REPORT ON EXAMINATION

OF THE

HANYS INSURANCE COMPANY

AS OF

DECEMBER 31, 1994

DATE OF REPORT NOVEMBER 27, 1997

EXAMINER ELSAID ELBIALLY, AFE

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November 27, 1997

Honorable Neil D. Levin
Superintendent of Insurance
Albany, NY 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 20606, dated January 6, 1994, attached hereto, I have made an examination into the condition and affairs of Hanys Insurance Company as of December 31, 1994 and submit the following report thereon.

The examination was conducted at the office of Hospital Insurance Management Company, Inc. (HIMCO), located at 217 Great Oaks Boulevard, Albany, New York 12203. HIMCO is the manager of Hanys Insurance Company.

Wherever the term “the Company” appears in this report, it refers to Hanys Insurance Company.

1. SCOPE OF EXAMINATION

The Company was previously examined as of December 31, 1989. This current examination covers the period from January 1, 1990, through December 31, 1994. Where deemed appropriate, transactions subsequent to the current examination period were reviewed.

The examination comprised of a complete verification of assets and liabilities as of December 31, 1994, a review of income and disbursements deemed necessary for such verification, and utilized, to the extent considered appropriate, work performed by the Company's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Company
Management and control
Company records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Company
Loss experience
Accounts and records
Reinsurance
Treatment of policyholders and claimants

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

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

2. DESCRIPTION OF THE COMPANY

The Company was incorporated on January 14, 1987, for the sole purpose of doing "personal injury liability insurance" as authorized by paragraph 13 of Section 1113(a) of the New York Insurance Law. The license issued restricts the writing power of the Company to providing only (i) "that kind of medical and dental malpractice excess liability insurance specified in Section 18 of Chapter 266 of the Laws of 1986, including any renewals, continuations or amendments to the foregoing provisions..."

In addition to the aforementioned coverage, the Company's license allows it to do, "...(ii) excess general liability insurance over $5 million for eligible not-for-profit agencies; and (iii) excess directors' and officers' liability insurance over $1 million for eligible not-for-profit agencies."

The Company amended its charter to authorize it to, in the future, seek to gain licensure to transact personal injury liability insurance without any restrictions, property damage liability insurance, and fidelity insurance specified in paragraphs 13, 14 and 16 respectively of Section 1113(a) of the New York Insurance Law. The charter amendment was approved by the Department on March 12, 1991. However, the 1987 license, and its restrictions, were in effect until the Insurance Department issued a new license to the Company on August 23, 1996. The new license authorized the Company to write accident and health, personal injury liability, property damage liability, and fidelity and surety insurance, as specified in paragraphs 3, 13, 14 and 16 of Section 1113(a) of the New York Insurance Law.

Pursuant to its original charter, the Company was authorized to issue 375,000 shares of voting, "Class A" common stock, and 375,000 shares of voting, "Class B" common stock, each at a par value of $1 per share.

The Company is jointly owned by two trusts formed solely for the purpose of holding the Company's shares, as follows:

A) FFH Hospitals Trust (1987), which was formed by its owner, the five major hospital affiliates of United Jewish Appeal-Federation of Jewish Philantrophies of New York Inc. (UJA/Federation) (a non-profit fund raising organization) and Federation of Jewish Philantrophies (FOJP Service Corporation) (a non-profit organization having one member: UJA/Federation), holds 80% of the voting shares of the Company.

B) HANYS Hospitals Trust (1987), which was formed by its owner, eighty-seven members of the Hospital Association of New York State (HANYS), holds 20% of the voting shares of the Company.

On December 18, 1987, the Company's board of directors passed a resolution to amend the Company's charter to authorize the issuance of 100,000 new, non-voting "Class C" shares, at a par value of $3 per share, for a price of $100 per share.

The charter's amendment was approved by the Insurance Department on March 12, 1991.

FFH Hospitals Trust (1987) purchased 100% of the Class C shares for $10 million. However, Hanys Hospital Trust (1987) has the option to acquire from FFH Hospitals Trust (1987), 50% of the Class C shares.

On December 16, 1994, the Company's Board of Directors passed a resolution to amend the Company's charter to authorize the issuance of up to 100,000 shares of non-voting, preferred stock, at a par value of 10 cents per share, for a price of $400 per share. The board of directors further approved, and the Company issued, 75,000 shares of this preferred stock, in 1995, to Hanys Member Hospitals Self Insurance Trust, for $30,000,000.

The charter's amendment was approved by the Insurance Department on March 2, 1995.

A. Management

The by-laws of the Company provided that the board of directors shall consist of fifteen members, seven of whom are nominated by holders of Class A common shares; and eight of whom are nominated by the holders of Class B common shares. The directors are elected each year at the annual meeting of the shareholders, and hold office for one year.

The members of the board of directors, as of December 31, 1994, were as follows:

Name and Residence	Principal Business Affiliation
Class A Directors	
Donald Ashkenase Great Neck, NY	Executive Vice President, Montefiore Medical Center
Eugene R. Daly Franklin Lakes, NJ	Treasurer, Hanys Insurance Co.; Vice President, Finance, FOJP Service Corporation
Thomas J. Hayes Chappaqua, NY	Chairman of the Board, Hanys Insurance Co. Executive Vice President, Beth Israel Medical Center
Robert Markowitz New York, NY	President, Hanys Insurance Company President, FOJP Service Corporation
Barry Stern New York, NY	Senior Vice President, Maimonides Medical Center
Leonard Weil Little Neck, NY	Director of Finance, Long Island Jewish Medical Center
Robert Wertheim Roslyn Harbor, NY	Senior Vice President, Business and Finance, Mount Sinai Medical Center

Name and Residence	Principal Business Affiliation
Class B Directors	
George Adams West Hempstead, NY	President, Lutheran Medical Center
Jeffrey Frerichs Yonkers, NY	Executive Vice President, Cabrini Medical Center
James Maher Skaneateles, NY	Chief Executive Officer, Crouse-Irving Memorial Hospital
Murray Marsh Jamestown, NY	Vice Chairman, Hanys Insurance Company; Chief Executive Officer, Women's Christian Association Hospital
A. Gordon McAleer Warwick, NY	Executive Director, Arden Hill Hospital
Mark Morris Niskayuna, NY	President, Hospital Insurance Management Company (HIMCO)
Edward G. Murphy Menands, NY	President, Seton Health System of Troy
Bertram J. Oppenheimer, MD Eastchester, NY	Secretary, Hanys Insurance Company; Administrator/CEO, Yonkers General Hospital

A review of the minutes of the Board of Directors' and sub-committees' meetings, during the period under examination, revealed the following:

1. All meetings were well attended. Each director had an acceptable attendance record for the meetings they were eligible to attend.

2. The Board of Directors or its finance committee failed to approve the investment transactions as required by the Insurance Law.

Pursuant to Section 1411(a) of the New York Insurance Law:

> "No domestic insurer shall make any loan or investment... unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan..."

It is recommended that all future investment transactions be approved by the Board of Directors or the finance committee. If approved by the finance committee, Section 1411(a) requires that, "...the committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting."

The principal officers serving the Company at December 31, 1994 were as follows:

Name	Title
Robert Markowitz	President
Eugene R. Daly	Treasurer
Bertram J. Oppenheimer	Secretary

B. Territory and Plan of Operation

The Company was licensed, in 1987, to write in New York State only, the kinds of insurance set forth in the following numbered paragraph of Section 1113(a) of the New York Insurance Law:

Paragraph	Kind of Insurance
13	Personal injury liability insurance, restricted to: (i) that kind of medical and dental malpractice excess liability insurance specified in Section 18 et. seq. of Chapter 208 of the Laws of 1987 and any renewals, continuations or amendments to the foregoing provisions, including Section 19 et. seq. of Chapter 294 of the Laws of 1985; (ii) excess general liability insurance over $5 million for eligible not-for-profit agencies; and (iii) excess directors' and officers' liability insurance over $1 million for eligible not-for-profit agencies.

On March 21, 1991, the Insurance Department approved the Company's amended charter to write personal injury liability insurance without any restrictions, and property damage liability insurance and fidelity insurance as specified in paragraphs 13, 14 and 16 respectively of Section 1113(a) of the New York Insurance Law.

However, the 1987 license, and its restrictions, were in effect until the Insurance Department issued a new license to the Company on August 23, 1996. The new license licensed the Company to write the kinds of insurance specified in paragraphs 3, 13, 14 and 16 of Section 1113(a) of the New York Insurance Law.

All policies written are either that kind of medical and dental malpractice excess liability insurance described in Section 18 of Chapter 208 of the Laws of 1987 or second layer excess medical malpractice liability insurance issued to individual physicians.

All policies are written on an occurrence basis and, as such, are non-assignable. If the first layer policies are terminated for any reason, there is no requirement for return premiums.

The Company does not utilize independent general agents in the solicitation of business. All premiums are either generated through the "New York State Hospital Excess Liability Pool" (The Pool) or directly collected from individual physicians who are covered under second layer excess policies.

The Pool, which was established effective July 1, 1986, pursuant to Chapter 266 of the Laws of 1986, as amended, was created for the purpose of providing a conduit for the transfer of funds from

general hospitals, Blue Cross plans and Medicaid, to licensed insurance carriers or trusts which provide the excess medical malpractice insurance coverage.

The Company is licensed to do an insurance business only in New York State. The following are direct premiums written for the period covered by this examination:

Calendar Year	Amount
1990	$52,675,601
1991	$31,822,269
1992	$41,059,714
1993	$63,872,725
1994	$76,272,973

C. Return Premiums

Chapter 938 of the Laws of 1990, amending Section 18 of the Laws of 1986, requires that a refund premium, related to profits from business written by the Company from 1987 to 1990, with respect to the State of New York share of premiums paid for that period, must be returned to the State of New York in subsequent periods. The return premium payment is to be made upon certification to the Company by the Superintendent that there is a reasonable likelihood, on an actuarial basis, that the moneys returned will not be needed to pay for the expected liabilities incurred by the Company for such policy periods.

Chapter 266 of the Laws of 1991, amending Chapter 266 of the Laws of 1986 and Chapter 938 of the Laws of 1990 requires, that if the Superintendent determines that the rates for policies of excess medical malpractice coverage, as established by the Superintendent, are projected to produce amounts greater than that required to satisfy the standard that premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency and reasonable reserves and surplus, therefore, then the

Superintendent may direct the company to return to the New York State Hospital Excess Liability Pool (the Pool) all or a portion of such premium that is projected to be greater than required.

Pursuant to Chapter 938 of the Laws of 1990 and Chapter 266 of the Laws of 1991, and based upon actuarial determinations, the Superintendent directed the Company to pay $9.5 million and $42 million to the State of New York and the Pool, respectively.

