

REPORT ON EXAMINATION

OF THE

HEALTH INSURANCE PLAN OF GREATER NEW YORK

AS OF

DECEMBER 31, 2001

DATE OF REPORT

NOVEMBER 5, 2004

EXAMINER

LISA M. FERNÉZ

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STATE OF NEW YORK
INSURANCE DEPARTMENT
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NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

November 5, 2004

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

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 21854, dated March 11, 2002, attached hereto, I have made an examination into the financial condition and affairs of the Health Insurance Plan of Greater New York, a domestic not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law, at its home office located at 7 West 34th Street, New York, New York 10001. The following report thereon is respectfully submitted.

A concurrent examination was made of the HIP Insurance Company of New York, an affiliated for-profit health insurance company licensed under the provisions of Article 42 of the New York Insurance Law. A separate report thereon has been submitted.

Wherever the terms "HIP" or "the Plan" appear in this report, without qualification, they shall be understood to refer to the Health Insurance Plan of Greater New York.

HIP filed its December 31, 2001 financial statements with this Department, reporting itself impaired in the amount of (\$2,152,773).

This examination has determined that as of December 31, 2001, the Plan's Statutory Reserves, required pursuant to Section 4310(d) of the New York Insurance Law, were impaired in the amount of (\$53,004,971), (*see Item 4, Statutory Reserves*).

At December 31, 2002, HIP's financial statements filed with this Department indicated that its required Statutory Reserves were fully restored.

1. SCOPE OF EXAMINATION

This examination covers the three-year period from January 1, 1999 through December 31, 2001. Where deemed appropriate, transactions occurring subsequent to this period were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2001 in accordance with Statutory Accounting Principles, as adopted by the Department; a review of 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 as called for in the Examiners Handbook of the National Association of Insurance Commissioners ("NAIC"):

- History of the Plan
- Management and control
- Corporate records
- Fidelity bond and other insurance
- Territory and plan of operation
- Growth of the Plan
- Loss experience
- Accounts and records

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

A special report on examination pertaining to certain practices and transactions regarding such items as compensation for officers and directors, involvement with political contributions, cleaning contracts, corporate automobiles, and apartment leases of the Health Insurance Plan of Greater New York and its affiliated companies was conducted as of September 21, 2000.

A separate examination into the manner in which the Health Insurance Plan of Greater New York and its subsidiary, HIP Insurance Company of New York, conduct their business practices and fulfill their contractual obligations to policyholders and claimants was conducted as of December 31, 1998.

2. DESCRIPTION OF THE PLAN

The Health Insurance Plan of Greater New York (“HIP”) was incorporated in 1944 as a not-for-profit corporation. It began operating as a not-for-profit prepaid medical group practice health plan on March 1, 1947. In 1967, HIP became a not-for-profit health service corporation as defined in Article 43 of the New York State Insurance Law. In addition, since 1978, HIP has been certified as a health maintenance organization (“HMO”) as defined in Article 44 of the New York Public Health Law.

Throughout most of its history, HIP acted as a traditional group model health insurer, arranging for medical care through contracted medical groups at wholly-owned or leased medical centers. During 1997, HIP began to expand its provider network in response to consumer demand, and now operates as a diversified model HMO. This updated model allows HIP members to receive healthcare services from a wide array of physicians who either practice at the traditional HIP medical centers or in their private offices. These physicians contract with HIP on a fee for service or global capitation basis. At December 31, 2001, HIP had a network of approximately 18,000 physicians.

HIP contracts annually with Independent Practice Associations (“IPAs”), Medical Groups and Hospital-based IPAs. Examples of these entities include: Central Brooklyn Medical Group, Continuum Health Partners (including Beth Israel Medical Center and Saint Luke’s–Roosevelt Hospital Center), Lenox Hill Hospital, Montefiore Medical Center, Queens/Long Island Medical Group, St. Barnabas Hospital and Staten Island Medical Group. HIP also contracts with large IPAs and, for the majority of those relationships, HIP pays those physicians directly on a discounted fee-for-service basis. The remaining IPAs (which are referred to as at-risk IPAs or

delegated IPAs) are compensated by HIP based on a capitation amount (per member per month or “PMPM”) to cover the costs of services provided to those HIP members affiliated with an at-risk IPA. Those physicians affiliated with an at-risk IPA are paid directly by the IPA.

During the examination period HIP contracted with six Medical Groups: Brooklyn (“BMG”), Central Brooklyn (“CBMG”), Kingsboro (“KMG”), Queens/Long Island (“QLIMG”), New York (“NYMG”), and Staten Island (“SIMG”). NYMG ceased operations in 2000 and, subsequent to the examination period, the three Brooklyn-based Medical Groups combined operations. As a result HIP currently contracts with three Medical groups; QLIMG, SIMG and CBMG. HIP pays the Medical Groups by means of a capitation payment. These Medical Groups and some of the IPA arrangements also include quality incentive bonus arrangements. Such additional compensation may be available for achieving certain performance goals in the areas of quality improvement, quality of care, and customer satisfaction.

A. Management and Controls

HIP’s by-laws provide that the affairs, property and business of HIP are governed by a board of directors, subject to its by-laws and to such rules and regulations as the board may adopt for that purpose and for the conduct of its meetings. During the three-year examination period, HIP’s board amended its by-laws three times wherein the requisite number of board members was changed from twenty-four (24) in 1999, to nineteen (19) in 2000, to seventeen (17) in 2001.

During the years 1999 and 2000, the Plan failed to maintain the number of directors prescribed in its by-laws. In 1999 and 2000, HIP’s board was comprised of twenty-two (22) and eighteen (18) directors, respectively.

It is recommended that the Plan abide by its by-laws and maintain the prescribed number of members on its board of directors.

The following listing, broken out by the classifications set forth in Section 4301(k) of the New York Insurance Law, represents HIP’s seventeen board members and their principal business affiliations as of December 31, 2001:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>	<u>Year First Elected</u>
<u>Subscriber Directors</u>		
Cynthia Chin-Marshall Patterson, NJ	Associate Administrator, D.C. 37, AFSCME, AFL-CIO	2001*
Kevin Gallagher Brooklyn, NY	President, Uniformed Firefighters Association	1996
Harold (Sonny) Hall Bronx, NY	International President, Transport Workers Union of America	1999**
Carl Haynes New Rochelle, NY	President, International Brotherhood of Teamsters/Local 237	1994
Judith Keiler New York, NY	Consumer Representative, HIP Member Council	1997
Carmelo Mallia Long Island City, NY	Consumer Representative, HIP Member Council	2001
Margaret Pan-Loo, Ph.D. Jamaica Estates, NY	Consumer Representative, HIP Member Council	1996
Peter Scarlatos West Babylon, NY	President, Uniformed Sanitationmen's Association	1993
<u>Officers-Directors</u>		
Daniel McGowan Centerport, NY	President & Chief Operating Officer, Health Insurance Plan of Greater New York	1997
Anthony Watson West Orange, NJ	Chairman and Chief Executive Officer, Health Insurance Plan of Greater New York	1990
<u>Name and Residence</u>	<u>Principal Business Affiliation</u>	<u>Year First Elected</u>

Public Interest Directors

Richard Berman Purchase, NY	President and Chief Executive Officer, Manhattanville College	1996
Elaine Friedman, Esq. Ardsley, NY	Attorney at Law	1998***
Paul Gibson Uniondale, NY	Manager, Continental Grain Company	1996
Ronald Jones Brooklyn, NY	Vice-President of Elementary Schools, United Federation of Teachers	1996
Yungman Lee New York, NY	President and Chief Executive Officer, United Orient Bank	2001
Peter Levin Albany, NY	Dean, School of Public Health, University at Albany	2001
John J. O'Connor Staten Island, NY	Executive Vice President and Chief Marketing Officer, Amalgamated Bank of New York	1992

* Previously served on board of directors during 1991.

** Previously served on board of directors from 1991 through 1998.

*** Previously served on board of directors from 1987 through 1997.

It should be noted that the following board changes transpired subsequent to December 31, 2001:

q On May 30, 2002, the following candidates, who previously served on the board of directors from 1991 through 2001, were re-elected to the board after taking a one-year hiatus:

- § Karen Davis, Subscriber Director
- § Morris Lee, Public Interest Director
- § Charles Wang, Public Interest Director

q On May 30, 2002, Oliver Gray was elected as a Subscriber Director.

q On May 30, 2002, Subscriber Directors Cynthia Chin-Marshall and Judith Keiler and Public Interest Director John O'Connor were not re-elected to the board.

q On November 26, 2002, Subscriber Director Kevin Gallagher resigned from the board.

- q On May 30, 2003, Public Interest Director John O'Connor, who previously served on the board of directors from 1992 through 2002, was re-elected to the board after taking a one-year hiatus.
- q On May 30, 2003, Subscriber Director Peter Scarlatos, who served on the board of directors since 1993, was not re-elected to the board.
- q On May 19, 2004, Subscriber Directors Carl Haynes and Sonny Hall were not re-elected to the board.

The examination review of HIP's corporate structure revealed that in 1999, HIP failed to list director Sonny Hall on the Jurat page of the filed annual statement. Based on information provided by HIP, Mr. Hall was re-elected to the Board, after a one-year absence, commencing May 1999. Further, in its 2001 annual statement HIP failed to list directors Yungman Lee and Peter Levin. The board of directors elected Messrs. Lee and Levin on October 11, 2001.

According to the NAIC Annual Statement Instructions:

"The insurer should file with the NAIC, by March 1, a copy of the NAIC Officers and Directors Information. Each year, the insurer should file this information on all new and current directors, trustees, and executive officers as shown on the Jurat page."

It is recommended that the Plan provide complete and accurate information in its filings with this Department, including filing a complete Jurat page that includes all required disclosures in accordance with NAIC Annual Statement Instructions.

Pursuant to Article II, Section I of HIP's by-laws, medical directors of certain medical groups providing services to HIP subscribers were members of HIP's board of directors until May 25, 2000. The examination review revealed that, although this Section of HIP's by-laws was never formally amended to exclude board participation from the medical groups, HIP has lacked provider representation on its board of directors since May 25, 2000.

Section 4301(k)(1) of the New York Insurance Law states in part:

“The board of directors of each health service, hospital service or medical expense indemnity corporation subject to this article shall be composed of persons who are representative of the member hospitals or licensed medical professionals of such corporations, persons covered under its contracts and the general public. The board of directors may also include persons who are employees of such corporations and who also serve as officers of such corporations.”

HIP violated Section 4301(k)(1) of the New York Insurance Law by failing to maintain a fully constituted board that included representation from the member hospitals or licensed medical professionals.

It is recommended that HIP reconstitute its board of directors to include members that represent its provider base and that such reconstitution be implemented in accordance with the board composition limits set forth in Article 4301(k)(1) of the New York Insurance Law.

Further, on May 25, 2000, HIP amended Article IV, Section II of its by-laws to delete a provision that required licensed medical professionals to be among the membership of its Executive Committee. Accordingly, since such date, HIP’s Executive Committee membership has also lacked any provider representation.

Section 4301(k)(1)(D) of New York Insurance Law states:

“Each such health service, hospital service or medical expense indemnity corporation shall have an executive committee the members of which shall be composed of representatives of any member hospitals or licensed medical professionals of such corporation, employee-officers of such corporation, persons covered under its contracts and the general public in the same proportions as the membership of the board of directors.”

HIP violated Section 4301(k)(1)(D) of the New York Insurance Law by failing to include representation from the member hospitals or licensed medical professionals on its Executive Committee.

It is recommended that HIP amend its by-laws to re-establish the requirement that licensed medical professionals serve on its Executive Committee and that such membership be maintained in the proportion set forth in Section 4301(k)(1)(D) of the New York Insurance Law.

At December 31, 2001, HIP had six standing committees of the board of directors: Audit, Compensation, Executive, Investment, Nominating and Quality Improvement. In addition to the requirements set forth in the by-laws of the board of directors, each of the committees is also subject to its own charter. A review of HIP's committee minutes revealed the following deviations from the Plan's by-laws and/or respective committee charters:

- q The charter of the Compensation Committee requires that meetings be held on a regular, quarterly basis. In both 1999 and 2001 the Compensation Committee held only two meetings.
- q The charter of the Audit Committee requires that meetings be held at least four times annually. In both 1999 and 2000 the Audit Committee met only three times.
- q HIP's by-laws require that the Nominating Committee consist of at least five members. For the May 2000 through May 2001 term, the Nominating Committee was comprised of only four members.
- q The Charter of the Quality Improvement Committee requires that meetings be held at a minimum frequency of four times a year. The Quality Improvement Committee met only three times in 2001.

It is recommended that the Plan abide by its by-laws and respective committee charters by maintaining the prescribed number of committee members and holding the requisite number of meetings.

It was noted that during the examination period, Mr. Anthony L. Watson, while serving as the Chief Executive Officer of the Company, also served on the Audit and Compensation Committees in 1999 and on the Nominating Committee from 1999 through May 2001.

Section 4301(k)(1)(E) of New York Insurance Law states in part:

“The board of directors of a health service, hospital service or medical expense indemnity corporation with a combined premium volume exceeding two billion dollars annually as

of December thirty-first, nineteen hundred ninety-six shall, in addition to its other responsibilities...establish one or more committees comprised solely of directors who are not officers or employees of the corporation. Such committee or committees shall have responsibility for recommending the selection of independent certified public accountants, reviewing the corporation's financial condition, the scope and results of the independent audit and any internal audit, nominating candidates for director for election by members, and evaluating the performance of officers deemed by such committee or committees to be principal officers of the company and recommending to the board of directors the selection and compensation of such principal officers."

The following data was extracted from Schedule T of HIP's filed annual statements for the examination period:

Year	2001	2000	1999
Premium	\$2,167,773,241	\$1,980,496,164	\$1,771,522,162

As demonstrated by the chart above, HIP's 2001 premium volume exceeded the \$2 billion benchmark specified in Section 4301(k)(1)(E). Accordingly, Mr. Watson's membership on the Nominating Committee through 2001 is a violation of Section 4301(k)(1)(E) of the New York Insurance Law.

Further, although Mr. Watson ended his membership participation on the Audit, Compensation and Nominating Committees during the examination period, it is noted that he continues to attend the majority of the meetings as a non-member invitee. Additionally, Mr. Daniel McGowan, HIP's President, Chief Operating Officer, and board of director (since 1997), also attends, as a non-member invitee, the majority of the meetings of these same three Committees.

The practice of senior officers participating as members at meetings of the Audit, Nominating and Compensation Committees is inconsistent with the purpose of establishing and maintaining independent committees of the board, as expressed in the provisions of Section 4301(k)(1)(E) of the New York Insurance Law, and should be discontinued.

It is recommended that the meetings of the abovementioned committees be conducted exclusively by independent board members, in accordance with the requirements of Section

4301(k)(1)(E) of the New York Insurance Law, with only committee members voting on matters before the committee. Attendance and participation at meetings by individuals that are not members of the committee, including senior company employees, will be limited to briefing the committee members.

A review was performed of the attendance at the sixteen board of directors' meetings held during the three-year examination period. The following directors were found to have attended less than 50% of the scheduled board meetings that they were eligible to attend during this period:

<u>Director's Name</u>	<u>No. of Meetings Attended</u>	<u>No. of Meetings Eligible to Attend</u>	<u>Attendance Percentage</u>
Kevin Gallagher	1	16	6%
Paula Gavin	2	8	25%
Sonny Hall	6	15	40%
Carl Haynes	7	16	44%
John O'Connor	5	16	31%
Catherine Ruiz	1	11	9%

A review was also performed of the attendance of directors that served on the various committees of the board during the examination period. The review revealed that although the Audit Committee held nine meetings from May 1999 through the end of 2001, Audit Committee member Paul Gibson attended only one of these meetings, and while the Quality Improvement Committee held six meetings from 1999 through May 2000, Quality Improvement Committee member John O'Connor attended only one of these meetings.

Attendance of directors at board and committee meetings is critical in exercising their duties in a management oversight function. Members of the board and its committees have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board and committee members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached. Members who fail to attend at least one-half of the regular meetings do not fulfill such criteria.

It is recommended that HIP take corrective action by developing a policy to evaluate whether board and committee members who are unable or unwilling to attend meetings consistently should resign or be replaced. Furthermore, in selecting prospective members, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.

It is noted that, of the directors listed above, only Mr. John O'Connor remains on HIP's board. Mr. O'Connor was not on the board for the period May 2002 through May 2003. However, he returned to the board in May 2003.

HIP's by-laws provide that the chairperson, vice chairperson, president, secretary and assistant secretary shall be elected by a majority vote of those directors present at the annual meeting of the board of directors. Each of the other officers shall be appointed by the Chief Executive Officer, subject to the board's approval.

The following is a listing of the principal officers of the Plan as of December 31, 2001:

<u>Name</u>	<u>Title</u>
Anthony Watson	Chairperson and Chief Executive Officer
Daniel McGowan	President and Chief Operating Officer
Michael Fullwood	Executive Vice President, Chief Financial Officer, Corporate Secretary and General Counsel
John Steber	Executive Vice President, Operations and Chief Information Officer
David Abernathy	Senior Vice President, Public Policy and Regulatory Affairs and Executive Director for HIP Administrators
Arthur Barnes	Senior Vice President, External Affairs and Corporate Contributions
Fred Blickman	Senior Vice President, Human Resources
Edward Lucy	Senior Vice President, Delivery Systems Management and Strategy
Ronald Maiorana	Senior Vice President, Public Affairs and Operations
Frank Olsen	Senior Vice President, Product Coordination/Oversight

Ronald Platt, MD	Senior Vice President, Medical Affairs and Chief Medical Officer
Larry Posner	Senior Vice President, Marketing and Sales and Chief Marketing Officer
Leslie Strassberg	Senior Vice President, Actuarial Services and Underwriting
Pedro Villalba	Senior Vice President, Information Technology
Giri Vuppala	Senior Vice President, Strategic Planning and Development

A review of the Plan's Conflict of Interest ("COI") policy and forms was conducted for the years 1999, 2000, and 2001. Such review revealed that the questions contained in the COI forms failed to adequately disclose certain information with respect to its employees, officers, and directors' outside business affiliations. Specifically, the questions in the COI forms failed to adequately elicit the name or nature of the business affiliation and, where applicable, the person's current employment position and work status.

It is recommended that, in order for the Plan to make a truly informed decision regarding whether a conflict of interest may exist, the Plan obtain full disclosure from its employees, officers, and directors with respect to their outside business affiliations.

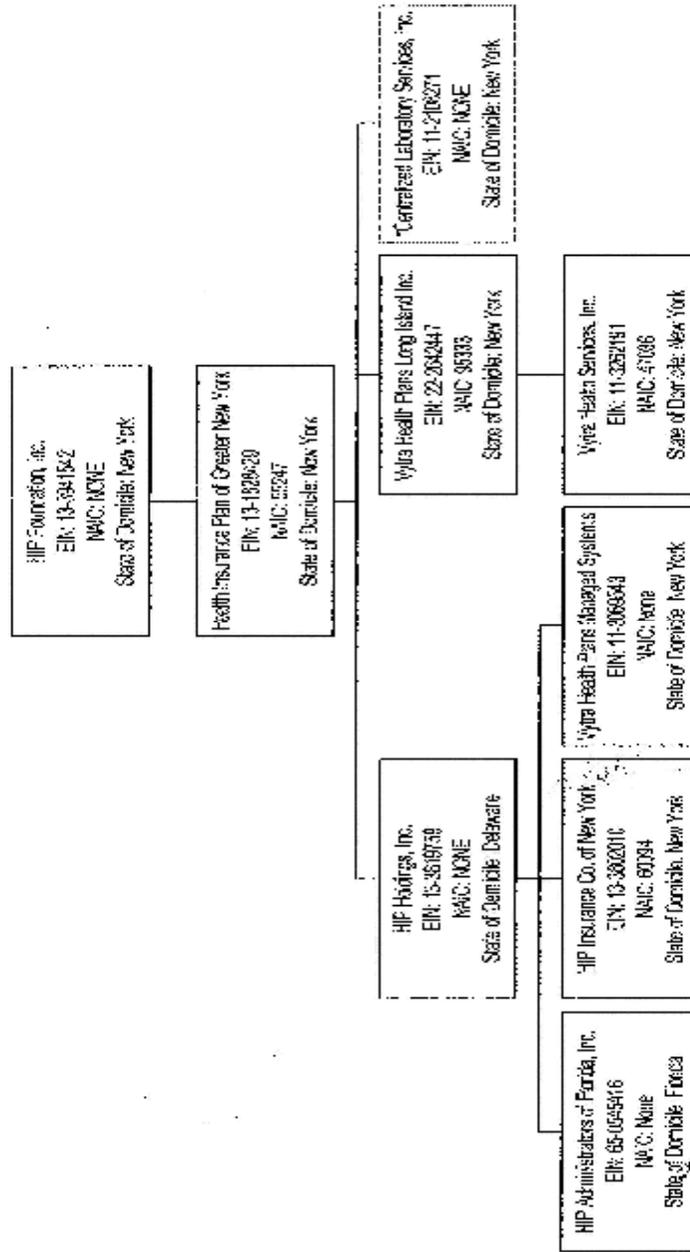
Further, although HIP's Conflict of Interest policy calls for annual distribution, completion and review of the COI forms, the examination review revealed that COI forms were not distributed by the Plan in 1999. HIP explained that the forms were not distributed in 1999 because they were being revised. HIP further explained that it intended to distribute the revised form during 1999, however, it underestimated the amount of time needed to complete such revisions. Accordingly, as the revised forms were not ready for distribution prior to 2000, and the Plan did not distribute the old forms in 1999, it used the updated form for both the 1999 and 2000 calendar years.

It is recommended that HIP comply with its Conflict of Interest policy and have its COI forms distributed, completed and reviewed on an annual basis.

B. Holding Company System

An organizational chart depicting the relationship between the Plan and significant entities in its holding company system as of December 31, 2001 is shown on the following page.

Organizational Chart



* Determined to be a member of HIP's holding company system during the examination period pursuant to Section 1501(a)(5) of the New York Insurance Law

HIP Foundation, Inc. (“HIP Foundation”) is the sole corporate member of HIP. HIP Foundation is a not-for-profit charitable organization formed in 1997 to support, and to act directly and indirectly as a member of, and to acquire and hold direct and indirect interests in, not-for-profit corporations and their affiliates.

As of November 30, 2001, HIP became the sole corporate member of Vytra Health Plan Long Island, Inc., a not-for-profit health maintenance organization (“HMO”), which owns Vytra Health Services, Inc., a not-for-profit health service corporation. HIP also acquired all issued and outstanding shares of Vytra Health Plan Managed Systems, Inc. (collectively referred to as “Vytra”). HIP subsequently transferred Vytra Health Plan Managed Systems to HIP Holdings, Inc., its wholly-owned holding corporation, through a capital contribution. Vytra, based in Melville, New York, with a subscriber base located principally on Long Island, provides health coverage for its members principally through its HMO. Vytra also provides Administrative Services Only (“ASO”) services. Membership and stock interests of Vytra were purchased from Winthrop-University Hospital Association and Excellus-Univera Foundation, Inc. at a cost of \$62 million. On December 31, 2001, HIP paid a \$31.7 million initial installment on the purchase. Pursuant to the issuance of two notes, HIP made additional principal payments of \$15.1 million each on December 13, 2002 and October 30, 2003.

On May 28, 2002, HIP formally submitted a request to the Department to pay the entire debt off early. Although the Department approved HIP’s request on November 7, 2002, HIP proceeded to pay the outstanding balance in two installments; the first installment was paid in December 2002 as scheduled, and the final installment, originally scheduled to be due on December 13, 2003, was paid only a few weeks early.

The transaction was recorded as a purchase, which resulted in goodwill in the amount of \$36.2 million. It is noted that, pursuant to Section 1302 of the New York Insurance Law and Regulation No. 172 (11 NYCRR 83), the Department does not recognize goodwill as an admitted asset for valuation purposes, which is consistent with HIP’s accounting treatment for the acquisition.

HIP owns 100% of the outstanding stock of HIP Holdings, Inc. (“HIP Holdings”), a Delaware holding corporation, which in turn owns all of the outstanding stock of HIP Insurance Company of New York, HIP Administrators of Florida, Inc., and Vytra Health Plan Managed Systems, Inc. A short description of each entity follows:

(A) HIP INSURANCE COMPANY OF NEW YORK (“HIPIC”)

HIPIC is a New York domiciled accident and health insurance company that was formed to market insurance products primarily to HIP members. Specifically, HIPIC underwrites the out-of-network portion of the Point of Service (“POS”) product offered jointly with HIP.

(B) HIP ADMINISTRATORS OF FLORIDA, INC. (“HIP Administrators”)

HIP Administrators is a Florida domiciled third party administrator that was formed in 1995 as a separately controlled affiliate of HIP.

(C) VYTRA HEALTH PLAN MANAGED SYSTEMS, INC.

Vytra Health Plan Managed Systems is a New York domiciled managed health care administrative services organization that was created in 1991 by Vytra’s former owners (detailed above).

During the examination period the following service arrangements were in effect between HIP and its various affiliates:

- q Since 1997, HIP Foundation has provided management oversight, philanthropic and integrated wellness services to HIP. In return, HIP has provided HIP Foundation with various services, such as, but not limited to, office space, utilities, insurance, accounting, legal, human resources, information technology, healthcare coverage and pension benefits.
- q Since 1995, HIPIC has underwritten the out-of-network benefits for the POS product jointly offered by HIP. As HIPIC has no dedicated employees or facilities, all services are provided to HIPIC by HIP.

- q Since 1997, HIP Administrators has provided HIP with claims processing, customer information, fulfillment, and direct marketing services. During the same period, HIP has provided HIP Administrators with information technology, investigation and management services, in addition to performing all administrative services, including the receipt and disbursement of cash.

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

“The following transactions between a domestic controlled insurer and any person in its 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 30 days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period...(3) rendering of services on a regular or systematic basis;”

Inter-company transactions between HIP and HIP Foundation:

Prior to November 2001, inter-company transactions between HIP and HIP Foundation were entered into without making the requisite filings and obtaining the superintendent’s non-disapproval as required by the above-cited statute. On November 29, 2001, HIP filed an Administrative Service Agreement with the Department that was non-disapproved on February 12, 2002. The effective date of the Agreement is June 1, 2002.

Inter-company transactions between HIP and HIPIC:

Prior to June 2001, inter-company transactions between HIP and HIPIC were entered into without making the requisite filings and obtaining the superintendent’s non-disapproval as required by the above-cited statute. On June 25, 2001, HIP filed an Administrative Service Agreement with the Department that was non-disapproved on August 22, 2001. The effective date of the Agreement is August 31, 2001.

Inter-company transactions between HIP and HIP Administrators:

Prior to November 2000, inter-company transactions between HIP and HIP Administrators were entered into without making the requisite filings and obtaining the superintendent’s non-disapproval as required by the above-cited statute. On November 8, 2000,

HIP filed an Administrative Service Agreement with the Department that was non-disapproved on April 27, 2001. The effective date of the Agreement is April 28, 2001.

HIP violated Section 1505(d)(3) of the New York Insurance Law when it entered into transactions with various members of its holding company system that entailed the rendering of services on a regular or systematic basis without giving prior written notice to the superintendent.

It is recommended that, prior to entering into transactions involving the rendering of services on a regular or systematic basis with any member of its holding company system, HIP notify the Department of its intention in writing, pursuant to the provisions of Section 1505(d)(3) of the New York Insurance Law.

As noted above, during the examination period the Plan filed multiple service agreements with the superintendent to account for services it was either rendering to or receiving from its affiliates on a regular or systematic basis. Notwithstanding these filings, the examination review revealed the following shortfalls in the disclosure of terms and/or administration of the agreements:

- q The Agreement between HIP and HIP Foundation fails to identify that HIP Foundation provides various philanthropic services to HIP members. This Agreement states that HIP Foundation will operate management oversight services along with the Integrative Wellness services to HIP Members. This Agreement, however, needs to be more specific as to the services included under this program.

- q The Agreement between HIP and HIPIC calls for the settlement of inter-company receivables on a monthly basis. However, neither party was found to abide by such settlement terms. In fact, during the period from September through December 2001, only one settlement was made, in the month of October.

It is recommended that HIP amend its Agreement with HIP Foundation to specify all services that are being received and submit the amended Agreement to the Department for non-disapproval pursuant to Section 1505(d)(3) of the New York Insurance Law.

It is also recommended that HIP settle its inter-company balances in accordance with the terms outlined in its administrative agreements.

CENTRALIZED LABORATORY SERVICES, INC.

During the examination period, the Plan and certain independent medical groups shared membership of Centralized Laboratory Services, Inc. (“CLS”), a related not-for-profit organization established in September 1965 through the joint sponsorship of HIP (50% share) and the Medical Groups under the Not-for-Profit Corporation Law of the State of New York. CLS operates in the New York City metropolitan area for the purpose of performing laboratory procedures and tests primarily to HIP-covered subscribers, as ordered by independent medical group physicians. Most of the revenue of CLS is generated from performing services to HIP members and, as a result, CLS is dependent on HIP for its ongoing corporate existence. Further, Anthony Watson, HIP’s Chairman and Chief Executive Officer, also served as the Chairman of CLS’ board of directors.

Section 1501(a) of the New York Insurance Law defines the terms “Control” and “Controlled person” as follows:

“(2) “Control” ... means the possession direct or indirect of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise; control shall be presumed to exist if any person directly or indirectly owns, controls or holds with the power to vote ten percent or more of the voting securities of any other person.

(5) “Controlled person” means any person other than a controlled insurer, who is controlled directly or indirectly by a holding company.”

Based on its relationship with HIP during the examination period, it is the Department’s position that CLS met the definition of a “Controlled person” as cited above. Accordingly, any transactions that were entered into between CLS and HIP, or between CLS and any other

member of HIP's holding company system, were subject to the provisions of Article 15 of the New York Insurance Law.

Effective January 1, 1977, HIP and CLS entered into a Laboratory Services Agreement. Under the terms of the Agreement, CLS provides HIP with laboratory testing services to persons enrolled in HIP's benefit plans or managed care programs. HIP neither filed this agreement with the Department for non-disapproval prior to commencing these transactions, nor has HIP submitted this Agreement to the Department to date. Further, prior to 1997, CLS provided services to HIP without having first implemented any formalized agreement.

Based upon the Department's analysis, HIP did not operate in compliance with Section 1505(d)(3) of the New York Insurance Law during the examination period since it did not notify the superintendent of its intention to receive services rendered by CLS on a regular or systematic basis.

Subsequent to the examination date, effective May 9, 2002, HIP became the sole corporate member of CLS by purchasing the remaining 50% of CLS' assets from the Medical Groups for \$826,751.

Although HIP has fully recognized CLS as a member of its holding company system since 2002, as of the date of this report, the Plan had not filed the Laboratory Services Agreement with the Department.

It is recommended that HIP immediately file its agreement with CLS with the Department, pursuant to the provisions of Section 1505(d)(3) of the New York Insurance Law, for the Department's review and non-disapproval.

During the examination period, and subsequent thereto, the following significant changes to the Plan's holding company structure occurred:

¶ HIP Health Plan of Florida, Inc.

Prior to October 19, 2000, the Plan was the controlling corporate member of HIP Health Plan of Florida, Inc. (“HIP-FL”), a Florida not-for-profit health maintenance organization, as well as the sole stockholder of HHPF, Inc. (“HHPF”), an inactive Florida domiciled corporation. Additionally, HIP Holdings, the Plan’s wholly-owned holding corporation, owned all of the outstanding stock of HIP Insurance Company of Florida, Inc. (“HIPIC-FL”) and HIP Administrators.

On October 19, 2000, the Plan, HIP-FL, HIP Holdings, HIP Administrators, HIPIC-FL and HHPF entered into an Amended and Restated Stock and Asset Purchase Agreement with Florida Health Plan Holdings, LLC (“FHPH”). Pursuant to the terms of the agreement, FHPH acquired all of the outstanding capital stock of HIPIC-FL and HHPF from HIP Holdings and HIP respectively. Also on October 19, 2000, HHPF acquired all of the assets and substantially all the liabilities of HIP-FL. In consideration the Plan received a note for \$16.5 million, which was guaranteed by National Century Financial Enterprises, Inc. (“NCFE”).

As a result of this transaction HIP recorded a gain of approximately \$14.2 million on its December 31, 2000 financial statements.

Prior to the sale, the Plan had a program whereby certain of its members received health care services directly from HIP-FL. Total capitation paid to HIP-FL under this program was approximately \$20.4 million for the year ended December 31, 2000. In addition the Plan also provided certain administrative and management services to HIP-FL for a fee.

In August 2001, FHPH, the purchaser of HIP-FL, instituted an action against HIP and three affiliates. HIP’s 2001 annual statement, *Notes to Financial Statements No. 14*, under the caption *Contingencies - Legal Matters*, states “The complaint alleges, among other things, fraud in the inducement, misrepresentation and breach of contract related to the sale of HIP-FL, and seeks an injunction to prevent the Plan from declaring a default of the promissory note given in connection with the sale and damages in excess of \$1.0 million. In connection with this action FHPH withheld the first, second and third installments on the note received by HIP and related interest at December 31, 2001 and 2002.”

A related action was filed on October 19, 2001 by NCFE, the guarantor of the promissory note given by FHPH in the HIP-FL sale transaction, against HIP and the same three affiliates. Per HIP's annual statement, this action similarly alleges fraud and misrepresentation in connection with the sale of HIP-FL, and seeks a declaratory judgment that the guaranty is unenforceable or should be reformed to reflect the true amount due under the note, and injunctive relief to enjoin the Plan from attempting to enforce the guaranty given by NCFE. In November 2002, NCFE filed a petition under chapter 11 of the bankruptcy code. Such filing stays actions that the Plan may take against NCFE.

¶ HIP Health Plan of New Jersey

HIP Health Plan of New Jersey ("HIP-NJ"), an affiliated New Jersey domiciled not-for-profit corporation, became statutorily insolvent in late 1998 and was placed under the control of the State of New Jersey's Department of Banking and Insurance. On March 5, 1999, the Superior Court of Middlesex County of the State of New Jersey ordered the liquidation of HIP-NJ.

On or about November 17, 2000, the State of New Jersey instituted an action against HIP. HIP's 2001 annual statement, *Notes to Financial Statements No. 14*, under the caption *Contingencies - Legal Matters*, states, "The complaint alleges, among other things, the Plan's breach of contract on the guaranty issued by the Plan to the State of New Jersey with respect to HIP-NJ's statutory surplus as required by New Jersey regulations, breach of contract in connection with the agreement between the Plan and HIP-NJ for HIP-NJ to arrange for the provision of medical services to Plan members residing in New Jersey, negligent misrepresentation in connection with actuarial opinions provided concerning the adequacy of HIP-NJ's claims liabilities for 1997, and breach of fiduciary duties."

In December 2003 HIP entered into a Settlement Agreement ("Agreement") with the State of New Jersey. Under the terms of the Agreement, effective July 6, 2004, final settlement on behalf of all interested parties represented by HIP is \$29 million. In a simultaneous

settlement, National Union, HIP's directors and officers' liability ("D&O") carrier, agreed to pay HIP \$10 million in full settlement of HIP's D&O claim in this matter under the terms of a "Release And Agreement" (*see Item 11, Contingent Liability*).

On July 26, 2004, HIP remitted the funds due the State of New Jersey in accordance with the terms of the Settlement Agreement.

q Group Council Mutual Insurance Company

Group Council Mutual Insurance Company ("GCMIC") was a mutual medical malpractice insurance carrier, whose policyholders were primarily doctors employed by the Medical Groups with which HIP contracts to provide medical services to many of HIP's subscribers. Pursuant to Article 74 of the New York Insurance Law, on March 19, 2002, the New York Supreme Court ordered that GCMIC should be liquidated by the superintendent.

In January 2002, HIP prepared but did not serve a suit for declaratory judgment, seeking a declaration that HIP is not liable for any of the existing or future liabilities of GCMIC.

q HIP Network Services IPA, Inc.

Subsequent to the examination date, HIP incorporated an IPA named HIP Network Services IPA, Inc. ("HIP IPA") in December 2002. The New York State Departments of Health and Education consented to the incorporation of this IPA on December 30, 2002 and January 29, 2003, respectively. During the first quarter of 2003, HIP assigned certain agreements it had with physicians in its network to HIP IPA for the purpose of managing the delivery of services to HIP members. HIP IPA had no activity for the year ended December 31, 2002.

C. Territory and Plan of Operation

HIP is a health service corporation licensed under Article 43 of the New York Insurance Law and, since 1978, HIP has been operating under the authority of Article 44 of the Public

Health Law as a health maintenance organization (“HMO”). As of December 31, 2001, HIP served approximately 774,000 members in the following New York counties: Albany, Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester, and Yates.

HIP is a diversified model HMO, offering various group and network based managed care products including standard HMO, Point of Service (“POS”), Preferred Provider Organization (“PPO”) and other hybrid plans, in addition to providing Administrative Services Only (“ASO”) contracts. The Plan’s revenues consist primarily of premiums earned for health insurance relating to services provided to its members by physicians under contract with the Plan. All premiums are written in New York State.

The Plan negotiates its contracts with independent Medical Groups and IPA networks on an annual basis.

As of December 31, 2001, the Plan’s primary internal business divisions were focused on the following segments: Commercial large and small employer group business, Medicare programs, and New York State sponsored programs including Medicaid, Child Health Plus (“CHP”) and Family Health Plus (“FHP”). CHP and FHP programs are geared toward providing HMO benefits to uninsured children and families who meet certain eligibility requirements.

During the examination period, HIP maintained three corporate offices in the Borough of Manhattan, New York. HIP’s corporate headquarters was located at 7 West 34th Street, with its other two offices at 132 W. 31st Street and 32 Old Slip, serving as locations for HIP’s Corporate Facilities/Real Estate Management Department and Management Information Services Department, respectively.

On April 11, 2003, HIP entered into a lease with New Water Street Corp., the owner of the property, for the lease of office and associated space for a new corporate headquarters at 55 Water Street in New York City. HIP consolidated its corporate headquarters and 31st Street

office locations, with the Old Slip space being maintained. The lease is for a period of twenty-one (21) years from the date of occupancy, which commenced in August of 2004.

D. Significant Operating Ratios

Based upon the results of this examination, the following ratios have been computed as of December 31, 2001:

Premium and Risk Revenue to Surplus	15.3 to 1
Liabilities to Liquid Assets	98.9%
Development of Unpaid Claims Ratio	11.8%
Change in Surplus	2.7%
Premium Receivable to Premium Revenue	4.5%

The underwriting ratios presented below are on an earned-incurred basis and encompass the January 1, 1999 to December 31, 2001 period covered by this examination:

	<u>Amounts</u>	<u>Ratios</u>
Claims incurred	\$5,055,689,477	85.47%
Claims adjustment expenses incurred	94,196,355	1.59%
Other underwriting expenses incurred	659,041,080	11.14%
Net underwriting gain	<u>106,207,642</u>	<u>1.80%</u>
Premiums earned	<u>\$5,915,134,554</u>	<u>100%</u>

The following are the expense ratios of the Plan for the examination period:

<u>Year</u>	<u>Premiums Written</u>	<u>Greater of Expenses Paid or Incurred</u>	<u>Expense Ratio %</u>
1999	\$1,781,013,265	\$248,342,932	13.9%
2000	\$1,980,496,165	\$243,154,741	12.3%
2001	\$2,167,773,241	\$349,416,181	16.1%

As reflected above, the Plan's expense ratios exceeded the 12.5% limit prescribed by Section 4309(a)(2) of the New York Insurance Law during the years 1999 and 2001. Pursuant to

instructions from the Department, HIP submitted a comprehensive Administrative Expense Reduction Plan on July 23, 1999, with subsequent updates submitted thereafter.

In calculating the expense ratio to determine Section 4309 compliance, all expenses, other than benefit payments, but including investment expenses, are subject to the limitations set forth in the Insurance Law. Prior to January 1, 2001, HIP recorded its net facility expense as a component of claims expense. Statements of Statutory Accounting Principles (“SSAP”) #22, effective January 1, 2001, requires that rental income be reported as investment income and that expenses incurred in operating the leased property (the Plan’s medical centers) be charged as incurred and included as investment expense. Accordingly, this change in reporting methodology slightly increased the Plan’s investment expense for the 2001 reporting year, which, in turn, contributed somewhat to the increase in its calculated expense ratio for the same period.

As of December 31, 2002 HIP’s expense ratio was within the 12.5% limit.

E. Investment Activities

The Plan has a cash management program which provides for the investment of excess cash balances in financial instruments that are readily convertible into cash. The Plan primarily invests its operating funds in obligations of the U.S. Government and its agencies. Additional types of investments include foreign government obligations, corporate debt securities, unaffiliated common stocks and money market funds. Investments that have maturities of one year or less from the date of purchase are considered short-term investments. The Plan also reported approximately \$80 million in real estate investments for properties occupied by the physicians managing its medical centers.

HIP utilizes the services of investment managers to effect its day to day investment activities. The investment managers are given broad authority to take any action deemed

necessary or desirable in the management of HIP's portfolio, subject to the Plan's Investment Policy and Guidelines.

During the examination review it was revealed that audits of HIP's investment activities were not conducted. Although it was determined that HIP engaged qualified investment managers to handle its day to day investment activities and had furnished guidelines that complied with statutory requirements, HIP's management retains the ultimate responsibility to ensure that applicable provisions of the New York Insurance Law are adhered to.

It is recommended that HIP's management abide by its fiduciary responsibilities and take a more active role in its oversight of the Plan's investment activities, and immediately implement procedures to conduct audits of its investments portfolio on a scheduled basis, at least annually.

Pursuant to the terms of the respective Investment Manager Agreements the securities held in the Plan's portfolio were confirmed to be held by Deutsche Bank Trust Company Americas, HIP's designated custodian.

During the examination review of HIP's investment activities, the following was noted:

¶ Bond Investments

Prior to the adoption of NAIC Codification ("Codification") in January 2001, statutory accounting principles historically called for bonds to be reported at amortized cost using an amortization methodology that the Department deemed acceptable. Codification, however, limits the calculation of amortization of bond premium or discount to the scientific interest (constant yield) method. Note that at no time prior to Codification was reporting bonds at fair market value ("FMV") an acceptable valuation method.

The examination review of HIP's investment portfolio revealed that HIP reported all bond investments held during the years 1999 and 2000 at FMV. As noted above, this method of valuing bonds was inconsistent with statutory accounting principles and accepted Department practices.

During the year 2001, pursuant to statutory accounting principles, HIP began reporting its bond investments at amortized cost. However, the Plan derived its amortized cost using the straight-line method of amortization, rather than the scientific interest method prescribed under Codification.

As the average duration of HIP's 2001 portfolio was calculated to be approximately 2.7 years, it was determined that, for reporting purposes, using either the straight-line or scientific interest amortization methodologies would yield immaterial differences. Accordingly, no examination change was made to the amount reported by HIP for its bond investments in its December 31, 2001 annual statement.

It is recommended that, for future filings with the Department, HIP report its bond investments using the prescribed amortization methodology.

¶ Equity Investments - WebMD

Prior to the examination period, HIP and four other unrelated health care entities — three health insurers, one hospital and one technology partner, in total — invested in a joint venture in The Health Information Network Connection (“THINC”). THINC was organized for the purpose of providing a community health information network for the metropolitan New York, New Jersey and Connecticut regions.

In January 2000, HIP exchanged its investment in THINC for warrants in unregistered shares of CareInsite, Inc., a publicly-held company engaged in developing internet-based clinical commerce applications. HIP exercised most of its warrants and, on January 14, 2000, received 918,004 shares of unregistered common stock of CareInsite, Inc.

On September 12, 2000, CareInsite merged into a wholly-owned subsidiary of Healtheon/WebMD Corporation, which changed its name to WebMD Corporation (“Web

MD”). In accordance with the merger agreement, the Plan exchanged its 918,004 shares of CareInsite for 1,193,535 shares of common stock of WebMD. At December 31, 2001 HIP’s investment in WebMD (1,193,535 shares at \$7.06 per share) was valued at \$8,426,357.

q Short-Term Investments

In its December 31, 2001 annual statement, Schedule DA – Part 1, HIP reported two investments in JPMorgan’s Prime Money Market Fund for a total amount of \$116,600,000.

Section 1404(a)(10)(B)(i) of the New York Insurance Law states:

“Investments made by an insurer (subject to 1403) shall not exceed the following limitations: (i) in any investment company qualifying under item (i) of subparagraph (A) hereof, ten percent of such insurer’s admitted assets as shown by its last statement on file with the superintendent and the aggregate amount of investment in such qualifying investment company shall not exceed twenty-five percent of insurer’s admitted assets as shown by its last statement on file with the superintendent.”

Section 1404(b) of the New York Insurance Law contains a “leeway provision” that allows for investments which do not qualify or are not permitted under Section 1404(a), provided that the aggregate cost of such investments does not exceed five percent of the admitted assets of the insurer as shown by its last statement on file with the superintendent. However, the insurer cannot rely on the leeway provision to exceed the limitations set forth in Section 1409(a) of the New York Insurance Law, which states the following:

“...no domestic insurer shall have more than ten percent of its admitted assets as shown by its last statement on file with the superintendent invested in, or loaned upon, the securities ...of any one institution.”

At December 31, 2001 the Plan reported admitted assets of \$840,007,884. Accordingly, HIP’s investment in JPMorgan Funds, reported in the amount of \$116,600,000, exceeded the prescribed investment limitation set forth in Section 1409(a) of the Insurance Law by \$35,599,212.

In a letter dated November 5, 2002, the Department advised HIP that its review of the Plan's 2001 filed annual statement revealed that HIP's short-term investments in JPMorgan were in excess of the limitations set forth in Section 1404 of the Insurance Law. In its response dated December 13, 2002, the Plan advised the Department that, in order to be in compliance with Section 1404, HIP had established two other money market fund accounts with two different institutions.

However, at December 31, 2002, HIP reported in its annual statement, Schedule DA – Part 1, an investment in JPMorgan's Prime Money Market Fund in the amount of \$140,700,000. For 2002, HIP's reported admitted assets were \$1,053,946,003. Accordingly, HIP continued to exceed the prescribed ten percent limitation by \$35,305,400.

This examination increased the Plan's assets at December 31, 2001 to \$847,478,017, before making a provision for non-admitting any excess investments. HIP's investment in JPMorgan's Prime Money Market Fund was recalculated using the adjusted examination figures. Such recalculation resulted in an excess investment of \$31,852,198.

Due to the materiality of the excess investment and the fact that HIP continued to violate this Section of the Insurance Law subsequent to advising the Department that it had taken corrective action, the excess investment of \$31,852,198 is deemed by this examination to be a non-admitted asset at December 31, 2001.

It is noted that HIP uses the JP Morgan investment as a short-term depository for federal reimbursement of Medicare claims, which Medicare remits at the end of each month. The account is "swept" of the funds on the first business day after the deposit is made. The use of a single fund as a depository for the entire amount is the sole reason for this statutory violation.

It is recommended that HIP comply with the statutory limitations set forth in Sections 1404(a)(10)(B)(i) and 1409(a) of the New York Insurance Law.

F. Bonds/Notes Payable

A summary of HIP's bonds/notes payable as of December 31, 2001 consisted of the following:

<u>Description</u>	<u>Amount</u>	<u>Maturity Date(s)</u>
Series 1990B-1	\$ 17,000,000	July 1, 2016
Series 1990C	35,000,000	July 1, 2010
Senior Notes	30,000,000	December 15, 2002
Vytra Notes	<u>30,254,000</u>	December 13, 2002 and 2003
Total Bonds	<u>\$112,254,000</u>	

As shown above, the total payable outstanding as of December 31, 2001 was \$112,254,000. All debt issues, with the exception of the Vytra Notes, are collateralized by the Plan's gross operating revenues. HIP pledged securities into a restricted account as collateral for the Vytra Notes. The total gross revenues needed to support the \$82,000,000 cumulative liability amounted to 9.8% of the \$840,007,884 of total reported admitted assets as of December 31, 2001. Section 1411(c) of the New York Insurance Law provides that no domestic insurer shall pledge more than 5% of its admitted assets unless the superintendent shall give approval. HIP received the requisite approvals from the Department.

During the review of this item it was revealed that, on December 19, 1997, the Plan issued Senior Notes in the amount of \$75 million with a scheduled maturity date of 2003.

Section 1204(c) of the New York Insurance Law states:

"No person, firm, association or corporation shall in this state issue, circulate or distribute any advertisement, circular, letter or other public announcement in connection with the sale or proposed sale to the public in this state of any securities of any insurer unless a copy of such announcement has been filed with the superintendent and approved by him."

In accordance with the provisions of Section 1204(c) of the New York Insurance Law, HIP obtained the superintendent's approval prior to making the debt offering. However, the filing with the Department and subsequent approval, dated December 9, 1997, was for \$65 million. Additionally, according to the filed Note Purchase Agreement, the notes were originally scheduled to mature in 2004, not 2003 as issued by HIP. Further, without obtaining the Department's prior approval, the Plan subsequently amended the agreement on five occasions where, pursuant to an amendment dated September 5, 2000, the notes were scheduled to be paid in five equal installments with a final maturity date of December 15, 2002.

HIP did not comply with the requirements of Section 1204(c) of the New York Insurance Law when HIP issued an additional \$10 million of Senior Notes in its debt offering and when it used a scheduled maturity date that differed from the date set forth in the approved agreement.

Further, the Plan did not comply with this Section of the Law by amending the terms of the original Notes Purchase Agreement on five occasions without obtaining the superintendent's prior approval.

It is recommended that HIP abide by the terms outlined in the superintendent's approval letter when issuing notes subject to the provisions of Section 1204(c) of the New York Insurance Law.

It is also recommended that HIP file with the Department proposed amendments to previously approved agreements prior to enacting them.

G. Provider/IPA Arrangements and Risk Sharing

Department Regulation No. 164 (11 NYCRR 101) was promulgated on August 1, 2001. Prior to its promulgation, HIP was required to file any contracts entered into with its providers with the Department of Health exclusively. While reviewing HIP's financial risk transfer agreements, it was noted that, in some instances, the Department of Health granted HIP

conditional approvals that were made subject to the approval of the Insurance Department. Upon further investigation the examination review revealed that HIP never filed these contracts with the Insurance Department.

HIP failed to comply with the Department of Health's instructions when it entered into transactions with providers under risk transfer agreements that were not filed with and approved by the Insurance Department.

Department Regulation No. 164 sets forth the standards for financial risk transfer between insurers and health care providers. Accordingly, this Regulation is applicable to all financial risk transfers that transpire between HIP and its Individual Practice Associations ("IPAs") and Health Care Providers ("HCPs"). It should be noted that HIP uses the terminology Medical Groups ("MGs") when referring to its HCPs.

A review of HIP's financial risk transfer agreements with its IPAs and HCPs revealed that HIP failed to comply with Section 101.4(b) of Department Regulation No. 164, which states:

"Notwithstanding any agreement to the contrary, the insurer retains full financial risk on a prospective basis for the provision of health care services pursuant to any applicable policy or contract. At all times, the insurer must be able to demonstrate to the satisfaction of the superintendent that the insurer can fulfill its non-transferable obligation to provide coverage for health care services to subscribers in any event, including the failure, for any reason, of a financial risk transfer agreement with a provider. In considering whether an insurer has satisfied its obligation to retain full financial risk, on a prospective basis, the superintendent shall consider the financial condition of the insurer and the health care provider, including a review of income and expenses, quality and liquidity of assets, establishment of adequate claim and other reserves, net worth, and any financial security deposit, as defined in section 101.5(b) of this Part, established by the health care provider."

In order to satisfy the requirements set forth above, the Department directed all HMOs to complete financial disclosure statements (referred to as Report #10) for all entities with which risk-bearing contractual relationships are maintained. The Department's instructions specifically call for each report to show the risk-bearing entities' ("RBE") results for each HMO with which the RBE contracts. This report is to be attached to the filed New York Data Requirements.

The examination review of HIP's compliance with Regulation No. 164 revealed that HIP filed Report #10 for its IPAs only. HIP failed to comply with the provisions of Section 101.4(b) of Regulation No. 164 by not filing Report #10 for its MGs.

Subsequent to the examination date, HIP commenced filing Report #10 for its MGs in 2003.

Section 101.4(g) of Regulation No. 164 contains a "grandfathering" provision that states the following:

"Financial risk transfer arrangements which are in effect on the effective date of this Part [August 1, 2001] and which receive all necessary Department of Health approvals, may continue in effect without having to meet the requirements of this Part except that the health care provider must comply with the provisions of section 101.9(a)(3) of this Part as respects the filing of audited financial statements for fiscal years which close on or after the effective date of this Part, until the contract renewal date; however, for agreements which are either automatically renewed or whose renewal date is more than thirty-six months after the effective date of this Part, the exemption from meeting all of the other requirements of this Part, including obtaining the superintendent's approval, shall not extend beyond thirty-six months."

As a result of this grandfathering provision, HIP was exempted during the examination period from other prescribed requirements set forth in the Regulation.

However, it is important to mention that Section 101.9(a)(3) of Regulation No. 164 requires that health care providers submit financial statements annually to the insurer and the superintendent, sworn to under penalty of perjury by the health care provider's chief financial officer, showing the health care provider's financial condition at the close of its fiscal year, together with an opinion of an independent certified public accountant ("CPA") on the financial statement of such health care provider. Although this Section indicates the responsibilities of the health care provider, the ultimate responsibility for the timely reporting and collection of these financial statements rests with HIP. It should be noted that the Department did not complete a review of the financial impact of the requirements and applications of Regulation No. 164.

Based on the above, it is recommended that HIP immediately take the necessary actions, where it has not already done so, to ensure its compliance with Department Regulation No. 164.

H. Abandoned Property

Section 1316 of the New York State Abandoned Property Law requires that certain unclaimed insurance proceeds be reported to the State of New York by April 1st of each year. During the examination review of HIP's Abandoned Property procedures and filings with the New York State Comptrollers Office, several deficiencies were noted.

Pursuant to the provisions of Article VII and Section 1316 of the New York Abandoned Property Law:

- ❑ Insurance Companies are required to file a preliminary report with the New York State Comptrollers Office even where there is no Abandoned Property due. This type of report should be mailed so that it is received by April 1st.

The Plan did not file the requisite preliminary reports from 1996 through 2000. (HIP was not required to file the 2001 report for 1997 Abandoned Property due to an ongoing audit by the New York State Comptrollers Office).

- ❑ Within 30 days of filing the preliminary report (or by May 1st) the insurer is required to publish the list of its Abandoned Property.

HIP's Publications of Abandoned Property were made on August 24, 2001 and on August 15, 2002. The Plan failed to publish the list of its Abandoned Property in a timely manner.

- ❑ By the close of business on September 10th, the preliminary report including a new Verification and Checklist should be finalized, and payment must be received in the Office of Unclaimed funds.

HIP failed to make Abandoned Property filings as required by statute that would have identified abandoned property held over from issue years 1994, 1995 and 1996 in a timely

manner. The report that contained abandoned property from those years was filed on September 11, 2001, whereas such reports should have been made in September 1998, 1999, and 2000, respectively.

HIP failed to comply with the abovementioned provisions of Article VII and Section 1316 of the New York Abandoned Property Law by not making requisite filings in a timely manner.

It is recommended that the Plan make all its Abandoned Property publications and filings in accordance with the provisions set forth in the Abandoned Property Law.

I. Accounts and Records

i. Examination Process

During the course of the examination, the examiner encountered instances where HIP employees were unable to provide complete and accurate responses to examination requests. This was due to the examiner's finding that sufficient documentation was not maintained to support some of its accounts (as detailed in this report). These instances caused delays in the examination process, especially when preliminary investigative work commenced prior to being able to determine that the documentation furnished by HIP was not supportive of the financial data being verified.

From the onset of the examination, bi-weekly meetings with HIP's Compliance Officer and designated examination liaison were held. These meetings were intended to expedite the examination process; however, they were not able to prevent the receipt of incomplete and erroneous information, as much of these problems stemmed from systems shortfalls and poor recordkeeping practices.

It is recommended that HIP take the appropriate steps to ensure that its records are maintained in a manner that supports the information filed in its financial statements, and that more efficient procedures for gathering information are implemented to expedite future examinations.

ii. Financial Statement Reporting

During the course of this examination it was noted that the Plan's reporting of certain items was not in accordance with prescribed statutory accounting principles and/or annual statement instructions, detailed as follows:

A. Furniture & Equipment

In its 2001 annual statement, HIP reported "Furniture and Equipment" as a non-admitted asset in the amount of \$9,332,020. The examination review revealed that, other than for fax machines and copiers, HIP did not maintain pertinent information that enabled it to physically locate the items comprising this account. Further, although the Plan started to tag and track new purchases of Furniture and Equipment in 2002, during the examination period, HIP's policy was to only tag items valued in excess of \$750. HIP had not conducted inventory checks of the tagged items.

Additionally, HIP's Fixed Assets Policy calls for Furniture and Equipment to be depreciated over each item's estimated useful life from 5 to 15 years using the straight line method beginning in the month the asset is made available for use. The examination review revealed that, although HIP consistently depreciated items classified as Furniture and Equipment on a straight-line basis, it assigned fixed depreciation periods of 120 months to all items without taking into account the individual item's actual useful life.

Based on the above, it is recommended that HIP:

§ Tag all Furniture and Equipment that qualify for depreciation.

- § Immediately expense and remove from its books for purposes of statutory filings, the remaining balance of any items comprising this account that cannot be located, are no longer in use, or have exceeded their depreciable life term.
- § Take into account each individual item's actual useful life when assigning the period over which the item will be depreciated.
- § Perform audits of its inventory to ensure that the controls in place for recording, valuing and safeguarding its Furniture and Equipment are adequate.

B. Investment in Vytra

In its 2001 annual statement, HIP reported as a non-admitted asset goodwill from its investment in Vytra Health Plans in the amount of \$38,591,239. The examination review revealed that HIP is amortizing the goodwill over a forty-year period.

Statements of Statutory Accounting Principles ("SSAP") No. 68, Paragraph 7, calls for goodwill resulting from the purchase of a Subsidiary, Controlled and Affiliate ("SCA") entity to be amortized over the period in which the acquiring entity benefits economically, not to exceed ten years. Although, with the promulgation of Department Regulation No. 172, the Department did not adopt Paragraph 7 of SSAP No. 68, the Department recognizes the rationale for the ten-year amortization period noted therein.

Accordingly, it is recommended that HIP review its basis for amortizing goodwill over a forty-year period, and make a determination as to whether utilizing a ten-year amortization period may be more appropriate.

C. Medical Group Equipment

In its 2001 annual statement HIP reported "Medical Group Equipment" as a non-admitted asset in the amount of \$5,943,425. The examination review of this item revealed the following:

1. Section 83.4(u) of Department Regulation No. 172 provides that durable medical equipment and fixtures be depreciated utilizing a depreciation schedule no less conservative than as set forth in the latest revision of “Estimated Useful Lives of Depreciable Hospital Assets” (Revised 1998 Edition).

HIP did not utilize a depreciation schedule that met the requirements of Regulation No. 172. Further, the depreciation methodology that it did employ failed to take into account the individual item’s actual useful life in that fixed depreciation periods of 96 months for Medical Equipment and 120 months for Medical Furniture & Fixtures were utilized.

2. Per its letter to the Department dated April 16, 2001, HIP advised that, “The Company discontinued purchasing additional medical equipment approximately two years ago when this responsibility was shifted to the medical group. Unfortunately, there is no ready way to change this accounting practice at this time. As the issue will disappear reasonably soon, I trust we may be allowed to continue the methodology until the depreciation of this equipment is completed.”

In 2003, HIP purchased Medical Equipment and Medical Furniture & Fixtures for Beth Israel MG. Additionally, HIP used the same depreciation methodology as described in item A above.

3. HIP engaged an outside party, General Electric Healthcare Services (“GE”), to perform regularly scheduled maintenance and inspection of the Medical Group Equipment. The inventory used and maintained by HIP is in different format and focuses on different categories as compared to the annual inventory report provided by GE. As a result, there is no ready way to correlate between HIP’s inventory and GE’s report.

Based on the above, it is recommended that HIP:

§ Immediately expense and remove from its books for purposes of statutory filings, the remaining balance of any items comprising this account that cannot be depreciated in accordance with Section 83.4(u) of Department Regulation No. 172.

- § Establish clear guidelines to ensure that any additional purchase of Medical Group Equipment is depreciated in accordance with Section 83.4(u) of Department Regulation No. 172.
- § Modify its inventory to incorporate an identical “Asset Id#” or other cross-referencing detail from the GE report to allow for better tracking of its Medical Group Equipment.

D. Allocation of Expenses

Department Regulation No. 30 sets forth classification and allocation methods to be used by casualty insurers for expense reporting.

Using Department Regulation No. 30 as a guide, the examination reviewed HIP’s expense allocations. This review revealed that the Plan did not employ uniform allocation methods when determining its various departments’ share of corporate expenses. In fact, HIP advised that there were instances where the allocations were based exclusively on the recommendations of the respective departments’ heads rather than formulaic determinations or other prescribed methods. HIP also advised that the methodologies utilized by certain departments had been altered between years.

When asked to support its allocation methodologies, HIP advised that minutes of the meetings with the respective departments were not kept. Additionally, the Plan did not maintain documentation supporting the rationale for either the methodologies applied or the change in methodologies between the years (*see Item 12, Record Retention*).

It is recommended that HIP utilize the principles of Department Regulation No. 30 in the determination of its expense allocations included in the financial statements filed with this Department.

E. Reporting Errors

HIP’s annual statements, as filed with the Department during the examination period, were found to contain numerous reporting errors and misclassifications of accounts. In some

instances, such erroneous reporting resulted in the Plan having to make revisions to previously filed schedules and exhibits. In other instances, various errors were first identified by the examination.

For example, the following reporting errors were among those identified during the examination review:

- q Statutory reserves were miscalculated for reporting year 2000.
- q The 2001 annual statement Schedule H, for both the HMDI and Data Requirements filings, contained inaccurate data.
- q Organization charts contained inconsistencies between years. For example, CLS was included in HIP's organization charts in 2000 and 2002, but was excluded in 2001.
- q The 2001 annual statement Schedule Y, Part 2 failed to reflect the entire year's inter-company transactions, as called for in the NAIC Annual Statement Instructions.
- q The 2001 annual statement Schedule Y, Part 2 also failed to reflect the Plan's transactions with CLS.

It is recommended that the Plan exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions when preparing its filings with the Department.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities reserves and unassigned funds as determined by this examination and as reported by the Plan as of December 31, 2001:

<u>Assets</u>	<u>EXAMINATION</u>		<u>PLAN</u>		<u>Surplus Increase (Decrease)</u>
	<u>Assets</u>	<u>Not Admitted Assets</u>	<u>Net Admitted Assets</u>	<u>Admitted Assets</u>	
Bonds	\$397,972,512	\$	\$397,972,512	\$397,972,512	\$
Common Stocks	27,643,651	501,023	27,142,628	27,142,628	
Mortgage loans	272,510		272,510	272,510	
Real estate	80,464,327		80,464,327	80,464,327	
Cash	(42,443,854)		(42,443,854)	(42,443,854)	
Short-term investments	134,075,724	31,852,198	102,223,526	134,075,724	(31,852,198)
Receivable for securities	55		55	55	
Restricted securities	42,226,358		42,226,358	42,226,358	
Investment in Vytra Health Plans	61,130,375	38,591,239	22,539,136	22,539,136	
Accident and health premiums due & unpaid	97,768,552	850,000	96,918,552	96,918,552	
Investment income due and accrued	3,942,418		3,942,418	3,942,418	
Amounts due from parents, subsidiaries and affiliates	1,498,351	125,927	1,372,424	1,372,424	
Furniture and equipment	9,332,020	9,332,020	0	0	
Electronic data processing equipment	12,514,354		12,514,354	12,514,354	
Medical group equipment	5,943,425	5,943,425	0	0	
Miscellaneous accounts receivable	784,013	456,129	327,884	327,884	
Leasehold improvements	48,380,482		48,380,482	48,380,482	
Other medical receivables	7,470,133		7,470,133	0	7,470,133
Drug inventory	874,543		874,543	874,543	
Prepaid expenses and other	29,793,364	29,793,364	0	0	
EDP application software	20,841,182	20,841,182	0	0	
Secured loans	12,025,375		12,025,375	12,025,375	
Due from Magellan	146,351		146,351	146,351	
Due from worker's comp customers	283,847		283,847	283,847	
Due from CLS	614,266		614,266	614,266	
Due from Vista Health Plans	357,992		357,992	357,992	
Total assets	<u>\$953,912,326</u>	<u>\$138,286,507</u>	<u>\$815,625,819</u>	<u>\$840,007,884</u>	<u>\$(24,382,065)</u>

<u>Liabilities</u>	<u>EXAM</u>	<u>PLAN</u>	<u>Surplus Increase (Decrease)</u>
Claims unpaid	\$335,671,386	\$307,584,941	\$(28,086,445)
Accrued medical incentive pool	10,108,010	10,108,010	
Unpaid claims adjustment expense	3,813,483	3,813,483	
Aggregate claim reserves	0	20,616,312	20,616,312
Premiums received in advance	71,665,054	71,665,054	
General expenses due or accrued	83,240,028	83,240,028	
Amounts withheld or retained for account of others	15,164,029	15,164,029	
Accrued interest payable	2,285,701	2,285,701	
Bonds payable	82,000,000	82,000,000	
Third party payor	20,923,593	20,923,593	
Notes payable for Vytra purchase	30,254,199	30,254,199	
Contingent liability for HIP-NJ	<u>19,000,000</u>	<u>0</u>	<u>(19,000,000)</u>
 Total liabilities	 <u>\$674,125,483</u>	 <u>\$647,655,350</u>	 <u>\$(26,470,133)</u>
 <u>Reserves and Special Funds</u>			
Statutory reserve	\$194,505,307	\$194,505,307	\$ 0
Unassigned surplus	<u>(53,004,971)</u>	<u>(2,152,773)</u>	<u>(50,852,198)</u>
 Total reserves and unassigned surplus	 <u>\$141,500,336</u>	 <u>\$192,352,534</u>	 <u>\$(50,852,198)</u>
 Total liabilities and surplus	 <u>\$815,625,819</u>	 <u>\$840,007,884</u>	 <u>\$(24,382,065)</u>

NOTE 1: HIP filed its December 31, 2001 financial statements with this Department, reporting itself impaired in the amount of \$(2,152,773). This examination has determined that as of December 31, 2001, the Plan's Statutory Reserves, required pursuant to Section 4310(d) of the New York Insurance Law, were impaired in the amount of \$53,004,971 (*see Item 4, Statutory Reserves*).

At December 31, 2002, HIP's financial statements filed with this Department indicated that its required Statutory Reserves were fully restored.

NOTE 2: Concurrent with the examination, the Internal Revenue Service was conducting an audit of HIP's Form 990, Return of Organization Exempt from Income Tax, for the 1998, 1999 and 2000 reporting years. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to such contingency. The IRS audit did result in HIP being reclassified from a Section 501(c)(3) charitable organization to a Section 501(c)(4) social welfare organization.

B. Underwriting and Investment Exhibit

Reserves and unassigned funds increased by \$78,183,291 during the three-year examination period, January 1, 1999 through December 31, 2001, detailed as follows:

Statement of IncomeUnderwriting Income

Premiums earned		\$5,915,134,554
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Deductions:

Claims incurred	\$5,035,073,165	
Claims adjustment expenses	94,196,355	
Administrative expenses incurred	556,412,171	
Soliciting expenses incurred	102,628,909	
Increase in reserves for accident & health contracts	<u>20,616,312</u>	

Total underwriting deductions		<u>5,808,926,912</u>
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Net underwriting gain		\$ 106,207,642
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Investment Income

Net investment income earned	44,147,445	
Net realized capital gains	<u>24,694,372</u>	

Net investment gain		68,841,817
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Other Income (Loss)

Other income/expenses		<u>1,278,703</u>
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Net income		<u>\$ 176,328,162</u>
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Reserves and Unassigned Funds

Reserves and unassigned funds as of December 31, 1998			\$ 63,317,045
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$176,328,162	\$	
Unrealized capital gains	19,247,434		
Change in non-admitted assets		38,919,821	
Cumulative effect of changes in Accounting principles	24,566,262		
Aggregate write-ins for gains/losses to surplus	<u>0</u>	<u>103,038,746</u>	
Total gains and losses	<u>\$220,141,858</u>	<u>\$141,958,567</u>	
Net increase in reserves and unassigned funds			<u>78,183,291</u>
Reserves and Unassigned Funds as of December 31, 2001, per report on examination			<u>\$141,500,336</u>

4. STATUTORY RESERVES

Section 4310(d) of the New York Insurance Law states in part:

“Every such corporation (subject to the provisions of Article 43) shall maintain a reserve, designated as the statutory reserve fund, which shall from time to time during each calendar year be increased in an amount equal to one per centum of the net premium income of such corporation during such whole calendar year, provided however, that:

(2) the statutory reserve fund at the end of any calendar year shall not exceed twelve and one-half per centum of the net premium income of such calendar year.”

Pursuant to Section 4310(d) of the New York Insurance Law, HIP is required to maintain a statutory reserve fund that meets the minimum reserve requirements set forth above. However, for all three years of the examination period, HIP’s reported statutory reserves failed to meet such minimum reserve requirements. Per the Plan’s filed annual statements for 1999, 2000 and 2001, HIP’s statutory reserves were impaired in the amounts of \$38,627,735, \$35,094,614 and \$2,152,773, respectively.

Pursuant to Section 4310(e)(1) of the New York Insurance Law HIP submitted a three year Plan of Restoration on May 15, 1999, with amended plans submitted on July 23, 1999, April 3, 2000, and May 1, 2001. Although HIP’s statutory reserves were not fully restored at December 31, 2001, the Department waived the 2001 statutory reserve requirement due to HIP’s improved financial condition.

However, based on the results of this examination, at December 31, 2001 the Plan’s required Statutory Reserves of \$194,505,307 were determined to be impaired in the amount of \$53,004,971, as follows:

- q HIP reported a statutory reserve deficiency of \$2,152,773 in its 2001 filed annual statement;
- q The contingent liability of \$19,000,000 that this examination established based on a lawsuit that existed as of the examination date, but was settled subsequent to the examination date (*see Item 2B, Holding Company System, HIP Health Plan of New Jersey and Item 11, Contingent Liability*); and

- q The Plan's excess investment of \$31,852,198 in JP Morgan Funds that this examination deemed to be a non-admitted asset at December 31, 2001 (*see Item 2E, Investment Activities*).

At December 31, 2002, HIP's financial statements filed with this Department indicated that its required statutory reserves were fully restored.

5. SHORT-TERM INVESTMENTS

The examination asset of \$102,223,526 is \$31,852,198 less than the \$134,075,724 reported by the Plan in its December 31, 2001 annual statement. The examination change is due to the Plan's excess investment in JPMorgan's Prime Money Market Fund as detailed in Item E, Investment Activities. The amount of the decrease was calculated based on the provisions of Sections 1404(a)(10)(B)(i) and 1409(a) of the New York Insurance Law, and the Plan's 2001 admitted assets as determined by this examination, before making a provision for non-admitting any excess investments.

6. ELECTRONIC DATA PROCESSING EQUIPMENT AND SOFTWARE

The examination asset of \$12,514,354 is the same as the amount reported by the Plan in its December 31, 2001 annual statement. However, the examination review revealed the following:

- A. On page 2, line 20 of its December 31, 2001 annual statement, HIP reported an admitted asset of \$12,514,354 for Electronic Data Processing ("EDP") Equipment and Software. Then on page 2.1, line 2206, HIP reported a not admitted asset of \$20,841,182 for EDP Application Software.

The examination of these line items revealed that HIP used page 2, line 20, to report its mainframe and personal computer hardware, while line 2206 was used to delineate its non-

operating system software. However, the annual statement instructions call for the reporting of EDP equipment, operating and non-operating systems software (net of accumulated depreciation) on one line of the annual statement only.

It is recommended that HIP adhere to the annual statement instructions and report all EDP equipment and software on the line specifically set apart for the disclosure of such information. HIP should continue to non-admit any EDP non-operating software.

B. HIP failed to maintain adequate and/or accurate documentation that would allow for a complete verification that this asset was reported fairly, as follows:

- q The examiner randomly sampled 29 items from a cost inventory report that HIP provided to support this asset. HIP was only able to provide detailed support (invoices and cancelled checks) for 11 of the sampled items (*see Item 12, Record Retention*).
- q Although the cost inventory report contained pertinent information such as asset identifications and tag numbers, the examination was unable to verify the completeness and/or accuracy of the report as HIP had not tagged all the EDP equipment that it had in use. Additionally, during the examination period, HIP's policy was to not tag and track any of its purchased Equipment with a value less than \$750 (e.g., printers, keyboards, monitors, etc...). This policy, however, did not prevent HIP from accounting for these items as admitted assets and, in most cases, depreciating them.
- q HIP consistently depreciated items classified in its EDP equipment hardware inventory on a straight-line basis, assigning fixed depreciation periods of 36 months for computer hardware and 60 months for mainframe hardware, regardless of the individual item's actual useful life.
- q Some of the items that HIP identified as EDP equipment (e.g., laptop carry cases, service warranties, consultation fees, keyboard drawer-kit, etc...), and depreciated accordingly, did not meet the definition of an admitted asset as set forth in Section 1301(a)(18) of the New York Insurance Law. Such items should have been expensed when the items were purchased or the services were rendered.

- q HIP did not have procedures in place to identify and remove from the fixed asset system any equipment that was no longer in use due to obsolescence or replacement.

Accordingly, it is recommended that HIP:

- § Establish clear guidelines to ensure that all the items classified as EDP equipment hardware are properly categorized and recorded as admitted assets in accordance with Section 1301(a)(18) of the New York Insurance Law.
- § Tag all EDP hardware equipment items that qualify for depreciation.
- § Identify any items listed in its EDP hardware inventory that have either been inappropriately classified or cannot be located and, for purposes of statutory filings, immediately expense any remaining value.
- § Develop and maintain a subsidiary ledger for this account and perform scheduled reconciliations between the data maintained by HIP's Information Systems Department and the subsidiary ledger maintained by HIP's Finance Department.
- § Establish clear guidelines for depreciation so that each individual item's actual useful life is determined when assigning the period over which the item is to be depreciated.
- § Perform audits of its inventory to ensure that the controls in place for recording, valuing and safeguarding its EDP equipment assets, admitted and non-admitted, are adequate.

7. LEASEHOLD IMPROVEMENTS

The examination asset of \$48,380,482 is the same as the amount reported by the Plan in its December 31, 2001 annual statement. However, the examination review revealed the following:

HIP was not able to provide documentation to adequately substantiate the value of the items that comprise this account. In response to the examination request to provide documentation supporting this annual statement item, HIP furnished a listing of its Leasehold Improvements (“LHI”) inventory at December 31, 2001 that consisted of two reports — one containing the total inventory cost and the other accumulated depreciation — linked only by a field titled Asset ID#. The examiners netted out the information contained in these two inventories to arrive at year-end amortized value.

After requesting supporting documentation for an initial sample of 35 items from HIP’s LHI inventory list as of December 31, 2001, it was discovered that the information contained therein, and used by the examination team to select the sample, contained data that could not be verified. In fact, after trying unsuccessfully to gather the requested support, the Plan advised that over the years it had made numerous conversions to the accounting system that altered the information contained in the date field of the inventory listing to report the most recent conversion date, rather than the original date the LHI was capitalized. This resulted in a sample of very old items.

Additionally, HIP maintained that all individual LHI amounts on its books at the time of each conversion were zeroed out and any remaining balances were combined onto a single asset line by location and depreciated over the remaining life of the respective lease (without regard to whether the individual asset’s estimated remaining useful life was of a shorter duration). HIP further advised that it did not retain the original date of each LHI for historical information purposes.

Based on the aforementioned, HIP provided a revised inventory format, programmed to take into account the system conversions, from which the examiner selected a modified sample of 35 items of what was believed to be more recent LHI items. However, after conducting some research into the revised sample, HIP advised that several of the items selected for review were older than the data indicated and, as such, had already been fully depreciated. It was not evident that HIP’s inventory contained fully depreciated items as the revised format that was furnished failed to include a data field indicating accumulated depreciation.

On October 8, 2003, HIP provided yet another LHI inventory that contained all the pertinent details, including amortized cost information, necessary to select a sample of items that would most fairly represent the composition of the account. From this inventory a sample of 18 items was extracted with a total amortized cost of \$16,343,870, representing approximately 34% of the reported LHI asset on HIP's 2001 annual statement.

However, of the 18 items sampled, HIP was only able to provide supporting documentation for 10 (*see Item 12, Record Retention*). These 10 items represented a total amortized cost of \$5,702,527 or approximately 35% of the \$16,343,870 sampled and less than 12% of the \$48,380,482 asset reported in the annual statement.

Based on the aforementioned, it is recommended that:

- § HIP establish and maintain a master inventory that contains, at a minimum, pertinent information such as location, original capitalization date, historical cost information, accumulated depreciation and amortized value of each LHI.
- § HIP account for each LHI's actual useful life when assigning the period over which the item will be amortized, not to exceed the remaining life of the original lease.
- § When system conversions are made, HIP refrain from combining the remaining balances of all LHI items onto a single asset line by location and then depreciating this combined balance over the remaining life of the respective lease.
- § HIP immediately expense for purposes of statutory filings, any items listed in its current LHI inventory for which supporting documentation cannot be produced.
- § HIP perform regularly scheduled reconciliations of the items contained in its inventory to ensure that items identified as LHI and amortized accordingly, qualify for such treatment, and that items that fail to qualify, due to changes in their condition or ownership of the asset, be expensed.

HIP's investments in leasehold improvements fall under the purview of Section 4301(e)(5) of the New York Insurance Law which states the following:

“To encourage the development in this state of health maintenance organizations as such term is defined in article forty-four of the public health law, the superintendent may modify any requirement applicable to health service corporations and other corporations organized under this article to permit such corporations to make fuller use of their resources in the development of such plans, including the acquisition and construction of hospitals, medical service centers and other health facilities and the equipment therefor, subject to such limitations as the superintendent shall deem necessary or proper to ensure the performance of contracts issued by such corporations and to protect the interests of persons covered under such contracts.”

In accordance with Section 4301(e)(5) of the Insurance Law, HIP and the Department entered into a Facilities Capital Expenditure Review Agreement (“Facilities Agreement”) on June 11, 1990, which was subsequently amended in 1996. Pursuant to the terms of the Facilities Agreement, HIP is required to keep the Department informed of its facility capital expenditures and secure the appropriate approvals when required. During the examination period, HIP was required to submit for review and approval all Facility Capital Projects valued over \$500,000 prior to the solicitation of construction bids. Aggregate expenditures over \$500,000 in a single facility were also subject to prior approval.

In order to verify the Plan’s compliance with the terms of the Facilities Agreement, the examiner selected a sample of leasehold improvement projects that were completed between the years 1997 and 2001 with aggregate expenditures over \$500,000. HIP was able to furnish supporting documentation (i.e., purchase orders, vouchers, and cancelled checks) for the work completed at the locations sampled. HIP was also able to provide copies of Capital Budget Reports that it had presented to the Department’s Real Estate Bureau for the period under review. However, as there was no ready way to match the LHI projects that were completed to the Capital Budget Reports presented, HIP was unable to demonstrate its compliance with the terms of the Facilities Agreement.

Based on the above, it is recommended that HIP utilize matching indices that enable it to track the leasehold improvement projects completed to the Capital Budget Reports presented to the Department.

It is further recommended that HIP refrain from soliciting construction bids or commencing any leasehold improvement projects without first obtaining the Department's requisite approval pursuant to the terms set forth in the Facility Agreement.

8. OTHER MEDICAL RECEIVABLES

The captioned asset has been established in the amount of \$7,470,133, which represents a reclassification of the Plan's Pharmacy Rebate Receivables. This account was initially netted directly against the Unpaid Claims reserve liability as a reconciling item. It is the Department's position that this methodology does not promote a thorough analysis of the claims liability, or the ability to readily age the captioned receivable from filed financial statements.

In its 2002 annual statement, HIP reported this item on its balance sheet as a Health Care Receivable asset in accordance with revised annual statement instructions and adopted NAIC Codification provisions.

9. CLAIMS RESERVES

In its December 31, 2001 annual statement HIP reported total claims reserves in the amount of \$338,309,263, comprised of the following components:

<u>Annual Statement Line Item Reference</u>	<u>Description</u>	<u>Amount</u>
1	Claims Unpaid	\$307,584,941
2	Accrued Medical Incentive Pool & Bonus Payments	10,108,010
5	<u>Aggregate Claim Reserves</u>	<u>20,616,312</u>
	Claims Reserves	<u>\$338,309,263</u>

¶ Claims Unpaid

The examination amount of \$335,671,386 is \$28,086,445 more than the \$307,584,941 reported by the Plan in its December 31, 2001 filed annual statement. The examination liability is more due to the following:

- § Reclassification of the Plan's Pharmacy Rebate Receivables of \$7,470,133 (*see Item 8, Other Medical Receivables*). This account was initially netted directly against the Unpaid Claims reserve liability as a reconciling item, thus lowering the actual liability.
- § Reclassification of the Aggregate Claim Reserves of \$20,616,312 (*see Aggregate Claim Reserves in this section*).

No additional changes were made to this liability. However, it should be noted that the Department performed an actuarial review of the information reported by HIP in the claims development schedule that was filed with the Department during calendar year 2002 and other supporting documentation deemed necessary for the review. Based on the actuary's review, the claims reserves contained in HIP's financial statements at December 31, 2001 were determined to reflect favorable claims development.

The examination review, however, revealed that such redundancy could be offset by possible unreported and/or underreported liabilities that HIP did not carry on its financial books during the examination period. Specifically, the examination noted various settlements with the Plan's IPAs and Medical Groups that fell outside the terms of the respective capitation agreements. Although the examination review revealed that the Plan's health care providers reported receivables due from HIP on its books for such anticipated settlements, the Plan's books did not reflect any liabilities in excess of the capitation arrangement.

As this examination was unable to fully quantify the liability resulting from these negotiated settlements, no financial change was made to the amount reported by the Plan for claims unpaid in its filed December 31, 2001 annual statement.

It is recommended that HIP review its financial reporting procedures to ensure that claims liabilities are properly recorded.

Further, it is also recommended that HIP prepare its annual statements in accordance with the NAIC Annual Statement Instructions for Health Companies.

¶ Accrued Medical Incentive Pool & Bonus Payments

The examination amount of \$10,108,010 is the same as the amount reported by the Plan in its December 31, 2001 filed annual statement. This amount represents the Plan's estimated liability for its share of the funding for the Market Stabilization Pool established under the purview of Department Regulation No. 146 (11 NYCRR 361).

¶ Aggregate Claim Reserves

The captioned liability of \$20,616,312, as reported by the Plan at December 31, 2001, has been eliminated and the reserve was reclassified to the claims unpaid liability (*see Claims Unpaid in this section*).

The liability amount reported by HIP as Aggregate Claim Reserves on line 5 of the annual statement represents the value of some future benefits which are to be provided after December 31, 2001, for claims which have already occurred as of December 31, 2001 (i.e. Incurred but not Reported or "IBNR" losses). Per the NAIC Annual Statement Instructions for Health Companies, IBNR losses are to be reported as a component of claims unpaid.

Accordingly, this examination has determined that the amount reported by the Plan as Aggregate Claim Reserves on page 3, line 5 of the annual statement should have instead been reported as Claims Unpaid on page 3, line 1.

SSAP #54, which was effective as of January 1, 2001, provides statutory guidance for income recognition and policy reserves for individual and group accident and health contracts. It is noted that, based on its interpretation of SSAP #54, HIP acted reasonably in its reporting of Aggregate Claims Reserves for 2001.

In its 2002 annual statement filing HIP properly reported this liability on page 3, line 1 as a component of claims unpaid.

10. UNPAID CLAIMS ADJUSTMENT EXPENSES

The examination liability of \$3,813,483 is the same as that reported by the Plan in its December 31, 2001 filed annual statement. However, the following is noted:

The following exhibit demonstrates HIP's "paid to paid" ratios (claims adjustment expenses paid expressed as a percentage of claims expenses paid on a calendar year basis), as calculated by this examination using information reported by HIP in its filed financial statements for the years ending December 31, 2000, December 31, 2001 and December 31, 2002 (the three most complete calendar years):

	<u>2000</u>	<u>2001</u>	<u>2002</u>
Total Medical & Hospital Paid Claims	\$1,656,772,077	\$1,767,811,148	\$1,980,476,737
Paid Claims Adjustment Expenses ("CAE")	32,778,034	36,440,773	36,634,950
Percentage of CAE	1.98%	2.06%	1.85%

As reflected in the chart above, HIP's reported paid claims expense averages just under 2% of total paid claims per calendar year. Nonetheless, HIP's unpaid claims adjustment liability as of the examination date is approximately 1.2% of its reported unpaid claims reserve for the same period. Accordingly, it appears that HIP may have under reserved this liability account at December 31, 2001. However, as the difference between the Plan's reported liability and the amount determined by this examination is deemed to be immaterial, no change has been made to the financial statements contained herein.

It is noted that, in addition to the examination analysis, an independent review of the Plan's data was performed by a Department actuary. Such review yielded results that are consistent with the findings described above.

It is recommended that HIP review its methodology for determining its Unpaid Claims Adjustment Expenses.

11. CONTINGENT LIABILITY

The captioned liability has been established in the amount of \$19,000,000. The liability was established based on a lawsuit that existed at the examination date, but which was settled subsequent to the examination date (*see Item 2B, Holding Company System, HIP Health Plan of New Jersey and Item 4, Statutory Reserves*). It is noted that, at the time the 2001 Annual Statement was being prepared, HIP did not have specific information to determine the amount of this liability.

12. RECORD RETENTION

During the examination period the Plan did not maintain a formal corporate-wide records retention plan.

Section 243.3(c) of Department Regulation No. 152 (11 NYCRR 243) states the following:

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

In lieu of a formal corporate-wide plan, HIP rested the responsibility for record retention with each individual department. Each department was required to ensure proper record keeping practices and to satisfy the information needs of the Company and any regulatory agencies.

During the examination period HIP failed to comply with Section 243.3(c) of Department Regulation No. 152 by not maintaining a formal corporate-wide records retention plan.

Subsequent to the examination period, HIP established a formal Record Retention Policy in 2002.

Further, Section 243.2 of Department Regulation 152 states the following:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain...(7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset, ownership, and source documents, for six calendar years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer.”

As noted throughout this report there were various instances where HIP failed to demonstrate adequate record retention practices.

For example, during the examination of the Plan’s Fixed Assets accounts, the examiner was unable to verify the actual value of the fixed assets because HIP did not maintain adequate documentation, including historical cost information, as follows:

- q For the review of EDP Equipment and Software, the examiner randomly selected 29 items from HIP’s cost inventory and requested invoices and cancelled checks for each of the items. The Plan was only able to provide the examiner with copies of the invoices and cancelled checks for 11 of the requested items.

- q For the review of Leasehold Improvements, the examiner randomly selected 18 items from the inventory. The Plan was only able to provide supporting documentation for 10 of the requested items.

Additionally, during the examination review of HIP’s administrative expenses, it was revealed that HIP was unable to furnish written documentation to support its expense allocations. HIP advised that the basis used for its departmental allocations was the recommendations and opinions of the heads of the individual departments. HIP further advised that it used a similar approach when it modified the model to reflect changes in the respective departments’ structure and functions between years. HIP did not maintain minutes of the discussions held with the

department heads, nor did it maintain documentation to support the rationale behind the expense model modifications.

It is recommended that HIP comply with the provisions set forth in Section 243.2 of Department Regulation No. 152 by maintaining the financial records necessary to verify its financial condition.

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management and Controls</u>	
i. It is recommended that the Plan abide by its by-laws and maintain the prescribed number of members on its board of directors.	5
ii. It is recommended that the Plan provide complete and accurate information in its filings with this Department, including filing a complete Jurat page that includes all required disclosures in accordance with Annual Statement Instructions.	8
iii. HIP violated Section 4301(k)(1) of the New York Insurance Law by failing to maintain a fully constituted board that included representation from the member hospitals or licensed medical professionals.	9
iv. It is recommended that HIP reconstitute its board of directors to include members that represent its provider base and that such reconstitution be implemented in accordance with the board composition limits set forth in Article 4301(k)(1) of the New York Insurance Law.	9
v. HIP violated Section 4301(k)(1)(D) of the New York Insurance Law by failing to include representation from the member hospitals or licensed medical professionals on its Executive Committee.	10
vi. It is recommended that HIP amend its by-laws to re-establish the requirement that licensed medical professionals serve on its Executive Committee and that such membership be maintained in the proportion set forth in Section 4301(k)(1)(D) of the New York Insurance Law.	10
vii. It is recommended that the Plan abide by its by-laws and respective committee charters by maintaining the prescribed number of committee members and holding the requisite number of meetings.	11

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management and Controls</u>	
viii. Mr. Watson’s membership on the Nominating Committee through 2001 is a violation of Section 4301(k)(1)(E) of the New York Insurance Law.	11
ix. The practice of senior officers participating as members at meetings of the Audit, Nominating and Compensation Committees is inconsistent with the purpose of establishing and maintaining independent committees of the board, as expressed in the provisions of Section 4301(k)(1)(E) of the New York Insurance Law, and should be discontinued.	12
x. It is recommended that the meetings of the Audit, Nominating and Compensation Committees be conducted exclusively by independent board members, in accordance with the requirements of Section 4301(k)(1)(E) of the New York Insurance Law, with only committee members voting on matters before the committee. Attendance and participation at meetings by individuals that are not members of the committee, including senior company employees, will be limited to briefing the committee members.	12
xi. It is recommended that HIP take corrective action by developing a policy to evaluate whether board and committee members who are unable or unwilling to attend meetings consistently should resign or be replaced.	13
xii. It is recommended that, in order for the Plan to make a truly informed decision regarding whether a conflict of interest may exist, the Plan obtain full disclosure from its employees, officers, and directors with respect to their outside business affiliations.	15
xiii. It is recommended that HIP comply with its Conflict of Interest policy and have its COI forms distributed, completed and reviewed on an annual basis.	15
B. <u>Holding Company System</u>	
i. HIP violated Section 1505(d)(3) of the New York Insurance Law when it entered into transactions with various members of its holding company system that entailed the rendering of services on a regular or systematic basis without giving prior written notice to the superintendent.	20

<u>ITEM</u>	<u>PAGE NO.</u>
B. <u> Holding Company System</u>	
ii. It is recommended that, prior to entering into transactions involving the rendering of services on a regular or systematic basis with any member of its holding company system, HIP notify the Department of its intention in writing, pursuant to the provisions of Section 1505(d)(3) of the New York Insurance Law.	20
iii. It is recommended that HIP amend its Agreement with HIP Foundation to specify all services that are being received and submit the amended Agreement to the Department for non-disapproval pursuant to Section 1505(d)(3) of the New York Insurance Law.	21
iv. It is recommended that HIP settle its inter-company balances in accordance with the terms outlined in its administrative agreements.	21
v. Based upon the Department’s analysis, HIP did not operate in compliance with Section 1505(d)(3) of the New York Insurance Law during the examination period since it did not notify the superintendent of its intention to receive services rendered by CLS on a regular or systematic basis.	22
vi. It is recommended that HIP immediately file its agreement with CLS with the Department, pursuant to the provisions of Section 1505(d)(3) of the New York Insurance Law, for the Department’s review and non-disapproval.	22
vii. In December 2003 HIP entered into a Settlement Agreement with the State of New Jersey. Under the terms of the Agreement, final settlement on behalf of all interested parties represented by HIP is \$29 million.	25
C. <u> Significant Operating Ratios</u>	
The Plan’s expense ratios exceeded the 12.5% limit prescribed by Section 4309(a)(2) of the New York Insurance Law during the years 1999 and 2001. Pursuant to instructions from the Department, HIP submitted a comprehensive Administrative Expense Reduction Plan on July 23, 1999, with subsequent updates submitted thereafter. As of December 31, 2002, HIP’s expense ratio was within the 12.5% limit.	28

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Investment Activities</u>	
It is recommended that HIP's management abide by its fiduciary responsibilities and take a more active role in its oversight of the Plan's investment activities, and immediately implement procedures to conduct audits of its investments portfolio on a scheduled basis, at least annually.	30
 <i><u>Bond Investments</u></i>	
i. The Plan reported all bond investments held during the years 1999 and 2000 at fair market value, which was inconsistent with statutory accounting principles and accepted Department practices.	30
ii. In 2001, pursuant to statutory accounting principles, HIP began reporting its bond investments at amortized cost. However, the Plan derived its amortized cost using the straight-line method of amortization, rather than the scientific interest method prescribed under Codification.	30
iii. It is recommended that, for future filings with the Department, HIP report its bond investments using the prescribed amortization methodology.	31
 <i><u>Short-term Investments</u></i>	
i. Based on the results of this examination, HIP's investment in JPMorgan's Prime Money Market Fund exceeded the prescribed investment limitation set forth in Section 1409(a) of the New York Insurance Law by \$31,852,198. Such excess investment is deemed by this examination to be a non-admitted asset at December 31, 2001.	32-33
ii. It is recommended that HIP comply with the statutory limitations set forth in Sections 1404(a)(10)(B)(i) and 1409(a) of the New York Insurance Law.	33

<u>ITEM</u>	<u>PAGE NO.</u>
E. <u>Bonds/Notes Payable</u>	
i. HIP did not comply with the requirements of Section 1204(c) of the New York Insurance Law when HIP issued an additional \$10 million of Senior Notes in its debt offering and when it used a scheduled maturity date that differed from the date set forth in the approved agreement.	35
ii. The Plan did not comply with Section 1204(c) of the New York Insurance Law by amending the terms of the original Notes Purchase Agreement on five occasions without obtaining the superintendent's prior approval.	35
iii. It is recommended that HIP abide by the terms outlined in the superintendent's approval letter when issuing notes subject to the provisions of Section 1204(c) of the New York Insurance Law.	35
iv. It is recommended that HIP file with the Department proposed amendments to previously approved agreements prior to enacting them.	35
F. <u>Provider/IPA Arrangements and Risk Sharing</u>	
i. HIP failed to comply with the Department of Health's instructions when it entered into transactions with providers under risk transfer agreements that were not filed with and approved by the Insurance Department.	36
ii. HIP failed to comply with the provisions of Section 101.4(b) of Regulation No. 164 by not filing Report #10 for its Medical Groups.	37
Subsequent to the examination date, HIP commenced filing Report #10 for its Medical Groups in 2003.	
iii. It is recommended that HIP immediately take the necessary actions, where it has not already done so, to ensure its compliance with Department Regulation No. 164.	38

<u>ITEM</u>	<u>PAGE NO.</u>
G. <u>Abandoned Property</u>	
i. HIP failed to comply with the provisions of Article VII and Section 1316 of the New York Abandoned Property Law by not making requisite filings in a timely manner.	39
ii. It is recommended that the Plan make all its Abandoned Property publications and filings in accordance with the provisions set forth in the Abandoned Property Law.	39
H. <u>Accounts and Records</u>	
1. <u>Examination Process</u>	
It is recommended that HIP take the appropriate steps to ensure that its records are maintained in a manner that supports the information filed in its financial statements, and that more efficient procedures for gathering information are implemented to expedite future examinations.	40
2. <u>Financial Statement Reporting</u>	
<u>Furniture and Equipment</u>	
i. It is recommended that HIP tag all Furniture and Equipment that qualify for depreciation.	41
ii. It is recommended that HIP immediately expense and remove from its books for purposes of statutory filings, the remaining balance of any items comprising its Furniture and Equipment account that cannot be located, are no longer in use, or have exceeded their depreciable life term.	41
iii. It is recommended that HIP take into account each individual purchase of furniture or equipment's actual useful life when assigning the period over which the item will be depreciated.	41
iv. It is recommended that HIP perform audits of its inventory to ensure that the controls in place for recording, valuing and safeguarding its Furniture and Equipment are adequate.	41

<u>ITEM</u>	<u>PAGE NO.</u>
H. <u>Accounts and Records</u>	
2. <i><u>Financial Statement Reporting</u></i>	
<i><u>Investment in Vytra</u></i>	
It is recommended that HIP review its basis for amortizing goodwill over a forty-year period, and make a determination as to whether utilizing a ten-year amortization period may be more appropriate.	42
<i><u>Medical Group Equipment</u></i>	
i. It is recommended that HIP immediately expense and remove from its books for purposes of statutory filings, the remaining balance of any items comprising this account that cannot be depreciated in accordance with Section 83.4(u) of Department Regulation No. 172.	43
ii. It is recommended that HIP establish clear guidelines to ensure that any additional purchase of Medical Group Equipment is depreciated in accordance with Section 83.4(u) of Department Regulation No. 172.	43
iii. It is recommended that HIP modify its inventory to incorporate an identical “Asset Id#” or other cross-referencing detail from the GE report to allow for better tracking of its Medical Group Equipment.	43
<i><u>Allocation of Expenses</u></i>	
It is recommended that HIP utilize the principles of Department Regulation No. 30 in the determination of its expense allocations included in the financial statements filed with this Department.	44
<i><u>Reporting Errors</u></i>	
It is recommended that the Plan exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions when preparing its filings with the Department.	44-45

<u>ITEM</u>	<u>PAGE NO.</u>
I. <u>Statutory Reserves</u>	
As a result of this examination, the Plan's 2001 Statutory Reserves, required pursuant to Section 4310(d) of the New York Insurance Law, were determined to be impaired in the amount of \$53,004,971.	50-51
At December 31, 2002, HIP's financial statements indicated that its required statutory reserves were fully restored.	
J. <u>Electronic Data Processing Equipment and Software</u>	
i. It is recommended that HIP adhere to the annual statement instructions and report all EDP equipment and software on the line specifically set apart for the disclosure of such information. HIP should continue to non-admit any EDP non-operating software.	52
ii. It is recommended that HIP establish clear guidelines to ensure that all the items classified as EDP equipment hardware are properly categorized and recorded as admitted assets in accordance with Section 1301(a)(18) of the New York Insurance Law.	53
iii. It is recommended that HIP tag all EDP hardware equipment items that qualify for depreciation.	53
iv. It is recommended that HIP identify any items listed in its EDP hardware inventory that have either been inappropriately classified or cannot be located and, for purposes of statutory filings, immediately expense any remaining value.	53
v. It is recommended that HIP develop and maintain a subsidiary ledger for this account and perform scheduled reconciliations between the data maintained by HIP's Information Systems Department and the subsidiary ledger maintained by HIP's Finance Department.	53

<u>ITEM</u>	<u>PAGE NO.</u>
J. <u>Electronic Data Processing Equipment and Software</u>	
vi. It is recommended that HIP establish clear guidelines for depreciation so that each individual item's actual useful life is determined when assigning the period over which the item is to be depreciated.	53
vii. It is recommended that HIP perform audits of its inventory to ensure that the controls in place for recording, valuing and safeguarding its EDP equipment assets, admitted and non-admitted, are adequate.	53
K. <u>Leasehold Improvements</u>	
i. It is recommended that HIP establish and maintain a master inventory that contains, at a minimum, pertinent information such as location, original capitalization date, historical cost information, accumulated depreciation and amortized value of each LHI.	55
ii. It is recommended that HIP account for each LHI's actual useful life when assigning the period over which the item will be amortized, not to exceed the remaining life of the original lease.	55
iii. It is recommended that, when system conversions are made, HIP refrain from combining the remaining balances of all LHI items onto a single asset line by location and then depreciating this combined balance over the remaining life of the respective lease.	56
iv. It is recommended that HIP immediately expense for purposes of statutory filings, any items listed in its current LHI inventory for which supporting documentation cannot be produced.	56
v. It is recommended that HIP perform regularly scheduled reconciliations of the items contained in its inventory to ensure that items identified as LHI, and amortized accordingly, qualify for such treatment, and that items that fail to qualify, due to changes in their condition or ownership, be expensed.	56

<u>ITEM</u>	<u>PAGE NO.</u>
K. <u>Leasehold Improvements</u>	
vi. It is recommended that HIP utilize matching indices that enable it to track the leasehold improvement projects completed to the Capital Budget Reports presented to the Department.	57
vii. It is recommended that HIP refrain from soliciting construction bids or commencing any Leasehold Improvement projects without first obtaining the Department's requisite approval pursuant to the terms set forth in the Facility Agreement.	57
L. <u>Claims Reserves</u>	
i. It is recommended that HIP review its financial reporting procedures to ensure that claims liabilities are properly recorded.	59
ii. It is recommended that HIP prepare its annual statements in accordance with the NAIC Annual Statement Instructions for Health Companies.	59
M. <u>Unpaid Claims Adjustment Expenses</u>	
It is recommended that HIP review its methodology for determining its Unpaid Claims Adjustment Expenses.	61
N. <u>Record Retention</u>	
i. HIP failed to comply with Section 243.3(c) of Department Regulation No. 152 by not maintaining a formal corporate-wide records retention plan.	62
Subsequent to the examination period, HIP established a formal Record Retention Policy in 2002.	
ii. It is recommended that HIP comply with the provisions set forth in Section 243.2 of Department Regulation No. 152 by maintaining the financial records necessary to verify its financial condition.	63

Appointment No. 21854

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Lisa Fernez

as a proper person to examine into the affairs of the

Health Insurance Plan of Greater New York

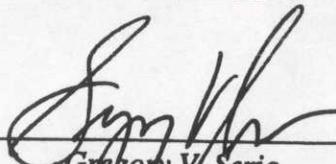
and to make a report to me in writing of the said

Company

with such information as she 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 11th day of March 2002



Gregory V. Serio
Superintendent of Insurance

