REPORT ON EXAMINATION

OF

MVP HEALTH INSURANCE COMPANY

AS OF

DECEMBER 31, 2003

DATE OF REPORT **MARCH 27, 2006**

EXAMINER **ELSAID ELBIALLY, CFE**

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

George E. Pataki
Governor

Howard Mills
Superintendent

March 27, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22141 dated January 30, 2004, attached hereto, I have made an examination into the condition and affairs of MVP Health Insurance Company (MVPHIC), a for-profit stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law. The following report is respectfully submitted.

The examination was conducted at the Company's home office located at 625 State Street, Schenectady, New York.

Whenever the term "Company" or "MVPHIC" appears herein without qualification, it should be understood to refer to MVP Health Insurance Company.

As a result of this examination, the Company was insolvent in the amount of $3,736,937 as of December 31, 2003 and the Company's minimum surplus was impaired in the amount of $4,036,937. Subsequent to the examination date, in March, 2004, with the approval of the Superintendent of Insurance, the Company received a Section 1307 of the New York Insurance Law loan in the amount of $18,000,000 from its ultimate parent, MVP Health Plan, Inc., which eliminated the aforementioned insolvency and impairment.

1. SCOPE OF EXAMINATION

The prior report on organization was made as of February 28, 2001. This examination covers the period from March 1, 2001 through December 31, 2003. The examination was conducted at the home office of the Company in Schenectady, New York. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2003, in accordance with generally accepted accounting principles (GAAP), 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 Company'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 Company
Management of the Company
Corporate records
Fidelity bonds and other insurance
Officers' and employers' welfare and pension plans
Territory and plan of operations
Growth of the Company
Accounts and records
Loss experience
Treatment of subscribers

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

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that directly impacted the Company's compliance with the New York Insurance and New York Public Health Laws. Significant findings relative to this examination are as follows:

- As a result of this examination, the Company was insolvent in the amount of $3,736,937, per this examination as of December 31, 2003 and its minimum surplus was impaired in the amount of $4,036,937. Subsequent to the examination date, in March, 2004, with the approval of the Superintendent of Insurance, the Company received a Section 1307 of the New York Insurance Law loan in the amount of $18,000,000 from its ultimate parent, MVP Health Plan, Inc., which eliminated the aforementioned insolvency and impairment.

- The Company failed to submit its administrative service agreement with its affiliate, MVP Service Corporation, to the New York Insurance Department.

- The Company failed to comply with New York Insurance Department Regulation No. 33, relative to reimbursement of its share of joint administrative expenses with its affiliates, MVP Service Corporation and MVP Health Plan, Inc.

- The Company understated claims adjustment expenses and its reserve for unpaid claims adjustment expenses, by failing to allocate administrative costs properly within expense categories in the Underwriting and Investment Exhibit, "Part 3-Analysis of Expense" schedule of the Company's annual statement.

- The Company failed to investigate and reconcile its bank accounts in a timely manner.

- The Company failed to adhere to the requirements of Statement of Statutory Accounting Principles (SSAP) No. 6 with regard to the reporting of its uncollected premiums on various schedules of its 2003 annual statement.

- The Company failed to adhere to its stated policy relative to group terminations.

- The Company failed to fully comply with the requirements of the Prompt Pay Law.
- The Company failed to issue Explanation of Benefits Statements (EOBs) to some members.

The examination findings are described in greater detail in the remainder of this report.

3. DESCRIPTION OF COMPANY

MVP Health Insurance Company was incorporated on April 24, 2000 as a for-profit health and accident insurer pursuant to Section 1201 of the New York Insurance Law. The Company was licensed in June 2001, to write insurance business as defined under Section 1113 (a) (3) of the New York Insurance Law.

The Company began operations by delivering health care services in the State of New York, in July 2001. The Company received approval to operate as an accident and health insurer in the State of Vermont on May 1, 2002.

The Company is a wholly owned subsidiary of MVPHIC Holding Corp., which is a wholly owned subsidiary of MVP Health Plan, Inc., the ultimate parent. The Company issued 60,000 shares of $5.00 par value per share capital stock on December 14, 2000, for a sale price of $5.00 per share, resulting in a total consideration of $300,000. In addition, MVPHIC received a capital/surplus contribution of $3,700,000 from its parent MVPHIC Holding Corp. In early 2002, the State of Vermont Insurance Department required an additional infusion of capital in order to issue a license to the Company. Therefore, the Company's paid in capital increased from $300,000 to $2,000,000 by the sale of an additional 340,000 shares at $5.00 par and sale value per share on February 11, 2002, to its parent, and the sole shareholder of the Company's outstanding stock, MVPHIC Holding Corp.

A. Management and control

Pursuant to the Company's charter and by-laws, management of the Company is vested in a board of directors consisting of thirteen members. As of December 31, 2003 the board of directors consisted of twelve members as set forth below:

Names and Residence	Principal Business Affiliation
Richard D'Ascoli, M.D. Niskayuna, New York	Orthopedics
Samuel L. Feldman Niskayuna, New York	President, CFL Life Plans, Inc
Joseph F. Heavey Poughkeepsie, New York	Administrator, The Children's Medical Group
John F. Houck, Jr., M.D. New Hartford, New York	Physician, Adirondack Community Physicians
Karen B. Johnson Schenectady, New York	Director of Development, Proctors Theatre
Herschel R. Lessin, M.D. Poughkeepsie, New York	Vice President, Hudson Valley Pediatric Group, PC
Mary C. Militano, Esq. Scotia, New York	Attorney
David W. Oliker Charlton, New York	President and Chief Executive Officer, MVP Health Plan, Inc.
Jon K. Rich Alplaus, New York	Retired
Joseph J. Schwerman, M.D. Hyde Park, New York	Emergency Physician, St. Francis Hospital
Leland C. Tupper Schenectady, New York	Retired
Timothy P. Wade Scotia, New York	Vice President, M&T Bank

The minutes of all meetings of the Board of Directors and committees thereof, held during the examination period were reviewed. During the examination period, board meetings were generally well attended; all directors attended at least half of the meetings they were eligible to attend. However, the board of directors of MVPHIC did not meet in calendar year 2003

It is recommended that the board of directors be-pro-active and meet at least once a year in order to exercise control and manage the affairs of the Company.

Shareholders meetings

Article III Section 1 of the by-laws of MVP Health Insurance Company states, in part,

> "… The annual meeting of the shareholders of the Company shall be held on the second Monday of December of each year, at an hour to be named in the notice of waiver of notice of the meeting for the election of Directors and for the transaction of such business as may properly come before the meeting. If the date of the annual meeting falls upon a legal holiday, the meeting shall be held on the next succeeding business day. The meeting shall be held at such place, either within or without the State of New York, as the Board of directors shall be determined. In the event the Board of directors does not determine otherwise, the annual meeting of shareholders shall be held at the office of the Company in Schenectady, New York…"

The Company failed to hold the annual meeting of the shareholders as required by Article III, Section 1 of its by-laws.

It is recommended that the Company's shareholders hold annual meetings as required by Article III, Section 1 of its by-laws.

The principal officers of the Company as of December 31, 2003 were as follows:

Name	Title
David Oliker	President
Denise V. Gonick, Esq.	Secretary
David Field	Treasurer

B. Territory and plan of operation

The Company is authorized to write accident and health insurance business in the State of New York starting in 2001 and the State of Vermont in 2002.

Based on the line of business for which the Company is licensed, the Company is required to have initial surplus of $450,000 and maintain a minimum surplus of $300,000 pursuant to Article 42 of the New York Insurance Law. In addition, the Company entered into a commitment with the New York Insurance Department upon licensing, to maintain a ratio of not more than 4:1 of net premium to capital and surplus.

The Company reported itself insolvent in the amount of $515,481 per its December 31, 2003 filed annual statement. As a result of this examination, the Company was insolvent in the amount of $3,736,937 and the Company's minimum surplus was impaired in the amount of $4,036,937 as of December 31, 2003.

Subsequent to the examination date, in March, 2004, with the approval of the Superintendent of Insurance, the Company received $18,000,000 of additional surplus in

the form of a loan from its ultimate parent, MVP Health Plan, Inc., pursuant to Section 1307 of the New York Insurance Law. Such Section 1307 loan eliminated the Company's insolvency and minimum surplus impairment as of March 31, 2004. The repayment of the Section 1307 loan and the accumulated accrued interest shall only be paid out of future free and divisible surplus of the Company and will be subject to the prior approval of the Superintendent.

The Company offers a variety of insurance products, such as a preferred provider option (PPO), an exclusive provider option (EPO), a point of service option (POS) and a traditional indemnity insurance product.

The mainstay of the Company's business is employer groups in both private and public sectors. The Company enrollment (rounded to nearest thousand) for each year under examination by product type was as follows:

	2001	2002	2003
PPO	-0-	6,000	27,000
POS	5,000	34,000	36,000
Total	5,000	40,000	63,000

The written premium (rounded) for each year under examination was as follows:

	2001	2002	2003
New York	$158,000	$12,530,000	$54,598,000
Vermont	-0-	-0-	9,176,000
Total	$158,000	$12,530,000	$63,774,000

During the examination period, the Company solicited business as a direct writer through the Company's own in-house licensed agents. Also, the Company utilized the services of licensed brokers, for the production of business.

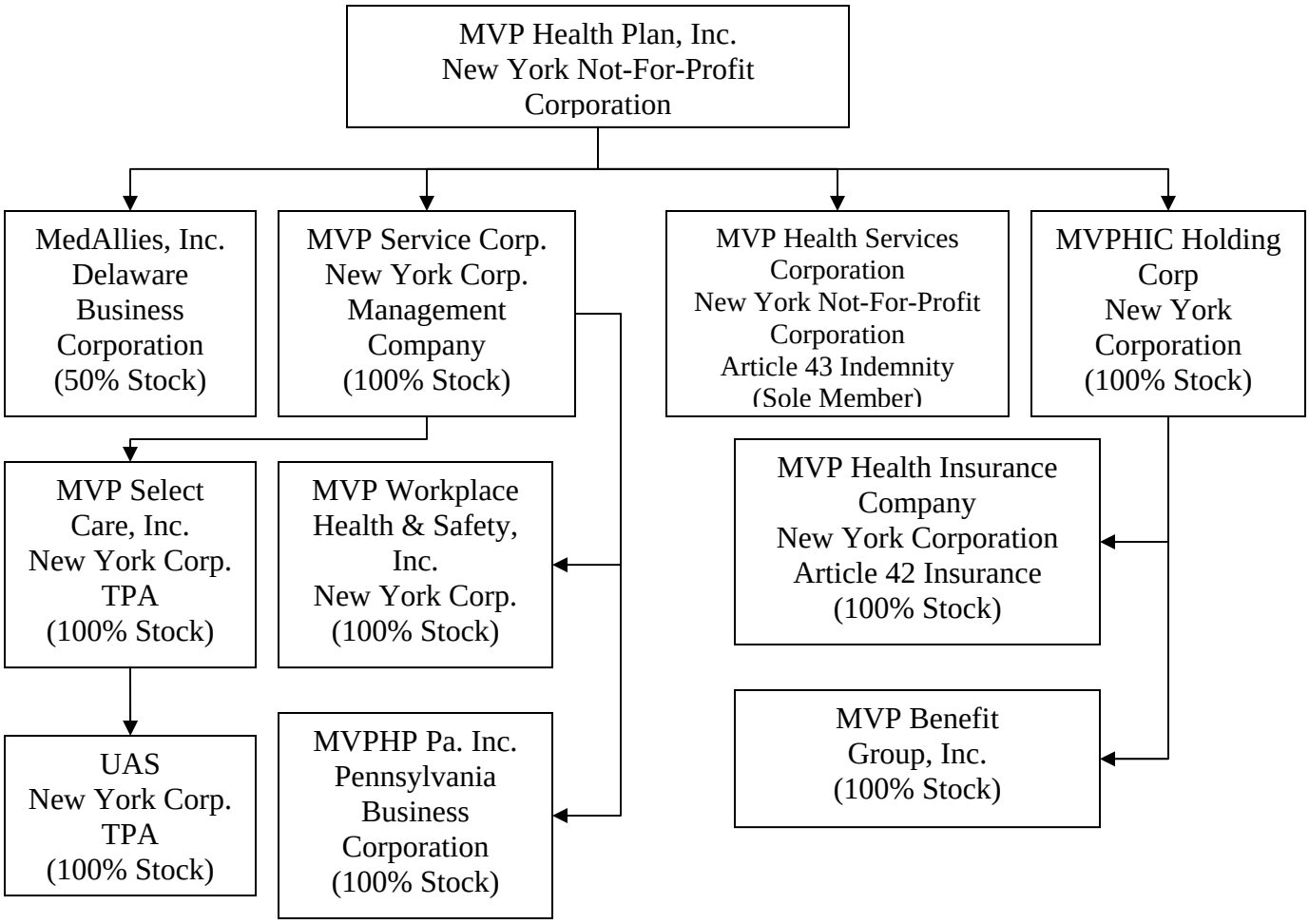
C. Reinsurance

For the period January 1, 2003 through December 31, 2003 MVPHIC had a reinsurance agreement in place with General Reinsurance Corporation, a New York State licensee. The covered services ceded under the agreement were medical services for individual and group accident and health policies. The Company's reinsurance premium rate is $3.60 per member per month, subject to a minimum reinsurance premium of $200,000 for the contract year. The reinsurance agreement contained all the required standard clauses, including the insolvency clause required by Section 1308 of the New York Insurance Law. The reinsurance limits of liability are 90% of $1,900,000 of net loss for each member for each contract year.

The Company is subject to a retention that includes a deductible of $100,000 per member per contract year, a coinsurance of 10% of net loss in excess of the deductible and any amounts in excess of the reinsurance limits of liability. General Reinsurance Corporation will pay to MVPHIC 90% of the amount of net loss in excess of the deductible subject to the reinsurance limits of liability.

D. Holding company system

The following chart depicts the Company in relationship to its affiliates within the holding company system. The percentages included in the chart indicate percentage of ownership



The Company has no employees. Therefore, it entered into an administrative service agreement with its affiliate MVP Service Corporation. (MVPSC), wherein various services are provided to the Company by MVPSC, including, but not limited to financial,

legal, internal operations, management information systems, marketing, consultation, utilization review services, claims administration, developing, revising and refining new health care service products, systems, policies and overall administration.

In addition, the billing for the Company's portion of the premium is billed along with MVP Health Plan, Inc.'s (MVPHP) portion of the premium and both amounts are collected by MVPHP. The following month, the premiums collected by MVPHP on behalf of the Company are transferred from MVPHP to the Company.

It is recommended that the Company revise its administrative service agreement to reflect the current premium billing arrangement between MVP Health Plan, Inc. (MVPHP), and the Company. Furthermore, the Company should submit its revised agreement to the New York Insurance Department pursuant to Sections 1504(a) and 1505(d) .of the New York State Insurance Law.

MVP Health Plan, Inc.

MVP Health Plan, Inc. (MVPHP) was incorporated on July 30, 1982, pursuant to Section 402 of the Not-for-Profit Corporation Law. MVPHP is a Type B Corporation under Section 201 of the Not-for-Profit Corporation Law. MVPHP was licensed as a Health Maintenance Organization (HMO) pursuant to Article 44 of the Public Health Law of the State of New York and obtained its certificate of authority to operate as an individual practice association (IPA) model HMO effective June 1, 1983.

MedAllies, Inc.

MedAllies, Inc. was incorporated on February 2, 2001 as a Delaware Business Corporation. It is a joint venture with Taconic IPA. MVP Health Plan, Inc. owns 50% of the stock of MedAllies, Inc. The purpose of the joint venture was to integrate clinical labs and payors to improve care on the provider side. It is a start-up and has not earned any profit yet.

MVP Service Corporation

MVP Service Corporation (MVPSC) was incorporated in 1990 as a New York Corporation that performs management services for the corporations affiliated with it (the Company, MVPHP, MVPHICHC, MVPHSC, and MVP Select Care). MVP Health Plan, Inc. owns 100% of the stock of MVPSC.

MVP Service Corporation also holds 100% of the stock of MVP Select Care, Inc. a New York Corporation that is a Third Party Administrator (TPA), 100% of the stock of MVPHP Pa, Inc. a Pennsylvania Business Corporation (incorporated May 1, 1996), and 100% of the stock of MVP Workplace Health & Safety, Inc., a New York corporation. (incorporated August 4, 1994 as MVP Corporatecare, Inc.; renamed on September 13, 1996 to MVP Workplace Health and Safety, Inc.).

In addition, MVP Service Corporation owns 50% of Comprehensive Health Solutions, Inc. (CHS) and CHS Pharmacy, Inc. (CHS Rx). These entities are accounted for on the equity method. CHS was formed to perform management services for an

ambulatory infusion center. CHS Rx was formed to provide pharmaceutical supplies to the ambulatory infusion center.

MVP Select Care, Inc.

MVP Select Care, Inc. (Select Care) is a for-profit New York Corporation wholly-owned by MVP Service Corporation. Select Care was incorporated in 1987 to provide administrative services to companies that self insure health care benefits.

MVP Select Care, Inc. owns 100% of Upstate Administrative Services (UAS) a New York Corporation licensed as a TPA. UAS business will be fully integrated into Select Care to obtain administrative efficiencies.

On November 16, 1992, Select Care entered into an administrative agreement with MVPSC whereby MVPSC provides for all the day-to-day operations of Select Care.

MVP Workplace Health & Safety, Inc.

MVP Workplace Health & Safety, Inc. (MVPWHS) is a for-profit corporation wholly-owned by MVPSC. MVPWHS was incorporated in 1994 to provide occupational health services. It is in the process of being dissolved.

MVPHP Pa, Inc.

MVPHP Pa, Inc. was formed to hold stock of insurance companies/HMOs to be licensed in the Commonwealth of Pennsylvania. However, to date, this Company remains

dormant since licenses to write insurance business or conduct an HMO business in the Commonwealth of Pennsylvania were not pursued.

MVP Health Services Corporation

MVP Health Services Corporation (MVPHSC) is a not-for-profit corporation whose sole member is MVPHP. MVPHSC was incorporated on October 8, 1992 and is licensed under Article 43 of the New York Insurance Law. MVPHSC used to offer the out-of-network portion of point-of-service (POS) health insurance products. Currently, MVPHSC is being used to issue indemnity dental insurance products only.

MVPHIC Holding Corp.

MVPHIC Holding Corp. was incorporated on November 22, 2000, pursuant to Section 402 of New York Business Corporation Law. It was specifically formed to hold the stock of MVP Health Insurance Company (MVPHIC). .MVPHIC Holding Corp. holds and controls 100% of the stock issued by MVPHIC. MVP Health Plan, Inc. in turn, owns and controls 100% of the stock of MVPHIC Holding Corp.

MVPHIC Holding Corp. currently has two licensing applications pending with the State of New Hampshire. One application is to form a domestic accident and health insurance company and the other application is to form a domestic HMO.

MVP Benefit Group, Inc.

MVP Benefit Group, Inc. a New York Business Corporation was incorporated March 12, 2003. MVP Benefit Group, Inc. is licensed as an insurance agent pursuant to

Section 2103 of the New York Insurance Law and as an insurance agent and insurance broker in the State of Vermont. It was formed for the purpose of transacting a brokerage business for the stop loss insurance offered to MVP Select Care groups. All other affiliated entities have separate reinsurance policies that are not brokered through MVP Benefit Group, Inc. MVPHIC Holding Corp. owns 100% of the stock of MVP Benefit Group, Inc.

E. Significant operating ratios

The following ratios have been computed as of December 31, 2003 based upon the results of this examination:

Net premiums written (2003) to Surplus	-17 to 1
Uncollected premiums to Surplus	-1.27 to 1
Cash and invested assets to Unpaid claims	54.0%
Surplus to Unpaid claims	-35.0%

The above ratios fall outside the NAIC benchmarks.

The underwriting ratios presented below are on an earned-incurred basis and encompass the thirty-four (34) month period covered by this examination.

	Amounts	Ratios
Claims	$73,019,508	96.7%
Claims adjustment expenses	3,065,646	4.0%
General administrative expenses	8,428,224	11.2%
Net underwriting loss	(9,002,348)	(11.9)%
Premium earned	$75,511,030	100.0%

F. Allocation of expenses

(a) The expense group "Claim Adjustment Expense" (CAE), reported in Underwriting and Investment Exhibit, "Part 3-Analysis of Expense" schedule of the Company filed December 31, 2003 annual statement, was calculated by applying a flat percentage to all expense categories. The Company was unable to provide the examiners with any supporting documentation or the rationale of the use of this flat percentage.

The examiners used New York State Insurance Department Regulations 30 (11NYCRR 20) and 33 (11 NYCRR 91) as guidelines, allocating the expenses to expense categories based on the guidelines provided within those regulations. The examiners calculated incurred expenses attributable to the CAE category at $2,285,640 compared with $447,850 reported by the Company.

The Company's understatement of its CAE expense allocation resulted in the following:

1. An examination increase in the Company's unpaid claim adjustment expense reserve to $407,544 as of December 31, 2003. The Company's reported unpaid claims adjustment expense as of such date in the amount of $208,495 was understated by $199,049.

2. An increase of $2,563,129 to claims adjustment expenses over the three year period under examination from the $502,517 reported on MVPHIC annual statements to $3,065,646 per this examination.

3. A decrease in the Company's administrative expenses by $2,364,080 from the $10,792,304 reported on the Company's filed annual statements during the three year examination period to $8,428,224, per this examination.

The difference between the increase of claims adjustment expenses and the decrease of administrative expenses is $199,049 which represents the increase in unpaid claim adjustment expenses liability per this examination as of December 31, 2003.

It is recommended that the Company apply the guidelines in New York Insurance Department Regulations No. 30 (11NYCRR 20) and No. 33 (11NYCRR 91) to revise and update its expense allocation methodology in order to reflect an appropriate allocation among the three expense groupings (i.e. Claim adjustment expense, general and administrative expense and investment expense) on the Underwriting and Investment Exhibit, "Part 3-Analysis of Expense" schedule of the Company's annual statement.

(b) The expense classification, "Salaries, wages and other benefits", reported in the Company's filed 2003 annual statement, Underwriting and Investment Exhibit, "Part 3-Analysis of Expenses", was overstated, since MVPHP charged the Company for all types of allocated expenses under "Salaries, wages, and other benefits".

It is recommended that the Company follow Regulation 33 (11 NYCRR 90), by not debiting its payment to MVPHP for all types of allocated expenses solely to salaries.

It is recommended that such payments be allocated to all appropriate expense classifications.

(c) The Company reimburses MVPHP and MVPSC for its share of joint administrative expenses based upon 8.25% of its premiums written. The 8.25% was referred to as estimated administrative costs in the initial capitalization plan of the Company submitted to the New York State Insurance Department. However, thereafter the agreement between the Company and its affiliate stated the following:

> "…The Company (MVPSC) shall use an allocation method for shared expenses consistent with provisions of New York Regulation No. 33."

Part 91.4(f)(vii)(5) of New York Insurance Department Regulation No. 33 (11NYCRR 91) states, in part,

> "General indexes such as premium volume, number of policies, and insurance in force shall not be used as basis for distributing costs among major annual statement lines of business, except where the incidence of cost is closely related to such general indexes, or except where there is no more appropriate basis for measurement"

It is recommended that the Company comply with Part 91.4(f)(vii)(5) of New York Insurance Department Regulation No. 33 (11 NYCRR 91) relative to reimbursement of its share of joint administrative expenses to MVPHSC as required by their administrative service agreement.

G. Cash

A review of the Company's cash policy, procedures and system control, with regard to its bank account reconciliations and un-cashed checks, revealed the following:

(1) There is no follow-up on outstanding checks that remained on the bank reconciliation, until deemed to be abandoned property.

It is recommended that the Company establish a follow-up procedure applicable to all checks which remain outstanding for six months from the date of issue.

(2) During the period under this examination, the Company, in several instances opened two bank accounts in relation to one general ledger account. The bank reconciliations of these accounts contained unidentified differences which were not fully investigated and reconciled in a timely manner.

It is recommended that the Company change its policy and open/reconcile one bank account instead of two associated with each general ledger account. Furthermore, it is recommended that the Company investigate any un-reconciled differences on bank reconciliations and correct them in a timely manner.

H. Uncollected premiums

A review of the Company's procedures, in regard to uncollected premiums, revealed the following:

(a) Statement of Statutory Accounting Principles (SSAP) No. 6 Paragraph 10 states, in part,

> "…any uncollectible receivable shall be written off and charged to income in the period the determination is made."

It is noted that the Company's practice is to charge the expense account of bad debt instead of charging the bad debt to income as required by SSAP No. 6.

It is recommended that Company comply with the requirement of SSAP No. 6 Paragraph 10 and charge bad debt to income.

(b) The Company reported on page 2 of its annual statements for all years during the examination period, premium receivables net of non-admitted amounts without showing the gross receivables. The annual statement instructions provide for the reporting of gross receivable, the non-admitted asset portion and the net admitted asset portion as per the following comparative chart:

	Admitted Assets	Not-admitted Assets	Net admitted Assets
Company	$5,360,548	-0-	$5,360,548
Examination	$5,560,548	$822,407	$4,738,141

It is recommended that, in the future, the Company comply with the annual statement instructions and appropriately report its gross premium receivables and non-admitted asset premium receivable on the annual statement.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus account as determined by this examination and as reported by the Company as of December 31, 2003.

Assets	Assets	Examination Not-Admitted Assets	Net-Admitted Asset	MVPHIC Net-Admitted Assets	Surplus Increase (Decrease)
Bonds	$1,279,626		$1,279,626	$1,279,626	
Cash and short term investment	4,486,169		4,486,169	4,486,169	
Investment income due and accrued	31,954		31,954	31,954	
Uncollected premium	5,360,548	$622,407	4,738,141	5,360,548	($622,407)
Reinsurance recoverable	1,635,741		1,635,741	1,635,741	
Federal income tax recoverable	1,134,422		1,134,422	1,134,422	
Net deferred tax asset	2,059,574	2,059,574			
Receivable from parent, subsidiaries and affiliates	7,170,174		7,170,174	7,170,174	
Prepaid expenses	45,254	45,254	0	0	0
Total asset	$23,203,462	$2,727,235	$20,476,227	$21,098,634	($622,407)

Liabilities	Examination	MVPHIC	Surplus Increase (Decrease)
Claims unpaid	$10,755,247	$8,355,247	($2,400,000)
Unpaid claims adjustment expenses	407,544	208,495	(199,049)
General expenses due and accrued	1,442,144	1,442,144	
Amount due to parent, subsidiaries and affiliates	11,608,229	11,608,229	0
Total liabilities	$24,213,164	$21,614,115	($2,599,049)
Capital and surplus			
Common capital stock	$2,000,000	$2,000,000	
Gross paid in and contributed Surplus	3,500,000	3,500,000	
New York State statutory deposit	200,000	200,000	
Unassigned funds (surplus)	($9,436,937)	(6,215,481)	($3,221,456)
Total capital and surplus	($3,736,937)	($515,481)	($3,221,456)
Total liabilities, capital and surplus	$20,476,227	$21,098,634	($622,407)

As a result of this examination, the Company was insolvent in the amount of $3,736,937 as of December 31, 2003 and its minimum surplus was impaired in the amount of $4,036,937. Subsequent to the examination date, in March, 2004, with the approval of the Superintendent of Insurance, the Company received a Section 1307 of the New York Insurance Law loan in the amount of $18,000,000 from its ultimate parent, MVP Health Plan, Inc., which eliminated the aforementioned insolvency and impairment. The repayment of the Section 1307 loan and accumulated interest shall only be paid out of future free and divisible surplus of the Company subject to the prior approval of the Superintendent of Insurance.

The Internal Revenue Service did not audit the tax returns filed by the Company during the period under this examination. The examiner is unaware of any potential exposure of the Company to any further tax assessment and no liability has been established.

B. Statement of revenue and expenses

Capital and surplus decreased by $7,759,595 during the period under this examination, March 1, 2001 through December 31, 2003, detailed as follows:

Revenue			
Net premium income			$75,511,030
Expenses			
Hospital and Medical			
Hospital/medical benefits	$60,646,054		
Other professional services	306,697		
Emergency room and out of area	2,587,744		
Prescription drugs	10,871,390		
Demographic and SMC pool expense	235,647		
Incentive pool	7,717		
Less: Net reinsurance recoveries	(1,635,741)		
Total hospital and medical		$73,019,508	
Administrative expenses			
Claim adjustment expenses	$3,065,646		
General administrative expenses	8,428,224		
Total administrative expenses		$11,493,870	
Total underwriting deductions			(84,513,378)
Net underwriting loss			($9,002,348)
Net investment income earned		$199,745	
Net realized capital loss		(1,015)	
Net investment gains			198,730
Net loss before federal income taxes			($8,803,618)
Federal income taxes refund			1,785,344
Net loss			$ (7,018,274)

C. Capital and surplus account

Capital and surplus per report on organization as of February 28, 2001			$4,022,658
	Gains in Surplus	Losses in Surplus	
Net loss from operation		$7,018,274	
Change in non-admitted assets		2,727,235	
Unrealized capital gain	$285,914		
Increase in paid in capital	1,700,000	0	
Total gains and losses	$1,985,914	$9,745,509	
Net decrease in capital and surplus			($7,759,595)
Capital and surplus per report on examination as of December 31, 2003			($3,736,937)

5. UNCOLLECTED PREMIUMS

The examination asset of $4,738,141 is $622,407 less than the $5,360,548 reported by MVPHIC in its December 31, 2003 annual statement. The examination change is due to the non-admitting of uncollected premiums that were due more than 90 days in accordance with SSAP No. 6 paragraph 9 a, that states, in part,

> "…,If an installment premium is over ninety days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be non-admitted."

6. CLAIMS UNPAID

The examination liability of $10,755,247 is $2,400,000 more than the $8,355,247 reported by MVPHIC in its December 31, 2003 annual statement. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and its filed annual statements.

7. UNPAID CLAIM ADJUSTMENT EXPENSES

The examination liability of $407,544 is $199,049 more than the $208,495 reported by MVPHIC in its December 31, 2003 annual statement. The examination change is due to a substantial increase in allocation of expenses to claims adjustment expenses using New York State Insurance Department Regulations 30 (11 NYCRR 20)and 33 (11 NYCRR 91) as guidelines, allocating the expenses to expense categories based on the guidelines provided within those regulations.

8. CONCLUSION

As a result of this examination the Company was insolvent in the amount of $3,736,937 as of December 31, 2003 and its minimum surplus was impaired in the amount of $4,036,937.

9. SUBSEQUENT EVENTS

Subsequent to the examination date, in March, 2004, with the approval of the Superintendent of Insurance, the Company received a Section 1307 of the New York Insurance Law loan in the amount of $18,000,000. Such loan eliminated the insolvency and minimum surplus impairment of the Company as of March 31, 2004. The repayment of the Section 1307 loan and the accumulated accrued interest shall only be paid out of future free and divisible surplus of the Company subject to the prior approval of the Superintendent of Insurance.

10. MARKET CONDUCT

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

A) Underwriting
B) Claims
C) Rating
D) Sales and advertising

The examiners' review revealed the following:

A. Underwriting

Termination of coverage

The Company's policy, in terminating group coverage for failure to pay premiums due, is as follows:

Any group with an outstanding balance from 30-60 days past due is sent a premium reminder letter along with a reconciliation to be due 10 business days from the date the letter is sent. Any group with an outstanding balance from 61-90 days past due is sent a letter by certified mail, along with a reconciliation to be due 10 business days from the date the letter is sent.

If the groups fails to pay after the two above letters are sent, the group is then sent a group termination letter by certified mail. The subscribers under the group policy are also sent a termination letter. All subscribers that were active under the group receive the subscriber termination letter offering them direct health care coverage.

A review revealed that the Company does not consistently adhere to its stated policy. Of the five sampled groups, it was determined that one group was terminated after eight months of non-payment of premium. Another two groups were terminated after five and seven months, respectively. Of the five groups reviewed, only one was terminated after 90 days.

It is recommended that the Company adhere to its stated policy for non payment of premium terminations for all groups.

B. Claims

1. Claims Processing

A review was performed by using a statistical sampling methodology covering the examination period in order to evaluate the overall accuracy and compliance environment of the Company's claims processing.

This statistical random sampling process, which was performed using the computer software program ACL, was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually or on a collective basis could be drawn for each item in the sample. The review incorporated processing attributes used by the Company in its own "Quality Analysis" of claims processing. The sample size was comprised of 167 randomly selected claims.

The sample of 167 claims was comprised of 31 denied claims and 136 paid claims.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a "claim," which is defined by the Company as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It was possible, through the computer systems

used for this examination, to match or “roll-up” all procedures on the original form into one line, which is the basis of the Department’s statistical sample of claims or the sample unit.

A paid claim was defined as any claim for which the Company was obligated to pay the claim or make the medical payment; a denied claim was one for which MVPHIC was not obligated to pay the claim or make the medical payment. Any claim which contains at least one service line for which the Company is not obligated to pay for the service was considered a denied claim, even if other service lines are paid (partially denied). There were seven claims in the sample that were partially denied.

The examiners and the Company determined that there existed ten claims which were “processed” incorrectly, according to the criteria used by both the Company and the Insurance Department examiners, not including any claims for which the Company issued an EOB that were not in compliance with §3234 of the New York Insurance Law.

It was further agreed upon that the Company was required to issue EOBs for all denied claims (wholly or partially denied) but in fact, either: (1) Failed to do so or (2) the EOBs' content was not in compliance with Section 3234 of the New York Insurance Law. There were 27 additional claims found to be in error, producing an accuracy rate of 77.8%.

If the EOB errors were not taken into consideration, the Company's claims processing accuracy rate would have been 94.0%. This is consistent with the Company's reported overall accuracy standard being above 98%.

2. Prompt Pay Law

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (Prompt Pay), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

> "…such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a healthcare provider within forty-five days of receipt of a claim or bill for service rendered."

Section 3224-a (b) of the New York Insurance Law states, in part,

> "…an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or to request all additional information needed to determine liability to pay the claim or make the health care payment…"

Section 3224-a (c) of the New York Insurance law states, in part,

> "… any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to

> the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest…"

A review was made of year 2003 claims, using ACL audit software, for compliance with Section 3224-a of the New York Insurance Law. The review also determined whether or not interest was appropriately paid pursuant to Section 3224-a (c) of the New York Insurance Law to those claimants not receiving payment within the timeframes required by Section 3224-a (a) and (b) of the New York Insurance Law.

A claim was defined as the total number of items submitted on a single claim form to which MVPHIC assigned a unique claim number. This definition was agreed to by both the examiners and MVPHIC.

The Company paid 140,999 claims and wholly or partially denied 36,693 claims for its New York State groups and providers/subscribers in calendar year 2003. Of these claims, a population of 2,188 claims was identified where payment date was more than 45 days after the receipt date. A second population of 3,848 claims was identified where the claim was denied more than 30 days after the receipt date. A sample of 167 claims was drawn from each of the populations described above.

The examiner's review of the sampled claims revealed violations of Sections 3224-a (a), (b) and (c) of the New York Insurance Law as shown in the following chart:

Description	Paid claims over 45 days	Denied claims over 30 days
Claim population	2,188	3,848
Sample size	167	167
Number of claims with errors	156*	106
Calculated Error Rate	93.41%	63.47%
Upper Error limit	97.18%	70.78%
Lower Error limit	89.65%	56.17%
Upper limit Claims in error	2,126	2,723
Lower limit Claims in error	1,962	2,161

* Of the 156 claims found to be in violation of Section 3224-a (a), 4 claims were also found to be in violation of Section 3224-a (c) because interest due of $2 or more was not paid.

The upper and lower error limits represent the range of potential error (e.g. if 100 samples were selected the rate of error would fall between these limits 95 times).

It is recommended that the Company improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.

3. Explanation of Benefits Statements

Explanation of Benefits Statements (EOBs) are an integral part of the link between the subscriber/contract-holder and their insurer, providing vital information as to how a claim was processed.

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

> "Every insurer, including health maintenance organizations … is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy…"

Section 3234(c) of the New York Insurance Law creates an exception to the requirements for the issuance of an EOB established in Section 3234(a) of the New York Insurance Law as follows:

> "[insurers] shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid directly to the participating facility or provider."

In addition, Section 3234(b) of the New York Insurance Law sets forth minimum standards for content of an EOB as follows:

"The explanation of benefits form must include at least the following:

(1) the name of the provider of service the admission or financial control number, if applicable;
(2) the date of service;
(3) an identification of the service for which the claim is made;
(4) the provider's charge or rate;
(5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
(6) a specific explanation of any denial, reduction, or other reason, including any other third-party payer coverage, for not providing full reimbursement for the amount claimed; and
(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made".

The review of claims processed revealed that the Company's procedures failed to include all situations that require the Company to issue an EOB because of its interpretation of the requirements of Section 3234 (a) and (b) of the New York Insurance Law. Therefore, the Company and its parent, MVP Health Plan, Inc. failed to issue approximately 40,000 EOBs to members as required by Section 3234(b) of the New York Insurance Law relative to claims which were wholly or partially denied to New York subscribers and/or providers.

It is recommended that the Company issue EOBs that include all of the requisite information required by Section 3234(a) and (b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

11. FRAUD PREVENTION AND DETECTION

A review was performed of the organization and structure of the Company’s special investigations unit (SIU), and their compliance with Article 4 of the New York Insurance Law, and New York Insurance Department Regulation 95 (11 NYCRR 86). The examination review indicated the Company's compliance with Article 4 of the New York Insurance Law and New York Insurance Department Regulation 95 (11 NYCRR 86).

12. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A	Minimum surplus	
	As a result of this examination, the Company was insolvent in the amount of $3,736,937, as of December 31, 2003 and its minimum surplus was impaired in the amount of $4,036,937. Subsequent to the examination date, in March, 2004, with the approval of the Superintendent of Insurance, the Company received a Section 1307 of the New York Insurance Law loan in the amount of $18,000,000 from its ultimate parent, MVP Health Plan, Inc., which eliminated the aforementioned insolvency and impairment.	1, 7, 25, 26
	Corporate matters	
B.	It is recommended that the board of directors be-pro-active and meet at least once a year in order to exercise control and manage the affairs of the Company.	6
C.	It is recommended that the Company shareholders hold annual meetings as required by Article III Section 1 of its by-laws.	6
	Holding company system	
D.	It is recommended that the Company revise its administrative service agreement to reflect the current premium billing arrangement between MVP Health Plan, Inc. (MVPHP), and the Company. Furthermore, the Company should submit its revised agreement to the New York Insurance Department pursuant to Sections 1504(a) and 1505(d) .of the New York State Insurance Law.	11
	Allocation of expenses	
E.	It is recommended that the Company apply the guidelines in New York Insurance Department Regulations No. 30 (11NYCRR 20) and No. 33 (11NYCRR 91) to revise and update its expense allocation methodology in order to reflect an appropriate allocation among the three expense groupings (i.e. Claim adjustment expense, general and administrative expense and investment expense) on the Underwriting and Investment Exhibit, “Part 3-Analysis of Expense” schedule of the Company’s annual statement.	17

ITEM PAGE NO.

Explanation of Benefits Statements (EOBs)

N. It is recommended that the Company issue EOBs that include all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

Respectfully submitted,

Elsaid E. Elbially
Principal Insurance Examiner, CFE

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

Elsaid E. Elbially being duly sworn, deposes and says that the foregoing report submitted By him is true to the best of his knowledge and belief.

Elsaid E Elbially

Subscribed and sworn to before me

this 23rd day of March, 2006.

Charles T. Lovejoy

Charles T. Lovejoy
Notary Public, State of New York
No. 31-4798952
Qualified in New York County
Commission Expires 1-26-10

Appointment No. ***22141***

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:

ELSAID ELBIALLY

as a proper person to examine into the affairs of the

MVP HEALTH INSURANCE COMPANY

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

Company

with such information as he shall deem requisite.

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

this *30th* day of *January 2004*

Gregory V. Serio
Superintendent of Insurance