These payments were made by the Company on March 12, 1991 and February 14, 1992, respectively.

In addition, during the first five policy years of the Pool, from July 1, 1986, through June 30, 1991, the cost of excess insurance allocated to Medicaid was paid by the State of New York, Department of Social Services. Subsequently, the Legislature determined that the State will no longer pay the Medicaid share of the Pool and provided for other sources of funds. Accordingly, Chapter 266 of the Laws of 1991 provided the following:

> "If there were no other sources of the Medicaid share, it would be the obligation of the practitioner who was insured under the excess policy and if the practitioner failed to make the required payment, the policy was to be canceled as of July 1, 1991."

The Company voluntarily paid to the Pool, all the Medicaid share for several policy years, regardless of whether a physician was insured for excess coverage with the Company or with other insurers. The policy years and amounts are as follows:

Policy year 1992/1993	$30,910,353
Policy year 1993/1994	$33,284,882
Policy year 1994/1995	$33,717,262

For the policy years 1995/1996 and 1996/1997, the Company paid to the Pool only its insureds' share of the Medicaid, which amounted to $18,537,668 and $14,705,063, respectively.

The Company reported, in its annual statements, the written premiums and earned premiums net of returned premiums.

D. Reinsurance

The Company does not assume any reinsurance business, and had only one type of cession agreement.

Every year, the Company entered into a stop loss reinsurance agreement with National Union Fire Insurance Company of Pittsburgh, PA. The reinsurer is a New York licensed insurer.

The examiner's review of the reinsurance agreement, for form and content, revealed the following:

1. Each year's agreement covered policies issued by the Company, during the policy year from July 1 to June 30; and

2. The agreement contained the required, standard clauses, including an insolvency clause which meets the requirements of Section 1308 of the New York Insurance Law.

Gross reinsurance premiums of each yearly agreement exceeded the limits permissible per Section 1308(e)(1)(A) of the New York Insurance Law, which states in part,

> "During any period of twelve consecutive months, without the superintendent's permission:
> (A) no domestic insurer, except life, shall by any reinsurance agreement cede an amount of its insurance on which the total gross reinsurance premiums are more than fifty percent of the unearned premiums on the net amount of its insurance in force at the beginning of such period..."

The Company did not request the Superintendent's permission.

When the above violation was brought to the Company's attention, it agreed to revise the reinsurance agreement in the future, and comply fully with the requirements of Section 1308 of the New York Insurance Law.

It is recommended that the Company comply with Section 1308(e)(1)(A) of the New York Insurance Law by limiting the gross reinsurance premiums of each yearly reinsurance agreement to the permissible limits, or request the Superintendent's permission to exceed the limitations.

On December 21, 1990, the Company, retroactively, implemented what it terms a "stop loss reinsurance agreement", effective August 1, 1987, wherein it ceded 100% of losses in excess of 48% of net earned premiums for policies issued during the period from August 1, 1987 to July 1, 1990. The amounts payable under the stop loss reinsurance agreement are not to exceed an aggregate of $150,000,000 inclusive of allocated loss adjustment expenses.

The reinsurance agreements covering each policy year beginning July 1, 1990, had various percentage of net premiums ceded; however, all had the maximum aggregate of $150,000,000.

The reinsurance agreement which covers policy year 1994/1995, with an effective date July 1, 1994, ceded 100% of the Company's losses in excess of $43,870,000.

The reinsurance agreements were signed after the effective date; as such, the losses involved under all reinsurance agreements were already incurred as of the cession. However, the consideration was equal

to or more than the amount of transferred reserves. The Company has reported these transactions as reinsurance in its annual statements filed for the years 1990 through 1996.

E. Holding Company System

The Company is jointly owned by the following two trusts:

1) FFH Hospitals Trust (1987), purchased 80% of the voting shares of the Company on April 29, 1987, consisting of all the Class A shares and 60% of the Class B shares, for a total of $8,800,000. With the inclusion of Class C non-voting shares, the trust investment represents 89.5% of the value of the common shares of the Company. FFH Hospitals Trust (1987) was formed and wholly-owned by the five major hospital affiliates of UJA/Federation and FOJP Service Corporation.

2) HANYS Hospitals Trust (1987), purchased 20% of the Company on April 29, 1987, consisting of 40% of the Class B shares, for a total consideration of $2,200,000. HANYS Hospital Trust (1987) has the option to acquire from the FFH Hospitals Trust (1987) all of the Class B shares. With the ` inclusion of Class C non-voting shares, the trust investment represents 10.5% of the value of the common shares of the Company. HANYS Hospital Trust (1987) was formed and wholly-owned by eighty-seven members of the Hospital Association of New York State (HANYS).

All of the beneficial shareholders are tax exempt organizations.

