REPORT ON EXAMINATION

OF

UNIVERA HEALTHCARE – SOUTHERN TIER, INC.

(FORMERLY KNOWN AS

NORTH AMERICAN HEALTHCARE, INC.)

AS OF

SEPTEMBER 30, 2000

DATE OF REPORT **JANUARY 15, 2002**

EXAMINER **ROBERT W. MCLAUGHLIN, CFE, CIE**

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

August 17, 2001

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

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 21434 dated July 22, 1999, attached hereto, I have made an examination into the condition and affairs of Univera Healthcare – Southern Tier, Inc. (formerly known as North American Healthcare, Inc.), as of September 30, 2000 and submit the following report thereon.

The examination was conducted at the Plan's home office located at 205 Park Club Lane, Buffalo, New York 14221.

Whenever the designations "Univera – Southern Tier or "the Plan" appear herein without qualification, they should be understood to mean Univera Healthcare – Southern Tier, Inc.

This examination determined that, as of September 30, 2000, the Plan was insolvent in the amount of $1,603,296 and the Plan's required contingency reserve of $1,748,721 was impaired by $3,352,017.

1. SCOPE OF EXAMINATION

The previous examination was conducted "post certification" as of October 31, 1995. This examination covered the period from November 1, 1995, through September 30, 2000. Where deemed appropriate, transactions subsequent to this period were also reviewed. The examination comprised a verification of assets and liabilities as of September 30, 2000, a review of the income and disbursements to the extent deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of Plan
Management and control
Corporate records
Territory and plan of operation
Loss experience
Reinsurance
Accounts and records
Growth of Plan

A systems review was also made of the Plan's computer system and processes. A separate Report on Examination as of November 17, 2000 was made relative to the findings of the systems review.

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 PLAN

The Plan, formerly known as North American Healthcare, Inc., is a for profit New York Business Corporation which was issued a certificate of authority on October 4, 1995 to operate an HMO pursuant to Article 44 of the New York State Public Health Law.

On December 30, 1999, 100% of the Plan's capital stock was purchased by The Health Care Plan, Inc. (d/b/a Univera Healthcare – WNY, Inc.). On October 2, 2000, the Plan changed its name to Univera Healthcare – Southern Tier, Inc.

A. Management

The Plan is a wholly owned subsidiary of The Health Care Plan, Inc., and, as such, is a member of the Univera Healthcare Foundation, Inc. (UHF) holding company system.

Pursuant to Article III, Section 3.1 of the Plan's by-laws, management of the Plan is vested in a board of directors. According to Article III, Section 3.2 of the by-laws, the board shall be comprised of not less than three (3) voting directors. Pursuant to the Plan's by-laws, at the annual meeting of the sole member of the Plan, the Plan's directors are elected for a term of one year. At September 30, 2000, a board consisting of five (5) directors exercised the corporate powers of the Plan.

At September 30, 2000, the Plan's board consisted of the following members as reported by the Plan in its filed September 30, 2000 quarterly statement:

Name and Residence	**Principal Business Affiliation**
Provider Representative	

Arthur R. Goshin, M.D. East Amherst, NY	President & CEO, The Health Care Plan, Inc.

Public Representatives

Bertha S. Laury Buffalo, NY	Retired
Harold Luce Frewsburg, NY	Retired
Theodore J. Scallon Syracuse, NY	Vice President, M&T Bank

Officer/Employee Representative

Frederick Yanni, Jr. Baldwinsville, NY	Chair, Board of Directors The Health Care Plan, Inc.

The minutes of all meetings of the Board of Directors and committees thereof held during the examination period were reviewed. All board meetings held during the examination period were well attended.

During the examination period, investment purchases were not acted upon or approved by the Plan's board of directors. Instead, the Plan's senior management authorized and acted upon the Plan's investments. Section 1411(a) of the New York Insurance law requires all investment purchases be authorized or approved by the Plan's board of directors.

It is recommended that the Plan comply with the investment authorization or approval requirements of Section 1411(a) of the New York Insurance Law.

The principal officers of the Plan, at September 30, 2000, were as follows:

Name	**Title**
Frederick F. Yanni, Jr.	Chair, Board of Directors
Arthur R. Goshin	President
Samuel S. Rabkin	Vice President/Secretary
Paul H. Huefner	Treasurer &CFO
Peter Rushefsky	Executive Director
Cary Vastola, D.O.	Medical Director
Gregg Broffman, M.D.	Corporate Medical Director

B. Territory and Plan of Operation

As of September 30, 2000, the Plan was licensed to operate as a health maintenance organization pursuant to the provisions of Article 44 of the New York State Public Health Law within the following counties of New York State:

Allegany	Genesee
Cattaraugus	Niagara
Chautauqua	Orleans
Chemung	Steuben
Erie	Wyoming

The Plan arranges for health care services for its managed care products through a series of contractual arrangements with group practices and preferred provider networks.

Inpatient services are provided through contractual arrangements with area hospitals. Prescription drug coverages are provided to network subscribers through an agreement with a third party administrator (TPA). Under the terms of the agreement the TPA is paid a monthly capitation for administrative services. Claims are paid on a discounted fee basis.

With regard to the Plan's point-of-service (POS) option, the subscriber may choose to use out of network providers. This option is provided through an arrangement with the Plan's parent, Univera Healthcare – WNY (U-WNY), whereby a companion contract is issued by U-WNY to provide the out-of-network coverage and Univera – Southern Tier provides the network coverage. The Plan reimburses the subscriber for covered services based upon a usual and customary fee schedule.

Risk Sharing

Withhold and Incentive Fund Arrangements .

The Plan maintained agreements with its participating physicians, which provided for specified percentage withholds of fees due these physicians. A 10% withhold applied to primary care physicians (PCPs) and a 12% withhold was applicable to specialists. At the end of each year, a settlement is made according to a formula that details performance criteria.

Year	Retained	Payout
1999	$541,290	$ 30,488
2000	595,387	0

It is noted that, as of September 30, 2000, the Plan also maintained capitation arrangements with one provider net work and two third party intermediaries. The Plan maintained a global capitation arrangement with said third party intermediaries covering all services for vision and chiropractic benefits.

Enrollment

The Plan markets its contracts to both groups and individuals. Enrollment during the period under review was as follows:

	HMO - only Membership	POS Membership	Total Membership
December 31, 1995	505	0	505
December 31, 1996	4,491	5,520	10,011
December 31, 1997	9,389	11,033	20,422
December 31, 1998	10,585	13,724	24,309
December 31, 1999	9,563	14,320	23,883
December 31, 2000	8,714	11,955	20,669

Plan membership at June 30, 2001 consisted of 18,673 members of which 18,420 were POS members and 253 were HMO-only members.

C. Reinsurance

At September 30, 2000, the Plan had the following reinsurance program in effect with an accredited reinsurer for its HMO business

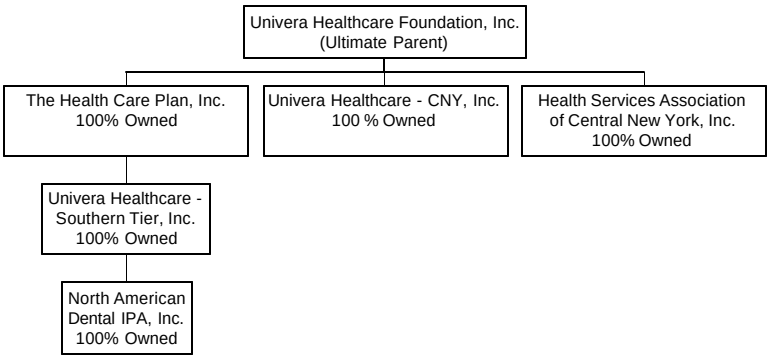
Hospital Expenses Type	Limits
Excess of loss two layers	90% of $500,000 excess of $200,000 of loss per member, per contract year 100% excess of $700,000 of loss per member, per contract year

The maximum lifetime reinsurance reimbursement payable under the contract for eligible hospital services for each member is $2,000,000. Continuation of benefits and out of area conversion benefits provisions are also included in the contracts.

All ceded reinsurance contracts effected during the examination period were reviewed. The contracts contained insolvency clauses as required by Section 1308 of the New York Insurance Law.

D. Holding Company System

The following abbreviated chart depicts the Plan and its relationship to its major affiliates as of September 30, 2000:



The Health Care Plan, Inc. (HCP)

HCP, the Plan's immediate parent, is organized pursuant to the provisions of both Article 43 of the New York Insurance Law and Article 44 of the New York State Public Health Law as a health maintenance organization.

On December 3, 1998, HCP entered into a merger agreement with the Plan, Health Services Association of Central New York, Inc. (HSA), and Univera Healthcare Foundation, Inc. (formerly HCP Foundation, Inc.). As part of the agreement, Univera Healthcare Foundation, Inc. became the ultimate parent of each of three organizations as sole corporate member of each organization.

In 2000, $1,800,000 was loaned to the Plan by its parent, HCP. The loan, approved by the Superintendent of Insurance, was granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to approval of the Superintendent of Insurance of the State of New York

Pursuant to a management agreement made between the Plan and HCP, management services relative to the operations of the Plan by HCP were provided on an actual cost allocation methodology.

North American Dental IPA, Inc.

The Plan is the sole corporate member of North American Dental IPA, Inc., a New York State not for profit independent practice association. As of September 30, 2000, North American Dental IPA, Inc. was a dormant operation.

Holding Company Filings

The Plan did not submit holding company filings to this Department for 1999 and 2000. Holding company filings are required to be made pursuant to Section 98-1.16 of the New York Health Department's Administrative Rules and Regulations (10 NYCRR 98).

It is recommended that the Plan, pursuant to Section 98-1.16 of the New York Health Department's Administrative Rules and Regulations (10 NYCRR 98), make all required Holding Company filings.

E. Underwriting Ratios

The underwriting ratios presented below are on an earned/incurred basis and encompass the period covered by this examination:

	Amounts	Ratios
Premiums earned	$129,821,808	
Medical expenses	$129,191,672	99.52%
Administrative expenses	18,234,618	14.05%

Underwriting gain (loss)	$ (17,604,482)	(13.57)%

F. Abandoned property

During the period covered by this examination, the Plan had not established procedures to comply with the provisions of Section 1315 and 1316 of the New York State Abandoned Property Law. No reports were filed by the Plan during the period under review. The Abandoned Property Law requires filings to be made to the Office of the Comptroller of the State of New York each year even if there are no checks to report.

It is recommended that the Plan comply with the reporting requirements of Section 1315 and Section 1316 of the New York State Abandoned Property Law.

G. Accounts and Records

A review if the Plan's accounts and records revealed the following:

1. Reporting inaccuracies:

A review of the Plan's Substitute Schedule H filed pursuant to Section 308(b) of the Insurance Law with the Plan's September 30, 2000 quarterly statement and the Schedule H filed with its December 31, 2000 annual statement, indicated that the Plan did not report all of the required data accurately. The Plan did not report its claims count and interest paid amounts as called for in Section 3 of Schedule H.

It is recommended that the Plan correctly complete its Schedule H in future filings with this Department

A review was made of the Plan's Schedule M as filed with the Plan's annual statement as of December 31, 1999. The data included in said schedule reflects data relative to grievances filed under Section 4408-a of the Public Health Law as well appeals filed pursuant to Article 49 of the Public Health Law.

The review encompassed an examination of the underlying support data used in compiling Schedule M. which was included in the Plan's filed December 31, 1999 annual statement. The examiner found that the Plan did not maintain detail that fully supported all data included within said schedule. Several of the amounts included in the Plan's Schedule M did not reconcile to the Plan's supporting data.

It is recommended that the Plan maintain adequate detail records to support the amounts reported in its filed Schedules M.

It was noted that the Plan included in its March 31, 2000 quarterly and subsequent statements revisions to its prior calendar year reported amounts. The revisions included the establishment of an asset for Goodwill derived from the purchase of the Plan by HCP. Goodwill is further discussed at item 4 of this Report on Examination.

The Plan failed to notify and provide this Department with formal revisions of its December 31, 1999 balance sheet which was restated in the Plan's subsequent 2000 quarterly and annual statement filings.

It is recommended that the Plan, in the future, request Department approval for any proposed changes to previously stated filings, and only make such changes when, and if, the Plan receives Department approval.

H. Records Retention Plan

At the time of examination, the Plan did not maintain a formal corporate-wide records retention plan. Part 243.3(c) of the Insurance Department Regulation 152 (11 NYCRR 243.3) states the following:

> *" An insurer shall establish and maintain a records retention plan. The plan shall include a description of the types of records being maintained, the method of retention, and the safeguards established to prevent alteration of the records…"*

It is recommended that the Plan establish and implement a formal records retention plan in compliance with the provisions of Part 243.3(c) of Department Regulation 152 (11 NYCRR 243.3).

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination, and as reported by the Plan as of September 30, 2000.

	EXAMINATION	PLAN	SURPLUS INCREASE (DECREASE)
Current assets			
Cash and cash equivalent	$ 6,422,369	$ 6,422,369	
Short-term investments	1,852,745	1,852,745	
Premiums receivable	167,431	167,431	
Aggregate write-ins for current assets	131,072	2,166,779	
Total current assets	$ 8,573,617	$ 8,573,617	$ 0
Other assets			
Goodwill	$ 0	$ 3,595,521	$(3,595,521)
Total other assets	$ 0	$ 3,595,521	$(3,595,521)
Property and equipment			
Total property and equipment	$ 0	$ 0	$ 0
Total assets	$ 8,573,617	$12,169,138	$(3,595,521)

	EXAMINATION	PLAN	SURPLUS INCREASE (DECREASE)
Current liabilities			
Accounts payable	$ 482,701	$ 482,701	
Claims payable	6,018,919	5,675,521	$(343,398)
Unearned premiums	5,503	5,503	
Amounts due to affiliates	3,669,790	3,669,790	0
Total current liabilities	$ 10,176,913	$ 9,833,515	$(343,398)
Other liabilities			
Loans and notes payable	0	$ 1,800,000	$1,800,000
Section1307 loan interest	0	45,000	45,000
Total other liabilities	0	$ 1,845,000	$1,845,000
Total liabilities	$ 10,176,913	$ 11,678,515	$1,501,602
Net Worth			
Paid in surplus	$ 1,200,000	$ 1,200,000	
Contingency reserve	1,748,721	1,439,478	$ 309,243
Unassigned funds	(4,552,017)	(2,148,856)	(2,403,161)
Total net worth	$ (1,603,296)	$ 490,622	$(2,093,918)
Total liabilities and net worth	$ 8,573,617	$ 12,169,137	

Note 1: As a result of this examination, as of September 30, 2000, the Plan was insolvent in the amount of $1,603,296. The Plan's required contingency reserve of $1,748,721 was impaired by $3,352,017 at that date. The Plan reported itself impaired in the amount of $948,857 in its September 30, 2000 quarterly statement filed with this Department.

Note 2: No liability appears on the above statement for loans principal in the amount of $1,800,000 and interest accrued thereon of $45,000. The loans were granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to approval of the Superintendent of Insurance of the State of New York

Note 3: The Internal Revenue Service has not audited the Plan. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenue and Expenses

Total net worth decreased $5,195,531 during the examination period, November 1, 1995 through September 30, 2000, detailed as follows:

Revenue

Premiums (Basic) Community rated	$113,310,550	
Premiums- (Drugs)	14,857,967	
Premiums (Other Riders)	2,915,602	
Reinsurance premiums	(1,759,328)	
Fee for service	497,017	
Investment income	0	
Other revenue	0	
Total revenue		$129,821,808

Expenses

Medical and hospital:

Physicians services	$ 38,760,145	
Other professional services	37,237,291	
Outside referrals	31,657	
Inpatient	33,138,955	
Incentive pool and withhold adjustments	0	
Other medical and hospital expenses	156,063	
Demographic pool expense (recovery)	641,986	
SMC Pool expense (recovery)	113,196	
Drug expense	17,649,074	
Emergency room, out of area	2,377,692	
Subtotal	$130,106,059	
Less: Copayments, C.O.B. and reinsurance recoveries	914,387	
Total medical and hospital expenses	$129,191,672	
Total administration expenses	18,234,618	
Total expenses		$147,426,290
Net income before taxes		$(17,604,482)
Provision for Federal income taxes		(4,541,700)
Net income		$(13,062,782)

C. Net Worth

	Increase (Decrease) in Net worth	
Net worth per examination as of October 31, 1995		$ 3,592,235
Net income	$(13,062,782)	
Paid in surplus	4,934,677	
Adjustment in ledger assets	1,132,574	
Section 1307 loans	1,800,000	
Total decrease in net worth		$(5,195,531)
Net worth per examination as of September 30, 2000		$(1,603,296)

4. GOODWILL

The examination admitted asset of $ 0 is $3,595,521 less than the $3,595,521 reported by the Plan in its filed September 30, 2000 quarterly statement.

The examination change is the result of the disallowance of the goodwill asset established by the Plan subsequent to the purchase of the Plan's capital stock by The Health Care Plan, Inc. The Plan reported goodwill under the Generally Accepted Accounting Principals (GAAP) concept of "Push Down" accounting which is recognized for GAAP reporting where entities are consolidated for reporting purposes. This is not recognized under statutory accounting where distinct reporting for insurers is required. For statutory purposes such goodwill should properly be reported on the books of the purchasing Company and therefore has been disallowed herein.

5. CLAIMS PAYABLE

The examination liability of $6,018,919 is $343,398 more than the $5,675,521 reported by the Plan in its filed September 30, 2000 quarterly statement.

The examination change reflects additional liabilities relative to a recent audit of the Plan's submissions to the New York Market Stabilization Pool for the period ending December 31, 1998, still payable by the Plan as of September 30, 2000.

6. LOANS AND NOTES PAYABLE AND SECTION 1307 LOAN INTEREST

The examination liability of $ 0 is $1,845,000 less than the $1,845,000 reported by the Plan in its filed September 30, 2000 quarterly statement relative to above items.

The Plan incorrectly reported the unpaid principal and interest balances on a Section 1307 loan received by the Plan from its parent, The Health Care Plan, Inc., in 2000. Pursuant to Section 1307 of the New York Insurance Law, repayment of principal and interest shall only be made out of free and divisible surplus, subject to approval of the Superintendent of Insurance. In addition such loan and interest thereon shall not be a part of the legal liabilities of such insurer. Therefore, no liability should be reported for either principal or interest on the loans.

7. CONTINGENCY RESERVE

The examination amount of $1,748,721 is $309,243 more than the $1,439,478 reported by the Plan in its filed September 30, 2000 quarterly statement for this item. The Plan's calculation of its escrow deposit component was incorrectly based on the Plan's prior year reported expenses.

The examination escrow deposit component of the Plan's contingency reserve was calculated on the Plan's projected hospital and medical expenses for the year 2000 as stated in its filed 1999 annual statement in accordance with Part 98-1.11(d) and (e) of the New York Department of Health Code, Rules and Regulations (10 NYCRR Part 98-1.11(d) and (e)) and this Department's Circular Letter Number 14 – 1991.

It is recommended that the Plan calculate the escrow deposit component of its contingency reserve on projected hospital and medical expenses for the following year in accordance with Part 98-1.11(d) and (e) of the New York Department of Health Codes, Rules and Regulations (10 NYCRR Part 98-1.11(d) and (e)) and this Department's Circular Letter Number 14-1991.

8. CONCLUSION

As a result of this examination, as of September 30, 2000, the Plan was insolvent in the amount of $1,603,296 and the Plan's required contingency reserve of $1,748,721 was impaired by $3,352,017 at that date.

9. SUBSEQUENT EVENTS

The Plan reported itself insolvent in the amount of $1,413,544 as of June 30, 2001. As of June 30, 2001, the Plan's required contingency reserve of $2,835,636 was impaired in the amount of $4,249,187.

On October 1, 2001, the Plan merged with Excellus Health Plan, Inc. The insolvency shown in this report was addressed by such merger.

10. MARKET CONDUCT ACTIVITIES

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

1. Sales and advertising
2. Underwriting
3. Rating
4. Claims

Underwriting

Forms and Rates

A review of the Plan's contract forms and riders in effect at the time of examination revealed that the following riders and rates had not received prior approval of the Superintendent of Insurance as required by Section 4308(a) of the New York Insurance Law as of the date of this report:

1. Basic $20-44MG-S (2001)
2. Copay-44-MG-S (2001) Copay rider $8.00
3. Copay-44-MG-S (2001) Copay rider $10.00
4. Copay-44-MG-S (2001) Copay rider $15.00
5. Hosp-44-MG-S (2001) Copay rider $0
6. Hosp-44-MG-S (2001) Copay rider $250
7. Hosp-44-MG-S (2001) Copay rider $400
8. AMSBURG –44-MG-S (2001) Ambulatory Surgery $8
9. AMSBURG –44-MG-S (2001) Ambulatory Surgery $10
10. AMSBURG –44-MG-S (2001) Ambulatory Surgery $15
11. AMSBURG –44-MG-S (2001) Ambulatory Surgery $20
12. RX$5/$10/$25 –44MG (2001)
13. RX$5/$15/$35 –44MG (2001)
14. RX$7/$15/$35 –44MG (2001)
15. RX$10/$20/50% –44MG (2001)
16. RX$10/$20/45 –44MG (2001)
17. DME-44MG-S (2001) DME 50%
18. DME-44MG-S (2001) DME 20%
19. ST-44MG-S (2001) ST 23
20. ST-44MG-S (2001) ST 25
21. OPTICAL2-44-MG-S (2001) Optical 2
22. OPTICAL3-44-MG-S (2002) Optical 3

It is recommended that the Plan adhere to the provisions of Section 4308(a) of the New York Insurance Law, and refrain from issuing any contracts or riders unless such contracts or riders are approved by this Department.

It is further recommended that the Plan adhere to the provisions of Section 4308(b) of the New York Insurance Law, and refrain from charging any initial premiums to its subscribers for coverages unless such initial premiums have been approved in writing by this Department.

Claims Settlement Practices

Explanation of Benefits Forms

A review of the Plan's Explanation of Benefits forms (EOBs) indicated that said forms did not fully comply with the requirements of Section 3234(b) of the New York Insurance Law

Section 3234(b) of the New York Insurance Law states in part,

"(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."

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

A review of the Plan's explanation of benefits forms indicated that said forms did not include an explanation for not providing full reimbursement. Also, the Plan's EOBs failed to include the wording, that "failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made".

It is recommended that the Plan include within its explanation of benefits forms all wording required by Section 3234(b) of the New York Insurance Law.

Section 3224-a of the New York Insurance Law – Prompt Payment Law

A review was made of the Plan's compliance with Section 3224-a of the New York Insurance Law (Prompt Payment Law).

Section 3224-a(a) of the New York Insurance Law states the following,

> *"Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the Superintendent that such claim or bill for health services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policy-holder or covered person or make a payment to a health care provider within forty-five days of receipt of claim or bill for services rendered."*

Section 3224-a(b) of the New York Insurance Law, which states the following:

"In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment."

In addition, Section 3224-a(c) states the following:

"Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim…to be computed from the date the claim or health care payment was required to be made…"

In this regard, a sample of paid claims for calendar year 2000 was made. The claims were reviewed for compliance with said sections of the New York Insurance Law. The results of said review were then projected for the population of claim payments made during the aforementioned period. A range of projected violations was quantified as having an upper limit of seven hundred eighty two (782)

claims and a lower limit of four hundred thirty one (431) claims in which claim payments were made in excess of forty – five (45) days of receipt for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a) or (b) of the New York Insurance Law. Interest on such claims was either not due or, if due, was paid correctly.

It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law, and make appropriate payment of all claims within the forty-five day period provided by the aforementioned section of the Insurance Law where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

Regulation 64 Compliance

A review was made of the Plan's claims files in order to determine compliance with Regulation 64 promulgated by the New York State Insurance Department. A review was also made of subscriber complaints in order to determine compliance with the requirements of Department Circular Letter No. 11(1978).

The review indicated that copies of Regulation 64 were not distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of said regulation.

In addition, the review noted that the many of the Plan's electronic claims files did not contain any or complete documentation as to the reason for delay in payment. Also, the Plan, did not record the date in which a communication was sent relative to a request for additional in formation on a claim. The Plan documented only the date such information was received from the subscriber or provider.

Part 216.11 of Department Regulation 64 (NYCRR 216.11) states, in part,

> *"…all insurers…must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimant."*

It is recommended that the Plan comply with Part 216.11 of Department Regulation 64 (NYCRR 216.11) and maintain its claims files in such a manner so that all events relating to a claims can be reconstructed by the Insurance Department examiners.

It is further recommended that copies of Regulation 64 be distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of said regulation.

11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

ITEM NO.		PAGE NO.
A.	**Conclusion / Subsequent Events**	
	As a result of this examination, as of September 30, 2000, the Plan was insolvent in the amount of $1,603,296 and the Plan's required contingency reserve of $1,748,721 was impaired by $3,352,017 at that date.	15,19
	The Plan reported itself insolvent in the amount of $1,413,544 as of June 30, 2001. As of June 30, 2001, the Plan's required contingency reserve of $2,835,636 was impaired in the amount of $4,249,180.	20
B.	**Board of Directors**	5
	It is recommended that the Plan comply with the investment authorization or approval requirements of Section 1411(a) of the New York Insurance Law.	
C.	**Holding Company Filings**	10
	It is recommended that the Plan, pursuant to Section 98-1.16 of the New York Health Department's Administrative Rules and Regulations (10 NYCRR 98), make all required Holding Company filings.	
D.	**Abandoned Property**	11
	It is recommended that the Plan comply with the reporting requirements of Section 1315 and Section 1316 of the New York State Abandoned Property Law.	

ITEM NO.		PAGE NO.
E.	**Accounts and Records**	
	It is recommended that the Plan correctly complete its Schedule H in future filings with this Department.	11
	It is recommended that the Plan maintain adequate detail records to support the amounts reported in its filed Schedule M.	12
	It is recommended that the Plan, in the future, request Department approval for any proposed changes to previously stated filings, and only make such changes when, and if, the Plan receives Department approval.	13
F.	**Records Retention Plan**	13
	It is recommended that the Plan establish and implement a formal records retention plan in compliance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243.3).	
G	**Contingency Reserve**	19
	It is recommended that the Plan calculate the escrow deposit component of its contingency reserve on projected hospital and medical expenses for the following year in accordance with Part 98-1.11(d) and (e) of the New York Department of Health Codes, Rules and Regulations (10 NYCRR Part 98-1.11(d) and (e)) and this Department's Circular Letter Number 14-1991.	

ITEM NO. **PAGE NO.**

H. **Forms and Rates**

It is recommended that the Plan adhere to the provisions of Section 4308(a) of the New York Insurance Law, and refrain from issuing any contracts or riders unless such contracts or riders are approved by this Department 21

It is further recommended that the Plan adhere to the provisions of Section 4308(b) of the New York Insurance Law, and refrain from charging any initial premiums to its subscribers for coverages unless such initial premiums have been approved in writing by this Department. 22

I. **Explanation of Benefits Forms** 23

It is recommended that the Plan include within its explanation of benefits forms all wording required by Section 3234(b) of the New York Insuranc Law.

J. **Section 3224-a of the New York Insurance Law – Prompt Payment Law** 25

It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law, and make appropriate payment of all claims within the forty-five day period provided by the aforementioned section of the Insurance Law where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

K **Regulation 64**

It is recommended that the Plan comply with Part 216.11 of Department Regulation 64 (11 NYCRR 216.11) and maintain its claims files in such a manner so that all events relating to a claim can be reconstructed by the Insurance Department examiners. 26

It is further recommended that copies of Regulation 64 be distributed to all persons directly responsible for the supervision, handling and settlement of claims as per Section 216.0(e)(6) of said regulation. 26

Respectfully submitted,

Robert W. McLaughlin, CFE,CIE
Principal Insurance Examiner

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

ROBERT W. MCLAUGHLIN, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Robert W. McLaughlin

Subscribed and sworn to before me

this_____ day of _____2001.

Appointment No. 21434

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Robert McLaughlin

as a proper person to examine into the affairs of the

North American Healthcare, Inc.

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

Company

with such other 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 22nd *day of* July *1999*

NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent