REPORT ON EXAMINATION

OF

WELLCARE OF NEW YORK, INC.

AS OF

SEPTEMBER 30, 2000

DATE OF REPORT **APRIL 13, 2001**

EXAMINER **BRUCE BOROFSKY**

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

April 13, 2001

Honorable Gregory V. Serio
Acting Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the directions contained in Appointment Number 21636, dated October 16, 2000, annexed hereto, I have made an examination into the condition and affairs of Wellcare of New York, Inc., a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the Public Health Law.

The examination took place at the offices of the ultimate Parent, Kiran C. Patel M.D., at 6800 Dale Mabry Highway, Tampa, FL. Wellcare of New York, Inc. is a wholly owned subsidiary of Wellcare Management Group. Wellcare Management is controlled by Dr. Kiran C. Patel who owns 55% of the entity.

Wherever the designations "the Plan", "the HMO", or "WCNY" appear herein, without qualification, they should be understood to indicate Wellcare of New York, Inc. Wherever the designations "WMG" or "the Parent" appear herein, without qualification, they should be understood to mean Wellcare Management Group, the immediate parent of the Plan.

As of the examination date, the Plan was determined to be insolvent in the amount of $1,465,680. Its capital was impaired in the amount of $1,528,640, and its statutory

minimum net worth requirement (contingent reserve fund/escrow deposit requirements of Part 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department) was impaired in the amount of $5,577,278.

However, as detailed under the Subsequent Events section of this report, a total of $4,897,124 in cash was infused into the Plan from October 1, 2000 through May 2, 2001. This amount remedies the insolvency and capital impairment determined by this examination and would reduce the statutory net worth impairment to $680,154 without considering any other adjustments for events occurring subsequent to September 30, 2000.

1. SCOPE OF EXAMINATION

The Plan was previously examined as of December 31, 1995. This examination covered the period from January 1, 1996 through September 30, 2000. Transactions subsequent to the period were reviewed where deemed appropriate.

The examination comprised a complete verification of assets and liabilities as of September 30, 2000 in accordance with generally accepted accounting principles (GAAP), a review of income and disbursements deemed necessary for 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:

History of the Plan
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
Business in force
Reinsurance
Accounts and records
Loss experience
Financial statements
Treatment of policyholders and claimants

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

2. DESCRIPTION OF PLAN

The Plan was incorporated under New York State Law on December 26, 1985 to develop and operate as a health maintenance organization ("HMO"). The New York

State Department of Health, effective February 12, 1987, granted a Certificate of Authority to the Plan for the purpose of operating as a for-profit HMO under the provisions of Article 44 of the New York Public Health Law.

In April 1999, WCNY filed financial statements with the Department showing itself to be insolvent as of December 31, 1998. As a result, WCNY agreed to a consent to rehabilitation, under the terms of which, the Department could commence court proceedings pursuant to Article 74 of the New York Insurance Law, and have an order entered into that would give the Department the right to take control of the operations of WCNY.

As a result of its extremely poor financial condition, and under the oversight of this Department and the Department of Health, on June 1, 1999, Dr. Kiran C. Patel, M.D. ("Patel"), the principal of Well Care HMO, Inc., a Florida corporation, purchased a 55% ownership in WCMG for $5 million. The funds were transferred to WCNY. Concurrent with this transaction, on June 1, 1999, WCNY sold its commercial business, including approximately 22,000 members, to Group Health Incorporated ("GHI") for $4,781,100.

Currently, WCNY's operations consist solely of Medicare, Medicaid and Child Health Plus members. It does have the authority to begin sales to commercial members, but has not done so at this time.

On July 28, 1999, the Federal Health Care Financing Administration ("HCFA") cited WCNY for failing to administer its Medicare contract services in an efficient and effective manner, and comply with the Medicare requirements for the prompt payment of claims. As a result, HCFA required WCNY to suspend all marketing to and enrollment of Medicare beneficiaries. As of the examination date, the suspension was still in place.

A. Management

The Plan's charter and by-laws call for it to be managed by a board of directors. The by-laws state that the number of directors shall be no less than three and no more than thirteen. The five directors of the Plan at September 30, 1999 were as follows:

Name and Residence	Principal Business Affiliation
Kiran C. Patel Tampa, FL	Chief Executive Officer Wellcare of New York, Inc.
Rupesh Shah Tampa, FL	Chief Executive Officer Well Care HMO, Inc.**
Pradip C. Patel Tampa, FL	President Well Care HMO, Inc.**
Guido D'Alessio* Kingston, NY	Retired
Stewart Munson Kingston, NY	Psychologist

* Enrollee representative - per the requirement of Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.11(f)).
** Well Care HMO, Inc. is an affiliated entity licensed as an HMO by the State of Florida.

