# REPORT ON EXAMINATION

# OF THE

# MVP HEALTH PLAN, INC.

# AS OF

# DECEMBER 31, 1999

**DATE OF REPORT** **DECEMBER 17, 2001**

**EXAMINER** **JOSEPH S. KRUG**

## TABLE OF CONTENTS

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

December 17, 2001

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

Dear Sir:

Pursuant to the instructions contained in Appointment Number 21521, dated April 10, 2000, annexed hereto, I have made an examination into the financial condition and affairs of the MVP Health Plan, Inc. as of December 31, 1999 at its home office located at 111 Liberty Street, Schenectady, New York 12305. The following report herein is respectfully submitted.

Wherever the terms "the HMO" or "MVP" appear herein without qualification they should be understood to refer to MVP Health Plan, Inc.

The net worth of $20,010,793 reported by the HMO as of December 31, 1999 was not changed as a result of this examination. As of December 31, 1999, the HMO's contingency reserve, as required by Part 98-1.11(d) of the Health Department Rules and Regulations {10NYCRR98 -1.11}, in the amount of $21,086,744 was impaired by $1,075,951.

## 1. SCOPE OF EXAMINATION

The prior examination was made as of December 31, 1995. The examination covers the four-year period from January 1, 1996 through December 31, 1999. The examination was conducted at the home office of the HMO in Schenectady, New York. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 1999, in accordance with generally accepted accounting principles (GAAP), a review of income and disbursements to the extent deemed necessary to accomplish such verification, and utilized to the extent considered appropriate, work performed by the HMO's independent certified public accountants. A review or audit was also made of the following items:

History of the HMO
Management of the HMO
Corporate records
Fidelity bonds and other insurance
Officers' and employers' welfare and pension plans
Territory and plan of operations
Growth of the HMO
Accounts and records
Loss experience
Treatment of subscribers

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. DESCRIPTION OF HMO

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

On March 8, 1982, the HMO and the IPA contracted, through an "IPA Service Agreement" to work together to provide for the administration of a comprehensive prepaid program of health care and for the delivery of health services. Subsequently, the HMO made similar arrangements with five other IPA's to achieve the same goal. This is discussed more fully in Item 2B of this report, "Territory and Plan of Operation."

### A. Management

The HMO's by-laws provide that the initial board shall consist of eighteen directors; thereafter, the size shall be fixed by resolution of the board at its annual meeting provided, however, that there shall not be less than twelve nor more than twenty five directors. The by-laws further provide that the directors shall serve three year staggered terms with an equal number of directors elected for each term.

As of December 31, 1999 the board of directors consisted of twenty members as set forth below:

| | **Name and Residence** | **Medical Specialty/ Principal Business Affiliation** |
|---|---|---|
| (a) | Physician Representatives (9) | |
| | Donald Bentrovato, M.D.<br>Schenectady, NY | Urology |
| | Richard D'Ascoli, M.D.<br>Schenectady, NY | Orthopedics |
| | Richard Gullott, M.D.<br>Scotia, NY | Internal Medicine |
| | John F. Houck, M.D.<br>New Hartford, NY | Physician |
| | Eleanor Kane, M.D.<br>Rhinebeck, NY | Internal Medicine |
| | Albert Loffredo, M.D.<br>Schenectady, NY | Pediatrics |
| | John Lusins, M.D.<br>Oneonta, NY | Neurology |
| | Leonard Meiselman, M.D.<br>Schenectady, NY | Radiology |
| | Joseph Schwerman, M.D.<br>Hyde Park, NY | Internal Medicine |
| (b) | Subscriber Representatives (7) | |
| | Burt Danovitz<br>Utica, NY | Executive Director<br>Resource Center for Independent Living |
| | Joseph F. Heavey<br>Poughkeepsie, NY | Associate Director,<br>Veterans' Hospital |
| | Karen B. Johnson | Director of Development, |

Schenectady, NY Proctors Theatre

| Name and Residence | Medical Specialty/ Principal Business Affiliation |
|---|---|
| Mary Cosgrove Militano<br>Scotia, NY | Attorney |
| Leland Tupper<br>Schenectady, NY | Treasurer,<br>MVP Health Plan, Inc. |
| John Van Schaick<br>Schenectady, NY | Retired Teacher |
| Timothy Wade<br>Scotia, NY | Bank Executive,<br>M&T Bank |

( c ) Community Representatives (4)

| | |
|---|---|
| S. Larry Feldman<br>Latham, NY | Insurance Executive,<br>CFK Life Plans, Inc. |
| Murray Jaros, Esq.<br>Albany, NY | Attorney,<br>New York State Association of Towns |
| Jon Rich<br>Alplaus, NY | Retired |
| Norma Westcott<br>Rexford, NY | Self Employed Consultant,<br>Westcott Enterprises, Inc. |

The examiner reviewed the minutes of the meetings of the board of directors and its various committees for the four-year period under review, and noted that such meetings were well attended; all directors attended at least half of the meetings they were eligible to attend.

The principal officers of the HMO as of December 31, 1999 were as follows:

| Name | Title |
|---|---|
| Joseph Schwerman, M.D. | Chairman |
| Murray M. Jaros | Vice Chairman |
| David W. Oliker | President |
| Richard D'Ascoli | Secretary |
| Leland Tupper | Treasurer |
| David Field | Chief Financial Officer |

## B. Territory and Plan of Operation

The HMO contracted with various independent practice associations (IPA's), to provide, through their combined efforts, a comprehensive prepaid program of health care and the delivery of health services.

All contracts are similar in nature and are covered together in this section. Each contract is entitled the "IPA Service Agreement" (hereinafter referred to as "the agreement") and was entered into with the following entities:

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

According to the agreement between the HMO and the IPA's, the HMO provides all administrative, marketing, enrollment, financial accounting, claims processing and payment, management information and other functions necessary, convenient or appropriate for the administration of a comprehensive prepaid health program. The IPA is responsible for establishing contractual relationships with physicians, health care professionals and other providers of health care and for arranging for and facilitating the provision and delivery of health services to members of the HMO. These agreements provide that such providers look solely to the IPA for compensation for covered services and at no time seek compensation from members except for nominal co-payments permitted under the members health service contracts. The contract between the provider's and the IPA's is silent regarding whether the provider may or may not seek payment for claims directly from the HMO.

The HMO makes capitation payments to the IPA's (based on a per member per month method) to cover the cost of all services rendered by the contracted providers. The IPA physicians are paid on a fee-for-service basis. Pursuant to its administrative duties specified in the IPA agreements, MVP processes and pays the provider claims using the IPAs' funds. Per the underlying agreements between the IPA's and their participating physicians, varying percentages (15% or 20%) are withheld by the IPA's and deposited in a withhold account. Amounts to be returned to the physicians are reviewed on an annual basis and any amounts not returned are recorded as reductions of medical expenses, with corresponding reductions of the related liability for physician risk withholding. In addition, the HMO has risk sharing arrangements with its New York IPA's to share in the cost variances for certain medical costs. These medical cost share arrangements differ depending on the IPA. The premise is that the HMO and its IPA's are responsible for certain components that effect one another. Under the agreement, the actual cost of these services is compared to budgeted costs and the difference is shared between the HMO and the IPA.

Incentive fund withhold summary for the years 1996 – 1999

| Year | Retained by IPA | Distributed to Providers |
|---|---|---|
| 1996 | $10,345,804 | $12,687,033 |
| 1997 | $10,310,156 | $ 5,884,219 |
| 1998 | $ 8,739,032 | $14,560,342 |
| 1999 | $ 8,935,145 | $14,281,625 |

It was noted that the collective net worth of the HMO's six IPA's, listed earlier in this Section was $(2,872,416) as of December 31, 1999. MVMA, the largest IPA, reported net worth of $(4,171,973) at that date.

As of December 31, 1999, the HMO's service area as authorized by the New York State Health Department, covered six regions which are served by the IPA's as follows:

**Eastern region** served by MVMA, covering the counties of Albany, Fulton, Hamilton, Montgomery, Rensselaer, Northern Greene and Columbia Counties, Saratoga, Schenectady, Schoharie, Warren and Washington, in the State of New York, and certain portions of the State of Vermont.

