota share reinsurance treaty, and all amendments from inception to date, for review and approval under Sections 1308(e) and 4310(d) of the Insurance Law. The Plan has complied with this recommendation.	18
I.	It is recommended that the Plan reclassify $17,100 of line 19, “Aggregate write-insurance for other than invested assets” representing “Premium Fully Reinsured Contracts” in accordance with NAIC HMDI annual statement instructions into line 11, “Amounts receivable relating to uninsured accident and health plans”. The Plan has complied with this recommendation.	21

ITEM		PAGE NO.
J.	It is recommended that the Plan reclassify $311, 337 of line 19, "Aggregate Write-insurance for Other Invested Assets" representing "Premium Receivable Cost Plus Contracts" in accordance with the NAIC HMDI annual statement instructions into line 11, "Amounts receivable relating to uninsured accident and health plans." The Plan has complied with this recommendation.	21
K.	It is recommended that the Plan reclassify $125,022 of line 19, "Aggregate Write-insurance for Other Invested Assets" representing "90% of Retention Settlements Due from DRC" in accordance with the NAIC HMDI annual statement instructions into line 13, "Reinsurance recoverable on loss and loss adjustment expenses." The Plan has complied with this recommendation.	22
L.	It is recommended that the Plan reclassify $31,291 of line 14, "Aggregate Write-insurance for Other Liabilities" represented by "Prefunded deposits of ASO Groups" in accordance with the NAIC HMDI annual statement instructions to line 10, "Liability for amounts held under uninsured accident and health plans". The Plan has complied with this recommendation.	23
M.	It is recommended that the Plan reclassify $370,732 of line 14, "Aggregate Write-insurance for Other Liabilities" represented by "Amounts Due ASO Groups" in accordance with the NAIC HMDI annual statement instructions to line 10, "Liability for amounts held under uninsured accident and health plans". The Plan has complied with this recommendation.	23

ITEM		PAGE NO.
N.	It is recommended that the Plan reclassify $735,692 of line 14, "Aggregate Write-insurance for Other Liabilities" representing "Amounts Due Reinsurer" to line 11 "Funds held by corporation under reinsurance treaties". The Plan has complied with this recommendation.	23
O.	It is recommended that the Plan report liability amounts on an insurance accounting basis prescribed by the NAIC accounting practice and procedure manual, that is an accrual basis. The Plan has complied with this recommendation.	24
P.	It is recommended that the Plan utilize the Underwriting and Investment Exhibit, Part 1, columns for their intended purposes, thereby placing experience rated premium refunds in column 7 "Reserve for Rate Credits and Retrospective Returns". The Plan has complied with this recommendation.	24
Q.	It is recommended that the Plan reclassify $885,700 representing loans granted pursuant to section 1307 of the New York Insurance Law from page 3, line 18, "Aggregate write-insurance for reserves and other funds" to page 3, line 17, "Surplus Notes". The Plan has complied with this recommendation.	24
R.	It is recommended that the Plan report and pay all abandoned property to the State Comptroller. The Plan has complied with this recommendation.	25

ITEM		PAGE NO.
S.	It is recommended that the Plan evince ultimate responsibility for the accurate presentation of its financial statements filings with the Department by reviewing completed compilation delegated through agency agreements to outside contractors. The Plan has complied with this recommendation.	29
T.	It is recommended that the Plan review claim payments for all incurral years reflected in all HMDI Annual Statement, Schedule P's for the years 1992 through 1996 and resubmit corrected Schedule P's to the Department. The Plan has complied with this recommendation.	29

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	**Management and Controls**	
i.	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 appropriate decisions may be reached by the board. 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.	5
ii.	It is recommended that the board comply with its by-laws and maintain the proper number of dentist to non-dentist directors.	5
iii.	It is recommended that the Plan rewrite its General Agency Agreement to reflect the responsibilities of all involved parties and submit that agreement to the Superintendent of Insurance for review.	7
iv.	It is recommended that the parties to the General Agency Agreement review the agreement to ensure all relevant clauses are being enforced as written.	7
v.	It is recommended that the Plan submit its DeltaCare USA Administration Agreement (DAA) to the Superintendent of Insurance for review.	7
vi.	It is recommended that the Plan report income generated from “leasing” its provider network to PaCa for NY residents who are enrolled through DeltaCare USA group contracts located outside of the State of New York as Risk Revenue in accordance with the NAIC Annual Statement Instructions.	8
vii.	It is recommended that DDNY submit a revised Annual Statement for 2002 and revised Quarterly Statements for 2003, that correctly report all risk revenue in the Statement of Revenue and Expenses and exclude all such revenue from premium income.	8

Appointment No. ***21984***

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:

Bruce Borofsky

as a proper person to examine into the affairs of the

Delta Dental of New York, 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 *17th* day of *January* *2003*

Gregory V. Serio
Superintendent of Insurance