

**MARKET CONDUCT REPORT ON EXAMINATION**

**OF**

**CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.**

**AND**

**CDPHP UNIVERSAL BENEFITS, INC.**

**AS OF**

**DECEMBER 31, 2014**

**DATE OF REPORT**

**APRIL 12, 2018**

**EXAMINER**

**KENNETH I. MERRITT**

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NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

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Andrew M. Cuomo  
Governor

Maria T. Vullo  
Superintendent

April 12, 2018

Honorable Maria T. Vullo  
Superintendent of Financial Services  
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31087 and 31088, dated January 24, 2015, annexed hereto, I have made an examination into the affairs of CDPHP Universal Benefits, Inc., a Non-Profit Medical and Hospital Indemnity corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law and its parent, Capital District Physicians' Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York State Public Health Law, as of December 31, 2014, and submit the following report thereon.

The examination was conducted at the home office of Capital District Physicians' Health Plan, Inc., and CDPHP Universal Benefits, Inc., located at 500 Patroon Creek Boulevard, Albany, New York.

Wherever the designations, "CDPHP" or the "HMO" appear herein, without qualification, they should be understood to indicate Capital District Physicians' Health Plan, Inc.

Wherever the designations “UBI” or the “Plan” appear herein, without qualification, they should be understood to indicate CDPHP Universal Benefits, Inc.

Wherever the designation “CDPHP Companies” appears herein, without qualification, it should be understood to indicate Capital District Physicians’ Health Plan, Inc. and CDPHP Universal Benefits, Inc., collectively.

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

## **1. SCOPE OF THE EXAMINATION**

The previous market conduct examination of the CDPHP Companies were conducted as of December 31, 2009. This market conduct examination of the CDPHP Companies covers the five-year period from January 1, 2010 through December 31, 2014. Market conduct activities occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination is confined to 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 actions were taken by the CDPHP Companies with regard to the comments and recommendations related to the market conduct items contained in the prior reports on examination.

Separate risk-focused examinations regarding the financial condition of the CDPHP Companies were conducted as of December 31, 2014. The resulting reports on examination were filed on February 8, 2017 for both CDPHP and UBI (separate report for each entity).

## **2. DESCRIPTION OF THE COMPANIES**

Capital District Physicians' Health Plan, Inc. was formed as a membership corporation on February 27, 1984, under Section 402 of the New York Not-for-Profit Corporation Law, and incorporated within the State of New York on April 13, 1984. The

members consist of physicians licensed by the State of New York. CDPHP was licensed as a health maintenance organization (HMO) pursuant to Article 44 of the New York State Public Health Law and obtained its certificate of authority to operate as an individual practice association (IPA) model HMO, effective April 30, 1984.

On December 31, 2000, membership in the HMO was opened up to physicians licensed by the State of New York, who applied for membership and met the criteria required by the HMO's by-laws to be accepted as member physicians.

The HMO is exempt from income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code.

As of December 31, 2014, the HMO reported total surplus in the amount of \$248,923,114 which is available for the fulfilment of its contractual obligations to policyholders and claimants.

CDPHP Universal Benefits, Inc. was formed on January 2, 1997, and incorporated on February 28, 1997, pursuant to Section 402 of the New York State Not-for-Profit Corporation Law. It was subsequently licensed on August 14, 1997, pursuant to Article 43 of the New York Insurance Law for the purpose of providing indemnity based, prepaid comprehensive health care services through arrangements with physicians, hospitals, and other providers.

The Plan is a Type D Corporation, as defined in Section 201 of the Not-for-Profit Corporation Law. The sole member of the Plan is CDPHP.

UBI was capitalized initially by means of a \$1,250,000 loan from its parent and sole member, CDPHP. As of December 31, 2014, the Plan reported total surplus in the amount of \$77,505,720 which is available for the fulfilment of its contractual obligations to policyholders and claimants.

### 3. **FRAUD WARNING STATEMENT**

The following requirements apply pursuant to the New York Insurance Law and Insurance Regulation No. 95 (“11 NYCRR 86”) relative to the intentional filing of a fraudulent claim or information and the disclosure of a fraud warning statement:

Section 403(d) of the New York Insurance Law, states the following:

“(d) All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms, except as provided for in subsection (e) of this section, shall contain a notice in a form approved by the superintendent that clearly states in substance the following:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

In addition, Section 86.4(a) of Insurance Regulation No. 95 (“11 NYCRR 86”) states in part:

“All applications provided to applicants for [non-automobile] commercial insurance and all claim forms for insurance, except personal automobile insurance, delivered to any person residing or located in this State (on and after February 2, 1994) in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information...”

In regard to a claimant’s submission of a claim for reimbursement, the following definitions apply pursuant to paragraphs (h) and (i) of Section 86.2 of Insurance Regulation No. 95:

“(h) Statement includes, but is not limited to, any notice, proof of loss, bill of lading, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical provider records, X-ray, test result and other evidence of loss, injury or expenses.”

“(i) Claim form includes any document supplied by an insurer or self-insurer, directly or indirectly, to a claimant which the claimant is required to complete or submit in support of a claim for benefits.”

The CDPHP Companies’ non-electronic claims submission procedures in effect during the examination period, provided their members with the alternative of calling or writing to the HMO and the Plan in lieu of the members filing a standard claim form. When calling or writing to the CDPHP Companies, the members were required to submit the supporting billing or invoice documentation in order to be reimbursed. A review of the CDPHP Companies “alternative hardcopy claims submission procedure” as noted above, found that such procedure did not include the communication and/or dissemination of the requisite fraud warning statement by the CDPHP Companies to the members.

The examiner questioned management regarding the alternative hardcopy claim submission procedure, including how the CDPHP Companies communicated the required fraud warning to the member(s) against filing fraudulent statements for a claim for



reimbursement. Management replied that such statement was available in the CDPHP Companies' member handbook and also on the CDPHP Companies' website.

The CDPHP Companies are reminded that when accepting non-electronic claim submissions, CDPHP and UBI must include and communicate the requisite fraud warning statement to the member as part of the procedure utilized.

It is recommended that the CDPHP Companies comply with Section 403(d) of the New York Insurance Law and Insurance Regulation No. 95 by ensuring that CDPHP and UBI provide the requisite fraud warning statement at the time of the members' submission of claims for reimbursement when the claim is filed by a means other than the hardcopy claim form.

#### **4. UTILIZATION REVIEW**

Article 49 of the New York State Public Health Law ("Public Health Law"), which applies to CDPHP, and Article 49 of the New York Insurance Law ("Insurance Law"), which applies to UBI, set forth the minimum utilization review program requirements including standards for: registration of utilization agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. The aforementioned Articles 49 of the Insurance and Public Health Laws also establish the enrollee's and insured's right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an enrollee's or insured's health care provider shall have the right to request a standard appeal and an external appeal.

With respect to the examiner's review of the CDPHP Companies utilization review processes and procedures the following was noted:

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

“(a) Every utilization review agent shall biennially report to the superintendent of financial services, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section.”

During the examination period, UBI failed to file biennially its utilization review plan with the Department.

It is recommended that UBI comply with Section 4901(a) of the New York Insurance Law by filing biennially with the Department, a report of its utilization review plan.

## 5. GRIEVANCES

Section 4408-a(7) of the New York State Public Health Law states in part:

“...The notice of a determination shall include...(iii) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.”

Section 4802(g) of the New York Insurance Law states in part:

“...The notice of a determination shall include: (3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.”

The CDPHP Companies' Administrative Manual contains an instruction for the member or the member's designee to file a grievance by either calling or writing to

CDPHP/UBI. To file a written grievance, the Manual further instructs the member to write a letter or ask the CDPHP Companies for a grievance form to fill out.

It is recommended that the CDPHP Companies update their Administrative Manual to reflect with the additional requirement of Sections 4408-a(7) of the New York State Public Health Law (CDPHP) and 4802(g) of the New York Insurance Law (UBI) that a grievance appeal form is to be included with the CDPHP Companies' issuance of adverse determination notices.

Section 4403(6)(c) of the New York State Public Health Law states in part the following:

“A health maintenance organization shall have a procedure by which a new enrollee upon enrollment or an enrollee upon a diagnosis, with a (i) a life threatening condition or disease or (ii) a degenerative and disabling condition or disease either of which requires specialize medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary specialty care...Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider...”

Section 4804(c) of the New York Insurance Law states in part the following:

“An insurer shall have a procedure by which a new insured upon enrollment in a managed care product, or an insured in a managed care product upon a diagnosis, with (i) a life threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialize medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care...Such specialist shall be permitted to

treat the insured without a referral from the insured's primary care provider..."

It was noted that CDPHP Companies' Corporate Policy and Procedures – "Specialist as Primary Care Physician," contained the following statement:

"A specialist can serve as a primary care physician for enrollees with a life threatening or a degenerative and disabling condition or disease, which requires specialized medical care over a prolonged period of time."

However, the examiner noted that the above referenced CDPHP Companies' guideline omits the wording "specialist shall be permitted to treat the insured without a referral from the insured's primary care provider."

It is further recommended that the CDPHP Companies update their Corporate Policy and Procedures – "Specialist as Primary Care Physician," to fully comply with Sections 4403-6(c) of the New York State Public Health Law (CDPHP) and 4804(c) of the New York Insurance Law (UBI). Specifically, the CDPHP Companies' Corporate Policy and Procedure – "Specialist as Primary Care Physician" should be revised to include the wording that a referral from the enrollee's/insured's primary care physician is not required in the case of a medical specialist performing dual primary care and specialty treatment on enrollees/insureds diagnosed with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease.

## **6. EXPLANATION OF BENEFITS STATEMENTS**

Sections 4408-a(2)(b) of the New York State Public Health Law and 4802(b)(2) of the New York Insurance Law state in part the following:

Section 4408-a(2)(b) of the New York Public Health Law states in part the following:

“The notice to an enrollee describing the grievance process shall explain...(iii) the right of an enrollee to designate a representative to file a grievance on behalf of the enrollee.”

Section 4802(b)(2) of the New York Insurance Law states in part the following:

“The notice to an insured describing the grievance process shall explain...(iii) the right of an insured to designate a representative to file a grievance on behalf of the insured.”

Explanations of Benefits statements (“EOBs”) issued during the examination period, included instructions to the enrollees/insureds on how to file a grievance with CDPHP and UBI. However, the CDPHP Companies failed to mention the right of the enrollee/insured to designate a representative to file a grievance on behalf of the enrollee/insured, in violation of Sections 4408-a(2)(b) of the New York State Public Health Law (CDPHP) and 4802(b)(2) of the New York Insurance Law (UBI).

It is recommended that the CDPHP Companies comply with Sections 4408-a(2)(b) of the New York State Public Health Law and 4802(b)(2) of the New York Insurance Law when issuing EOBs and apprise the enrollees/insureds of their right to designate a representative to file a grievance on their behalf.

## 7. CLAIMS REVIEW

### A. Standards For Prompt, Fair And Equitable Settlement Of Claims For Health Care And Payments For Health Care Services (“Prompt Pay Law”)

A review was made of the CDPHP Companies claims processing procedures and internal controls to assure compliance with Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” (Prompt Pay Law).

A review of the CDPHP Companies’ compliance with Section 3224-a was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, only one problem area was noted.

The CDPHP Companies outsourced their pharmacy claims processing, including the compilation of their pharmacy claims data files to a certain pharmacy benefit manager (“PBM”) during the exam period.

Department Circular No. 9 (1999) dated May 25, 1999 states in part the following:

“In order to fulfill its responsibility to oversee the claims adjudication process it is critical that the board adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations. One way for the board to ensure itself that such procedures are in place is to direct the officers responsible for claims adjudication to (i) issue, and update as necessary, a claims manual which sets forth the company’s claims adjudication procedures; (ii) distribute the claims manual and necessary updates to all persons responsible for the supervision, processing and

settlement of claims and obtain an acknowledgement of receipt...It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.

The board is reminded that its responsibilities to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management, administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself..."

A review of the PBM data files, which represented the PBM's payments to the retail pharmacies and other suppliers, revealed a significantly high rate of late payments for both CDPHP (15.53%) and UBI (15.79%). The CDPHP Companies disputed the ratios and after researching the data files, management explained that there was an underlying problem with the PBM's reported paid dates insofar as the reported payment dates were not necessarily the actual dates which the PBM paid the pharmacies. Certain of the payment dates in question were adjusted dates involving administrative and technical areas of pharmacy rebates administration. After multiple attempts to correct the issues and provide the examiner with more reliable paid dates within the data files, CDPHP management eventually informed the examiners that the PBM could not reconstruct the previously reported paid dates.

Management is reminded that it is the CDPHP Companies' responsibility to ensure that the PBM's payments to retail pharmacies and other prescription drug

suppliers are in compliance with the prompt pay requirements of Section 3224-a of the Insurance Law.

It is recommended that the CDPHP Companies in their compliance with the Department's Circular Letter No. 9 (1999), establish additional monitoring/oversight procedures regarding its PBM's claims payments to the retail pharmacies and other prescription drugs suppliers. Such procedures should ensure that the PBM's data files to CDPHP's and UBI's paid pharmacy claims include all payment dates, including the original and adjustment payment dates for each claim.

B. Contraceptive Claims Processing

Section 3216(i)(17)(E) of the New York Insurance Law states in part the following:

“In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (F) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for preventive care and screenings that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force...

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.”



Section 3221(l)(8)(A)(E)(F) of the New York Insurance Law states in part the following:

“Every insurer issuing a group policy for delivery in this state that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services...

“(E) In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every group policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (G) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for preventive care and screenings that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force...

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.”

“(F) The requirements of this paragraph shall also be applicable to a blanket policy of hospital, medical or surgical expense insurance covering students pursuant to subparagraph (C) of paragraph three of subsection (a) of section four thousand two hundred thirty-seven of this chapter.”

Section 4303(j)(3) of the New York Insurance Law states in part the following:

“In addition to paragraph one or two of this subsection, every contract that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under paragraph four of this subsection, shall provide coverage for the following preventive care and screenings for subscribers, and such coverage shall not be subject to annual deductibles or coinsurance:...”

(A). evidence-based items or services for preventive care and screenings that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force...

(D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) of this

paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration.”

A review of the CDPHP Companies’ contraceptive claims processed in 2014 found that the CDPHP Companies incorrectly applied co-payments on a portion of the contraceptive claims relative to the billing code J1050. The co-payments affected 93 total claims between CDPHP and UBI.

It is recommended that the CDPHP Companies comply with Sections 3216(i)(17)(E) and 3221(l)(8)(A)(E)(F) of the New York Insurance Law by refraining from applying cost sharing to members on covered contraceptive benefits which are subject to the “no cost sharing” provision of the aforementioned statutes.

It is also recommended that the CDPHP Companies comply with Section 4303(j)(3) of the New York Insurance Law by refraining from applying cost sharing to members on covered contraceptive benefits which are subject to the “no cost sharing” provision of the aforementioned statutes.

It is further recommended that the CDPHP Companies reimburse all members affected by the erroneous charges delineated above, including interest, where applicable, pursuant to New York Insurance Law section 3224-a(c).

## 8. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior reports on examination included five (5) market conduct related recommendations detailed as follows (page number refers to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Utilization Review</u>	
1. It is recommended that the CDPHP Companies continue to treat their LOCC determinations as medical necessity denials. According, the HMO and the Plan must comply with Section 4903.3 of the New York Public Health Law and Section 4903(c) of the New York Insurance Law by issuing to their enrollees/insureds notices of adverse determinations within one business day, respectively, as required, when denying medical necessity care to the enrollee/insured on the basis of CDPHP Companies' concurrent utilization review process.	8
CDPHP and UBI have complied with this recommendation.	
<u>Grievances</u>	
2. It is recommended that CDPHP fully comply with Section 4408-a(7) of the New York Public Health Law and ensure that an appeal form is included along with its notice of determination of the grievance that CDPHP issues to its enrollee.	9
CDPHP Companies have complied with this recommendation.	
<u>Record Retention</u>	
3. It is recommended that CDPHP and UBI comply with Department Regulation No. 152 (11 NYCRR 243.2(b)(5)) by maintaining proper records of their agent certificates of appointment and agent termination notices.	10
CDPHP and UBI have complied with this recommendation.	

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4. It is recommended that the CDPHP Companies establish internal procedures that include either a manual or system-generated listing by applicant names, lines of business, date applied, date declined, and reason(s) for the declinations and that enable CDPHP and UBI to have easy access to their denied application forms. 11

CDPHP and UBI have complied with this recommendation.

Advertising and Marketing

5. It is recommended that the CDPHP Companies comply with Section 4224(c) of the New York Insurance Law and refrain from the practice of offering inducements for the purposes of attracting prospective enrollees/insureds to enroll with the HMO and the Plan. 11

CDPHP and UBI have complied with this recommendation.

9. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
<p>A. <u>Fraud Warning Statement</u></p> <p>It is recommended that the CDPHP Companies comply with Section 403(d) of the New York Insurance Law and Insurance Regulation No. 95 by ensuring that CDPHP and UBI provide the requisite fraud warning statement at the time of the members' submission of claims for reimbursement when the claim is filed by a means other than the hardcopy claim form.</p>	7
<p>B. <u>Utilization Review</u></p> <p>It is recommended that UBI comply with Section 4901(a) of the New York Insurance Law by filing biennially with the Department, a report of its utilization review plan.</p>	8
<p>C. <u>Grievances</u></p> <p>i. It is recommended that the CDPHP Companies update their Administrative Manual to reflect the additional requirement of Sections 4408-a(7) of the New York State Public Health Law (CDPHP) and 4802(g) of the New York Insurance Law (UBI) that a grievance appeal form is to be included with the CDPHP Companies' issuance of adverse determination notices.</p> <p>ii. It is further recommended that the CDPHP Companies update their Corporate Policy and Procedures – "Specialist as Primary Care Physician," to fully comply with Sections 4403-6(c) of the New York State Public Health Law (CDPHP) and 4804(c) of the New York Insurance Law (UBI). Specifically, the CDPHP Companies' Corporate Policy and Procedure – "Specialist as Primary Care Physician" should be revised to include the wording that a referral from the enrollee's/insured's primary care physician is not required in the case of a medical specialist performing dual primary care and specialty treatment on enrollees/insureds diagnosed with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease.</p>	9 10
<p>D. <u>Explanation of Benefits Statements</u></p> <p>It is recommended that the CDPHP Companies comply with Sections 4408-a (2)(b) of the New York State Public Health Law and 4802(b)(2) of the New York Insurance Law when issuing EOBs</p>	11

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and apprise the enrollees/insureds of their right to designate a representative to file a grievance on their behalf.

E. Claims Review

- |      |   |    |
|------|---|----|
| i.   | It is recommended that the CDPHP Companies in their compliance with the Department's Circular Letter No. 9 (1999), establish additional monitoring/oversight procedures regarding its PBM's claims payments to the retail pharmacies and other prescription drugs suppliers. Such procedures should ensure that the PBM's data files to CDPHP's and UBI's paid pharmacy claims include all payment dates, including the original and adjustment payment dates for each claim. | 14 |
| ii.  | It is recommended that the CDPHP Companies comply with Sections 3216(i)(17)(E) and 3221(l)(8)(A)(E)(F) of the New York Insurance Law by refraining from applying cost sharing to members on covered contraceptive benefits which are subject to the "no cost sharing" provision of the aforementioned statutes.   | 16 |
| iii. | It is also recommended that the CDPHP Companies comply with Section 4303(j)(3) of the New York Insurance Law by refraining from applying cost sharing to members on covered contraceptive benefits which are subject to the "no cost sharing" provision of the aforementioned statutes.   | 16 |
| iv.  | It is further recommended that the CDPHP Companies reimburse all members affected by the erroneous charges delineated above, including interest, where applicable, pursuant to New York Insurance Law section 3224-a(c).  | 16 |

Respectfully submitted,

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Kenneth I. Merritt  
Principal Insurance Examiner

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

KENNETH I. MERRITT, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

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Kenneth I. Merritt

Subscribed and sworn to before me  
This \_\_\_\_ day of \_\_\_\_\_ 2018

NEW YORK STATE  
DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

**Kenneth Merritt**

as a proper person to examine the affairs of

**CDPHP-Universal Benefits, Inc.**

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

**Plan**

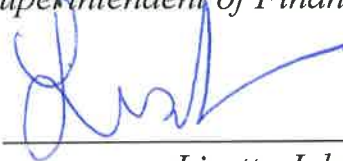
with such other information as he shall deem requisite.

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

this 24th day of January, 2015

BENJAMIN M. LAWSKY  
Superintendent of Financial Services

By:



---

Lisette Johnson  
Bureau Chief  
Health Bureau





*NEW YORK STATE*  
**DEPARTMENT OF FINANCIAL SERVICES**

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

**Kenneth Merritt**

as a proper person to examine the affairs of

**Capital District Physicians Health Plan**

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

**Plan**

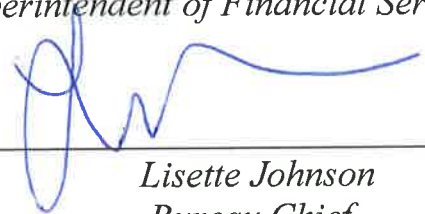
with such other information as he shall deem requisite.

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

this 24th day of January, 2015

**BENJAMIN M. LAWSKY**  
Superintendent of Financial Services

By:



Lisette Johnson  
Bureau Chief  
Health Bureau

