

REPORT ON EXAMINATION

OF

DENTCARE DELIVERY SYSTEMS, INC.

AS OF DECEMBER 31, 2010

DATE OF REPORT

NOVEMBER 7, 2013

EXAMINER

EDOUARD MEDINA

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

November 7, 2013

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30620, dated December 1, 2010, 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, 2010, and submit the following report thereon.

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

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

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2005. This examination was a combined (financial and market conduct) examination and covers the five-year period January 1, 2006 through December 31, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2011 Edition* (the “Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook and where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2010 were reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner’s assessment of risk in the Plan’s operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan. The examiner planned and performed the examination to evaluate the Plan’s current financial condition, as well as identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined

management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually for the years 2006 through 2010, by the accounting firm of Libero & Kappel, LLP ("LK"). The Plan received an unqualified opinion in each of those years. It should be noted that the Plan dismissed Libero & Kappel, LLP effective December 31, 2010.

Section 89.4(c) of Department Regulation No. 118 (11 NYCRR 89.4), "*Audited financial statements*", states in part:

"If the CPA is dismissed or resigns:

- (1) The Company shall notify the superintendent within five business days of the event.
- (2) The Company shall submit a letter to the superintendent within 15 business days of the event detailing with specificity the nature and extent of any disagreements at the decision-making level with the former CPA..."

Effective with the preparation and submission of the audited financial statements for year ending 2010 and due to the dismissal of Libero & Kappel, LLP, the Plan retained a new accounting firm, Withhum, Smith and Brown. A letter regarding the dismissal of LK was submitted to the Department in February 2011 by the Plan, more than two months after the dismissal. Where deemed necessary by the examiner, audit workpapers of Withhum, Smith and Brown were reviewed and relied upon in conjunction with this examination.

It should be noted that the Plan failed to comply with the requirements of Section 89.4(c)(1) of Department Regulation No. 118 (11 NYCRR 89.4(c)(1)) when it did not notify the Department within five business days of the dismissal of Libero & Kappel, LLP.

Additionally, the Plan failed to comply with the requirements of Section 89.4(c)(2) when it failed to submit a letter, detailing the specifics of the dismissal, to the Department within 15 business days of the dismissal.

It is recommended that the Plan complies with the requirements of Sections 89.4(c)(1) and (c)(2) of Department Regulation No. 118 by notifying the Department, of any dismissals of any accounting firm it is receiving services from and by submitting a letter detailing the specifics of such dismissals in accordance with the timeframes specified in the Regulation.

The examiner reviewed the corrective actions taken by the Plan with respect to the recommendations contained in the prior report on examination. The results of the review are contained in Item 7 of this report.

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

2. DESCRIPTION OF THE PLAN

Dentcare Delivery Systems, Inc. (“Dentcare”) is a not-for-profit health service corporation licensed on December 31, 1978, pursuant to the provisions of Article 43 of the New York Insurance Law. Dentcare writes only dental insurance.

Dentcare provides dental benefits through a network of participating general dentists and specialists. Dentcare 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

Pursuant to the Plan’s charter and by-laws, management of the Plan is to be vested in a Board of Directors consisting of not less than three (3) nor more than twelve (12) members. As of the examination date, the Board of Directors was comprised of the following five (5) members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
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 Investigators and Security, New York City Department of Homeless Services
Michael Korngold Searingtown, NY	Dentist, Dentcare Delivery Systems, Inc.
Nicole Mastantuono Cedarhurst, NY	Office Manager, Valley Stream Dental Association

According to its by-laws, the Plan's Board of Directors is required to meet four times a year, and may hold special meetings as desired. The Board of Directors of Dentcare met twenty (20) times during the period of January 1, 2006 through December 31, 2010. A review of the minutes of the Board of Directors' meetings indicated that meetings were generally well attended with all members attending at least 50% of the meetings they were eligible to attend.

The principal officers of Dentcare as of December 31, 2010 were as follows:

<u>Name</u>	<u>Title</u>
Glenn J. Sobel	President
Nicole Mastantuono	Secretary
Mary Jean Kelly	Treasurer

A review of the Plan's management and controls revealed the following:

1. Although Dentcare's Board of Directors approved the Plan's investment transactions for the period under examination, the Plan was unable to provide the examiner with written

investment guidelines used for the purchase of such investments. The Department regards the adoption of investment guidelines as a prudent business practice.

It is recommended that, as a good business practice, the Plan establishes formal written investment guidelines to be used when purchasing or disposing of investments.

2. Department Circular Letter No. 9 (1999), *“Adoption of procedure manuals”*, 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 the applicable statutes, rules and regulations...”

Department Circular Letter No. 9 (1999) recommends that the Board obtain a certification annually: (i) from either the Plan’s 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 was asked to provide the annual certifications as specified in items (i) and (ii) above for the period under examination. It should be noted that the Plan provided a “SAS 70 Report” as proof of its annual certification. However, the Department does not deem SAS 70 Reports as an acceptable substitute for the annual certifications specified in Department Circular Letter No. 9 (1999).

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

Subsequent to the examination date, the Plan adopted procedures to comply with this recommendation.

3. Department Circular Letter No. 9 (1999), "*Adoption of procedure manuals*", states in part:

"...The board is reminded that its responsibilities to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management, administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself..."

Further, Department Circular Letter No. 9 (1999) requires the Board of Directors to be kept up to date on the claims processing functions of the Plan.

It is recommended that the Plan complies with the requirements of Circular Letter No. 9 (1999) by updating its Board of Directors on claims processing functions.

Subsequent to the examination date, the Plan adopted procedures to comply with the requirements of Circular Letter No. 9 (1999).

B. Territory and Plan of Operation

Dentcare is licensed pursuant to the provisions of Article 43 of the New York Insurance Law and is authorized to write dental business in all counties of the State of New York. The Plan's primary service area consists of the Greater New York Metropolitan area.

The Plan's direct premiums written and enrollment during five-year examination period were as follows:

<u>Calendar Year</u>	<u>Direct Premiums Written</u>	<u>Enrollment</u>
2006	\$ 54,262,884	352,885
2007	\$ 54,726,536	349,717
2008	\$ 49,299,617	279,436
2009	\$ 47,302,201	266,572
2010	\$ 46,129,658	260,917

C. Service Agreement

A service agreement, effective August 25, 1994, was entered into between Dentcare and Healthplex, Inc. ("Healthplex"). 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 including marketing, claims processing, electronic data processing, quality control and actuarial services it performs for Dentcare.

