REPORT ON EXAMINATION

OF THE

PREFERRED ASSURANCE COMPANY, INC.

AS OF

DECEMBER 31, 2004

DATE OF REPORT **JANUARY 16, 2007**

EXAMINER **JOSEPH S. KRUG**

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

Eliot Spitzer
Governor

Eric R. Dinallo
Acting Superintendent

January 16, 2007

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in compliance with the instructions contained in Appointment Number 22360, dated May 3, 2005, annexed hereto, I have made an examination into the financial condition and affairs of Preferred Assurance Company, Inc, a not-for-profit corporation, licensed under Article 43 of the New York Insurance Law as of December 31, 2004 and submit the following report;

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

Whenever the terms "Plan" or "PAC" appear in this report, they refer to Preferred Assurance Company, Inc.

1. SCOPE OF EXAMINATION

The Plan was previously examined as of December 31, 2000. This examination covered the period from January 1, 2001 through December 31, 2004. Transactions subsequent to the date of examination were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2004, a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work preformed by the Plan's independent certified public accountants. A review or audit was also made of the following items:

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

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

2. EXECUTIVE SUMMARY

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

- The Plan did not set up a system of staggered terms for board members.
- The Plan entered into contracts with is officers that contain evergreen clauses that are in violation of Section 4312(b) of the New York Insurance Law.
- The Plan failed to comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five (45) day period provided by the aforementioned section of the Insurance Law, where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.
- The Plan failed to pay appropriate interest in those instances where the interest calculated pursuant to Section 3224-a(c) of the New York Insurance Law is $2.00 or more and where there is not an appropriate reason for delay in payment as specified in Sections 3224-a(a) and (b) of the New York Insurance Law.

3. DESCRIPTION OF PLAN

Preferred Assurance Company was incorporated under Section 402 of the Not-For-Profit Corporation Law on June 2, 1992. A license to do business within New York State as a non-profit Health Service Corporation pursuant to the provisions of Article 43 of the New York Insurance Law was obtained on August 6, 1992. The Plan commenced the issuance of insurance contracts early in 1993.

The Plan is a membership corporation as defined in the not-for-profit corporation law. Pursuant to Article I of its by-laws the Plan has one member only, which is Preferred Care, Inc.

A. Management

The by-laws of the Plan provide for management to be vested in a Board of Directors to consist of not less than four directors. The exact number of directors shall be determined from time to time by a resolution of a majority of the directors of the Corporation. In the event of a vacancy on the Board of Directors, a new director shall be appointed to fill such vacancy for the balance of the term by a majority vote of the remaining directors.

The by-laws of the Plan provide that directors shall be elected for a term of three years and that the board, by resolution, may stagger the terms of directors so as to provide that the terms of one-third of the directors shall expire each year. Until a system of staggered terms is established, all directors shall serve a term of one year.

During the period under review, directors were elected to one-year terms. As noted in the previous report on examination, a system of staggered terms for the Plan's directors has not been established.

It is once again recommended that the Plan set up a system of staggered terms for its directors.

As of December 31, 2004, the board of directors was comprised of eight (8) members as set forth below:

Name and Residence	**Principal Business Affiliation**
Provider Representative	
Tammi, Schlotzhauer, MD Rochester, NY	Physician, Rheumatology Associates of Rochester, Rochester, NY
Public Representatives	
Gary Bonadona Webster, NY	Director, Rochester Regional Joint Board, UNITE HERE, AFL-CIO, CLC Rochester, NY
Michael Copeland Rochester, NY	Manager, Human Resources, Alstom Signaling, Inc. Rochester, NY
Anthony M. Constanza Webster, NY	Retired
William Reddy Rochester, NY	Treasurer & Chief Operating Officer, Veterans' Outreach Center, Inc., Rochester, NY
Wilfred J. Schrouder Penn Yan, NY	Retired
Gerald E. VanStrydonck Fairport, NY	Sigma Marketing Group, Rochester, NY
Officer-Employee	
John Urban Rochester, NY	President and Chief Financial Officer, RAHMO, Rochester, NY

As evidenced by the above table, the composition of the board of directors is not in compliance with the requirements for public and member representatives as set forth in Section 4301(k)(1)(A) and (B) of the New York Insurance Law directors which states in part,

> "(k)(1) The board of directors of each health service, hospital service or medical expense indemnity corporation subject to this article shall be composed of persons who are representative of the member hospitals or licensed medical professionals of such corporation, persons covered under its contracts and the general public….
>
> (A) one-half in number, as nearly as possible, shall be persons covered under a contract or contracts issued by such health service, hospital service or medical expense indemnity corporation, and who are generally representative of broad segments of such covered persons, and
>
> (B) one-half in number, as nearly as possible, shall be persons whose background and experience indicate that they are qualified to act in the broad public interest, whether or not they are persons covered under a contract or contracts issued by such health service, hospital service or medical expense indemnity corporation."