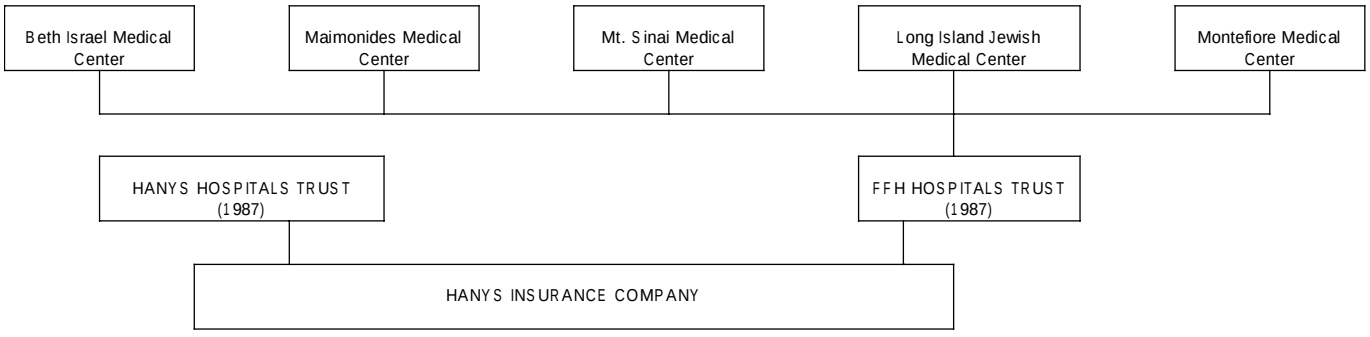
Note: Class A and Class B common shares are identical with the exception that Class A shareholders can elect 7 members of the board of directors, while Class B shareholders can elect 8.

The combined total of $11,000,000 ($8,800,000 + $2,200,000) represents $750,000 of paid in capital and $10,250,000 of gross paid-in and contributed surplus.

The ultimate source of funds used to purchase the Company's shares was FFH Insurance Company, a Bermuda insurer. FFH Insurance Company paid FFH Hospitals Trust (1987) $11,000,000 in exchange for a non-recourse promissory note due December 31, 1997, secured by the HANYS Insurance Company shares. Of this amount, FFH Hospitals Trust (1987) paid $8,800,000 to the Company for shares purchased, and loaned $2,200,000 to HANYS Hospitals Trust (1987) in a similar non-recourse secured promissory note due June 30, 1997. HANYS Hospitals Trust (1987) then used the funds to purchase its share of the Company.

Both FFH Insurance Company and FFH Hospitals Trust (1987) are owned by the five major hospital affiliates of the UJA/Federation and FOJP Service Corporation.

The following is an organizational chart illustrating the ownership of Hanys Insurance Company:



F. Significant Operating Ratios

The following ratios have been computed as of December 31, 1994, based upon the results of this examination:

Net premiums written (1994) to surplus as regards policyholders	.38:1
Liabilities to Liquid assets (cash and invested assets less investment in affiliates)	70.19%

The above ratios fall within the benchmark ranges set forth in the Insurance Regulatory Information System of the National Association of Insurance Commissioners.

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

	Amounts	Ratios
Losses incurred	$ 72,491,000	64.4%
Loss adjustment expenses incurred	15,281,646	13.6
Other underwriting expenses incurred	10,123,590	9.0
Net underwriting gain	14,614,061	13.0
Premiums earned	$112,510,297	100.0%

G. Abandoned Property Law

The Company failed to submit abandoned property reports to the State of New York Comptroller's Office, as required by Section 1316 of the New York State Abandoned Property Law, which states in part,

> "Any amount issued and payable on or after July first, nineteen hundred seventy-four 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..."

Please note, insurance companies which neither hold nor owe abandoned property are still required to file a negative abandoned property report with the Comptroller's Office.

It is recommended that the Company request the special abandoned property forms from the Comptroller's office and file them annually on a timely basis, as required.

H. Legal Expenses

Beginning with the organization of the Company, the law firm of Ackerman, Salwen and Glass ("the Law Firm") has provided various legal services. Several employees of the Law Firm, including the Senior Partner, Joel Glass ("the Senior Partner") were among the original officers of the Company. The legal services provided included formation of the Company, assistance in obtaining licenses from this Department, filing of policy forms, rates and corporate agreements with the State, and acting as assistant secretaries of the Company. Members of the Law Firm also attended all meetings of the board of directors, (including sub-committees thereof). In addition, the Law Firm was given the authority to manage, defend and settle all claims on behalf of the Company. Management has represented that there was no formal written agreement between the Company and the Law Firm that granted such broad claims settlement authority to the Law Firm.

During the previous examination, it was discovered that payments were made to the Law Firm without detailed supporting vouchers. This was a violation of Section 1217 of the New York Insurance Law which states in part that:

> "No domestic insurance company shall make any disbursement of one hundred dollars or more unless evidenced by a voucher...If such disbursement be for services and disbursements, such vouchers shall set forth the services rendered and itemize the disbursements..."

At the examiner's request the Company provided the detailed vouchers. Examination review indicated several instances of duplicate billings and overcharges by the Law Firm as well as duplicate payments by the Company. This matter was brought to the Company's attention and all payments made to the Law Firm were reviewed, corrected and adjusted by the Company. Additionally, the Company represented that it had instituted a series of internal controls to avoid a recurrence of this situation.

A review of the Company's underlying records indicated that the following amounts were paid to the Law Firm for claims related legal expenses for the years 1990 through 1995:

Calendar Year	Claims Related Legal Expenses Paid	Percentage Increase Over Previous Year
1990	$ 267,839	
1991	$ 688,140	157%
1992	$ 677,701	(2%)
1993	$ 850,019	25%
1994	$1,047,862	23%
1995	$1,203,435	15%

It should be noted that the legal expenses charged by the Senior Partner and a staff attorney increased substantially from $197,325 and $77,985 respectively in 1990 to $355,410 and $167,553 respectively in 1991.