During the review of the Plan's service agreement with Healthplex, Inc. the following was noted:

1. In the prior report on examination, it was recommended that Dentcare's management perform a complete analysis of its service agreement with Healthplex and consider solicitation of other entities that can perform the same services. It was further recommended that the results of the completed analysis be shared with Dentcare's Board,

and discussions and decisions regarding this matter be detailed in the minutes of Dentcare's Board meeting(s) with supporting documentation being appended to the minutes.

For the period under examination, it was noted that Dentcare's management still had not performed such recommended analysis. Furthermore, there was 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 again recommended that Dentcare's management performs a detailed analysis of its service agreement with Healthplex, Inc. and considers the solicitation of other entities that can perform the same services as Healthplex, Inc.

2. In accordance with the service agreement, Healthplex was to (1) provide monthly financial reports to Dentcare, (2) obtain liability insurance coverage on behalf of Dentcare, and (3) provide some marketing services for Dentcare. Upon review by the examiner, it was determined that Healthplex, Inc., no longer provided monthly financial reports to the Plan nor did Healthplex obtain liability insurance coverage on behalf of the Plan; however, Dentcare was in the process of obtaining its own liability insurance coverage. In regards to the marketing services, the service agreement did not specify what services were to be included in the marketing efforts. Upon review of the expense analysis in the Plan's 2010 filed annual statement it was noted that Dentcare recorded incurred expenses for marketing. Upon inquiry it was determined that the Plan was also conducting some marketing efforts of its own. It should also be noted that Healthplex, Inc. was administering Dentcare's distribution system as part of its marketing activities.

It is recommended that Dentcare complies with the provisions detailed in its service agreement with Healthplex, Inc.

It is further recommended that the service agreement clearly identify those services Healthplex, Inc. is to render to the Plan and those services the Plan will perform itself.

D. Significant Operating Ratios

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

	<u>Amounts</u>	<u>Ratio</u>
Claims incurred	\$ 207,307,222	82.35%
Claims adjustment expenses incurred	1,466,145	.58%
General administrative expenses incurred	41,273,516	16.40%
Net underwriting gain	<u>1,687,114</u>	<u>.67%</u>
Premiums earned	<u>\$ 251,733,997</u>	<u>100.00%</u>

E. Reinsurance

The Plan neither assumed nor ceded any reinsurance during the examination period.

F. Abandoned Property Law

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 and the following violations were noted:

1. Section 1316 of the New York Abandoned Property Law, “*Unclaimed insurance proceeds other than life insurance*”, 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 on or before the first day of April in each succeeding year.”

The preliminary abandoned property report for the period ending January 1, 2006, due on or before April 1, 2007, was not provided to the New York State Comptroller; in violation of the requirements of Section 1316 of the New York Abandoned Property Law.

It is recommended that the Plan complies with the requirements of Section 1316 of the New York Abandoned Property Law by filing the requisite abandoned property reports with the Office of the New York State Comptroller.

2. Section 1316 of the New York Abandoned Property Law, “*Unclaimed insurance proceeds other than life insurance*”, states in part:

“...Within thirty days following the filing of the report of abandoned property with the comptroller pursuant to subdivision two of this section, the insurer shall cause to be published a list of such abandoned property in the same manner as that prescribed for life insurance companies by section seven hundred two of this chapter.”

The Plan also failed to publish a list of names and last known address of persons of Suffolk County appearing to be entitled to abandoned cash amounts for the period ending January 1, 2007, therefore violating the requirements of Section 1316 of the New York Abandoned Property Law.

It is recommended that the Plan complies with the requirements of Section 1316 of the New York Abandoned Property Law by annually publishing a list of names with the last known addresses of persons appearing to be entitled to abandoned property.

It is further recommended that the Plan files proof of such publication with the Office of the State Comptroller.

G. Conflict of Interest Policy

The Plan does not have a conflict of interest policy or a code of conduct policy in effect. Prudent business practices dictate that the Plan's management establishes formal procedures to govern relations between the Plan and its directors, officers and responsible employees who are charged with the conduct of its affairs. Such formal procedures should note unacceptable practices and should recite in clear language the standards of performance expected of each directors, officers and responsible employee. These procedures should also be implemented in such a manner that the Board or designated officer properly oversee and handle any conflicts disclosed. Management should designate a responsible officer, who reports directly to the Board, to implement these procedures and oversee the distribution of Conflict of Interest statements and questionnaires to all directors, officers, and responsible employees. Such statements should be completed no less than once a year.

It is recommended that the Plan establishes a written conflict of interest policy and/or a code of conduct policy.

Subsequent to the examination date, the Plan adopted procedures to comply with this recommendation.

H. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain accounts was not in accordance with Statutory Accounting Principles, New York Insurance Law, and/or Department Regulations. A description of such items is as follows:

1. Section 1217 of the New York Insurance Law, "*Vouchers for disbursements*", states in part:

"No domestic insurance company shall make any disbursement of one hundred dollars or more unless evidenced by a voucher signed by or on behalf of the payee as compensation for goods or services rendered for the company, and correctly describing the consideration for the payment..."

During a review of the expenses the examiner found that Healthplex, Inc. charged Dentcare \$8,487 for holiday parties and gifts to providers. Dentcare was unable to provide the original invoices for two components of this charge, Luncheon/ Flowers/ Entertainment in the amount of \$2,750 and Allocation of Awards /Raffles in the amount of \$1,367. The Plan was unable to verify these charges.

It is recommended that the Plan complies with the requirements of Section 1217 of the New York Insurance Law by obtaining proper documentation for all of its disbursements that are one hundred dollars or more.

2. Paragraph 10 of Statement of Statutory Accounting Principle ("SSAP") No. 6, "*Uncollected premium balances, bills receivable for premiums and due from agents and brokers*", of the NAIC's Accounting Practices and Procedures Manual, states in part:

“...If, in accordance with SSAP No. 5, it is probable the balance is uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made.”

A review of the Plan’s accounts receivable showed that the allowance for doubtful accounts was netted against the receivables. This practice is not in compliance with Paragraph 10 of Statement of Statutory Accounting Principles (“SSAP”) No. 6.

It is recommended that the Plan complies with the requirements of Paragraph 10 of SSAP No. 6 by writing off and charging its uncollectible receivables to income.

3. Sections 1305(a) and (b)(1) of the New York Insurance Law, “*Unearned premium reserves*”, states in part:

“(a) Every authorized insurer shall... maintain reserves equal to the unearned portions of the gross premiums charged or unexpired or unexpired risks and policies.
(b)(1) No deductions may be made from the gross premiums in force except for original premiums cancelled on risks terminated or reduced before expiration...”

Paragraph 3 of SSAP No. 5 of the NAIC’s Accounting Practices and Procedures Manual, “*Liabilities, contingencies and impairments of assets*”, states:

“A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity’s financial statements when incurred.”

A review of the Plan’s Unearned Premium account showed that the Plan erroneously recorded certain premiums as earned.

The Plan makes an adjustment at the beginning of each month to establish the liability account and to adjust back the receivable account. This practice is in violation of Sections 1305(a) and (b)(1) of the NYIL and is not in compliance with Paragraph 3 of SSAP No. 5.

It is recommended that the Plan complies with the requirements of Sections 1305(a) and (b)(1) of the New York Insurance Law and Paragraph 3 of SSAP No. 5 by maintaining reserves equal to the unearned portions of the gross premiums charged.

4. Section 1301(a)(16) of the New York Insurance Law, “*Admitted assets*”, states in part:

“(a)... there may be allowed as admitted assets of such insurer... only the following assets owned by such insurer...

(16) Gross deferred tax assets, provided that such assets shall be deemed admitted to the extent provided by regulations promulgated by the superintendent...”

Section 1302(a)(2) of the New York Insurance Law, “*Assets not admitted*”, states:

“(a) In addition to assets not admitted pursuant to section one thousand three hundred one of this article, the following shall not be allowed as admitted assets of a domestic or foreign insurer or the United States branch of an alien insurer in any determination of its financial condition:

(2) Prepaid or deferred charges for expenses except as provided in paragraph sixteen of subsection (a) of section one thousand three hundred one of this article, and commissions paid by the insurer.”

A review of the Plan’s December 31, 2010 annual statement showed that the Plan included on the Assets page (page 2), line 24 – “*Health care and other amounts receivable*”, prepaid expenses in the amount of \$98,095. This is a violation of Section 1302(a)(2) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 1302(a)(2) of the New York Insurance Law by refraining from admitting prepaid expenses unless such prepaid expenses are considered an exception as defined by Section 1301(a)(16) of the New York Insurance Law.

It should be noted that no changes were made to the financial statements contained herein.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities, and surplus as determined by this examination as of December 31, 2010. This is the same as the balance sheet filed by the Plan in its December 31, 2010 annual statement:

<u>Assets</u>	<u>Examination</u>	<u>Plan</u>
Cash and short term investments	\$ 9,491,449	\$ 9,491,449
Other invested assets	2,536,898	2,536,898
Uncollected premiums and agents' balances in the course of collection	423,787	423,787
Health care and other amounts receivable	<u>98,095</u>	<u>98,095</u>
Total assets	\$ <u>12,550,229</u>	\$ <u>12,550,229</u>
 <u>Liabilities</u>		
Claims unpaid	\$ 1,978,242	\$ 1,978,242
Accrued medical incentive pool and bonus amounts	1,200,000	1,200,000
Unpaid claims adjustment expenses	24,598	24,598
Aggregate health policy reserves	531,866	531,866
Premiums received in advance	369,803	369,803
General expenses due or accrued	<u>155,728</u>	<u>155,728</u>
Total liabilities	\$ <u>4,260,237</u>	\$ <u>4,260,237</u>
 <u>Capital and Surplus</u>		
Statutory reserve	\$ 5,766,207	\$ 5,766,207
Unassigned funds (surplus)	2,523,785	2,523,785
Total capital and surplus	\$ <u>8,289,992</u>	\$ <u>8,289,992</u>
Total liabilities, capital and surplus	\$ <u>12,550,229</u>	\$ <u>12,550,229</u>

Note: 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. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased by \$1,497,800 during the five-year examination period January 1, 2006 through December 31, 2010, detailed as follows:

Revenue

Premium earned	\$ 251,733,997	
Net investment gains	1,100,762	
Net gain or (loss) from agents' or premiums balances charged off	<u>(236,313)</u>	
Total revenue		\$ 252,598,446

Expenses

Other professional services	\$ 207,307,222	
Claim adjustment expenses	1,466,145	
General administrative expenses	36,261,616	
Incentive pool, withhold adjustments and bonus amounts	<u>5,011,900</u>	
Total expenses		\$ <u>250,046,883</u>
Net income		\$ <u>2,551,563</u>

Changes in Capital and Surplus

Capital and surplus, per report on examination,
as of December 31, 2005

\$ 6,792,192

	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$ 2,551,563		
Net unrealized capital losses		\$ 23,992	
Change in nonadmitted assets	8,565		
Change in surplus notes		925,000	
Aggregate write-ins for losses	<u> </u>	<u>113,336</u>	
Net gain in capital and surplus			\$ <u>1,497,800</u>

Capital and surplus, per report on examination,
as of December 31, 2010

\$ 8,289,992

4. CLAIMS UNPAID

The examination liability of \$1,978,242 is the same as the amount reported by the Plan in its filed annual statement as of December 31, 2010.

The examination analysis of the unpaid claims reserve 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 in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2010.

5. UNPAID CLAIMS ADJUSTMENT EXPENSES

The examination liability of \$24,598 is the same as the amount reported by the Plan in its filed annual statement as of December 31, 2010. 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 its filed annual statements.

6. 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 review was directed at the practices of the

Plan in the following major areas:

- A. Agents and brokers
- B. Claims processing
- C. Prompt Pay Law
- D. Explanation of benefits statements
- E. Underwriting, rating and issuance of policy forms
- F. Grievances and utilization review
- G. Advertising and marketing
- H. Record retention
- I. Fraud prevention

A. Agents and Brokers

Section 2102(a)(1)(A) of the New York Insurance Law, “*Acting without a license*”,

states:

“(a)(1) No person, firm, association or corporation shall act as an insurance producer, insurance adjuster or life settlement broker in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter.”

Section 2114(a)(3) of the New York Insurance Law, “*Life, accident and health insurance*

agents; Commissions”, states in part:

“(a)(3) No insurer... doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating, or selling in this state any new contract of accident or health insurance... except to a licensed accident and health insurance agent of such insurer... or to a licensed insurance broker of this state...”

Section 2112(e)(2) of the New York Insurance Law, “*Acting without a license*”, states in

part:

“(e)(2) Renewal or other deferred commissions may be paid to a person... for selling, soliciting or negotiating insurance in this state if the person... was required to be licensed under this article at the time of the sale, solicitation or negotiation and was so licensed at that time.”

1. A review was performed of the Plan’s sales distribution system. For the period under review the Plan provided a listing of 1,500 producers it used to sell its product. It was noted that 812 of the 1,500 producers listed, were operating without a license and were receiving sales commissions as well as renewal commissions, in violation of the requirements of Sections 2102(a)(1), 2114(a)(3) and 2102(e)(2) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 2102(a)(1) of the New York Insurance Law by ensuring that individuals who sell its products are licensed.

It is also recommended that the Plan complies with the requirements of Section 2114(a)(3) of the New York Insurance Law by paying commissions only to those individuals who are licensed producers.

It is further recommended that the Plan complies with the requirements of Section 2102(e)(2) of the New York Insurance Law by paying renewal and other deferred commissions only to those individuals who were licensed producers at the time of the initial sell, solicitation or negotiation of the Plan’s product.

2. Section 2112(a) of the New York Insurance Law, “*Certificate of appointment of an insurance producer to act as an agent and notice of termination of an insurance producer*”, states:

“(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization.”

The examiner was provided with a list of the Plan’s agents. To determine the Plan’s compliance with the filing requirements of Section 2112(a) of the New York Insurance Law, a sample of agent names was chosen from the list. It was noted that the Plan did not file a certificate of appointment with the Department for some of its agents, in violation of Section 2112(a) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 2112(a) of the New York Insurance Law by ensuring that certificates of appointments for all of its agents are filed with the Department.

3. Section 2112(c) of the New York Insurance Law, *“Certificate of appointment of an insurance producer to act as an agent and notice of termination of an insurance producer”*, states:

“(c) Certificates of appointment shall be valid until (i) terminated by the appointing insurer after a termination in accordance with the provisions of the agency contract; (ii) the license is suspended or revoked by the superintendent; or (iii) the license expires and is not renewed.”

Section 2112(c) of the New York Insurance Law dictates that the Plan may terminate its agents for either probable cause; if the agent’s license has been suspended or revoked by the Department or if the license has expired and not renewed. The Plan did not terminate any of its agents even though they no longer sold products for the Plan, may have had their license suspended or revoked or their license expired. Furthermore, the Plan should include in its agent contracts, any actions that may lead to the termination of an agent.

It is recommended that the Plan complies with the requirements of Section 2112(c) of the New York Insurance Law by terminating those agents who have not written business for the Plan, whose license has expired and has not been renewed or whose license has been suspended or revoked by the Department.

It is also recommended that the Plan includes in its agent contracts, any actions that may lead to the termination of an agent.

Subsequent to the examination date, the Plan amended its agent contracts to include actions that may lead to termination of an agent.

4. Section 4235(h)(1) of the New York Insurance Law, "*Group accident and health insurance*", states:

"Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state."

The Plan violated Section 4235(h)(1) of the New York Insurance Law when it did not pay its agents according to the commission schedule that was submitted to and approved by the Department. The fee schedule allows a maximum 3% commission for individual and small group coverage. It was found that the Plan paid up to 23% commission to its agents.

It is recommended that the Plan complies with the requirements of Section 4235(h)(1) of the New York Insurance Law by using the agent commission schedule approved by the Department to pay its agents.

B. Claims Processing

A review of the Plan's claims practices and procedures was performed by selecting a statistical sample of claims adjudicated during the period January 1, 2010 through December 31, 2010. The review evaluated the overall accuracy and compliance environment of the Plan's claims processing.

This 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.

As noted previously the Plan only writes dental insurance. The examiner selected a sample of 50 claims for review. During this review the examiner found ten claims (20%) reviewed to be in error and because of that the examiner increased the sample size to include 117 additional claims for a total of 167 claims reviewed. Of the 167 claims reviewed, a total of 77 claims (46%) were found to be processed with an error. All 77 items were related to the same processing error, which is detailed below.

For the purposes 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 the Plan's claims processing system. This claim may consist of various lines, procedures or service

dates. It was possible, through the computer system 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 the Plan for the period January 1, 2010 through December 31, 2010, as included in its annual statement filed with the Department.

The examination review revealed that the overall claims processing financial accuracy level was 100% but the overall claims processing procedural accuracy level was 54%. 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/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is considered 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 were 77 procedural errors.

It was determined that the Plan sometimes used the wrong receipt dates for the claims it processed. When the Plan received a paper claim a sequential number is assigned to the claim in the mail room. The system tracks down all the sequential numbers assigned for the day. For example, all claims received on February 23, 2010 carried a sequential number between 17335476 and 17342725. Thus, claim number 17340714 which falls between these two numbers should have a received date of February 23, 2010. However, the Plan used March 1, 2010 as the received, which is the date the claim was entered in the system. Based upon the volume of claims received on a particular day, not all claims get entered into the system on the date claims are received. The examiner found 77 cases where the processors entered and used different

received dates from the received date registered at the mailroom. It should be noted that because the Plan used the incorrect date to process some of the claims it received, the examiner could not verify the Plan's compliance with the Prompt Pay Law.

It is recommended that the Plan uses the correct receipt dates when processing its claims.

The following chart illustrates the Plan's procedural accuracy:

Dentcare Delivery Systems, Inc.,
Summary of Procedural Accuracy

Population	130,967
Sample Size	167
Number of claims with errors	77
Calculated error rate	46.11%
Calculated accuracy rate	53.89%
Upper error limit	53.67%
Lower error limit	38.55%
Calculated claims in error	60,389
Upper limit claims in error	70,289
Lower limit claims in error	50,488

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

During the last examination it was noted that a Plan's executive approved an override to a claim resulting in an overpayment even though the Plan did not have a formal written policy to perform such activity. Further analysis of the claim revealed that the policyholder was a Healthplex, Inc. employee and additional overpayments of past claims were ascertained. A review of the policyholder's claim history for the period of April 19, 1999 through December 9, 2005 found an overpayment of \$2,485 (189%) over the maximum allowable amount typically paid to a specialist by Dentcare.

It was recommended in the prior report on examination, that the Plan ceases the practice of allowing officers/directors to override contract provisions. Such practice of not allowing overrides would ensure that the claims did not receive a higher level of benefit. Additionally, it was recommended that the Plan recoup the amount of \$2,485 from the policyholder/Healthplex, Inc. employee.

The Plan recouped the \$2,485. However, the Plan has not yet put in place policies and procedures to prevent officers/directors from overriding contract provisions that allow higher levels of reimbursement.

It is again recommended that the Plan adopts policies and procedures that will prevent officers/directors from overriding contract provisions that allow claims to receive higher levels of reimbursement.

C. Prompt Pay Law

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

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

“(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy (“covered person”) 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 thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered...”

As previously mentioned in Item 6B of this report, the examiner reviewed 167 claims. During the review of the claims it was determined that the Plan had sometimes used incorrect receipt dates for processing these claims. Although the review revealed that none of these claims were paid more than forty-five days (thirty days in the case of electronic claims) or denied more than thirty days from the date of receipt, being that the wrong receipt date was used to process these claims the examiner could not make a determination as to if the Plan was compliant with Section 3224-a of the New York Insurance.

It is again recommended that the Plan uses the correct receipt dates when processing its claims.

D. Explanation of Benefits Statements

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

Sections 3234(b)(5) and (b)(7) of the New York Insurance Law, “*Explanation of benefits forms relating to claims under certain accident and health insurance policies*”, state:

“(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;

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.”

The sample selected for analyzing the EOBs was the same as used for the claims processing review noted above.

Upon reviewing the Plan’s EOBs, it was determined that they did not contain the information required by Section 3234(b)(5) of the New York Insurance Law.

Additionally, the description of the time limit, place and manner in which an appeal of a denial of benefits must be brought was provided in a separate document labeled “Your Right to Appeal”. The appeal right document and the EOB are two separate documents and there is no reference to the appeal right document made in the EOB. By not having the appeal rights information included directly on the EOB, the Plan is in violation of the requirements of Section 3234(b)(7) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Sections 3234(b)(5) and (b)(7) of the New York Insurance Law by incorporating in its EOBs all of the provisions outlined in the aforementioned statutes.

E. Underwriting, Rating and Issuance of Policy Forms

A review of the Plan's underwriting practices revealed the following violations of Department Regulations and New York Insurance Law:

1. In the prior report on examination it was noted that 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. The examiner reviewed a sample of the Plan's Group Benefit Policy pages for the period under examination. It should be noted that the Plan's Group Benefit Policy pages for some of these insureds were not corrected and as such did not inform the subscribers that they were responsible for any additional cost above the Plan's maximum allowance to out of-network providers.

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

2. Part 55.2(a) of Department Regulation No. 78 (11 NYCRR 55.2(a)), "*Notice to employees concerning termination of group accident and health insurance policies*", states:

"An insurer who intends to terminate a group policy or contract of accident, or health, or accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificate holders under a group policy shall give the policyholder at least 30 days prior written notice of its intent to terminate coverage. The notice to the policyholder shall set forth in detail the policyholder's obligation under Labor Law, section 217, and under this Part, to notify each certificate holder resident in New York State of the intended termination of the group policy."

The Plan violated the above Regulation when it failed to provide one of its policyholders with at least 30 days notice of its intent to terminate. The Plan only provided the policyholder with a 10 day notice of its intention to terminate coverage.

It is recommended that the Plan provides its policyholders with at least 30 days prior written notice of its intent to terminate coverage, as required by Part 55.2(a) of Department Regulation No. 78.

Subsequent to the examination date, the Plan adopted procedures to comply with the aforementioned provision of Part 55.2(a) of Department Regulation No. 78.

3. Section 2601(a)(4) of the New York Insurance Law, “*Unfair claim settlement practices; penalties*”, states in part:

“(a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices...

(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear...”

It was noted that once a group becomes delinquent in paying its premium, the Plan’s computer system will change the status of the group to “active delinquent”. This status prevents any claims, regardless of whether the claim was for services provided during a “non-delinquent” month, from being paid or processed for this group. For example if a group’s premium was not paid for the month of December, but had been paid for October and November, the status of the member company would become “active delinquent” for December, however, claims submitted by the group, during this period, for services performed in October or November would not be

paid by the Plan. This may lead to the Plan not processing claims for services rendered during a period for which premiums were already paid.

It was determined that such practice, as described above may constitute an unfair claims settlement practice, as defined by Section 2601(a)(4) of the New York Insurance Law.

It is recommended that the Plan revises its termination procedures and processes claims issued for services rendered during the periods for which premiums have already been paid by the group.

Additionally, although the Plan has never been fined for violations of the Prompt Pay Law, Section 3234-a(a) of the New York Insurance Law, such practices if not remedied could potentially lead to such violations.

4. Section 3201(b)(1) of the New York Insurance Law, “ *Insurance contracts – life, accident and health, annuities*”, states in part:

“(b)(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law...”

The Plan did not obtain the Department’s approval for its insurance application form. This is a violation of the abovementioned Section.

It is recommended that the Plan complies with the requirements of Section 3201(b)(1) of the New York Insurance Law by obtaining the Department’s approval for all insurance application forms used by the Plan.

F. Grievances and Utilization Review

During the course of the examination ten (10) grievance cases and the Plan's policies on grievance and utilization review were reviewed to ascertain its compliance with Articles 48 and 49 of the New York Insurance Law. The following violations were noted:

1. Section 4802(g)(3) of the New York Insurance Law, "*Managed care health insurance contracts*", states:

“(g) The notice of a determination shall include:
(3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.”

When a grievance was upheld, the Plan did not communicate to the member what procedures to follow for the filing of an appeal of a grievance determination. This is a violation of Section 4802(g)(3) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 4802(g)(3) of the New York Insurance Law by communicating to the member what procedures to follow for filing an appeal of a grievance determination.

2. Section 4324 of the New York Insurance Law, "*Disclosure of information*", states in part:

“(a)Each health service, hospital service, or medical expense indemnity corporation... shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the subscriber contract or certificate, containing at least the information set forth below... The information to be disclosed shall include at least the following:
(1) a description of coverage provisions; health care benefits; benefits maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits, will be covered...”

(3) a description of utilization review policies and procedures, used by the corporation, including:

(A) the circumstances under which utilization review will be undertaken...

(7) a description of the grievance procedures to be used to resolve disputes between the corporation and a subscriber..."

Based upon the examiner's review of the Plan's Certificate of Insurance it appears that the Plan does not establish a difference between a Grievance and a Utilization Review Appeal. In the booklet called "Certificate of Insurance" the Plan describes utilization review level I appeal, level II appeal, and external appeal. The utilization review level II appeal is described as a grievance in the booklet. The Plan failed to indicate that the grievance process and utilization reviews are two different processes that require different procedures. A grievance is triggered when an insurer denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of a contract. However, a utilization review appeal is triggered when health care services, which would otherwise be covered under the terms of a contract that have been provided, are being provided or are proposed to be provided to a member, are denied because such services are, after review by the insurer, determined to be not medically necessary.

It is recommended that the Plan complies with the requirements of Section 4324 of the New York Insurance Law by revising its Certificate of Insurance booklet to properly identify processes used to appeal a grievance decision and processes used to appeal a utilization review decision.

3. Section 4903(d) of the New York Insurance Law, "*Utilization review determinations*", states:

"(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

Item 5, “Retrospective Review”, of the Plan’s Utilization Review Policy and Procedure (UM 7.1) states that “reviews are made and notification provided within 14 days, but in no event later than 44 days after receipt.” This policy is in violation of the requirements of Section 4903(d) of the New York Insurance Law, which states that notification is to be delivered within 30 days of receipt of all the necessary information.

It is recommended that the Plan complies with the requirements of Section 4903(d) of the New York Insurance Law by providing the retrospective review notification within 30 days of receipt of all necessary information.

Subsequent to the examination date, the Plan adopted procedures to comply with this recommendation.

4. Section 4903(c) of the New York Insurance Law, “*Utilization review determinations*”, states in part:

“A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured’s designee, which may be satisfied by notice to the insured’s health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday...”

Item 4, “Concurrent Review”, of the Plan’s Utilization Review Policy and Procedure (UM 7.1) states that “reviews are made and notification provided within 1 business day, but in no event later than 14 days after receipt.” This policy is in violation of Section 4903(c) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 4903(c) of the New York Insurance Law by providing the concurrent review notification within the required number of days as stated in the statute.

5. Section 4903(b) of the New York Insurance Law, “*Utilization review determinations*”, states:

“A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured’s designee and the insured’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

Item 3, “Prospective Review”, of the Plan’s Utilization Review Policy and Procedure (UM 7.1) states that “*reviews are made and notification provided within 1 business day, but in no event later than 14 days after receipt.*” This policy is in violation of Section 4903(b) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 4903(b) of the New York Insurance Law by providing the prospective review notification within the required number of days as stated in the statute.

Subsequent to the examination date, the Plan adopted procedures to comply with the requirements of Section 4903(b) of the New York Insurance Law.

G. Advertising and Marketing

A review of the Plan’s advertisement practices was conducted to ascertain compliance with Department Regulations and the New York Insurance Law. The following violations were noted:

1. Part 215.16 of Department Regulation No. 34 (11 NYCRR 215.16), “*Statements about and insurer*”, states:

“An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.”

One of the Plan’s advertisements stated “*Healthplex Does Dental Best Because Dental Is All We Do.*” Since the Plan did not use any established rating systems to arrive at this statement with regards to its TPA, such is seen as being misleading and therefore a violation of Part 215.16 of Department Regulation No. 34.

It is recommended that the Plan complies with the requirements of Part 215.16 of Department Regulation No. 34 by using advertisement language that is not misleading.

2. The Plan stated that its Cadent Plus Plan (“CPP) is underwritten by Dencare and Atlantis Health Plan. The Plan includes Atlantis Health Plan in the advertisement of CPP because the Plan provides dental coverage to the members of Atlantis Health Plan, however, Atlantis does not underwrite any portion of this product. Upon review it was determined that this practice was misleading to the members. They may feel that they are covered by both companies, Dencare and Atlantis Health Plan. Therefore, Dencare is in violation of Part 215.16 of Department Regulation No. 34 (11 NYCRR 215.16).

It is again recommended that the Plan complies with the requirements of Part 215.16 of Department Regulation No. 34 by removing the name of Atlantis Health Plan from all of its advertisements.

3. Section 4224(c) of the New York Insurance Law, “*Life, accident and health insurance; discrimination and rebating; prohibited inducements and interdependent sales*“, states in part:

“Except as permitted by section three thousand two hundred thirty-nine of this chapter, no such life insurance company and no such savings and insurance bank and no officer, agent, solicitor or representative thereof and no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds, or other securities, or any dividends or profits accruing or to accrue thereon, or any valuable consideration or inducement whatever not specified in such policy or contract...”

The Plan advertised that one of its dental plans, OMNI DENTAL PLAN, included a discount vision plan at no additional cost. This discount was not initially included in the policy and therefore, is considered as an inducement. This is a violation of Section 4224(c) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 4224(c) of the New York Insurance Law by not providing any inducements with its offered policies.

H. Record Retention

Part 243.2(b) of Department Regulation No. 152 (11 NYCRR 243.2(b)), “*Records required for examination purposes and retention period*“, states in part:

“Except as otherwise required by law or regulation, an insurer shall maintain:

(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer...”

A review was conducted with regard to the Plan's retention of policy records, applications and contracts, claim files, licensing records, financial records and other records subject to Part 243.2(b) of Department Regulation No. 152. The following was noted:

The Plan was unable to provide copies of the initial termination letters it sent out to groups that were being terminated by the Plan. The Plan instead provided the examiner with a copy of a template letter and a printout containing the name of the group and a date, as proof that a termination letter was sent out. If a member were to seek proof that a termination letter was indeed sent out, the Plan would not be able to generate the (initial) letter that it sent.

It is recommended that the Plan complies with the requirements of Part 243.2(b) of Department Regulation No. 152 by maintaining all termination of coverage notifications as required by the Regulation.

I. Fraud Prevention

Section 409(b)(1) of the New Insurance Law, "*Fraud prevention plans and special investigations units*", states:

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

A review was conducted of the Plan's Fraud Prevention program. The Plan's compliance with New York Insurance Law Sections 405 and 409, and Department Regulation No. 95 with respect to the reporting of fraud cases to the Department was also reviewed.

For the examination period, it was determined that the Plan had not sufficiently staffed its fraud prevention division. The Plan's fraud prevention division was staffed with only four individuals, including two who were also responsible for processing claims. It should be noted that because the Plan's failure to maintain its Special Investigations Unit ("SIU") separate from its underwriting or claims functions it is in violation of Section 409(b)(1) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 409(b)(1) of the New York Insurance Law by providing a properly staffed Special Investigations Unit that is also maintained separate from the underwriting and claims function of the Plan.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2005, contained the following twenty-one (21) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Management and Controls</u>	
1. It is recommended that the Plan complies 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
<i>The Plan has complied with this recommendation.</i>	
2. It is recommended that the Plan establish written investment guidelines to be used when purchasing or disposing of investments.	5
<i>The Plan has not complied with this recommendation. A similar comment is contained in this report.</i>	
3. It is recommended that the Plan comply with Circular Letter No. 9 (1999) by obtaining the required annual certifications.	6
<i>The Plan has not complied with this recommendation. A similar comment is contained in this report.</i>	
<u>Service Agreement</u>	
4. It is recommended that the aforementioned waiver of expenses be referenced in the notes to Dentcare's financial statements.	8
<i>The Plan has complied with this recommendation.</i>	
5. 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
<i>The Plan has complied with this recommendation.</i>	

ITEM NO.**PAGE NO.**Service Agreement (Cont'd)

6. 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

The Plan has not complied with this recommendation. A similar comment is contained in this report.

Abandoned Property Law

7. It is recommended that the Plan comply with Section 1316 of the New York Abandoned Property Law and file the requisite abandoned property reports with the Office of the New York State Comptroller on a timely manner. 11

The Plan has complied with this recommendation.

8. It is also recommended that the Plan annually publish a list of names and last known addresses of persons appearing to be entitled to abandoned cash amounts and to file proof of such publication with the Office of the State Comptroller as per Section 1316 of the New York Abandoned Property Law. 11

The Plan has not complied with this recommendation. A similar comment is contained in this report.

Accounts and Records

9. It is recommended that the Plan comply with the amortization methodology prescribed in Paragraph 6 of SSAP No. 26 when calculating the amortized value of its bonds. 12

The Plan has complied with this recommendation.

10. It is recommended that the Plan report all premiums receivable over ninety (90) days due as non-admitted, as prescribed by Paragraph 9(a) of SSAP No. 6. 12

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Accounts and Records (Cont'd)

11. It is recommended that the Plan exercise due care when preparing its Annual Statement and its New York Supplement to Article 43 Corporations. 13

The Plan has not complied with this recommendation. A similar comment is contained in this report.

12. 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 No. 118. 14

The Plan has not complied with this recommendation. A similar comment is contained in this report.

13. 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. 15

The Plan has complied with this recommendation.

Claims Processing

14. 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. 23

The Plan has not complied with this recommendation. A similar comment is contained in this report.

15. It is further recommended that the Plan recoup the amount of \$2,485 from the policyholder, with interest. 23

The Plan has complied with this recommendation.

Explanation of Benefits Statements

16. 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. 25

The Plan has not complied with this recommendation. A similar comment is contained in this report.

ITEM NO.**PAGE NO.**Explanation of Benefits Statements (Cont'd)

17. 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. 25

The Plan has complied with this recommendation.

Underwriting, Rating and Issuance of Policy Forms

18. 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. 27

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 the document consistent with the Certificate of Insurance.

The Plan has complied with this recommendation.

Out-of-network Reimbursement Option

19. 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. 28

The Plan has not complied with this recommendation. A similar comment is contained in this report.

Advertising and Marketing

20. 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. 28

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.****Record Retention**

21. 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. 29

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

The Plan has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Management and Controls</u>	
i. It is recommended that the Plan complies with the requirements of Sections 89.4(c)(1) and (c)(2) of Department Regulation No. 118 by notifying the Department, of any dismissals of any accounting firm it is receiving services from and by submitting a letter detailing the specifics of such dismissals in accordance with the timeframes specified in the Regulation.	4
ii. It is recommended that, as a good business practice, the Plan establishes formal written investment guidelines to be used when purchasing or disposing of investments.	7
iii. It is recommended that the Plan complies with the requirements of Department Circular Letter No. 9 (1999) by obtaining the required annual certifications. Subsequent to the examination date, the Plan adopted procedures to comply with the requirements of Department Circular Letter No. 9 (1999).	8
iv. It is recommended that the Plan complies with the requirements of Circular Letter No. 9 (1999) by updating its Board of Directors on claims processing functions. Subsequent to the examination date, the Plan adopted procedures to comply with this recommendation.	8
B. <u>Service Agreement</u>	
i. It is again recommended that Dentcare’s management performs a detailed analysis of its agreement with Healthplex, Inc. and considers the solicitation of other entities that can perform the same services as Healthplex, Inc.	10
ii. It is recommended that Dentcare complies with the provisions detailed in its service agreement with Healthplex, Inc.	11
iii. It is further recommended that the service agreement clearly identifies those services Healthplex, Inc. are to render to the Plan and those services the Plan will perform itself.	11

<u>ITEM</u>	<u>PAGE NO.</u>
C. <u>Abandoned Property Law</u>	
i. It is recommended that the Plan complies with the requirements of Section 1316 of the New York Abandoned Property Law by filing the requisite abandoned property reports with the Office of the New York State Comptroller.	12
ii. It is recommended that the Plan complies with the requirements of Section 1316 of the New York Abandoned Property Law by annually publishing a list of names with the last known addresses of persons appearing to be entitled to abandoned property.	13
iii. It is further recommended that the Plan files proof of such publication with the Office of the State Comptroller.	13
D. <u>Conflict of Interest</u>	
It is recommended that the Plan establishes a written conflict of interest policy and/or a code of conduct policy.	13
Subsequent to the examination date, the Plan adopted procedures to comply with this recommendation.	
E. <u>Accounts and Records</u>	
i. It is recommended that the Plan complies with the requirements of Section 1217 of the New York Insurance Law by obtaining proper documentation for all of its disbursements that are one hundred dollars or more.	14
ii. It is recommended that the Plan complies with the requirements of Paragraph 10 of SSAP No. 6 by charging its uncollectible receivables to income.	15
iii. It is recommended that the Plan complies with the requirements of Sections 1305(a) and (b)(1) of the New York Insurance Law and Paragraph 3 of SSAP No. 5 by maintaining reserves equal to the unearned portions of the gross premiums charged.	16
iv. It is recommended that the Plan complies with the requirements of Section 1302(a)(2) of the New York Insurance Law by refraining from admitting prepaid expenses unless such prepaid expenses are considered an exception as defined by Section 1301(a)(16) of the New York Insurance Law.	17

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Agents and Brokers</u>	
i. It is recommended that the Plan complies with the requirements of Section 2102(a)(1) of the New York Insurance Law by ensuring that individuals who sell its products are licensed.	22
ii. It is also recommended that the Plan complies with the requirements of Section 2114(a)(3) by paying commissions only to those individuals who are licensed producers.	22
iii. It is further recommended that the Plan complies with the requirements of Section 2102(e)(2) of the New York Insurance Law by paying renewal and other deferred commissions only to those individuals who were licensed producers at the time of the initial sell, solicitation or negotiation of the Plan's product.	22
iv. It is recommended that the Plan complies with the requirements of Section 2112(a) of the New York Insurance Law by ensuring that certificates of appointments for all of its agents are filed with the Department.	23
v. It is recommended that the Plan complies with the requirements of Section 2112(c) of the New York Insurance Law by terminating those agents who have not written business for the Plan, whose license has expired and has not been renewed or whose license has been suspended or revoked by the Department.	24
vi. It is also recommended that the Plan includes in its agent contracts, any actions that may lead to the termination of an agent. Subsequent to the examination date, the Plan amended its agent contracts to include actions that may lead to the termination of an agent.	24
vii. It is recommended that the Plan complies with the requirements of Section 4235(h)(1) of the New York Insurance Law by using the agent commission schedule approved by the Department to pay its agents.	25
G. <u>Claims Processing</u>	
i. It is recommended that the Plan uses the correct receipt dates when processing claims.	27
ii. It is again recommended that the Plan adopts policies and procedures that will prevent officers/directors from overriding contract provisions that allow claims to receive higher levels of reimbursement.	28
iii. It is again recommended that the Plan uses the correct receipt dates when processing its claims.	29

<u>ITEM</u>	<u>PAGE NO</u>
H. <u>Explanation of Benefit Statements</u>	
It is recommended that the Plan complies with the requirements of Sections 3234(b)(5) and (b)(7) of the New York Insurance Law by incorporating in its EOBs all of the provisions outlined in the aforementioned statutes.	30
I. <u>Underwriting, Rating and Issuance of Policy Forms</u>	
i. It is again recommended that the Plan revises the wording in its Group Benefit Policy pages to clearly reflect that subscribers are responsible for any additional costs above the Plan's maximum allowance to out-of-network providers.	31
ii. It is recommended that the Plan provides its policyholders with at least 30 days prior written notice of its intent to terminate coverage, as required by Part 55.2(a) of Department Regulation No. 78. Subsequent to the examination date, the Plan adopted procedures to comply with the provisions of Part 55.2(a) of Department Regulation No. 78.	32
iii. It is recommended that the Plan revises its termination procedures and processes claims issued for services rendered during the periods for which premiums have already been paid by the group.	33
iv. It is recommended that the Plan complies with the requirements of Section 3201(b)(1) of the New York Insurance Law by obtaining the Department's approval for all insurance application forms used by the Plan.	33
J. <u>Grievances and Utilization Review</u>	
i. It is recommended that the Plan complies with the requirements of Section 4802(g)(3) of the New York Insurance Law by communicating to the member what procedures to follow for filing an appeal of a grievance determination.	34
ii. It is recommended that the Plan complies with the requirements of Section 4324 of the New York Insurance Law by revising its Certificate of Insurance booklet to properly identify processes used to appeal a grievance decision and processes used to appeal a utilization review decision.	35

ITEM**PAGE NO****Grievances and Utilization Review (Cont'd)**

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| iii. | It is recommended that the Plan complies with the requirements of Section 4903(d) of the New York Insurance Law by providing the retrospective review notification within 30 days of receipt of all necessary information.

Subsequent to the examination date, the Plan adopted procedures to comply with this recommendation. | 35 |
| iv. | It is recommended that the Plan complies with the requirements of Section 4903(c) of the New York Insurance Law by providing the concurrent review notification within the required number of days as stated in the statute. | 37 |
| v. | It is recommended that the Plan complies with the requirements of Section 4903(b) of the New York Insurance Law by providing the prospective review notification within the required number of days as stated in the statute.

Subsequent to the examination date, the Plan adopted procedures to comply with the requirements of Section 4903(b) of the New York Insurance Law. | 37 |
| K. <u>Advertising and Marketing</u> | | |
| i. | It is recommended that the Plan complies with the requirements of Part 215.16 of Department Regulation No. 34 by using advertisement language that is not misleading. | 38 |
| ii. | It is again recommended that the Plan complies with the requirements of Part 215.16 of Department Regulation No. 34 by removing the name Atlantis Health Plan from all of its advertisements. | 38 |
| iii. | It is recommended that the Plan complies with the requirements of Section 4224(c) of the New York Insurance Law by not providing any inducements with its offered policies. | 39 |
| L. <u>Record Retention</u> | | |
| | It is recommended that the Plan complies with the requirements of Part 243.2(b) of Department Regulation No. 152 by maintaining all termination of coverage notifications as required by the Regulation. | 40 |

ITEM**PAGE NO**M. Fraud Prevention

It is recommended that the Plan complies with the requirements of Section 409(b)(1) of the New York Insurance Law by providing a properly staffed Special Investigations Unit that is also maintained separate from the underwriting and claims function of the Plan.

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Appointment No. 30620

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Edouard Medina

as a proper person to examine into the affairs of the

Dentcare Delivery Systems, Inc.

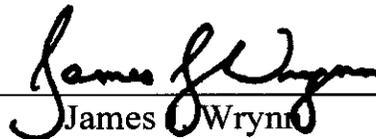
and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

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

this 1st day of December, 2010



James J. Wrynn
Superintendent of Insurance

