REPORT ON EXAMINATION

OF

ORANGE-ULSTER SCHOOL DISTRICTS HEALTH PLAN

AS OF

DECEMBER 31, 2006

DATE OF REPORT	**NOVEMBER 10, 2008**
EXAMINER	**VICTOR ESTRADA**

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

David A. Paterson
Governor

Eric R. Dinallo
Superintendent

November 10, 2008

Honorable Eric R. Dinallo
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in compliance with the directions contained in Appointment Number 22696, dated March 25, 2008, annexed hereto, I have made an examination into the condition and affairs of Orange-Ulster School Districts Health Plan, a municipal cooperative health benefit plan licensed under the provisions of Article 47 of the New York Insurance Law, as of December 31, 2006, and respectfully submit the following report thereon.

The examination was conducted at the Plan's home office located at 163 Harriman Heights Road; Monroe, New York.

Wherever the term, "the Plan" appears herein, without qualification, it should be understood to indicate Orange-Ulster School Districts Health Plan.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of June 30, 2003. This examination covers the period from July 1, 2003 through December 31, 2006. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2006, in accordance with Statutory Accounting Principles (SAP), as adopted by the Department, 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 as called for in the *Examiners Handbook of the National Association of Insurance Commissioners (NAIC):*

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

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations 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 laws, regulations or rules, or which are deemed to require explanation or description.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicate areas of weakness and/or directly impacted the Plan's compliance with the New York Insurance Law. The most significant findings of this examination include the following:

- The Plan was not a signed party to the contract allowing the delegation of the utilization review function. The Plan, in its oversight of the claims settlement function, did not require that third parties acting on its behalf file the Plan's required utilization review plan with the Superintendent of Insurance.

- The Plan did not file its December 31, 2006 annual statement and its March 31, 2007 quarterly statement with the Superintendent of Insurance within the required time-frames. In addition, the Plan did not prepare and furnish an annual independent actuarial opinion as required by Section 4705(e) of the New York Insurance Law for the year ending 2006.

- The Plan did not maintain aggregate stop-loss coverage as required by Section 4707(a)(1) of the New York Insurance Law.

- The Plan failed to comply with Section 405 of the New York Insurance Law by not reporting a suspected incident of fraud to the New York Insurance Department's Frauds Bureau.

3. DESCRIPTION OF PLAN

The Plan is a municipal cooperative health benefit plan operating under the provisions of Article 47 of the New York Insurance Law. It operates exclusively for the benefit of the employees/retirees and their dependents, of member school districts (SD) and the Orange-Ulster

Board of Cooperative Educational Services (BOCES). The Plan has been in existence since 1982 and is composed of eighteen school districts and the Orange-Ulster BOCES. It was issued a certificate of authority on November 1, 2000, pursuant to the provisions of Article 47 of the New York Insurance Law.

The Plan participants are as follows:

Chester Union Free SD
Cornwall Central SD
Eldred Central SD
Florida Union Free SD
Goshen Central SD
Greenwood Lake Union Free SD
Highland Falls Central SD
Kiryas Joel Village SD
Warwick Valley SD
Orange-Ulster BOCES
Middletown City SD
Minisink Valley Central SD
Monroe-Woodbury Central SD
Pine Bush Central SD
Marlboro Central SD
Port Jervis City SD
Tuxedo Union Free SD
Valley Central SD
Washingtonville SD

The Plan's home office is located at 163 Harriman Heights Road; Monroe, New York. At this location most administrative functions are performed, except for the claims functions detailed below. In addition, accounting functions are performed at the Orange-Ulster BOCES' office located in Goshen, New York.

The Plan entered into administrative services agreements whereby certain third party administrators (TPAs) process health benefit claims submitted. As of December 31, 2006, the Plan maintained the following administrative services agreements:

(1) Independent Employee Consultation Services, Inc. (INDECS) – Claims processing;

(2) Caremark, Inc. – Prescription drugs claims processing.

The Plan is billed an administration fee by such TPAs for services rendered.

During the examination period, medical utilization review was performed by HealthCare Strategies (HCS). INDECS entered into an agreement with HCS, however, the Plan was not a party to this agreement.

The Plan is required to comply with Article 49 of the New York Insurance Law (Utilization Review and External Appeal) as a condition of its New York Insurance Department certification. Section 4900(i) of the New York Insurance Law permits delegation of utilization review (UR) activities by an insurer to a contracted UR.

Section 4900(i) of the New York Insurance Law states:

> "Utilization review agent" means an insurer subject to article thirty-two or forty three of this chapter performing utilization review and any independent utilization review agent performing utilization review under contract with such insurer."

Orange-Ulster is not a party to the contract delegating the UR function. The requirements of the above mentioned statute obliges the Plan to be a party to the contract with the UR agent.

It is recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs either directly or indirectly by the Plan.

A. Management and Controls

Pursuant to its Municipal Cooperation Agreement, the management of the Plan is vested in a board of directors. The Municipal Cooperation Agreement of the Plan specifies that the board of directors shall consist of the Superintendent of Schools, or his/her designee, for the aforementioned School Districts and the Orange-Ulster BOCES. As of the examination date, the board of directors was composed of 19 members. The board met at least once each quarter in compliance with its by-laws.

As of December 31, 2006, the members of the board of directors of the Plan, with their principal business affiliations, were as follows:

Name and Residence	Principal Business Affiliation
Joseph Abbondanza Jeffersonville, NY	Business Manager, Goshen Central SD
Janet Barbour Newburgh, NY	Assistant Superintendent-Business, Washingtonville SD
Steven Bernardo Bronx, NY	Business Manager, Kiryas Joel Village SD
Erin Brennan Newburgh, NY	Business Administrator, Chester Union Free SD
Deborha Brush Pine Bush, NY	Assistant Superintendent-Business, Pine Bush Central SD

Name and Residence	Principal Business Affiliation
Lorelei Case Port Jervis, NY	Assistant Superintendent-Business, Port Jervis City SD
Howard Cohen Florida, NY	Business Official, Florida Union Free SD
John Guarracino Monroe, NY	Business Administrator, Greenwood Lake Central USFD
Thomas Gustainis Warwick, NY	Assistant Superintendent-Business, Warwick Valley SD
Rachelle Harmer Cornwall, NY	Business Official, Highland Falls Central SD
Deborah McBride Heppes Goshen, NY	Assistant Superintendent-Finance, Orange-Ulster BOCES
Priscilla Holden Middletown, NY	Assistant Superintendent-Business, Minisink Valley Central SD
Richard Hooley Montgomery, NY	Assistant Superintendent-Business, Valley Central SD
Ivan Katz Eldred, NY	Superintendent, Eldred Central SD
Elizabeth McKean Goshen, NY	Deputy Superintendent, Middletown City SD
Neysa Sensenig	
Harvey Sotland Warwick, NY	Assistant Superintendent-Business, Cornwall Central SD
John Staiger Central Valley, NY	Superintendent, Monroe-Woodbury Central SD
Joseph Zanetti Wallkill, NY	Assistant Superintendent-Business, Tuxedo Union Free SD

The minutes of all of the board of directors' meetings held during the period under examination were reviewed. The review revealed that the meetings were generally well attended. However, designees from Eldred Central SD and Kiryas Joel Village SD did not attend any of the meetings that were held during 2004-2006. In addition, no attendance at board meetings was noted for the designees of Cornwall Central SD, Eldred Central SD, and Livingston Manor Central SD for the six month period from July 1, 2003 through December 31, 2003. It should be noted, however, that sufficient members were present at the board meetings for a quorum. It should also be noted that Eldred Central SD is not located in Orange County and the Municipal Cooperation Agreement calls for only school districts in Orange County to be entitled to vote at board meetings.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Board members who fail to attend at least one-half of the board's meetings, unless appropriately excused, do not fulfill such criteria.