It is recommended that the Plan re-structure its board of directors so that its public and member representatives are composed in equal number in compliance with Section 4301(k)(1)(A) and (B) of the New York Insurance Law.

It should be noted that subsequent to the affiliation with MVP Health Plan, Inc. the board members for PAC remained the same.

The board meets at times as fixed by the board of directors or at special meetings as may be called by the Chairperson or by any two of the board members.

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

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

Name	Title
John Urban	President
Thomas Combs	Treasurer
Robert Oppenheimer*	Secretary

* indicates non-salaried officer

Affiliation with MVP Health Plan, Inc.

On January 6, 2006, Preferred Care, Inc. became affiliated with MVP Health Plan, Inc. ("MVP"), a tax-exempt New York State not-for-profit corporation and Health Maintenance Organization licensed pursuant to Article 44 of the New York State Public Health Law. Under the terms of the agreement, Preferred Care, Inc. and MVP reorganized their respective enterprises under a holding company structure, with MVP HealthCare, Inc. (formally Preferred Care, Inc.) as the ultimate holding company (Parent) and the direct or indirect parent company of all of the Preferred Care, Inc. subsidiaries and of MVP and all of its subsidiaries. The Parent funded an independent charitable foundation ("Foundation") with an approximate $200,000,000 cash payment. The Parent was funded from the proceeds of the $80,000,000 bank term loan (discussed below) and by cash transfers from RAHMO in the amount of $107,000,000 and MVP and its

subsidiaries in the amount of $43,500,000. In addition, the Parent is required to contribute an additional amount to the Foundation in the approximate amount of $27,000,000, which is payable on January 6, 2012. The additional contribution to the Foundation is expected to be funded by the subsidiaries of the Parent.

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

Evergreen Clause

As discussed in the concurrent Report on Examination for RAHMO as of December 31, 2004, in 2005, RAHMO paid John Urban, its President and Chief Executive Officer, $2.55 million in compensation, including a bonus of $2,045,000. RAHMO was reimbursed by two other companies within the Preferred Care, Inc. Holding Group, both for-profit entities, as follows: $313,537 from Preferred Administrative Services, Inc. and $1,237 from Preferred Financial Services, Inc. According to RAHMO, the share of the bonus between the companies was based upon a cost allocation methodology.

It must be noted that certain aspects of the compensation agreement, as they pertain to the Plan, violate New York Insurance Law Section 4312(b) (McKinney 2006) which provides as follows:

> "(b) No corporation subject to the provisions of this article shall hereafter enter into any agreement, directly or indirectly, with an officer, director or salaried employee of such corporation whereby it agrees that for any services rendered or to be rendered he shall receive any salary, compensation or emolument that will extend beyond a period of thirty-six months from the date of such agreement, except that payment of an amount not in excess of twenty percent for the years nineteen hundred eighty-five and nineteen hundred eighty-six and thirty-three and one-third percent for the year nineteen hundred eighty-seven and thereafter of the salary or other compensation of any of its officers or employees, other than a mechanic, workingman or laborer, may by written contract be deferred beyond such period of thirty-six months, which contract may include conditions to be met by such officer or employee before payment will be made. No such corporation shall grant any pension to any officer, director or trustee thereof or to any member of his family after death, except that such corporation may, in pursuance of the terms of a retirement plan adopted by the board of directors of such corporation and approved by the superintendent, provide for any person who is a salaried officer or employee of such corporation, a pension payable at the time of his retirement by reason of age or disability, and also life insurance benefits payable at his death."

Thus, if it is possible for an agreement to provide payments to an officer at a time that is beyond thirty-six months from the date of such agreement, such an agreement is inconsistent with New York Insurance Law Section 4312(b). The employment agreement, as amended, at issue here is inconsistent with the statute in several ways.

First, the agreement contains an evergreen clause. In Opinion of General Counsel No. 05-02-24 (February 18, 2005), the Department stated that such clauses are not permitted by New York Insurance Law Section 4312(b).

An evergreen clause is a contract clause that provides for an automatic renewal of the contract or a portion thereof.

The agreement also provides, as part of the original agreement, for a two year continuation of salary, bonus and supplemental retirement payments to Mr. Urban upon either termination without cause or breach of contract by the corporations that are parties to the agreement. The provision is inconsistent with the Insurance Law since it is possible that the two year continuation period may extend beyond the thirty-six month period from the date of the agreement.

