REPORT ON EXAMINATION

OF THE

CHAUTAUQUA COUNTY SCHOOL DISTRICTS' MEDICAL HEALTH PLAN

AS OF

JUNE 30, 2012

DATE OF REPORT	**OCTOBER 31, 2014**
EXAMINER	**CHARLES J. McBURNIE**

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Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

October 31 , 2014

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 30705, dated April 14, 2011, attached hereto, I have made an examination into the condition and affairs of Chautauqua County School Districts' Medical Health 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, 2012, and respectfully submit the following report thereon.

The examination was conducted at the home office of Veracity Benefits by Design (the Plan's third party administrator), located at 7 West Third Street, Jamestown, New York.

Wherever the designations "CCSDMHP" or the "Plan" appear herein, without qualification, they should be understood to refer to Chautauqua County School Districts' Medical Health 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 THE EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2006. This examination of the Plan was a combined (financial and market conduct) examination and covered the period from July 1, 2006 through June 30, 2012. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2012 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2012 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 of 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 the Plan. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus this was the first risk focused 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 2006 through 2008, by the accounting firm Bahgat & Laurito-Bahgat, CPAs, P.C. ("Bahgat & Laurito") and for fiscal years 2009 through 2011, by Buffamante, Whipple, Buffafaro, P.C. ("BWB"). The Plan also retained the external audit services of Bahgat & Laurito-Bahgat, CPAs, P.C. for fiscal year 2012. The Plan received unqualified opinions in each of the above indicated

years. Certain audit work papers of BWB and Bahgat & Laurito were 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. The results of the examiner's review are contained in Item 6 of this report.

2. DESCRIPTION OF THE PLAN

The Plan provides benefits to covered employees and their eligible dependents. On November 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 (largely the individual school districts) have agreed to share the costs and assume the liabilities for medical, surgical, prescription drugs, and hospital benefits provided to covered employees (including retirees) and their dependents.

There are currently eighteen school districts and one BOCES participating in the Plan. The Plan's participants as of June 30, 2012 were as follows:

Bemus Point Central Schools District
Brocton Central Schools District
Cassadaga Valley Central Schools District
Chautauqua Lake Central Schools District
Clymer Central Schools District
Dunkirk City Schools
Erie-2 BOCES
Falconer Central Schools District
Forestville Central Schools District
Fredonia Central Schools
Frewsburg Central Schools District
Jamestown Public Schools
Panama Central Schools District
Pine Valley Central Schools District
Ripley Central Schools District
Sherman Central Schools District
Silver Creek Central Schools District
Southwestern Central Schools District
Westfield Central Schools District

A. Corporate Governance

Pursuant to the municipal cooperative agreement, management of the Plan is to be vested in a governing board which comprises one representative from each participating school district, including BOCES. The governing board of the Plan as of June 30, 2012 was as follows:

Name & Residence	Affiliation
Jacqueline Latshaw Bemus Point, New York	Superintendent, Bemus Point Central Schools District
John Hertlein Brocton, New York	Superintendent, Brocton Central Schools District
Scott Smith Cassadaga, New York	Superintendent, Cassadaga Valley Central Schools District
Benjamin Spitzer Mayville, New York	Superintendent, Chautauqua Lake Central Schools District
Keith Reed Clymer, New York	Superintendent, Clymer Central Schools District

Name & Residence	Affiliation
Gary Cerne Dunkirk, New York	Superintendent, Dunkirk City Schools
Robert Guiffreda Fredonia, New York	Superintendent, Erie 2 BOCES
Stephen Penhollow Falconer, New York	Superintendent, Falconer Central Schools District
John O'Connor Forestville, New York	Superintendent, Forestville Central Schools District
Paul DiFonzo Fredonia, New York	Superintendent, Fredonia Central Schools District
Danielle O'Connor Frewsburg, New York	Superintendent, Frewsburg Central Schools District
Daniel Kathman Jamestown, New York	Superintendent, Jamestown Public Schools
Bert Lictus Panama, New York	Superintendent, Panama Central Schools District
Peter Morgante South Dayton, New York	Superintendent, Pine Valley Central Schools District
Karen Krause Ripley, New York	Superintendent, Ripley Central Schools District
Thomas Schmidt Sherman, New York	Superintendent, Sherman Central Schools District
David Kurzawa Silver Creek, New York	Superintendent, Silver Creek Central Schools District
Daniel George Jamestown, New York	Superintendent, Southwestern Central Schools District
Margaret Sauer Westfield, New York	Superintendent, Westfield Central Schools District

According to its municipal cooperative agreement, the governing board of the Plan is to meet (quarterly) in the months of October, January, April and July, at a site within the geographic area served by the Erie 2 Board of Cooperative Educational Services.

The minutes of all meetings of the governing board were reviewed. All such meetings were generally well attended. However, it was noted that of the twenty-one (21) meetings held during the period under examination, three members of the governing board failed to attend at least one-half of the meetings, they were eligible to attend.

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 decisions may be reached by the board.

It is recommended that board members who are unable or unwilling to attend meetings consistently resign or be replaced.

The principal officers of the Plan as of June 30, 2012 were as follows:

Officer	Title
Marlene Pryzbycien	Chairperson
Brent Agett	Vice Chairperson
Charity Mucha	Chief Financial Officer
Deanna Schettine	Secretary

The board of governors has designated Damon & Morey LLP as Attorney-in-Fact, who is authorized to receive service on a summons or other legal paper in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Plan.

Medical coverage is provided to covered employees, retirees and their eligible dependents through self-insurance administered by a third party administrator, in accordance with the Plan's summary plan description and as defined in the plan booklet.

Article 5-G of the New York General Municipal Law authorizes municipal corporations to enter into a Municipal Cooperation Agreement for the performance of those functions or activities in which they could engage individually.

Article 47 of the New York Insurance Law specifically permits the establishment of municipal cooperative health benefit plans. Such plans are required, pursuant to Section 4705 of the New York Insurance Law, to be established and maintained under a Municipal Cooperative Agreement. The Municipal Cooperative Agreement and any amendment thereto shall be approved by each participating municipal cooperative by majority vote of each such cooperative's governing body.

During the examination period, it was determined that the Plan charged a 0.5% interest penalty for payments deposited after the 15th of every month (regardless of what day the 15th falls on e.g. Saturday, Sunday or Holiday). A review of the Municipal Cooperative Agreement revealed that there was no such provision within the Agreement stipulating the assessment of interest penalties related to the late payment of premiums.

It is recommended that, if it is the intention of the Plan to continue to charge interest relative to late premium payments, that the Plan amends its Municipal Cooperative Agreement to reflect such interest payment provision.

Sections 4709 (a)&(b) of the New York Insurance Law state in part:

> "(a) The governing board of the municipal cooperative health benefit plan shall deliver or cause to deliver the plan document to all participating municipal corporations and to unions which are the exclusive collective bargaining representatives of employees covered by the plan and the summary plan description to every employee or retiree of participating municipal corporations covered by the plan..."
>
> "(b) The summary plan description shall be subject to regulation as if it were a health insurance subscriber certificate, provided that the superintendent may modify or suspend any provisions of this chapter or regulation promulgated thereunder pertaining to scope or type of coverage, if the superintendent determines…"

A review of CCSDMHP's Summary Plan Description ("Benefits Summary") revealed that CCSDMHP failed to include in its Benefits Summary the fact that its provider network does not exist in all geographic areas where the Plan's POS product is marketed.

It is recommended that the Plan amend its Summary Plan Description to disclose the fact that the Plan's provider network does not exist in all geographic areas where the Plan's POS product is marketed.

A similar recommendation was included in the Department's prior report on examination.

A review of the Plan's corporate governance structure revealed that the Plan's governing board did not adopt written guidelines that define the duties and responsibilities of the position of the Plan's treasurer.

It is recommended that as a prudent business practice, the Plan's governing board adopt written procedures that define the duties and responsibilities of the Plan's treasurer.

A review of the governing board's meeting minutes revealed that, in October 2008, Express Scripts Inc. (Third Party Administrator for Pharmacy Claims) experienced a security breach in its computer system. The system breach, which resulted in the compromising and inadequate protection of sensitive clients' information, affected approximately 1,500 members of Chautauqua County School Districts' Medical Health Plan. Express Scripts, Inc. provided the required notices of such breach to the New York Attorney General's office and to the affected Chautauqua policyholders.

A. Territory and Plan of Operation

The Plan provides health benefits in New York's Chautauqua County. The Plan provides its members with medical and hospital coverage, prescription drug coverage and vision benefits. The Plan reported annual written premiums of $49,108,912 as of June 30, 2012. The Plan's membership as of June 30, 2012 was 3,708 members.

Below is a summary of the Plan's annual premium writings and corresponding member enrollment for the period covering this examination:

Year	2007	2008	2009	2010	2011	2012
Premiums Written	$35,507,635	$36,926,203	$39,673,713	$44,081,933	$47,011,286	$49,108,912
Increase/ (Decrease)		$1,418,568	$2,747,510	$4,408,220	$2,929,363	$2,097,626
% Change		4.%	7.%	10.%	6.6%	4.5%

Year	2007	2008	2009	2010	2011	2012
Enrollment	4,147	4,069	4,100	4,052	3,904	3,708
% Change		-1.9%	0.76%	-1.2%	-3.7%	-5.02%

The Plan's written premium increased $13,601,277 or 38.3% between the period 2007 and 2012. Such increase was attributable to annual rate increases during the examination period. Conversely, member enrollment in the Plan decreased by a total of 439 members or 10.6%, between 2007 and 2012, due to consolidation of some job positions within the Plan's participating school districts and some vacant positions not being replaced.

C. Administrative Service Agreements

The following is a listing and description of the Plan's administrative and third party agreements effective as of June 30, 2012:

(i) HealthNow New York Inc, d/b/a Blue Cross and Blue Shield of Western New York ("HealthNow")

- Preparation and distribution of identification cards.
- Maintenance of appropriate records of each Plan participant.
- Preparation and distribution of enrollment forms and benefit claim forms.
- Access to HealthNow's network of participating providers.
- Notification to the Plan's claimant of denials, the basis for the denials and the claimant's right to appeal the denials.
- Utilization review services.

(ii) Veracity Benefit Designs, Inc. ("VBD")

- Update the Summary Plan Document ("SPD").
- Provide local health care trends to the Plan's governing board.
- Monitor plan administration to ensure claims are paid in accordance with the Summary Plan Description.
- Provide services that include filing Quarterly and Annual statements, corresponding with the Department and facilitating external audits.
- Develop benefit plan announcements, prepare plan packets consisting of plan details and enrollment applications, claim forms, claim filing instructions and contact information.
- Provide access to benefit counselors to resolve claim and coverage issues and assist in the grievance and appeal procedure.

(iii) Express Scripts, Inc. ("ESI") and Express Scripts Senior Care, Inc.

- Pharmacy benefits/administrative services.
- Rebate and reporting services to Medicare D plans.
- Pharmacy network contracting, claims processing services for covered drugs, perform standard concurrent utilization review analysis and formulary management services.
- Provide first level review of written requests for appeal from members or participating pharmacies that consist of ministerial verification that claim(s) were processed in accordance with the Plan's benefits package/member eligibility.

(iv) Vision Service Plan, Inc. ("VSP")

- Enrollment of eligible enrollees and provide the Plan with vision care brochures that summarize the terms and conditions of the vision plan.
- Provide access to its network of member doctors defined as an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care that have contracted with VSP.
- Furnish benefit authorization prior to the covered person obtaining plan benefits from a member doctor.
- Provide utilization review services to the Plan relative to such vision benefits.

(v) The Guardian Life Insurance Company of America ("Guardian")

- Assist in the design of the Plan's dental benefit structure.
- Provide eligibility determinations for program benefit, process claims, provide access to network providers, and perform utilization review services.

- Furnish the Plan with benefit booklets, enrollment cards, claim forms, and other supplies for the administration of the dental benefit plan.

(vi) Milliman, Inc. ("Milliman")

- Provide annual actuarial certification of compliance regarding the Plan's premium rating, claims reserve process and stop-loss requirement, as required by New York Insurance Law Article 47.

(vii) Damon & Morey Attorneys at Law, LLP

- Provide legal services to the Plan.

(viii) Bahgat & Laurito-Bahgat, P.C.:

- Provide financial attestation and audit services to the Plan.

D. Stop-Loss Coverage

As of June 30, 2012, the Plan maintained the following stop-loss coverage with Sun Life Insurance and Annuity Company of New York:

Specific Benefit Coverage

Specific benefit deductible	Maximum of $300,000, per covered member.
Covered benefits	Medical including prescription drugs.
Reimbursement percentage	100% of eligible expenses.
Aggregating specific deductible	$115,000 January 1, 2012 to December 31, 2012.

Aggregate Excess Stop-Loss Coverage

Excess of loss - lifetime maximum	100% of $1,000,000 excess of $300,000.

During the examination period, the Plan maintained both specific excess stop-loss coverage and aggregate excess stop-loss coverage as required by Section 4707 of the

New York Insurance Law. The assuming companies which issued the stop-loss coverage during the examination period were authorized to do business in New York. Prior to June 30, 2012, the Plan maintained stop-loss coverage with three other insurance companies which were also authorized to do business in New York.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and net worth as of June 30, 2012, as contained in the Plan's 2012 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in its June 30, 2012 filed annual statement.

As noted previously in this report, the firm of Bahgat & Laurito-Bahgat, CPAs, P.C. was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of June 30th for fiscal years 2006 through 2008 and the firm of Buffamante, Whipple, Buffafaro, P.C. was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of June 30th for fiscal years 2009 through 2011 in the examination period, and the related statutory-basis statements of operations, capital and net worth, and cash flows for the year then ended.

Bahgat & Laurito-Bahgat, CPAs, P.C. and Buffamante, Whipple, Buffaro, P.C. concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan for each firm's respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets	Examination	Plan
Cash and cash equivalents	$23,765,230	$23,765,230
Prepaid claims	111,000	111,000
Total assets	$23,876,230	$23,876,230
Liabilities		
Claims payable	$ 8,070,357	$ 8,070,357
Claims payable Unearned premiums	1,138,708	1,138,708
Total liabilities	$ 9,209,065	$ 9,209,065
Net worth		
Contingency reserves	$ 2,455,446	$ 2,455,446
Retained earnings/Fund balance	12,211,719	12,211,719
Total net worth	$14,667,165	$14,667,165
Total liabilities and net worth	$23,876,230	$23,876,230

B. Statement of Revenue and Expenses and Net Worth

Net worth increased $8,951,940 during the examination period, July 1, 2006 through June 30, 2012, detailed as follows:

Revenue		
Premiums	$ 252,309,682	
Investment income	1,931,392	
Aggregate write-ins for other revenue	3,108,483	
Total revenues		$ 257,349,557
Expenses		
Hospital and medical claims	$ 152,229,370	
Drug claims	67,562,382	
Vision & dental claims	11,782,513	
Net claims incurred	$ 231,574,265	
Administrative expenses	16,823,352	
Total expenses		248,397,617
Net income		$ 8,951,940

	Gains in Net Worth	Losses in Net Worth	
Net worth, per report on examination, as of June 30, 2006			$ 5,715,230
Net income	$ 8,951,940		
Net increase in net worth			$ 8,951,940
Net worth, per report on examination, as of June 30, 2012			$14,667,170

Footnote: The Plan's reported net worth in the amount of $14,667,165 as of June 30, 2012, is $5 less than the Plan's net worth of $14,667,170, as per the report on examination as of June 30, 2012. The difference is due to rounding.

4. CLAIMS PAYABLE

The examination liability of $8,070,357 is the same as the amount reported by the Plan in its filed annual statement as of June 30, 2012.

The examination analysis of the claims unpaid reserve 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 during the examination. The examination reserve was based upon actual 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.

The Plan's liability for claims unpaid was established in compliance with Section 4706(a)(1) of the New York Insurance Law. The Plan received approval from the Department to reduce the required minimum amount of unpaid claims reserve from 25% to 17% of total incurred claims expenses, starting with the quarter ending December 31, 2011.

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 subscribers 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 areas:

(A) Claims processing
(B) Claim forms review
(C) Utilization review
(D) Rating
(E) Grievances

A. Claims Processing

Claims attribute review

A review of claims adjudicated by the Plan was performed by using a statistical sampling methodology covering claims processed during the period July 1, 2011 through

June 30, 2012, in order to evaluate the overall accuracy and compliance of the Plan's claims processing environment.

A statistical random sampling process was performed using ACL for Windows© an auditing software program. The sampling methodology was devised to test various attributes deemed necessary for the proper processing of claims and to reach conclusions about all predetermined attributes, individually or on a combined basis. The review incorporated processing attributes used by the Plan in its own quality analysis of claims processing. The sample size was 50 randomly selected claims. These claims were processed by the Plan's TPA, HealthNow New York, Inc. d/b/a Blue Cross/Blue Shield of Western New York ("HealthNow"); an entity licensed pursuant to Article 43 of the New York Insurance Law.

The examiner's review of the fifty (50) claims indicated no problem areas.

Claims prompt payment review

A review to test for compliance with Section 3224-a of the New York Insurance Law ("Prompt Pay Law") was performed by using a statistical sampling methodology covering claims submitted to the Plan during the period July 1, 2011 through June 30, 2012.

The review of the Plan's submitted medical and hospital claims for the period, July 1, 2011 through June 30, 2012 relative to compliance with Section 3224-a of the New York Insurance Law, noted the following.

There were no Section 3224a(a) of the New York Insurance Law violations noted from the review.

Potential violations of Section 3224-a(b) of the New York Insurance Law were reviewed through the isolation of all claims that took more than 30 days to deny a claim or request additional information regarding a claim. The result of the examiner's analysis revealed a population of 5,594 possible violations. A sample of 167 claims was extracted from the population and reviewed. Of this sample, there were 45 confirmed violations.

Summary of Violations of Section 3224-a(b) of the New York Insurance Law

Total claim population	133,962
Population of claims adjudicated after 30 days of receipt	5,594
Sample size	167
Number of claims with violations	45
Calculated violation rate	27%
Calculated claims in violation	1,510

It is recommended that the Plan take steps to ensure compliance with Section 3224-a(b) of the New York Insurance Law.

B. Claim Form Review

Parts 86.4(a) and (b) of Insurance Regulation No. 95 (11 NYCRR 86.4) state in part;

> "(a) Except with respect to automobile insurance, all claim forms for insurance, and all applications for commercial insurance and accident and health insurance provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State shall contain the following…
>
> "(b) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals to the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation..."

A review of the Plan's pharmacy claim forms distributed by Express Scripts, Inc. (third party administrator for pharmacy claims) revealed that said forms did not contain the language required by Insurance Regulation No. 95 (11 NYCRR 86.4), as indicated above.

It is recommended that the Plan amend its pharmacy claim forms to comply with the requirements of Sections 4(a) and (b) of Insurance Regulation No. 95.

C. Utilization Review (UR)

During the examination period, the Plan contracted with HealthNow New York, Inc. d/b/a Blue Cross/Blue Shield of Western New York (a third-party administrator) as its utilization review agent. It should be noted that HealthNow used the utilization review program developed by the Plan.

Section 4901(a) of the New York Insurance Law states:

> "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 subsection (b) of this section."

The examiner ascertained that the Plan's existing utilization review program from 2010 was embedded into the Summary Plan Description, which was submitted to the Department on October 13, 2010 and thereafter approved by the Department on October 26, 2010. Although the Utilization Review Plan was filed as an ancillary document inside the Plan Summary Description, it was not appropriately filed for review pursuant to Section 4901(a) of the New York Insurance Law.

It was also noted that in CCSDMHP's subsequent filing of an amended Plan Summary Description, which was approved by the Department effective April 16, 2012, the filing again contained CCSDMHP's Utilization Review Plan.

It is recommended that the Plan file its Utilization Review Plan on a separate, stand-alone basis, to comply with the requirements of Section 4901(a) of the New York Insurance Law.

A similar recommendation was included within the prior report on examination.

Section 4916(b) of New York Insurance Law states in part:

> "Each health care plan and external appeal agent shall annually, in such form as the superintendent shall require report the number of external appeals requested by insured and the outcome of any such external appeals…"

It was determined that during the examination period the Plan had one (1) case that went to an external appeal. It was further determined that the Plan failed to report to the Department the number of external appeals requested by its members and the outcomes of any such external appeals.

It is recommended that the Plan comply with Section 4916(b) of the New York Insurance Law and annually report the number of external appeals requested by its members and the outcomes of any such external appeals to the Department.

D. Rating

Premium rates are developed by the Plan based on the collective review of its past claims experience and projections of the Plan's future financial performance. Such premium rates are established and approved by the governing board prior to the Plan's fiscal year end. By law, the rates must be community rated.

Section 4705(d)(5)(B) of the New York Insurance Law states in part the following:

> "The governing board shall establish premium equivalent rates for participating municipal co-operatives on the basis of a community rating methodology filed with and approved by the superintendent…"

When requested, CCSDMHP failed to provide the examiner with a copy of the rating methodology that was to be filed as required in accordance with Section 4705(d)(5)(B) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law by submitting a rating methodology for approval by the Superintendent, prior to implementing such rates.

E. Grievances

Section 4802(n) of the New York Insurance Law states the following:

> "(n) An insurer shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the insured's acknowledgement of the grievance, if any; the determination made by the insurer including the date of the determination, and the titles and, in the case of a clinical determination, the credentials of the insurer's personnel who reviewed the grievance. If an insured files an appeal of the grievance, the file shall include the date and a copy of the insured's appeal, the determination made by the insurer including the date of the determination, and the titles and, in the case of clinical determinations, the credentials of the insurer's personnel who reviewed the appeal."

A review of the Plan's grievance procedures as administered by Express Scripts Inc. as a third party administrator revealed that CCSDMHP failed to maintain (1) a file on each grievance and associated appeal, if any, and (2) a record of the date in which each grievance was filed in accordance with the above section of the Insurance Law.

It is recommended that the Plan comply with the requirements of Section 4802(n) of the New York Insurance Law by ensuring that the Plan maintains a grievance file in accordance with the aforementioned Section of the Insurance Law.

It is also recommended that the Plan monitors the activities of Express Scripts, Inc. and ensure that the third party administrator is properly adhering to the grievance procedures mandated by Section 4802(n) of the New York Insurance Law.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included six (6) recommendations detailed as follows (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Reinsurance	
1.	It is recommended that the Plan submit a request for waiver of maintenance of aggregate stop loss reinsurance coverage to this Department or maintain such aggregate stop loss reinsurance coverage in accordance with Section 4707 (a)(1) & (2) of the New York Insurance Law.	10
	The Plan has complied with this recommendation.	
	Market Conduct	
2.	It is recommended that the Plan process all clean claims and all claims services lines which are not in dispute within 45 days	15
	The Plan has complied with this recommendation.	
3.	It is recommended that, if it is the intention of the Plan to continue to have BCBSWNY adjust claims on the Plan's behalf, that those employees, who perform claim adjusting services on behalf of the Plan, be licensed as independent adjusters in accordance with Sections 2102 (a)(1) and 2108(a)(3) of the New York Insurance Law.	17
	The Plan has complied with this recommendation.	

ITEM NO. **PAGE NO.**

Policy Forms and Benefits

4. It is recommended that the Plan obtain New York State Insurance Department approval prior to offering any new products including any amended policy forms or riders in accordance with Section 4709(b) of the New York Insurance Law. 17

The Plan has complied with this recommendation.

5. It is recommended the Plan amend its' Summary Plan Description to disclose the fact that the Plan's provider network does not exist in all geographic areas where the Plan's POS product is marketed. 18

The Plan did not comply with this recommendation. A similar recommendation is included within this report on examination.

Utilization Review

6. It is recommended that the Plan file its utilization review procedures with the New York State Insurance Department in accordance with Section 4704(a)(8) of the New York Insurance Law. 18

The Plan did not comply with this recommendation. A similar recommendation is included within this report on examination.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____

Charles J. McBurnie
Insurance Examiner

STATE OF NEW YORK)
) SS:
)
COUNTY OF NEW YORK)

Charles J. McBurnie, being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____/S/_____

Charles J. McBurnie

Subscribed and sworn to before me
This _____ day of _____2014

Appointment No. **30705**

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:

Charles McBurnie

as a proper person to examine into the affairs of the

Chautauqua County School Districts' Medical Health 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 he shall deem requisite.

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

This 14th day of April, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR