REPORT ON EXAMINATION

OF

UNIVERA HEALTHCARE – CNY, INC.

AS OF

SEPTEMBER 30, 2000

DATE OF REPORT **JANUARY 15, 2002**

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

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

August 17, 2001

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

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 21525 dated April 10, 2000, attached hereto, I have made an examination into the condition and affairs of Univera Healthcare – CNY, Inc., as of September 30, 2000 and submit the following report thereon.

The examination was conducted at the Plan's home office located at 8278 Willett Parkway, Baldwinsville, New York 13027.

Whenever the designations "U - CNY" or "the Plan" appear herein without qualification, they should be understood to mean Univera Healthcare – CNY, Inc. Where the term "HSA" appears herein without qualification, it should be understood to mean Health Services Association of Central New York, Inc., an affiliate and contracted provider of health services.

As a result of this examination, the Plan was insolvent as of September 30, 2000, in the amount of $9,245,787, and the Plan's statutory reserve, required pursuant to Section 4310(d) of the Insurance Law, of $7,972,773 was impaired by $17,218,560.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of September 30, 1996. This examination covered the period from October 1, 1996, through September 30, 2000. Where deemed appropriate, transactions subsequent to this period were also reviewed. The examination comprised a verification of assets and liabilities as of September 30, 2000, a review of the income and disbursements to the extent deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items called for in the Examiners Handbook of the National Association of Insurance Commissioners:

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

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

2. DESCRIPTION OF PLAN

The Plan, formerly known as Health Services Medical Corporation of Central New York, Inc., is a health maintenance organization (HMO) which offers prepaid comprehensive health care benefits to subscribers. The Plan was authorized by the New York State Health Department to operate as an HMO pursuant to Article 44 of the New York State Public Health Law on September 1, 1977. On October 1, 1992, the Plan was granted a license to operate pursuant to Article 43 of the New York Insurance Law.

In 1999, the Plan changed its name to Univera Healthcare – CNY, Inc.

A. Management

The sole member of the Plan is Univera Healthcare Foundation, Inc., (UHF) a corporation as defined in Section 102(a)(5) of the Not-For-Profit Corporation Law. Univera Healthcare Foundation, Inc. formerly known as HCP Foundation, Inc., was formed in 1989, for the principal purposes of advancing research in the organization and delivery of medical, health and hospital services, and medical research.

In 1998, Univera Healthcare Foundation, Inc.'s Certificate of Incorporation was amended to change the corporate purposes to include that of a supporting organization under Section 509(a)(3) of the US Internal Revenue Code of 1986 and to specifically identify The Health Care Plan, Inc, Health Services Medical Corporation of Central New York and Health Services Association of

Central New York, Inc. as supported organizations. As of September 30, 2000, pursuant to UHF's Certificate of Incorporation and by-laws, its members consisted of two groups. The Class A member group was comprised of six (6) individuals who were directors of Univera Healthcare – CNY, Inc. The Class B member group was comprised of seven (7) individuals, who are directors of The Health Care Plan, Inc.

As of September 30, 2000, HCP and Univera Healthcare – CNY, Inc. were jointly operated by the Univera Healthcare Foundation, Inc. board of directors and senior officers. Several directors and senior officers of HCP and Univera Healthcare – CNY, Inc. held similar positions in both Plans.

Pursuant to Article III, Section 3.01 Plan's by-laws, management of the Plan is vested in a board of directors. According to Article III, Section 3.02 of the by-laws, the board shall be comprised of not more than fifteen (15), or less than seven (7) voting directors. Pursuant to the Plan's by-laws, at the annual meeting of the sole member of the Plan, the Plan's directors are elected for term of three years. At September 30, 2000, a board consisting of thirteen (13) directors exercised the corporate powers of the Plan. In accordance with its by-laws, the board meets at least once in each calendar quarter.

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

Name and Residence	Principal Business Affiliation
Provider Representatives	
James H. Abbott DeWitt, NY	Retired
Name and Residence	Principal Business Affiliation
James E. Introne Manlius, NY	President & CEO, Loretto Geriatric Center
Arthur R. Goshin, M.D. East Amherst, NY	President & CEO, Univera Healthcare – CNY, Inc..
Subscriber Representative	
George W. Wicks, DVM Central Square, NY	Retired
Public Representatives	
Stephen C. Ames Williamsville, NY	Retired
George S. Deptula, Esq. Syracuse, NY	Attorney, Hiscock & Barley, LLP
Catherine A. Gale Manlius, NY	Attorney, Gale & Dancks, LLC
Bertha S. Laury Buffalo, NY	Retired
LeRoy G. Merriam Central Square, NY	Retired
Theodore J. Scallon Syracuse, NY	Vice President, M&T Bank
Casper F. Sedgwick Fayetteville, NY	Retired

Stephen Suhowatsky Fayetteville, NY	President & CEO Syracuse Supply Company

Officer/Employee

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

At September 30, 2000, the Plan's board consisted of eight (8) public representatives, three (3) provider representatives, one of which was also an officer/employee member, one (1) subscriber representative and one (1) designated officer employee representative.

Section 4301(k)(1)(A)&(B) of the New York Insurance Law provides for equal representation, as nearly equal as possible, relative to subscriber and public representatives on the board of directors. Also, Section 4301(k)(1)(D) provides for the Plan's executive committee to have its member representatives in the same proportions as the membership of the board of directors.

It is thus recommended that the number of directors on the Plan's board representative of subscribers and the number of directors representative of the public be as equal as possible in compliance with Section 4301(k)(1)(A)&(B) of the New York Insurance Law. It is further recommended the Plan comply with Section 4301(k)(1)(D) of the New York Insurance Law and maintain its member representatives in the same proportions as the membership of the board of directors.

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

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

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

It was noted that minutes of the Plan's Committee meetings were not taken in all instances during the examination period.

It is recommended that the Plan maintain minutes of all Committee meeting held by the Plan.

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

Name	Title
Frederick F. Yanni, Jr.	Chair, Board of Directors
Arthur R. Goshin	President & CEO
James E. Introne	Secretary
LeRoy G. Merriam	Treasurer
Samuel S. Rabkin	EVP, Legal Affairs and Government Relations And Corporate General Counsel
Robert S. Wilkinson	EVP, Plan Operations
Timothy J. Finan	EVP, Health Service Operations
Ginger E. Parysek	Senior VP, Human Resources
Lesley K. Lannan	Sr. VP, Marketing & Sales
Paul H. Huefner	Sr. VP, Finance & Budgeting Services

A review of the Plan's minutes of meetings indicated that, since 1998, the Plan's Secretary and Treasurer were not elected on an annual basis. Article IV, Section 4.01(4) of the Plan's by-laws states in part, …

> *"The Secretary and Treasurer shall be elected at the annual meeting of the Board. Each officer shall hold office until the next annual meeting of the Board…"*

It is recommended that the Plan elect its Secretary and Treasurer on an annual basis in compliance with its by-laws.

B. Territory and Plan of Operation

The Plan is licensed to do business as a non-profit health service corporation within this State pursuant to the provisions of Article 43 of the New York Insurance Law.

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

All of the following Counties:

Broome	Onondaga
Chemung	Schuyler
Cortland	Steuben
Herkimer	Tioga
Oneida	Tompkins

Portions of the following Counties:

Cayuga	Oswego
Madison	

On January 12, 2001, the Plan was issued a new Certificate of Authority, which deleted Broome County and portions of Madision County.

Pursuant to an agreement between the Plan and Health Services Association of Central, NY, Inc. (HSA), services are provided to Plan subscribers by HSA employees and/or contracted individuals at HSA's nine medical centers in operation at September 30, 2000. Non-subscribers are also able to utilize the medical centers subject to a fee for service charge.

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

At September 30, 2000, the Plan provided HMO coverage for Medicare beneficiaries (Medicare Parts A and B) in Onondaga, Oswego and Cortland Counties and portions of Cayuga and Madison Counties of this State. It was noted that the Plan discontinued its Medicare coverage at December 31, 2000. The Plan also offered a dental benefit contract in specified counties.

In addition to the Counties listed above, the Plan's PPO product, which is issued under the Plan's Insurance Law Article 43 authority, is also offered in additional areas of upstate New York through a preferred provider network. Said additional Counties include Jefferson, St. Lawrence and Seneca Counties as well as portions of Cayuga, Oswego and Steuben Counties

With regard to the Plan's PPO option, the subscriber can also choose to use out of network providers. The Plan will reimburse the subscriber for covered services based upon a usual and customary fee schedule.

