REPORT ON EXAMINATION

OF

PUPIL BENEFITS PLAN, INC.

AS OF

DECEMBER 31, 2010

DATE OF REPORT	**MARCH 19, 2013**
EXAMINER	**FROILAN ESTEBAL**

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March 19, 2013

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

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30723, dated June 8, 2011, attached hereto, I have made an examination into the condition and affairs of Pupil Benefits Plan, Inc., a not-for-profit corporation licensed pursuant to Article 43 of the New York Insurance Law, as of December 31, 2010, and respectfully submit the following report thereon.

The examination was conducted at the home office of Pupil Benefits Plan, Inc. located at 101 Dutch Meadows Lane, Glenville, New York.

Wherever the designations, the "Plan" or "Pupil Benefits" appear herein, without qualification, they should be understood to indicate Pupil Benefits Plan, Inc. Additionally, 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, 2007. This examination of the Plan was a combined (financial and market conduct) examination and it covered the three-year period from January 1, 2008 through December 31, 2010. The financial component of the examination was conducted as such term is defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2010, were also 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 examiner planned and performed the examination to evaluate the Plan's financial condition, as well as to identify prospective risks that may threaten the future solvency of Pupil Benefits Plan, Inc. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this examination was the first such type of examination of the Plan. The examiner planned and performed the examination to evaluate Pupil Benefit'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 2008 through 2010, by the accounting firm of Marvin and Company, P.C. ("Marvin"). The Plan received an

unqualified opinion from Marvin in each of those years. Certain audit work papers of Marvin were reviewed and relied upon in conjunction with this examination.

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination.

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

2. EXECUTIVE SUMMARY

The examination revealed several operational deficiencies that occurred during the examination period. Following are the significant findings of the examination included within this report on examination:

- The Plan failed to comply with the maximum administrative expense limitation prescribed by Section 4309(a)(2) of the New York Insurance Law. A similar finding was included in the prior report on examination**.**
- The Plan failed to comply with the provisions of New York Insurance Law Section 2102(a)(1).
- The Plan failed to comply with Section 3224-a(a) and Section 3224-a(b) of the New York Insurance Law (Prompt Pay Law).
- The Plan failed to comply with Department Regulation No. 64 by not maintaining a log of complaints received from members and providers.
- The Plan's disaster recovery/business continuity plan is outdated and lacking key information necessary to support procedures that are necessary to address an actual disaster or similar event.

3. DESCRIPTION OF THE PLAN

Pupil Benefits Plan, Inc. is a not-for-profit, medical expense indemnity corporation organized pursuant to the Not-For-Profit Corporation Law and is licensed under Article 43 of the New York Insurance Law. Pupil Benefits commenced business on July 18, 1941. The Plan provides hospital, medical and dental benefits for accidental bodily injuries sustained by elementary and high school students incurred while engaging in school sponsored activities. Benefits under the Plan's policies are secondary; therefore, all other primary insurance policies, except Medicaid, Tricare, Child Health Care Plus and Employee Retirement Income Security Act ("ERISA"), must be exhausted before payments are made by the Plan. The Plan's maximum exposure, per injury, is $50,000.

The Plan was exempt from Federal income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code through June 30, 1987. Effective July 1, 1987, the Plan became subject to Federal income taxes due to changes adopted in the Tax Reform Act of 1986.

As a not-for-profit corporation, the Plan is exempt from New York State Tax, pursuant to Article 33, Section 1512 of New York Tax Law.

A. Corporate Governance

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board consisting of twenty-four members, who are elected annually. The board meets at least once during each calendar year in accordance with its by-laws. The directors of the Plan as of December 31, 2010 were as follows:

Name and Residence	Principal Business Affiliation
Provider Representatives	
Eric Aronowitz M.D. Schenectady, New York	Orthopedic surgeon
Donald Henline M.D. Potsdam, New York	Orthopedic surgeon
Lawrence Wiesner Binghamton, New York	Orthopedic surgeon
Public Representative	
David Civale D.C. Scotia, New York	Chiropractor
Thomas Heinzelman Hudson Falls, New York	Athletic Director, Hudson Falls Central School District
Daniel MacGregor Ballston Spa, New York	President, Pupil Benefits Plan, Inc.
Michael Picciano Weedsport, New York	Retired Superintendent, Weedsport Central School District

Name and Residence	Principal Business Affiliation
Virginia Plaisted, D.D.S. Glenmont, New York	Dentist
Luigi Rende Waterford, New York	Certified Athletic Trainer

Carol Rog Chenango Forks, New York	Past President, Pupil Benefits Plan, Inc.
Wilson Bruce Watkins New Rochelle, New York	Retired superintendent, Briarcliff Manor Central School District
Theodore Woods North Rose, New York	Recording Secretary, Pupil Benefits Plan, Inc.