It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.

The principal officers of the Plan as of December 31, 2006 were as follows:

Name	Title
Joseph Zanetti	Chairman
Priscilla D. Holden	Secretary
Ike A. Lovelass	Executive Director

Article 2, item 10 of the Plan's Municipal Cooperation Agreement and by-laws states in part:

> "The duties and responsibilities of the Board of Directors in the governance and implementation of the Health Plan shall include but not be limited to the following:
>
> 10. To prepare a report showing the financial condition of the Plan, in such form as is acceptable to the Superintendent of Insurance, together with an audit and opinions thereon, by an independent certified public accountant, of the financial condition…: such report, to be completed not later than one-hundred twenty (120) days after the close of the Plan's fiscal year."

Additionally, Section 4710(a)(2) of the New York Insurance Law states:

> "(a) The governing board of the municipal cooperation health benefit plan shall:
>
> (2) annually not later than one hundred twenty days after the close of plan year, file a report with the superintendent showing the financial condition and affairs of the plan (including an annual independent financial audit statement and independent actuarial opinion) as of the end of the preceding plan year…"

As a result of submitting its 2006 annual statement to the Superintendent of Insurance eighty-five (85) days beyond such annual statement's due date and submitting its March 2007 quarterly statement to the Superintendent sixty (60) days beyond such statement's due date, the Plan was notified on December 17, 2007, of a fine to be assessed by this Department. In this regard, the Plan was assessed a penalty relative to the aforementioned late financial statement submissions. The Plan paid a fine in the amount of $21,750 to the Department on January 10, 2008.

It is recommended that the Plan comply with the annual and quarterly statement instructions and submit its required annual and quarterly statements to the Superintendent of Insurance, within one-hundred and twenty (120) days after the close of the Plan's fiscal year and forty five (45) days after the close of each quarter, respectively.

It is also recommended that the Plan comply with Section 4710(a)(2) of the New York Insurance Law and submit its required annual statements to the Superintendent of Insurance, within one-hundred and twenty (120) days after the close of the Plan's fiscal year.

Section 4705(c)(2) of the New York Insurance Law states:

> "(c) A municipal cooperation agreement shall include a provision:
>
> (2) designating one governing board member to have custody of all reports, statements and other documents of the plan."

The Plan was unable to provide the examiner with all of the administrative service contracts between INDECS and HCS relative to services provided to the Plan during the examination period.

It is recommended that the Plan comply with Section 4705(c)(2) of the New York Insurance Law and maintain custody of all administrative service contracts relative to services provided to the Plan by INDECS and HCS.

Section 4705(e)(3) of the New York Insurance Law states:

> "(e) The municipal cooperation agreement shall provide for the following to be prepared and furnished to the governing board, to participating municipal corporations, to unions which are the exclusive bargaining representatives of employees covered by the plan and to the superintendent:
>
> (3) an annual independent actuarial opinion on the financial soundness of the plan, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid in the current year and projected for the next fiscal year."

The Plan was unable to provide the examiners with an independent actuarial opinion for the year ended December 31, 2006.

It is recommended that the Plan comply with Section 4705(e) of the New York Insurance Law by preparing and furnishing an annual independent actuarial opinion to the entities indicated in such section of the New York Insurance Law.

B. Territory and Plan of Operation

As of December 31, 2006, the Plan held a certificate of authority to operate the business of a municipal cooperative health benefit plan as authorized by Section 4704 of the New York Insurance Law in the counties of Orange, Sullivan and Ulster.

The Plan's enrollment has been very stable during the examination period, consisting of 8,281 members at December 31, 2006, as compared to December 31, 2005, when the enrollment level was 8,236. Enrollment as of June 30, 2003 was 8,253.

C. Stop-Loss Coverage

In accordance with the requirements of Section 4707(a)(2) of the New York Insurance Law, the Plan had stop-loss coverage in effect from an authorized insurer as of the examination date as follows:

Specific/Individual Excess Loss

Excess of loss	100% of $500,000 excess of $100,000 per member, per contract year

Aggregate Excess of Loss

Section 4707(a)(1) of the New York Insurance Law states:

> "(a) The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:
>
> (1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year."

The Plan did not have in place aggregate stop-loss coverage as required by Section 4707(a) (1) of the New York Insurance Law.

It is recommended that the Plan obtain and maintain aggregate stop-loss coverage in compliance with Section 4707(a)(1) of the New York Insurance Law.

D. Conflict of Interest Policy

The Plan has a conflict of interest policy in place. Board members are required to sign the conflict of interest disclosure form annually, however, during the exam period, specifically in

2005-2006, board members representing Kiryas Joel and Eldred Central did not sign the required disclosure form.

It is recommended that all board members sign the required conflict of interest disclosure form on an annual basis.

E. Report of Independent Certified Public Accountant (CPA)

The Plan's independent CPA report relative to the Plan's financial statements as of December 31, 2006 and during the examination period did not contain a reconciliation for the differences between the amounts reported in the Plan's filed annual statement and the amounts reported in the auditor's reports, as required by Section 307(b) of the New York Insurance Law.

Section 307(b)(2) of the New York Insurance Law states in part:

> "…an insurer may comply by filing statements prepared in accordance with generally accepted accounting principles, provided that appropriate reconciliation is made of the differences between net income and capital and surplus reported on that basis and reported in the annual statutory statement filed with the superintendent."

It is recommended that the Plan comply with Section 307(b)(2) of the New York Insurance Law and submit to this Department the applicable CPA report relative to the Plan's financial statements, including a reconciliation of the differences between amounts reported in the filed annual statements and the amounts reported in the CPA report.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2006. This statement is the same as the balance sheet filed (first revision as of November 20, 2007) by the Plan.

Assets	
Cash	$ 45,373,347
Short-term investments	14,600,997
Premiums receivable	86,308
Total assets	$ 60,260,652
Liabilities	
Accounts payable	$ 591,298
Claims payable	12,894,350
Claim stabilization reserve	14,200,000
Unearned premiums	7,716,370
Total liabilities	$ 35,402,018
Net Worth	
Contingency reserves	$ 4,503,111
Retained earnings (fund balance)	20,355,523
Total net worth	24,858,634
Total liabilities and net worth	$ 60,260,652

B. Statement of Revenue, Expenses and Net Worth

Net worth increased $23,596,899 during the examination period, July 1, 2003 through December 31, 2006, detailed as follows:

Revenue		
Premiums	$289,992,425	
Net investment income	3,434,444	
Total revenue		$293,426,869
Expenses		
Total medical and hospital expenses	$238,439,575	
Administration expenses	12,965,422	
Total expenses		251,404,997
Net Income		$ 42,021,872

Changes in Net Worth

Net worth, as of June 30, 2003, per report on examination			$ 1,261,735
	Gains in Net Worth	Losses in Net Worth	
Net income	$42,021,872		
Increase in claim stabilization reserve		$(14,105,538)	
Aggregate write-ins for other net worth items	_____	(4,319,435)	
Total gains and losses	$42,021,872	$(18,424, 973)	
Net increase in net worth			23, 596,899
Net worth, as of December 31, 2006, per report on examination			$ 24,858,634

5. CLAIMS PAYABLE (INCLUDING CLAIM STABILIZATION RESERVE)

The examination liabilities for claims payable in the amount of $12,894,350 and claims stabilization reserve in the amount of $14,200,000 are the same as the amounts reported by the Plan as of December 31, 2006.

Section 4706 (a)(1) of the New York Insurance Law requires that the governing board of a municipal cooperative health benefit plan establish a reserve fund, including a reserve for the payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount will be adequate. The Plan was granted approval by this Department on June 15, 2005 to reduce its reserves for claims and related expenses to 17% of ($12,894,350 claims payable and a $14,200,000 claim stabilization reserve, which are reflected in the balance sheet contained herein as liabilities) from 25% of the current year's expected incurred claims and expenses.

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

6. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Plan 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 more precise scope of a market conduct examination.

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

A. Claims processing
B. Utilization review
C. Plan document
D. Fraud prevention and detection

A. Claims Processing

The examination included a review of the Plan's claims settlement practices and oversight of the claims adjudication process by Plan management. INDECS is the Plan's third party administrator of claims. As such, INDECS is responsible for most aspects of claims settlement, including grievances and appeals and issuance of explanation of benefits statements. However, the management of Orange-Ulster School Districts Health Plan retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related Regulations, and therefore its management must be diligent in its oversight of the claims settlement function.

A review of INDECS' claims practices and procedures was performed by using a statistical sample covering claims paid during the period of January 1, 2006 through December 31, 2006, in order to evaluate the overall accuracy and compliance environment of its claims

processing. The examiner selected a sample of hospital and medical claims and evaluated the selected claims on a stop and go basis, testing various attributes deemed necessary for successful claims processing activity.

The term, "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. A "claim" is defined by INDECS as groupings of six line items (e.g. procedures or services) on any claim form. Each additional six lines on the claim form are entered into the claims system as a separate claim. This claim may consist of various lines, or procedures. It is possible, through the computer system used for this examination, to match or "roll-up" all procedures on the six line items into one line, which is the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by the Plan for the period January 1, 2006 through December 31, 2006.

It was noted that INDECS does not perform any formal quality control reviews or audits to check the accuracy of recorded claims transactions (e.g., payment dollar, payment incidence, coding, procedural and total claim accuracy), nor does it have any benchmarks by which to measure accuracy or timeliness of payments made. INDECS does, however, track claims "exceptions" (calls received from provider or members regarding amount paid and or provider status) as they occur and makes the necessary adjustments. INDECS provided the examiners with its daily error register capturing 128 claims that were adjusted during the fourth quarter of 2006.

The following represents examples of errors included within INDECS' daily error register:

- "Duplicate payments / claims adjuster error
- Other coverage primary, did not coordinate benefits
- Excess co-pays taken

It is recommended that the Plan require INDECS to implement periodic audits within a proactive quality assurance program in order to identify and correct errors that may be occurring on an ongoing basis, in addition to retroactive reviews resulting from external contact.

B. Utilization Review

Sections 4901, 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum program standards and requirements for utilization review determinations and appeals of adverse determinations by utilization review agents, respectively.

Sections 4901(a) and (b)(1) of the New York Insurance Law state:

> "(a) Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to section (b) of this section."
>
> "(b) Such report shall contain a description of the following:
>
> (1) The utilization review plan."

HealthCare Strategies (HCS) provided the examiners with a Utilization Renewal Registration from the New York Department of Health, which is valid until August 14, 2009. HCS has not yet filed a report with the Insurance Department per the requirements of Article 49 of the New York Insurance Law.

While it was apparent that HCS had filed a plan with the New York Department of Health as required by Section 4901(1) and Section 4902(2)(a) of the Public Health Law, which contains similar requirements to the above statute, such plan was not provided to the examiner in its entirety. In this regard, the Plan has not filed, on a biennial basis, its utilization review plan with the New York Insurance Department.

It is recommended that the Plan, in its oversight of the claims settlement function, require that third parties acting on its behalf, comply with Sections 4901(a) and (b)(1) of the New York Insurance Law and submit the Plan's utilization review plan with the New York Insurance Department on a biennial basis.

C. Plan Document

The plan document (benefit contract) states that:

> "(a) The Plan requires that employees submit appropriate official documentation of eligibility when enrolling themselves or their family members in the Plan. Coverage will not begin until documentation of eligibility (such as marriage or birth certificates, tax returns, etc.) has been submitted as requested by the Plan."

There was one instance where the Plan did not comply with this requirement.

It is recommended that the Plan comply with its plan document and request pertinent documentation of eligibility when enrolling members.

D. Fraud Prevention and Detection

Section 405 of the New York Insurance Law states in part:

> "Any person licensed pursuant to the provisions of this chapter, and any person …who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent insurance transaction is about to take place, or has taken place, shall within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form...."

There was one instance whereby an alleged fraud involving payment of claims for services provided to an alleged ineligible member was not submitted to this Department's Frauds Bureau.

It is recommended that the Plan comply with Section 405 of the New York Insurance Law and report any known or suspected incidents of fraud to the New York Insurance Department's Frauds Bureau.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained twenty-five comments and recommendations as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
	Insolvency	
1.	This examination has determined that the Plan was solvent in the amount of $1,261,735, but its contingency reserve of $3,028,008 was impaired in the amount of ($1,766,273) as of June 30, 2003. Refer to item 4 herein. As of the exam date the Plan is in compliance with its contingency reserve requirements and had a net worth of $24,858,634.	1, 13, 28
	Description of Plan	
2.	It is recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs either directly or indirectly by the Plan. The Plan has not complied with this recommendation. A similar recommendation is made in this report.	5
3.	Management It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan. The Plan has not complied with this recommendation. A similar recommendation is made in this report.	7

ITEM NO.		PAGE NO.
4.	It is recommended that the Plan complies with its Municipal Cooperation Agreement and by-laws by appointing a Chief Fiscal Officer. The Plan has complied with this recommendation.	8
5.	It is recommended that the Plan complies with §4705(c)(2) of the New York Insurance Law by maintaining custody of all relevant documents in its home office. The Plan has not complied with this recommendation. A similar recommendation is made in this report.	8
	Conflict of Interest	
6.	It is recommended that the Plan adopts a formal code of ethics and requires that its directors and officers annually sign conflict of interest statements. The Plan has complied with this recommendation.	10
7.	It is also recommended that the Plan provides accurate responses when filling out General Interrogatories filed with this Department. The Plan has complied with this recommendation.	10
	Accounts and Records	
8.	It is recommended that the Plan presents its accounts in compliance with the requirements of Statement of Statutory Accounting Principles #2, paragraph 5. The Plan has complied with this recommendation.	11
9.	It is recommended that the Plan takes the necessary steps to complete its Schedule F (“Claims Payable Analysis”) in accordance with the annual statement instructions. The Plan has complied with this recommendation.	12

ITEM NO.		PAGE NO.
10.	It is recommended that the Plan exercises due diligence in preparing its annual statement and reports the actual balances from the previous year's annual statement in the "prior year" column in the "current year" annual statement. The Plan has complied with this recommendation.	12
	Market Conduct	
11.	It is recommended that the Plan modify its contract documents to conform to the aforementioned statutory changes. It is further recommended that the Plan reprocess all claims where such benefits were not properly afforded since the effective date of each respective statute. The Plan has complied with this recommendation. Examiner noted adjudicated claims for such benefits during 2005-2006.	17
	Claims Processing Oversight	
12.	It is recommended that Plan management fulfills its responsibility for compliance with New York Insurance statutes, rules, and regulations, as regards claims settlement practices, via stronger oversight of its TPA's practices. The Plan has retained its independent accountant to annually review claims paid on its behalf.	18
13.	It is further recommended that all "claims settlement" recommendations be brought to the attention of INDECS and immediately remedied. INDECS was made aware of all "claims settlement" recommendations.	18

ITEM NO.		PAGE NO.
14.	It is recommended that INDECS continue to take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider providing retraining to individuals who consistently appear on the daily error register. The Plan has complied with this recommendation.	21
15.	It is recommended that external audits of INDECS' claims processing function(s) be performed on an annual basis and that the results be provided to the Plan's management. The Plan has complied with this recommendation.	21
16.	It is also recommended that the Plan obtains periodic reports from INDECS that measure claims processing accuracy, and that it obtains the results of all internal reviews and audits of INDECS' claim processing functions. The Plan obtains periodic reports, however, no measure of claims processing accuracy is provided. A similar recommendation is included within this report on examination.	21
17.	It is recommended that INDECS investigate possible system enhancements that will facilitate the application of prior allowances to aged claims to ensure they receive the proper reimbursement of benefits. As a result of cost benefit analysis, INDECS has decided not to comply with this recommendation. A similar recommendation is contained within this report on examination.	21
	Utilization Review	
18.	It is recommended that the Plan, in its oversight of the claims settlement function, require that third parties acting on its behalf comply with §4901 (a) and (b)(1) of the New York Insurance Law. The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.	23

ITEM NO.		PAGE NO.
19.	It is further recommended that HCS file the required documentation with the Insurance Department. HCS has not complied with this recommendation. A similar recommendation is included within this report on examination.	23
20.	Should any "determination" be made, then the Plan should provide written notices to insureds and providers regarding utilization review determinations in accordance with §4903(b) of the New York Insurance Law. The Plan has complied with this recommendation.	24
21.	It is recommended that the utilization review notices provided to Plan members agree with the Plan's appeal instructions. The Plan has complied with this recommendation.	24
22.	Therefore, it is recommended that the Plan's agreement with INDECS be amended to include verification that all claims settlement functions contracted out to third parties, by INDECS, be audited, and that the results of these audits be submitted to Plan management for their review. The Plan has complied with this recommendation.	25
23.	It is further recommended that the Plan's agreement with INDECS contains performance measurements for the claims settlement functions performed by INDECS, and any other party it contracts with. The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.	25
	Explanation of Benefits (EOB)	
24.	It is recommended that the Plan modify its EOBs to comply with §3234(b)(7) of the New York Insurance Law. The Plan provided evidence that its EOBs were amended, in March 2004 to include wording regarding potential forfeiture of members' appeal rights.	26

ITEM NO.		PAGE NO.
	Grievances, Appeals and Complaints	
25.	It is recommended that all Appeals Committee's written responses to members cite the reasons for its decisions, and the specific plan provisions upon which their review decision was based. The Plan has complied with this recommendation.	27

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Description of Plan	
	It is recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs either directly or indirectly by the Plan.	6
B.	Management	
i.	It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.	8
ii.	It is recommended that the Plan comply with the annual and quarterly statement instructions and submit its required annual and quarterly statements to the Superintendent of Insurance, within one hundred and twenty (120) days after the close of the Plan's fiscal year and forty-five (45) days after the close of each quarter, respectively.	10
iii.	It is also recommended that the Plan comply with Section 4710(a)(2) of the New York Insurance Law and submit its required annual statements to the Superintendent of Insurance, within one-hundred and twenty (120) days after the close of the Plan's fiscal year.	10
iv.	It is recommended that the Plan comply with Section 4705(c)(2) of the New York Insurance Law and maintain custody of all administrative service contracts relative to services provided to the Plan by INDECS and HCS.	10
v.	It is recommended that the Plan comply with Section 4705(e) of the New York Insurance Law by preparing and furnishing an annual independent actuarial opinion to the entities indicated in such section of the New York Insurance Law.	11

ITEM **PAGE NO.**

I. Fraud Prevention and Detection

It is recommended that the Plan comply with Section 405 of the New York Insurance Law and report any known or suspected incidents of fraud to the New York Insurance Department's Frauds Bureau. 21

Appointment No. 22696

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **Eric R. Dinallo** , Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Victor Estrada

as a proper person to examine into the affairs of the

Orange-Ulster School Districts Plan

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

Plan

with such information as he shall deem requisite.

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

this 25th day of March 2008

Eric R. Dinallo
Superintendent of Insurance