REPORT ON EXAMINATION

OF THE

CAYUGA-ONONDAGA AREA

SCHOOL EMPLOYEES' HEALTHCARE PLAN

AS OF

JUNE 30, 2010

DATE OF REPORT **MARCH 16, 2012**

EXAMINER **GAIL A. ROSS**

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March 16, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30653, dated January 26, 2011, attached hereto, I have made an examination into the condition and affairs of Cayuga-Onondaga Area School Employees' Healthcare Plan, a municipal cooperative health benefit plan licensed pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2010, and respectfully submit the following report thereon.

The examination was conducted at the home office of Cayuga-Onondaga Area School Employees' Healthcare Plan located at 1879 West Genesee Street, Auburn, New York.

Wherever the designations "the Plan" or "COASEHP" appear herein, without qualification, they should be understood to indicate the Cayuga-Onondaga Area Schools Employees' Healthcare Plan.

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

It should be noted that the New York State Insurance Department merged with the New York State Banking Department on October 3, 2011 to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of June 30, 2004. This examination of the Plan was a combined (financial and market conduct) examination and covered the six-year period from July 1, 2004 through June 30, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* ("the Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to fiscal year June 30, 2010 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilized that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of COASEHP. The risk-focused examination approach was included

in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually, for fiscal years 2005 through 2010, by the accounting firm Cuddy and Ward, LLP. The Plan received an unqualified opinion in

each of those years. Certain audit work papers of Cuddy and Ward, LLP were reviewed and relied upon in conjunction with this examination.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which require explanation or description.

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

2. DESCRIPTION OF THE PLAN

The Board of Cooperative Educational Services ("BOCES") and eight (8) member school districts ("Participants") formed a Consortium, effective July 1, 1981. The purpose of the Consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance.

On August 10, 2001, the Plan was issued a certificate of authority by the Superintendent of Insurance under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority, the Participants agreed to share the costs and assume the liabilities for medical, surgical, prescription drugs, and hospital benefits provided to covered employees (including retirees) and their dependents.

Cayuga-Onondaga Area School Employees' Healthcare Plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). To be a grandfathered health plan, the policy or group health plan must have had at least one individual enrolled in coverage on March 23, 2010, and the policy or plan must have continuously covered someone since March 23, 2010. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan means the plan has the discretion not to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits. See Item 5B of this report on examination for additional details regarding this issue.

There are currently eight school districts and the BOCES participating in the Plan. The Plan Participants are as follows:

Cato-Meridian Central School District
Cayuga-Onondaga Board of Cooperative Educational Services
Jordan-Elbridge Central School District
Moravia Central School District
Port Byron Central School District
Skaneateles Central School District
Southern Cayuga Central School District
Union Springs Central School District
Weedsport Central School District

A. Management and Controls

Pursuant to the Municipal Cooperative Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from each participating school district, including BOCES. The governing board of the Plan as of June 30, 2010 was as follows:

Name and Residence	Principal Affiliation
Dale Bates Cincinnatus, New York	Assistant Superintendent, Skaneateles Central School District
David Boyle Oakfield, New York	Assistant Superintendent, Cayuga-Onondaga Board of Cooperative Educational Services
Jeffrey Carmichael Moravia, New York	Business Administrator, Moravia Central School District
Phillip Grome Camillus, New York	Business Administrator, Weedsport Central School District
William Hamilton Skaneateles, New York	Assistant Superintendent of Business & Finance, Jordan-Elbridge Central School District
Crosby Lamont Elba, New York	Assistant Superintendent, Cato-Meridian Central School District
Margaret Robbins Otisco, New York	Business Manager, Union Springs Central School District
Patricia Shaw Owasco, New York	Business Administrator, Port Byron Central School District
Martha Stevermer Rushville, New York	Business Administrator, Southern Cayuga Central School District

According to its Municipal Cooperative Agreement, the governing board is to meet annually in the month of July and shall call special meetings at any time. The governing board scheduled regular bi-monthly meetings during the period under

examination. The minutes of all meetings of the governing board were reviewed. All such meetings were well attended.

It was noted that although the Plan's Board established specific committees, such committees were not formalized within the Plan's Municipal Cooperative Agreement or other corporate documents.

It is recommended that the Plan revise its Municipal Cooperative Agreement or by-laws to include the additional standing committees, or eliminate such standing committees.

A similar recommendation was made in the prior report on examination.

Section 624(a) of the New York Business Corporation Law states:

> "(a) Each corporation shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its shareholders, board and executive committee…"

During the period under examination the Board went into executive sessions, however, it should be noted that the Plan was unable to provide the examiner with the minutes from these meetings.

It is recommended that the Plan comply with the requirements of Section 624(a) of the New York Business Corporation Law by maintaining minutes of all meetings held.

Section 312(b) of the New York Insurance Law states:

> "(b) A copy of the report on examination shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report."

The Plan's board members did not sign a statement confirming that each such member had received and read the prior report on examination (as of June 30, 2004).

It is recommended that the Plan and its board of governors comply with the requirements of Section 312(b) of the New York Insurance Law.

The principal officers of the Plan as of June 30, 2010 were as follows:

Officers	**Title**
David Boyle	Chairperson and President
Dale Bates	Vice Chairperson & Chief Financial Officer
Kathleen Oliver	Treasurer
Evelyn Waterman	Secretary

Subsequent to the examination date, David Boyle resigned from the Plan effective July 31, 2011. Effective August 1, 2011, the governing board elected Dale Bates as Chairperson and President and Peter Colucci as Vice Chair and Chief Financial Officer. Also, Kathleen Oliver resigned as Treasurer effective June 30, 2011. Debra Beyor was elected Treasurer effective July 1, 2011.

The board of governors has designated Mathew Fletcher as the Attorney-in-Fact and custodian for all Plan reports, records, and statements.

B. Territory and Plan of Operation

The Plan provides health benefits in Cayuga and Onondaga counties within New York State. The Plan had annual written premiums of $23,632,386 for the fiscal year ending June 30, 2010. The Plan's enrollment as of June 30, 2010 was 2,479 members. There was no significant change in membership during or subsequent to the examination period. The Plan's participating school districts remained the same throughout the examination period.

C. Corporate Governance

A review of the Plan's service contract with Cuddy and Ward, LLP, the Plan's Certified Public Accounting ("CPA") firm, indicated that such CPA firm was not responsible for rendering an opinion on the Plan's internal control systems.

Article 8 of the Plan's Municipal Cooperation Agreement states in part:

> "The following reports are to be prepared and furnished to the Board, to participating school districts and BOCES, to unions which are the exclusive collective bargaining representatives of employees covered by the Plan, and to the Superintendent of the Department of Insurance:
>
> a. annually, not later than one hundred and twenty days after the close of the Plan's fiscal year, a report showing the financial condition and affairs of the Plan, in such form and providing such other information as the Superintendent may prescribe, together with an audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the Plan …"

Further, Section 4705(e)(1) of the New York Insurance Law states in part:

> "(e) The municipal cooperation agreement shall provide for the following to be prepared and furnished to the governing board… and to the superintendent:

> (1) an annual audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the municipal cooperative health benefit plan;"

It is recommended that the Plan amend its contract with its CPA firm to include a review and rendering of an opinion of the Plan's internal control systems on an annual basis, in order to comply with the requirements of Section 4705(e)(1) of the New York Insurance Law and the Plan's municipal cooperation agreement.

A similar recommendation was made in the prior report on examination.

A review of the Plan's corporate governance structure revealed that the governing board did not adopt written procedures that would allow the board to obtain a certification, annually, from either an internal auditor or independent CPA that the responsible officers have implemented the procedures adopted by the board, and from the Plan's general counsel, a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.

It is recommended that, as a prudent business practice, the board adopt written procedures that would require the board to obtain annual certification, either from an internal auditor, the Plan's independent CPA firm or the Plan's general counsel, to the effect that the Plan's responsible officers have implemented procedures adopted by the board and that the Plan's current claims adjudication procedures, including those set forth

in current claims manuals, are in accordance with applicable statutes, rules and regulations.

Also, as part of the corporate governance structure, the Plan's responsibilities include overseeing management's handling of the claims adjudication process relative to outside parties who, pursuant to an agreement with the Plan, perform claims adjudication procedures.

It is recommended that, as a prudent business practice, the Plan's Board of Governors obtain annual certifications from its third-party claims administrators that claims are being processed in accordance with the plan document and applicable statutes, rules and regulations.

D. Stop-Loss Coverage

Section 4707(a)(2) of the New York Insurance Law states:

> "(a) The governing board of the municipal cooperative health benefit plan shall obtain and maintain on the behalf of the plan a stop-loss insurance policy or policies providing …
>
> (2) specific stop loss coverage with specific retention amount or attachment point not greater than four percent of the amount certified by a qualified actuary to represent the plan's expected claims for the current fiscal year."

As required by Section 4707 of the New York Insurance Law, the Plan maintains both aggregate stop-loss coverage and specific stop-loss coverage. The insurer is

authorized in New York. The following is a summary of the Plan's stop-loss program as of June 30, 2010:

Type	Limits
Excess-of-loss (one layer)	100% of $800,000, excess of $250,000 per member, per contract year.
Aggregate excess-of-loss	$1,000,000 excess of annual aggregate attachment point ($18,421,690), for the current contract period.

The two stop-loss agreements in effect at June 30, 2010, included the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

The specific stop-loss retention amount/attachment point for fiscal year 2010 was greater than four percent of the Plan's expected claims.

It is recommended that the Plan comply with the requirements of Section 4707(a)(2) of the New York Insurance Law and maintain specific stop-loss coverage with a retention amount not greater than four percent of the amount certified by a qualified actuary to represent the Plan's expected claims for the current fiscal year.

E. Administrative Services Agreements

The Plan entered into contractual agreements with the following vendors that provided various administrative services to the Plan:

1. EBS RMSCO, Inc. (RMSCO)

RMSCO acts as the processor of the Plan's claims. RMSCO is to ensure accurate and prompt payment of claims, meet with the Plan's board of governors as deemed necessary to conduct the business of the Plan, provide mandated reports and documentation to regulators and others as required, keep the Plan's participants informed of benefit issues, assist in the review and revision of plan benefit structure and design, provide a computerized on-line system for developing and maintaining comprehensive employee benefit records, provide third-party claims processing services relative to the payment of claims and provide the Plan with access to its provider network.

Section 2101(g)(1) of the New York Insurance Law states in part:

> "(g) In this article "adjuster" means any "independent adjuster" as defined below:
>
> (1) the term "independent adjuster" means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer as are incidental to such claims and also includes any person who for compensation or anything of value investigates and adjusts claims on behalf of any independent adjuster…"

Section 2102(a)(1) of the New York Insurance Law states:

> "(a)(1) No person, firm, association or corporation shall act as an insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

Section 2108(a)(3) of the New York Insurance Law states in part:

> "(a)(3) No adjusters shall act on behalf of an insurer unless licensed as an independent adjuster…"

A review of the claims adjudication process by the examiner revealed that neither RMSCO nor any of its employees assigned to process the Plan's claims possessed a New

York claims adjuster license, while acting in its capacity for the Plan. This is a violation of Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law.

It is recommended that RMSCO, Inc. and each of its employees who perform claim adjusting services in New York (for the Plan) be licensed as independent claims adjusters, in accordance with Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law.

2. Corporate Care Management (Corporate Care)

   Corporate Care provides utilization review services to the Plan and its members in accordance with the Plan's utilization review program. Such services include: prospective case identification services (including pre-certification services), case management services, high cost claim reviews and retrospective claim reviews (including reviews of appeals).

3. Beech Street Corporation

   Beech Street Corporation arranges for the provision of health care services from selected health care providers. In this regard RMSCO purchases access to the Beech Street Corporation health care networks on behalf of the Plan.

4. Express Scripts ("ESI")

   ESI provides on-line claims processing services for covered drugs dispensed by participating pharmacies, mail service pharmacies, or CuraScript (specialty drugs).

5. Cuddy & Ward, LLP

   Cuddy & Ward, LLP provided accounting support and auditing services to the Plan during the examination period.

F. Conflict of Interest Policy

The Plan has a conflict of interest policy in place. For such policy to be effective, it is a good business practice to have board members and senior officers sign the conflict of interest disclosure form annually.

It was noted that during the examination period, July 1, 2004 to June 30, 2010, the board members did not sign the disclosure form.

It is recommended that all board members and officers of the Plan sign the required conflict of interest disclosure statement on an annual basis.

G. Accounts and Records

1. Pharmaceutical rebate receivables

Paragraph 24 of Statements of Statutory Accounting Principles ("SSAP") No. 84 of the NAIC Accounting Practices and Procedures Manual states:

> "(24) the financial statements shall disclose the method used by reporting entity to estimate pharmaceutical rebate receivables. Furthermore, for the most recent three years and for each quarter therein, the reporting entity shall also disclose the following: a.) the estimated balance of pharmacy rebate receivable as reported on the financial statements; b.) Pharmacy rebates as invoiced or confirmed in writing; and c.) Pharmacy rebates collected."

The Plan did not comply with Paragraph 24 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual when it failed to disclose in its annual statements, the method used to estimate its reported pharmaceutical rebate receivables.

It is recommended that the Plan comply with Paragraph 24 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual and disclose in its annual statements the method used to estimate its reported pharmaceutical rebate receivables.

2. Annual statement filings

Section 4710(a)(2) of the New York Insurance Law states in part:

> "(a) The governing board of the municipal cooperation health benefit plan shall:
>
> (2) annually not later than one hundred twenty days after the close of plan year, file a report with the superintendent showing the financial condition and affairs of the plan (including an annual independent financial audit statement and independent actuarial opinion) as of the end of the preceding plan year…"

It was noted that during the examination period, the Plan filed its annual statements each year beyond the required filing period. During the examination period, the Plan filed its annual statements seven to thirty-nine days beyond the required filing date.

It is recommended that the Plan comply with the requirements of Section 4710(a)(2) of the New York Insurance Law and submit its required annual statements to the Superintendent of Financial Services, within the required filing period.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of June 30, 2010. This statement is the same as the balance sheet reported by the Plan in its filed annual statement:

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Assets	Examination	Plan
Cash and cash equivalents	$13,186,753	$13,186,753
Premiums receivable	1,735,386	1,735,386
Total assets	$14,922,139	$14,922,139
Liabilities		
Accounts payable	$ 176,861	$ 176,861
Claims payable	3,560,086	3,560,086
Total liabilities	$3,736,947	$3,736,947
Net worth		
Contingency reserves	$ 1,181,619	$ 1,181,619
Retained earnings	10,003,573	10,003,573
Total net worth	$11,185,192	$11,185,192
Total liabilities and net worth	$14,922,139	$14,922,139

B. Statement of Revenue and Expenses and Net Worth

Net worth increased $10,380,956 during the six-year examination period, July 1, 2004 through June 30, 2010, detailed as follows:

Revenues		
Premiums	$121,102,041	
Investment income	482,851	
Aggregate write-ins for other revenue	1,962,673	
Total revenues		$ 123,547,565
Expenses		
Hospital and medical claims	$ 96,056,192	
Drug claims	13,206,275	
Claims subtotal	$109,262,467	
Reinsurance expenses net of recoveries	134,284	
Net claims incurred	$109,396,751	
Administrative expenses	4,183,191	
Total expenses		113,579,942
Net income		$ 9,967,623

	Gains in Net worth	Losses in Net worth	
Net worth, per report on examination, as of June 30, 2004			$ 804,236
Net income	$9,967,623		
Increase in contingency reserve	460,964		
Aggregate write-ins for changes in retained earnings	_____	$47,631	
Net increase in net worth			$10,380,956
Net worth, per report on examination, as of June 30, 2010			$11,185,192

4. CLAIMS PAYABLE

The examination liability of $3,560,086 is the same as the amount reported by the Plan as of June 30, 2010.

The Plan's liability for unpaid claims was established in compliance with the requirement of Section 4706(a)(1) of the New York Insurance Law. The Plan received permission from the Department on July 27, 2006 to reduce the required minimum amount of its unpaid claims reserve from 25% of total expected incurred claims and expenses to 17% of total incurred claims and expenses, starting with the quarter ending June 30, 2006.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on

statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to subscribers and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

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

A Claims processing
B Policy forms / benefits
C Utilization review
D Underwriting and rating

A. Claims **Processing**

Claims attribute review

A claims attribute review was performed for claims submitted to the Plan during the period, July 1, 2009 through June 30, 2010. A statistical random sampling process was performed testing several attributes deemed to be necessary for the successful

processing of claims. The objective of the sampling process was to test and reach conclusions about all predetermined attributes, individually or in combination.

The claims attribute review did not reveal any problem areas.

Claims prompt payment review

A review to test for compliance with the Prompt Pay Law, Section 3224-a of the New York Insurance Law, was performed by using a statistical sampling methodology covering claims submitted to the Plan during the period July 1, 2009 through June 30, 2010.

The review of the Plan's submitted medical and hospital claims data for the period, July 1, 2009 through June 30, 2010 relative to compliance with Section 3224-a of the New York Insurance Law did not reveal any problem areas.

B. Policy Forms / Benefits

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

> "(a) the governing board of the municipal cooperative health benefit 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..."

The Plan failed to submit its Modified Traditional policy form, which contains a co-payment risk sharing arrangement, to the Superintendent for approval prior to implementation.

It is recommended that the Plan comply with the requirements of Section 4710(a)(1) of the New York Insurance Law and submit all new or revised policy forms to the Superintendent of Financial Services for approval prior to implementation.

According to the Patient Protection and Affordable Care Act ("PPACA"), as amended by the Health Care and Education Reconciliation Act, in order to maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

Section 1251 of the Patient Protection and Affordable Care act states in part:

> "The following language can be used to comply with disclosure requirement:
>
> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan

> status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]"

The Plan did not provide notification to its members, in any plan materials, beginning with the first year to which such provisions would otherwise apply that described the benefits provided under the plan or health insurance coverage and that indicated that the Plan is a grandfathered health plan within the meaning of Section 1251 of the PPACA.

It is recommended that the Plan comply with the requirements of Section 1251 of the Patient Protection and Affordable Care Act and include the required disclosure statement to its members.

On May 5, 2011, the Plan filed Amendment No. 12 to its plan document, which included the aforementioned disclosure statement, with the Department.

The Department approved Amendment No. 12 on September 16, 2011.

C. Utilization Review (UR)

Cayuga-Onondaga Area School Employee's Healthcare Plan contracted with Corporate Care Management, a third party administrator, as its utilization review agent.

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

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

Corporate Care failed to file its utilization review program on behalf of the Plan on a biennial basis with the Superintendent, as required by Section 4901(a) of the New York Insurance Law.

It is recommended that the Plan ensure that Corporate Care Management include the Plan as an entity covered under Corporate Care's utilization review program filed with the Superintendent, as required by Section 4901(a) of the New York Insurance Law.

D. Rating

The Plan's premium rates are developed by the Plan based on a review of its past claims experience and projections of the Plan's future financial performance. Such premium rates which must be community rated, are established and are approved by the Plan's governing board, prior to each plan year.

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 corporation on the basis of a community rating methodology filed with and approved by the superintendent…"

A review of the Plan's rating methodology revealed that the Plan's premium rates during the examination period, although approved by the Plan's board of governors, were not developed from a community rating methodology formula which had been filed with and approved by the Superintendent.

It is recommended that the Plan comply with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law by establishing premium rates based upon a community rating methodology formula which has been filed with and approved by the Superintendent of Financial Services.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included eight (8) recommendations detailed as follows (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Management	
1.	It is recommended that, if it is the intent of the Plan, that the Plan eliminates the standing committees and act upon all matters at the board level. *The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.*	4
	Accounts and Records	
2.	It is recommended that the Plan maintain a Code of Conduct policy and that annual conflict of interest reporting on the part of the Plan's officers, key employees and board of governors. *Although the Plan has adopted its own code of conduct policy, the board of governors has not, annually signed the conflict of interest statement. A similar recommendation is included within this report on examination.*	6
	Internal Controls	
3.	It is recommended the Plan amend the contract with its CPA firm to include an opinion of the Plan's internal control systems in order to comply with Section 4705(e)(1) of the New York Insurance Law. *The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.*	7

ITEM NO.		PAGE NO.
	Annual and Quarterly Statement Preparation	
4.	It is recommended that the Plan complete NY Schedule F – Claims Payable Analysis by including a reconciliation footnote that reflects the statutory reserve that exceeds the actuarially determined unpaid claims. Column C and Column D of Section 1 of Schedule F should reconcile to the claims payable amount reported on line 2 of Report # 1 – Part B: Liabilities and Net Worth of its annual statement for both the current and prior year. *The Plan has complied with this recommendation.*	7
	Cash and Cash Equivalents	
5.	It is recommended that the Plan eliminate any cash balances not specific to its Plan document from its books of account and cash account. *The Plan has complied with this recommendation.*	11
	Accounts Payable	
6.	It is recommended that the Plan report its entire accounts payable balance in its Quarterly and Annual Statements to this Department. *The Plan has complied with this recommendation.*	11
	Market Conduct	
7.	It is recommended that the Plan commit to settle clean claims within 30 days. *The Plan has complied with this recommendation.*	14

ITEM NO.		PAGE NO.
8.	It is recommended the Plan obtain New York State Insurance Department approval prior to marketing any new products including any amended policy forms or riders in accordance with Section 4709(b) of the New York Insurance Law. *The Plan has not complied with this recommendation. A similar recommendation is included within this report on examination.*	15

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM	PAGE NO.
A. Management and Controls	
i. It is recommended that the Plan revise its Municipal Cooperative Agreement or by-laws to include the additional standing committees or eliminate such standing committees. A similar recommendation was made in the prior report on examination.	7
ii. It is recommended that the Plan comply with the requirements of Section 624(a) of the New York Business Corporation Law by maintaining minutes of all meetings held.	7
iii. It is recommended that the Plan and its board of governors comply with the requirements of Section 312(b) of the New York Insurance Law.	8
B. Corporate Governance	
i. It is recommended that the Plan amend its contract with its CPA firm to include a review and rendering of an opinion of the Plan's internal control systems on an annual basis, in order to comply with the requirements of Section 4705(e)(1) of the New York Insurance Law and the Plan's municipal cooperation agreement. A similar recommendation was made in the prior report on examination.	10
ii. It is recommended that, as prudent business practice, the board adopt written procedures that would require the board to obtain annual certification, either from an internal auditor, the Plan's independent CPA firm or the Plan's general counsel, to the effect that the Plan's responsible officers have implemented procedures adopted by the board and that the Plan's current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable statutes, rules and regulations.	10

ITEM **PAGE NO.**

Appointment No. **30653**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Gail Ross

as a proper person to examine into the affairs of the

Cayuga-Onondaga Area School Employees' Healthcare Plan

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

Municipal Cooperative Health Benefit Plan

with such other information as he shall deem requisite.

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

This 26th day of January, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR