REPORT ON EXAMINATION

OF

HEALTHNOW NEW YORK INC.

AS OF

DECEMBER 31, 2003

DATE OF REPORT	**JULY 12, 2006**
EXAMINER	**JOSEPH S. KRUG**

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

George E. Pataki
Governor

Howard Mills
Superintendent

July 12, 2006

Honorable Howard Mills
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 No. 22228, dated May 17, 2004, and attached hereto, I have made an examination into the condition and affairs of HealthNow New York Inc., a domestic non-profit health service corporation as of December 31, 2003 and respectfully submit the following report thereon.

The examination was conducted at HealthNow New York Inc.'s home office located at 1901 Main Street, Buffalo, NY.

Wherever the term, "Plan" appears in this report without qualification, it should be understood to refer to HealthNow New York Inc.

A concurrent examination was made of the Plan's line of business health maintenance organization. The Plan's health maintenance operations are marketed under the name, "Community Blue", in the Buffalo division area and under the name,

"HealthNow", in the Albany division area. The results of such examination are included in an Appendix A to this Report.

The Plan reported reserves and unassigned funds of $221,993,959 as of December 31, 2003. As of December 31, 2003, the Plan's required to be maintained statutory reserve of $222,134,436 was impaired in the amount of $140,477. Subsequent to this report date, the Plan has filed quarterly and annual statements which indicate a removal of the impairment.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of September 30, 1999. This examination covered the period from October 1, 1999 through December 31, 2003. Where deemed appropriate, transactions subsequent to this period were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2003, in accordance with the Statutory Accounting Principles as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit of the following items was conducted as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Plan
Management and control
Corporate records
Fidelity bond and other insurance
Employee relations and welfare
Territory and plan of operation
Loss experience
Reinsurance
Accounts and records
Growth of the Plan
Market conduct activities

A review was also made to ascertain what actions have been taken by the Plan with regard to comments and recommendations contained in the following four prior reports on examination:

1) Market Conduct Report on Examination as of March 15, 1999

2) Report on Examination as of September 30, 1999

3) Interim Market Conduct Report on Examination as of February 1, 2000

4) Special Report on Examination as of December 10, 2003

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 Plan, in some instances, failed to comply with the annual statement instructions in the preparation of its filed financial statements to this Department.

- The Plan failed to appropriately reconcile its financial records, annual and quarterly statement filings including its Healthy New York Report No. 4 filings, its Section 4308(h) of the New York Insurance Law reports and its Healthy New York Loss ratio reports. Also the Plan failed to book all appropriate receivables and accruals on its books and report such receivables and accruals in all related filings and reports according to instructions.

- On four (4) separate occasions during the examination period, the Plan paid commissions to its brokers in excess of commission rates filed with this Department.

- Subsequent to the examination period, the Plan in some instances did not abide by the provisions of Section 4308(g)(2) of the New York Insurance Law and provide at least thirty (30) days advance written notice of a rate increase to each contract holder and subscriber.

- The Plan should make appropriate refunds of premiums to its direct payment subscribers, as directed by this Department, in compliance with Section 4308(h) of the New York Insurance Law.

- In certain instances, the Plan failed to calculate experience rated group premiums in accordance with Department approved formulas as required by Part 52.40 of Department Regulation 52 (11 NYCRR 52.40).

- The Plan should revise its procedures regarding retroactive terminations for non-payment so at to provide for all terminations for non-payment to take place within the thirty (30) day grace period included within its contracts or amend such contracts to provide for a time period commensurate with the present practice.

- The Plan 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 Plan should adjust all infertility mandated claims for the period, September 1, 2002 to the present, that were incorrectly processed, including those not originally identified for adjustment by the Plan in a subsequent internal review and as noted herein relative to a subsequent Department review. A subsequent on-site Department review indicated that certain infertility mandated claims related to infertility surgical procedures and infertility related drugs had not been identified and appropriately paid by the Plan during the aforementioned period,

- The Plan does not always report suspicious activity to this Department within thirty (30) days as required by Section 405(a) of the New York Insurance Law.

- The Plan does not budget enough funds for advertising to increase public awareness of fraud, in furtherance of Section 409(c)(5) of the New York Insurance Law.

- In eight (8) instances of presentations to employer groups and/or brokers, the Plan failed to comply with the requirements of Department Regulation 34 (11 NYCRR 215.11) relative to its sales and marketing advertising.

- The Plan failed to comply with the underwriting guidelines for sole proprietors as set forth in Section 4317(f)(3) of the New York Insurance Law.

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

3. DESCRIPTION OF PLAN

The Plan is a non-profit health service corporation organized under the provisions of the Membership Corporation Law and Article 43 of the New York Insurance Law. The Plan was incorporated on September 26, 1939 and commenced business in 1940

As a result of its merger with WholeHealth Insurance Network Inc, from December 30, 1992, the Plan acquired operations in the Albany area, which it currently operates as a separate division. From the merger date through May 1, 1996 The Company operated under the corporate name, Blue Cross and Blue Shield of Western New York, Inc. On May 2, 1996, the Plan changed its name to New York Care Plus Insurance Company, Inc. Subsequently, on October 1, 1998, the Plan changed its name to HealthNow New York Inc., its current name. The Plan, as of December 31, 2003, operated under the names of Blue Cross and Blue Shield of Western New York relative to its western New York division and Blue Shield of Northeastern New York relative to its eastern New York division.

On August 1, 1985, the Plan began the operations of Community Blue; a health maintenance organization (HMO) authorized pursuant to Article 44 of the New York

Public Health Law. Community Blue, an individual practice association (IPA) health maintenance organization, functions as a line of business of the Plan in eight (8) counties of western New York. On August 15, 1995, the Plan was granted authority to expand its Article 44 service area and began doing business as an HMO in twelve (12) counties of eastern New York. The HMO line of business operates under the names of Community Blue in its western New York division and HealthNow in its eastern division.

A. Management

HealthNow Systems, Inc. is the sole member of the Plan. HealthNow Systems, Inc., was formed in 1996 under the name, New York Care Plus Holding Company, Inc. to act as a holding company for the Plan and its affiliates.

Article IV, Section 2(a) of the Plan's by-laws indicates that the number of members of the board of directors shall not be less than seventeen (17) nor more than twenty-one (21). As of December 31, 2003, the Plan's board of directors consisted of eighteen (18) members. The board meets at least four (4) times a year.

Plan board members are elected at the Plan's annual membership meeting which is held in March of each year. Per agreement with this Department, Plan board directors are the same directors as those who are elected to the HealthNow Systems Inc. board of directors.

According to Article IV, Section 2(a) of the Plan's by-laws, the Chairperson of the Board of Directors and the President and Chief Executive Officer shall be members of the Board of Directors.

The Plan's directors, as of December 31, 2003, were as follows:

Name and Residence	**Principal Business Affiliation**
Provider Representatives	
Steven B. Boyle Slingerlands, NY	Chief Executive Officer, St. Peter's Hospital
Patrick J. Buttarazzi, MD	Auburn Facility Health Services Director, NYS Department of Corrections
Harry L. Metcalf, M.D. Williamsville, NY	Chairman of the Board, Highgate Medical Group
Public Representatives	
Lois B. DeFleur, PhD	President, Binghamton University (State University of New York at Binghamton)
James B. Foster Hamburg, NY	Chief Executive Officer, Lake Shore Hospital, Inc.
Parmalier D. Murphy, D.D.S. Williamsville, NY	Dentist, Private Practice
James J. O'Brien, Esq. Amherst, NY	Partner, O'Brien & O'Brien
Norman Rickard Vero Beach, FL	Retired
Louise Woerner	Chairman and CEO, Health Care Resources

Name and Residence	**Principal Business Affiliation**
John M. Brown Orchard Park, NY	Retired
Joseph J. Castiglia West Falls, NY	Chairman of the Board, Sisters of Charity Hospital
Thomas M. Fricano, Salem, SC	Retired
Mark D. Higgins West Seneca, NY	Civil Service Employees Association
Thomas J. Murrer, CPA Westfield, NY	President, Renold, Inc.
Cindy Vastola Kenmore, NY	Assistant Vice President, Small Business Services, Key Bank
Richard J. Zipp Wilson, NY	Retired
Officer-Employee	
Alphonso O'Neil-White	Interim President and Chief Executive Officer, HealthNow New York Inc.

The minutes of all meetings of the board of directors and committees thereof held during the examination period were reviewed. During the period under review, the board met at least four (4) times in each calendar year in accordance with its by-laws. Based upon this review, it was determined that such meetings were well attended. The board excused absences.

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

Name	**Title**
Alphonso V. O'Neil-White	Interim President*
James A. Cardone	Executive Vice President, Operation Support Services, Chief Financial Officer and Treasurer
Cheryl Howe	Executive Vice President, Health Services and Marketing Management
Stephen G. Jepson	Senior Vice President, Chief Operating Officer, Buffalo Market
Gary J. Kerl	Senior Vice President, Chief Information Officer
Nora K. McGuire	Senior Vice President, Marketing and Business Development
David J. Uba	Senior Vice President, Strategic Initiatives
William T. Wickis	Senior Vice President, Customer Service and Claim Operations
Jeffrey L. Adams	Vice President, Chief Actuary
George L. Busch	Vice President, Finance
Pauline A. Cataldi	Vice President, Claim Operations
John A. Gillespie, MD	Vice President, Medical Director, Western New York
Renee R. Fleming,	Vice President, Corporate Pharmacy Services
Linda M. Navarra	Vice President, Systems Services
Ralph F. Volpe	Vice President, Human Resources and Administrative Services

*On July 22, 2004 was named President and Chief Executive Officer

B. Territory and Plan of Operation

I. Description of Service Area

As a non-profit health service corporation, the Plan is licensed to do business throughout the State of New York, pursuant to the provisions of Article 43 of the New York Insurance Law. The Plan currently operates four divisions as follows:

Buffalo Division

The Buffalo division, doing business as Blue Cross and Blue Shield of Western New York, includes the following eight counties of Western New York:

Allegany	Chautauqua	Genesee	Orleans
Cattaraugus	Erie	Niagara	Wyoming

Albany Division

The Albany division, doing business as Blue Shield of Northeastern New York, operates in the following counties:

Region I (Upstate)	Albany	Greene	Schenectady
	Clinton	Montgomery	Schoharie
	Columbia	Rensselaer	Warren
	Essex	Saratoga	Washington
	Fulton		
Region II (Downstate)	Dutchess	Putnam	Ulster
(Operates as HealthNow)	Orange	Sullivan	

The Albany division was acquired by the Plan through the merger with WholeHealth Insurance Network on December 30, 1992.

Central New York Division

The Central New York division operates in the following counties:

Cayuga	Livingston	Ontario	Tompkins
Chemung	Monroe	Oswego	Wayne
Cortland	Onondaga	Schuyler	

Binghamton Division

The Plan operates the Upstate Medical Division (UMD) in Binghamton, NY. This division, acquired through the merger with WholeHealth Insurance Network, is used solely for the administration of the Medicare B contract. In accordance with a contract with Centers for Medicare & Medicaid Services (CMS), the Plan processes Medicare B claims for Medicare recipients in forty-five (45) counties of New York State. The Plan is reimbursed for all administrative costs, in accordance with certain guidelines, in connection with this program.

II. Premiums and Benefits

The Plan charges its subscribers community or experience rated premium rates and issues policies and riders which are subject to approval by the Superintendent of Insurance. Benefits provided by the Plan include hospital, medical/surgical, prescription drug, dental, vision, major medical and comprehensive coverages.

The Plan as of December 31, 2003, provided the following coverages:

Commercial

The Plan's coverages within an eight (8) county western New York territory include two (2) traditional indemnity plans, two (2) traditional preferred provider plans, an exclusive provider (EPO) plan, two (2) standard HMO plans, two (2) HMO plans with an out of network option and two (2) experienced rated Point-of Service products. The Plan's coverages within its eighteen (18) county eastern New York territory include two (2) traditional indemnity plans and four (4) types of preferred provider plans, and an exclusive provider (EPO) plan. Within twelve (12) counties of eastern New York, the Plan also offers three (3) HMO products and two (2) products which combine HMO benefits with a point of service benefit and two (2) experienced rated Point-of Service products.

Senior Blue

This product provides HMO coverage for Medicare beneficiaries (Medicare Parts A or B). Most services are subject to a $10.00 co-payment. Senior Blue is marketed in three (3) counties of western New York.

Community Care

This product provides HMO coverage for Medicaid beneficiaries in Erie County only.

Child Health Plus

Child Health Plus, a New York State funded health insurance program, provides low or no cost health insurance to children up to the age of nineteen (19). Benefits under this program include inpatient and outpatient facility and medical services. Office visits

are subject to a $3.00 co-payment. Premiums are based upon income guidelines. Child Health Plus is offered by the Plan in all twenty-six (26) counties of New York State in which the Plan does business.

The Plan also participates in Healthy New York and Family Health Plus.

Other Products

In addition, the Plan provides coverage to subscribers out of the Plan's operating area. Hospital coverage is coordinated by means of the Inter-Plan Service Benefit Bank which is administered by the national Blue Cross and Blue Shield Association (BCBSA), located in Chicago, Illinois.

The Plan also services members of national groups that are situated in the Plan's operating area, but whose parent companies or home offices are located in another Blue Cross' operating area. Those Blue Cross companies that hold the master contracts of the groups (Control Plans), reimburse the Plan for the claims of members of such national groups. Expenses incurred in connection with servicing national account subscribers' claims are reimbursed to the Plan. In addition to servicing other control plans, BCBSWNY is the control plan for various western New York based national groups.

The majority of contracts issued by the Plan are on a community rated or rolling rate basis. The Plan also maintains experience rated arrangements. The Plan issues Administrative Services Contracts ("ASC") to certain larger groups whereby the Plan is reimbursed for the cost of claims paid plus administrative service charges. The Plan also provides stop-loss coverage to its experience rated and ASC contract holders.

As of December 31, 2003 health care services were provided to 669,699 members. The following chart shows annual membership changes by number and percentage:

	1998	1999	2000	2001	2002	2003
Members	674,183	679,463	616,961	622,664	649,875	669,699
Change %		+0.1%	-9.2%	+0.1%	+4.4%	+3.1%

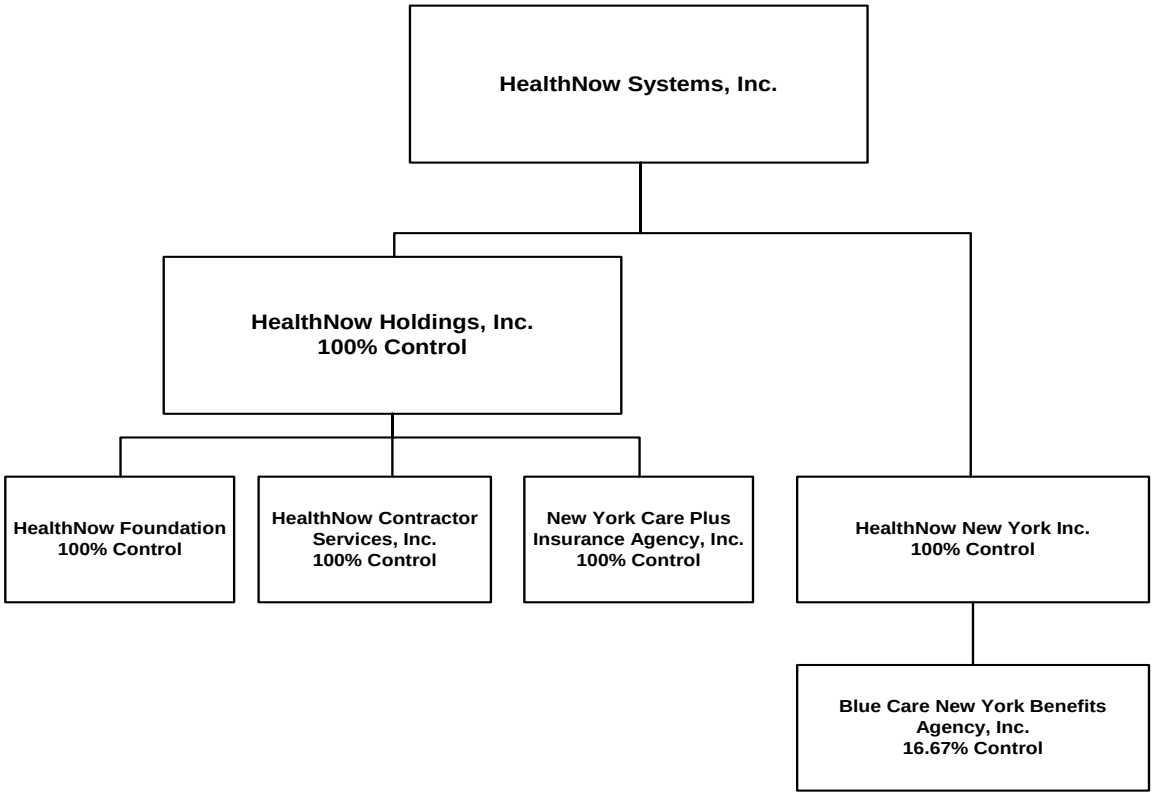
The Plan conducts business through direct writing as well as use of independent brokers.

C. Reinsurance

At December 31, 2003 the Plan did not maintain any reinsurance protection.

D. Holding Company System

The following chart depicts the Plan and its relationship to its parent and affiliates as of December 31, 2003:



The following is a description of the Plan's affiliations as of December 31, 2003:

1. HealthNow Systems, Inc. (formerly New York Care Plus Holding Company, Inc.)

On March 15, 1996, the Plan received approval from this Department to form a holding company pursuant to Section 1506 of the New York Insurance Law. The corporation was formed under Section 102(a)(5) of the New York Not-for-Profit Corporation Law for the purpose of acting as a holding company. HealthNow

Systems, Inc. (formerly New York Care Plus Holding Company, Inc.), through amendments of the by-laws of HealthNow New York Inc. (formerly, New York Care Plus Insurance Company, Inc.), became the sole member of the Plan.

As indicated in the above chart, HealthNow New York Inc. is a wholly owned subsidiary of HealthNow Systems, Inc. As such, this Department has mandated that the HealthNow Systems, Inc. board of directors will be comprised of the same directors as HealthNow, Inc. In accordance with Article IV, Section 2(b) of its by-laws, the board of directors of HealthNow Systems, Inc. are identical to that of HealthNow New York Inc.

It was noted that for years 1999 through 2003, the Plan participated in consolidated federal corporate income tax filings with HealthNow Systems, Inc. However, the Plan did not have a consolidated tax agreement in effect with HealthNow Systems, Inc. as required by Section 1505(d) of the New York Insurance Law.

It is recommended that the Plan maintain a consolidated tax agreement with HealthNow Systems, Inc. as required by Section 1505(d) of the New York Insurance Law. It is further recommended that said consolidated tax agreement be constructed in conformity with Circular Letter No. 33 of 1979.

2. HealthNow Holdings, Inc.

As of December 31, 2003, this entity was a wholly owned subsidiary of HealthNow Systems Inc. and currently is the for-profit holding company for HealthNow Foundation, New York Care Plus Insurance Agency, Inc. and HealthNow Contractor Services, Inc., which are all subsidiaries of HealthNow Systems, Inc. The shares of HealthNow Holdings were transferred to HealthNow New York Inc. in April, 2004.

3. HealthNow Foundation (Not-for-Profit Corporation 501(c)(3))

HealthNow Foundation (Foundation) is organized exclusively for charitable purposes in the United States and abroad within the meaning of Sections 170(c)(2)(B) and 501(c)(3) of the Code. The sole member of the Foundation is HealthNow Holdings, Inc.

4. HealthNow Contractor Services, Inc.

HealthNow Contractor Services, Inc. is a wholly owned subsidiary of HealthNow Holdings, Inc. This entity was dormant as of December 31, 2003.

5. Blue Care New York Benefits Agency, Inc. (BCNYBA)

The Plan maintained a 16.67% controlling interest in Blue Care New York Benefits Agency, Inc. (BCNYBA) as of December 31, 2003. The Plan, along with four other New York Blue Cross and Blue Shield Plans, formed BCNYBA, then

known as New York Administrative Plan Services, Inc., in 1995 for the purpose of providing insurance marketing services for said Plans.

6. New York Care Plus Insurance Agency, Inc. (NYCPIA)

The Plan, in 1997, formed New York Care Plus Insurance Agency, Inc. for the purpose of operating as an accident & health and life insurance agency. As of the date of this report, New York Care Plus Insurance Agency, Inc. has remained a dormant operation.

The following is a description of the inter-company agreements in effect between HealthNow New York Inc. and other members of the holding company as of the examination date:

a. Administrative Services Agreement between HealthNow New York Inc. and New York Care Plus Insurance Agency, Inc.

HealthNow New York Inc. and New York Care Plus Insurance Agency, Inc. entered into an Administrative Services Agreement effective November 1, 2002, and, pursuant to Section 1505(a)(3) of the New York Insurance Law, the New York State Insurance Department requested that certain revisions be made to such agreement. A revised and restated Administrative Services Agreement was submitted to the Department on June 30, 2003. On July 7, 2003 the Department approved the revised agreement.

The above agreement shall be for an initial term of one (1) year and automatically renew for successive one (1) year period, unless terminated sooner. Either party may terminate this agreement, without cause, at any time by giving written notice to the other party at least thirty (30) days in advance of the termination date specified in such notice.

b. Administrative Services Agreement between HealthNow New York Inc. and Blue Care New York Benefits Agency

HealthNow New York Inc. and other New York State Blue Cross and Blue Shield entities entered into an Administrative Services Agreement with Blue Care New York Benefits Agency (Blue Care) effective January 1, 1997. The following is a summary of the services provided by Blue Care to HealthNow New York Inc. and such other Blue Cross and Blue Shield Plans under the agreement:

a) assisting in the development of new health insurance products;
b) assisting in the development of coordinated marketing strategies;
c) assisting in the development of sales training and marketing programs;
d) providing quarterly sales training programs at each of the Plans;
e) preparation of marketing programs;
f) assisting in the development of coordinated and/or uniform policies and procedures with respect to administration of the Plans' products;
g) maintaining and providing information on products and services offered by competitors;
h) providing such other services as may be requested by any Plan which is related to the services described in the agreement.

The Blue Cross and Blue Shield Plans compensate Blue Care for the services performed under the Agreement by reimbursing Blue Care for its actual direct and indirect costs in providing services.

The above agreement shall be for an initial term of one (1) year and automatically renew for successive one (1) year period, unless terminated sooner. Either party may terminate this agreement by providing the other party with ninety (90) days prior written notice.

E. Significant Operating Ratios

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

Change in Capital and Surplus	72.3%

The above ratio is outside Department benchmark guidelines. The Plan experienced positive underwriting results in the traditional product lines in 2002 and 2003, particularly in the Buffalo area.

The underwriting ratios presented below are on an earned-incurred basis and encompass the October 1, 1999 to December 31, 2003 period covered by this examination:

	Amount	Ratio
Claims incurred	$5,147,699,017	86.1%
Claims adjustment expenses incurred	328,037,492	5.5%
Other underwriting expenses incurred	409,944,999	6.8%
Net underwriting gain	96,482,015	1.6%
Premiums earned	$5,982,163,523	100.0%

Following are the administrative expense ratios of the Plan:

Year	Premiums Written	Administrative Expenses Paid	Administative Expense Ratio	Maximum Allowed
1999	$1,068,593,345	$ 159,001,043	14.9%	12.5%
2000	$1,127,167,694	$ 153,407,503	13.6%	12.5%
2001	$1,286,022,790	$ 162,363,105	12.6%	12.5%
2002	$1,521,154,315	$ 186,950,625	12.3%	12.5%
2003	$1,777,075,489	$ 199,129,723	11.2%	12.5%

As noted in the above schedule, the Plan exceeded the 12.5% administrative expense limitation prescribed by Section 4309(b) of the New York Insurance Law for the years 1999, 2000 and 2001.

It is thus recommended that the Plan comply with the 12.5% administrative expense ratio limitation prescribed by Section 4309(b) of the New York Insurance Law.

F. Section 1307 loans

In December of 1992, in conjunction with its merger with WholeHealth Insurance Network, Inc., the Plan obtained approval from the New York Insurance Department to enter into Section 1307 loan agreements with the following entities:

Name	Amounts
Blue Cross and Blue Shield Association	$10,000,000
Blue Cross and Blue Shield of Central New York, Inc.	5,000,000
Blue Cross and Blue Shield of Michigan, Inc.	3,000,000
Blue Cross of the Rochester Area Inc. and Blue Shield of the Rochester Area, Inc.	2,000,000
Blue Cross and Blue Shield of Utica-Watertown, Inc.	1,000,000
Total Section 1307 loans	$21,000,000

In 1995, the Plan received the permission of the Superintendent of Insurance to repay $15,300,446 of these loans plus accrued interest thereon of $2,082,059. The balance of Section 1307 loans outstanding at December 31, 2003 was $5,699,554. In 2004, the Plan, after receiving appropriate permission from the Superintendent of Insurance, repaid all of such outstanding Section 1307 loans.

G. Statutory Reserve

Section 4310(e) of the New York State Insurance Law requires Article 43 corporations to maintain a statutory reserve fund. The Plan reported reserves and unassigned funds of $221,993,959 as of December 31, 2003. As of December 31, 2003, the Plan's required to be maintained statutory reserve of $222,134,436 was impaired in the amount of $140,477.

It should be noted that as of December 31, 2004, the Plan reported reserves and unassigned funds of $275,291,491. As of that date, the Plan's required to be maintained statutory reserve of $257,655,936 indicated a surplus of $17,635,555.

H. Accounts and Records

The examination review of the Plan's 2003 filed annual statement indicated that, the Plan's numerous reporting errors, misclassifications of asset, liability, income and expense items as outlined in the previous report on examination had decreased. However, some annual statement filing errors were noted during the examination period that caused the Plan to file revisions to previously filed schedules and exhibits relative to its 2003 annual statements.

In light of the above, it is again recommended that the Plan comply with the annual statement instructions and exercise greater care in the preparation of its filed financial statements to this Department.

I. Healthy NY Reporting

HealthNow New York Inc. acknowledged, during the review, that its Healthy New York filings contained information based on different incurred dates, including a significant inconsistency involving the stop loss receivable booked - reported at $1,600,000 on the Plan's Healthy New York 4th Quarter 2003 report and approximately $534,000 on its Report No. 4 of the filed Data Requirements statement as of December 31, 2003.

It was determined during the review process that the Company had booked, on its financial records, the $534,000 receivable only - reflecting stop loss dollars recovered in 2003 (an apparent accounting error). The Plan's representatives acknowledged that

HealthNow New York Inc. never booked, on its financial books, the $1,600,000 stop-loss recovery reflected in its Healthy New York 4th quarter report.

It is recommended that, in the future, the Plan appropriately reconcile its financial records, annual and quarterly statement filings including its Healthy New York Report No. 4 filings, its Section 4308(h) of the New York Insurance Law reports and its Healthy New York Loss ratio reports. In those instances where such financial filings differ, it is recommended that the Plan submit a detailed reconciliation of the differences as an attachment to such reports.

It is further recommended that the Plan book all appropriate receivables and accruals on its books and report such receivables and accruals in all related filings and reports according to instructions.

J.. EDP TESTING

The previous report on examination contained a comment that all critical business functions be tested at the recovery site in order to provide assurance of continuity of business in a recovery situation. A further comment also appeared in the previous report on examination indicating that the Plan should schedule a test for full data recovery. Although some tests were conducted, time restraints of the Plan's present two 24 hour recovery exercise time slots for one year prevented full testing of all critical business functions as well as full data recovery. It should be noted that the Plan indicated that the new Disaster Recovery contract with IBM provides two 48 hour recovery exercises which

should allow sufficient time to perform a total exercise of all the Plan's mission critical systems.

In light of the above, it is once again recommended that all critical business functions be tested at the recovery site in order to provide assurance of continuity of business in a recovery situation.

Furthermore, it is once again recommended that the Plan schedule a test for full data recovery.

K. BUSINESS CONTINUITY PLANNING (BCP) – BINGHAMTON DIVISION

The previous report on examination contained a comment that the Binghamton division's Business Continuity Plan (BCP) should contain similar wording and terms as its third party claims administrator's BCP. As of December 31, 2003, it was noted that the Binghamton division's Business Continuity Plans had not been amended to contain similar wording and terms as its third party claim administrator's BCP. The Plan has advised that such wording and terms changes are not expected be incorporated into the Plan's Business Continuity Plan until 2006.

Therefore, it is once again recommended that the Binghamton division's Business Continuity Plan contain similar wording and terms as its third party claims administrator's Business Continuity Plan.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities, reserves and unassigned funds as determined by this examination as of December 31, 2003. This statement is the same as the balance sheet filed by the Plan.

Assets	Assets	Non-admitted Assets	Net-admitted Assets
Bonds	131,548,779		131,548,779
Preferred stocks	5,749,420		5,749,420
Common stocks	77,177,127		77,177,127
Cash and short-term investments	178,744,073		178,744,073
Deferred compensation	5,096,686		5,096,686
Funds deposited in Trust - Non participating providers	535,389		535,389
Interest due and accrued	2,336,105		2,336,105
Uncollected premiums	65,491,153	4,302,673	61,188,480
Net deferred tax asset	9,854,581		9,854,581
Electronic data processing equipment	2,598,419		2,598,419
Equipment, furniture and supplies	1,438,069	1,438,069	0
Health care and other amounts receivable	23,993,073		23,993,073
Other assets nonadmitted	445,395	445,395	0
ITS accounts	1,566,545		1,566,545
Amounts due from Demographic Pools	8,883,194		8,883,194
ASO accounts	6,170,027		6,170,027
Aggregate write-ins for all other assets	37,338,825	18,144,539	19,194,286
Total assets	$558,966,860	$24,330,676	$534,636,184

Liabilities

Claims unpaid	$180,040,000
Accrued medical incentive pool and bonus amounts	34,516,752
Unpaid claims adjustment expenses	12,959,920
Aggregate health policy reserves	3,862,648
Premium received in advance	17,578,362
General expenses due or accrued	18,573,826
Current Federal and foreign income tax payable and interest thereon	2,985,300
Amounts withheld or retained for the account of others	1,117,888
Public goods pool	3,172,146
Other accrued expenses	6,546,946
Post retirement hospital medical coverage	11,275,812
Reserve for unclaimed checks	1,740,221
ITS Program	5,092,307
Other payables	3,702,783
Additional minimum pension liability	7,833,849
Aggregate write-ins for all other liabilities	1,643,465
Total liabilities	$312,642,225

Reserves and Special Funds

Statutory reserve	$222,134,436
Section 1307 loans	5,699,554
Unassigned funds	(5,840,031)
Total reserves and unassigned funds	221,993,959
Total liabilities, reserves and unassigned funds	$534,636,184

NOTE 1: As of December 31, 2003, the date of this examination, the Plan maintained total reserves and unassigned funds of $221,993,959. The Plan's statutory reserves were impaired in the amount of $140,477 as of December 31, 2003. Subsequent to this report date, the Plan has filed quarterly and annual statements which indicate a removal of the impairment.

NOTE 2: The Internal Revenue Service has not audited the Plan. 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.

NOTE 3: No liability appears on the above statement for loans in the amount of $5,699,554 and accrued interest thereon in the amount of $3,779. The loans were granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus subject to the prior approval of the Superintendent of Insurance of the State of New York.

B. Statement of Revenue and Expenses

For the period, October 1, 1999, through December 31, 2003, reserves and unassigned funds increased $133,189,853 detailed as follows:

Statement of Income

Underwriting Income		
Premiums earned		$5,982,163,523
Deductions:		
Claims incurred	$5,147,699,017	
Claims adjustment expenses incurred	328,037,492	
Other underwriting expenses incurred	409,944,999	
Total underwriting deductions		5,885,681,508
Net underwriting gain		$ 96,482,015
Investment Income		
Net investment income earned	$35,092,187	
Realized capital losses	(1,934,250)	
Net investment gain		33,157,937
Other Income		
Miscellaneous income	$18,783,418	
Net other income		18,783,418
Net income before federal income taxes		$ 148,423,370
Federal income taxes		26,673,671
Net Income		$ 121,749,699

Reserves and Unassigned Funds

Reserves and unassigned funds per report on examination as of September 30, 1999			$88,804,107
	Gains in Surplus	Losses in Surplus	
Net income	$121,749,699	$	
Unrealized capital gains	10,720,780		
Change in not-admitted assets	6,108,994		
Additional minimum pension liability	8,403,947		
Cumulative effect of changes in accounting principals		(11,384,165)	
Aggregate write-ins for losses in surplus	_____	(2,409,403)	
Total gains and losses	$146,983,420	$(13,793,568)	
Net increase in reserves and unassigned funds			$133,189,852
Reserves and unassigned funds per report on examination as of December 31, 2003			$221,993,959

5. UNCOLLECTED PREMIUMS

The examination asset of $61,188,480 is the same as the amount reported by the Plan as December, 31, 2003. However, the following was noted:

Unreconciled difference

A review of this item revealed a difference, as of December 31, 2003, between the uncollected premium amounts reported in the general ledger and the aged accounts receivable report in the amount of $1,298,040. For year 2003, this difference varied between 1.1 million and 1.3 million.

It is recommended that the Plan reconcile the uncollected premium amount reported in its general ledger and the amount reported in its aged accounts receivable report.

6. ELECTRONIC DATA PROCESSING EQUIPMENT

The examination asset of $2,598,419 is the same as the amount reported by the Plan as of December 31, 2003.

The Plan, as of December 31, 2003, continued to report its telephone system within the captioned item. Although the depreciated cost of said telephone system had reached a de minimus amount as of December 31, 2003, it is noted that the Plan continued to report said telephone system under the above caption despite the fact that the previous three (3) Reports on Examination have recommended that it be reported as a not-admitted asset.

Section 1301(a)(18) of the New York Insurance Law allows electronic data processing equipment to be reported as an admitted asset if such system constitutes, “a data processing, record keeping, or accounting system…”

It is recommended that the Plan comply with the provisions of Section 1301(a)(18) of the New York Insurance Law and report its current and future telephone system under the non-admitted asset caption, “Equipment, furniture and supplies”.

It should be noted that the Plan indicated through correspondence with the examiners that it would “transfer the un-depreciated balance of the computerized telephone system to a non-admitted asset for the May, 2005 reporting period.”

7. CLAIMS UNPAID

The examination liability of $180,040,000 is the same as the amount reported by the Plan as December 31, 2003.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and filed annual statements.

8. MARKET CONDUCT ACTIVITIES

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

a.) Claims processing
b.) Prompt pay
c.) Schedule H preparation
d.) Schedule M preparation
e.) Policy forms and rating
f.) Agents and brokers
g.) Disclosure (direct pay, small group and Healthy NY access)
h.) Frauds prevention

A. Claims Processing

A review of HealthNow New York Inc.'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, 2003 through December 31, 2003. The claims tested were selected from the population of claims adjudicated during the review period. In order to achieve the goals of this review, claim populations were segregated by Managed Care and Indemnity.

These primary populations were then further 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.

To ensure the completeness of the claims population, the total dollars paid were accumulated and reconciled to the financial data reported by the Plan. 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%.

B. Prompt Payment of Claims

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."
>
> "(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 2003 was selected for each system 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.

Managed Care

The following is a summary of the prompt pay review findings for the Managed Care lines of business for Hospital and Medical claims:

Description	**Hospital** Paid claims over 45 days Section 3224-a(a)	**Medical** – Paid claims over 45 days Section 3224-a(a)
Claim population	13,438	43,271
Sample size	167	167
Number of claims with errors	20	28
Calculated Error Rate	11.98%	16.77%
Upper Error limit	16.90%	22.43%
Lower Error limit	7.05%	11.10%
Upper limit Claims in error	2,271	9,707
Lower limit Claims in error	948	4,803

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 28 Medical claims found to be in violation of Section 3224-a(a), 1 claim also violated Section 3224-a(c) because interest due of $2 or more was not paid.

Indemnity

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

Description	Paid claims over 45 days Section 3224-a(a)
Claim population	25,389
Sample size	167
Number of claims with errors	22
Calculated Error Rate	13.17%
Upper Error limit	18.30%
Lower Error limit	8.04%
Upper limit Claims in error	4,647
Lower limit Claims in error	2,042

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 22 claims found to be in violation of Section 3224-a(a), 3 claims also violated Section 3224-a(c) because interest due of $2 or more was not paid.

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

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

C. Commissions to Brokers

The Plan paid commissions to certain brokers relative to HMO business during the period, January 1, 2003 – December 31, 2003 in excess of the rates which the Plan had filed with this Department. Section 4312(a) of the New York Insurance Law states in part,

> "…Commissions shall be included in the corporation's rate manual and rate filings…"

Part 52.42(e) of Department Regulation 62 (11NYCRR 52.42(e)) states in part,

> "…No licensed insurance broker shall receive such commissions or fees from an HMO, unless the HMO has filed the actual rate to be paid and included the anticipated expenses for such payments to insurance brokers in its application to amend its community premiums rates pursuant to the provisions of Section 4308 of the New York Insurance Law. Such rate shall be incorporated into the HMO's premium rate manual…"

In light of the above, it is recommended that the Plan, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to its brokers in excess of its commission rates filed with this Department.

D. Notification of Rate Increase

Subsequent to the examination date, it was noted that one thousand one hundred eleven (1,111) direct pay subscribers were billed for rates effective on the 15th of the month without being sent a thirty (30) day notice of a rate increase. Section 4308(g)(2) of the New York Insurance Law states:

> "No rate increase may be imposed unless at least thirty days advance written notice of such increase has been provided to each contract holder and subscriber."

It is recommended that the Plan abide by the provisions of Section 4308(g)(2) of the New York Insurance Law and provide at least thirty (30) days advance written notice of a rate increase to each contract holder and subscriber.

E. Response to New York Insurance Department Inquiries

During the review of complaints made to the New York Insurance Department, it was determined that Plan does not always respond to Department complaints in a timely manner. The review revealed four (4) instances in which the Plan's response to Department complaint inquiries ranged from 18 to 54 calendar days. New York Insurance Department Regulation 64, Part 216.4(d) (11 NYCRR 216.4(d)) states:

> "Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall, within 10 business days, furnish the department with the available information requested respecting the claim."

It is recommended that the Plan comply with the provisions of New York Insurance Department Regulation 64, Part 216.4(d) (11 NYCRR 216.4(d)) and respond within 10 business days from date of receipt of an inquiry from the New York Insurance Department.

F.) Experience Rating

During the review of experience rated groups it was noted that the Plan included certain surcharges to groups that were not part of the approved formula. For example, the Plan included a surcharge for "capitated administration" of .5%. According to the Plan, this represents the administrative cost for those groups who have requested specific benefits added to their contract, such as, chiropractic care, radiologist, or mental health services. However, this .5% was not part of the approved formula. In another instance, it was noted that the annual trend factor used by the Plan to calculate the annual trend was not the approved factor. The factor used was 8% instead of the 7% that was approved. Furthermore, a formula error was noted, the Plan submitted for approval to this Department, a 1.5% increase to the risk retention percentage rather than an intended 3.0% increase. This resulted in certain groups being charged the 3% intended increase rather than the approved 1.5% increase. In all of the previously mentioned instances, the Plan's use of unapproved rating methodologies resulted in the groups being charged a higher premium than was permitted.

Part 52.40 of Department Regulation 62 (11 NYCRR 52.40) states the following:

> "Contracts of master group insurance may be experience-rated only in accordance with a formula or plan previously furnished to the department."

It is recommended that Plan calculate experience rated group premiums using only approved formulas in compliance with the requirements of Part 52.40 of Department Regulation 62 (11 NYCRR 52.40).

G. Sales and Advertising

The Plan disseminated comparison benefit summary charts in 2004 which contained instances of misleading and/or incomplete comparisons of other Plans' benefits. A total of eight (8) such comparison benefit summary charts were found to have been presented to employer groups and/or brokers. This is a violation of New York Insurance Department Regulation 34 (11 NYCRR 215.11) which states:

> "An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance."

It is recommended that the Plan comply with the requirements of Department Regulation 34 (11 NYCRR 215.11) relative to its sales and marketing advertising.

H. N.Y. Schedule M Reporting

A review of N.Y. Schedule M indicated that the Plan was not able to reconcile the information that it reported in the 2003 Annual Statement Data Requirements for Health Maintenance Organizations Table 2 – Utilization Review Appeals to the underlying supporting documentation. The amount of utilization review appeals reported in Table 2 of the Data Requirements was substantially more than the amount reported in the Plan's utilization review appeals logs.

It is recommended that the Plan reconcile the amounts reported in Schedule M of its Annual Statement Data Requirements for Health Maintenance Organizations to the underlying utilization review appeals logs.

I. Retroactively Terminated Groups

During the examination period, the Plan failed to terminate for non-payment certain groups during the thirty (30) day grace period included in the Plan's contracts. The Plan, in certain instances terminated such groups for non-payment several months in excess of the contract grace period – retroactive to the date of the last month payment was made.

It is recommended that the Plan revise its procedures regarding retroactive terminations for non-payment so as to provide for all terminations for non-payment to take place within the thirty (30) day grace period included within its contracts or amend such contracts to provide for a time period commensurate with the present practice.

J. Third Party Claims

i) Claims processed by CMG and Davis Vision Corporation

The Market Conduct Report on Examination as of March 15, 1999 contained a recommendation that the Plan perform periodic audits of claims processed by CMG and Davis Vision Corporation. Although an audit was performed in 2000, no further audits have been done.

Therefore, it is once again recommended that the Plan perform periodic audits of claims processed by CMG and Davis Vision Corporation.

ii.) Electronic interface claims submissions

The Market Conduct Report on Examination as of March 15, 1999 also contained a recommendation that the Plan's internal auditors conduct periodic audits of the reconciliations of EDI and internal claims submissions in order to determine that said submissions are accurately routed to the appropriate claims system. It was noted that there have been no periodic audits since July 26, 1999.

Therefore, it is once again recommended that Plan's internal auditors conduct periodic audits of the reconciliations of EDI and internal claims submissions in order to determine that said submissions are accurately routed to the appropriate claims system.

K. Frauds Review

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

i.) 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 was noted that the Plan only filed four (4) IFB's with the Fraud Bureau during 2002 and 2003. Based upon the above review, it appears that the Plan does not always report fraudulent claim activity within the 30 day limitation prescribed by Section 405(a) of the New York Insurance Law.

It is recommended that the Plan report all transactions which are suspected to be fraudulent to the Department's Frauds Bureau within the 30 day limitation as prescribed by Section 405(a) of the New York Insurance Law.

ii.) Section 409 of the New York Insurance Law mandates the filing of fraud prevention plans and details the requirements of such plans. Specifically, Section 409(c)(5) states:

> "(c)The plan shall provide for the following:...(5)public awareness of the cost and frequency of fraudulent activities, and the methods of preventing fraud;"

In 2003, the Plan had premium writings of almost $1.8 billion. For that same year, it was also noted that the Plan only spent approximately $3,300 on advertising for public awareness of fraud.

It is recommended that the Plan comply with the requirements of Section 409(c)(5) of the New York Insurance Law and substantially increase the amount spent on advertising for public awareness of fraud.

L. Premium Refunds

A review of claims data for the years 2000 through 2004 determined that the Plan must refund premiums totaling $14,926,228 to some of it's subscribers as required by Section 4308(h) of the New York Insurance Law which states:

> "(1) Each calendar year, a corporation subject to the provisions of this article shall return, in the form of aggregate benefits incurred for each contract form filed pursuant to the alternate procedure set forth in subsection (g) of this section, at least eighty-five percent for individual direct payment contracts or seventy-five percent for small group and small group remittance contracts, but, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent in nineteen hundred ninety-four, for any direct payment, group or group remittance contract, not in excess of one hundred five percent of the aggregate premiums earned for the contract form during that calendar year. Corporations subject to the provisions of this article shall annually report, no later than May first of each year, the loss ratio calculated pursuant to this subsection for each such contract form for the previous calendar year.
>
> (2) In each case where the loss ratio for a contract form fails to comply with the eighty-five percent minimum loss ratio requirement for individual direct payment contracts, or the seventy-five percent minimum

loss ratio requirement for small group and small group remittance contracts, as set forth in paragraph one of this subsection, the corporation shall issue a dividend or credit against future premiums for all contract holders with that contract form in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year plus the amount of the dividends and credits shall equal no less than eighty-five percent for individual direct payment contracts, or seventy-five percent for small group and small group remittance contracts, of the aggregate premiums earned for the contract form in the previous calendar year. The dividend or credit shall be issued to each contract that was in effect as of December thirty-first of the applicable year and remains in effect as of the date the dividend or credit is issued. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the dividends and credits, as well as an explanation of the corporation's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a contract holder or subscriber."

The following schedule summarizes the amounts to be refunded broken down by region and year:

i.) Direct Pay Medicare Supplement/Complement Plans:

Year	Region	Earned Premiums	Incurred Claims	Loss Ratios	Premium Refunds
2000	Albany	10,433,562	9,483,686	90.90%	
2000	Buffalo	13,637,539	7,423,003	54.43%	
2000	**Combined**	**24,071,101**	**16,906,689**	**70.24%**	**2,350,192**
2001	Albany 1	10,302,109	7,486,499	72.67%	755,188
2001	Albany 2	705,304	540,209	76.59%	24,034
2001	Buffalo	14,925,801	12,217,128	81.85%	-
2000	**Combined**	**25,933,214**	**20,243,836**	**78.06%**	**779,222**

Year	Region	Earned Premiums	Incurred Claims	Loss Ratios	Premium Refunds
2002	Albany 1	9,359,439	6,792,591	72.57%	694,960
2002	Albany 2	616,693	582,905	94.52%	-
2002	Buffalo	16,057,358	12,055,749	75.08%	790,137
2002	**Combined**	**26,033,490**	**19,431,245**	**74.64%**	**1,485,098**
2003	Albany 1	7,978,951	5,983,660	74.99%	399,501
2003	Albany 2	556,901	417,475	74.96%	28,046
2003	Buffalo	15,821,425	11,896,598	75.19%	760,542
2003	**Combined**	**24,357,277**	**18,297,733**	**75.12%**	**1,188,089**
2004	Albany 1	6,409,790	5,996,298	93.55%	-
2004	Albany 2	554,691	485,885	87.60%	-
2004	Buffalo	15,199,011	12,273,569	80.75%	-
2004	**Combined**	**22,163,492**	**18,755,752**	**84.62%**	**-**
2000-04	**Combined**	**122,558,574**	**93,635,255**	**76.40%**	**5,802,600**

B. Direct Pay Medicare Plans in Buffalo Region:

2000	Buffalo	7,708,641	5,177,915	67.17%	988,998
2001	Buffalo	10,409,043	6,781,390	65.15%	1,545,844
2002	Buffalo	11,626,399	5,674,787	48.81%	3,626,332
2003	Buffalo	9,404,369	4,561,042	48.50%	2,962,453
2000-03	**Combined**	**39,148,452**	**22,195,134**	**56.69%**	**9,123,628**
Total					**14,926,228**

It is recommended that the Plan refund premiums to its subscribers as required by Section 4308(h) of the New York Insurance Law.

M. Infertility Mandated Claims

The Plan provides coverage for artificial insemination on most of its Community Blue and Traditional Blue health plans offered by employer groups. On September 1, 2002, Section 4303(s)(1) of the New York Insurance Law (Infertility Mandate) was enacted. The Infertility Mandate, required that certain infertility related benefits be provided in policies that provide hospital, medical/surgical, and/or prescription drugs benefits.

Section 4303(s)(1) of the New York Insurance Law states in part,

> *"A hospital service corporation or health service corporation which provides coverage for hospital care shall not exclude coverage for hospital care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility; provided, however that:*
> *…(B) …in no case shall such coverage exclude diagnostic tests and procedures provide as part of such hospital care that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug coverage provided pursuant to this subsection."*

It was determined that the Plan had processed certain artificial insemination claims incorrectly for members between the ages of 21 through 44 during the examination and subsequent period. The Plan subsequently received a directive from the Department to adjust claims related to the Infertility Mandate that were denied or not adjusted properly from September 1, 2002 to the present. Furthermore, the Plan was

directed to send letters to providers requesting such providers to refund all overpayments collected from their patients.

The Plan provided this Department with a listing of claims received during the period from November 22, 2002 through June 30, 2005 which the Plan had identified as in need of adjustment in order to comply with the provisions of Sections 3221(k) and Sections 4303(s) of the New York Insurance Law. Such listing was subsequently updated by the Plan for those claims which had not been initially identified as needing adjustment under the infertility claim mandate. Such updated listing identified approximately 2,000 claims as having been subsequently identified, adjusted and paid - with prompt payment interest applied.

This Department subsequently initiated an on-site review of the Plan's infertility mandated claims, as a part of this examination, in order to determine whether the Plan had appropriately identified all relevant infertility mandated claims and had made appropriate adjustments to such claims. Utilizing ACL software, a review was made of the Plan's 2003 annual claims date base. The on-site review revealed the following:

The Plan failed to identify and adjust all infertility mandated procedural coded claims relative to calendar year 2003 medical and hospital claim payments. Based on a sample of identified infertility procedural coded claims which were found to be improperly paid, a projection of infertility mandated procedural claims in need of further adjustment in order to comply with Sections 3221(k)(6) and 4303(s) of the New York

Insurance Law was compiled.. Such projection resulted in an upper limit of five hundred eighty-three (583) and a lower limit of three hundred forty-four (344) infertility mandated procedural claims for calendar year 2003 which had not been properly adjudicated for compliance with the infertility mandate.

It was further noted that the Plan had not included non-injectible infertility drug claims within its review of applicable infertility mandated drug claims.

It is recommended that the Plan re-review its claims data for the period, September 1, 2002 to the present, and identify and appropriately pay all infertility mandated claims, including non-injectible infertility drug claims, that were incorrectly processed. It is also recommended that appropriate payment of prompt payment interest be included with such adjusted claims payments.

N. Health Benefits

The Plan provides coverage of fitness club membership under which plan enrollees are entitled to discounts for selected memberships at participating fitness facilities. Generally, such services are included and are charged to incurred claims in the Plan's community-rated lines of business. Corresponding rates calculated by the Plan do not take these expenses into account. Theses expenses cannot be construed as health benefits. Instead, such expenses are more properly defined as enrollment inducements. Section 4224(c) of the New York Insurance Law states:

> "No …insurer doing in this state the business of accident and health insurance … shall pay allow or give, or offer to pay, allow or give, directly or indirectly, as inducement to any person to insure… any valuable consideration or inducement whatever which is not specified in such policy or contract."

It is recommended that the Plan comply with New York Insurance Law Section 4224(c) and discontinue its coverage of fitness club membership until such time as the benefits therein are made part of the member contracts and are appropriately rated.

9. SUBSEQUENT EVENTS

A. Underwriting – Sole Proprietor

It was noted that the Plan did not adhere to approved guidelines in the sole proprietor market. In a letter dated May 4, 2005 from the New York Insurance Department, the Plan was directed to revise its guidelines for enrollment of "groups of one" a/k/a sole proprietors and to stop the implementation of the February 21, 2005 underwriting guidelines. Approved guidelines for enrollment of sole proprietors are specified in Section 4317(f)(3) of the New York Insurance Law which state:

> "3) The insurer may require members of the association purchasing health insurance to verify that all employees electing health insurance are legitimate employees of the employers, as documented on New York state tax form NYS-45-ATT-MN or comparable documentation. In order to be eligible to purchase health insurance pursuant to this subsection and obtain the same group insurance products as are offered to groups, a sole employee of a corporation or a sole proprietor of an unincorporated business or entity must (A) work at least twenty hours per week, (B) if purchasing the coverage through an association group, be a member of the association for at least sixty days prior to the effective date of the insurance policy, and (C) present a copy of the following documentation to the insurer or health plan administrator on an annual basis:

(i) NYS tax form 45-ATT, or comparable documentation of active employee status;

(ii) for an unincorporated business, the prior year's federal income tax Schedule C for an incorporated business subject to Subchapter S with a sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or

(iii) for a business in business for less than one year, a cancelled business check, a certificate of doing business, or appropriate tax documentation; and

(iv) such other documentation as may be reasonably required by the insurer as approved by the superintendent to verify eligibility of an individual to purchase health insurance pursuant to this subsection.

(4) Notwithstanding the provisions of item (I) of clause (i) of subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, for purposes of this section, an association group shall include chambers of commerce with less than two hundred members and which are 501C3 or 501C6 organizations."

It is recommended that the Plan comply with the underwriting guidelines for enrollment of sole proprietors as set forth in Section 4317(f)(3) of the New York Insurance Law.

10. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The four (4) prior reports on examination contained the following comments and recommendations. The items listed below refer only to those comments and recommendations which the Plan had not fully complied as of the date of this examination. All other prior report on examination comments and recommendations were noted as having been complied. (The page numbers refer to the prior report on examination.)

ITEM		PAGE NO.
	COMMENTS AND RECOMMENDATIONS FROM MARKET CONDUCT REPORT AS OF MARCH 15, 1999	
A.	Third party claims processing	18

It is recommended that the Plan perform periodic audits of claims processed by CMG and Davis Vision Corporation.

The Plan has not fully complied with this recommendation. Although an audit was performed in 2000, no further audits have been done. It is again recommended that the Plan perform periodic audits of claims processed by CMG and Davis Vision Corporation.

B.	Electronic data interface claims submissions	19

It is recommended that the Plan's internal auditors conduct periodic audits of the aforementioned reconciliations of EDI and internal claims submissions in order to determine that said submissions are accurately routed to the appropriate claims system.

The Plan has not complied with this recommendation. There have been no periodic audits since July, 26, 1999.

ITEM		PAGE NO.
C.	Claims Settlement Practices – Prompt payment of claims	24

It is recommended that the Plan, in the future, comply with all prompt payment procedures mandated by Section 3224-a(c) of the New York Insurance Law.

The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.

D.	Schedule M review	31

It is recommended that the Plan maintain adequate detail records to support the amounts reported in its filed Schedule M.

The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.

ITEM PAGE NO.

COMMENTS AND RECOMMENDATIONS FROM REPORT ON EXAMINATION AS OF SEPTEMBER 30, 1999

A. Consolidated Federal Corporate Income Tax Filings 18

It is recommended that the Plan maintain a consolidated tax agreement with New York Care Plus Holding Company, Inc. as required by Section 1505(d) of the New York Insurance Law. It is further recommended that said consolidated tax agreement be constructed in conformity with Circular Letter No. 33 of 1979.

The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.

B. Statutory Reserve Impairment 23, 24, 46

The Plan reported reserves and unassigned funds of $96,947,491 as of June 30, 2000. As of June 30, 2000, the Plan's required to be maintained statutory reserve of $133,886,668 was impaired in the amount of $36,939,177.

It is recommended that the Plan, pursuant to Section 4310(d) of the New York Insurance Law, take the necessary steps to remove its statutory reserve impairment.

As of December 31, 2003, the Plan had not complied with this recommendation. Subsequent to this report date, the Plan has filed quarterly and annual statements which indicate a removal of the impairment.

C. Electronic Data Processing Equipment 18

It is again recommended that the Plan properly report its telephone system under the non-admitted asset, "Equipment, furniture and supplies", in accordance with Section 1302 of the New York Insurance Law.

The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.

ITEM PAGE NO.

COMMENTS AND RECOMMENDATIONS FROM - APPENDIX B OF THE REPORT ON EXAMINATION AS OF SEPTEMBER 30, 1999

A. It is recommended that The Plan ensure that all critical business functions are tested in the recovery site in order to provide assurance of continuity of business in a recovery situation. 92

The Plan has partially complied with this recommendation. Although some tests were conducted, time restraints of the two 24 hour recovery exercise time slots for one year prevented full testing of all critical business functions. A similar comment is contained in this report.

B. It is recommended that the Plan, at some point in the future, schedule a test for full data recovery. 93

As noted above, the Plan has partially complied with this recommendation. Although some tests were conducted, time restraints of the two 24 hour recovery exercise time slots for one year prevented full testing of all critical business functions. A similar comment is contained in this report.

C. It is recommended that an overall review of the Business Continuity Plans within each Plan division be made. Said division BCPs should be examined for completeness and consistency. In this regard, the Binghamton BCP should contain similar wording and terms as the Plan's third party claims administrator's Business Continuity Plan. 95

As the examination date, the Plan has not complied with this recommendation. The Plan indicated that Binghamton's Business Continuity Plans will be incorporated in 2006.

ITEM PAGE NO.

COMMENTS AND RECOMMENDATIONS FROM INTERIM MARKET CONDUCT REPORT AS OF FEBRUARY 1, 2000

A. Section 3224-a of the New York Insurance Law (Prompt Payment Law) 23,24

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

The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.

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ITEM PAGE NO.

COMMENTS AND RECOMMENDATIONS FROM THE SPECIAL REPORT ON EXAMINATION AS OF DECEMBER 10, 2003

A. **Prompt Payment Interest** 15

It is recommended that the Plan continue to review its procedures relative to the payment of claims beyond the forty-five (45) day limitation and interest thereon as set forth by Section 3224-a of the New York Insurance Law and report the results of such review to this Department.

The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.

11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

ITEM		PAGE NO.
V.	Subsequent Events	50

Underwriting – Sole Proprietor

It is recommended that the Plan comply with the underwriting guidelines for enrollment of sole proprietors as set forth in Section 4317(f)(3) of the New York Insurance Law

APPENDIX A

HMO OPERATIONS

TABLE OF CONTENTS

1. SCOPE OF EXAMINATION

The Plan's health maintenance operations are marketed under the name, "Community Blue", in the Buffalo division area and under the name, "HealthNow" in the Albany division area. Where the term, "HMO" appears in this report, it shall refer to the aggregate HMO operations of HealthNow New York Inc.

The previous examination of the Plan's HMO operations was conducted as of September 30, 1999. This examination covers the period from October 1, 1999 through December 31, 2003, and was done in conjunction with the examination of HealthNow New York Inc. Where deemed appropriate, transactions subsequent to this period were also reviewed.

2. DESCRIPTION OF HMO

The HMO is operated as a Public Health Law Article 44 line of business HMO from the Plan's corporate headquarters at 1901 Main Street, Buffalo, New York under the name, Community Blue and from the Plan's branch office at 30 Century Hill Drive, Latham, New York under the name of Health Now.

A. Management

The board of directors and officers of HealthNow New York Inc. provide the management for the HMO.

B. Territory and Plan of Operation

At December 31, 2003, the approved service area as per Community Blue's Certificate of Authority consisted of the same eight (8) counties in the western New York area as those served by HealthNow New York Inc. In addition, at December 31, 2003, its Certificate of Authority for the HealthNow service area included the following twelve counties:

Albany	Essex	Montgomery
Schenectady	Clinton	Fulton
Rensselaer	Warren	Columbia
Greene	Saratoga	Washington

Community Blue and HealthNow, by contract, provides subscribers and their dependents with comprehensive health benefits. These benefits are marketed to local groups and individuals. The HMO is involved in Medicare, Medicaid, Child Health Plus, Family Health Plus, and Healthy New York lines of business. The HMO also participates in a POS contract issued by the Article 43 Corporation.

The HMO is operated as a network model HMO. Participating physicians and hospitals individually contract with Community Blue in the Buffalo division area and HealthNow in the Albany division area to provide services to subscribers. Subscribers then select a participating physician to act as their primary care physician (PCP). The PCP coordinates all benefits delivered to the subscribers.

When treatments are required by subscribers outside of the specialty of any PCP, the PCP refers the subscribers to other participating physicians specializing in the required area. The following chart shows the HMO enrollment during the period under examination by line of business:

Line of business	1999	2000	2001	2002	2003
HMO Only	178,085	160,615	153,092	136,411	117,256
POS	149,345	177,373	200,065	211,195	191,605
Healthy New York	0	0	556	1,910	4788
Medicare	20,622	26,773	31,033	40,260	47,147
Medicaid	16,674	17,084	19,930	28,273	37,447
Child Health Plus	23,820	25,572	19,636	18,069	15,810
Family Health Plus	0	0	821	13,224	20,865
Total	388,546	407,417	425,133	449,342	434,918

Enrollment changes by service area during the period under examination were as follows:

Community Blue – Buffalo Service Area

	Contracts	Members
December 31, 1999	164,450	320,431
December 31, 2000	169,152	314,501
December 31, 2001	181,839	336,709
December 31, 2002	197,909	343,214
December 31, 2003	196,729	315,541

Community Blue – Albany Service Area

	Contracts	Members
December 31, 1999	44,108	68,115
December 31, 2000	58,913	92,916
December 31, 2001	57,553	88,424
December 31, 2002	72,007	106,128
December 31, 2003	81,459	119,377

C. Subsidization

During the examination period, the Plan's HMO operations accounted for an aggregate loss to HealthNow New York Inc. in the amount $33,117,882 detailed as follows:

Year	Community Blue (Buffalo)	HealthNow (Albany)	Total HMO Gain (Loss)
1999*	$4,366,484	$(1,251,277)	$3,115,207
2000	(29,216,286)	(3,820,067)	(33,036,353)
2001	(26,211,850)	8,631,573	(17,580,277)
2002	8,986,237	(9,666,076)	(679,839)
2003	41,822,000	(26,758,622)	15,063,378
Totals	$(253,415)	$(32,864,469)	$(33,117,882)

* Last three months of 1999

D. Risk Sharing

At December 31, 2003, the Plan maintained agreements with its participating physicians, which provided for specified percentage withholds of fees due these physicians. In the Buffalo division, a 10% withhold applied to primary care physicians (PCPs) with a 15% withhold applicable to specialists. In the Albany division, a 10% withhold was applied to both PCPs and specialists.

Incentive Fund Withhold Summary

For the Years 1999-2003

	Retained	Payout
1999	$3,000,000	$10,482,675
2000	$20,791,273	$500,000
2001	$17,670,394	$4,744,818
2002	$3,172,665	$16,910,746
2003	$2,809,654	$18,818,296

The withhold payments were based on contractual arrangements with the relevant providers.

PCPs are assigned to clusters (groups) for which a specific medical expense budget is allocated based on the age, sex, and benefit of the members of said physicians. The aggregate budget for each cluster of PCPs is compared to the total claims expense for

those members of a cluster. The surplus or deficit arising from the aforementioned comparison is shared equally between the physicians and the HMO. Further, the physician share is divided between the PCPs and specialists. The return of withhold is based on the experience of each cluster of PCPs as well as the experience of each physician within the cluster, and is allocated to the PCPs and specialists based on the withhold dollars contributed by each group. The surplus return is capped at the total of the amount of the withhold.

In addition, the Plan, at December 31, 2003, maintained numerous capitation arrangements with medical groups, intermediaries and other providers. Capitation arrangements were made with the following intermediaries as of December 31, 2003:

Prism Network Inc. and Prism Independent Practice Association
Cole National
Davis Vision Inc. and Subsidiaries
APS
University Pediatrics
Quest Diagnostics

E. Accounts and Records

Separate general ledger accounts are maintained for specified HMO liabilities, revenues and expenses. However, as the Plan's operations are reported as a line of business, a specific balance sheet relative to HMO operations only is not maintained.

1. FINANCIAL STATEMENTS

A. Balance Sheet

As noted above, since the Plan's HMO operations are reported as a line of business, a balance sheet is not included in this report relative to its operations.

B. Statement of Revenue and Expenses

The following shows the revenue and expenses of the Plan's HMO operations (Community Blue and Health Now) as reported by the Plan for the period October 1, 1999 through December 31, 2003:

MEMBER MONTHS		21,408,659
Revenues		
Total premium revenue		$3,668,955,915
Expenses		
Medical and Hospital:		
Hospital/medical benefits	$1,818,463,847	
Other professional services	174,243,735	
Emergency room and out-of-area	563,600,161	
Prescription drugs	559,707,040	
GME and Pooling	67,199,258	
Rider expense	31,589,903	
Incentive pool and withhold adjustment	51,121,431	
Subtotal	$3,265,925,375	
Less:		
Stop-loss fund recoveries	32,622,561	
Total hospital and medical		$3,233,302,814
Claim adjustment expenses		186,682,876
General administrative expenses		282,208,107
Total underwriting deductions		$3,702,193,797
Net underwriting loss		$ (33,237,882)
Overall HealthNow New York Inc. gain for period, October 1, 1999 through December 31, 2003		$121,749,699
HMO percentage of overall HealthNow New York Inc. gain for period		(27.3%)

4. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to subscribers and claimants.

The following was noted relative to the Plan's health maintenance organization operations:

A. Commissions to Brokers

It was noted that the HMO paid commissions to certain brokers during the period, January 1, 2003 – December 31, 2003 in excess of the rate which the Plan had filed with this Department. Section 4312(a) of the New York Insurance Law states in part,

> "…Commissions shall be included in the corporation's rate manual and rate filings…"

Part 52.42(e) of Department Regulation 62 (11NYCRR 52.42(e)) states in part,

> "…No licensed insurance broker shall receive such commissions or fees from an HMO, unless the HMO has filed the actual rate to be paid and included the anticipated expenses for such payments to insurance brokers in its application to amend its community premiums rates pursuant to the provisions of Section 4308 of the New York Insurance Law. Such rate shall be incorporated into the HMO's premium rate manual…"

In light of the above, it is once again recommended that the HMO, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to its brokers in excess of its commission rates filed with this Department.

5. COMPLIANCE WITH THE PRIOR REPORT ON EXAMINATION

The prior report on examination contained two comments and recommendations relative to the Community Blue line of business. (The page numbers refer to the prior report on examination.):

ITEM		PAGE NO.
A.	Commissions to Brokers	68,69
	It is recommended that the HMO, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to its brokers in excess of its commission rates filed with this Department.	
	The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.	
B.	Guaranteed Rating – Rolling Rate Methodology	69
	It is recommended that the HMO refrain from changing its insured's anniversary dates.	
	The Plan has complied with this recommendation.	

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

ITEM		PAGE NO.
A.	Commissions to Brokers	
	It is once again recommended that the HMO, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to its brokers in excess of its commission rates filed with this Department.	76

Respectfully submitted,

Joseph S. Krug
Associate Insurance Examiner

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

Joseph S. Krug, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Joseph S. Krug

SANDRA J ZAHN
Notary Public, State of New York
No. 01ZA6015829
Qualified in Erie County
Commission Expires 11-9-06

Subscribed and sworn to before me
this 9th day of August 2006

Appointment No. ***22228***

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:

Joseph Krug

as a proper person to examine into the affairs of the

HealthNow New York 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 17th day of *May 2004*

Gregory V. Serio
Superintendent of Insurance