

REPORT ON EXAMINATION
OF THE
ROCHESTER AREA HEALTH MAINTENANCE ORGANIZATION, INC.
AS OF
DECEMBER 31, 2000

DATE OF REPORT

OCTOBER 9, 2002

EXAMINER

JOSEPH S. KRUG

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

October 9, 2002

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

Sir:

Pursuant to the instructions contained in Appointment Number 21728, dated April 10, 2001, attached hereto, I have made an examination into the condition and affairs of the Rochester Area Health Maintenance Organization, Inc., a not-for-profit corporation, as of December 31, 2000 and submit the following report thereon.

The examination was conducted at the HMO's home office located at 259 Monroe Avenue, Rochester, New York 14607.

Where the term, "HMO" appears herein without qualification, it should be understood to indicate the Rochester Area Health Maintenance Organization, Inc.

As of December 31, 2000, the HMO's contingency reserve, as required by Part 98-1.11(d) of the Health Department Rules and Regulations (10 NYCRR 98), in the amount of \$20,039,572 was impaired by \$10,873,755. The HMO filed a Plan of Restoration with this Department dated February 17, 2001. This Plan of Restoration was approved by this Department. As of December 31, 2001, the HMO reported unimpaired net worth of \$26,02,498, however these numbers have not been examined.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1995. This examination covers the five-year period from January 1, 1996 through December 31, 2000. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2000, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

- History of HMO
- Management and control
- Corporate records
- Fidelity bonds and other insurance
- Employee welfare and pension plans
- Territory and plan of operation
- Market conduct activities
- Growth of HMO
- Business in force
- Reinsurance
- Accounts and records

A review was also made to ascertain what action was taken by the HMO with regard to comments and recommendations 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. DESCRIPTION OF COMPANY

Rochester Area Health Maintenance Organization, Inc., doing business as Preferred Care, provides prepaid comprehensive health care coverage for its enrolled members. The HMO was incorporated in New York State as a not-for-profit corporation on August 18, 1977. On October 18, 1979, the HMO became federally qualified as a health maintenance organization under Title XIII of the Public Health Service Act. Effective November 1, 1979, the HMO received authority to conduct business pursuant to Article 44 of the New York State Public Health Law.

The HMO is a subsidiary of Preferred Care, Inc., a not-for profit corporation, and is controlled through a common boards of directors. At December 31, 2000, the sole member of the HMO was Preferred Care, Inc.

A. Management

Pursuant to the HMO's charter and by-laws, management of the HMO is vested in a board of directors consisting of not less than three members. As of the examination date, the board of directors was comprised of fifteen (15) members. The board meets at such times as fixed by the board of directors or at special meetings as may be called by the Chairperson or by any two of the board members.

At December 31, 2000, the HMO's board of directors was as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Rivka Chatman Pittsford, NY	Director, Continental Dental Assistant School
Michael Copeland Rochester, NY	Manager, Industrial Relations, Alstom Signaling, Inc.
Anthony J. Costanza Rochester, NY	Retired

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Joseph DePaolis Rochester, NY	Vice President, Business Development, DeCarolis Truck Rental
Michael C. Dwyer, Esq. Rochester, NY	Attorney, Underberg and Kessler
Julian Gordon Rochester, NY	Retired
Robert Oppenheimer, Esq. Pittsford, NY	Attorney, Chamberlain, D' Amanda, Oppenheimer and Greenfield
Michael, Pichichero, MD Rochester, NY	Physician, Elmwood Pediatric Group
Michael Schneider, MD Rochester, NY	Physician, Olsan Medical Group
Wilfred J. Schrouder Penn Yan, NY	Vice President, Human Resource Services, Rochester Gas and Electric
Tammi Shlotzhauer, MD Rochester, NY	Physician, Rheumatology Associates of Rochester
Derek tenHoopen, MD Pittsford, NY	Physician, West Ridge Ob/Gyn
James Tobin, MD Rochester, NY	Associate Medical Director, ViaHealth Managed Care Services
John Urban Rochester, NY	President, Rochester Area Health Maintenance Organization, Inc.

The minutes of all of the Board of Directors' meetings and committees thereof held during the examination period were reviewed. The review indicated that all meetings were well attended.

At December 31, 2000, the non-salaried corporate officer of the HMO was as follows:

<u>Title</u>	<u>Name</u>
Secretary	Robert Oppenheimer

The HMO's principal salaried officers as of December 31, 2000 were as follows:

<u>Title</u>	<u>Name</u>
Chairperson	Michael Dwyer
Vice Chairperson	Rivka Chatman
President	John Urban
Chief Financial Officer/Treasurer	Thomas Combs
Vice President	Norene Burdine
Medical Director	Preston. Strosnider, M.D.
Vice President	Lynette Loomis
Vice President	Kathleen Dahl

B. Territory and Plan of Operation

At December 31, 2000, the HMO, pursuant to a Certificate of Authority issued by the New York Department of Health, was authorized to conduct operations in the following counties of New York:

Livingston	Monroe	Ontario
Seneca	Wayne	Yates
Genesee	Orleans	Wyoming

The HMO conducts business only in New York State with reported premium revenue of \$400,791,434 in 2000. The HMO did not use the services of independent agents or brokers during the examination period. The HMO did not maintain any branch offices at December 31, 2000.

Risk Transfer

Effective January 1,1999, the HMO entered into risk arrangements with two Independent Practice Associations (IPAs) for physician services to RAHMO members.

Greater Rochester Independent Practice Association, Inc., (GRIPA) and “RCIPA IPA No. 1” were compensated for their services on a global basis using a percentage of premium calculation adjusted for the age/sex mix of their members. Under the terms of the agreement, the IPAs were at risk for the cost of hospital inpatient, outpatient, and specialty physicians services, with the exception of agreed upon carveouts. The risk arrangement with GRIPA continued in 2000 and covered 26% of the HMO’s membership.

In January 2000, Preferred Care, Inc. purchased 100% of the issued and outstanding stock of RCIPA IPA No.1, Inc., and subsequently renamed it Genesee Region Preferred Health Network, Inc., (PHN). PHN provides physician services to RAHMO members via its contracts with a network of medical providers located throughout Monroe and surrounding counties. PHN is compensated by the HMO for its services on a percentage of premium basis adjusted for the age/sex mix of its membership. Such compensation is recorded as claims expense on RAHMO. RAHMO has an agreement with PHN to process the IPA medical expenses, both hospital and physician, for which PHN is at risk for. PHN’s risk is limited to the provider withhold pool. Claims exceeding the recorded PHN compensation, and not recoverable via retention of the withhold, are absorbed by the HMO and recorded as additional claims expense. Such losses amounted to \$15,401,306 in 2000. PHN served approximately 61% of the HMO’s membership in 2000.

The HMO also contracts with hospitals and other providers in its operating area for inpatient, outpatient, and other services. Rates for inpatient services (excluding Medicare and Medicaid) are negotiated with each hospital. Medicare inpatient services are reimbursed based on rates developed under the Prospective Payment System issued by the Health Care Financing Administration. Medicaid inpatient services are reimbursed based on rates established by the State of New York in accordance with the Health Care Reform Act of 1997. Medicare and Medicaid inpatient, hospital outpatient and ancillary service payments are based on contractual arrangements with hospitals and

other providers, which include risk-sharing arrangements, as well as fee-for service arrangements.

Enrollment

The HMO's combined enrollment decreased from 164,553 at December 31, 1995, the date of the previous examination to 163,923 at December 31, 2000. This decrease amounts to approximately 0.3% during the examination period. In 2001, combined enrollment decreased to 154,769, representing a decrease of 5.6% since December 31, 2000.

C. Reinsurance

Following is a description of the HMO's ceded reinsurance program in effect at December 31, 2000:

<u>Lines of Business Covered</u>	<u>Type of Cession</u>	<u>Limits</u>
<u>Commercial & Medicare</u>		
Eligible hospital services (authorized reinsurer)	Excess of Loss	<p>90% excess of \$100,000 of loss per member, per contract year if paid at a "Fixed Fee" or at any other hospital located in the State of New York</p> <p>80% excess of \$100,000 of loss per member, per contract year if not paid at a "Fixed Fee" or at any other hospital located outside the State of New York</p> <p>50% excess of \$100,000 of loss per member, per contract year if non-emergency admissions into the following Pennsylvania Hospitals:</p> <ul style="list-style-type: none"> ▪ Presbyterian Medical Center in Pittsburgh, PA ▪ Hospital and Medical Center of University of PA in Philadelphia, PA ▪ Thomas Jefferson Hospital in Philadelphia, PA

<u>Lines of Business Covered</u>	<u>Type of Cession</u>	<u>Limits</u>
Eligible hospital services related to organ and bone marrow transplant or peripheral stem cell transplant(s) for the period of confinement in which the transplant occurs (authorized reinsurer)	Excess of Loss	90% excess of \$100,000 of loss per member, per contract year if paid at an Approved LifeTrac Transplant Rate 80% excess of \$100,000 of loss per member, per contract year if paid at an Approved Non-LifeTrac Transplant Rate
<u>Commercial & Medicare</u>		50% excess of \$100,000 of loss per member, per contract year if paid at other than above 50% excess of \$100,000 of loss per member, per contract year if related to retransplantation of same tissue type performed within one year of the date of the initial transplant
Emergency Out of Area Services (authorized reinsurer)	Excess of Loss	80% excess of \$100,000 of loss per member, per contract year

The maximum lifetime reinsurance indemnity payable under this agreement for eligible hospital services for each member is \$2,000,000. The monthly premium for the above reinsurance coverage is \$0.74 per commercial member and \$1.60 per Medicare member.

The reinsurer will continue Plan Benefits for Members from the date of Plan Insolvency through the contract period after Plan insolvency for which premium had been paid to the Plan, but for not more than 60 days, if such premium is paid prior to the date of Plan Insolvency.

The HMO also maintains New York State Stop-Loss Reinsurance for Medicaid individual enrollees. Under the terms of the agreement, New York State will reimburse

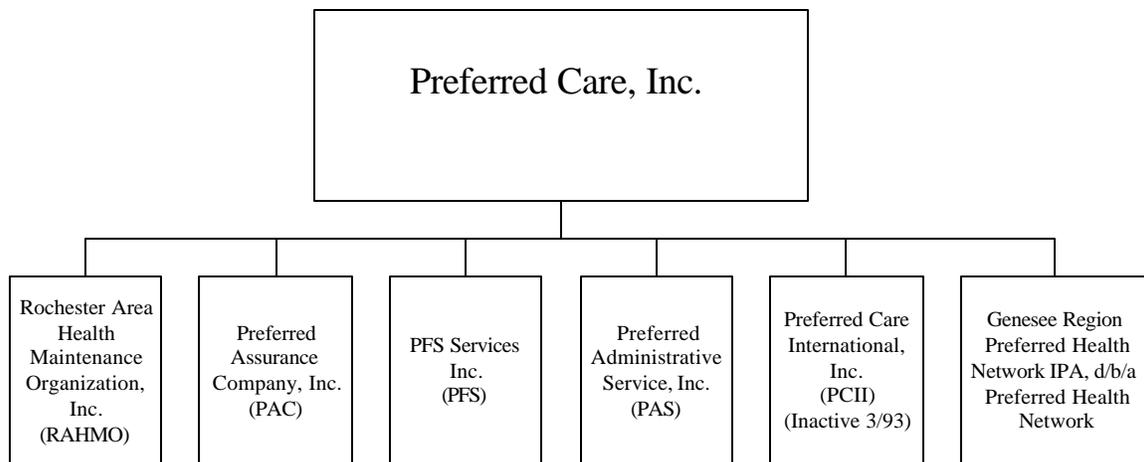
the HMO a portion of the costs incurred for inpatient hospital services calculated at Medicaid rates in excess of \$50,000 subject to co-insurance. New York State assumes full-risk for costs in excess of \$250,000.

D. Holding Company System

The HMO is controlled by its sole member, Preferred Care, Inc. and accordingly, is subject to the holding company report filing requirements of Part 98-1.16(e) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1). During the examination period, the HMO failed to make any of the required holding company filings.

It is recommended that the HMO make the appropriate holding company filings required under Part 98.16-1(e) of the Administrative Rules and Regulations of the New York Health Department. (10 NYCRR 98-1).

Preferred Care, Inc. (PC, Inc.), formerly known as Preferred Holding Company, Inc. is the ultimate holding company in the holding company organization. Preferred Care Holding Company, Inc. was formed in 1996 pursuant to Section 402 of the New York Not-For-Profit Corporation Law for the purpose of acting as a holding company and promoting and improving the delivery of health services in the community. The following chart depicts the HMO and its relationship to affiliates, as of December 31, 2000:



As indicated in the organizational chart, Preferred Care, Inc. controls the HMO and the following entities described below:

Preferred Assurance Company, Inc.

Preferred Assurance Company, Inc. (PAC) is licensed to do business within New York State as a non-profit health corporation pursuant to the provisions of Article 43 of the New York Insurance Law.

At December 31, 2000, the HMO had made Section 1307 loans to PAC in the aggregate amount of \$7,998,461.

Preferred Financial Services, Inc.

Preferred Financial Services, Inc. (PFS) is a for profit corporation which operates as an insurance agency/broker. PFS offers life, disability and 401K administrative services to groups and individuals.

Preferred Administrative Services, Inc.

Preferred Administrative Services, Inc. (PAS) is a for profit corporation which provides management and information services related to health services to outside parties. PAS also provides administrative claims services as a third party administrator to self insured groups.

Preferred Care International, Inc.

Preferred Care International, Inc. (PCI) is a for profit corporation which was established in order to develop a Canadian subsidiary, Preferred Care, Inc. of Canada (Soins Privileges). Preferred Care Inc. of Canada was established to provide consulting and management services to Canadian managed care organizations. In 1993, Preferred Care, Inc. of Canada ceased operations. Since 1993, Preferred Care International, Inc. has remained dormant.

E. Internal Controls / Disaster Recovery

The HMO does not have an internal controls section. It was noted that, at December 31, 2000, the HMO did not maintain a disaster recovery plan. A disaster recovery plan is essential to the maintenance of continuity of services to the HMO's subscribers in the event of a disaster.

It is recommended that the HMO develop and maintain a disaster recovery plan. A similar comment was contained in the prior report on examination.

F. Investments**Cash and equivalents**

The HMO reported an asset in the amount of \$39,229,041 as of December 31, 2000. It was noted that the HMO, as of the examination date, included within the aforementioned amount an investment in a money market mutual fund which exceeded the limitations of Section 1409(a) of the New York Insurance Law by \$31,077,158. No change is reported herein under Item 3, Financial Statements, because the HMO divested itself of this investment on January 11, 2002.

It is recommended that the HMO, in the future, comply with the investment requirements of Section 1409(a) of the New York Insurance Law. A similar comment was contained in the prior report on examination.

Custodial Agreement

A review of the HMO's custodial agreements for the safeguarding of securities indicated the following protective covenants and provisions were not included. The Department regards these protective covenants and provisions as indicative of prudent business practices.

1. The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the HMO 60 day

written notice of any material change in the form of amount of such insurance or termination of this coverage.

2. The bank will at all times give the securities held by the bank thereunder the same care the bank gives its own property of a similar nature.
3. The bank shall furnish the HMO (at least quarterly) with a list of such securities showing a complete description of each issue, which shall include the number of shares or par value of bonds so held at the end of each quarter.
4. The bank shall maintain records sufficient to verify information HMOs are required to report in the Annual Statement blanks of the Insurance and Health Departments of the State of New York.
5. The bank shall furnish the HMO with the appropriate affidavits in the form as may be acceptable to the bank and to the New York Insurance Department in order for the securities referred to in such affidavits to be recognized as admitted assets of the HMO.
6. Access shall be during the Bank's regular hours and specifying those persons who shall be entitled to examine on the Bank's premises securities held by the bank and bank's records regarding securities held, but only upon furnishing the bank with written instructions to that effect from any authorized officer.
7. Written instructions hereunder shall be signed by any two of the HMO's authorized officers specified in a separate list for this purpose which will be furnished to the bank from time to time signed by the treasurer or an assistant and certified under the corporate seal by the secretary or an assistant secretary.
8. In connection with any situation involving registration of securities in the name of a nominee of a bank custodian, the custodian agreement should empower the bank to take such action
9. The agreement should have a provision that would give the HMO the opportunity to secure the most recent report on the review of the custodian's system of internal control, pertaining to custodian record keeping, issued by internal or independent auditors.

It is recommended that the HMO include the enumerated protective covenants and provisions in its custodial agreements.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2000, and as reported by the HMO.

	<u>Examination</u>	<u>HMO</u>	Surplus Increase (Decrease)
<u>Assets</u>			
<u>Current Assets</u>			
Cash and cash equivalents	\$39,229,042	\$39,229,042	\$ 0
Premiums receivable	8,874,417	8,874,417	0
Investment income receivables	185,909	185,909	0
Health care receivables	584,149	584,149	0
Amounts due from affiliates	9,083,847	9,083,847	0
Provider settlement receivable	1,380,648	1,380,648	0
Provider advances	12,537,422	12,537,422	0
Miscellaneous	<u>259,350</u>	<u>259,350</u>	<u>0</u>
Total current assets	<u>\$72,134,784</u>	<u>\$72,134,784</u>	<u>\$ 0</u>
<u>Other Assets</u>			
Notes receivable	37,500	37,500	0
Investment in RHN	<u>2,017,475</u>	<u>2,017,475</u>	<u>0</u>
Total other assets	<u>\$2,054,975</u>	<u>\$2,054,975</u>	<u>\$0</u>
<u>Property and equipment</u>			
Furniture and equipment	\$431,953	\$431,953	\$ 0
Leasehold improvements	0	151,534	(151,534)
EDP equipment	<u>6,897,127</u>	<u>6,897,127</u>	<u>0</u>
Total property and equipment	<u>\$7,329,080</u>	<u>\$7,480,614</u>	<u>\$(151,534)</u>
Total assets	<u>\$81,518,839</u>	<u>\$81,670,373</u>	<u>\$(151,534)</u>

	<u>Examination</u>	<u>HMO</u>	Surplus Increase (Decrease)
<u>Liabilities and Net Worth</u>			
<u>Current liabilities</u>			
Accounts payable	\$ 6,200,617	\$ 6,200,617	\$ 0
Claims payable	34,989,654	33,139,022	(1,850,632)
Accrued medical incentive pool	438,978	438,978	0
Unearned premiums	13,273,942	13,273,942	0
Amounts due to affiliates	15,401,306	15,401,306	0
Capital lease payable	<u>480,510</u>	<u>480,510</u>	<u>0</u>
Total current liabilities	<u>\$70,785,007</u>	<u>\$68,934,375</u>	<u>\$(1,850,632)</u>
<u>Other liabilities</u>			
Capital lease payable	<u>\$1,568,015</u>	<u>\$1,568,015</u>	<u>\$ 0</u>
Total other liabilities	<u>\$1,568,015</u>	<u>\$1,568,015</u>	<u>\$ 0</u>
Total liabilities	<u>\$72,353,022</u>	<u>\$70,502,390</u>	<u>\$(1,850,632)</u>
<u>Net worth</u>			
Contingency reserve	\$20,039,572	\$20,039,572	\$ 0
Retained earnings/Fund balance	<u>(10,873,755)</u>	<u>(8,871,589)</u>	<u>(2,002,166)</u>
Total net worth	<u>\$9,165,817</u>	<u>\$11,167,983</u>	<u>\$(2,002,166)</u>
Total liabilities and net worth	<u>\$81,518,839</u>	<u>\$81,670,373</u>	

Note 1: The Balance Sheet shown above includes no provision for distributions from the Demographic and Specified Medical Conditions Pools. For Pool year 1999, the Pool administrator's calculation indicates the HMO would receive \$16,848 from the Pools based on the demographic calculation. Based on this calculation, and review by the Examiner, it appears that the HMO may receive Pool distributions in excess of the amount recorded above for pool years 1999 and 2000. However, the amount of such distributions cannot be fully determined at this time.

As of December 31, 2000, the HMO's contingency reserve, as required by Part 98-1.11(d) of the Health Department Rules and Regulations (10 NYCRR 98), in the amount of \$20,039,572 was impaired by \$10,873,755. The HMO filed a Plan of Restoration with this Department dated February 17, 2001. This Plan of Restoration was approved by this Department. As of December 31, 2001, the HMO reported unimpaired net worth of \$26,02,498, however these numbers have not been examined.

B. Statement of Revenue and Expenses

Net worth decreased \$7,727,701 during the period under examination, January 1, 1996 through December 31, 2000, detailed as follows:

Revenue

Premiums	\$1,613,989,247	
Investment income	<u>8,274,314</u>	
Total revenue		\$1,622,263,561

ExpensesMedical and Hospital

Physician services	\$ 520,925,426	
Emergency room, out-of-area	40,483,152	
Inpatient	423,177,408	
Other medical and hospital expenses	523,217,413	
Drug expense	<u>36,960,478</u>	
Subtotal		\$1,544,763,877
Less:		
Reinsurance recoveries	137,500	
Co-payments	69,604,589	
C.O.B. and subrogation	<u>28,321,512</u>	
Subtotal		<u>(98,063,601)</u>
Total medical and hospital		1,446,700,276
Total administration		<u>149,639,737</u>
Total expenses		<u>1,596,340,013</u>
Net income (loss) from operations		22,527,096
Extraordinary items		<u>(14,679,798)</u>
Net income		<u>\$7,847,299</u>

Reconciliation of Net Worth

Net worth per report on examination as of December 31, 1995			\$ 16,893,518
	<u>Increases</u>	<u>Decreases</u>	
Net income from operations	\$7,847,299		
Prepaid Health Network Contingency Reserve		<u>(15,575,000)</u>	
Net decrease in net worth			<u>(7,727,701)</u>
Net worth per report on examination as of December 31, 2000			<u>\$ 9,165,817</u>

4. LEASEHOLD IMPROVEMENTS

The examination amount of \$ 0 is \$151,534 less than the \$151,534 reported by the HMO in its December 31, 2000 annual statement.

Section 4310(h) of the New York Insurance Law requires prior approval of the Superintendent of Insurance for leasehold improvements. The HMO did not obtain approval for its leasehold improvements.

Thus, the above leasehold improvements which were not approved have been deducted as a not admitted asset in this Report on Examination.

It is recommended that the HMO not-admit its leasehold improvements, these items should be expensed as incurred.

5. CLAIMS PAYABLE

The examination liability of \$34,989,654 is \$1,850,632 greater than the \$33,139,022 reported by the HMO in its December 31, 2000 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 HMO's internal records and in its filed annual statements.

6. IMPACT OF STATUTORY ACCOUNTING PRINCIPLES

Effective January 1, 2001, the HMO is required to comply with new statutory accounting principles (SAP) established by the National Association of Insurance Commissioners (NAIC), except where modified by Department Regulation 172, to allow certain prescribed practices. These new accounting rules may result in changes in the

reported value for certain assets and liabilities. The HMO did not determine the effects of codification until the December 31, 2001 annual statement.

This examination included an analysis to determine the effect of the new accounting rules on the HMO's December 31, 2001 net worth. The analysis concluded that, had the new rules been in place as of that date, the HMO's net worth would have decreased \$6,276,355. This decrease would have been the result of the following changes:

Property and equipment	\$(4,548,786)
Leasehold improvements	(104,782)
Provider settlements receivable	(1,376,270)
Prepaid expenses	<u>(246,517)</u>
Total	<u>\$(6,276,355)</u>

Based on a limited review of the December 31, 2001 Annual Statement filed with the Department on March 28, 2002, it appears that the HMO is properly recognizing the impact of Statutory Accounting Principles in such statements. However, such Annual Statement has not been subjected to examination

7. CONCLUSION

As of December 31, 2000, the HMO's contingency reserve, as required by Part 98-1.11(d) of the Health Department Rules and Regulations (10 NYCRR 98), in the amount of \$20,039,572 was impaired by \$10,873,755. The HMO filed a Plan of Restoration with this Department dated February 17, 2001. This Plan of Restoration was approved by this Department. As of December 31, 2001, the HMO reported unimpaired net worth of \$26,02,498, however these numbers have not been examined.

8. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was directed at practices of the HMO in the following major areas:

- a). Claims processing
- b). Prompt Pay
- c). Frauds Review

a) Claims Processing

The review of claims was performed by using The Department's statistical sampling methodology in order to evaluate the overall accuracy and compliance environment of the HMO's claims processing. The review period included January 1, 2000 through December 31, 2000). The claims tested were selected from the population of claims adjudicated during the review period.

The sampling process was devised to test various claims attributes deemed necessary for financial and processing accuracy. The objective of this sampling process was to be able to test and reach conclusions about such errors relative to the population of processed claims

In order to achieve the goals of this review, claims were segregated into two primary populations:

- a) Hospital Claims
- b) Medical Claims

A random statistical sample of 167 claims was drawn from each of these two populations.

The examination of sample claims revealed that the overall claims processing procedural accuracy level was estimated at approximately 97.60%. Claims processing procedural accuracy is defined as the percentage of times a claim was processed in accordance to the HMO's claim processing guidelines. An error in processing procedural accuracy may or may not affect the financial accuracy. The overall claims processing financial accuracy level was approximately 99.10%. Claims processing financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. The accuracy level is determined by subtracting the calculated error rate from 100%.

No errors were found in the sample of 167 hospital claims. Of 167 medical claims reviewed, 8 contained one or more procedural errors. Of these 8 claims, 3 contained one or more financial errors. No trends in the type of error were noted.

The following charts illustrate the claims processing procedural accuracy and claims processing financial accuracy for medical claims as determined by this examination:

Summary of Procedural Accuracy –Medical Claims

	<u>HMO-NY Medical</u>
Claim Population	2,190,699
Sample Size	167
Number of claims with Procedural Errors	8
Calculated Error Rate	<u>4.79%</u>
Upper Error limit	8.03%
Lower Error limit	1.55%
Upper limit Claims in error	<u>175,903</u>
Lower limit Claims in error	<u>33,985</u>

Note: The Upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Summary of Financial Accuracy – Medical Claims

	<u>HMO-NY Medical</u>
Claim Population	2,190,699
Sample Size	167
Number of claims with Financial Errors	3
Calculated Error Rate	<u>1.80%</u>
Upper Error limit	3.81%
Lower Error limit	0.22%
Upper limit Claims in error	<u>84,485</u>
Lower limit Claims in error	<u>0</u>

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

b.) Prompt Pay

Claims were tested to determine the HMO's compliance with the provisions of Section 3224-a of the New York Insurance Law. This review of claims was also performed by using a statistical sampling methodology covering the review period from January 1, 2000 through December 31, 2000.

The claims tested were selected from a sub-population of claims adjudicated during the review period, representing claims that were paid 45 days or more after the date of receipt. The results were as follows:

- a) Hospital Claims – 89,645
- b) Medical Claims – 44,944

A random statistical sample of 167 claims for each of the two groups was then selected. It should be noted that for the purpose of this review, those medical costs identified as Medicare payments were excluded.

No prompt pay violations were found in the sample of 167 hospital claims.

The following summarizes the results of the Prompt Pay review for medical claims:

Summary of Prompt Pay Review – Medical Claims

	<u>HMO-NY Medical</u>
Claim Population	44,944
Sample Size	167
Number of claims with Procedural Errors	5
Calculated Error Rate	<u>2.99%</u>
Upper Error limit	5.58%
Lower Error limit	0.41%
Upper limit Claims in error	<u>2,507</u>
Lower limit Claims in error	<u>184</u>

Note: The Upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

c.) Frauds Review

As part of the examination, an on-site Frauds Review was conducted. This review indicated the following:

- 1) Section 405(a) of the New York Insurance Law states:

“Any person licensed pursuant to the provisions of this chapter, and any person engaged in the business of insurance in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent 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 and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require.”

Based upon the above review, it appears that the HMO does not always report transactions that may be fraudulent within the 30 days prescribed by Section 405(a) of the New York Insurance Law.

It is recommended that the HMO's report transactions that may be fraudulent as stated in Section 405(a) of the New York Insurance Law within 30 days.

2) Relative to the fraud prevention plan, Section 409(b)1 of the New York Insurance Law states:

“The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigation unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims functions of an insurer, and shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent. An insurer shall include in such plan staffing levels and allocations of resources in such full-time special investigations unit as may be necessary and appropriate for the proper implementation of the plan pursuant to subsection (d) of this section.”

It was determined that the Manager of the Special Investigation Unit, who is the HMO's only qualified investigator, devotes approximately 50% of her time to activities and assignments not related to fraud prevention. Section 409(b)1 of the New York Insurance Law requires full-time devotion to these activities.

It is recommended that the HMO establish a full-time special investigation unit as required by Section 409(b)(1) of the New York Insurance Law.

9. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included twenty-one recommendations detailed as follows (page number refers to the prior report on examination):

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. <u>Nominating Committee - Minutes of Meetings</u></p> <p>It was recommended that the HMO formalize all service and loan arrangements with the affiliates in question.</p> <p>The HMO has complied with this recommendation.</p>	<p>5</p>
<p>B <u>Reinsurance contracts</u></p> <p>It is recommended that the HMO include in the contract termination provisions a proviso requiring that a 60 days' prior written notice of termination be sent, to both the ceding insurer and the New York State Superintendent of Insurance and Commissioner of Health, except when the reason for termination does not permit such timely notice.</p> <p>The HMO's reinsurance contracts contain acceptable language relative to this recommendation.</p>	<p>8</p>
<p>C. <u>Administrative service and loan agreements with affiliates</u></p> <p>1. It is recommended that the HMO maintain formal administrative service and loan agreements with its affiliates and Rochester Individual Practice Association in all instances.</p> <p>The HMO has complied with this recommendation.</p> <p>2. It is recommended that the HMO comply with the provisions of its effected administrative agreements or amend said agreements in order to provide for present practices.</p> <p>The HMO has complied with this recommendation.</p>	<p>14</p> <p>14</p>

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Internal controls</u>	
1. It is recommended that the HMO develop and maintain a disaster recovery plan.	16
The HMO has not complied with this recommendation. A similar comment is repeated in this report.	16
2. It is recommended that the HMO comply with Part 243.2(b)(4) of the Codes, Rules and Regulations of the New York Insurance Department (11NYCRR 243.2(b)(4)) relative to the maintenance of its claims files.	
The HMO has complied with this recommendation.	
E. <u>Investments</u>	
1. It is recommended that the HMO's board of directors review and approve the HMO's investments and loans as required by Section 1411(a) of the New York Insurance Law.	17
The HMO has complied with this recommendation.	
2. It is recommended that the protective covenants and provisions prescribed by this Department as necessary safeguards and controls relative to a custodial agreement be included in the HMO's custodial agreement.	17
The HMO has not complied with this recommendation. A similar comment is repeated in this report.	

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Annual statement reporting</u>	
1. It is recommended that the HMO properly age all reported unpaid claims on Schedule H – Section 1 of its annual statements in compliance with the NAIC Annual Statement Instructions - HMO manual.	18
The HMO has complied with this recommendation.	
2. It is recommended that, in the future, the HMO properly complete the “Notes to Financial Statements” section relative to its filed NAIC Association Edition annual statement in accordance with the NAIC Annual Statement Instructions HMO manual.	18
The HMO has complied with this recommendation.	
G. <u>Compensation to officers</u>	
1. It is recommended that the HMO’s board of directors establish annually the compensation of HMO officers in compliance with Article II, Section 12 of its by-laws and Section 715(f) of the New York Not-For-Profit Corporation Law.	19
The HMO has complied with this recommendation.	
2. It is recommended that the HMO exclude from its bonus and employment agreement with its officers any reference to bonuses predicated on the profit of not-for-profit corporations in compliance with Section 508 of the New York Not-For-Profit Corporation Law.	20
The HMO has complied with this recommendation.	

<u>ITEM</u>	<u>PAGE NO.</u>
H. <u>Level premium rates</u>	
1. It is recommended that the HMO, pursuant to Part 52.42(b)(iii)(a) of the Codes, Rules and Regulations of the New York Insurance Department (11NYCRR (52.42(b)(iii)(a)), use an approved remitting agent agreement or level premium rider with all groups with which the HMO effects level premium rate arrangements.	20
The HMO has complied with this recommendation.	20
2. It is recommended that said remitting agent agreements and/or level premium riders be executed by all parties to said arrangements.	
The HMO has complied with this recommendation.	
I. <u>Cash and cash equivalents</u>	
It is recommended that the HMO, in the future, comply with the investment requirements of Section 1409(a) of the New York Insurance Law.	24
The HMO has not complied with this recommendation. A similar comment is repeated in this report.	
J. <u>Notes receivable</u>	
It is recommended that the HMO dispose of its loans to insolvent physician groups is an Assumption Agreement and Consent or similar arrangement with a solvent institution is not completed in an expedient manner.	26
The HMO has complied with this recommendation.	

<u>ITEM</u>	<u>PAGE NO.</u>
K. <u>Market conduct</u>	
1. It is recommended that the HMO obtain the approval of the Superintendent of Insurance for all contracts and riders prior to issuance as required by Section 4308(a) of the New York Insurance Law.	29
The HMO has complied with this recommendation.	
2. It is recommended that the HMO maintain a central log to monitor complaint activity in the format prescribed by Circular Letter No. 11 of 1978.	30
The HMO has complied with this recommendation.	
3. It is recommended that the HMO acknowledge the receipt of subscriber payable claims within the 15 day period required by Part 216.4(a) of the Codes, Rules and Regulations of the New York Insurance Department (11NYCRR 216.4(a)).	30
The HMO has complied with this recommendation.	
4. It is recommended that, with regard to unsettled claims, the HMO issue the appropriate letter to the claimant or the claimant's authorized representative as required by Part 216.6(c) of the Codes, Rules and Regulations of the New York Insurance Department (Regulation 64)	30
The HMO has complied with this recommendation.	
5. It is recommended that the HMO include within its denial notices to claimants the wording required by Part 216.6(h) of the Codes, Rules and Regulations of the New York Insurance Department (11NYCRR 216.6(h)).	30
The HMO has taken appropriate action for compliance with this recommendation.	

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. <u>Holding Company System</u> It is recommended that the HMO make the appropriate holding company filings required under Part 98.16(e) of the Administrative Rules and Regulations of the New York Health Department. (10NYCRR Part 98.16(e)).</p>	9
<p>B. <u>Internal Controls / disaster recovery</u> It is once again recommended that the HMO develop and maintain a disaster recovery plan.</p>	11
<p>C. <u>Investments</u> 1. It is once again recommended that the HMO, in the future, comply with the investment requirements of Section 1409(a) of the New York Insurance Law.</p> <p>2. It is recommended that the HMO include the enumerated protective covenants and provisions in its custodial agreements..</p>	11 12
<p>D. <u>Leasehold improvements</u> It is recommended that the HMO not-admit its leasehold improvements, these items should be expensed as incurred</p>	17
<p>E. <u>Conclusion</u> As of December 31, 2000, the HMO's contingency reserve, as required by Part 98-1.11(d) of the Health Department Rules and Regulations {10NYCRR98-1.11}, in the amount of \$20,039,572 was impaired by \$10,873,755. The HMO filed a Plan of Restoration with this Department dated February 17, 2001. This Plan of Restoration was approved by this Department. As of December 31, 2001, the HMO reported unimpaired net worth of \$26,02,498, however these numbers have not been examined.</p>	18
<p>F. <u>Frauds review</u> 1) It is recommended that the HMO's report suspicious activity as stated in Section 405(a) of the New York Insurance Law within 30 days.</p> <p>2) It is recommended that the HMO establish a full-time special investigation unit as required by Section 409(b)(1) of the New York Insurance Law.</p>	23 23

Appointment No. 21728

**STATE OF NEW YORK^{RK}
INSURANCE DEPARTMENT**

I, **GREGORY SERIO**, Acting Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Joseph Krug

as a proper person to examine into the affairs of the

ROCHESTER AREA HMO, INC.

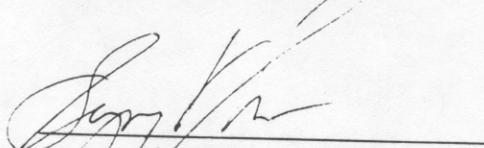
and to make a report to me in writing of the said

Company

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 10th day of April 2001



(by) Gregory Serio
Acting Superintendent