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

**Mid-Hudson region** served by (TIPA), covering the counties of Dutchess, Orange, Putnam and Ulster, and the southern portion of Columbia and Greene Counties.

**South Central region** served by SCIPA covering the counties of Delaware and Otsego.

**Southern Tier region** served by Two Rivers covering the counties of Broome, Chenango and Tioga.

**Onondaga County** served by Midstate.

On March 20, 1993, the HMO was issued a Certificate of Authority to transact the business of Health Maintenance Organization in the State of Vermont. As mentioned above, this region is served by MVMA and Vermont Managed Care.

The HMO's enrollment grew by 3.9% during the examination period and another 16.3% in year 2000. The net result of enrollment activity for the years under examination is as follows:

| | 12/31/1996 | 12/31/1997 | 12/31/1998 | 12/31/1999 | 12/31/2000 |
|---|---|---|---|---|---|
| New York | 257,805 | 285,349 | 234,424 | 251,961 | 261,005 |
| Vermont | 5,470 | 11,311 | 10,601 | 21,516 | 55,293 |
| Total Members | 263,275 | 296,660 | 245,025 | 273,477 | 316,298 |

It should be noted that the above enrollment numbers do not include self-insured groups. At December 31, 1999 there were approximately 48,000 self-insured participants. MVP Select Care, Inc., a wholly owned subsidiary of the HMO, administers these groups.

## C. Reinsurance

At December 31, 1999, the HMO had a reinsurance agreement with Employers Reinsurance Corporation, an accredited reinsurer, on a per member per contract year basis. This agreement, requires the reinsurer to pay specified percentages of all eligible hospital claims paid by the HMO during the contract year in excess of a

$200,000 per case deductible. Payments exceeding the deductible for certain service areas are eligible for recovery under the reinsurance agreement. Covered services are reimbursable by the reinsurer in general at 80-90% of costs in excess of the deductible. The following is an analysis:

Hospital Services

Transplant services:

- 80% in excess of $200,000 with those hospitals that the HMO has a written contract with.
- 80% in excess of $200,000 with those hospitals that do not have a written contract with the HMO and the average charge per day is $3,000 or less.
- 50% in excess of $200,000 with those hospitals that do not have a written contract with the HMO and the average charge per day is greater than $3,000.

Other services

- 90% in excess of $200,000 with those hospitals that the HMO has a written contract with.
- 90% in excess of $200,000 with those hospitals that do not have a written contract. with the HMO and the average charge per day is $1,500 or less.
- 80% in excess of $200,000 with those hospitals that do not have a written contract. with the HMO and the average charge per day is greater than $1,500.

The agreement applies to all members of the HMO with the exception of Vermont subscribers who are only covered by the transplant provision. This is largely due to the full risk transfer arrangement that has been in effect in Vermont (as described in Section 2, E herein). The HMO's cost in regard to the agreement varies by service region from $.325 to $.395 per member per month. There is a lifetime maximum reinsurance benefit of $2,000,000 per member. The agreement contained all the required standard clauses, including the insolvency clause required by Section 1308 of the Insurance Law. The insolvency section provides for continuation of direct benefits under certain

conditions liability in the event of the HMO's insolvency, but such coverage is limited to $5,000,000 for all members, all agreements and agreement periods combined. (See comments 1 and 2 in the next paragraph of this report).

The agreement includes continuation of benefits provision within its insolvency protection language. This provision requires the reinsurer cover MVP members who are confined to an inpatient facility with certain limitations. It also requires prospective continuation of benefits for all MVP members who have paid their contract premium. The language included in MVP's current reinsurance contract specifies a sixty (60) day time limit. However, based on monthly premium billing this coverage generally creates an exposure for up to thirty-one days of claims.

A review of the reinsurance contract revealed that the application of an aggregate limit of liability of $5,000,000 to the insolvency protection afforded under the continuation of coverage provision. Although the Insurance Department does not require the Plan to obtain reinsurance coverage, the Department views reinsurance in general, and continuation of benefits provisions in particular, as an integral part of protection for the Plan's members against insolvency. In MVP's case the potential liability for covering members for up to thirty-one days beyond insolvency is far in excess of the $5 million limitation included in the reinsurance contract, thereby significantly diminishing the impact of the continuation of coverage provision.

It is recommended that the HMO revise its agreement with its reinsurer so as to allow for full effect of the continuation of benefits provision contained within the insolvency language of such agreement.

Reinsurance contracts are approved by the Department during the initial certification of an HMO pursuant to Part 98.5(b)(7) of the Administrative Rules and Regulations of the Health Department {10 NYCRR98.5(b)(7)} to assure that they contain required provisions relative to insolvency protection and continuation of coverage. Further,

Part 98.8(b) requires the prior approval of the Superintendent and the Commissioner for changes in risk sharing with insurers (i.e. reinsurance contracts) as follows.

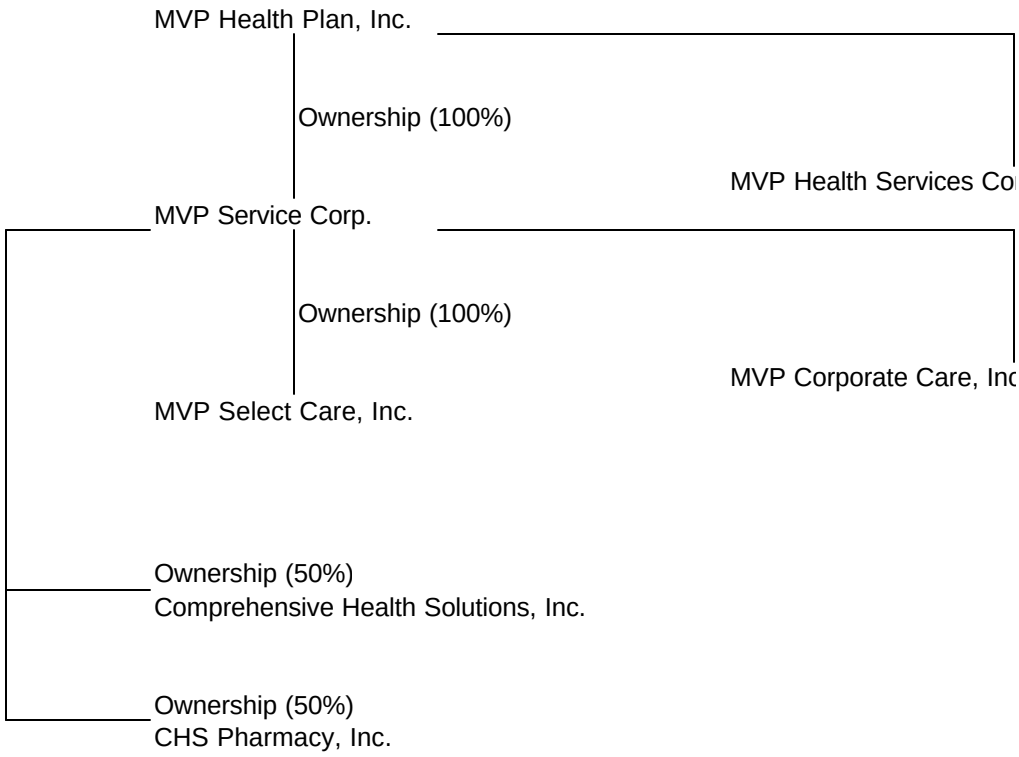
> *"(b) Any amendments to the risk-sharing arrangements contained in any contracts between the HMO and insurers shall not be entered into without prior approval of the Commissioner and the superintendent. All new contracts with new types of health services providers, and material amendments to existing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

It is recommended that the Plan submit the reinsurance agreement in effect to the New York State Insurance Department for review and approval in accordance with Public Health Law, Part 98-1.8(b) of the Health Department Regulations.

The Schedule S data, as contained in the Plan's filed annual statements for the period under examination, was found to accurately reflect its reinsurance transactions.

## D. Holding Company System

The following chart depicts the HMO in relationship to its affiliates within the holding company system as of December 31, 1999:



## E. Risk Transfer

### Vermont Business

On March 20, 1993, the HMO was issued a Certificate of Authority to transact the business of Health Maintenance Organization in the state of Vermont. On January 1, 1997, the HMO entered into an agreement with Fletcher Allen Health Care, Inc. (FAHC) and Vermont Managed Care, Inc. (VMC). VMC was formed to develop and implement managed care programs for its providers which are designed to maximize the value of health care to both subscribers and providers and to keep care management decisions in the hands of providers. VMC is a taxable non-profit organization whose sole corporate member is FAHC. FAHC established VMC as a Physician Hospital Organization (PHO). A PHO is an integrated delivery system consisting of hospitals and physicians who have agreed to provide services to subscribers enrolled with the HMO. As a PHO, VMC provides or arranges for all physician services, including primary care and specialty services, and all hospital services, including inpatient and outpatient services to members of the HMO who select a VMC provider as a primary care physician. It should be noted that FAHC is one of the health care providers participating in the delivery of managed care to the HMO (hospital and physician groups) and also provides various administrative services to VMC. The agreement between the HMO and VMC provides for MVP to pay a monthly capitation based upon membership to VMC. This monthly "global payment" covers all medical services with the exception of the following carve outs: chiropractic services, transplants, routine dental, prescription drugs, and eyeglasses. The contract specifically states that the HMO is not responsible for any amount in excess of the capitation paid by the HMO to VMC. The capitation at December 31, 1999 varied from $92.10 to $130.76 per member per month depending on the size of the group and contract type.

At December 31, 1999, there were approximately 22,000 Vermont subscribers, at December 31, 2000 there were approximately 55,000 Vermont subscribers. Based upon a review, the following is noted:

At September 30, 1999 the net worth of VMC was in a deficit position in the amount of ($5,116,676) and at September 30, 2000 the deficit was ($3,085,996). It is recommended that the HMO take steps to identify any exposure to potential additional liability resulting from VMC's insolvent condition by either: re-evaluating the adequacy of its capitation payment and VMC's financial resources; restructuring the contract to change the extent of risk transfer; or working with VMC to attain great administrative expense efficiency.

The HMO has indicated that it has taken steps to address this recommendation.

Subsequent the date of the examination, at January 1, 2001, the HMO contracted with an additional four IPA's in the Vermont Area as follows:

1. Central Vermont Physicians Hospital Organization
2. Darthmouth Hitchcock Alliance
3. Physicians Services of Vermont
4. United Health Alliance

It should be noted that these agreements do not incorporate full risk transfer. The HMO retains full or partial risk under these arrangements. Membership covered under these arrangements is minimal as of the date of this report.

**New York Chiropractic Services**

Effective January 1, 1998, the HMO entered into a contractual arrangement with Access Managed Health Care IPA, Inc. (Access), a Pennsylvania corporation. The HMO had contracted with Access to provide chiropractic services for all HMO subscribers. Under this agreement, Access was responsible for claims processing and payments to chiropractors. Furthermore, Access agreed to pay interest or penalties due to late payments as required by the New York State Prompt Pay Law. In 1999, Access found itself in

financial difficulty and failed to pay claims on a timely basis. This resulted in providers seeking reimbursement from the HMO. Numerous providers contacted the Insurance Department and filed formal complaints against the HMO since it was a MVP contract under which such chiropractic benefits were available. The HMO terminated the contract effective January 1, 2000. The HMO incurred approximately $250,000 in claim costs pertaining to this agreement in the year 2000 for chiropractic claims with dates of service December 31, 1999 and prior.

The Department notified the HMO that it would hold the HMO responsible for one hundred forty one (141) prompt pay violations committed by Access. On March 29, 2001 the HMO agreed to pay a $33,800 fine for prompt pay violations. The HMO has filed a “breach of contract” action against Access.

## 3. FINANCIAL STATEMENTS

### A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 1999. This statement is the same as the balance sheet filed by the HMO in its annual statement filed with the Department as of December 31, 1999.

| | |
|---|---|
| Current Assets | |
| Cash and cash equivalents | $ 9,382,523 |
| Short-term investments | 17,494,225 |
| Premiums receivable | 28,469,148 |
| Investment income receivables | 850,819 |
| Reinsurance recoverable on paid losses | 1,359,440 |
| Provider advances | 6,008,001 |
| Miscellaneous receivables | 6,013,321 |
| Prepaid expenses | 1,217,647 |
| Total current assets | $ 70,795,124 |
| Other Assets | |
| Restricted cash and other assets | $ 299,627 |
| Long-term investments | 27,427,636 |
| Common stocks | 65,268 |
| Amounts due from affiliates | 1,979,948 |
| Investment in MVP Service Corp. | 213,339 |
| Total other assets | $ 29,985,818 |
| Property and Equipment | |
| Furniture and equipment | $ 391,274 |
| EDP equipment | 4,842,306 |
| Total property and equipment | $ 5,233,580 |
| Total assets | $106,014,522 |

Liabilities

| | |
|---|---|
| Accounts payable | $ 9,408,983 |
| Claims payable | 64,371,467 |
| Accrued medical incentive pool | 625,479 |
| Unearned premiums | 5,719,918 |
| Amounts due to affiliates | 5,877,882 |
| Total current liabilities | $ 86,003,729 |

Net Worth

| | |
|---|---|
| N.Y.S. Contingency reserve fund | $ 21,086,744 |
| Retained earnings/Fund balance | (1,075,951) |
| Total net worth | $ 20,010,793 |
| Total liabilities and net worth | $106,014,522 |

The net worth of $20,010,793 reported by the HMO as of December 31, 1999 was not changed as a result of this examination. As of December 31, 1999, the HMO's contingency reserve, as required by Part 98-1.11(d) of the Health Department Rules and Regulations {10NYCRR98-1.11}, in the amount of $21,086,744 was impaired by $1,075,951.

## B. Statement of Revenue and Expenses

Net worth decreased $11,631,169 during the period under examination, January 1, 1996 through December 31, 1999, detailed as follows:

| | | | |
|---|---|---|---|
| Revenue | | | |
| Premiums | $1,572,622,340 | | |
| Investment income | 7,905,404 | | |
| Total revenue | | | $1,580,527,744 |
| Expenses | | | |
| Medical and Hospital | | | |
| Physician services | $ 703,858,026 | | |
| Other professional services | 15,259,001 | | |
| Emergency room, out-of-area | 144,863,821 | | |
| Inpatient | 322,132,170 | | |
| Incentive pool and withhold adjustments | 12,561,154 | | |
| Drug expense | 184,221,613 | | |
| Rider expense | 40,853,796 | | |
| Demographic pool expense | 12,812,473 | | |
| SMC pool recovery | (208,106) | | |
| Vermont Managed Care global fees | 23,012,386 | | |
| Bassett Health Network global fees | 4,592,280 | | |
| Subtotal | | $1,463,958,614 | |
| Less: | | | |
| Reinsurance recoveries | 1,331,756 | | |
| C.O.B. and subrogation | 36,150,777 | | |
| Subtotal | | (37,482,533) | |
| Total medical and hospital | | $1,426,476,081 | |
| Total administration | | $ 165,682,832 | |
| Total expenses | | | $1,592,158,913 |
| Net income (loss) from operations | | | $ (11,631,169) |

Change in Net Worth

| | |
|---|---|
| Net worth per report on examination as of December 31, 1995 | $ 31,641,962 |
| Net income (loss) from operations | $ (11,631,169) |
| Net worth per report on examination as of December 31, 1999 | $ 20,010,793 |

## 4. CLAIMS PAYABLE

The examination liability for claims payable of $64,371,467 is the same as the liability reported by the HMO as of December 31, 1999. The examiner utilized claims payments made during the first nine months of 2000 for claims with dates of service on or prior to December 31, 1999, plus an estimate of claims payments to be made subsequent to September 30, 2000, for claims incurred on or prior to the examination date. The latter estimate is based upon analysis of the HMO's past experience in making claims payments more than nine months subsequent to a reserve date. The examination liability developed in this manner was not materially different from the HMO's liability and therefore, the HMO's liability was not modified herein.

It should be noted that the claims paid reconciliation problem referred to herein under item 5 of this report impacted the analysis of claims payable. An integral part in the analysis of claims payable involves using prior year paid claims information to develop factors used to project ultimate reserves. Since the 1999 paid claims information remains in question, then the factors that were developed as a result of using that information also remain in question. Accordingly, the ultimate reserves that were determined by using these factors may be different from the amount shown herein.

## 5. MARKET CONDUCT

In the course of this examination a review was made of the manner in which the HMO 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.

## A. Claims Review

During the course of the examination, the HMO did not provide paid claims data files that reconciled to the information reported by the HMO in Schedule H of its 1999 Annual Statement. As a result, the examiners were unable to utilize the Department's sampling to test the integrity of the claims data the HMO reported in its 1999 annual statement. Accordingly, the integrity of that data could not be determined. Furthermore, this impacted the Department's ability to adequately perform a review to test the HMO's compliance with Section 3224-a of the New York Insurance Law (Prompt Pay Law).

Based upon the above, a more detailed review of the claims adjudication system at MVP Health Plan, Inc. is necessary.

The Department will conduct a more detailed review of claims adjudication in general, and compliance with Section 3224-a ("Prompt Pay Law") specifically, at a later date.

## 6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

| ITEM | | PAGE NO. |
|---|---|---|
| A. | It is recommended that the HMO maintain its board composition at no more than forty-nine percent duly licensed physicians as required by its by-laws.<br><br>The HMO has complied with this recommendation. | 5-6 |
| B. | It is once again recommended that the election of members of the board be taken via secret ballot instead of via voice.<br><br>The HMO has complied with this recommendation. | 6 |
| C. | It is recommended that the HMO comply with its by-laws and require each director to serve on at least one committee.<br><br>The HMO has complied with this recommendation. | 6 |
| D. | It is recommended that board members who are unable or unwilling to attend meetings consistently should resign or be replaced.<br><br>The HMO has complied with this recommendation. | 7 |
| E. | It is recommended that in the future the HMO comply with its by-laws as regards vacancies on the board of directors.<br><br>The HMO has complied with this recommendation. | 7 |
| F. | It is recommended that the HMO maintain a clear record of its board of directors' attendance by indicating the presence or absence (both excused and unexcused) of each board member at all board meetings. | 7-8 |

The HMO has complied with this recommendation.

G. It is recommended that the HMO either comply with the risk sharing arrangements per the IPA Service Agreements or revise the agreements to reflect the current risk sharing arrangements. 10

The HMO has complied with this recommendation.

H. It is recommended that the HMO submit the amended IPA Service Agreements to the Department of Health for approval. It is further recommended that in the future the HMO make timely submissions to the Department of Health as required by Part 98.8(b) of the Administrative Rules and Regulations of the Health Department (10 NYCRR Part 98.8(b)). 10

The HMO has not complied with this recommendation.

Subsequent to the examination, the HMO redrafted the IPA Service Agreements and submitted them to the Department of Health.

I. It is recommended that the HMO monitor the cost of services provided to MVP Workplace Health & Safety, Inc., Comprehensive Health Solutions, Inc. and CHS Pharmacy, Inc. which are paid by the HMO. Any material changes in the cost of services provided to these entities would require that a formal time study be conducted so that all joint expenses could be allocated on a fair and equitable basis. 19

The HMO has complied with this recommendation.

J. It is recommended that the HMO request the New York State group enrollment information from New York State Department of Civil Service as frequently as such information is available so that it may reconcile the membership data at various cut-off dates throughout the year in an effort to reduce any future write-offs to a minimal amount. 20

The HMO has complied with this recommendation.

K. It is recommended that the HMO develop and implement formal follow-up procedures with regards to checks which remain outstanding. It is future recommended that the HMO document the results of any follow-up procedures performed including, but not limit to, references to check 22

numbers and check dates when checks are reissued or when it is determined that a check should be voided for duplicate payment. All such records and documents relating to uncashed items should be retained.

The HMO has complied with this recommendation.

L. It is recommended that the HMO conform to its established guidelines on investment policy or revise it's existing guidelines to incorporate It's current practices. 22

The HMO has complied with this recommendation.

M. It is recommended that in the future the HMO comply with the NAIC guidelines and file all securities which are not on file with the SVO for valuation and determination of an NAIC designation. 23

The HMO has complied with this recommendation.

N. It is recommended that for future examinations the HMO make every effort to facilitate such examination. 23

The HMO has complied with this recommendation with the exception of the paid claims data request as referred to in item 5 of this report.

O. It is recommended that, in the future, the HMO adhere to the Annual Statement Instructions by reporting all transactions among holding company system members required to be disclosed in Schedule M Part 2 of the Annual Statement. 24

The HMO has complied with this recommendation.

P. It is recommended that, in the future, the HMO adhere to the NAIC's Annual Statement Instructions for Health Maintenance Organizations when preparing its financial statements to ensure that items are reported on the appropriate lines. 26

The HMO has complied with this recommendation.

Q. It is recommended that HMO management take steps to ensure that, in the future, all the necessary adjustments and entries are completed on a timely basis to allow for the preparation of a "...full and true statement of all assets and liabilities and of the conditions and affairs of the said HMO..." as they attest to in the jurat to the statutory blank. 30

The HMO has complied with this recommendation.

R. It is recommended that, in the future, the HMO maintain a complete advertising file so that all advertisements may be available for review by this Department and so that a complete appraisal of the representations made to the public can be performed. 32

The HMO has complied with this recommendation.

S. It is recommended that, in the future, the HMO receive approval for all contracts and riders. 33

The HMO has complied with this recommendation.

T. It is recommended that the HMO settle all account balances in the manner prescribed in Regulation 62. 33

The HMO has complied with this recommendation.

U. It is noted that the HMO calculated the guaranteed rate reconciliation for a large employer group incorrectly resulting in a $61,730 shortfall in the premiums collected from the group. Management has agreed to recover the shortfall from the group. 34

The HMO has complied with this recommendation.

V. It is recommended that the HMO revise its complaint log to comply with the Department's Circular Letter #11 (1978). 35

The HMO has complied with this recommendation.

W. It is recommended that the HMO be mindful of the 15 day response time promulgated by Part 98.14(d) of the Administrative Rules and Regulations of the Health Department (10 NYCRR Part 98.14(d)) and respond to all grievances or complaints in a timely manner. 36

The HMO has complied with this recommendation.

## 7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

The following is a summary of comments and recommendations made in the body of this report:

| ITEM | | PAGE NO. |
|---|---|---|
| A. | It is recommended that the HMO revise its agreement with its reinsurer so as to allow for full effect of the continuation of benefits provision contained within the insolvency language of such agreement. | 11 |
| B. | It is recommended that the Plan submit the reinsurance agreement in effect to the New York State Insurance Department for review and approval in accordance with Public Health Law, Part 98-1.8(b) of the Health Department Regulations. | 12 |
| C | It is recommended that the HMO take steps to identify any exposure to potential additional liability resulting from VMC's insolvent condition by either: re-evaluating the adequacy of its capitation payment and VMC's financial resources; restructuring the contract to change the extent of risk transfer; or working with VMC to attain great administrative expense efficiency. | 15 |
| D. | As of December 31, 1999, The HMO's required contingency reserve of $21,086,744 was impaired in the amount of $1,075,951. | 18 |
| E. | The Department will conduct a more detailed review of claims adjudication in general, and compliance with Section 3224-a ("Prompt Pay Law") specifically, at a future date. | 22 |

Respectfully submitted,

_____
Joseph S. Krug
Associate Insurance Examiner

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

JOSEPH S KRUG, being duly sworn, deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

_____
Joseph S. Krug

Subscribed and sworn to before me

this _____day of _____2001.