REPORT ON EXAMINATION

OF

DENTCARE DELIVERY SYSTEMS, INC.

AS OF

DECEMBER 31, 2005

DATE OF REPORT **FEBRUARY 18, 2010**

EXAMINER **ROY ZABALA**

TABLE OF CONTENTS

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

David A. Paterson
Governor

James J. Wrynn
Superintendent

February 18, 2010

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 22483, dated March 10, 2006, attached hereto, I have made an examination into the condition and affairs of Dentcare Delivery Systems Inc., a not-for-profit health service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2005. The following report thereon is respectfully submitted.

The examination was conducted at the home office of Dentcare Delivery Systems, Inc., located at 333 Earle Ovington Boulevard, Uniondale, New York 11553.

Wherever the terms “the Plan” or “Dentcare” appear herein, without qualification, they should be understood to refer to Dentcare Delivery Systems, Inc.

1. SCOPE OF EXAMINATION

Dentcare Delivery Systems, Inc. was previously examined as of December 31, 2001. The current examination covered the four-year period from January 1, 2002 through December 31, 2005. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2005 were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2005, in accordance with Statutory Accounting Principles ("SAP"), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and to the extent considered appropriate, utilized work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the *Examiners Handbook of the National Association of Insurance Commissioners* ("NAIC"):

History of the Plan
Management and controls
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
Business in force
Reinsurance
Loss experience
Accounts and records
Market conduct activities

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. DESCRIPTION OF PLAN

Dentcare Delivery Systems, Inc. is a not-for-profit health service corporation licensed on December 1, 1978, pursuant to the provisions of Article 43 of the New York Insurance Law. Dentcare is licensed to operate in all New York State counties and writes only dental insurance.

Dentcare provides dental benefits through a network of participating general dentists and specialists. The Plan offers traditional fee-for-service dental plans, as well as managed care contracts. The fee-for-service dental plans can be based on a fixed schedule of benefits or can be reimbursed according to percentages of "usual, customary and reasonable" charges. Managed care contracts are on a prepaid (capitated) basis.

A. Management and Controls

The principal officers of Dentcare as of December 31, 2005 were as follows:

Name	Title
Glenn J. Sobel	President
Nicole Mastantuono	Secretary
Mary Jean Kelly	Treasurer

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board of directors consisting of no less than three, and no more than twelve members, which may from time to time be increased or decreased by resolution of the board.

The board of directors was comprised of the following five members as of December 31, 2005:

Name and Residence	Principal Business Affiliation
Susannah Cort Bayside, NY	Senior Medical Product Leader, Adventis Pharmaceuticals
Elyse Greenfield New York, NY	Director of Public Relations, NYU College of Dentistry
Johnnie Lee Harris Kew Gardens, NY	Supervisor, Fraud Investigator and Security – New York City Department of Homeless Services
Michael Korngold Searingtown, NY	Practicing Dentist, Dentcare Delivery Systems, Inc., Panel Provider
Nicole Mastantuono Cedarhurst, NY	Office Manager, Valley Stream Dental Association, Inc.

In accordance with its by-laws, the regular meetings of the Plan's board of directors are held four times a year, including an annual meeting at the first regular meeting of the calendar year. Additionally, the board may hold special meetings as desired. The board of directors of Dentcare met seventeen (17) times during the examination period of January 1, 2002 through December 31, 2005. A review of the minutes of the board of directors' meetings held during the examination period indicated that board meetings were generally well attended.

Section 1411(a) of the New York Insurance Law states:

> "No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting."

A review of the minutes of the Plan's board of directors' meetings held during the examination period revealed that neither the board members nor a committee of the board were involved in the approval process of Dentcare's investments and that investment reports were not provided to the board as required by Section 1411(a) of the New York Insurance Law.

It is recommended that the Plan comply with the provisions stated in Section 1411(a) of the New York Insurance Law by having its board or appropriate committee authorize or approve all of its investments.

Further, the Plan was unable to provide written investment guidelines to the examiner for the period under examination. The examiner did not uncover any investments made by the Plan during the examination period that were not permitted by the New York Insurance Law. However, it is recommended that the Plan establish written investment guidelines to be used when purchasing or disposing of investments.

Subsequent to the examination period, the Plan's board of directors established and approved investment guidelines.

Department Circular Letter No. 9 (1999), dated May 25, 1999, "Adoption of Procedure Manuals", was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and insurers licensed to write health insurance in New York State.

Department Circular Letter No. 9 (1999) states in part:

> "It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations…
>
> Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations…"

Circular Letter No. 9 (1999) recommends that the board obtain a certification annually: (i) from either the Plan director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the Plan's general counsel, a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations. The Plan failed to comply with these requirements of the abovementioned Circular Letter.

It is recommended that the Plan comply with Circular Letter No. 9 (1999) by obtaining the required annual certifications.

B. Territory and Plan of Operation

Dentcare is licensed to write business in all counties of New York State and only writes dental insurance. The Plan's primary service area consists of the greater New York metropolitan area.

The Plan's written premiums and enrollment for the four-year examination period were as follows:

Calendar Year	Written Premiums	Enrollment
2002	$ 53,436,962	415,604
2003	$ 49,852,315	373,725
2004	$ 53,967,356	368,361
2005	$ 54,204,464	365,726

C. Service Agreement

A service agreement, effective August 25, 1994, was entered into between Dentcare and Healthplex, Inc. Healthplex, Inc. ("Healthplex") was formed as a publicly traded company in 1984 to provide services as a third party administrator ("TPA") for various dental programs. In 2000, Healthplex was converted from a public company to a privately held company. Under the terms of the service agreement, Healthplex is compensated for services such as marketing, claims processing, electronic data processing, quality control and actuarial services it performs for Dentcare. The service agreement was approved by this Department.

During the review of the service agreement between Dentcare and Healthplex, the examiner observed the following:

- The service agreement contains a clause that requires the fees to be the lesser of two methods, subject to a maximum of fifteen percent (15%) of Dentcare's premiums (Dentcare's statutory expense limit). For every year during the examination period the actual expenses incurred by Healthplex, on behalf of Dentcare, exceeded the 15% cap.

  This action causes the operating results of Dentcare to be distorted, as its expenses are shown at a lower amount than actually incurred on its behalf.

- The management of Dentcare did not complete an analysis of the terms of the service agreement. Further, there is no evidence that Dentcare's management solicited bids from other companies, to determine if another entity could perform the same services as Healthplex, at a lower cost.

It is recommended that the aforementioned waiver of expenses be referenced in the notes to Dentcare's financial statements.

It is recommended that Dentcare annually provide the Department with an accounting of total compensation paid to Healthplex for each calendar year and a copy of the compensation calculations received from Healthplex pursuant to Exhibit I of the Service Agreement.

It is recommended that Dentcare's management perform a detailed analysis of its agreement with Healthplex and consider the solicitation of other entities that can perform the same services as Healthplex. The results of this analysis should be shared with Dentcare's board, and discussions and decisions regarding this matter should be detailed in the minutes of Dentcare's board meeting(s). Further, all documentation provided to the board should be appended to the minutes of the applicable board meetings.

D. Reinsurance

The Plan neither assumed nor ceded any business during the examination period. This is consistent with the prior examination period.

E. Section 1307 Loan

As of December 31, 2005, the Plan reported $925,000 as segregated surplus under the caption, “Section 1307 loans”, in its filed annual statement. This item represents amounts borrowed from Healthplex, Inc., pursuant to the provisions of Section 1307(a) of the New York Insurance Law (“Contingent Liability for Borrowings”). This loan agreement was submitted to and approved by the Superintendent of Insurance pursuant to the provisions of Section 1307(d) of the New York Insurance Law.

Subsequent to the examination date, on November 22, 2006, the Superintendent of Insurance granted permission for Dentcare to repay principal, in the amount of $300,000 and interest accrued in the amount of $55,899 to Healthplex, Inc. These amounts were for part of the principal and interest accrued thereof, through September 30, 2006. Further, in December 2008, with the permission of the Superintendent of Insurance, Dentcare made a payment of $682,439 to Healthplex, Inc., consisting of the remaining $625,000 of principal, and interest accrued through December 2, 2008, in the amount of $57,439.

F. Significant Operating Ratios

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

	Amounts	Ratios
Claims incurred	$ 181,686,036	84.58%
Claims adjustment expenses incurred	807,465	.38%
General administrative expenses incurred	31,394,262	14.62%
Net underwriting gain	910,458	.42%
Premiums earned	$ 214,798,221	100%

G. Abandoned Property Law

Section 1316 of the New York Abandoned Property Law states in part:

> "…Any amount issued and payable… to a resident of this state on or because of a policy of insurance other than life insurance… shall be deemed abandoned property if unclaimed for three years by the person entitled thereto…. such abandoned property shall be reported to the comptroller annually on or before the first day of April…"

The Plan's abandoned property reports for the period under examination were reviewed to ascertain compliance with the filing requirements of Section 1316 of the New York Abandoned Property Law. It was noted that the abandoned property reports for the period ending December 31, 2000 and December 31, 2001, due on or before April 1st 2004 and April 1st 2005, respectively, were not submitted until after their due dates.

In addition, the Plan did not file an abandoned property report with the Office of the New York State Comptroller for calendar year 1999 (2002 filing). The Plan stated that it did not have any funds to remit to the State Comptroller's Office under Section 1316 of the Abandoned Property Law during the aforementioned period of time. Nevertheless, insurance companies which neither hold nor owe abandoned property are still required to submit abandoned property reports pursuant to the provisions of Section 1316 of the New York Abandoned Property Law.

Furthermore, the Plan also failed to publish a list of names and last known addresses of persons appearing to be entitled to abandoned funds for the periods ending December 31, 2001 (2004 filing) and December 31, 2000 (2003 filing), in accordance with Section 1316 of the New York Abandoned Property Law.

It is recommended that the Plan comply with the requirements of Section 1316 of the New York Abandoned Property Law and file the requisite annual abandoned property reports with the Office of the New York State Comptroller in a timely manner.

It is also recommended that the Plan annually publish a list of names and last known addresses of persons appearing to be entitled to the abandoned cash amounts, if required under Section 1316 of the New York Abandon Property Law. It is further recommended that the Plan provide proof of such filing with the Office of the State Comptroller, as per the requirements of Section 1316 of the New York Abandoned Property Law.

H. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with certain Statements of Statutory Accounting Principles or the NAIC Annual Statement Instructions. A description of such items is as follows:

1. Paragraph 6 of Statement of Statutory Accounting Principles ("SSAP") No. 26 states:

> "Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

A review of the Plan's Schedule D – Part 1 ("Bonds Owned December 31, at Book/Adjusted Carrying Values") revealed that the Plan applied the "straight line method" for the valuation of its bonds, rather than the "scientific" (constant yield) interest method required by SSAP No. 26.

The amount of the amortization variance was immaterial and no change was made to the financial statements herein.

It is recommended that the Plan comply with the amortization methodology required by Paragraph 6 of SSAP No. 26 when calculating the carrying value of its bonds.

2. Paragraph 9(a) of Statement of Statutory Accounting Principles ("SSAP") No. 6 states:

> "9. Nonadmitted amounts are determined as follows:
>
> a. Uncollected Premium - To the extent that there is no related unearned premium, any uncollected premium balances which are over ninety days due shall be non-admitted. If an installment premium is over ninety days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be non-admitted."

A review of the Plan's aged premiums receivable balances revealed that the Plan failed to classify a portion of the receivables that were over ninety (90) days past due as a "non-admitted asset". The amount overdue was deemed immaterial by the examiner and no change was made to the financial statements herein.

It is recommended that the Plan report all premiums receivable over ninety (90) days past due as a non-admitted asset, as required by Paragraph 9(a) of SSAP No. 6.

3. It was noted that Dentcare failed to exercise due care when filing its 2005 Annual Statement and New York Supplement. The following errors were noted by the examiner:

- The Plan incorrectly reported negative balances in its Schedule M – Grievances and Utilization Appeals (2005 NY Supplement, page NY 14, line 7, columns 1 and 2).

Subsequent to the examination date, the Plan submitted a revised Schedule M to the Department.

- The total claim count of 15,726 in Schedule H (NY) Section 1 – Aging Analysis of Claims Unpaid (2005 NY Supplement, page, NY 7, line 4, column 11) was incorrectly stated.

  Subsequent to the examination date, the Plan submitted a revised Schedule H (NY) Section 1 to the Department.

- The total of Exhibit NY6D – "Dental Claims Incurred by Year by Enrollment Classification" (2005 NY Supplement, page NY 36, line 5, column 1) did not equal the total of Exhibit NY6G – "All Lines Recapitulation, Claims Incurred During Year by Enrollment Classification" (2005 NY Supplement, page NY 39, line 5, column 1).

- The Note on page 3 of the 2005 Annual Statement should state, "No liability appears in the balance sheet for a loan in the amount of $925,000 and accrued interest in the amount of $28,152." Further, the footnote should be shown at the bottom of the balance sheet in accordance with the requirements of Section 1307(c) of the New York Insurance Law.

It is recommended that the Plan exercise due care when preparing its Annual Statements and New York Supplement filings with this Department.

4. Section 89.2(b) of Department Regulation No. 118 (11 NYCRR 89.2) – "Requirement for independent certified public accountant", states in part:

> "Every insurer subject to this Part shall retain an independent Certified Public Accountant (CPA)… Such contract must specify that…
>
> (b) any determination by the CPA that the insurer has materially misstated its financial condition as reported to the superintendent or that the insurer does not meet minimum capital or surplus to policyholder requirements set forth in the Insurance Law shall be given by the CPA, in writing, to the superintendent within 15 calendar days…"

A review of the Plan's contract with its independent certified public accountant revealed that the contract was not in compliance with Section 89.2(b) of Department Regulation 118, since it did not specify that the independent certified public accountant would notify the superintendent, in

writing, within fifteen calendar days of identifying any material misstatement(s) of the insurer's financial condition, or if the insurer did not meet the minimum capital or surplus to policyholders requirements. It is essential that the Department obtain the above information to monitor and determine the financial impact of any (potential) material issues concerning the Plan.

It is recommended that the Plan revise its contract with its independent certified public accountant to include the language as set forth in Section 89.2(b) of Department Regulation 118.

5. The Plan allocated all expenses paid to Healthplex in connection with their services agreement (detailed in Section 2C of this report) on line 14 ("Outsourced services including EDP, claims, and other services") of "Part 3 – Analysis of Expenses" of the Underwriting and Investment ("U&I") Exhibit contained in its 2005 filed annual statement. The examiner's analysis of these expenses revealed that Dentcare did not comply with the NAIC Annual Statement Instructions for this Exhibit.

The NAIC Annual Statement Instructions for the preparation of Part 3 – Analysis of Expenses of the Underwriting and Investment Exhibit states:

> "A reporting entity that pays any non-affiliated entity (including a managing general agent) for the management, administration, or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification items as follows:
>
> a. If the total payments for claims handling or adjustment services equals or exceeds 10 percent of the "Total Claim Adjustment Expenses Incurred", allocate these costs to the appropriate expense classification items as if these costs had been borne directly by the reporting entity.
>
> b. Allocate payments for services other than claims handling or adjustment services to the appropriate expense classifications as if these costs had been borne directly by the company, if the total of such fees paid to the non-affiliate(s) equals or exceeds 10 percent of Column 3, Line 26. If the total is less than 10 percent, the company may report the payments on Line 14."

The Plan recorded all expenses paid to Healthplex in connection with services it provided to Dentcare on line 14 (“Outsourced services including EDP, claims, and other services”) of Part 3 of the U&I Exhibit in its filed 2005 annual statement. The examiner determined that the expense amounts paid exceeded the ten percent (10%) thresholds noted above and therefore should have been allocated to the appropriate expense classification. Therefore, the Plan failed to comply with the NAIC Annual Statement Instructions with regard to the preparation of “Part 3 – Analysis of Expenses”, of the Underwriting and Investment Exhibit contained in its 2005 annual statement.

It is recommended that Dentcare complete “Part 3 – Analysis of Expenses” of its Underwriting and Investment Exhibit in accordance with the NAIC Annual Statement Instructions.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as determined by this examination as of December 31, 2005. This is the same as the balance sheet filed by the Plan in its December 31, 2005 annual statement:

Assets	Examination	Plan
Bonds	$ 998,561	$ 998,561
Cash and short term investments	8,908,750	8,908,750
Aggregate write-ins for invested assets	1	1
Investment income due and accrued	10,779	10,779
Uncollected premiums and agents' balances in the course of collection	1,186,485	1,186,485
Total assets	$ 11,104,576	$ 11,104,576

Liabilities	Examination	Plan
Claims unpaid	$ 2,804,099	$ 2,804,099
Accrued medical incentive pool and bonus amounts	700,000	700,000
Unpaid claims adjustment expenses	35,019	35,019
Premiums received in advance	607,959	607,959
General expenses due or accrued	28,919	28,919
Amounts withheld or retained for the account of others	92,171	92,171
Aggregate write-ins for other liabilities	44,217	44,217
Total liabilities	$ 4,312,384	$ 4,312,384
Capital and surplus		
Statutory reserve	$ 5,365,180	$ 5,365,180
Surplus notes	925,000	925,000
Unassigned funds (surplus)	502,012	502,012
Total capital and surplus	$ 6,792,192	$ 6,792,192
Total liabilities, capital and surplus	$ 11,104,576	$ 11,104,576

Note 1: No liability appears in the balance sheet for a loan in the amount $925,000 and accrued interest thereon in the amount of $28,152. This loan was granted pursuant to Section 1307 of the New York State 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.

Note 2: The Internal Revenue Service did not audit the tax returns filed by the Plan for the period of examination. The examiner is unaware of any potential exposure of the Plan to any further assessment, and no liability has been established herein relative to such contingency.

B. Underwriting and Investment Exhibit

Capital and surplus increased by $1,679,947 during the four-year examination period, January 1, 2002 through December 31, 2005, detailed as follows:

Revenue		
Premiums earned (net of reinsurance)	$ 214,798,221	
Net investment gain	357,831	
Net loss from agents or premiums balances charged off	(198,510)	
Aggregate write-ins for other income or expenses	1	
Total revenue		$ 214,957,543
Expenses		
Hospital and medical	$ 181,686,036	
Claims adjustment expenses	807,465	
General administrative expenses	31,394,262	
Total expenses		$ 213,887,763
Net income		$ 1,069,780

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus per report on examination as of December 31, 2001			$ 5,112,245
Net income	$ 1,069,780		
Change in non-admitted assets		$ 20,213	
Change in surplus notes	659,180		
Aggregate write-ins for losses in surplus		28,800	
Net increase in capital and surplus			$ 1,679,947
Capital and surplus per report on examination as of December 31, 2005			$ 6,792,192

4. CLAIMS RESERVES

The examination liability for claims reserves of $2,804,099 is the same as that reported by the Plan in its filed annual statement as of December 31, 2005.

The examination claims reserves were based upon actual payments made subsequent to the examination date, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's historical payment experience, appropriately modified for current claims payment patterns. The examination analysis was conducted in accordance with generally accepted actuarial principles and was based on statistical information contained in the Plan's internal records and in its filed and quarterly statements, as verified during the examination.

5. 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 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 review was directed at the practices of the Plan in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Explanation of benefits statements
D. Underwriting, rating and issuance of policy forms
E. Out-of-network reimbursement option
F. Advertising
G. Record retention

A. Claims Processing

A review of the Plan's claims practices and procedures was performed by using a statistical methodology covering claims adjudicated during the period of January 1, 2005 through December 31, 2005, in order to evaluate the overall accuracy and compliance environment of its claims processing. A sample size of 167 claims was selected for review. It should be noted that the Plan only writes dental insurance.

The statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each item in the sample.

For the purpose of this report, a "claim" as defined by the Plan is the total number of items submitted by a single provider with a single claim form, as reviewed and entered into its claims processing system. This claim may consist of various lines, procedures or service dates. It was possible, through the computer program used for this examination, to match or "roll-up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims or the sample unit. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by Dentcare for the period January 1, 2005 through December 31, 2005, as included in its annual statement filed with the Department for calendar year 2005.

The examination review revealed that the overall claims processing financial accuracy level was 99.4% and the overall claims processing procedural accuracy level was also 99.4%.

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with Dentcare's claim processing guidelines and Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such, it is counted both as a financial error and a procedural error. In summary, of the 167 claims reviewed, there was one procedural error, which resulted in one financial error.

The following charts illustrate the financial and procedural claims accuracy findings summarized above:

Summary of Financial Claims Accuracy

Population	187,741
Sample size	167
Number of claims with errors	1
Calculated error rate	.60%
Upper error limit	1.77%
Lower error limit	0%
Calculated claims in error	1,126
Upper limit claims in error	3,321
Lower limit claims in error	0

Note: 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).

Summary of Procedural Claims Accuracy

Population	187,741
Sample size	167
Number of claims with errors	1
Calculated error rate	.60%
Upper error limit	1.77%
Lower error limit	0%
Calculated claims in error	1,126
Upper limit claims in error	3,323
Lower limit claims in error	0

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

It should be noted that the procedural error and resulting financial error from the sampled claims reviewed by the examiner related to one specific claim. For this claim a Dentcare executive approved an override to a claim resulting in it being paid above the schedule amount. The Plan did not have a formal written policy to allow for such activity. Further analysis of the claim revealed that the policyholder was a Healthplex, Inc. employee and additional overpayments of past claims were also discovered. A review of the policyholder's claim history for the period of April 19, 1999 through December 9, 2005 revealed an "overpayment" (over the schedule amounts) of $2,485, or 189% over the maximum allowable amount typically paid to a specialist by Dentcare for the services rendered.

It is recommended that the Plan not allow its officers or directors to override contract provisions without due cause and proper approval. It is also recommended that the Plan develop a formal written policy to address such instances.

It is further recommended that the Plan recoup the amount of $2,485 from the policyholder, with interest.

B. Prompt Pay Law

Section 3224-a(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" (the "Prompt Pay Law"), requires all insurers to pay undisputed claims or the undisputed portion of the claim within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

> "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."

The Plan appeared to be in compliance with the requirements of Section 3224-a(a) of the New York Insurance Law. A review of Dentcare's claims adjudicated in calendar year 2005 revealed that none were paid more than forty-five days after the date of receipt.

C. Explanation of Benefits Statements

As part of the review of Dentcare's claims practices and procedures, an analysis of the explanation of benefits statements ("EOB") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and Dentcare. It should clearly communicate to the subscriber and/or provider that the Plan has processed a claim and how that claim was processed. It should also clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed the provider. It should also serve as the documentation to recover any money from coordination of benefits with other carriers.

A review of Dentcare's practices and procedures indicated that it failed to comply with the provisions of Section 3234(b)(5) of the New York Insurance Law, which states:

> "(b) The explanation of benefits form must include at least the following:
>
> (5) The amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed."

It was noted that the amount the insured was responsible for, as stated in the Plan's explanation of benefits statements, was unclear. For example, there were amounts that were not payable to the provider due to contractual arrangements between Dentcare and the provider, but it was not clear that the insured was not responsible for paying that amount.

It is recommended that the Plan comply with the requirements of Section 3234(b)(5) of the New York Insurance Law, by clearly detailing the subscribers' financial responsibility on their explanation of benefits statements.

Additionally, the Plan's third party administrator's name, Healthplex, Inc. ("Healthplex") was printed on top of each EOB. Further, the EOB directed subscribers to Healthplex' website for questions regarding the explanation of benefits statements. This can create confusion for the subscriber(s) as to who is actually providing the insurance coverage.

It is recommended that the Plan provide a clause, in a conspicuous location on its explanation of benefits statements and related correspondence, stating that, Dentcare has contracted with Healthplex to act as its administrator (of your dental plan) and that Healthplex processes requests for services and payment of claims for certain dental procedures.

D. Underwriting, Rating and Issuance of Policy Forms

The examiner's review of the Plan's policy forms uncovered an inconsistency in the application of the definition of the term "Deductible", as contained in the Plan's Certificate of Insurance and its Group Application Form.

The term "Deductible" is defined in the Certificate of Insurance booklet distributed to each subscriber by their employer as follows:

> *"The term Deductible means the fixed amount which the Member must pay for Covered Services in a Calendar Year before Coinsurance is applied..."*

The term "Deductible" was also defined in the Plan's Group Application Form, which also serves as the Group Policy, as follows:

> *"The term Deductible means the fixed amount which the Member must pay for Covered Services in a Calendar Year prior to the application of Coinsurance when using the Out-of-Network Option."*

The main difference in the above definitions of "Deductible" is that the Group Policy applies the definition of deductible to only out-of-network benefits, whereby the Certificate of Insurance applies the deductible to both in-network and out-of-network benefits. Therefore, an ambiguity exists between the Group Policy and the Certificate of Insurance. The examiner's review determined that Dentcare charged a deductible to all subscribers, regardless of whether the subscriber used a participating (in-network) or non-participating (out-of-network) provider.

Section 3221(a)(6) of the New York Insurance Law states in part:

> "That the insurer shall issue either to the employer or person in whose name such policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage…"

Because of the differences in the abovementioned two documents, Dentcare did not issue a certificate setting forth the essential features of the insurance coverage under the Group Policy, in violation of Section 3221(a)(6) of the New York Insurance Law.

It is recommended that Dentcare comply with the requirements of Section 3221(a)(6) of the New York Insurance Law and make the amendments necessary to bring consistency to its Group Application Form and its Certificate of Insurance Booklet.

Subsequent to the examination date, on November 21, 2006, Dentcare submitted a revised group contract to the New York Insurance Department for approval to make this document consistent with the Certificate of Insurance.

E. Out-of-Network Reimbursement Option

Several of Dentcare's 2006 Group Benefit Policy pages contained a description of the Plan's reimbursement option for "out-of-network" services, but did not inform the subscribers that they were responsible for any additional cost above the Plan's maximum allowance to out-of-network providers. However, for the 2005 Group Benefit Policy page, the description of the out-of-network reimbursement option clearly states that the subscribers were responsible for any additional cost above the Plan's maximum allowance to out-of-network providers.

It is recommended that the Plan revise the wording in its Group Benefit Policy page to clearly reflect that subscribers are responsible for any additional costs above the Plan's maximum allowance to out-of-network providers.

F. Advertising

Section 215.13(a) of Department Regulation No. 34 - "Identity of Insurer" states:

> "The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all of its advertisements. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer."

Healthplex' website contains several pages that describe Dentcare's products. The website also provides insureds with an opportunity to request information regarding Dentcare's products. The information includes pamphlets, brochures and applications for insurance, however, it is not clear which company will actually be providing the insurance. Although Dentcare and Healthplex have an extensive business relationship, they are not affiliated entities. As the website does not contain language which details the relationship between the two parties, such advertising may cause confusion to subscribers and potential subscribers, with respect to their association.

It is recommended that the Plan comply with the requirements of Section 215.13(a) of Department Regulation No. 34 by clearly noting the name of the entity providing the healthcare

coverage, as well as the nature of the affiliation of Dentcare and Healthplex in all applicable advertisements and other communications.

G. Record Retention

Section 243.2(b)(8) of Department Regulation No. 152 - "Records required for examination purposes and retention period" states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

Dentcare maintained its grievance file for a period of five years, not six as required by Section 243.2(b)(8) of Department Regulation No. 152.

It is recommended that Dentcare establish a record retention policy in compliance with Section 243.2(b)(1) of Department Regulation No. 152 and maintain all of its grievance files for a minimum of six years.

Subsequent to the examination period, Dentcare amended its policy to maintain its grievance files for a period of ten (10) years.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained thirty-five (35) comments and recommendations as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
	Management	
1.	It is recommended that Dentcare comply with its by-laws and Section 4301(k)(1)(D) of the Insurance Law by establishing an executive committee. It is further recommended that, in accordance with its bylaws, Dentcare establish such other committees as are specified in its bylaws. The Plan has complied with this recommendation.	4
2.	It is recommended that Dentcare implement the necessary procedures to comply with Section 4301(k)(3) of the New York Insurance Law and ensure that no person who has served as a director for ten consecutive years be elected for an additional term of office until at least one year has elapsed since the expiration of his prior term of office. The same recommendation was contained in the previous report on examination. The Plan has complied with this recommendation.	5
3.	It is recommended that Dentcare submit to the Department supporting documentation to justify the monthly expense allowance paid to Director Muir. If such expense allowance is unable to be justified, it is recommended that Dentcare cease such expense reimbursements and take the necessary steps to recover any inappropriate payments. The Plan has complied with this recommendation.	5
4.	It is recommended that Dentcare assure that those directors appointed to represent the public are qualified to represent the broad public interest of the residents of the state of New York. The Plan has complied with this recommendation.	6

ITEM NO.		PAGE NO.
5.	It is recommended that Dentcare properly report, in its annual statement filings, all officers in accordance with the NAIC Annual Statement Instructions. The Plan has complied with this recommendation.	7
6.	It is recommended that Dentcare's Board meeting minutes indicate the purpose of attendance of invited guests. The Plan has complied with this recommendation.	7
	Conflict of Interest Statement and Responses	
7.	It is recommended that Dentcare ensure management accurately discloses all potential conflicts on their annual conflict of interest statements. The Plan has complied with this recommendation.	7
	Territory and Plan of Operation	
8.	It is recommended that Dentcare accurately report the number of its providers in its filed annual statement. The Plan has complied with this recommendation.	8
	Relationship with Healthplex	
9.	It is recommended that Dentcare compile the actual expenses incurred under the service agreement with Healthplex through such methods as the determination of actual expenses, cost studies and time allocations of personnel and then submit the results to the Department within sixty days of the filing of this report. The Plan has complied with this recommendation.	10
10.	It is recommended that Dentcare establish a written agreement with International Healthcare detailing the specific basis for transactions between the companies. The Plan has complied with this recommendation.	12

ITEM NO. **PAGE NO.**

Accounts and Records

11. It is recommended that Dentcare report as premium only income that is derived from the sale of its insurance products. 12

The Plan has complied with this recommendation.

12. It is recommended that Dentcare develop and maintain contracts that specify the nature of the product sold and financial obligations of the parties in these non-insurance arrangements. 14

The Plan has complied with this recommendation.

13. It is recommended that the Plan report income generated from "leasing" its provider network as Risk Revenue in accordance with the NAIC Annual Statement Instructions. 14

The Plan has complied with this recommendation.

14. It is further recommended that Dentcare properly record risk revenue derived only from leasing its own provider network and ensure that any income from Healthplex' business is excluded. 14

The Plan has complied with this recommendation.

15. It is recommended that Dentcare submit a revised Annual Statement for 2002 and revised Quarterly Statements for 2003 that correctly report all risk revenue in the Statement of Revenue and Expenses and exclude all such revenue from premium income. 15

The Plan has complied with this recommendation.

16. It is recommended that in the future Dentcare comply with the Department's Section 308 requests for information. 16

The Plan has complied with this recommendation.

17. It is recommended that Dentcare complete its financial statements in accordance with the NAIC instructions and properly classify all administrative expense items. 16

The Plan has complied with this recommendation.

ITEM NO.		PAGE NO.
18.	It is recommended that Dentcare track administrative expenses related to the risk revenue business separately from the administrative expenses related to the insured business. The Plan has complied with this recommendation.	17
19.	It is recommended that Dentcare review its accounting practices relative to the proper classification of premium income and expense items in 2001 and 2002 for impact on the expense limitation set forth in Section 4309 of the New York Insurance Law. It is further recommended that Dentcare submit its findings to the Department for review within sixty days of the filing of this report. The Plan has complied with this recommendation.	17
20.	It is recommended that any adjustments in the management fee due to Healthplex, pursuant to the administrative services agreement, resulting from application of the Section 4309 limitation to Dentcare's restated premium income be settled immediately. The Plan has complied with this recommendation.	17
	Market Conduct Activities	
21.	It is recommended that Dentcare maintain an advertising file that contains all advertisements in accordance with Section 215.17 of Regulation No. 34. This includes but is not limited to direct mailings sent in response to website inquiries and brochures distributed to prospective insureds describing group policies in which Dentcare is an insurer. The Plan has complied with this recommendation.	21
22.	It is recommended that Dentcare maintain a system of control over its advertisements in accordance with Section 215.2(b) of Regulation No. 34. The Plan has complied with this recommendation.	21

ITEM NO.		PAGE NO.
23.	It is recommended that Dentcare comply with Regulation No. 34 Section 215.13 by revealing the identity of the insurer in all advertisements sent to prospective insureds who request the information from Healthplex' website. The Plan did not comply with this recommendation. A similar recommendation is contained herein.	24
24.	It is recommended that Dentcare reveal the identity of the insurer in advertisements including those that market Dentcare's product in conjunction with another licensed insurer's medical or dental products. The Plan has complied with this recommendation.	24
25.	It is recommended that Dentcare review all current and future advertisements to assure compliance with Section 215.5 of Regulation No. 34. The Plan has complied with this recommendation.	25
26.	It is recommended that Dentcare properly complete its Certificate of Compliance contained in its annual statement filing pursuant to Regulation No. 34. The Plan has complied with this recommendation.	25
27.	It is recommended that Dentcare file its commission plan with the Department. The Plan has complied with this recommendation.	25
28.	It is recommended that Dentcare review all its policy forms in use and make the necessary modifications to ensure compliance with all statutory mandates set forth in Article 43 of the Insurance Law and submit them to the Insurance Department for approval. The Plan has complied with this recommendation.	26

ITEM NO.		PAGE NO.
29.	It is recommended that Dentcare reduce all insurance contracts to writing in accordance with Section 4306 of the New York Insurance Law. It is further recommended that Dentcare submit the aforementioned contracts to the Insurance Department for approval in accordance with Section 4308(a) and 4308(b) of the New York Insurance Law. The Plan has complied with this recommendation.	27
30.	It is recommended that Dentcare maintain its policy form submissions including the approval letter and stamped approved copy of the policy form for all forms submitted to the Department in accordance with Regulation No. 152. The Plan has complied with this recommendation.	27
31.	It is again recommended that Dentcare comply with Section 4308(a) of the Insurance Law by filing all policy forms with the Department prior to marketing the products. The Plan has complied with this recommendation.	28
32.	It is recommended that Dentcare comply with Section 3224-a(a) of the New York Insurance Law and pay undisputed claims within forty-five days of receipt. The Plan has complied with this recommendation.	28
33.	It is recommended that Dentcare record the date that resubmitted claims are received. The Plan has complied with this recommendation.	29
34.	It is recommended that Dentcare modify its EOBs to conform to Section 3234(b) of the Insurance Law by including the appeal language. The Plan has complied with this recommendation.	30
35.	It is recommended that Dentcare establish a special investigations unit and file a fraud prevention plan with the Superintendent, pursuant to Section 409 of the New York Insurance Law. The Plan has complied with this recommendation.	30

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Management and Controls	
i.	It is recommended that the Plan comply with the provisions stated in Section 1411(a) of the New York Insurance Law by having its board or appropriate committee authorize or approve all of its investments.	5
ii.	It is recommended that the Plan establish written investment guidelines to be used when purchasing or disposing of investments. Subsequent to the examination period, the Plan's board of directors established and approved investment guidelines.	5
iii.	It is recommended that the Plan comply with Circular Letter No. 9 (1999) by obtaining the required annual certifications.	6
B.	Service Agreement	
i.	It is recommended that the aforementioned waiver of expenses be referenced in the notes to Dentcare's financial statements.	8
ii.	It is recommended that Dentcare annually provide the Department with an accounting of total compensation paid to Healthplex for each calendar year and a copy of the compensation calculations received from Healthplex pursuant to Exhibit I of the Service Agreement.	8
iii.	It is recommended that Dentcare's management perform a detailed analysis of its agreement with Healthplex and consider the solicitation of other entities that can perform the same services as Healthplex. The results of this analysis should be shared with Dentcare's board, and discussions and decisions regarding this matter should be detailed in the minutes of Dentcare's board meeting(s). Further, all documentation provided to the board should be appended to the minutes of the applicable board meetings.	8

Appointment No. 22483

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Roy Zabala

as a proper person to examine into the affairs of the

Dentcare Delivery Systems, 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 10th day of March 2006

Howard Mills
Superintendent of Insurance