In what appeared to be an effort to control legal expenses, beginning in 1992, the Company, by verbal agreement with the Law Firm, capped the amount of fees to be paid to the Senior Partner and the staff attorney, at $250,000 and $187,500, respectively.

The capped amount of legal fees remained in effect until December 31, 1995.

Although the number of claims reported to the Company increased during the periods shown above, it appears that the increase in claims related legal expenses was driven by additional factors, most notably, questionable billing practices by the Law Firm.

During the examination period, all claim notices and inquiries were sent by the Company to the Law Firm. Upon receipt, the Law Firm established either an asserted or unasserted case file on a per physician, per incident basis. Asserted claims are those claims where the Company has received a formal indication that an occurrence of malpractice has been alleged against an insured physician. Unasserted claims involve inquiries or occurrences reported to the Company for which there is no formal indication that a claim will be presented to the Company, or allegation of malpractice against an insured physician. For example, it was noted in one instance that a physician sent the Company a request for medical records that he received from a patient's attorney, in connection with the patient's application for Social Security disability benefits. The Company identified this informational request as an unasserted claim notice and forwarded this matter to the law firm. Examination review indicated that it was a common practice of the Company to refer such routine requests to the Law Firm. Separate claim numbers were assigned to each case file in those instances where the physician was insured by the Company for multiple years and an occurrence date could not be detemined.

It appears that there was a verbal agreement between the Law Firm and the Company authorizing the Law Firm to bill the Company for two hours time, at a rate of $125 or $150 per hour, depending on the attorney assigned, to establish each newly reported case. This applied to both asserted and unasserted cases. Information provided to the examiners indicated that this agreement appeared to be based upon representations from the Law Firm regarding the time involved in opening a newly reported case file.

While certain fees were charged the Company by the Law Firm on a per case basis, other charges were predicated on the number of claim files opened.

Examination review revealed thirty-one instances in 1994 where Law Firm attorneys opened more than twelve case files in a given day, thereby permitting the firm to charge in excess of twenty-four hours for those days, solely for claims related matters. This is a clear indication that the two hours billed for opening case files was excessive. Based on these facts, it would appear that the Company management contributed to the increased legal costs by agreeing to such an arrangement.

In addition to the two hours charge noted above, a review of billings submitted by the Law Firm revealed that during 1990, the Senior Partner of the firm, routinely charged the Company for 0.3 hours for reviewing each newly reported case. At that time, a senior partner's services were billed at a rate of $250 per hour. In 1991, and thereafter his/her hourly time charge per case increased to either 0.6 or 0.8 hours. At the same time, his/her hourly billed rate increased to $300 per hour and thereafter increased to $350 per hour. According to the Company, there was no agreement between the Law Firm and the Company authorizing these routine charges. According to information provided to the examiners, the Law Firm's office manager was instructed by the senior partner to record these routine charges when each new case file was established. A review of a sample of unasserted claim files by the examiners did not indicate any work product evidencing such reviews.

In addition to the two hour case set up charge and the routine loading of the Senior Partner's reviewing charge, the Law Firm billed the Company for either 0.6 hours or 1.0 hour for paralegal services at a rate of $50 per hour. The paralegal's charges were based on the total number of claim files established as

opposed to number of case files established. Thus, if an asserted or unasserted case was reported to the Company where the physician was insured for four years, the Company was charged as follows:

Function	Hours Charged	Hourly Rate	Total
Initial case opening	2.0	$125	$250
Review by the senior partner	.8	350	280
Paralegal charge*			
4 claims x .6 hours per claim	2.4	50	120
Total			$650

* Paralegal charges are based on number of claims, not case files.

The costs associated with opening and reviewing a case file appears to be excessive in that it involves the services of a senior partner, a staff attorney, and a paralegal. For asserted cases, initial notification to an insurer usually consists of a subpoena or letter from a claimant's attorney. For unasserted claims, the notification usually consists of an inquiry. Based on the limited information that is usually provided at the initial notification stage, the Law Firm's frequent practice of billing for the services of a senior partner and paralegal in addition to the two hours charged by an attorney represented excessive charges that should have been questioned by Company management.

In addition to the charges set forth above, it was noted that once a claim file was established, a paralegal would be assigned the duty of preparing a report of all claims at a set interval, at which time the Company was billed for either .6 hours or 1.0 hours for his/her services per claim file at a rate of $50 per hour. Examination review indicated that this practice constituted the law firm's normal billing procedures relative to claims files and was not questioned by Company management.

The Combined Coordinating Council ("CCC") is a Trust that writes excess malpractice insurance. Pursuant to a memorandum of understanding between the Hanys Insurance Company and CCC dated May 4, 1993, CCC began compensating the Company for past and future lobbying and legislative efforts. The compensation amounts agreed upon were $200,000 payable in 1993 and $75,000 payable on the first day of July of 1994, 1995 and 1996. A review of the Law Firm's billings indicated that charges of $74,340, $178,605 and $146,790 (a total of $399,735) were billed and paid by the Company for the Senior Partner's services. These charges were for calendar years 1993, 1994 and 1995, respectively. In addition, the Company agreed to compensate the Senior Partner an additional $175,660, $71,395 and $102,945 (a total of $350,000) by assigning to him moneys owned by CCC. Despite the fact that the Senior Partner was assigned these moneys, the Company could not provide any detailed information to demonstrate that the Senior Partner performed any services that would entitle the Law Firm to such payments. Furthermore, CCC failed to provide the Company with any evidence that it actually paid $350,000 to the Senior Partner.

The Company did not record the $350,000 assigned to the Senior Partner as part of its legal expenses for the years 1993, 1994 and 1995. It should be noted that the Senior Partner also provides legal services to CCC.

On July 18, 1996 the Company received a check of $75,000 from CCC for the year 1996.

In late 1995, Company management initiated an audit of billings from the Law Firm in 1994 and 1995. At a Board of Directors' meeting held March 15, 1996, management concluded that the billings were appropriate in the sense that the work billed by the Law Firm was actually performed and was supported by work product. They further concluded that the professional nature of the work performed was adequate. However, they also concluded that since claims related legal expenses represent a significant expense to the Company, controls should be implemented to better manage and reduce expenses. On October 16, 1995, the Company awarded a retainer contract to the Senior Partner, whereby he would be paid $250,000 for all legal services provided to the Company during calendar year 1996. Effective February 1, 1996, claims adjusting functions were split between the Company and the Law Firm whereby each party's duties and responsibilities were defined. Additionally, specific limitations were placed on the amount that the Law Firm could charge the Company for calendar year 1996.

As noted previously, the Law Firm also provided general legal services to the Company. A review of the minutes of the Board of Directors' meetings indicated that at least three attorneys from the Law Firm attended all meetings of the Board of Directors as well as sub-committees thereof. The Company was billed by the Law Firm for attendance at these meetings. The minutes did not always reflect the participation of the lawyers in discussions at the meetings, thereby calling into question the need for their attendance at such meetings.

It should be noted that the management of the Company did not adequately oversee the activities and billings of the Law Firm, as required by item ii of sub-section 1, of section II, of the management agreement between HIMCO and the Hanys Insurance Company.

Members of the board of directors have a fiduciary responsibility to oversee the activities of the Company. Management of the Company failed to develop effective review procedures which resulted in continued overpayment of legal fees to the Law Firm and the Senior Partner. In turn, board members failed to insure that proper procedures were developed. It is recommended that any board members unwilling or unable to fulfill their fiduciary responsibilities to the Company be replaced.

I. Service Agreement

The Company does not employ any full-time employees; therefore, its administration was provided by HANYS Services Inc. (HSI), under the terms of a management agreement, dated July 1, 1987.

On September 26, 1989, the Company's Board of Directors passed a resolution to switch the management of the Company from HSI to the new management company, "Hospital Insurance Management Company, Inc." (HIMCO). HSI is a for profit corporation and a wholly-owned subsidiary of Hospital Association of New York State (HANYS), while HIMCO is a for-profit corporation, wholly-owned by Mr. Mark Morris.

HSI and HIMCO, with the consent of the Company, signed an assignment and assumption agreement, effective November 1, 1989.

The Company and HIMCO entered into an amended and restated management agreement, effective November 1, 1989. This agreement is similar to the one it replaced, with the exception of the compensation for services provided.

Under the new agreement, the compensation to HIMCO is based on, and determined by, an annual budget, which HIMCO develops and submits to the Company for approval. The budget reflects the full projected cost of the Company's operations for the year, including an annual payment to the Hospital Association of New York State in the amount of $150,000.

HIMCO's yearly budget does not include allocated loss expenses, legal expenses, or any compensation due to independent service providers engaged by the Company to provide actuarial, investment, financial, legal, or other services. These other types of expenses are paid by the Company pursuant to separate agreements to be entered into between the Company and such independent providers.

The following are the examiner's observations of the service agreement:

i. The last two lines of Section 1 of Article III on page 10 of the agreement which read, "including an annual payment to the Hospital Association of New York State (HANYS) in the amount of $150,000," should be deleted.

ii. The last paragraph of Section 5 of Article III on page 11 of the agreement should be amended to include the following:

"The management agrees that it shall pay and reimburse the Company all savings in case the approved projected cost budget exceeds the actual cost."

iii. The last paragraph of Section 2 of Article IV on page 11 of the agreement should be revised to read,

"The Company shall reimburse the management for such third party expenses as set forth in Article III, Section 2 which are properly incurred in the performance of such services in accordance with a schedule to be agreed upon between management and the Company."

The prior report on examination of the Company had recommended that the Company submit its agreement with HIMCO to the Department for approval. The Company has failed to submit its amended and restated agreement with HIMCO to the Department for approval.

It is again recommended that the Company submit its agreement with HIMCO to the Department for approval.

The management fees incurred by HIMCO, for the years under examination were as follows:

1990	$ 674,749
1991	$ 929,921
1992	$1,031,181
1993	$1,187,816
1994	$1,116,114

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities, and surplus as determined by this examination as of December 31, 1994 and as reported by the Company.

	EXAMINATION				COMPANY	
Assets	Ledger Assets	Non-Ledger Assets	Not-Admitted Assets	Admitted Assets	Admitted Assets	Surplus Increase (Decrease)
Bonds	$227,199,935	$	$	$227,199,935	$227,199,935	$
Cash on hand and on deposit	(117,526)			(117,526)	(117,526)	
Short-term investments	37,083,815			37,083,815	37,083,815	
Uncollected premiums	153,502,423		32,303,232	121,199,191	153,502,423	(32,303,232)
Interest, dividends and real estate income due and accrued	2,504,885			2,504,885	2,504,885	
Total assets	$420,173,532	$ 0	$32,303,232	$387,870,300	$420,173,532	$(32,303,232)

Liabilities, Surplus and Other Funds	Examination	Company	Surplus Increase (Decrease)
Losses	$117,591,000	$227,485,000	$109,894,000
Loss adjustment expenses	18,265,000	46,522,000	28,257,000
Other expenses	266,302	266,302	
Taxes, licenses and fees	750,539	750,539	
Federal income tax	19,850,117	2,682,371	(17,167,746)
Unearned premiums	55,067,753	55,067,753	
Reinsurance premiums payable	259,271	259,271	
Medicaid premium refund payable	34,300,805	34,300,805	
Due to broker/dealer	25,933,281	25,933,281	
Total liabilities	$272,284,068	$393,267,322	$120,983,254
Capital paid up	$1,050,000	$1,050,000	$
Gross paid in and contributed surplus	19,950,000	19,950,000	
Unassigned funds	94,586,232	5,906,210	88,680,022
Surplus as regards policyholders	$115,586,232	$26,906,210	$88,680,022
Total liabilities and surplus	$387,870,300	$420,173,532	

B. Underwriting and Investment Exhibit

Surplus as regards policyholders increased $27,023,737 during the five year examination period from January 1, 1990 through December 31, 1994, detailed as follows:

Statement of Income

Underwriting Income		
Premiums earned		$112,510,297
Deductions:		
Losses incurred	$72,491,000	
Loss adjustment expenses incurred	15,281,646	
Other underwriting expenses incurred	10,123,590	
Total underwriting deductions		97,896,236
Net underwriting gain		$14,614,061
Investment Income		
Net investment income earned	$62,506,624	
Net realized capital gains	4,548,604	
Net investment gain		67,055,228
Other Income		
Commission on ceded reinsurance	$6,978,265	
Net other income		$6,978,265
Net income before federal income taxes		$88,647,554
Federal income taxes incurred		21,546,278
Net income		$67,101,276

Capital and Surplus Account

Surplus as regards policyholders as of December 31, 1989, per report on examination			$88,562,495
	Gains in Surplus	Losses in Surplus	
Net income (loss)	$67,101,276	$	
Net unrealized capital losses		9,531,592	
Change in non-admitted assets		30,545,947	
Total gains and losses	$67,101,276	$40,077,539	
Net increase in Surplus as regards policyholders			27,023,737
Surplus as regards policyholders, as of December 31, 1994 per report on examination			$115,586,232

Note: The Internal Revenue Service did not commence any audit, of the Company's federal income tax returns, since inception on August 1987. The examiner is aware of a potential exposure of the Company to a further tax assessment, and an additional liability of $17,167,746, has been established herein, relative to such contingency.

4. UNCOLLECTED PREMIUMS

The examination admitted asset of $121,199,191, is $32,303,232 less than the $153,502,423, reported by the Company as of the examination date. The decrease consists of the following:

A. $4,223,545, represents the Company's share of premium receivables, due to the New York State Excess Liability Pool, from hospitals that are distressed, bankrupt, or closed

B. $28,079,687, represents the Company's share of premium receivables, due from New York State Blue Cross Plans, for policy years 1986/1987 through 1993/1994. Due to the legislative termination of the Diagnostic Related Group (DRG) system, in year 1997, the Health Department is no longer able to add a surcharge to the inpatient claims. Therefore, there is no procedure available for the recoupment of amounts due from the Blue Cross Plans.

5. LOSSES AND LOSS ADJUSTMENT EXPENSES

The examination liability of $135,856,000, is $138,151,000 less than the $274,007,000, reported by the Company as of the examination date.

This change is summarized as follows:

	Examination	Company	Decrease
Losses	$117,591,000	$227,485,000	$109,894,000
Loss adjustment expenses	18,265,000	46,522,000	28,257,000
Totals	$135,856,000	$274,007,000	$138,151,000

The examination reserves were calculated in accordance with generally accepted actuarial principles, and were based upon actuarial assumptions considered appropriate, relative to the coverages afforded by the Company.

The examination, and the Company, reserves are reflected net of anticipated future investment income on medical malpractice reserves. The calculation of the present value of such reported reserves was based upon interest rate of 6.5%, per year, for this examination and the Company.

This discount has been allowed due to the protracted period involved in the settlement of malpractice claims, during which, period earnings will be derived from investments corresponding to the reserves for such claims, and related reserves for the expenses of settlement.

6. FEDERAL INCOME TAXES

The examination liability of $19,850,117, is $17,167,746 more than the $2,682,371, reported by the Company as of the examination date.

The increase is due to the examination's significant reduction of the Company's premium receivables, losses and loss adjustment expense reserves.

7. TREATMENT OF POLICYHOLDERS AND CLAIMANTS

In the course of the examination, a review was made of the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants.

The review was general in nature, and is not to be construed to encompass the generally more precise scope of a market conduct investigation, which is the responsibility of the Property and Casualty Insurance Bureau of this Department.

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

A) Advertising
B) Underwriting
C) Rating
D) Claims

No problem areas were encountered, with the exception that the Company issued and/or renewed second layer excess medical malpractices policies to 557 different physicians, for the policy periods under

examination. In addition, the Company issued, to an additional 135 physicians, second layer excess policies, for policy year 1995/1996.

The Company was not authorized to write second layer excess medical malpractice policies during the policy periods referred to above. As such, the Company was in violation of Section 1102(a) of the New York Insurance Law, which states in part:

> "No person, firm, association, corporation...shall do business in this state unless authorized by a license in force..."