Similarly, the bonus compensation arrangement is inconsistent with New York Insurance Law Section 4312(b) since, except possibly in the case of the occurrence of a transaction in which the control of the corporations changed, the amount of the bonus could not be determined until 2005 when the financial performance of the corporations from 2002 through 2004 were calculated. Thus, the bonus compensation could have been paid after the thirty-six month period starting from the date of the agreement.

Finally, a provision in the agreement, added by amendment dated December 16, 2005, provides for two years of reimbursement to Mr. Urban for his costs to obtain medical coverage with such continuation to terminate at such time as Mr. Urban becomes eligible for Medicare or obtains health insurance from another employer. This provision is of indefinite duration since it is subject to the Evergreen clause. Thus, reimbursement to Mr. Urban under this provision could also extend

beyond the thirty-six month period from the date of the agreement and is also inconsistent with New York Insurance Law Section 4312(b).

It is recommended that the Plan refrain from entering into contracts with is officers that contain evergreen clauses that are in violation of Section 4312(b) of the New York Insurance Law.

B. Territory and Plan of Operation

Preferred Assurance Company, Inc. is licensed to do business throughout the state of New York, as a non-profit health service corporation, pursuant to the provisions of Article 43 of the New York Insurance Law. The Plan provides hospital, medical and other health services through indemnity contracts or preferred provider arrangements. Indemnity contracts are issued to small groups and individuals on a community rated basis and to large groups on an experience rated basis. Contracts providing managed care coverage, based on a preferred provider organization (PPO) are offered. Administrative service contracts (ASC), provide indemnity or preferred provider contracts, to certain large self-insured groups who reimburse the Plan for the cost of claims plus administrative charges. However, during the examination period, PAC only provided coverage of hospital, medical and other health services for the out of network component of Rochester Area Health Maintenance Organization Inc.'s (a sister corporation) point of service product in the Rochester metropolitan area.

The Plan commenced business early in 1993 in both the Rochester and Albany areas. Contracts issued in the Rochester area consist mainly of a point of service indemnity contract that complements the basic benefit package offered by affiliated Rochester Area Health Maintenance

Organization (RAHMO). The contract covers health maintenance organization subscribers who elect to seek services outside RAHMO's provider network. Although enrollment in the Rochester area was quite minimal beginning in 2004 there has been a substantial increase in the business written by PAC was evidenced by the following chart:

	2001	2002	2003	2004
Net Premiums Written	$300,206	$248,244	$113,848	$981,405

The increase is in net premiums written noted in the above schedule was primarily due to PAC's increase in coverage of hospital, medical and other health services for the out of network component of Rochester Area Health Maintenance Organization Inc.'s point of service product. Such business experienced a large increase in 2004. PAC does not use any agents or brokers.

C. Reinsurance

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

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

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

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

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

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

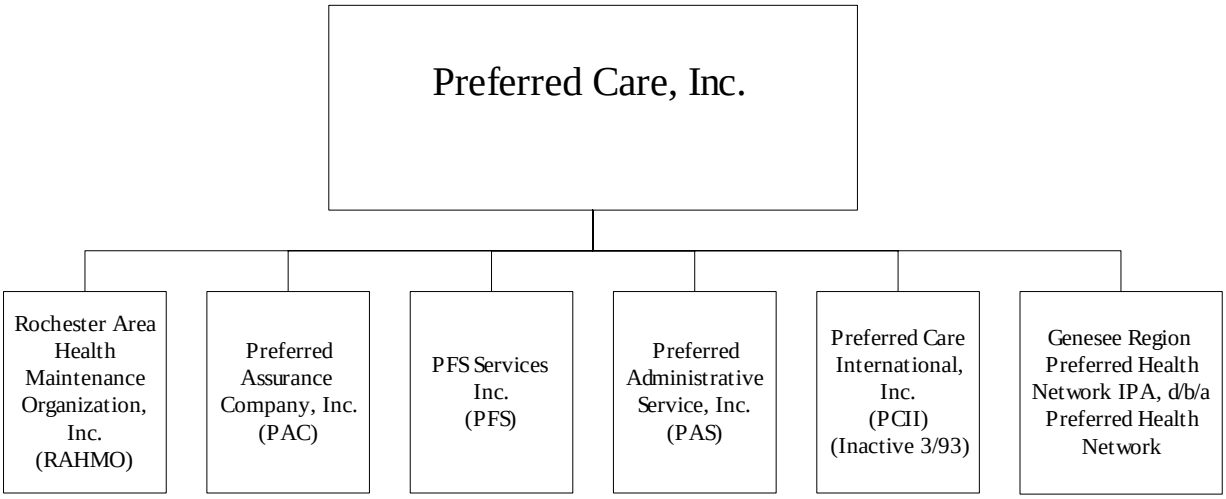
It is recommended that PAC amend its reinsurance contract with Zurich American Insurance Company to include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

D. Holding Company System

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

As of December 31, 2004, Preferred Care, Inc. (PC, Inc.), formerly known as Preferred Holding Company, Inc. was the ultimate holding company in the holding company organization. Preferred Care Holding Company, Inc. was formed in 1996 pursuant to Section 402 of the New York Not-For-Profit Corporation Law for the purpose of acting as a holding company and

promoting and improving the delivery of health services in the community. The following chart depicts the Plan and its relationship to affiliates, as of December 31, 2004:



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

Rochester Area Health Maintenance Organization, Inc. (RAHMO)

Rochester Area Health Maintenance Organization, Inc. conducts business in nine counties of New York State. It is a health maintenance organization which operates on the individual practice association model. RAHMO had 163,923 members as of December 31, 2004.

Preferred Financial Services, Inc.

Preferred Financial Services, Inc. (PFS) is a for profit corporation which operates as an insurance agency/broker. PFS offers life, disability and 401K administrative services to groups and individuals.

Preferred Administrative Services, Inc.

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

Preferred Care International, Inc.

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

E. Significant Operating Ratios

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

Development of Unpaid Claims	89.5%

The above ratio is outside Department benchmark guidelines.

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

	Amount	Ratio
Claims incurred	$495,805	30.1%
Claims adjustment expenses incurred	24,371	1.5%
Other underwriting expenses incurred	270,085	16.4%
Net underwriting gain	854,442	52.0%
Premiums earned	$1,644,703	100.0%

F. Administrative Services Agreement

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

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

It was noted that this agreement was not submitted to the Superintendent of Insurance and has not been approved. Section 1505(d) of the New York Insurance Law states in part,

> "The following transactions between a domestic controlled insurer and any person in its holding company system may not entered into unless the insurer has notified the superintendent in writing of its intention to enter into any transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period:
> …(3) rendering of services on a regular or systematic basis…"

It is recommended that PAC comply with the requirements of Section 1505(d) of the New York Insurance Law and act to obtain approval from the Superintendent of Insurance relative to its administrative services agreement with RAHMO.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the Plan's assets, liabilities and total reserves and unassigned funds as of December 31, 2004, it is the same as reported by the Plan.

	Assets	Nonadmitted Assets	Net Admitted Assets
Assets			
Cash , cash equivalents and short-term investments	$445,590		$445,590
Investment income due and accrued	336		336
Uncollected premiums	11,755		11,755
Receivables from parent, subsidiaries and affiliates	919,973	919,973	0
Healthcare and other amounts receivable	1,469	1,469	0
Total assets	$1,379,123	921,442	$457,681
Liabilities			
Claims unpaid			$94,483
Premiums received in advance			3,150
General expenses due and accrued			733
Total liabilities			$98,366
Surplus			
Surplus notes			$7,998,461
Statutory reserve			122,676
Unassigned funds (surplus)			(7,761,822)
Total surplus			$359,315
Total liabilities and surplus			$457,681

Note 1: No liability appears in the examination balance sheet relative to a loan in the amount of $7,998,461 and interest thereon in the amount of $5,228,106. The loan was granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to the prior approval of the Superintendent of Insurance of the State of New York.

Note 2: The Internal Revenue Service has not made any audits the Plan. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenues and Expenses

Surplus increased $64,911 during the period under examination, January 1, 2001 through December 31, 2004, detailed as follows:

Income		
Net premium income	$ 1,644,703	
Aggregate Write-ins for 0ther health care related revenues	0	
Total revenues		$1,644,703
Expenses		
Hospital/medical benefits	$ 522,074	
Aggregate write-ins for other medical and hospital	(26,269)	
Subtotal	495,805	
Net reinsurance recoveries (less)	0	
Total hospital and medical (less)	495,805	
Claim adjustment expenses (less)	24,371	
General administrative expenses (less)	270,085	
Total underwriting deductions		790,261
Net underwriting gain or (loss)		$854,442
Net investment income earned	18,194	
Net realized capital gains and (losses)	0	
Net investment gains and (losses)		18,194
Net income before federal and foreign income taxes incurred		872,636
Federal and foreign income taxes incurred		0
Net income		$ 872,636

C. Reconciliation of Capital and Surplus

Capital and surplus per report on examination as of December 31, 2000			$ 294,404
	Increases	Decreases	
Net income from operations	$872,636	$	
Change in non admitted assets		(807,725)	
Net change in capital and surplus			64,911
Capital and surplus per report on examination as of December 31, 2004			$359,315

5. CLAIMS UNPAID

The examination liability of $94,483 is the same as the amount reported by the Plan as of the examination date. The examination analysis was conducted using statistical information contained in the Plan's internal records and in its filed annual statements and information provided by the Plan. Such analysis utilized payments made through December 31, 2005 on claims incurred prior to the examination date, plus an estimate of future payments for such claims based on historical claims payment patterns

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 directed at practices of the Plan in the following major areas:

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

A.) CLAIMS PROCESSING

A review of the Plan's claims practices and procedures was performed. This review was performed by using a statistical sampling methodology covering the scope period in order to evaluate the overall accuracy and compliance environment of the Plan's claims processing. The

review encompassed the period from January 1, 2004 through December 31, 2004. The claims tested were selected from the population of claims adjudicated during the review period.

Since the primary population was relatively small, hospital and medical claims were combined. The random samples were drawn from this combined population. For purposes of this project, those medical costs characterized as Medicare, capitated, and SMC payments were excluded.

This statistical random sampling process was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes within the selected populations, individually or on a combined basis. For example, if ten (10) attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample. The following parameters were established to determine the sample size for the statistical sampling model:

a) Confidence Level

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

b) Tolerance Error

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

c) Expected Error

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

d) Sample Size

The sample size for each of the populations described herein was comprised of one hundred sixty seven (167) randomly selected unique claims. A second random sample of fifty (50) items from each of the populations was also generated as "replacement items" in the event it was determined a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized.

e) Sample Unit

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

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

The examination of sample claims revealed that the overall claims processing procedural accuracy level was estimated at approximately 95.81%. Claims processing procedural accuracy is

defined as the percentage of times a claim was processed in accordance to the Plan's claim processing guidelines. An error in processing procedural accuracy may or may not affect the financial accuracy. The overall claims processing financial accuracy level was approximately 94.61%. Claims processing financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. The accuracy level is determined by subtracting the calculated error rate from 100%.

The following charts illustrate the claims processing financial accuracy and claims processing procedural accuracy for hospital and medical claims combined as determined by this examination:

Description	**Financial**	**Procedural**
Claim population	2,064	2,064
Sample size	167	167
Number of claims with errors	9	7
Calculated Error Rate	5.39%	4.19%
Upper Error limit	8.81%	7.23%
Lower Error limit	1.96%	1.15%
Upper limit Claims in error	182	149
Lower limit Claims in error	41	24

b.) PROMPT PAYMENT

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services," states:

> "(a) Except in a case where the obligation of an insurer … to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."
>
> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment.
>
> Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section."

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

In this regard, a statistical sample of claims paid during calendar year 2004 was selected from a population of claims that were paid more than forty-five (45) days from receipt. The claims were reviewed for compliance with Section 3224-a of the New York Insurance Law. The results of the review were then projected for the total population of claim payments made during the period.

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

Description	Paid claims over 45 days Section 3224-a(a)	Denied over 30 days
Claim population	543	368
Sample size	167	167
Number of claims with errors	21	18
Calculated Error Rate	12.57%	10.78%
Upper Error limit	17.60%	15.48%
Lower Error limit	7.55%	6.08%
Upper limit Claims in error	96	57
Lower limit Claims in error	41	22

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Note 2: Of the 21 claims found to be in violation of Section 3224-a(a), 7 claims also violated Section 3224-a(c) because interest due of $2 or more was not paid.

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

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

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

ITEM		PAGE NO.
A.	Board of Directors	
	It is recommended that the Plan set up a system of staggered terms	4
	The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.	
B.	Accounts and records	
	1. It is recommended that the Plan exercise greater care in the preparation of its annual statement.	12
	The Plan has complied with this recommendation.	
	2. It is recommended that the PLAN comply with Section 1307(c) of the New York Insurance Law which requires a footnote, in all filed statements, showing the unpaid amounts.	12
	The Plan has complied with this recommendation.	
C.	Disaster recovery	
	It is recommended that the Plan develop and maintain a disaster recovery plan.	12
	The Plan has complied with this recommendation.	

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. ***22360***

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Joseph Krug

as a proper person to examine into the affairs of the

Preferred Assurance Company, Inc.

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

Company

with such information as he shall deem requisite.

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

this *3rd* day of *May 2005*

Howard Mills
Acting Superintendent of Insurance