Subscriber Representatives

David Alena Lyons, New York	Assistant Superintendent, Lyons Central School District
Margaret Boice Norwich, New York	Assistant Superintendent, Norwich City School District
Edward Cinelli Bayport, New York	Executive Director Section XI, NYSPHSAA
Douglas Kenyon Glens Falls, New York	Executive Director Section II, NYSPHSAA
Stanley Maziejka Saratoga Springs, New York	Superintendent, Stillwater Central School District
Michael McCarthy, Saratoga Springs, New York	Superintendent, Mechanicville Central School District
Cliff Moses Morrisville, New York	Retired Superintendent, Galway Central School District
Patrick Pizzarelli Long Beach, New York	Past President, NYSPHSAA
Ryan Sherman, Saratoga Springs, New York	Superintendent, Schylerville Central School District
Name and Residence	Principal Business Affiliation
Martha Slack Massena, New York	Retired Athletic Director
Kathy Sullivan Johnstown, New York	Superintendent, Johnstown Central School District

Dean Veenhof Gilbertsville, New York	Retired Past President, NYSPHSAA

The minutes of all meetings of the board of directors and committees thereof held during the examination period were reviewed. All board and committee meetings held during the examination period were well attended, with every member attending at least 50% of the meetings they were eligible to attend.

The principal officers of the Plan at December 31, 2010 were as follows:

Name	Title
Daniel N. MacGregor	President
Theodore Woods	Secretary
Thomas D. McGuire	Treasurer

The members of the board of directors participate on a voluntary basis and the board is comprised mostly of high ranking current and retired school district officials. Daily operations are conducted under the supervision of the Plan's Executive Director, Thomas McGuire, who is assisted by the Plan's Chief Marketing Officer, Elaine McDuffee. Both officers provide invaluable service and leadership to the staff of the Plan, such that it would pose a great difficulty for the Plan to find a suitable replacement in the event that either one was to leave the Plan. Such a void would pose a great risk of interruption to the Plan's operations. At the time of the examination, the Plan had not devised a succession plan relative to the aforementioned officers.

It is recommended that the Plan develop and implement a succession plan for its primary officers. It is recommended that such succession plan be approved by the Plan's board of directors.

B. Territory and Plan of Operation

The Plan is authorized to operate throughout New York State. All business is conducted from its home office in Glenville, New York.

Enrollment in the Plan is achieved by means of group contracts made with elementary, middle and high schools registered and approved by the Board of Regents of the State of New York. For the 2009/2010 school year, the Plan insured 365 schools with approximately 707,504 covered students. The table below indicates the direct premiums written during the examination period.

Year	Direct Premiums Written
2008	$5,038,753
2009	$5,425,462
2010	$5,847,393

C. Reinsurance

The Plan did not maintain any reinsurance arrangements during the period under examination.

D. Significant Operating Ratios

The following ratios have been computed as of December 31, 2010, based upon the results of this examination:

Net premiums written to surplus	3.5 to 1
Cash and invested assets to unpaid claims	128.6%
Surplus to unpaid claims	29.6%
Claims and expenses paid to premiums written	68.0%

The above ratios fall within the benchmark ranges set forth in the Fast Analysis Solvency Tools scoring ratios of the National Association of Insurance Commissioners (NAIC).

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

	Amount	Ratio
Claims incurred	$13,509,180	82.82%
Claims adjustment expenses incurred	1,310,262	8.03%
General administration expenses incurred	2,398,863	14.71%
Net underwriting loss	(906,697)	(5.56%)
Premiums earned	$16,311,608	100.00%

E. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with statutory accounting principles or annual statement instructions. A description of such items is as follows:

1. Enterprise Risk Management / Internal Controls

The Plan does not assess risk in a systemic fashion nor does it adequately document strategies used to mitigate identified risk. In this regard, the Plan does not have a formal internal control process in place. Internal control documentation makes a risk-focused examination more effective and efficient. Although the Plan is not required to comply with Sarbanes Oxley ("SOX") and Model Audit Rule ("MAR"), Department Regulation No. 118 requirements, documentation of the Plan's internal control procedures should be prepared.

