REPORT ON EXAMINATION

OF THE

ROCHESTER AREA HEALTH MAINTENANCE ORGANIZATION, INC.

AS OF

DECEMBER 31, 2004

DATE OF REPORT **JANUARY 16, 2007**
EXAMINER **JOSEPH S. KRUG**

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

Eliot Spitzer
Governor

Eric R. Dinallo
Acting Superintendent

January 16, 2007

Honorable Eric R. Dinallo
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 22359, dated May 3, 2005, attached hereto, I have made an examination into the condition and affairs of the Rochester Area Health Maintenance Organization, Inc., a not-for-profit corporation licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2004, and submit the following report thereon.

A review was made of the HMO's information system and operations with the assistance of INS Regulatory Insurance Services, Inc. The results of such review are included in Appendix A of this report.

The examination was conducted at the HMO's home office located at 259 Monroe Avenue, Rochester, New York 14607.

Where the designations, "HMO" or "RAHMO", appear herein without qualification, they should be understood to indicate the Rochester Area Health Maintenance Organization, Inc.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 2000. This examination covers the four-year period from January 1, 2001 through December 31, 2004. 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, 2004 in accordance with statutory accounting principles as adopted by this Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO'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:

History of HMO
Management and control
Corporate records
Fidelity bonds and other insurance
Employee welfare and pension plans
Territory and plan of operation
Market conduct activities
Growth of HMO
Business in force
Reinsurance
Accounts and records

A review was also made to ascertain what action was taken by the HMO with regard to comments and recommendations in the prior report on examination. This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies during the examination period. The most significant findings of this examination include the following:

- The HMO violated Section 508 of the New York Not-For-Profit Corporation Law by paying bonuses to its officers predicated on the profit of not-for-profit corporations.

- The HMO failed to comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five (45) day period provided by the aforementioned section of the Insurance Law, where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

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

- The HMO violated Section 4308(g)(1) of the New York Insurance Law and Circular Letter No. 13 (2005), by using language which may be considered inaccurate and misleading in communications with subscribers - including references to New York State approval of rate increase filings made in accordance with Section 4308(g)(1) of the New York Insurance Law.

- The HMO did not comply with Section 308(a) of the New York Insurance Law and respond to New York Insurance Department inquiries promptly.

- The HMO's failed to report suspicious activity as stated in Section 405(a) of the New York Insurance Law within 30 days.

- The HMO failed to establish a full-time special investigation unit as required by Section 409(b)(1) of the New York Insurance Law.

3. DESCRIPTION OF COMPANY

Rochester Area Health Maintenance Organization, Inc., doing business as Preferred Care, provides prepaid comprehensive health care coverage for its enrolled members. The HMO was incorporated in New York State as a not-for-profit corporation on August 18, 1977. On October 18, 1979, the HMO became federally qualified as a health maintenance organization under Title XIII of the Public Health Service Act. Effective November 1, 1979, the HMO received authority to conduct business pursuant to Article 44 of the New York State Public Health Law.

The HMO, as of December 31, 2004, was a subsidiary of Preferred Care, Inc., a not-for-profit corporation, and was controlled through a common board of directors. At December 31, 2004, the sole member of the HMO was Preferred Care, Inc.

RAHMO is an IPA model HMO, it contracts with one or more independent practice associations (IPAs) to provide health care services to its members. Physicians are members of the IPA and are reimbursed for services rendered through a fee schedule or capitated basis as established by the IPA as a whole.

A. Management

Pursuant to the HMO's charter and by-laws, management of the HMO is vested in a board of directors consisting of not less than three members. As of the examination date, the board of directors was comprised of fourteen (14) members. The board meets at such times as fixed by the board of directors or at special meetings as may be called by the Chairperson or by any two of the board members.

At December 31, 2004, the HMO's board of directors was as follows:

Name and Residence	**Principal Business Affiliation**
Gary Bonadona* Webster, NY	Director, Rochester Regional Joint Board, UNITE HERE, AFL-CIO, CLC, Rochester, NY
Michael Copeland* Rochester, NY	Manager, Human Resources, Alstom Signaling, Inc., Rochester, NY
Anthony M. Constanza* Webster, NY	Retired
Bryan Hetherington Rochester, NY	Public Interest law Office of Rochester, Rochester, NY
Linda Miller* Pittsford, NY	Vice President, Development, Department 56 Inc. Rochester, NY
Robert Oppenheimer Pittsford, NY	Attorney, Chamberlain, D'Amanda, Oppenheimer & Greenfield, Rochester, NY
Michael Pichichero, MD Rochester, NY	Physician, Elmwood Pediatric Group, Rochester, NY
William Reddy* Rochester, NY	Treasurer & Chief Operating Officer, Veterans' Outreach Center, Inc., Rochester, NY
Michael Schneider, MD Rochester, NY	Physician, Olsan Medical Group, Rochester, NY
Wilfred J. Schrouder* Penn Yan, NY	Retired
Tammi Schlotzhauer, MD Rochester, NY	Physician, Rheumatology Associates of Rochester, Rochester, NY
Derek tenHoopen, MD Pittsford, NY	Physician, West Ridge OB/GYN. Rochester, NY

Name and Residence	Principal Business Affiliation
John Urban* Rochester, NY	President and Chief Financial Officer, RAHMO, Rochester, NY
Gerald E. VanStrydonck Fairport, NY	Sigma Marketing Group, Rochester, NY

* Indicates enrollee

Subsequent to the January 6, 2006 merger with MVP, the following individuals composed RAHMO's board:

Name and Residence	Principal Business Affiliation
Donald A. Bentrovato, M.D. Schenectady, NY	Urologist
Gary Bonadonna* Webster, NY	Director, Rochester Regional Joint Board, UNITE HERE, AFL-CIO, CLC, Rochester, NY
Michael Copeland* Rochester, NY	Manager, Human Resources, Alstom Signaling, Inc., Rochester, NY
Anthony M. Constanza* Webster, NY	Retired
Burt Danovitz, Ph.D. Utica, NY	Executive Director, Resource Center for Independent Living
Richard J. D'Ascoli, M.D. Schenectady, NY	Orthopedic Surgeon

Name and Residence	**Principal Business Affiliation**
Joseph A, DePaolis Rochester, NY	Retired
Alan Goldberg Albany, NY	President, First Albany Capital
Richard F. Gullott, M.D. Scotia, NY	Retired
Joseph F. Heavey, Poughkeepsie, NY	Associate Director, Veteran's Hospital
John F. Houck Jr., M.D. New Hartford, NY	Physician
Murray M. Jaros, Esq Albany, NY	Attorney, New York State Association of Towns
Karen B. Johnson Schenectady, NY	Director of Development, Proctors Theatre
Herschel Lessin, M.D. Poughkeepsie, NY	Vice President, Hudson Valley Pediatric Group, PC
Ernest Levy, M.D. Oneonta, NY	Neurosciences and Radiology
William Reddy* Rochester, NY	Treasurer & Chief Operating Officer, Veterans' Outreach Center, Inc., Rochester, NY
Jon Rich Alplaus, NY	Retired
Arthur J. Roth Loudonville, NY	Retired
Michael Schneider, MD Rochester, NY	Physician, Olsan Medical Group, Rochester, NY

Name and Residence	Principal Business Affiliation
Wilfred J. Schrouder* Penn Yan, NY	Retired
Joseph J. Schwerman, M.D. Hyde Park, NY	Internal Medicine
Leland Tupper Schenectady, NY	Treasurer, MVP Health Plan, Inc.
Gerald E. Van Strydonck Fairport, NY	Sigma Marketing Group, Rochester, NY
Norma C. Westcott Rexford, NY	Consultant, Westcott Enterprises, Inc.

* Indicates enrollee

The minutes of all of the Board of Directors' meetings and committees thereof held during the examination period were reviewed. The review indicated that all meetings were well attended.

The HMO's principal salaried officers as of December 31, 2004 were as follows:

Name	Title
Wilfred Schrouder	Chairperson
Tammi Shlotzhauer, MD	Vice Chairperson
John Urban	President & Chief Executive Officer
Lisa Brubaker	Sr. Vice President and Chief Operations Officer
Kathleen Dahl	Vice President, Human Resources
Dominic Galante, MD	Vice President, Medical Quality Management
Patrick Glavey	Vice President, Sales and Marketing
Kevin Husted	Vice President, Information Technology

Name	Title
Dennis Kant	Vice President and Controller
Lynette Loomis	Vice President, Marketing and marketing Services
Matthew MacKinnon	Vice President, Network Operations
Carl Maleri	Vice President, Underwriting and Analysis
Carl Reed	Vice President, Pharmacy
Robert Oppenheimer*	Secretary

* indicates non-salaried officer

Subsequent to RAHMO's affiliation with MVP Health Plan, Inc., the HMO's principal salaried officers were as follows:

Name	Title
David Oliker	President & Chief Executive Officer
Lisa Brubaker	Executive Vice President
Thomas Combs	Treasurer
Denise Gonick	Secretary

Affiliation with MVP Health Plan, Inc.

On January 6, 2006, Preferred Care, Inc. became affiliated with MVP Health Plan, Inc. ("MVP"), a tax-exempt New York State not-for-profit corporation and Health Maintenance Organization licensed pursuant to Article 44 of the New York State Public Health Law. Under the terms of the agreement, Preferred Care, Inc. and MVP reorganized their respective enterprises under a holding company structure, with MVP HealthCare, Inc. (formally Preferred Care, Inc.) as the ultimate holding company (Parent) and the direct or indirect parent company of all of the Preferred Care, Inc. subsidiaries and of MVP and all of its subsidiaries. The Parent funded an independent charitable foundation ("Foundation") with an approximate $200,000,000 cash

payment. The Parent was funded from the proceeds of the $80,000,000 bank term loan (discussed below) and by cash transfers from RAHMO in the amount of $107,000,000 and MVP and its subsidiaries in the amount of $43,500,000. In addition, the Parent is required to contribute an additional amount to the Foundation in the approximate amount of $27,000,000, which is payable on January 6, 2012. The additional contribution to the Foundation is expected to be funded by the subsidiaries of the Parent.

In connection with the affiliation, the Parent obtained a five year $80,000,000 bank term loan. Payments of the loan are expected to be funded by the subsidiaries of the Parent. However, pursuant to the New York State Department of Health's approval of the affiliation, dated January 5, 2006, the HMO and any subsidiary of the HMO may not transfer any funds to another entity if such transfer would result in the HMO having a net worth that is less than 12.5% of net premium income for the most recent 12-month period, as of the insurer's most recent filing of the Annual or Quarterly NAIC Health Statement.

Executive Bonus Arrangements

In 2005, RAHMO paid John Urban, its President and Chief Executive Officer, $2.55 million in compensation, including a bonus of $2,045,000. RAHMO was reimbursed by two other companies within the Preferred Care, Inc. Holding Group, both for-profit entities, as follows: $313,537 from Preferred Administrative Services, Inc. and $1,237 from Preferred Financial Services, Inc. According to RAHMO, the share of the bonus between the companies was based upon a cost allocation methodology.

The bonus was calculated, in accordance with Section 4(d) of John Urban's employment agreement with the Holding Group and its member companies for the term of January 1, 2002 to December 31, 2004, as amended by agreements dated April 4, 2003 and January 29, 2004. Section 4(d) of the agreement, as amended, provides as follows:

> "(4)(d)(1) In addition to the bonus provided for in Paragraph 4(b), Employee shall receive a bonus for services actually rendered and performed if the following conditions are met:
>
> (i) Rochester Area Health Maintenance Organization, Inc. remains NCQA certified;
>
> (ii) The Corporations remain independent; provided, however, that the Corporations shall be deemed to have waived such condition if the Board determines, in the exercise of its fiduciary duty, that the Corporations' mission and purpose warrant a merger, affiliation, sale of assets, conversion or other similar transaction in order to strengthen the Corporations or allow the community to benefit from the substantial value that exists as a result of the performance of the Corporations; and
>
> (iii) The Corporations continue to meet all statutory cash and reserve requirements.
>
> (2) The amount of the bonus provided for in this paragraph shall be ten percent (10%) of the amount of the surplus added during the term of this contract over and above twenty-one million dollars ($21,000,000), provided, however, that:
>
> (i) The Corporations shall have the ability to adjust the percentage of the bonus up or down by no more than 5% to reflect other performance measures established by the Board of Directors; and
>
> (ii) The maximum compensation payable to Employee pursuant to this Section 4(d) shall be $2,045,000.00."

The cap was added by the April 2003 amendment as follows:

> "(3) Any bonus earned pursuant to this paragraph (d) shall be paid on the earlier of (i) April 1, 2005; or (ii) the closing of a transaction in which there is a change of control of the Corporations, provided, however, that the conditions of subparagraph (1) of this paragraph are otherwise satisfied at the time of such closing."

During an examination of RAHMO conducted in 1996, the Department discovered that the employment agreement for CEO John Urban contained a bonus provision, substantially similar, if not identical, to the one described in this report. The Department's examination report quoted the language of New York Not-For-Profit Corp. Law Section 508 and recommended that RAHMO comply with such section by specifically excluding from its compensation plan for officers any bonus predicated on the profit of not-for-profit corporations. At the time of the Department's 2000 examination of RAHMO, none of the employment agreements based any form of compensation upon the profit of not-for-profit corporations.

New York Not-For-Profit Corp. Law § 508 (McKinney 2005) provides as follows:

> "A corporation whose lawful activities involve among other things the charging of fees or prices for its services or products shall have the right to receive such income and, in so doing, may make an incidental profit. All such incidental profits shall be applied to the maintenance, expansion or operation of the lawful activities of the corporation, and in no case shall be divided or distributed in any manner whatsoever among the members, directors, or officers of the corporation."

In addition, New York Not-For-Profit Corp. Law § 515 (McKinney 2005) provides in relevant part, as follows:

a) "A corporation shall not pay dividends or distribute any part of its income or profit to its members, directors or officers.

b) A corporation may pay compensation in a reasonable amount to members, directors, or officers for services rendered . . ."

Thus, although a not-for-profit corporation may pay a reasonable compensation to its members, directors or officers for services rendered, it may not share its profits with such persons in any manner whatsoever. Since the amount of the bonus at issue is based upon a certain percentage of excess profits, up to a specified cap, the portion of the bonus that is attributable to RAHMO, a not-for-profit company, constitutes a share of profits of RAHMO and is, therefore, prohibited by New York Not-For-Profit Corp. Law Sections 508 and 515.

It is recommended that the HMO exclude from its bonus and employment agreement with its officers any reference to bonuses predicated on the profit of a not-for-profit corporation in compliance with Section 508 of the New York Not-For-Profit Corporation Law. It is also recommended that the HMO put in place governance procedures for adequate board oversight of its officer compensation program.

B. Territory and Plan of Operation

At December 31, 2004, the HMO, pursuant to a Certificate of Authority issued by the New York Department of Health, was authorized to conduct operations in the following counties of New York:

Livingston	Monroe	Ontario
Seneca	Wayne	Yates
Genesee	Orleans	Wyoming

The HMO conducts business only in New York State with reported premium revenue of $670,881,573 in 2004.

The HMO writes the following lines of business: HMO, POS, Medicare, Medicaid, and Healthy NY. It should be noted that the out-of-network portion of POS is handled by Preferred Assurance Company.

The following table summarizes the HMO's membership during the period under examination:

	HMO	POS	Government	Total
December 31, 2001	107,089	475	47,205	154,769
December 31, 2002	86,201	659	61,264	148,124
December 31, 2003	94,050	1,940	66,165	162,155
December 31, 2004	87,145	7,354	69,514	164,013

The HMO did not use the services of independent agents during the examination period, however, brokers were used. The HMO did not maintain any branch offices at December 31, 2004.

Risk Transfer

RAHMO contracts annually with Genesee Region Preferred Health Network IPA, Inc., d/b/a Preferred Health Network (PHN), a wholly-owned subsidiary of Preferred Care, Inc., and the

Greater Rochester Independent Practice Association, Inc., (GRIPA) (collectively the IPAs) to provide physician services to subscriber members. The IPAs are compensated for their services on a capitated basis adjusted for the age/sex demographic of their members. The IPAs are at risk for hospital inpatient, outpatient, and physician services. The IPAs withhold a percentage of the amounts paid to participating physicians for accumulation in a risk pool. The following table summarizes the percentages of withhold as of December 31, 2004 by each IPA:

IPA	Commercial	Medicare	Medicaid
GRIPA	10.0%	7.5%	N/A
PHN	10.0%	0.0%	N/A
Medicaid	N/A	N/A	10.0%
Lifetime	10.0%	0.0%	N/A

Losses beyond the withhold pool are absorbed by RAHMO. PHN served 60% and 59% of RAHMO's members in 2004 and 2003, respectively. The risk arrangement with GRIPA served 25% of RAHMO's members in 2004 and 2003. The remaining 15% and 16% of RAHMO's membership in 2004 and 2003, respectively, was served by the Lifetime Health Practice Risk Pool (approximately 5% for both years) and the Medicaid Hospital Risk Pool (approximately 10% for both years).

The HMO also contracts with hospitals and other providers in its operating area for inpatient, outpatient, and other services. Rates for inpatient services (excluding Medicare and

Medicaid) are either negotiated with each hospital or paid at the negotiated rate through RAHMO's national network of contracted providers. Medicare inpatient services are reimbursed based on rates developed under the Prospective Payment System issued by the Centers for Medicare and Medicaid Services. Medicaid inpatient services are reimbursed based on rates established by the State of New York in accordance with the Health Care Reform Act of 2000. Medicare and Medicaid inpatient, hospital outpatient and ancillary service payments are based on contractual arrangements with hospitals and other providers which include risk-sharing arrangements, as well as fee-for service arrangements.

C. Reinsurance

Following is a description of the HMO's ceded reinsurance program in effect at December 31, 2004:

Lines of Business Covered	Type of Cession	Limits
Commercial and Medicare		
Eligible hospital services (authorized reinsurer)	Excess of Loss	90% excess of $200,000 of loss per member. Maximum benefit payable per covered member per policy year is $1,000,000. Maximum benefit payable in all per policy year is $2,500,000.
Human organ and bone marrow transplant	Aggregate	$500,000 aggregate deductible. Coverage is provided for all Non - GRIPA commercial members.

The monthly premium for the excess of loss coverage for GRIPA commercial and Medicare members is $0.40 per member. The monthly premium for the excess of loss coverage for Non -

GRIPA commercial members is $0.32 and for Non - GRIPA Medicare members is $0.40 per member. The monthly premium for the Non - GRIPA aggregate human organ and bone marrow transplant coverage is $2.02 per commercial member.

The HMO also maintains New York State Stop-Loss Reinsurance for Medicaid individual enrollees. Under the terms of the agreement, New York State will reimburse the HMO a portion of the costs incurred for inpatient hospital services calculated at Medicaid rates in excess of $50,000 subject to co-insurance. New York State assumes full-risk for costs in excess of $250,000.

During the review of RAHMO's reinsurance contracts in effect at December 31, 2004, it was determined that the contract with Zurich American Insurance Company did not contain the required insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law. Section 1308(a)(2)(A)(i) of the New York Insurance Law states in part,

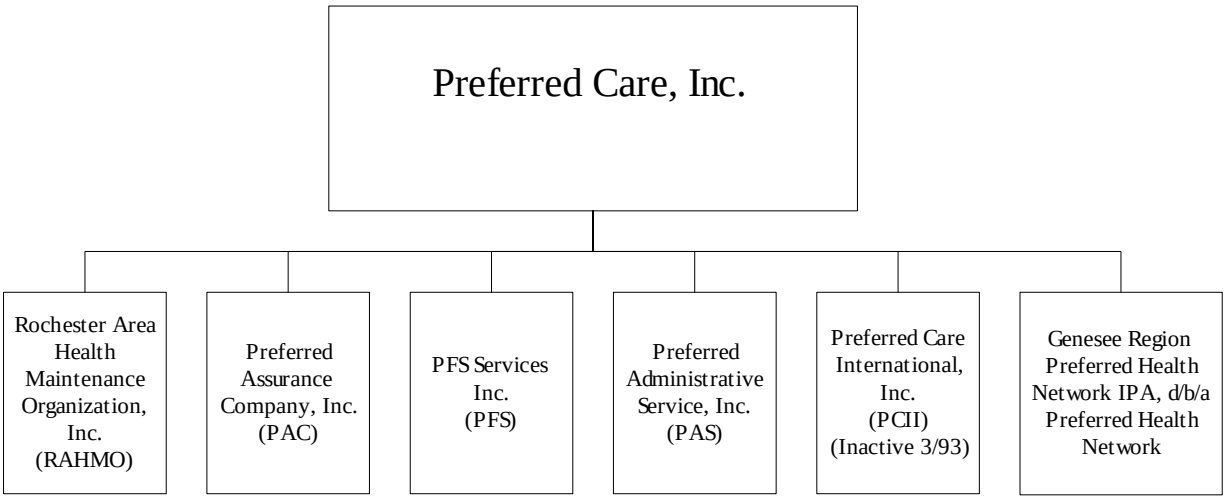
> "…reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer…"

It is recommended that RAHMO amend its reinsurance contract with Zurich American Insurance Company to include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

D. Holding Company System

The HMO, as of December 31, 2004, was controlled by its sole member, Preferred Care, Inc. and accordingly, was subject to the holding company report filing requirements of Part 98-1.16(e) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1). It should be noted that the HMO appropriately made all the required holding company filings during the period under examination.

As of December 31, 2004, Preferred Care, Inc. (PC, Inc.), formerly known as Preferred Holding Company, Inc. was the ultimate holding company in the holding company organization. Preferred Care Holding Company, Inc. was formed in 1996 pursuant to Section 402 of the New York Not-For-Profit Corporation Law for the purpose of acting as a holding company and promoting and improving the delivery of health services in the community. The following chart depicts the HMO and its relationship to affiliates, as of December 31, 2004:



As indicated in the organizational chart, Preferred Care, Inc., as of December 31, 2004, controlled the HMO and the following entities described below:

Preferred Assurance Company, Inc.

Preferred Assurance Company, Inc. (PAC) is licensed to do business within New York State as a non-profit health corporation pursuant to the provisions of Article 43 of the New York Insurance Law. PAC provides coverage of hospital, medical, and other health services for the out-of-network component of RAHMO's point-of-service product in the Rochester metropolitan area.

At December 31, 2004, the HMO had made Section 1307 loans to PAC in the aggregate amount of $7,998,461.

Preferred Financial Services, Inc.

Preferred Financial Services, Inc. (PFS) is licensed by the New York Insurance Department for the solicitation, negotiation, and sale of life and accident/health insurance, including long-term disability insurance, pensions and retirement benefits.

Preferred Administrative Services, Inc.

Preferred Administrative Services, Inc. (PAS) is a for-profit corporation which provides management and information services related to health services to outside parties. PAS also provides administrative claims services as a third party administrator to self insured groups.

Preferred Care International, Inc.

Preferred Care International, Inc. (PCI) is a for profit corporation which was established in order to develop a Canadian subsidiary, Preferred Care, Inc. of Canada (Soins Privileges). Preferred Care Inc. of Canada was established to provide consulting and management services to Canadian managed care organizations. In 1993, Preferred Care, Inc. of Canada ceased operations. Since 1993, Preferred Care International, Inc. has remained dormant.

E. Administrative Services Agreement

In February of 1998 the HMO executed an Administrative Services Agreement with its affiliate, PAC. According to this agreement, various services are provided to the Plan by RAHMO including, but not limited, to the following:

a) financial systems and services
b) claims administration
c) information services
d) provider and member services and relations
e) medical policies, utilization review and quality assurance
f) underwriting services
g) contracts for services
h) purchase and leases
i) reports to Board
j) licensing
k) marketing

It was noted that this agreement was not submitted to the Insurance Department and was not approved. Part 98-1.11(b) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1) states:

> "No funds the aggregate of which involves five percent or more of the MCO's admitted assets at last year-end shall be transferred or loaned from the MCO article 44 business to any other business, function or contractor of the MCO, or to any subsidiary or member of the MCO's holding company system over the course of a single calendar year, without the prior approval of the commissioner…"

It is recommended that RAHMO comply with the requirements of Part 98-1.11(b) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1) and obtain approval for its Administrative Services Agreement with PAC.

F. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the January 1, 2001 to December 31, 2004 period covered by this examination:

	Amount	Ratio
Claims incurred	$1,899,115,516	86.4%
Claims adjustment expenses incurred	19,769,492	0.9%
Other underwriting expenses incurred	166,771,173	7.6%
Net underwriting gain	111,781,372	5.1%
Premiums earned	$2,197,437,553	100.0%

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2004, and as reported by the HMO. This statement is the same as the balance sheet filed by the HMO.

	Ledger Assets	Non-admitted Assets	Net Admitted Assets
Assets			
Bonds	$47,163,933	0	$47,163,933
Cash , cash equivalents and short-term investments	156,337,173	0	156,337,173
Investment income due and accrued	504,061	0	504,061
Uncollected premiums	9,647,775	71,5670	9,576,208
Electronic data processing equipment and software	5,030,738	4,215,687	815,051
Furniture and equipment	1,201,158	1,201,158	0
Receivables from parent, subsidiaries and affiliates	577,869	0	577,869
Healthcare and other amounts receivable	11,542,474	6,625,541	4,916,933
Other assets non-admitted	1,239,313	1,239,313	0
Leasehold improvements	0	0	0
Other receivables	1,553,338	689,342	863,996
Total assets	$234,797,831	$14,042,608	$220,755,224
Liabilities			
Claims unpaid			$ 35,497,231
Premiums received in advance			39,570,790
General expenses due and accrued			5,810,360
Federal and foreign income taxes payable and interest thereon			20,000
Amounts withheld or retained for the account of others			7,190,241
Amounts due parent, subsidiaries and affiliates			9,761,624
Total liabilities			$97,850,246
Surplus			
Contingency reserve			$33,544,079
Unassigned funds (surplus)			89,360,899
Total surplus			$122,904,978
Total liabilities and surplus			$220,755,224

Note 1: The Balance Sheet shown above includes no provision for distributions to or from the Demographic and Specified Medical Conditions Pools. For Pool years 1999 to 2003, the Pool administrator's calculation indicates the HMO has a liability of $453,748. Furthermore, the Pool administrator's calculation indicates the HMO has a liability of $983,014 for 2004. In 2005, RAHMO made payments to the Specified Medical Conditions Pool of $2,017,986 for the period 1999 to 2004. In 2005, RAHMO received a distribution from the 1999 and 2000 demographic pool of $581,224.

Note 2: There have not been any audits by the Internal Revenue Service of the Plan's federal income tax returns. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenue and Expenses

Surplus increased $113,739,161 during the period under examination, January 1, 2001 through December 31, 2004, detailed as follows:

Income		
Net premium income	$ 2,197,210,912	
Aggregate write-ins for other health care related revenues	226,641	
Total revenues		$ 2,197,437,553
Expenses		
Hospital/medical benefits	$ 1,243,363,557	
Emergency room and out-of-area	73,882,377	
Prescription drugs	105,972,382	
Aggregate write-ins for other medical and hospital	475,949,175	
Subtotal	1,899,167,491	
Net reinsurance recoveries	(51,975)	
Total hospital and medical	1,899,115,516	
Claims adjustment expenses	19,769,492	
General administrative expenses	166,771,173	
Total underwriting deductions		2,085,656,181
Net underwriting gain		$ 111,781,372
Net investment income earned	7,898,515	
Net realized capital gains	108,608	
Net investment gains		8,007,123
Net income before federal and foreign income taxes incurred		119,788,495
Federal and foreign income taxes incurred		0
Net income		$ 119,788,495

C. Change in Surplus

Surplus per report on examination as of December 31, 2000			$ 9,165,817
	Increases	Decreases	
Net income from operations	$119,788,495	$	
Cumulative effect of changes in accounting principles		(6,275,738)	
Change in non admitted assets		(6,092,228)	
Preferred Health Network Contingency Reserve	7,098,000		
Capital lease payable		(779,368)	
	$126,886,495	$(13,147,334)	
Net change in surplus			113,739,161
Surplus per report on examination as of December 31, 2004			$122,904,978

5. CLAIMS PAYABLE

The examination liability of $35,497,231 is the same as the amount reported by the HMO in its December 31, 2004 filed 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 HMO's internal records and in its filed annual statements.

6. MARKET CONDUCT ACTIVITIES

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

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

a) Claims processing
b) Schedule H preparation
c) Schedule M preparation
d) Policy forms and rating
e) Brokers
f) Disclosure (Direct pay, small group & Healthy NY access)
g) Frauds prevention

A. Claims Processing

A review of the HMO's claims practices and procedures was performed. This review was performed by using a statistical sampling methodology covering the scope period in order to evaluate the overall accuracy and compliance environment of the Plan's claims processing. The review encompassed the period from January 1, 2004 through December 31, 2004. The claims tested were selected from the population of claims adjudicated during the review period.

These primary populations were divided into hospital and medical claims segments. Random samples were drawn from each of the segment groups. For purposes of this project, those medical costs characterized as Medicare, capitated, and SMC payments were excluded.

This statistical random sampling process 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 within the selected populations, individually or on a combined basis. For example, if ten (10) attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample. The following parameters were established to determine the sample size for the statistical sampling model:

a) Confidence Level

The rate was set at 95%, which infers that there is a 95% chance that the sample will yield an accurate result.

b) Tolerance Error

The rate was set at 5%. It was determined that a 5% error rate would be acceptable for this sample.

c) Expected Error

It was anticipated that a 2% error rate exists in the entire population subject to sampling, which was deemed acceptable for the model design.

d) Sample Size

The sample size for each of the populations described herein was comprised of one hundred sixty seven (167) randomly selected unique claims. A second random sample of fifty (50) items

from each of the populations was also generated as "replacement items" in the event it was determined a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized.

e) Sample Unit

The term, "claim" can be defined in a myriad of ways. For purposes of these procedures, the Department defines a claim as the total number of items submitted with a single claim form, which is the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population, the total dollars paid were accumulated and reconciled to the financial data reported by the HMO. To verify each service (item) that resulted in no payment, a reconciliation of transaction counts was performed.

The Plan's internal performance measurement for claims accuracy is 97%.

Two (2) procedural errors were found in the sample of 167 hospital claims. Of 167 medial claims reviewed, one (1) financial and one (1) procedural error were found. No trends in the type of error were noted.

B. Prompt Payment

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," states:

> "(a) Except in a case where the obligation of an insurer … to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a

health care provider within forty-five days of receipt of a claim or bill for services rendered."

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

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

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

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section."

"(c) … any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

In this regard, a statistical sample of claims paid during calendar year 2004 was selected from a population of claims that were paid more than forty-five (45) days from receipt. The claims

were reviewed for compliance with Section 3224-a of the New York Insurance Law. The results of the review were then projected for the total population of claim payments made during the period.

The following is a summary of the prompt pay review findings for the combined Hospital and Medical claims paid over 45 days and denied over 30 days:

Description	Paid claims over 45 days Section 3224-a(a)	Denied over 30 days
Claim population	8,289	184,469
Sample size	167	167
Number of claims with errors	75	11
Calculated Error Rate	44.91%	6.59%
Upper Error limit	52.45%	10.35%
Lower Error limit	37.37%	2.82%
Upper limit Claims in error	4,348	19,091
Lower limit Claims in error	3,097	5,211

Note 1: 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.)

Note 2: Of the 75 claims found to be in violation of Section 3224-a(a), 16 claims also violated Section 3224-a(c) because interest due of $2 or more was not paid.

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

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

C. Improper Premium Notices

The examiners requested that RAHMO provide us with premium notices it has issued to subscribers in the past 2 years. During a review of premium notices issued to subscribers in the past 2 years, it was noted that certain premium notices issued by RAHMO contain wording that may be considered inaccurate and misleading. A review of the HMO's Personal Plan and Healthy New York premium notices indicates that the following language was included in such notices,

> "...These rate increases must be approved by New York State before the new rate is reflected in your monthly bill. ... Please note the State may approve the entire requested increase, a portion of the requested increase, or deny the request for an increase. Upon State approval, your bill will reflect your new rate..."

Circular Letter No 13 (2005) states in part,

> "...Because rate filings made pursuant to Section 4308(g)(1) are deemed approved upon submission to the Department, it is inaccurate and misleading for an insurer or HMO to state or imply in its notices to subscribers, or in any other communication with subscribers, that a rate increase obtained pursuant to this provision has been approved by the Department. Such rate increases are filed with the Department and

deemed approved by operation of law. Since the Department can neither approve nor disapprove rate increases under Section 4308(g)(1), it is inappropriate for an insurer or HMO to suggest otherwise in its communications with subscribers..."

It is recommended, pursuant to Section 4308(g)(1) of the New York Insurance Law and Circular Letter No. 13 (2005), that RAHMO cease and desist the inclusion of language which may be considered inaccurate and misleading in communications with subscribers - including references to New York State approval of rate increase filings made in accordance with Section 4308(g)(1) of the New York Insurance Law.

D. Grievance Register

The HMO's internal grievance register was compared to the HMO's 2004 filed Schedule M-Table 1 of the New York Data Requirements statement. It was noted that the HMO included grievances from ASO business in Schedule M -Table 1 of the New York Data Requirements statement as evidenced by the following table:

	Filed in 2004
Per 2004 Schedule M – Table 1	345
Per grievance register	165
Difference (ASO business)	180

All HMOs are required to report the number of initial grievances filed with the HMO within Schedule M as per the annual statement instructions. ASO business should not be reported in Schedule M-Table 1 of the New York Data Requirements. According to annual statement instructions, only managed care business should be reported.

It is recommended that the HMO include only grievances related to managed care business within its Schedule M-Table 1 of the New York Data Requirements in compliance with annual statement instructions.

E. Appeals Register

The HMO's appeal register was compared to Schedule M-Table 2 of the New York Data Requirements. It was noted that the HMO included appeals from ASO business in Schedule M – Table 2 of the New York Data Requirements as evidenced by the following table:

	Filed in 2004
Per Schedule M – Table 2	149
Per appeal register	113
Difference (ASO business)	36

All HMOs are required to report the number of appeals filed with the HMO within Schedule M as per the annual statement instructions. ASO business should not be reported in Schedule M-

Table 2 of the New York Data Requirements. According to annual statement instructions, only managed care business should be reported.

It is recommended that the HMO include only appeals related to managed care business within its Schedule M-Table 2 of the New York Data Requirements in compliance with annual statement instructions.

F. Utilization Review

During the review of standard appeals, it was noted in several instances that the HMO failed to send acknowledgement letters within the required timeframe. Section 4802(h)(i) of the New York Insurance Law states:

> "Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision."

It is recommended that the HMO comply with the provisions of Section 4802(h)(i) of the New York Insurance Law regarding acknowledgement letters.

During the review of grievances it was noted that the HMO failed to resolve some grievances within the required time frame. Section 4802(d)(2) of the New York Insurance Law states:

> "(d)…All grievances shall be resolved in an expeditious manner, and in any event, no more than: (2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract;"

It is recommended that the HMO comply with the provisions of Section 4802(d)(2) of the New York Insurance Law regarding the resolving of grievances in an expeditious manner.

During the review of appeals, it was noted in several instances that the HMO failed to resolve some appeals within the required time frame. Section 4802(k)(2) of the New York Insurance Law states:

> "(k) The insurer shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than: (2) thirty business days after the receipt of all necessary information in all other instances."

It is recommended that the HMO comply with the provisions of Section 4802(k)(2) of the New York Insurance Law regarding the resolving of appeals in an expeditious manner.

During the review of appeals, it was noted in several instances that the HMO failed to show that someone at a higher level than the personnel that reviewed the initial grievance reviewed the appeal and overturned the prior decision. Section 4802(j) of the New York Insurance Law states:

> "(j) The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination."

It is recommended that the HMO comply with the provisions of Section 4802(j) of the New York Insurance Law regarding having the proper personnel review appeals.

G. Explanation of Benefits Forms

During the review of explanation of benefits forms, it was noted that such forms were missing some of the requisite information. Section 3234(b) of the New York Insurance Law lists the requirements that such forms must include:

> "(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."

During the review of the explanation of benefit forms it was noted that some of the requisite information pertaining to item seven (7) of Section 3234(b) of the New York Insurance Law was not included. Specifically, "…the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and 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.", was not included. Accordingly, subscribers and/or providers are not being properly informed of their appeals rights.

It is recommended that the HMO modify its explanation of benefits forms to comply with Section 3234(b) of the New York Insurance Law.

H. Failure to Respond to New York Insurance Department Inquiries

A desk audit letter was sent by the New York State Insurance Department to the HMO on September 15, 2005. Several phone calls were made to Officers of the Plan attempting to obtain a response. Follow-up letters were also sent to the Plan on January 19, 2006 and then again on April 4, 2006. Section 308(a) of the New York Insurance Law states:

> "The superintendent may also address to any health maintenance organization or its officers or any authorized insurer or its officers any inquiry in relation to its transactions or condition or any matter connected therewith. Every corporation or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of a corporation, as he shall designate, and affirmed by them as true under the penalties of perjury. In the event any corporation or person does not provide a good faith response to an inquiry from the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance or health maintenance organization coverage, within a time period specified by the superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such corporation or person not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response, but in no event shall such penalty exceed seven thousand five hundred dollars."

It is recommended that the Plan comply with Section 308(a) of the New York Insurance Law and respond promptly to inquiries made by the Department.

I. Frauds Review

As part of the examination, an on-site Frauds Review was conducted. This review indicated the following:

Based upon the review of filings with the New York Insurance Department's Frauds Bureau, it was noted that the HMO did not always report transactions that may be fraudulent within the 30 days prescribed by Section 405(a) of the New York Insurance Law

1) Section 405(a) of the New York Insurance Law states:

> "Any person licensed pursuant to the provisions of this chapter, and any person engaged in the business of insurance in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent transaction is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require."

It is recommended that the HMO report transactions that may be fraudulent within 30 days to this Department as provided within Section 405(a) of the New York Insurance Law.

2) Relative to the fraud prevention plan, Section 409(b)(1) of the New York Insurance Law states:

> "The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigation unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims functions of an insurer, and shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent. An insurer shall include in such plan staffing levels and allocations of resources in such full-time special investigations unit as may be necessary and appropriate for the proper implementation of the plan pursuant to subsection (d) of this section."

It was determined that the Manager of the Special Investigation Unit, who is the HMO's only qualified investigator, devotes approximately 50% of her time to activities and assignments not related to fraud prevention. Section 409(b)(1) of the New York Insurance Law requires full-time devotion to these activities.

It is recommended that the HMO establish a full-time special investigation unit as required by Section 409(b)(1) of the New York Insurance Law.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

ITEM		PAGE NO.
A.	Holding Company System	
	It is recommended that the HMO make the appropriate holding company filings required under Part 98.16(e) of the Administrative Rules and Regulations of the New York Health Department. (10NYCRR Part 98.16(e)).	9
	The HMO has complied with this recommendation.	
B.	Internal Controls / disaster recovery	
	It is once again recommended that the HMO develop and maintain a disaster recovery plan.	11
	The HMO has complied with this recommendation.	
C.	Investments	
	1. It is once again recommended that the HMO, in the future, comply with the investment requirements of Section 1409(a) of the New York Insurance Law.	11
	The HMO has complied with this recommendation.	
	2. It is recommended that the HMO include the enumerated protective covenants and provisions in its custodial agreements.	12
	The HMO has complied with this recommendation.	
D.	Leasehold improvements	
	It is recommended that the HMO not-admit its leasehold improvements, these items should be expensed as incurred.	17
	The HMO has complied with this recommendation.	

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

APPENDIX A

SYSTEMS REVIEW

1. SCOPE OF EXAMINATION REVIEW

INS Services, Inc. (INS), an independent contractor of INS Regulatory Insurance Services, Inc., was retained by the New York State Insurance Department to conduct a review of the Information Systems of Rochester Area Health Maintenance Organization, Inc. and Preferred Assurance Company Inc. (collectively referred to as "Company" or "Preferred Care" in this report).

The review provided information relative to testing of the operating effectiveness of specific policies and procedures relating to the Company's information systems covering the period from January 1, 2004 to October 6, 2005.

The review included procedures to obtain reasonable assurance that:

- The Company's responses to the Department's Evaluation of Controls in Information Systems Questionnaire presented fairly, in all material aspects, the aspects of the Company's policies and procedures that may be relevant to its information technology (IT) internal control structure;
- The control structure policies and procedures were suitably designed to achieve the control objectives implicit in the Questionnaire, if those policies and procedures were complied with; and,
- Such policies and procedures had been placed in operation as of and for the examination period ended December 31, 2004, and from that date to the date of the INS report, October 6, 2005.

A list of applications that were included in the scope of their evaluation and the function of each of the applications is as follows:

Application	Function
AMISYS and Related Custom (Preferred Care Developed) Applications	Managed Care including Enrollment, Premium Processing, Accounts Receivable , and Claims
Data Warehouse	Actuarial, Data Summarization for Financial Reporting (Intermediate Data Store Between AMISYS and the General Ledger)
Oracle Financials	General Ledger, Accounts Payable and Expenses
Telemagic	Sales and Accounts Receivable support
HSS – APC/DRG Grouper and Pricer	Pricing of Inpatient and Outpatient Claims

The following are the observations and recommendations made by INS as a result of its review:

A. Computer room access by Webmaster

The Webmaster, whose responsibilities largely equate to that of a programmer, and a number of individuals have long-term access to the computer room. However, their job responsibilities do not require such access.

Access by more individuals to the computer room than necessary increases the possibility that an unauthorized entrance or activity could occur. An even higher risk is involved with programmers who have access to the computer room. They have the resources and ability to alter code and anything in the computer room for malicious or financial purposes.

It is recommended that the Company review and evaluate the list of individuals with access to the computer room. Changes should occur to allow only individuals who require access to perform their jobs. The Webmaster's access should be terminated.

B. Computer room access by visitors

Visitors to the computer room who do not have card reader access are not required to sign in.

Without a documented log-in, the Company would lack the audit trail to investigate problems that may occur in the computer room.

It is recommended that visitors to the computer room who do not have card reader access should be required to sign in. A sign-in log would allow the Company to investigate problems, and determine if such problems could be traced to the activity of a specific individual.

C. Documentation of change network configuration

The Company has not documented the process used to change network configuration. Formal documentation is presently under development.

Without a documented process to change network configuration, the Company increases the risk of endangering the integrity of the network and the safety of customer's personal information.

D. Reports containing PHI

At times the mailroom can be a thoroughfare for Preferred Care employees. Numerous open mail cubicles or bins contain reports with names, addresses healthcare and pharmacy data of covered individuals, i.e., private health information (PHI). An employee may inadvertently or intentionally read a report containing private health information, and worse, divulge that information, thus resulting in a HIPAA violation.

In addition to the possibility of HIPAA violations, certain Preferred Care employees may be viewing healthcare information of fellow workers or their families, as they are also likely to be covered by Preferred Care policies.

It is recommended that reports containing PHI be enveloped or labeled in such a way that only appropriate employees have access. It is further recommended that those reports be labeled

with a warning reminding employees that unauthorized viewing of the information may be in violation of HIPAA.

E. Immediate removal of network access for terminated employees

Upon termination of an employee, the Company does not immediately disable network login, and application, remote, and voice mail accesses.

Ultimately, damage to computer resources and Company reputation can occur if an unauthorized, and possibly bitter, former employee continues to have access to these resources.

Those charged with the security of access controls should respond promptly to any termination (both voluntary and involuntary), by following established procedures. In the event that an employee is terminated at the end of the day, after-hours support should respond immediately and disable access to the building and data systems. Managers should be required to contact the help desk or security at any time of day to ensure that access is promptly disabled.

The security team should monitor the entries in the termination binder each month in an effort to enforce timeliness of account termination, consistent with the Company's written procedures.

2. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. ***22359***

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***Howard Mills***, Acting Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Joseph Krug

as a proper person to examine into the affairs of the

Rochester Area HMO, Inc.

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 *3rd* day of *May* *2005*

Howard Mills
Acting Superintendent of Insurance