However, it should be noted that, for the years indicated above, the Company filed rates for a second layer excess medical malpractice insurance, and received approval for those rates from the State of New York Insurance Department. Also, the Company filed the policy forms for a second layer excess medical malpractice insurance and received approval thereon.

On August 23, 1996, the Insurance Department issued a new license to the Company, which authorized it to issue the second layer excess medical malpractice policies.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report contained thirteen comments and recommendations detailed as follows: (Page numbers refer to prior report)

ITEM NO.		PAGE NO.
1.	It is recommended that the Company act within the scope of authority of its approved charter and comply with the requirement of Section 1206 of the New York Insurance Law.	5-6

ITEM NO.		PAGE NO.
	The Company has complied with the recommendation.	
2.	The Company's by-laws were not in conformity with its charter as regards the number of members of the board of directors.	6
	This was remedied by a board resolution on September 26, 1989.	
3.	Compensation to directors for attending board of directors' meetings was contrary to the Company's by-laws.	9
	This was remedied by a board resolution on September 26, 1989.	
4.	The Company issued, in 1989, eight polices of second layer excess medical malpractice liability insurance without a license.	11
	The Company issued second layer excess medical malpractice policies to 557 different physicians, for the policy periods under examination, without a license.	
	This same violation is included under Item H. of this report.	
5.	The Company, in its filed 1987 and 1988 annual statements failed to fully comply with the provisions of Regulation 30 and failed to report allocated and unallocated loss adjustment expenses in Schedule P.	15
	The Company has complied fully with the provisions of Regulation 30, and properly reported allocated and unallocated loss adjustment expenses in Schedule P.	
6.	The Company incorrectly responded "Yes" to interrogatory number 8(c) on page 15 of its filed 1987, 1988, and 1989 annual statements.	15-16
	Subsequently, the board of directors established a conflict of interest report guideline.	
7.	It is recommended that the Company report promptly to the National Association of Insurance Commissioners (NAIC) all acquisitions of securities unlisted in the NAIC Valuation Manual.	16-17
	The Company has complied with this recommendation.	
8.	The Company did not follow the instructions to Schedule D in its filed 1987 and 1988 annual statements.	17
	The Company has complied with the instructions for its filed 1989 annual statement, and thereafter.	

ITEM NO.		PAGE NO.
9.	The Company did not maintain adequate vouchers pertaining to certain legal expenses, as required by Section 1217 of the New York Insurance Law. Internal controls have been implemented to avoid a recurrence of this situation. The Company did not adequately oversee the activities and billings of the law firm. There are six recommendations, included under Items D thru I of this report.	17
10.	It is recommended that the Company submit its agreement with HIMCO, to the Department, for approval. The Company has not complied with this recommendation. The same recommendation is included under Item J of this report.	18-20
11.	The Company's contract with its accounting firm, Ernst & Young failed to fully comply with the requirements of Department Regulation No. 118. The Company has complied with Regulation No. 118.	21
12.	It is recommended that the Company report its loss and loss adjustment expense reserves on page 3 of its filed annual statement gross of discount with a separate write-in contra liability to reflect any anticipated future income. Changes in annual statement instructions render this point moot.	26
13.	It is recommended that the Company calculate the premium for the physicians who join the hospitals during any given month, on a pro-rata basis instead of charging a full month's premium. The Company has complied with this recommendation.	28

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM.		PAGE NO.
A.	It is recommended that all future investment transactions be approved by the Board of Directors or the finance committee.	7
B.	It is recommended that the Company comply with Section 1308(e)(1)(A) of the New York Insurance Law by limiting the gross reinsurance premiums of each yearly reinsurance agreement to the permissible limits or request the Superintendent's permission to exceed the limitations. The Company did not request the Superintendent's permission.	11-12
C.	It is recommended that the Company request the special abandoned property forms from the Comptroller's office and file them annually on a timely basis, as required.	15
D.	Members of the board of directors have a fiduciary responsibility to oversee the activities of the Company. Management of the Company failed to develop effective review procedures which resulted in continued overpayment of legal fees to the Law Firm and the Senior Partner. In turn, board members failed to insure that proper procedures were developed. It is recommended that any board members unwilling or unable to fulfill their fiduciary responsibilities to the Company be replaced.	23
E.	It is recommended that the Company submit its agreement with HIMCO, to the Department for approval.	25
F.	The Company violated Section 1102(a) of the New York Insurance Law. by issuing second layer excess medical malpractice liability policies in years 1992 through 1995. The Company was not licensed for this until August 23, 1996.	31

Respectfully submitted,

_____/S/_____
Elsaid Elbially, AFE
Associate Insurance Examiner

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

ELSAID ELBIALLY being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Elsaid Elbially

Subscribed and sworn to before me

this _____day of _____1997.

APPOINTMENTS NO. 20606

STATE OF NEW YORK

INSURANCE DEPARTMENT

I, SALVATORE R. CURIALE, Superintendent of Insurance of the

State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

ELSAID ELBIALLY

as proper person to examine into the affairs of the

HANYS INSURANCE COMPANY, INC.

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

COMPANY

with such other information as he/ shall deem requisite.

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

this 6th day of January 19 94

SALVATORE R. CURIALE

Superintendent of Insurance

(by) Deputy Superintendent

Form 7 (rev. 11/87)