The principal officers of the Plan as of September 30, 1999, were as follows:

Name	Title
Kiran C. Patel	Chief Executive Officer
Harold Smith	Assistant Vice-President
Carol K. McAllister	Chief Accounting Officer

The September 2000 Quarterly Statement and New York Data Requirements, and the Insurance Holding Company System Annual Registration Statement, dated September 15, 2000, do not contain the proper list of directors.

The Plan was not able to provide evidence that the board held any meetings between June 1, 1999, the date Dr. Patel purchased the Plan, and April 2000. In light of the financial and operating problems facing the Plan, this failure appears to be a significant breach in the board's oversight responsibilities.

The by-laws of the Plan require that there be an annual meeting of the shareholders within sixty days of the end of each fiscal year. There is no evidence to show that such a meeting was held within the required time parameter.

The Plan does not maintain a code of ethics. Nor does the Plan require its officers or directors to annually sign conflict of interest statements.

Circular Letter No. 9(1999), relating to the adoption of procedures manuals, was implemented on May 25, 1999. That Circular Letter requires that the minutes of the board of directors reflect a discussion of the Circular Letter. No record of such a discussion appears within the Plan's board minutes. The import of the matters discussed in the letter are such that they should have been addressed.

The Circular Letter also recommends that the board obtain the following certifications annually: from the company's independent CPA: (i) that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual are in accordance with applicable statutes, rules and regulations. The Plan was not able to provide such certifications.

It is recommended that the Plan list the proper board members when so required within Departmental filings.

It is recommended that the Plan hold board meetings on a regular basis.

It is recommended that the Plan comply with its by-laws and hold its annual stockholder's meeting within 60 days of the end of each fiscal year.

It is recommended that the Plan adopt a formal Code of Ethics. It is further recommended that the Plan require its Directors and Officers to annually sign statements confirming they have not materially violated such a code.

It is recommended that Circular Letter No. 9(1999) be distributed to all board members at the board's next regularly scheduled meeting. Such distribution, receipt and any subsequent discussion should be recorded in the minutes of the respective board's meeting.

It is recommended that the board obtain the following certifications annually: (i) from the company's independent CPA that the responsible officers have implemented the claims procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual are in accordance with applicable statutes, rules and regulations.

B. Territory and Plan of Operation

As of September 30, 1999, the Plan held a certificate of authority to operate in the following counties of New York State:

Albany	Greene	Queens	Ulster
Bronx	Kings	Rennselaer	Warren
Broome	Montgomery	Rockland	Washington
Columbia	New York	Saratoga	Westchester
Delaware	Orange	Schenectady	
Dutchess	Otsego	Schoharie	
Fulton	Putnam	Sullivan	

During the period January 1, 1996 through September 30, 2000, the HMO experienced a net decrease in enrollment of 67,940 insureds. An analysis of the decrease in enrollment is set forth below:

	1996	1997	1998	1999*	2000
Enrollment, Jan. 1	93,498	85,601	71,223	65,970	28,776
Net loss	(7,897)	(14,378)	(5,253)	(37,194)	(3,218)
Enrollment, end of period	85,601	71,223	65,970	28,776	25,558

* Reflects the sale of approximately 22,000 commercial (non- Medicare/ Medicaid) to GHI HMO Select, Inc. on June 1, 1999

C. Reinsurance

At the examination date, the Plan maintained a reinsurance policy with a licensed insurer, ReliaStar Life Insurance Company. That coverage lapsed on November 30, 2000. Subsequent to the exam date, the Plan was in negotiation for a new contract with the same insurer. The limits of coverage are expected to be as follows:

90% in excess of $115,000 per Member per Diem for Medicaid members subject to a $2,000,000 lifetime cap.

90% in excess of $100,000 per Member per Diem for Medicare members subject to a $2,000,000 lifetime cap.

