REPORT ON EXAMINATION

OF THE

JEFFERSON-LEWIS et. al. SCHOOL

EMPLOYEES' HEALTHCARE PLAN

AS OF

JUNE 30, 2010

DATE OF REPORT	**MARCH 8, 2013**
EXAMINER	**ELSAID ELBIALLY, CFE**

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March 8, 2013

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30658, dated March 14, 2011, attached hereto, I have made an examination into the condition and affairs of Jefferson-Lewis et. al. School Employees' Healthcare Plan, a municipal cooperative health benefit plan licensed pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2010. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Jefferson-Lewis et. al. School Employees' Healthcare Plan located at 853 James Street, Clayton, New York.

Wherever the designations, the "Plan" or "J-LSEHP" appear herein, without qualification, they should be understood to indicate Jefferson-Lewis et. al. School Employees' Healthcare Plan.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2005. This examination of the Plan was a combined (financial and market conduct) examination and covered the five year period of July 1, 2005 to June 30, 2010. The financial component of the examination was conducted as a financial examination, as such term is defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* ("the Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to fiscal year June 30, 2010 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilized that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of J-LSEHP. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually, for fiscal years 2005 through 2010, by the Plan's CPA firm. Certain audit work papers of Poulsen & Podvin, LLC. was reviewed and relied upon in conjunction with this 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 require explanation or description.

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

2. DESCRIPTION OF THE PLAN

Jefferson-Lewis Cooperative Board of Cooperative Educational Services ("J-LBOCES") and its fifteen original member school districts ("Participants") formed a Consortium in 1979. The purpose of the Consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance. The Plan provides benefits to covered employees and their eligible dependents as defined in the Plan booklet.

On June 1, 2001, the Plan was issued a certificate of authority by the then Superintendent of Insurance, under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority, the Participants have agreed to share the costs and assume the liabilities for hospital, medical, and surgical benefits provided to the employees (and retirees) and their dependents.

There are fifteen school districts and one Board of Cooperative Educational Services (BOCES) participating in the Plan. The Plan Participants are as follows:

Alexandria Bay Central School District	Jefferson-Lewis BOCES
Beaver River Central School	LaFargeville Central School
Belleville Henderson Central School	Lowville Central School
Carthage Central School	Lyme Central School
Copenhagen Central School	Sackets Harbor Central School
General Brown Central School	South Lewis Central School
Indian River Central School	Thousand Island Central School
Jefferson Community College	Watertown City School District

A. Corporate Governance

Pursuant to its revised and restated 2006 Municipal Cooperative Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from each participating school district, including BOCES. The governing board of the Plan as of June 30, 2010 was as follows:

Name	Municipality
Sarah Baldwin	Jefferson Community College
Julie Gayne	Sackets Harbor Central School District
Barbara Greene	Jefferson-Lewis BOCES.
Wally Keeler	Alexandria Bay Central School District
Kenneth J. McAuliffe	Lowville Central School District
Marcia Mundy	Copenhagen Central School District
Michelle Papin	LaFargeville Central School District
Cathy Porter	Carthage Central School District

Name	Municipality
Douglas Premo	South Lewis Central School District
Sandra Rooney	Lyme Central School District
Dennis Schrecengast	Indian River Central School District
Sally Switzer	Thousand Island Central School District
Laura Tousant	Beaver River Central School District
Michele Traynor	General Brown Central School District
Lynne Wight	Watertown City School District
Deborah Vink	Belleville Henderson Central School District

According to the Plan's by-laws, the governing board is to meet quarterly during each fiscal year. The minutes of the meetings of the governing board held during the examination period and subsequent thereto were reviewed. The meetings of the governing board were well attended with every member attending at least 50% of the meetings they were eligible to attend. The standing committees of the governing board are the Executive Committee, the Appeals Review Committee, and the Finance Committee.

Section 624(a) of the New York Business Corporation Law states in part:

> "(a) Each corporation shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its shareholders, board and executive committee…"

It was noted that although the Plan's Board established specific Committees, minutes of those meetings were not formalized and maintained.

It is recommended that the Plan maintains formalized minutes of Committee meetings of the Governing Board.

The Appeals Review Committee is defined as the Executive Committee and the three elected voting members of the governing board. However, the members of the Appeals Review Committee were not formally appointed through Board resolution.

It is recommended that the members of the Appeal Review Committee be formally appointed through board resolution.

The Plan entered into contractual agreements with the following vendors to provide various administrative services to the Plan:

- Progressive Management Consulting, LLC (PMC) is the general manager and Comptroller of the Plan. As Plan general manager, PMC defines a strategic plan of action for the Plan. PMC works with POMCO, Inc., ("POMCO"), which provides services to the Plan as described below, to ensure accurate and prompt payment of claims. PMC meets with the Board of Trustees as deemed necessary to conduct the business of the Plan. PMC provides mandated reports and documentation to regulators and others as required to keep Plan participants informed of benefit issues, and assists in the review and revision of plan benefit structure and design.

- POMCO, Inc. provides a computerized on-line system for developing and maintaining comprehensive employee benefit records, POMCO provides administrative and third party claims processing services relative to the payment of claims. POMCO provides the Plan with access to its provider network as well as access to the provider network of its contractual partner, Multi Plan Inc. The Multi Plan provider network is available in all 50 states of the US. POMCO also utilizes Preferred Medical Claim Solutions (PMCS) as a claim payment re-pricer (for discounts) for outpatient claims when the provider is not in the POMCO or Multi Plan network.

- CareMark CVS is a pharmacy benefit manager ("PBM") that provides a prescription drug plan for eligible covered persons of the Plan. This includes a network of retail and mail service pharmacies, electronic claim adjudication, and a claim processing

system for pharmacy claims adjudication. Also, the PBM provides a prescription drug benefit management service for designing and managing prescription drug benefits.

- Davis Vision provides administrative and information services to members of the plan relating to its vision plan benefits. Davis Vision provides laboratory services, processing of claims, data entry and clerical processing. Davis Vision provides management reporting of billing statements quality care reports and/or other reports as required. Davis Vision provides a panel of private offices for eye exams and dispensing services to the members. Davis Vision also has a comprehensive program for quality assurance.

- KBM Management Inc. (KBM), provides consulting services to the Plan's Trustees as required, on matters regarding negotiations with employee groups. KBM also provides actuarial services and assists in obtaining alternative markets for stop-loss coverage as well as reviewing and investigating claims which affect stop-loss coverage. KBM assists in the negotiation of administrative agreements of the Plan.

- Poulsen & Podvin, LLC provides accounting services to the Plan.

The principal officers of the Plan as of June 30, 2010 were as follows:

Name	Title
Barbara Greene	Vice Chairperson
Edgar Higgins	Plan Manager
Kenneth McAuliffe	Chairperson
Sally Switzer	Treasurer
Diane Wright	Secretary

B. Territory and Plan of Operation

The Plan provides health benefits in the counties of Jefferson and Lewis in New York State. The Plan had annual premiums written of $45,829,489 for the fiscal year ending June 30, 2010. There has not been any significant change in membership during the examination period. The Plan's participating school districts remained the same throughout the examination period.

C. Reinsurance

In 2008, J-LSEHP discontinued its stop-loss coverage and instead held one hundred fifty (150) percent of the mandatory minimum statutory reserve. Since the minimum statutory reserve was based upon twenty-five (25) percent of claims incurred, the plan held thirty-seven and one-half (37.5) percent of incurred claims as the claims payable reserve. This also required a fifty (50) percent increase in the surplus account. The surplus account was increased from five (5) percent of annualized earned premium to seven and one-half (7.5) percent. In 2010, the Plan purchased reinsurance, eliminating the need for the fifty (50) percent increase in reserves and net worth. Subsequently, the Department performed an actuarial analysis and reduced the required claims payable reserve from twenty-five (25) percent of incurred claims to seventeen (17) percent.

As of the examination date, the Plan maintained a specific and aggregate stop-loss insurance policy with an effective date of March 1, 2010 and expiration date of February 28, 2011. The policy provides medical and prescription drug reinsurance coverage and is issued by a licensed insurer, in accordance with New York Insurance Law Section 4707(a).

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

> "(a) The governing board of the municipal cooperative health benefit plan shall obtain and maintain on the behalf of the plan a stop-loss insurance policy or policies 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; …"

It was noted that the aggregate attachment point mandated by New York Insurance Law Section 4707(a) is greater than one hundred twenty-five (125) percent of the expected claims for the current fiscal year based upon the 2010 budget. The projected claims were $48,635,443. The minimum aggregate stop loss attachment point for the policy obtained in March 2010 is $69,508,582. This is less than one hudred fify (150) percent of the expected claims.

It is recommended that the Plan complies with New York Insurance Law Section 4707(a)(1) and reduce the aggregate attachment point of its stop loss coverage to one hundred twenty-five (125) percent of expected claims for the current fiscal year.

The following is a summary of the Plan's stop-loss insurance specific coverage and aggregate coverage retentions (deductibles) and limits at June 30, 2010:

<u>Specific excess-of-loss coverage</u>	
Coverage	Medical and prescription drug 100% of $1,000,000 per covered person, excess of $750,000 per covered person.
Run-in-period limitation	$150,000 per covered person.
<u>Aggregate excess-of-loss coverage</u>	
Coverage	Medical and prescription drug 100% paid aggregate losses in excess of $69,508,382 with a maximum reimbursement limit of $1,000,0000 and a maximum limit per covered person of $750,000.
Run-in-period limitation	$10,426,257.30 all covered persons combined.

D. Investments

Section 1411(a) of the New York Insurance Law states in part:

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

A review of the minutes of the Governing Board meetings for the period under examination found that specific investments were not approved through Board resolution. Instead, investment reports were provided to the Governing Board periodically. Therefore, the Plan did not comply with New York Insurance Law Section 1411(a).

It is recommended the Plan complies with New York Insurance Law Section 1411(a) by obtaining approval of specific investments through resolution of the Governing Board or a subcommittee thereof.

The Plan's investment guidelines indicate procedures that are to be established and followed. No such procedures have been established.

Therefore, it is recommended that the Plan establishes procedures relative to investments in accordance with its investment guidelines.

E. Accounts and Records

A review of the Plan's accounts and records during the examination period revealed the following:

1. Prescription drug coverage is provided by CareMark CVS under a subcontracted agreement with POMCO. However, the CareMark CVS agreement is not formalized. This resulted from the previous pharmacy benefit manager (PBM) Eckerd Health Services (EHS), formerly named Pharmacare, being acquired by CareMark CVS and the PBM services continuing under the original contract.

It is recommended that the Plan amends its prescription benefits management contract to reflect current corporate names.

2. It was noted through a review of the Governing Board minutes that signatories on bank accounts are not authorized through board resolution.

It is recommended that the Plan authorizes bank signatories through board resolution.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination and reported by the Plan in its filed annual statement as of June 30, 2010. This statement is the same as the balance sheet filed by the Plan as of June 30, 2010.

Assets	Examination	Plan
Cash and cash equivalents	$ 2,467,992	$ 2,467,992
Short-term investments	20,057,400	20,057,400
Investment income receivable	475,527	475,527
Aggregate write-ins for current assets	55,795	55,795
Total assets	$ 23,056,714	$ 23,056,714
Liabilities		
Accounts payable	34,392	34,392
Claims payable	6,495,072	6,495,072
Unearned premiums	156,820	156,820
Total liabilities	$ 6,686,284	$ 6,686,284
Net worth		
Contingency reserves	$ 2,315,669	$ 2,315,669
Retained earnings/fund balance	14,054,761	14,054,761
Total net worth	$ 16,370,430	$ 16,370,430
Total liabilities and net worth	$ 23,056,714	$ 23,056,714

B. Statement of Revenue and Expenses and Net Worth

Net worth increased by $8,431,328 during the five-year examination period, July 1, 2005 through June 30, 2010, detailed as follows:

Revenue			
Premium and related revenue			$212,231,866
Medical and hospital expenses			
Hospital/medical benefits	$151,575,192		
Prescription drugs	46,339,855		
Reinsurance expenses	1,271		
Total medical and hospital		$197,916,318	
Administrative expenses			
Compensation	451,592		
Marketing	101,379		
Professional fees	119,513		
Administrative fees	7,536,459		
Consultant fees	209,017		
Office expense	25,540		
Summary of other write-ins	1,227,785		
Total administrative expenses		9,671,285	
Total expenses			207,587,603
Net underwriting gain			$4,644,263
Investments and other income			3,787,065
Net income			$8,431,328

Net Worth

	Gains in Net Worth	Losses in Net Worth	
Net worth, per report on examination, as of June 30, 2005			$7,939,102
Net income	$8,431,328		
Net increase in net worth			$8,431,328
Net worth, per report on examination, as of June 30, 2010			$16,370,430

4. CLAIMS UNPAID

The examination liability of $6,495,072 is the same as the amount reported by the Plan in its June 30, 2010 filed annual statement. 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 its filed annual statements as verified by the examiner.

The Department performed an actuarial analysis and reduced the required claims payable reserve from twenty-five (25) percent of incurred claims to seventeen (17) percent.

The examination reserve was based upon actual claims payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate

was calculated based on actuarial principles, which utilized the Plan's experience in projecting the ultimate cost of claims incurred on or prior to June 30, 2010.

5. MARKET CONDUCT ACTIVITIES

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 generally more precise scope of a market conduct examination.

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

A. Policy forms
B. Claims processing
C. Utilization review
D. Third party claim negotiator

A. Policy Forms

Section 4710(a)(1) of the New York Insurance Law states in part:

> "(a) the governing board of the municipal cooperative health benefit plan shall:
>
> (1) file for approval with the superintendent a description of material changes in any information provided in the application for certificate of authority in the form and manner prescribed by the superintendent..."

The prior examination report noted that Jefferson Lewis et. al. School Employees' Healthcare Plan did not obtain approval for the forms in use, however, during the prior

examination period the forms were submitted to the Department for review and approval. On June 9, 2011, the Department's approval was obtained for the revised and restated Plan document, effective July 1, 2011. A review of the form in use for the period under examination, July 1, 2006 through June 30, 2010, indicated that the mandated benefit afforded by the Well Woman Act was not implemented in a timely fashion. Therefore, the Plan did not comply with Section 4710(a) during calendar years 2003 to 2010. It was determined that eighty-four claims for benefits related to contraceptives that amounted to $11,405.55 were erroneously processed.

It is recommended that the Plan complies with the requirements of Section 4710(a)(1) of the New York Insurance Law and submit necessary documents in a timely manner to ensure compliance.

B. Claims Processing

1. Claims Attribute Sample

A claims attribute review was performed for claims submitted to the Plan during the period, January 1, 2010 through December 31, 2010. A statistical random sampling process was performed testing several attributes deemed to be necessary for the successful processing of claims.

The random sampling process was performed using ACL, an auditing software program. The sampling methodology was devised to test various attributes deemed necessary for successful processing of claims and to test and reach conclusions about all predetermined attributes, individually or on a combined basis. The review incorporates

processing attributes used by POMCO in its own "Quality Analysis" of claims processing. The sample size was comprised of 100 randomly selected claims from targeted sub-populations.

The review did not uncover any processing errors, according to the criteria used by both the Plan and the New York State Department of Financial Services.

2. Claims Prompt Payment Law Review

A review to test for compliance with the Prompt Pay Law, Section 3224-a of the New York Insurance Law, was performed by using a statistical sampling methodology covering medical and hospital claims submitted to the Plan during the period January 1, 2010 through December 31, 2010.

The review revealed no issues in regard to compliance with Section 3224-a of the New York Insurance Law.

3. Explanation of Benefits Statements

Explanation of Benefits Statements (EOBs) are an integral part of the link between the subscriber/contract-holder and their insurer, providing vital information as to how a claim was processed.

Sections 3234(a) and (b)(6) of the New York Insurance Law state in part:

> "(a) Every insurer, including a health maintenance organization… is required to provide the insured or subscriber with an explanation

> of benefits form in response to the filing of any claim under a policy…
>
> (b) The explanation of benefits form must include at least the following…(6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed;"

A review of a sample of the Plan's paid and denied claims for members/providers residing or located in New York State during the period from January 1, 2010 through December 31, 2010 was performed. The review encountered instances in which EOBs issued by the Plan did not provide a specific explanation of denial, reduction or other reasons as required by New York Insurance Law Section 3234(b)(6).

It is recommended that the Plan adheres to the requirements of New York Insurance Law Section 3234(b)(6) by citing the specific reason why there was not full reimbursement of a claim.

C. Utilization Review

The Plan contracted with POMCO, a third party administrator, as its utilization review agent.

New York Insurance Law Section 4903(e) states:

> "(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
> (1) the reasons for the determination including the clinical rationale, if any;
> (2) instructions on how to initiate standard and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and

> (3) notice of the availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal."

It was noted that the denial notices for the first adverse determination did not contain instructions on how to initiate expedited appeals pursuant to Section 4904 of the New York Insurance Law and an external appeal pursuant to Section 4914 of the New York Insurance Law.

It is recommended that the Plan fully complies with Section 4903(e) of the New York Insurance Law and include all required information in its notices of adverse determination.

Section 4903(d) of the New York Insurance Law states:

> "(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of all necessary information."

The Plan failed to issue notices of first adverse determination to members/providers relative to its retrospective review of claims involving medical necessity, as required by New York Insurance Law Section 4903(d).

It is recommended that the Plan fully complies with Section 4903(d) of the New York Insurance Law and issue notices of adverse determination to members/providers when claims are denied based on utilization review decisions.

New York Insurance Law Section 4903(c) states in part:

> "(c) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information…"

The Plan did not issue the adverse determination notice for one of the five concurrent utilization review files selected by the examiner.

It is recommended that the Plan complies in all instances with New York Insurance Law Section 4903(c) and provide a notice of determination to the insured or insured's designee by telephone and in writing within one business day of receipt of the necessary information on concurrent utilization review requests.

New York Insurance Law Section 4903(b) states in part:

> "(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

The Plan issued the required notice of adverse determination on all files selected. However, the notices were not issued within three business days of receipt of the necessary information.

It is recommended that the Plan complies with the timeframe prescribed by Section 4903(b) of the New York Insurance Law and provide the required notice of determination within three business days, by telephone and in writing, to the insured/insured's designee on prospective utilization reviews.

New York Insurance Law Section 4904(c) states in part:

> "(c)…The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing…"

The Plan did not provide written acknowledgement of the filing of the appeals as required by Section 4904(c) of the New York Insurance Law.

It is recommended that the Plan provides written acknowledgement, within 15 days of the filing of an appeal, in accordance with New York Insurance Law Section 4904(c).

Section 410.9 of Department Regulation No. 166 (11 NYCRR 410.9 (e)) states:

> "Each notice of a final adverse determination of an expedited or standard utilization review appeal under section 4904 of the Insurance Law shall be in writing, dated and include the following:
> (1) a clear statement describing the basis and clinical rationale for the denial as applicable to the insured;
> (2) a clear statement that the notice constitutes the final adverse determination;
> (3) the health care plan contact person and his or her telephone number;
> (4) the insured coverage type;
> (5) the name and full address of the health care plan utilization review agent;
> (6) the utilization review agent contact person and his or her telephone number;

> (7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
> (8) a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and
> (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal."

The final adverse determination letter sent by the Plan to its members as a result of the Level 1 appeal did not include all of the nine items required by Department Regulation No. 166 (11 NYCRR 410.9 (e)).

It is recommended that the Plan complies with Department Regulation No. 166, and include the nine mandated requirements within each notice of final adverse determination of an expedited or standard appeal issued pursuant to New York Insurance Law Section 4904.

D. Third Party Claims Negotiator

POMCO provides third party claim negotiation services on behalf of J-LSEHP. POMCO provides these services and sub-contracts with two other entities AllMed and Multiplan to provide these services. The third party negotiations are used to negotiate discounts with non-participating providers and also on high risk claims. In reviewing these services the examiner found that Allmed and Multiplan negotiate with non-participating providers through the use of a letter that makes an offer of a negotiated

settlement. The valuation of claims establishes Allmed and MultiPlan as a claims "adjuster", as such term is defined in New York Insurance Law Section 2101(g)(1) which states in pertinent part:

> "(g) In this article "adjuster" means any "independent adjuster" as defined below:
>
> (1)...any person, firm, association or corporation who, or which, for money, commission or any other thing of value acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer.."

New York Insurance Law Section 2108(a)(1) states in pertinent part:

> "(a)(1) Adjusters shall be licensed as independent adjusters or as public adjusters."

New York Insurance Law Section 2108(a)(3) states in pertinent part:

> "(a)(3) No adjuster shall act on behalf of an insurer unless licensed as an independent adjuster, and no adjuster shall act on behalf of an insured unless licensed as a public adjuster."

A review of claims adjudication processes by the examiner revealed that neither Allmed nor Multiplan, assigned to process the Plan's claims, possessed a New York claims adjuster license, while acting in this capacity for the Plan. This is a violation of Sections 2108(a)(1) and 2108(a)(3) of the New York Insurance Law, as stated above.

It is recommended that the Plan ensures that its third party claim negotiators, Allmed and Multiplan, maintain a New York license to adjust claims, in compliance with New York Insurance Law Section 2108(a)(1).

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on organization included twelve (12) recommendations detailed as follows (page number refers to the prior report on organization).

ITEM NO.		PAGE NO.
1.	It is recommended the Plan comply with the requirements of Section 1411(a) of the New York Insurance Law *The Plan did not comply with this recommendation. A similar recommendation is included in this report under item C, i.*	10
2.	It is recommended the Plan enter into a proper custodian agreement with its custodian bank for its investment account. The custodian agreement should contain the prudent protective covenants and provisions as set forth in the Department's guidelines. *The Plan has complied with this recommendation.*	11
3.	It is recommended the Plan establish a follow-up procedure and send an initial letter of inquiry to the payee for all checks which remain outstanding for three months from the date of issue. *The Plan has complied with this recommendation.*	12
4.	It is recommended that the Plan payment for contracted services be made only after such services are rendered in accordance with the requirement of Section 4705(d)(2)(B) of the New York Insurance Law. *The Plan has complied with this recommendation.*	12
5.	It is recommended the Plan revise its policy forms and riders as directed by the Insurance Department in order to be in compliance with Section 4303 and 4308(a) of the Insurance Law. *The Plan has complied with this recommendation.*	17

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6.	It is recommended that POMCO, Inc and each of its employees who perform claim adjusting services for the Plan be licensed as independent adjusters in accordance with Section 2101(g)(1) and Section 2108(a)(3) of the New York Insurance Law. *The Plan has complied with this recommendation.*	18
7.	It is recommended the Plan stop the practice of assigning claim numbers to third party administrative fee invoices. Such fees should be reported as claim adjustment expenses. *The Plan has complied with this recommendation.*	19
8.	It is recommended that the Plan issue EOB's that include all of the requisite information required by Section 3234(a) and (b) of the New York Insurance Law. Accordingly, insurers will be properly informed of their appeal rights and how their claims are processed. *The Plan did not comply with this recommendation. A similar recommendation is included in this report under item F.*	21
9.	It is recommended the Plan or POMCO, on behalf of the Plan, file a current utilization review report with the New York State Insurance Department in accordance with Section 4704(a)(8) and Article 49 of the New York Insurance Law , or, in the alternative register as a utilization review agent with the New York Department of Health. *The Plan has complied with this recommendation.*	23
10.	It is recommended the Plan fully complies with Section 4903(e) of the New York Insurance Law and includes all the required information in its notice of adverse determination when prospective or concurrent review is conducted. *The Plan did not comply with this recommendation. A similar recommendation is included in this report under item G, i.*	24

ITEM NO. **PAGE NO.**

11. It is recommended the Plan send proper notice of final adverse determination of expedited and standard utilization review appeals in accordance with Section 4904(c) and 4910(b) of the New York Insurance Law. 24

The Plan did not comply with this recommendation. A similar recommendation is included in this report under item G, v.

12. It is recommended the Plan issue a notice of first adverse determination to its members for retrospective review of non-participating provider/member submitted claims and also, claims of par providers in cases where the member is financially liable, when missing medical necessity information is not received. 25

The Plan has complied with this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Corporate Governance	
i.	It is recommended that the Plan maintains formalized minutes of Committee meetings of the Governing Board.	6
ii.	It is recommended that the members of the Appeal Review Committee be formally appointed through board resolution.	7
B.	Reinsurance	
	It is recommended that the Plan complies with New York Insurance Law Section 4707(a)(1) and reduce the aggregate attachment point of its stop loss coverage to one hundred twenty-five (125) percent of expected claims for the current fiscal year.	10
C.	Investments	
i.	It is recommended the Plan complies with New York Insurance Law section 1411(a) by obtaining approval of specific investments through resolution of the Governing Board or a subcommittee thereof.	11
ii.	It is recommended that the Plan establishes procedures relative to investments in accordance with its investment guidelines.	11
D.	Accounts and Records	
i.	It is recommended that the Plan amends its prescription benefits management contract to reflect current corporate names.	12
ii.	It is recommended that the Plan authorizes bank signatories through board resolution.	12
E.	Policy Forms	
	It is recommended that the Plan complies with the requirements of Section 4710(a)(1) of the New York Insurance Law an submit necessary documents in a timely manner to ensure compliance.	17

ITEM **PAGE NO.**

F. Explanation of Benefits Statements

It is recommended that the Plan adheres to the requirements of New York Insurance Law Section 3234(b)(6) by citing the specific reason why there was not full reimbursement of a claim. 19

G. Utilization Review

i. It is recommended that the Plan fully complies with Section 4903(e) of the New York Insurance Law and include all required information in its notices of adverse determination. 20

ii. It is recommended that the Plan fully complies with Section 4903(d) of the New York Insurance Law and issue notices of adverse determination to members/providers when claims are denied based on utilization review decisions. 20

iii. It is recommended that the Plan complies in all instances with New York Insurance Law Section 4903(c) and provide a notice of determination to the insured or insured's designee by telephone and in writing within one business day of receipt of the necessary information on concurrent utilization review requests 21

iv. It is recommended that the Plan complies with the timeframe prescribed by Section 4903(b) of the New York Insurance Law and provide the required notice of determination within three business days, by telephone and in writing to the insured/insured’s designee on prospective utilization reviews. 22

v. It is recommended that the Plan provides written acknowledgement, within 15 days, of the filing of an appeal, in accordance with New York Insurance Law Section 4904(c). 22

vi. It is recommended that the Plan complies with Department Regulation No. 166, and include the nine mandated requirements within each notice of final adverse determination of an expedited or standard appeal issued pursuant to New York Insurance Law Section 4904. 23

ITEM **PAGE NO.**

H. Third Party Claims Negotiator

It is recommended that the Plan ensures that its third party claim negotiators, Allmed and Multiplan, maintain a New York license to adjust claims, in compliance with New York Insurance Law Section 2108(a)(1). 24

Appointment No. **30658**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Elsaid Elbially

as a proper person to examine into the affairs of the

Jefferson-Lewis et. al. School Employees Healthcare Plan

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

Municipal Cooperative Health Benefit Plan

with such other information as she shall deem requisite.

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

This 14th day of March, 2011

James J. Wrynn
Superintendent of Insurance