In addition, the Plan also markets, under its Article 43 license, hospital and medical indemnity contracts.

Risk Sharing

Withhold and Incentive Fund Arrangements

At September 30, 2000, the Plan maintained withhold arrangements with two of its participating physician networks, which provided for specified percentage withholds of fees due these physicians ranging from 10% to 20% At the end of each year, a settlement is made according to a formula that details performance criteria.

Incentive Fund Withhold Summary
For the Years 1997 - 2000

Year	Retained	Distributed
1997	$ 150,000	$ 2,041,707
1998	200,361	99,000
1999	390,555	780,745
2000	795,605	400,000

IPA and Network Capitation Arrangements

The Plan at September 30, 2000, maintained capitation arrangements with Individual Practice Associations and medical groups. It was noted that at year-end 2000, with the exception of Health Services

Association, Inc., the Plan had discontinued its capitation arrangements with all of its IPAs and provider networks and instituted fee for service arrangements. However, the agreements with said IPAs and networks were not amended in all cases to reflect said compensation methodology changes.

A review of the Plan's capitation arrangement with HSA for 2000 and 2001 revealed that the capitation arrangement was changed to provide for a stop-loss arrangement to HSA whereby the Plan would pay any costs exceeding $50,000 relative to out of center referrals and inpatient claims. However, the contract between the Plan and HSA was not amended to provide for said stop-loss arrangement.

It is recommended that the Plan amend its contracts with its IPAs and networks, in order to reflect the Plan's current compensation and stop-loss methodology with each IPA or provider network.

It is further recommended that, pursuant to Section 4325(d) of the New York Insurance Law and Department Regulation 164 (11 NYCRR 101), the Plan maintain complete contracts with all capitated providers and that such contracts, not previously approved by the New York Department of Health, be submitted for approval to the Superintendent of Insurance.

Enrollment

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

	HMO Membership	Article 43 Membership	Total Membership
December 31, 1996	85,125	22,300	107,425
December 31, 1997	87,775	15,437	103,212
December 31, 1998	83,867	10,053	93,920
December 31, 1999	81,346	12,489	93,835
December 31, 2000	60,050	9,514	77,564

It is noted that the Plan's total membership decreased by approximately 27.8% during the examination period.

Plan membership at June 30, 2001 consisted of 61,624 members of which 2,812 were Article 43 members and 58,812 were HMO members.

C. Reinsurance

At September 30, 2000, the Plan had the following reinsurance program with an accredited reinsurer in effect for its HMO business including Medicare and its Point of Service (POS) in and out of network business.

Hospital Expenses

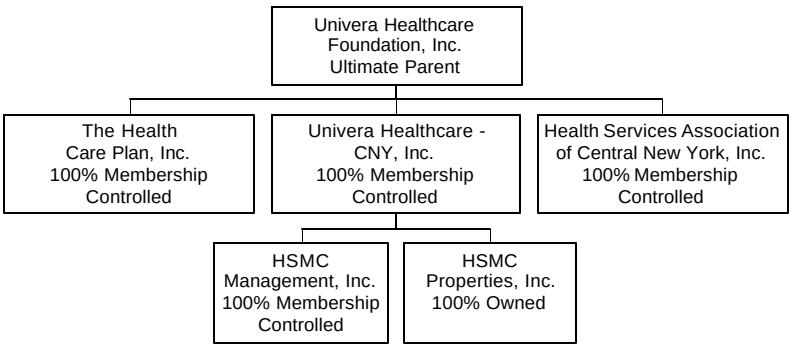
Type	Limits
Excess of loss two layers	90% of $500,000 excess of $200,000 of loss per member, per contract year 100% excess of $700,000 of loss per member, per contract year

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

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

D. Holding Company System

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



Univera Healthcare Foundation, Inc.

Univera Healthcare Foundation, Inc. was the ultimate holding company and sole corporate member of the Plan as of September 30, 2000 (see item 2A, herein)

The Plan is a controlled insurer of Univera Healthcare Foundation, Inc. As such, this Department has mandated that the Univera Healthcare Foundation, Inc. board of directors be determined in accordance with the provisions of Section 4301(k) of the New York Insurance Law.

As of September 30, 2000, HCP and Univera Healthcare – CNY, Inc. were jointly operated by the Univera Healthcare Foundation, Inc. board of directors and senior officers. Several directors and senior officers of HCP and Univera Healthcare – CNY, Inc. held similar positions in both Plans.

The Health Care Plan, Inc. (HCP)

HCP is organized pursuant to the provisions of both Article 43 of the New York Insurance Law and Article 44 of the New York State Public Health Law as a health maintenance organization On

December 3, 1998, the Plan entered into a merger agreement with Health Services Association of Central New York, Inc. (HSA), HCP (d/b/a Univera Healthcare – WNY, Inc.) and Univera Healthcare Foundation, Inc. (formerly HCP Foundation, Inc.).

As a result of the agreement, Univera Healthcare Foundation, Inc. became the ultimate parent of each of three organizations as sole corporate member of each organization.

During the examination period, Univera - WNY made a total of $4,500,000 in New York Insurance Law Section 1307 loans to Univera Healthcare – CNY, Inc. As provided in Section 1307,

repayment of principal and interest shall only be made out of free and divisible surplus, subject to the approval of the Superintendent of Insurance of the State of New York

In 2000, Univera Healthcare – WNY made a non-subordinated loan in the amount of $1,700,000 to Univera Healthcare, CNY, Inc. In 2001, Univera Healthcare – WNY made additional non-subordinated loans of $5,800,000 to U-CNY.

Section 1505(c) of the New York Insurance Law states,

> *"The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year end.*

Section 1505(d)(1) of the New York Insurance Law states in part,

> *"The following transactions between a domestic controlled insurer and any person in the holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit and he has not disapproved it within such period:*
>
> > *1) sales, purchases, exchanges, loans or extensions of credit, or investments, involving more than one-half of one percent but less than five percent of the insurer's admitted assets at last year end.*

With regard to the aforementioned 2000 loan (non-Section 1307), both Univera – WNY and U – CNY, as controlled insurers, exceeded the limitation prescribed by Section 1505(d)(1) of the New York Insurance Law by not notifying the Superintendent of Insurance of such transaction at least thirty days prior thereto prior to making such loan.

With regard to the aforementioned 2001 loans (non-Section 1307), U-CNY and U-WNY did not comply with the provisions of Section 1505(c) of the New York Insurance Law by not obtaining the Superintendent of Insurance's prior approval for said loans.

It is recommended, pursuant to Section 1505(c) of the New York Insurance Law, that the Plan obtain the approval of the Superintendent of Insurance for the loans made by U-WNY to U-CNY in

2001. In addition, it is recommended that the Plan, in the future, comply with the notification and prior approval requirements of Section 1505(c) and (d) of the New York Insurance Law.

Health Services Association of Central New York, Inc. (HSA)

Health Services Association of Central New York, Inc., is a not for profit corporation organized under Article 28 of the New York Public Health Law. As indicated above, the sole member of HSA is Univera Healthcare Foundation, Inc. Pursuant to an agreement with the Plan, HSA provides comprehensive outpatient medical and physician services for U – CNY subscribers on a capitated basis.

As noted in the prior Report on Examination, although a contractual arrangement exists between the Plan and HSA regarding physician and other clinically related health care services, the contract itself is silent regarding reimbursement of administrative expenses between the two parties. In addition, as noted at item 4 of this report, during 1999 and 2000, U – CNY made advances on capitation payments to HSA in the amount of $13 million which were not made under a formal agreement between the two affiliates.

It is recommended that the parties involved enter into a formalized expense sharing agreement. It is recommended that the Plan and HSA execute a formal agreement or amendment to the current capitation contract relative to the aforementioned additional advances on capitation payments made by the Plan to HSA.

HSA reported itself insolvent in the amount of $7,933,376 and $13,890,261 at December 31, 1999 and December 31, 2000, respectively.

HSMC Management, Inc.

HSMC Management, Inc. is a wholly owned, for profit subsidiary of the Plan. HSMC Management, Inc. was formed primarily to provide management services relative to an HMO operation formerly owned by the Plan. As of September 30, 2000, HSMC Management, Inc.'s only source of revenue was from rental income from a building and property leased to the Plan.

H.S.M.C. Properties, Inc.

H.S.M.C. Properties, Inc. was formed in 1999 as a wholly owned non-profit property holding company subsidiary of the Plan. H.S.M.C. Properties, Inc.'s holdings at September 30, 2000 consisted of a building and property, which were transferred to H.S.M.C. Properties, Inc. from HSMC Management, Inc. in 1999. In 2001, the building and property were transferred to Univera – CNY.

During the period under review, the Plan did not make all of its required Regulation 115 filings.

It is recommended that the Plan comply with the requirements of Department Regulation 115 (11 NYCRR 81-2) and file all required reports in a timely manner.

E. **Abandoned Property Law**

It was noted that the Plan did not file all abandoned property reports with the Office of the Comptroller of the State of New York during the period under examination.

Section 1316 of the New York Abandoned Property Law provides for filings relative to unclaimed checks to be made to the Office of the Comptroller of the State of New York.

In March, 2001, the Plan filed a Verification and Checklist for Unclaimed Property with the State Comptroller's Office for the period ended December 31, 2000.

F. Underwriting Ratios

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

	Amounts	Ratios
Premiums earned	$602,843,820	
Medical expenses	$554,817,265	92.03%
Administrative expenses	86,705,128	14.38%
Underwriting gain (loss)	$ (38,678,573)	(6.41)%

G. Accounts and Records

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

Schedule H

A review of the Plan's Schedule H filed with the Plan's December 31, 1999 annual statement indicated that the Plan used a formula relative to the amounts included in said schedule.

However, the Plan did not maintain support for use the formula itself nor documentation supporting amounts included in the formula used in the compilation of this schedule.

It is recommended that the Plan maintain sufficient support relative to the amounts reported in its future Schedule H filings with this Department.

Schedule M

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

The review encompassed an examination of the underlying support data used in compiling Schedule M which was included in the Plan's filed December 31, 1999 annual statement. The Plan did not maintain

underlying support detail, which fully supported all data included within said schedule. Several of the amounts included in the Plan's Schedule M did not reconcile to the Plan's supporting data.

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

H. Records Retention Plan

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

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

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

3. FINANCIAL STATEMENTS

A. Balance Sheet

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

	EXAMINATION	PLAN	SURPLUS INCREASE (DECREASE)
Current assets			
Cash and cash equivalent	$ (882,095)	$ (882,095)	
Short-term investments	4,978,910	4,978,910	
Premiums receivable	3,456,489	3,456,489	
Investment income receivable	32,531	32,531	
Health care receivables	0	0	
Amounts due from affiliates	0	16,681,533	$(16,681,533)
Aggregate write-ins for other assets	750,080	750,080	
Total current assets	$8,335,9145	$25,017,448	$(16,681,533)
Other assets			
Common stocks	$ 1,427,572	$ 1,427,572	
Amounts due from affiliates	1,150,000	1,150,000	
Aggregate write-ins for other assets	1,847,661	1,847,661	
Total other assets	$ 4,425,233	$ 4,425,233	$ 0
Property and equipment			
Land, building and improvements	$ 4,382,752	$ 4,382,752	
Furniture and equipment	929,466	929,466	
Leasehold improvements	0	0	
EDP equipment	4,598,577	4,598,677	
Total property and equipment	$ 9,910,795	$ 9,910,795	$ 0
Total assets	$22,671,943	$39,353,476	$(16,681,533)

	EXAMINATION	PLAN	SURPLUS INCREASE (DECREASE)
Current liabilities			
Accounts payable	$ 201,713	$ 201,713	
Claims payable	18,100,596	18,100,596	
Accrued medical incentive pool	(341,831)	(341,831)	
Unearned premiums	360,154	360,154	
Loans and notes payable	696,687	696,687	
Amounts due to affiliates	4,058,217	4,058,217	
Aggregate write-ins for Current liabilities	3,663,542	3,663,542	
Total current liabilities	$26,739,078	$26,739,078	$ 0
Other liabilities			
Loans and notes payable	$ 4,366,912	$ 4,366,912	
Annuity payable	811,740	811,740	
Total other liabilities	$ 5,178,652	$ 5,178,652	$ 0
Total liabilities	$31,917,730	$31,917,730	$ 0
Net Worth			
Surplus Notes	$ 4,500,000	$ 4,500,000	0
Statutory reserve	7,972,773	$ 7,972,773	0
Retained earnings	(21,718,560)	(5,037,027)	(16,681,533)
Total net worth	$ (9,245,787)	$ 7,435,746	$(16,681,533)
Total liabilities and net worth	$ 22,671,943	$ 39,353,476	

Note 1: As a result of this examination, the Plan was insolvent as of September 30, 2000 in the amount of $9.245.787. The Plan's required statutory reserve, required pursuant to Section 4310(d) of the Insurance Law, of $7,972,773 was impaired by $17,218,560. The Plan reported its statutory reserve as impaired in the amount of $537,027 in its September 30, 2000 quarterly statement filed with the Department.

Note 2: No liability appears on the above statement for loans principal in the amount of $4,500,000 and interest accrued thereon of $375,576. The loans were granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to approval of the Superintendent of Insurance of the State of New York.

Note 3: The Balance Sheet shown above includes no provision for distributions from the Demographic and Specified Medical Condition Pools. For Pool Year 1999, the Pool's administrator's calculation indicates the Plan would receive $0 from the Pools based on the demographic calculation. Based on this calculation, and review by the Examiner, it appears

that the Plan may receive Pool distributions in excess of the amount recorded above for pool years 1999 and 2000. However, the amount of such distributions cannot be fully determined at this time.

B. Statement of Revenue and Expenses

Total net worth decreased $24,724,521 during the examination period, October 1, 1996 through September 30, 2000, detailed as follows:

Revenue

Premiums (Basic) Community rated	$516,901,567	
Premiums- (Drugs)	65,586,304	
Premiums (Other Riders)	697,758	
Title XVIII-Medicare	18,236,642	
Title XIX-Medicaid	2,253,928	
Reinsurance premiums	(832,379)	
Investment income	2,070,059	
ASO revenue	10,914,688	
Other revenue	14,834,554	
Total revenue		$630,663,121

Expenses

Medical and hospital:

Physicians services	$284,279,880	
Other professional services	10,962,150	
Inpatient	137,893,891	
Incentive pool and withhold adjustments	354,947	
Other medical and hospital expenses	45,473,624	
Demographic pool expense (recovery)	117,030	
SMC Pool expense (recovery)	(56,000)	
Drug expense	76,240,460	
Rider expense	278,409	
Subtotal	$555,644,391	
Less: C.O.B. and Reinsurance Recoveries	$ 827,126	
Total medical and hospital expenses	$554,817,265	
Total administration expenses	86,705,128	
Total expenses		$641,452,393
Net income before taxes		$ (12,452,988)
Extraordinary items		(90,000)
Provision for Federal income taxes		0

Net income	$ (12,542,998)

C. Net Worth

Net worth per examination as of September 30, 1996		$ 14,681,881
	Increase (Decrease) in Net worth	
Net income	$(12,542,998)	
Change in not admitted assets	(16,681,553)	
Section 1307 loans	4,500,000	
Total decrease in net worth		$(24,724,531)
Net worth per examination as of September 30, 2000		$ (9,245,787)

4. AMOUNTS DUE FROM AFFILIATES

The examination admitted asset of $ 0 is $16,681,533 less than the $16,681,533 reported by the Plan in its September 30, 2000 quarterly statement.

The examination change is the result of the disallowance as an admitted asset of balances due the Plan from the Plan's affiliate, Health Services Association of Central New York, Inc. (HSA), Pursuant to an agreement with the Plan, HSA provides comprehensive outpatient medical and physician services for Plan subscribers under a capitation arrangement. The above receivable balances represented, primarily, advances from Univera – CNY to HSA in 1999 and 2000 which, as of the examination date, had not been paid back to Univera - CNY

A review of the HSA audited financial statement as of December 31, 2000 indicated that HSA was insolvent in the amount of $13,890,261 as of said date. The HSA audited financial statement as of December 31, 2000 indicated only approximately $33,000 in liquid assets.

Circular Letter 1975-15 states in part,

> *"1. Inter-company balances.*
>
> *Any such receivable over 90 days should be deducted as a not admitted asset."*

Thus, based on HSA's aforementioned insolvent position, its failure to make repayments to the Plan and apparent inability to make payment on the amount due the Plan, this receivable has been classified as a not – admitted asset in this Report on Examination.

5. CONCLUSION

As a result of this examination, the Plan was insolvent as of September 30, 2000, in the amount of $9,245,787 and the Plan's statutory reserve, required pursuant to Section 4310(d) of the New York Insurance Law, of $7,972,773 was impaired by $17,218,560.

6. SUBSEQUENT EVENTS

The Plan reported total capital and surplus of $(18,063,971) as of June 30, 2001. As of June 30, 2001, the Plan's required statutory reserve of $8,094,095 was impaired in the amount of $26,158,066.

7. MARKET CONDUCT ACTIVITIES

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

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

Underwriting

Forms and Rates

A review of the Plan's contract forms and riders in effect at the time of examination revealed the contract certificate CERT-43MGGF-C-2001, Group Certificate of Coverage – Preferred Plan and rates thereon had not received prior approval of the Superintendent of Insurance prior to issuance as required by Section 4308(a) of the New York Insurance Law. As of the date of this writing, the Plan had not received approval from the Superintendent of Insurance for the use of this form and the rates charged thereon.

It is recommended that the Plan obtain approval of contracts and riders prior to issuance as required by Section 4308 of the New York Insurance Law.

Claims Settlement Practices

Explanation of Benefits Forms

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

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

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

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

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

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

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

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

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

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

> *"In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of claim:*
>
> *(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or*

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

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

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

In this regard, samples of paid claims for calendar years 1999 and 2000 were made. The claims were reviewed for compliance with the relevant sections of the New York Insurance Law. The results of the review were then projected for the population of claim payments made during the aforementioned periods. The following schedule quantifies the Plan's projected violations of Section 3224-a of the New York Insurance Law based on the results of this examination's claims payment review.

The following schedule shows the range of projected violations of Section 3224-a of the New York Insurance Law relative to the combined years of 1999 and 2000:

Column 1 shows the total projected Section 3224-a violations.
Column 2 shows those violations for which interest was not due or, if due, was paid correctly.
Column 3 shows those violations for which interest was due but not paid or not paid correctly.

(1)	(2)	(3)
Section 3224-a(a) of the NYIL	Section 3224-a(c) of the NYIL	Section 3224-a(c) Of the NYIL

Upper Limit 22,468	21,786	682
Lower Limit 15,327	15,312	15

Projected violations listed in the above schedule under the heading, Column 1, "Section 3224-a(a) of the NYIL", relate to claim payments made in excess of forty-five (45) days of receipt for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a) or (b) of the New York Insurance Law.

Projected violations listed in the above schedule under the heading, Column 2, "Section 3224-a(c) of the NYIL", relate to claim payments made in excess of forty-five (45) days of receipt for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a) or (b) of the New York Insurance Law and interest was either not due or, if due, was paid correctly.

It is noted that Section 3224-a(c) indicates the following relative to the non-payment of interest.

> *"…When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."*

Projected violations listed in the above schedule under the heading, Column 3, "Section 3224-a(c) of the NYIL", relate to claim payments made in excess of forty-five (45) days of receipt for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a)

or (b) of the New York Insurance Law and interest payments due have been calculated over $2.00 and were not paid to the provider or subscriber.

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

It is further recommended that the Plan pay appropriate interest in those instances where the interest calculated pursuant to Section 3224-a(c) of the New York Insurance Law is $2.00 or more, and where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

Regulation 64 Compliance

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

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

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

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

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

It is recommended that the Plan comply with Part 216.11 of Department Regulation 64 (NYCRR 216.11) and maintain its claims files in such a manner so that all events relating to a claim can be reconstructed by the Insurance Department examiners, including the maintaining of all pertinent claim information relative to communications made to providers and subscribers.

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

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included eleven recommendations detailed as follows (The page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
A.	**Management**	4-5
	It is recommended that the Plan comply with Section 1202(a)(2) of the New York Insurance Law by maintaining 13 members on the board of directors, or by amending its by-laws to fix the number of directors..	
	The Plan complied with this recommendation by maintaining thirteen (13) members on its board of directors at September 30, 2000.	
	It is recommended that the Plan comply with Sections 4301(k)(1) and 4301(k)(1)(D) of the New York Insurance Law.	
	The Plan has not complied with this recommendation. A similar recommendation is included within this Report on Examination.	

ITEM NO. **PAGE NO.**

B. **Holding Company System** 8

It is recommended that a formalized expense sharing agreement be entered into between the Plan and HSA.

The Plan has not complied with this recommendation. A similar recommendation is included within this Report on Examination.

C. **Abandoned Property Law** 8

It is recommended that the Plan file an abandoned property report pursuant to Section 1316 of the New York Insurance Law.

The Plan has complied with this recommendation.

D. **Custodial Agreements** 9

It is recommended that the Plan execute a custodial agreement with the custodian bank that includes the safeguards deemed mandatory by the Department to protect the Plan's assets.

The Plan closed the bank custodial account during the examination period.

E. **Investments and Accounts** 9

It is recommended that, in the future, the Plan remain in compliance with Section 1409 of the New York Insurance Law at all times.

The Plan has complied with this recommendation.

ITEM NO. **PAGE NO.**

It is recommended that the Plan maintain accurate, complete and centralized workpapers supporting amounts reported in its filed annual and quarterly statements. 9

The Plan has complied with this recommendation.

It is recommended that the Plan request the New York State group's enrollment information from the New York State Civil Service Department as frequently as such information is available so that it may reconcile the membership data at various cut-off dates throughout the year in an effort to reduce the amount of future write-offs. 9-10

The Plan has complied with this recommendation.

F. **Conclusion** 15

As a result of this examination, the Plan's required statutory reserve of $15,899,484 is impaired as of September 30, 1996 in the amount of $420,740. The Plan reported itself impaired as of that date in the amount of $1,217,603. The examination reduction of the liability, Claims Payable, in the amount of $796,863 reduced this impairment.

As a result of this examination, the Plan was insolvent as of September 30, 2000, in the amount of $9,245,787 and the Plan's statutory reserve, required pursuant to Section 4310(d) of the New York Insurance Law, of $7,972,773 was impaired by $17,218,560. The Plan reported an insolvency of $14,672,980 as of March 31, 2001. As of March 31, 2001, the Plan's required statutory reserve of $8,048,785 was impaired in the amount of $22,721,765.

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

ITEM NO. **PAGE NO.**

ITEM NO.		PAGE NO.
F.	**Regulation 115 Holding Company Reports**	19
	It is recommended that the Plan comply with the requirements of Department Regulation 115 (11 NYCRR 81-2) and file all required reports in a timely manner.	
G.	**Accounts and Records**	
	It is recommended that the Plan maintain sufficient support relative to the amounts reported in its future Schedule H filings with this Department	20
	It is recommended that the Plan maintain adequate detail records to support the amounts reported in its filed Schedules M.	21
H.	**Records Retention Plan**	22
	It is recommended that the Plan establish and implement a formal records retention plan in compliance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243.3).	
I.	**Forms and Rates**	28
	It is recommended that the Plan obtain approval of contracts and riders prior to issuance as required by Section 4308 of the New York Insurance Law.	
J.	**Explanation of Benefits Forms**	29
	It is recommended that the Plan include within its explanation of benefits forms all wording required by Section 3234(b) of the New York Insurance Law.	

ITEM NO. **PAGE NO.**

Respectfully submitted,

Robert W. McLaughlin, CFE,CIE
Principal Insurance Examiner

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

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

Robert W. McLaughlin

Subscribed and sworn to before me

this_____ day of _____ 2001.

Appointment No. 21525

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Robert W. McLaughlin

as a proper person to examine into the affairs of the

Health Services Medical Corporation of Central New York, Inc.
DBA Univera Healthcare – CNY, Inc.

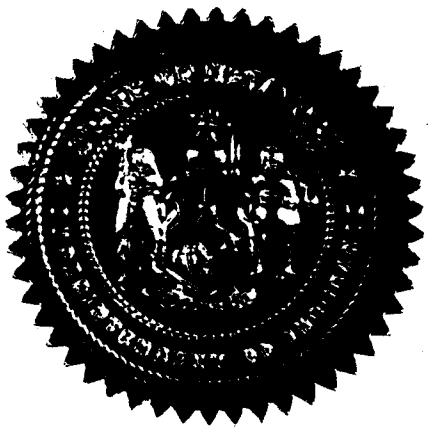
and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

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

this 10th *day of* April 2000



NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent