REPORT ON EXAMINATION

OF

PUTNAM/NORTHERN WESTCHESTER

HEALTH BENEFITS CONSORTIUM

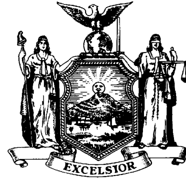
AS OF

JUNE 30, 2007

DATE OF REPORT	**OCTOBER 9, 2009**
EXAMINER	**ANDRE BLACKMAN**

TABLE OF CONTENTS

ITEM NO.		PAGE NO.
1.	Scope of examination	2
2.	Executive summary	3
3.	Description of Plan	3
	A. Management and controls	5
	B. Territory and plan of operation	8
	C. Stop-loss insurance	9
	D. Accounts and records	10
	E. Custodial agreements	11
4.	Financial statements	12
	A. Balance sheet	12
	B. Statement of revenues, expenses and net worth	13
5.	Unearned premium reserve	14
6.	Claims payable	15
7.	Market conduct	16
	A. Claims processing	16
	B. Explanation of benefits statements	17
	C. Complaints, appeals and grievances	20
	D. Rating	22
8.	Compliance with prior report on examination	24
9.	Summary of comments and recommendations	27



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

David A. Paterson
Governor

James J. Wrynn
Superintendent

October 9, 2009

Honorable James J. Wrynn
Superintendent of Insurance
Albany, NY 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 22695, dated September 18, 2008, attached hereto, I have made an examination into the condition and affairs of the Putnam/Northern Westchester Health Benefits Consortium, a municipal cooperative healthcare plan licensed pursuant to Article 47 of the New York Insurance Law as of June 30, 2007. The following report thereon is respectfully submitted.

The examination was conducted at the home office of Putnam/Northern Westchester Health Benefits Consortium located at 200 BOCES Drive, Yorktown Heights, New York.

Wherever the designations “the Plan”, “PNW” or “Consortium” appear herein, without qualification, they should be understood to indicate the Putnam/Northern Westchester Health Benefits Consortium.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of June 30, 2002. This examination covers the five-year period from July 1, 2002 through June 30, 2007. Transactions occurring subsequent to June 30, 2007 were reviewed where deemed appropriate by the examiner.

This examination comprised a verification of the Plan's assets and liabilities as of June 30, 2007, in accordance with statutory accounting principles (SAP), as adopted by the Department, a review of income and disbursements 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 as called for in the *Examiners Handbook of the National Association of Insurance Commissioners* (NAIC):

History of the Plan
Management and controls
Territory and plan of operation
Accounts and records
Claims processing
Complaints, appeals and grievances
Rating

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

2. EXECUTIVE SUMMARY

This examination uncovered certain operational deficiencies of the Plan that had an impact on the Plan's ability to comply with Article 47 and other selected provisions of the New York Insurance Law. Within this report, the following significant findings can be found in more detail:

- The Plan did not comply with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law when it failed to submit its community rating methodology to the Department for approval.
- The Plan's municipal cooperative agreement did not contain the required language related to the sharing of costs and assumption of liabilities…of all participating municipal corporations.

3. DESCRIPTION OF PLAN

The Putnam/Northern Westchester Health Benefits Consortium was organized in 1987 pursuant to Article 5-G of the New York General Municipal Law for the purpose of providing health insurance benefits to its member districts. The Superintendent of Insurance issued a certificate of authority in the name of the Plan pursuant to Article 47 of the New York Insurance Law on June 30, 2002. The Consortium, comprised of 14 municipal school districts, fund the Plan. The Consortium's objective is to administer a low-cost, self-funded, medical program of health insurance that provides hospital, medical and prescription drug benefits for more than 16,000 employees, retirees and dependents. The Plan provides benefits as defined in the Plan Document (the group contract issued by the municipal cooperative health benefit plan to participating municipal corporations describing the terms and

conditions of coverage) to employees of the participating school districts and their eligible dependents, and retirees.

Districts applying for membership in the Plan may do so on approval of a majority of the Consortium's Board. The Plan's premium rates are established by its Finance Committee.

As of June 30, 2007, fourteen (14) school districts, including the Putnam/Northern Westchester BOCES participated in the Plan. As of June 30, 2007, the Plan's participants were as follows:

- Brewster Central School District
- Briarcliff Manor Union Free School District
- Chappaqua Central School District
- Croton-Harmon Union Free School District
- Garrison Union Free School District
- Haldane Central School District
- Hendrick Hudson Central School District
- Lakeland Central School District
- Mahopac Central School District
- Peekskill City School District
- Putnam Valley Central School District
- Putnam/Northern Westchester BOCES
- Somers Central School District
- Yorktown Central School District

The Plan offers health insurance to the employees, spouses, dependents and retirees of each municipal corporation that are part of the Consortium. Health benefits for covered members are subject to a Plan Document that contains all the terms, provisions and limitations of the health benefit contract and is on file with the Department. The Plan is additionally subject to certain provisions of the General Municipal Law and the Education Law of New York State.

A. Management and Controls

Pursuant to its municipal cooperation agreement, the management of the Plan is to be vested in a board of trustees. The municipal cooperation agreement of the Plan specifies that the board of trustees shall consist of five individuals selected by the majority of Plan members and shall serve until and unless removed from office by the majority of Plan members. The board of trustees meets at least two times during each fiscal year, as required by Article IV of the Plan's municipal cooperative agreement.

As of June 30, 2007 the five members of the board of trustees were as follows:

Name and Residence	Principal Business Affiliation
David Chapman New Windsor, New York	Assistant Superintendent for Business, Mahopac School District
Gloria Colucci Hopewell Junction, New York	Superintendent, Garrison Union Free School District
Dr. Thomas P. Higgins, Jr. Brookfield, Connecticut	Assistant Superintendent for Administration, Putnam-Northern Westchester BOCES
Raymond Morningstar Mohegan Lake, New York	Assistant Superintendent for Business, Lakeland Central School District
Marc Space Lake Peekskill, New York	Superintendent, Putnam Valley Central School District

Additionally, pursuant to the municipal cooperation agreement, the Plan has established a joint governance board comprised of twelve members, including the five Plan trustees. The joint governance board operates in accordance with the terms of a Joint Governance Agreement, effective July 1, 1992. Such Agreement provides for the joint governance board to act on matters affecting the

administration of the Plan. The agreement requires the board to meet at least two times during each calendar year. The members of the governing board of the Plan as of June 30, 2007 were as follows:

Name	Principal Business Affiliation
Linda Ammann	Teacher, Mahopac Central School District
David Chapman	Assistant. Superintendent of Business, Mahopac Central School District
John Chow	Business Administrator, Chappaqua Central School District
Gloria Colucci	Superintendent, Garrison Union Free School District
Dr. Thomas P. Higgins, Jr.	Assistant, Superintendent of Administration, Putnam N. Westchester BOCES
Jane Hitney	School Nurse, Hendrick Hudson School District
Raymond Morningstar	Assistant Superintendent of Business, Lakeland Central School District
John Roden	Retired, Yorktown Central School District
Marc Space	Superintendent, Putnam Valley Central School District
Anne Tinsley	Employee, Chappaqua Central School District
Mary Uhle	Retired, Brewster Central School District

The minutes of all meetings of the Board of Trustees, the Joint Governance Board and committees thereof held during the examination period were reviewed. All meetings were well attended, with all members attending at least 50% of the meetings they were eligible to attend.

The officers of the Consortium as of June 30, 2007 were as follows:

Dr. Thomas P. Higgins, Jr.	President
Gloria Colucci	Secretary
Todd Currie	Chief Financial Officer
Michael Skerritt	Treasurer

A review of the Consortium's municipal cooperation agreement revealed that such agreement did not contain a required provision mandated by Section 4705(a)(2) of the New York Insurance Law.

Section 4705(a)(2) of the New York Insurance Law states in part that the municipal cooperation agreement shall include the following:

> " ... all participating municipal corporations agree to share the costs of and assume the liabilities for medical, surgical and hospital benefits provided under the municipal cooperative health benefit plan to the covered employees (including retirees) and their dependents of all participating municipal corporations…"

It is recommended that the Plan amend its municipal cooperation agreement to include the complete statement regarding the sharing of costs and the assumption of liabilities for medical, surgical and hospital benefits provided under the municipal cooperative health benefit plan as required by Section 4705(a)(2) of the New York Insurance Law.

The Consortium entered into contractual arrangements with the following consultants for services:

- Aetna Life Insurance Company (ALIC) - effective January 1, 2001.
  Aetna Life Insurance Company provides claims administration, patient management and network access services to Consortium members.

- The Segal Company - effective January 2002 and terminated June 30, 2007.
  The Segal Company provided general consulting services including claims auditing. Effective July 1, 2007, Deloitte & Touche LLP replaced The Segal Company with regard to general consulting services.

- Healthcare Data Management ("HDM") - effective July 1, 2007.
  HDM replaced The Segal Company and will provide claims auditing services to the Plan beginning in 2008.

- PFM Asset Management LLC. ("PFM") - effective December 12, 2005.
  PFM is the investment advisor of the Plan. PFM provides investment research and supervision of the Consortium's managed funds.

- MBIA, Inc. - effective January 1, 2005.
  Provides fund management services to the Plan using a cooperative asset pool.

Other third parties utilized by the Plan include Towers Perrin for actuarial services, Aquarius Capital for actuarial services, Sayles Evans for legal counsel, and Raymond F. Wager, CPA for financial auditing and annual statement certification.

B. Territory and Plan of Operation

As of June 30, 2007, the Plan maintained a certificate of authority to operate the business of a municipal cooperative health benefit plan, as authorized by Section 4704 of the New York Insurance Law, in the counties of Putnam and Westchester in New York State.

As of June 30, 2007, the Plan provided coverage to 8,018 members. Membership was fairly stable during the examination period. Plan members were enrolled at the local school district level.

The total direct premiums written and the membership census during the examination period were as follows:

Plan Year	Direct Premiums Written	Membership
2007	75,139,769	8,018
2006	66,536,905	7,936
2005	64,082,799	7,801
2004	58,446,480	7,741
2003	47,944,508	7,640

C. Stop-Loss Insurance

The Plan is required to maintain both specific and aggregate stop-loss insurance in order to limit its exposure to medical and prescription drug expense losses. At June 30, 2007, and in accordance with Section 4707(a) of the New York Insurance Law, the Plan had the following stop-loss coverage in place with Aetna Life Insurance Company, an authorized insurer:

Specific excess stop-loss coverage

Excess of loss coverage: 100% of $2,000,000, excess of $1 million loss level, individual lifetime stop-loss level $2,000,000.

Aggregate excess stop-loss coverage

Excess of loss coverage: 125% of expected benefits up to a $5 million maximum annual stop-loss payment.

D. Accounts and Records

The Consortium holds an account in a Cooperative Liquid Asset Securities System (NY-CLASS), where The Bank of New York is the custodian, and from which premiums and claims are processed. Aetna Life Insurance Company (ALIC), the Plan's third party administrator (TPA) relative to claims processing, periodically notifies the Plan's Treasurer of a funding request to cover paid benefits. In response to the funding request, a distribution by wire of Plan assets is effected through a transfer from the Consortium's NY-CLASS account to the administrator of funds (MBIA - MISC).

The Plan's Treasurer has the authority to process transactions from the Plan's NY-CLASS account including transfers and payments. It was noted that the authority of the Treasurer to act on behalf of the Plan was not subject to proper controls such as a second signatory requirement when executing transfers and payments.

It is recommended that the Plan put in place additional controls such as a second signatory requirement in regard to the activities of the Plan's Treasurer.

During the course of the examination, the Plan agreed to implement a modification of its internal control procedure within its Treasury operations. The internal control modification would prevent changes to the Plan's wire templates, and require a second signature in order to modify existing templates.

E. Custodial Agreements

At the examination date, it was noted that the Consortium had contracted with two custodians, US Bank Wachovia (for the holding of the Consortium's investments) and JP Morgan Chase (for the holding of certain cash equivalents).

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

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

It is recommended that the Plan comply with Section 4710(a)(1) of the New York Insurance Law by submitting its custodial agreements to the New York Insurance Department for approval.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of June 30, 2007. This statement is the same as the balance sheet filed by the Plan.

Assets	
Cash and cash equivalents	$ 15,133,558
Short-term investments	10,008,905
Premiums receivable	1,330,044
Investment income receivables	237,644
Aggregate write-ins for current assets	834,793
Total assets	$ 27,544,944
Liabilities	
Accounts payable	496,435
Claims payable	9,007,839
Additional IBNR	3,343,386
Claims stabilization reserve	6,812,341
Reserve for other obligations	1,000,000
Reserve in lieu of stop loss	1,000,000
Unearned premium reserve	3,297
Total liabilities	$ 21,663,298
Net Worth	
Contingency reserves	$ 3,556,989
Retained earnings/fund balance	2,324,657
Total net worth	$ 5,881,646
Total liabilities and net worth	$ 27,544,944

B. Statement of Revenue, Expenses and Net Worth

Net worth increased $3,652,576 during the five-year examination period, July 1, 2002 through June 30, 2007, detailed as follows:

Revenue		
Premiums and related revenue	$ 308,150,461	
Investment income	2,827,506	
Aggregate write-ins for other revenues	6,489,465	
Total revenue		$ 317,467,432
Expenses		
Hospital/medical benefits	$ 209,233,977	
Prescription drugs	78,006,327	
Aggregate write-ins for other expenses	2,047,351	
Reinsurance expenses	1,142,163	
Total medical and hospital expenses	$ 290,429,818	
Administrative expenses		
Third party administration	16,941,204	
Total expenses		$ 307,371,022
Net income		$ 10,096,410

Change in Net Worth

	Gains in Net Worth	Losses in Net Worth	
Net worth as of June 30, 2002, per report on examination			$ 2,229,070
Net income	$10,096,410		
Change in IBNR		$ 1,517,195	
Change in claim stabilization reserve		6,412,341	
Change in contingency reserves	1,214,982		
Change in termination reserve		1,214,982	
Other charges to net worth		600,000	
Stop loss reserve		1,000,000	
A/R adjustment	_	51,312	
Net increase in net worth			3,652,576
Net worth as of June 30, 2007, per report on examination			$ 5,881,646

5. UNEARNED PREMIUM RESERVE

The examination liability of $3,297 is the same as the amount reported by the Plan as of June 30, 2007. However, in a communication to this Department, the Plan indicated that in any instances in which it did not set up an adequate unearned premium reserve, that it maintained enough additional unassigned net worth (surplus) to cover any short-fall. Section 4706(a)(2) of the New York Insurance Law states in part:

> " ... the governing board of a municipal cooperative health benefit plan shall establish a reserve fund … including:
>
> (2) a reserve for unearned premium equivalents;"

It is recommended that the Plan establish and maintain a reserve for unearned premiums in accordance with the requirements of Section 4706(a)(2) of the New York Insurance Law.

6. CLAIMS PAYABLE

The examination liability of $12,351,225 is the same as the amount reported by the Plan in its filed annual statement as of June 30, 2007.

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

The Plan was granted approval by this Department, on April 11, 2007, to reduce its reserves for claims payable and related expenses, required by Section 4706(a)(1) of the New York Insurance Law, from the statutorily mandated 25% to 17% of the Plan's current year's expected incurred claims.

7. MARKET CONDUCT

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 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. Certain recommendations to Plan management included herein under the Market Conduct subsection resulted from ALIC's failure to adhere to claim processing rules in full compliance with applicable statutes. Therefore, these recommendations included herein also apply to Aetna Life Insurance Company (ALIC), in its role as a third party administrator with regard to the performance its contractual duties on behalf of the Plan.

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

A. Claims processing
B. Explanation of benefits statements
C. Complaints, appeals and grievances
D. Rating

A. Claims Processing

A review of the Plan's claims practices and procedures was performed. This review was performed by using a sampling methodology in order to evaluate the Plan's overall claims processing accuracy and level of regulatory compliance. ALIC is the Plan's third party administrator (TPA) for claims processing. Subject to a written agreement with the Plan, ALIC is responsible for all claims processing results, including such claims settlement practices as utilization review, claims payment and check issuance, subscriber notices, grievances, appeals, and explanation of benefits statements.

The Segal Company, the Plan's claims auditor for the period under examination, issued an audit report in 2006 relative to claims processing accuracy. It should be noted that effective June 30, 2007 the Plan no longer used The Segal Company. Beginning July 1, 2007 the new claims auditors was Healthcare Data Management.

According to The Segal Company's audit report, ALIC, "…met established performance guarantees for financial accuracy and turnaround time." The Plan's stated goal for "turnaround" is the payment of all medical claims within twelve calendar days. According to the report, ALIC (on behalf of the Plan) achieved 84% compliance with the twelve day claims payment goal.

A review of the Plan's claims practices and procedures relating to medical claims was completed by the examiner using a random sample drawn from the Plan's paid claims for the Plan year ending June 30, 2007. For the purposes of this review a limited claims sample was selected to analyze the claims for processing accuracy. The results of the examiner's review were similar to the results reflected in the Segal Company's audit report.

B. Explanation of Benefits Statements (EOBs)

An EOB contains important information that links the payer and the subscriber or provider of services with any available remedies to claims payment discrepancies, disputes and appeals. The EOB should clearly communicate how the claim was processed and also state the right to an appeals procedure available to the member and provider. The Plan's EOBs did not contain the above required language relative to its member's appeal rights.

Section 3234(b) of the New York Insurance Law sets forth the requirements relative to the content of explanation of benefit statements. Specifically, Section 3234(b)(7) of the New York Insurance Law states in part:

> "(b) The explanation of benefits form must include at least the following…
>
> (7)… 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."

The examiner reviewed the explanation of benefits statements ("EOBs") sent to subscribers and providers of the Plan through the Plan's TPA, ALIC. EOBs communicate the Plan's benefit determinations for a subscriber or covered member and transmit vital information relating to the subscriber's rights. The EOBs sent by ALIC did not state that failure to comply with the appeal procedure requirements may lead to forfeiture of the consumer's right to appeal.

Although ALIC, pursuant to its contractual arrangement with the Plan, is responsible for sending EOBs on behalf of the Plan to the Plan's members and providers, the management of Putnam/Northern Westchester Health Benefits Consortium retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related regulations. Therefore, the Plan's management must be diligent in its oversight of its market conduct activities, including the dissemination of EOBs. In this regard, although ALIC is regulated by the State of Connecticut, it is incumbent upon ALIC to be aware of and comply with pertinent New York Insurance Laws and regulations when processing the Plan's claims and in providing appropriate documents, including EOBs, to the Plan's members and providers on the Plan's behalf.

It is recommended that the Plan comply with the requirements of Section 3234(b)(7) of the New York Insurance Law and ensure that the requirement that a member's failure to comply with appeals procedures can lead to that member's forfeiture of the right to challenge a denial of benefits is included on all of the explanation of benefits statements issued to its members and providers.

It is further recommended that Plan management fulfill its responsibility for compliance with New York Insurance statutes, rules, and regulations, and ensure that ALIC, as its TPA, acts in accordance with Section 3234(b)(7) of the New York Insurance Law and issues the required notification with its EOBs that a member's failure to comply with appeals procedures can lead to that member's forfeiture of the right to challenge a denial of benefits.

A similar recommendation was made in the prior two Reports on Examination of the Plan.

In regard to the foregoing, it is recommended that the Plan identify, and notify by letter, all members who had an appeal rejected because of timeliness, of their right to appeal a claim made during the period January 1, 2004 through June 30, 2007, where the member received an EOB without adequate appeal rights language. In addition, for members who had an appeal rejected because of timeliness during the period July 1, 2002 through December 31, 2003 (a time frame in which the Plan has indicated its TPA would not be able to identify members who had an appeal of a claim rejected because of timeliness), where the member received an EOB without adequate appeal rights language, it is recommended that the Plan advise members, by means of a notice within the next two printings of the Consortium Newsletter, of their right to appeal a past claim where the member received an EOB without adequate appeal rights language.

C. Complaints, Appeals and Grievances

Complaints

The Plan's Risk Manager, who manages the day-to-day operations of the Plan, takes member's complaints by phone, e-mail, and occasionally by US mail. It has been found that the complaints received directly from members "…are informal and sometimes go undocumented." The Department requires that every insurer maintain a central complaint log that contains both complaints filed directly with the Department and complaints logged directly with the Plan or its designee.

Department Circular Letter No. 11 (1978) states the following:

> "As part of its complaint handling function, the company's consumer services department will maintain an ongoing central log to register and monitor all complaint activity."

Notwithstanding that the Plan's TPA (Aetna) records complaints received by it on behalf of the Plan, and provides an abridged listing of those complaints to the Plan Administrator, it was noted that the Plan failed to record and maintain a complete log of all complaints made directly to the Plan by its members. The tracking of all complaints to register and monitor all complaint activity will enable the Plan to recognize trends and address underlying issues in a more timely and efficient manner.

It was also noted that Plan Document did not contain specific information available to members such as the mailing address, phone number, website or e-mail address on where and how to file a complaint regarding benefits under the Plan.

It is recommended that the Plan maintain a complaint log in a manner consistent with Circular Letter No. 11 (1978).

It is further recommended that the Plan include all complaints received by it, or by its TPA on behalf of its members, in one document.

It is also recommended that the Consortium amend its Plan Document to contain specific information as to the procedure an affected person may follow in order to file a complaint with the New York Insurance Department and the Plan's Office of Risk Management, including the mailing address, phone numbers, website and e-mail address for such complaint filings.

Appeals and Grievances:

The Plan's TPA, ALIC, performs the grievance and appeals procedures for Plan members. Aetna provides a monthly report to the Consortium for complaints, grievances, and utilization reviews that includes the case ID, dates and case disposition. The Plan's Office of the Risk Manager receives and files this information. It was noted that Aetna did not conduct a case-level audit of the grievance and appeals process which it conducts on behalf of the Plan.

Section 4704(a)(8) of the NYIL provides that as a condition for the issuance for a certificate of authority, a municipal cooperative health benefit plan shall have:

> "…established a fair and equitable process for claims review, dispute resolution and appeal procedures…which are satisfactory to the superintendent;"

The Plan has a grievance and appeals process included in its filed Plan Document, which appears to be "fair and equitable", however, no objective analysis is done to determine if the Plan's

administrator complies with the grievance process outlined for members in the Plan Document. The potential exists that members are adversely affected by a grievance process that doesn't provide its members all of their appeal rights.

A review of ALIC's appeals process was contained in Segal's 2006 "Analysis and Evaluation of the Plan's Claims Processing and Payment Procedures". This analysis was not a comprehensive review that fully covered Aetna's grievance and appeals process.

It is therefore recommended that the Consortium perform, or retain a consultant to perform, a case-level audit of its grievance and appeals practices and all such practices performed on its behalf by any third parties.

D. Rating

Rates are developed by the Plan based on a review of the Plan's evaluation of past claims experience and projections of the Plan's future financial performance. Rates are established and are approved by the Plan's Joint Governing Board in advance of the Plan year and 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…"

Although the Plan did provide its community rating methodology to the examiner, the Plan failed to obtain the approval of the Superintendent of Insurance for such methodology.

It is recommended that the Plan submit its community rating methodology to the Superintendent of Insurance for his approval in accordance with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law.

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on organization included nineteen recommendations detailed as follows (page numbers refer to the report on organization:

ITEM NO.		PAGE NO.
1.	This examination has determined that the Plan was insolvent in the amount of ($3,111,673), and its contingency reserve of $3,513,300 was impaired in the amount of ($6,624,973) as of June 30, 2002. The Plan has eliminated the insolvency and impairment.	1, 9, 23
2.	It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan. The Plan has complied with this recommendation.	5
3.	It is recommended that the Plan maintain the required stop-loss policies in accordance with §4707(a) of the New York Insurance Law or request a waiver as set forth in §4707(b)(1) of the New York Insurance Law. Subsequent to the exam date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department. The Plan has complied with this recommendation.	7
4.	It is recommended that the Plan adopt a formal code of ethics and require that its directors and trustees annually sign conflict of interest statements. The Plan has complied with this recommendation.	7
5.	It is recommended that the Plan take the necessary steps to complete its Schedule F ("Claims Payable Analysis") and Report #2, Statement of Revenue, Expenses and Net Worth, in accordance with the annual statement instructions. The Plan has complied with this recommendation.	8
6.	It is recommended that the Plan take the necessary steps to complete the Net Worth section of the annual statement in accordance with the annual statement instructions.	8

The Plan has complied with this recommendation.

ITEM NO.		PAGE NO.
7.	It is recommended that the Plan maintain the required reserves as called for in §4707 of the New York Insurance Law. Subsequent to the examination date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department. The Plan has complied with this recommendation.	12
8.	It is recommended that the Plan maintain the required contingency reserve as called for in §4707(b)(1) of the New York Insurance Law. Subsequent to the examination date, effective January 1, 2003, the Plan placed stop-loss insurance with Aetna Life and Casualty, an authorized insurer. The agreement is currently under review by the Department. The Plan has complied with this recommendation.	14
9.	It is recommended that Plan management fulfill its responsibility for compliance with New York Insurance Department statutes, rules, and regulations, as regards claims settlement practices via stronger oversight over its TPA's practices. The Plan has not complied with this recommendation. Similar recommendations are included within this report on examination.	16
10.	It is further recommended that all claims settlement recommendations noted herein be immediately brought to Aetna's attention and remedied. The Plan has complied with this recommendation.	16
11.	In addition, the provisions of the TPA agreement with Aetna or its successor should be strengthened to specifically address the processing of claims in compliance with New York Insurance Department statutes, rules and regulations, and Plan guidelines. The Plan has complied with this recommendation.	16
12.	It is recommended that Aetna comply with the comments and recommendations in the Segal report, and that the Plan receive a report from Aetna detailing all remedial action that has been implemented, or will be implemented, to address said comments and recommendations. The Plan has complied with this recommendation.	18

ITEM NO.		PAGE NO.
13.	It is further recommended that the Plan or its TPA prepare a report identifying all HCRA eligible New York State facility claims during the examination period, and subsequent thereto, in order to determine its potential HCRA surcharge liability, and immediately effect payment to the New York Department of Health The Plan has complied with this recommendation.	18
14.	It is also recommended that the Plan, via Aetna as its TPA, implement immediate steps to accurately administer the HCRA surcharge. The Plan has complied with this recommendation.	18
15.	It is recommended that the Plan obtain periodic reports from its TPA that measure claims processing accuracy and the timeliness of claim payments. The Plan has complied with this recommendation.	18
16.	It is recommended that the Plan comply with §4903(b) of the New York Insurance Law and make UR determinations which require pre-authorization within three days of receipt of the necessary information. The Plan has complied with this recommendation.	19
17.	It is recommended that the Plan comply with Section 243.2(b)(4) of Department Regulation 152 (11 NYCRR 243.2(b)), by retaining all documentation necessary to verify a claim, for a period of six years, or until after the filing of the report on examination, whichever is longer. The Plan has complied with this recommendation.	20
18.	It is recommended that the Plan modify its EOBs to comply with §3234 (b)(2),(3) and (7) of the New York Insurance Law. This recommendation is the result of the failure of the Plan's TPA, Aetna to issue EOBs in a manner compliant with §3243(b) of the New York Insurance Law. A previous comment was made herein regarding Plan management's oversight of the claims processing function. The Plan has not complied with this recommendation. A similar recommendation is included within this report.	20
19.	It is recommended that the Plan's management evaluate Aetna's implementation of the grievance process. The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.	20

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Management and controls	
	It is recommended that the Plan amend its municipal cooperation agreement to include the complete statement regarding the sharing of costs and the assumption of liabilities for medical, surgical and hospital benefits provided under the municipal cooperative health benefit plan as required by Section 4705(a)(2) of the New York Insurance Law.	7
B.	Accounts and records	
	It is recommended that the Plan put in place additional controls such as a second signatory requirement in regard to the activities of the Plan's Treasurer.	10
C.	Custodial agreements	
	It is recommended that the Plan comply with Section 4710(a)(1) of the New York Insurance Law by submitting its custodial agreements to the New York Insurance Department for approval.	11
D.	Unearned premium reserve	
	It is recommended that the Plan establish and maintain a reserve for unearned premium in accordance with the requirements of Section 4706(a)(2) of the New York Insurance Law.	15
E.	Explanation of benefits statements (EOBs)	
	i. It is recommended that the Plan comply with the requirements of Section 3234(b)(7) of the New York Insurance Law and ensure that the requirement that a member's failure to comply with appeals procedures can lead to that member's forfeiture of the right to challenge a denial of benefits is included on all of the explanation of benefits statements issued to its members and providers.	19

ITEM		PAGE NO.
ii.	It is further recommended that Plan management fulfill its responsibility for compliance with New York Insurance statutes, rules, and regulations, and ensure that ALIC, as its TPA, acts in accordance with Section 3234(b)(7) of the New York Insurance Law and issues the required notification with its EOBs that a member's failure to comply with appeals procedures can lead to that member's forfeiture of the right to challenge a denial of benefits.	19
iii.	It is recommended that the Plan identify, and notify by letter, all members who had an appeal rejected because of timeliness, of their right to appeal a claim made during the period January 1, 2004 through June 30, 2007, where the member received an EOB without adequate appeal rights language. In addition, for members who had an appeal rejected because of timeliness during the period July 1, 2002 through December 31, 2003 (a time frame in which the Plan has indicated its TPA would not be able to identify members who had an appeal of a claim rejected because of timeliness), where the member received an EOB without adequate appeal rights language, it is recommended that the Plan advise members, by means of a notice within the next two printings of the Consortium Newsletter, of their right to appeal a past claim where the member received an EOB without adequate appeal rights language.	19
F.	<u>Complaints, appeals and grievances</u>	
i.	It is recommended that the Plan maintain a complaint log in a manner consistent with Circular Letter No. 11 (1978).	20
ii.	It is further recommended that the Plan include all complaints received by it, or by its TPA on behalf of its members, in one document.	20
iii.	It is also recommended that the Consortium amend its Plan Document to contain specific information as to the procedure an affected person may follow in order to file a complaint with the New York Insurance Department and the Plan's Office of Risk Management, including the mailing address, phone numbers, website and e-mail address for such complaint filings.	20

ITEM		PAGE NO.
iv.	It is recommended that the Consortium perform, or retain a consultant to perform, a case-level audit of its grievance and appeals practices and all such practices performed on its behalf by any third parties.	22
G.	Rating	
	It is recommended that the Plan submit its community rating methodology to the Superintendent of Insurance for his approval in accordance with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law.	23

Appointment No. **22695**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Andre Blackman

as a proper person to examine into the affairs of the

Putnam /Northern Westchester Health Benefits Consortium

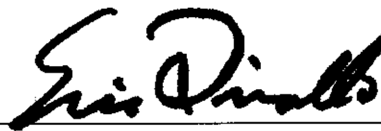
and to make a report to me in writing of the said

Municipal Cooperative Health Benefit Plan

with such information as he shall deem requisite.

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

this 18th day of September 2008



Eric R. Dinallo
Superintendent of Insurance