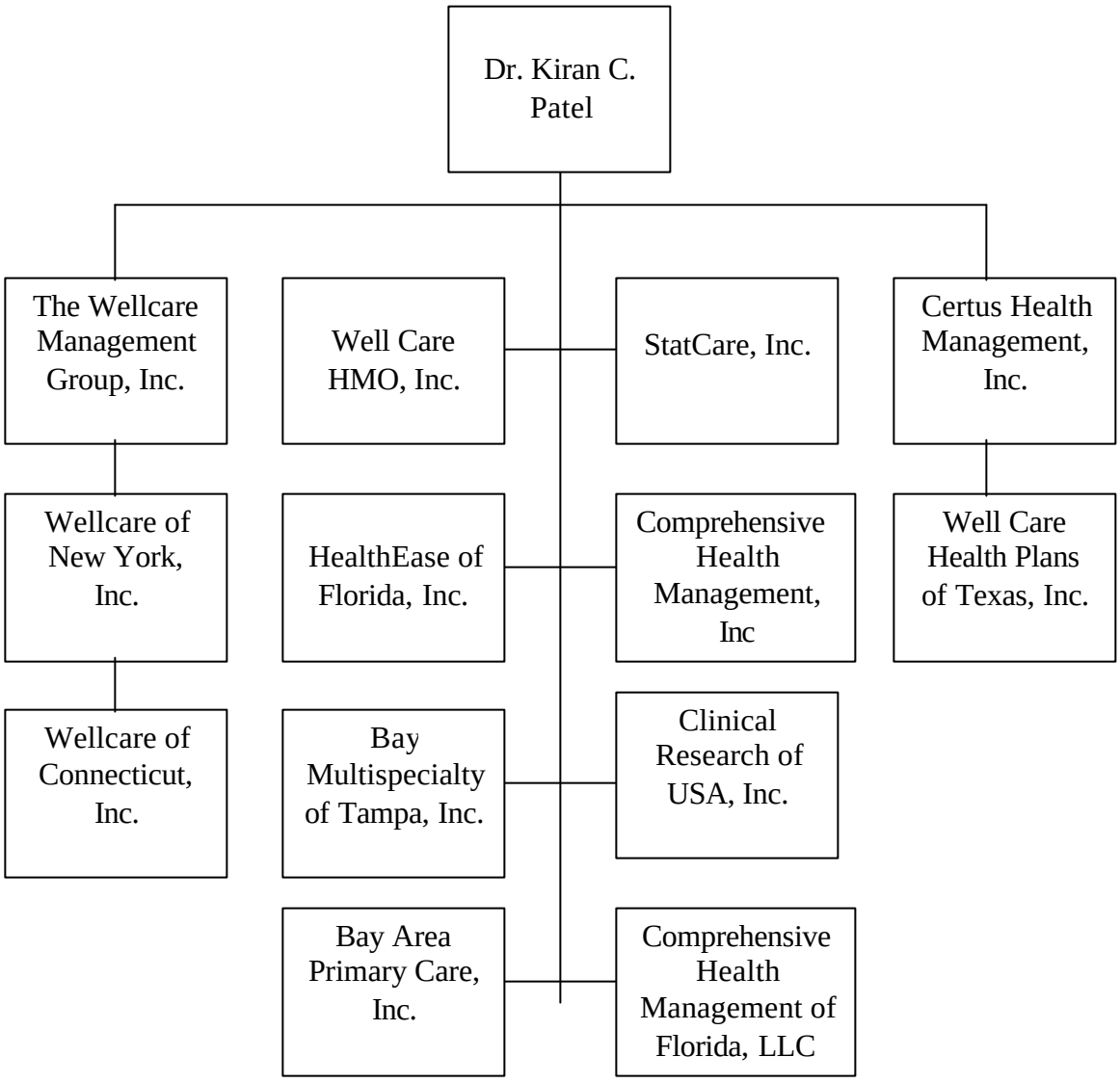
There will be no reinsurance coverage for Child Health Plus members.

The proposed reinsurance agreement contains all of the standard clauses required by the New York State Insurance Department.

D. Holding Company System

The Plan is a controlled HMO under the definitions set forth in Part 98-1.2(i) of the Administrative Rules and Regulations of the Health Department.

Prior to the transactions involving Dr. Patel and GHI, detailed in Item 2 of this report, WellCare Management Group, Inc. ("WCMG"), a publicly traded company, was the ultimate parent in the holding company system. Upon Dr. Patel's purchase of WCNY, the structure of the Holding Company was as follows:



The Plan has a Management Agreement in place with an affiliate, Comprehensive Health Management, Inc. ("CHM" or the "Company"). Part 98-1.11(h) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.11(h)) provides that Management Contracts shall only be effective with the prior written consent of the commissioner of the Department of Health. The Plan was notified on June 11, 1999 that prior to approval, certain changes would need to be made to the agreement. Those changes were never implemented. As such, the Plan has been operating without an approved Management Agreement.

The agreement states the following:

> "The cost for all necessary computer and information system usage, including…major equipment required in order to perform [services for claims…], …shall be the sole responsibility of CHM."

The agreement also states:

> "WCNY shall be responsible for the cost for all employees relating to claims processing."

During April 2000, CHM transferred the cost of the claim processing software license, valued at over $300,000, to the Plan. According to the agreement, this expense should be that of the Manager. Conversely, the Manager has been paying the cost of the employees that perform claims processing. This expense belongs to the Plan. As such, it appears that neither entity is complying with the terms of the agreement regarding the sharing of expenses.

During the examination period, the Plan made several loans to its parent and affiliates. There was no formal documentation to support any of these loans. Part 98-1.11(b) of the Administrative Rules and Regulations of the Health Department (10NYCRR Part 98-1.11(b)) states the following in this regard:

> "…notice [to the superintendent and commissioner] shall be required for transfers or loans involving five percent or more of the HMO's admitted assets at last year-

end."

With admitted assets on December 31, 1999 of $18,042,402, notification to the Department was required when the loans made in year 2000 exceeded $902,120. In this regard, the Plan was in violation of the cited regulation on April 21, 2000 when it had an outstanding receivable of $965,145. The balance peaked at $981,050 on April 30, 2000 and then was reduced to an appropriate level by May 1, 2000. The Plan also failed to divulge these loans within its various financial statements as required.

The Plan has one subsidiary, Wellcare of Connecticut, Inc. (WCCT). On September 1, 2000 the Plan obtained a New York Insurance Law Section 1307 loan from the parent in the amount of $800,000 cash. These funds were simultaneously transferred to WCCT as a subordinated loan in compliance with the requirements of the Connecticut Insurance Law. This transfer, however, was insufficient to offset the subsidiary's continuing operating losses. As a result, WCCT's carrying value on the Plan's balance sheet was zero as of the examination date.

The Plan was not able to document the nature and details of several transactions within the Holding Company system. This is a violation of 10NYCRR Part 98-1.10(b), which states the following:

> "The books, accounts and records of each party to all such transactions [within the Holding Company] shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties."

It is recommended that the Plan comply with 10NYCRR Part 98-1.11(h) and obtain approval of its Management Agreement.

It is recommended that the Plan comply with the terms of its Management Agreement.

It is recommended that all loans/transfers be properly documented, include repayment provisions, and be signed by the appropriate officers.

It is recommended that the Plan comply with 10NYCRR Part 98-1.11(b) and notify the Department when the balance of the loans it is making to its affiliates or Parent exceeds 5% of its admitted assets.

It is recommended that all loans/transfers be divulged in the appropriate locations within the financial statements and within the Holding Company statement.

It is recommended that the Plan comply with 10NYCRR Part 98-1.10(b) and maintain its books, accounts and records so as to disclose the nature and details of all transactions.

E. Schedule H

The Plan does not maintain the data used to complete Schedule H in a format that permits subsequent review of the data in the Schedule. Instead, the Plan maintains the data in a summarized form and on paper only.

The September 30, 2000 Schedule H filed by the Plan does not contain 100% of the outstanding claims as required by the instructions to that document.

It is recommended that the Plan maintain underlying Schedule H data in an electronic format and in sufficient detail to permit a full examination of such data.

It is recommended that the Plan file complete and accurate Schedule H reports.

3. CORPORATE RESTRUCTURING

In conjunction with Dr. Patel's June 1999 purchase of 55% ownership interest in WCMG, Dr. Patel purchased a newly authorized series of senior convertible preferred stock (Series A) of WCMG, which provided him with 55% of WCMG's voting power. The preferred stock was subject to mandatory conversion into common stock upon the amendment of WCMG's certificate of incorporation to increase the number of authorized shares of common stock from 20 million to 75 million. The shares were convertible into 55% of the then outstanding common stock (after giving effect to such conversion) and were subject to anti-dilution rights under which Dr. Patel will generally preserve his 55% interest in WellCare until there are 75 million shares of common stock issued and outstanding.

As a condition to the closing of the Patel and GHI transactions described in Section 2 of this report, various hospitals, physicians and other health care providers entered into settlement agreements to settle claims for services provided to WCNY members through April 30, 1999. The settlement agreements stipulated that the providers accept a payment of 30% of the balance owed them by the Plan at that date. The Plan was also required to pay the providers an additional 5% of the balance owed on February 1 each year thereafter for three years subsequent to the year of settlement, contingent upon the provider's continuing participation in the WCNY network.

As of the report date, the first two settlement payments have been made. The final obligation is due on February 1, 2002 and a reserve in the amount of $1,051,712 has been established for this purpose.

4. ELECTRONIC DATA PROCESSING

All of the Plan's electronic data processing (EDP) is performed by CHM under the management agreement.

In today's automated environment, a company's EDP Department is one of the most critical parts of an ongoing operation. Failures within computer systems can result in a total breakdown of operations. Claim histories may be lost, the claim adjudication process may come to a standstill, and financial records may be disrupted or destroyed.

An analysis of the Electronic Data Processing (EDP) processes and systems used to maintain the financial systems and to process claims for the Plan revealed the following:

A. Management Controls

The Company does not maintain a budget for the EDP department. Only through the maintenance and monitoring of a budget can the Company establish priorities and set goals.

The Company does not provide ongoing in-house training for its EDP staff to ensure their key competencies.

It is recommended that an annual budget be established using long-term and short-term goals as a base.

It is recommended that the Company provide ongoing in-house training for its EDP staff.

B. Organizational controls

There is inadequate segregation of duties and quality control within the EDP Department. Failure to adequately segregate such areas can lead to problems regarding the independence of decision-making and further opens the door to possible collusion and misappropriation of assets.

It is recommended that incompatible functions such as the initiation and authorization of transactions and the custody of assets be performed outside of the EDP

Department. It is also recommended that the functions of system design and programming be adequately segregated from computer operations and data entry functions. Finally, it is recommended that there be a control group within the EDP department whose duties include a.) scheduling of input and output, b.) acting as a liaison between computer operations and user departments, c.) recording of input controls and error controls, and d.) reviewing output for accuracy and disposition.

C. System and Program Development

The Company does not perform cost justifications when developing systems and programs. Additionally, once it has been determined that a change is to be made, the Company does not appear to perform adequate cost analyses in order to determine the most effective method of achieving that change.

It is recommend that cost justifications be performed when developing systems and programs. It is further recommend that when a goal has been determined, a thorough cost analysis be performed in order to determine the most effective method of achieving that goal.

D. Operations

The disaster recovery plan, which is maintained on-site, does not include alternative facilities in the event of a lengthy interruption of service. In the event of a hurricane, the current plan is to remove the servers from the building. There is no plan at all in the event of a fire.

There is also insufficient contingency planning. Such planning can be invaluable when systems falter or fail.

It is recommended that a back-up copy of the disaster recovery plan be stored in a safe facility off-site. It is further recommended that the Company obtain an alternative facility from which to operate in the event of an emergency. Finally, it is suggested that

the Company have the Plan’s disaster recovery plan professionally and independently evaluated.

It is recommended that contingency planning for the Wide Area Network (WAN), critical computer programs, operating systems, and data files be performed. Additionally, it is recommended that user departments develop manual-processing procedures for use as a contingency in the event EDP functions are disrupted.

5. FINANCIAL STATEMENTS

A. Balance sheet

The following compares the assets, liabilities and net worth as determined by this examination to those reported by the Plan in its September 30, 2000 filed Quarterly Statement:

	Examination	Plan	Net Worth Increase (Decrease)
Assets			
Current assets:			
Cash	$ (3,254,859)	$ (3,254,859)	$
Premiums Receivable	4,597,062	4,861,062	(264,000)
Amounts due from affiliates	1,432,077	1,432,077	
Other receivables – net	688,450	1,019,881	(331,431)
Prepaid expenses	417,705	483,234	(65,529)
Advances to providers	503,666	503,666	
Total current assets	$ 4,384,101	$ 5,045,061	$ (660,960)
Other assets:			
Refundable deposits	$ 29,540	$ 29,540	$
Other L/T receivables	0	28,288	(28,288)
Restricted cash	3,263,455	3,263,455	
Total other assets	$ 3,292,995	$ 3,321,283	$ (28,288)
Property and equipment:			
Furniture and equipment	$ 310,480	$ 310,480	
Total property and equipment	$ 310,480	$ 310,480	
Total assets	$ 7,987,576	$ 8,676,824	$ (689,248)

	Examination	Plan	Net Worth Increase (Decrease)
Liabilities			
Current Liabilities:			
Accounts payable	$	$ 26,110	$ 26,110
Claims payable	6,276,950	5,335,462	(941,488)
Unearned premiums	47,139	47,139	
Aggregate write-ins for current liabilities	1,765,241	$ 1,765,241	
Total current liabilities	$ 8,089,330	$ 7,173,952	$ (915,378)
Other Liabilities			
Aggregate write-ins for other liabilities	$ 1,363,926	$ 1,363,926	$
Total other liabilities	$ 1,363,926	$ 1,363,926	$
Total liabilities	$ 9,453,256	$ 8,537,878	$ (915,378)
Net worth:			
Common Stock	$ 62,960	$ 62,960	$
Paid in surplus	17,877,160	17,877,160	
Surplus notes	19,746,490	19,746,490	
Contingency reserves	4,111,598	4,111,598	
Retained earnings/fund balance	(35,882,142)	(34,277,516)	(1,604,626)
Aggregate write-ins for other net worth items	$ (7,381,746)	(7,381,746)	
Total net worth	$ (1,465,680)	$ 138,946	$ (1,604,626)
Total liabilities and net worth	$ 7,987,576	$ 8,676,824	

Note 1: As of the examination date, the Plan was determined to be insolvent in the amount of $1,465,680. Its capital was impaired in the amount of $1,528,640, and its statutory minimum net worth requirement (contingent reserve fund/escrow deposit requirements of Part 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department) was impaired in the amount of $5,577,278.

B. Statement of revenue, expenses and net worth

Reserves and unassigned funds decreased $8,618,683 during the examination period, January 1, 1996 through September 30, 2000, detailed as follows:

Revenue		
Premiums	$ 548,507,395	
Investments	1,019,033	
Other revenues	1,134,332	
Total revenue		$ 550,660,760
Expenses		
Medical and hospital expenses		
Physicians' services	$ 49,563,939	
Other professional services	28,194,663	
Outside referrals	198,470,691	
Emergency room, out-of-area	1,759,387	
Inpatient	151,520,248	
Demographic Pool (Recovery)	1,492,977	
Medical expense - 1994 recoup	1,356,208	
Drug expense	45,257,820	
Rider expense	4,937,519	
Other expense	1,772,480	
Mental health	1,445,699	
Dental	510,590	
Vision	312,282	
Lab	228,308	
X-Ray, Radiology	1,038,539	
Transportation	19,260	
Home Health Care	582,119	
Reinsurance expenses, net of recoveries	(9,310,016)	
Total medical and hospital expenses	$ 479,152,713	
Total plan administration expenses	$ 124,564,459	
Total operating expenses		$ 603,717,172
Net operating income		$ (53,056,412)
Provision for federal income taxes		(2,591,511)
Extraordinary item (Note 2)		(12,379,572)
Net income		$ (38,085,329)

Note 2: The extraordinary item consists of the provider settlement described in Section Three of this report.

Changes in Net Worth

	Gains in Net Worth	Losses in Net Worth	
Net worth per examination as of December 31,1995			$ 7,153,003
Net income		$(38,085,329)	
Change in common stock		(999)	
Net increases in paid in surplus	$ 7,993,000		
Net increase in surplus notes	19,562,715		
Net increases in contingency reserve		(3,504,347)	
Change in non-admitted assets		(2,844,260)	
Changes in retained earnings	8,260,537		
Net decrease in net worth			(8,618,683)
Net worth per examination as of September 30, 2000			$ (1,465,680)

6. PREMIUMS RECEIVABLE

The examination asset of $4,597,062 is $264,000 less than the $4,861,062 reported by the Plan in its filed Quarterly Statement as of September 30, 2000.

The Plan maintained a balance of $881,530 as being due from New York State for Medicaid premium billings that had been submitted incorrectly by the Plan. These billings had been rejected and the claims were in the process of being corrected and re-billed. Of the total shown, $264,000 in receivables represented monthly billings for which the Plan did not possess an itemized claim breakdown. Instead, the Plan utilized an extrapolation from the months for which it did have an itemization. The examination non-admitted this $264,000 balance.

7. OTHER RECEIVABLES – NET

The examination asset of $688,440 is $331,431 less than the $1,019,881 reported by the Plan in its filed Quarterly Statement as of September 30, 2000. The examination non-admitted the following amounts:

- Pharmacy rebates for $97,181: The examiner was not furnished with a copy of the agreement by which the Plan was paid pharmacy rebates. Nor had the Plan received such rebates in over 180 days.
- Subrogation for $234,250: The Plan recognized the uncollectibility of this balance by writing down the balance on December 31, 2000.

8. PREPAID EXPENSES

The examination asset of $417,705 is $65,529 less than the $483,234 reported by the Plan in its filed Quarterly Statement as of September 30, 2000.

The change in this account is attributed to two factors; the first is a $68,430 reduction in prepaid taxes resulting from the Plan's inability to provide supporting documentation. The second is the reversal of a negative balance of $2,901 established when the Plan over-amortized its advance payment of dues to the Health Plan Association ("HPA"), a lobbying group.

9. OTHER LONG-TERM RECEIVABLES

The examination asset of $0 is $28,288 less than the $28,288 reported by the Plan in its filed Quarterly Statement as of September 30, 2000. The balance represents a reinsurance receivable for which the Plan cannot provide any support documentation.

10. CLAIMS PAYABLE

The examination liability of $6,276,950 is $941,488 greater than the $5,335,462 reported by the Plan in its filed Quarterly Statement as of September 30, 2000.

This adjustment reflects the additional liability for unpaid claims as determined by the Plan's actuaries at December 31, 2000. The number has been applied to the September 30, 2000 date because enrollment was constant in the interim between the two dates and it is thus expected that the liability was similarly understated at the examination date.

11. ACCOUNTS PAYABLE

The examination liability of $0 is $26,110 less than the $26,110 reported by the Plan in its filed Quarterly Statement as of September 30, 2000.

This adjustment resulted from the Plan's decision to terminate its relationship with the HPA before the annual fee had been paid.

12. SUBSEQUENT EVENTS

Subsequent to this examination, the Plan received three cash infusions from Dr. Patel in the form of loans pursuant to New York Insurance Law §1307. These loans, in the amounts of $2,200,000, $1,356,391, and $750,000 were made during October 2000, November 2000, and March 2001 respectively and were made in order to meet Department requirements to restore the Plan's impaired contingency reserve. In the first two cases, the funds provided, and in the third case, $250,000 were immediately passed to WCCT in the form of subordinated statutory loans from the Plan to that entity to meet Connecticut regulatory requirements. At December 31, 2000, WCCT has a positive asset carrying value on the Plan's books of $1,665,093.

Upon Dr. Patel's acquisition of control of the Plan on June 1, 1999, he submitted a program to restore the Plan's contingency reserve to 100% of its required level over a

three year period, ending on June 1, 2002. In the interim, the Department has allowed the Plan to maintain its contingency reserve at no less than 50% of its required level. The Plan has received periodic cash infusions to maintain its contingency reserve at this level. Accordingly, on May 2, 2001, the Plan received an additional capital infusion of $590,733 to cure an impairment in the required minimum contingency reserve permitted by the Superintendent at December 31, 2000. Said reserve level at this date is $1,408,598. The aggregate cash infused into the Plan from October 1, 2000 through May 2, 2001 amounted to $4,897,124.

Subsequent to the examination, ProMedco, a medical management company with five Independent Practice Association (IPA) subsidiaries utilized by the Plan, filed for bankruptcy. Although the Plan maintains that it is protected from this bankruptcy by virtue of the agreements with the individual providers in the IPA, the Department has directed the Plan to provide its estimate of ProMedco's quantitative provider claim liability for services rendered to the Plan's enrollees. The amount of this liability is presently unknown.

13. THE EFFECT OF STATUTORY ACCOUNTING PRINCIPLES

Effective January 1, 2001, the Plan will be required to comply with new accounting rules established by the National Association of Insurance Commissioners (NAIC), as modified by Department Regulation 172 (11NYCRR Part 83). These accounting rules may result in changes in the way certain assets and liabilities are to be reported.

This examination conducted an analysis to determine the effect of the new accounting rules on the Plan's September 30, 2000 net worth. Based upon the analysis it is estimated that, had the new rules been in place as of the examination date, the Plan's net worth would have decreased $804,546. This decrease, which will be reported in the

Plan's March 31, 2001 Quarterly Statement, would have been the result of the following changes:

Non-admission of computer software	$271,000
Addition of claim adjustment expenses	533,546
Total	$804,546

14. CONCLUSION

As of the examination date, the Plan was determined to be insolvent in the amount of $1,465,680. Its capital was impaired in the amount of $1,528,640, and its statutory minimum net worth requirement (contingent reserve fund/escrow deposit requirements of Part 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department) was impaired in the amount of $5,577,278

However, as detailed under the Subsequent Events section of this report, a total of $4,897,124 in cash was infused into the Plan from October 1, 2000 through May 2, 2001. This amount remedies the insolvency and capital impairment determined by this examination and would reduce the statutory net worth impairment to $680,154 without considering any other adjustments for events occurring subsequent to September 30, 2000.

15. MARKET CONDUCT

A. Frauds Prevention

Part 86.4(a) of the New York Rules and Regulations (11NYCRR Part 86.4(a)) requires that all claim forms utilized by the Plan contain a warning in regard to the perpetration of fraud. The Plan has not complied with this requirement.

Part 86.6(b) of the New York Rules and Regulations (11NYCRR Part 86.6(b)) requires that the Plan establish an in-service training program for claims personnel to enable them to identify and evaluate instances of suspected insurance fraud. As of the date of this report, the Plan has failed to implement such training program.

Part 86.6(d)(10) of the New York Rules and Regulations (11NYCRR Part 86.6(d)(10)) requires that the Plan file an annual report with the Insurance Frauds Bureau no later than January 15 of each year. The Plan failed to file its annual report for the year 2001.

It is recommended that the Plan provide all interested parties with claim forms containing the fraud warning required by Part 86.4(a) of the New York Rules and Regulations (11NYCRR Part 86.4(a)).

It is recommended that the Plan hold in-service training programs for claims personnel to enable them to identify and evaluate instances of suspected insurance fraud as required by 11NYCRR Part 86.6(b).

It is recommended that the Plan file a fraud report by January 15 of each year as required by 11NYCRR Part 86.6(d)(10)).

16. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM.		PAGE NO.
	MANAGEMENT	
A.	It is recommended that the Plan list the proper board members when so required within Departmental filings.	6
B.	It is recommended that the Plan hold board meetings on a regular basis.	6
C.	It is recommended that the Plan comply with its by-laws and hold its annual stockholder's meeting within 60 days of the end of each fiscal year.	7
D.	It is recommended that the Plan adopt a formal Code of Ethics. It is further recommended that the Plan require its Directors and Officers to annually sign statements confirming they have not materially violated such a code.	7
E.	It is recommended that Circular Letter No. 9(1999) be distributed to all board members at the board's next regularly scheduled meeting. Such distribution, receipt and any subsequent discussion should be recorded in the minutes of the respective board's meeting.	7
F.	It is recommended that the board obtain the following certifications annually: (i) from the company's independent CPA that the responsible officers have implemented the claims procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual are in accordance with applicable statutes, rules and regulations.	7

HOLDING COMPANY SYSTEM

Q. It is recommended that incompatible functions such as the initiation and authorization of transactions and the custody of assets be performed outside of the EDP Department. It is also recommended that the functions of system design and programming be adequately segregated from computer operations and data entry functions. Finally, it is recommended that there be a control group within the EDP department whose duties include a.) scheduling of input and output, b.) acting as a liaison between computer operations and user departments, c.) recording of input controls and error controls, and d.) reviewing output for accuracy and disposition. 14

R. It is recommend that cost justifications be performed when developing systems and programs. It is further recommend that when a goal has been determined, a thorough cost analysis be performed in order to determine the most effective method of achieving that goal. 15

S. It is recommended that a back-up copy of the disaster recovery plan be stored in a safe facility off-site. It is further recommended that the Company obtain an alternative facility from which to operate in the event of an emergency. Finally, it is suggested that the Company have the Plan's disaster recovery plan professionally and independently evaluated. 15

T. It is recommended that contingency planning for the Wide Area Network (WAN), critical computer programs, operating systems, and data files be performed. Additionally, it is recommended that user departments develop manual-processing procedures for use as a contingency in the event EDP functions are disrupted. 16

FRAUD CONTROL

U. It is recommended that the Plan provide all interested parties with claim forms containing the fraud warning required by 11NYCRR Part 86.4(a). 25

V. It is recommended that the Plan hold in-service training programs for claims personnel to enable them to identify and evaluate instances of suspected insurance fraud as required by 11NYCRR Part 86.6(b). 25

W. It is recommended that the Plan file a fraud report by January 15 of each year as required by 11NYCRR Part 86.6(d)(10). 25

Respectfully submitted,

_____/s/_____
Bruce Borofsky
Senior Insurance Examiner

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

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

_____/s/_____
Bruce Borofsky

Subscribed and sworn to before me
This _____ day of _____2001

Appointment No. 21636

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, 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

Wellcare of New York, 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 the name and affixed the official Seal of this Department, at the City of New York,

this 16th *day of* October *2000*

NEIL D. LEVIN
Superintendent of Insurance

(by) *Gregory Serio*
First Deputy Superintendent