The Plan's limited internal control procedures limit the evaluation of internal control procedures mostly to observance and interviews. As a result, the examiners used professional judgment and determined there was a high likelihood it would be inefficient to test the operating effectiveness of the internal controls relating to the Plan's key functional areas for the examination period. Accordingly, the examination team took a non-controls reliance strategy for the current financial examination period which covers the period, January 1, 2008 through December 31, 2010.

The Plan's external auditors also stated that internal controls documentation at the Plan is a concern and thus needs to be improved upon. The Plan's external auditors however, did not reflect this observation through a management letter to the Plan. The auditors noted that internal control evaluation is not part of its audit plan.

Section 307(b) (1) of the New York Insurance Law states in part;

> "…Each such insurer shall furnish the superintendent with an evaluation by such accountant of the accounting procedures and internal control systems of the insurer that are necessary to the furnishing of the opinion…"

It is recommended the Plan require its CPA firm to provide the Department with the evaluation of the accounting procedures and internal control systems of the Plan as required by Section 307(b) (1) of the New York Insurance Law.

Additionally, at small companies such as Pupil Benefits where proper segregation of duties may not be feasible and/or cost prohibitive, documentation of internal control processes enhances the awareness and highlights employees' and officers' duties and responsibilities.

It is recommended that the Plan formalizes and documents its internal controls processes and procedures, segregated by key functions.

It is also recommended that the Plan perform a general risk assessment of its operations and implement and document strategies that mitigate such risk. It is further

recommended that such risk mitigation strategies be reviewed and approved by the Plan's board of directors.

2. Limitation of Expenses

In accordance with the provisions of Section 4309(a)(2) of the New York Insurance Law, the Plan's expenditures during any one year, for expenses other than benefit payments made to or on behalf of persons covered under contracts issued by the Plan, are limited to 19% of its premiums received during such year.

Section 4309(a)(2) of the New York Insurance Law states in part:

> "No corporation subject to the provisions of this article shall, during any one year, disburse more than the percentages hereafter prescribed of the aggregate amount of the premiums received during such year as expenditures for expenses…twenty per centum reduced by one per centum for each five million dollars or fraction thereof above one million dollars of premiums received…"

The examination review revealed that the Plan's ratio of expenses paid to direct premiums written, for each of the three years under examination, was above the maximum ratio mandated by Section 4309(a)(2) of the New York Insurance Law, as follows:

Year	Direct Premiums Written	Expenses Paid	Plan's Expense Ratio	Maximum Expense Ratio Per Section 4309(a)(2) of the NYIL
2008	$5,038,753	$1,116,512	22.16%	19%
2009	$5,425,462	$1,317,533	24.28%	19%
2010	$5,847,393	$1,275,080	21.81%	19%

It is recommended that the Plan complies with the requirements of Section 4309(a)(2) of the New York Insurance Law relative to the limitation of expenses.

3. CPA Contracted Duties

The Plan contracts with an independent certified public accountant (CPA) to perform an audit of its financial statements on a Generally Accepted Accounting Principles (GAAP) basis. In addition to this audit, the CPA firm also provides accounting services to the Plan for a negotiated fee. The services include: receiving financial information from the Plan; maintaining the general ledger of the Plan and posting entries to the Plan's general ledger, which are later reviewed and approved by the Plan's Treasurer.

Department Regulation No. 118, Section 89.5(e)(1)(i) states the following;

> "(e)(1) A Company may not utilize for any purpose of this Part any work performed or prepared by a CPA if that CPA also contemporaneously provides any of the following non-audit services to that company:
> (i) bookkeeping or other services related to the accounting records or financial statements of the company;"

Further, such CPA firm also compiled the data from the Plan's books of account to complete the New York statutory "Annual", "Quarterly" and "Supplement" filings during the examination period.

The American Institute of Certified Public Accountants (AICPA) has the following rule in place:

> **AICPA 01, Rule 101—Independence.**
>
> "A member in public practice shall be independent in the performance of professional services as required by standards promulgated by bodies designated by Council".

It is recommended that the Plan complies with Department Regulation No. 118, Section 89.5(e) and cease the practice of having its CPA firm perform accounting and ancillary functions of the Plan's books that such CPA firm also audits and provides an opinion on.

It is recommended that the Plan's board of directors review the practice of having its CPA firm conduct duties which appear to be in conflict with AICPA .01 Rule 101.

4. Information Technology

The Information Technology ("IT") portion of the examination was performed in accordance with the guidelines outlined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* (the "Handbook"), utilizing a modified Exhibit C (*Evaluation of Controls in Information Technology*) approach. The review was modified because the Plan is not required to comply with either the Sarbanes-Oxley Act ("SOX"), or the NAIC's Model Audit Rule ("MAR") Department Regulation No. 118. The Plan is also not required to follow the Control Objectives for Information and related Technology ("COBIT") framework.

These waivers are all granted because the Plan's premium volume is below the thresholds stipulated under the above mentioned requirements.

The objective of the examiner's review was to assess the Plan's IT general controls ("ITGC") and procedures through the identification of inherent risk, mitigating controls and residual risk. Key areas targeted during the review included the following:

- IT management and organizational controls;
- Application and operating system software change controls;
- System and program development controls;
- Overall systems documentation;
- Logical and physical security controls;
- Contingency planning;
- Local and wide area networks;
- Personal computers; and
- Server controls.

During the Review of IT general controls, the following was noted:

A. The Plan's two file servers are enclosed in a glass cabinet, which is not locked, and accessible to anyone within the Plan's office.

B. The Plan does not have an image or digital copy of its paper claims documents.

C. The Plan's office does not have sprinklers or other fire prevention equipment, leaving IT equipment such as file servers, desktop computers and paper claim files unprotected.

D. The Plan claims data backup is achieved through an online company. Access and control is maintained by the Plan's systems programmer, who is a consultant that operates from Atlanta, Georgia. The Plan does not maintain processes and procedures to retrieve claims or other important data in the event of a disaster. Further, the backup data processes have not been tested for effectiveness.

It is recommended that the Plan improves the existing internal controls of its IT environment by developing and incorporating the following within its IT control procedures:

- Ensure that file server cabinets remain locked and secure at all times, with access only to authorized personnel.
- Evaluate and consider an image and/or digital backup of its paper claims data thereby reducing the risk of losing claims information and other valuable documentation.
- Invest in a fire suppression system or other fire prevention equipment to protect the Plan's equipment such as file servers, desktop computers and claims documentation.
- Develop and document processes and procedures to retrieve claims data from the online data company, as well as test for accuracy and effectiveness of such retrieval process.

5. Disaster Response Plan

The Plan submitted a disaster response plan to the Department on December 1, 2004. A review of the response shows that key contact information has changed since its adoption. Updated information with regard to the Plan's operational processes is missing from the recovery plan. Specifically, the names and contact numbers of current IT consultants are not included in the disaster response plan.

It is recommended that the Plan re-evaluate and update its disaster recovery and business continuity plan utilizing the guidelines stated in Department Circular Letter No. 2 (February 17, 2011).

A review of the Plan's disaster response plan revealed the following:

A. The Plan's Vendor contact list has not been updated since 2004)

B. The disaster response plan notes several possible alternate sites, however it has not been determined if the sites mentioned are capable of handling work spaces and actual business continuity in the event of a disaster.

C. The disaster response plan does not address the steps necessary to continue or regenerate its IT business applications and claims processing in the event of a disaster that would disable the Plan's equipment and facilities.

D. The disaster response plan does not contain the processes and procedures necessary to retrieve claims data backed up through its internet on-line vendor and have not tested it for its effectiveness.

It is recommended that the Plan re-evaluate and amend its Disaster Response Plan by developing and incorporating the following enhancements and procedures:

- Re-evaluate and update the outdated vendor contact list to include current IT hardware and programming consultants to be used in the event of a disaster or disruption to its computer systems and other essential operations.

- Determine alternate (disaster recovery) sites that will provide for necessary IT equipment, as well as space for employees to continue their functions.

- Assess and incorporate steps necessary to continue or regenerate its IT business applications and claims processing in the event of a disaster that disables the Plan's claims processing equipment and facilities.

- Incorporate within the Plan's Disaster Response Plan the processes and procedures related to the Plan's operations and periodically test claims data which has been backed-up on line or incorporated in a data warehouse for access, accuracy and effectiveness.

- Periodically test existing disaster recovery/business continuity plans and make improvements as deemed necessary.

- Incorporate the guidelines of Department Circular Letter No. 2 (February 17, 2011) within the Plan's Disaster Response Plan.

4. FINANCIAL STATEMENTS

A. Balance Sheet

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

Assets	Examination	Plan
Bonds	$3,648,067	$3,648,067
Common stocks	642,668	642,668
Real estate	267,328	267,328
Cash and short-term investments	4,036,965	4,036,965
Investment income due and accrued	36,947	36,947
Uncollected premiums	137,810	137,810
Health care and other receivables	8,589	8,589
Total assets	$8,778,374	$8,778,374
Liabilities		
Claims unpaid	$3,140,000	$3,140,000
Unpaid claims adjustment expenses	320,330	320,330
Current federal and foreign income tax payable and interest thereon	13,162	13,162
Premiums received in advance	3,052,661	3,052,661
General expenses due or accrued	556,168	556,168
Aggregate write-ins for other liabilities	1,527	1,527
Total liabilities	$7,083,848	$7,083,848
Surplus		
Statutory reserve	$765,135	$765,135
Unassigned funds (surplus)	929,391	929,391
Total reserves and unassigned funds	$1,694,526	$1,694,526
Total liabilities and surplus	$8,778,374	$8,778,374

Note: The Internal Revenue Service has not conducted any federal income tax audits of the Plan through tax year 2010. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein for such contingency.

B. Statement of Revenue, Expenses and Surplus

Surplus decreased $669,829 during the three-year examination period, January 1, 2008 through December 31, 2010, detailed as follows:

Revenue		
Net premium income	$16,311,608	
Net investment income	298,301	
Net realized capital gain	(13,062)	
Other income	96,097	
Total revenue		$16,692,944
Expenses		
Claims incurred	$13,509,180	
Claims adjustment expenses	1,310,262	
General administrative expenses	2,398,863	
Total expenses		17,218,305
Net loss before federal income taxes		(525,361)
Federal income taxes incurred		(2,815)
Net loss		$ (522,546)

Changes in Surplus

	Gains in Surplus	Losses in Surplus	
Surplus, per report on examination, as of December 31, 2007			$ 2,364,355
Net loss		$ 522,546	
Change in net unrealized capital gains		148,672	
Change in not admitted assets	$ 1,389	-	
Net decrease in surplus			(669,829)
Surplus, per report on examination, as of December 31, 2010			$ 1,694,526

5. CLAIMS UNPAID

The examination liability of $3,140,000 for the above captioned account 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 claims unpaid 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 its filed annual statements as verified by the examiner 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.

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. Advertising
C. Complaints
D. Claims processing review

A. Agents and Brokers

Neither of the two Plan's officers, acting as agents, writes direct business without a New York license. It was noted that a portion of new business is derived through direct sales. Furthermore, those involved in the direct sales initiatives (Executive Director and Marketing Manager) are not licensed as agents. Between 2008 and 2011, 6 school contracts were obtained by unlicensed employees of the Plan.

Section 2102(a)(1) of the New York Insurance Law states:

> "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."

It is recommended that the Plan complies with the provisions of Section 2102(a)(1) of the New York Insurance Law.

B. Advertising

The Plan does not maintain a general advertising log of all advertising materials produced in New York. Specifically it was noted that the Plan does not maintain a file of all advertisements produced in accordance with the requirements of Department Regulation No. 34 (11 NYCRR 215.17(a)), which states:

> "(a) Advertising file. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by the department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

It is recommended that the Plan complies with Department Regulation No. 34 (11 NYCRR 215.17(a)) and maintain a log of all advertisements.

C. Complaints

The Plan does not maintain a general complaint log as required by Department Regulation No. 64. The Plan did not maintain a log of the complaints that are not received by the Department's Consumer Services Bureau, in violation of Department Regulation No. 64. New York Insurance Department Office of General Counsel Opinion No. 03-11-22 concludes the following:

> "An authorized insurer is required by regulation 64 to maintain a log of all complaints it receives, irrespective of whether the complaints were also lodged with the New York State Insurance Department."

It is recommended that the Plan complies with Department Regulation No. 64 and maintain a log of complaints received, regardless of whether they are received from the Department's Consumer Service Bureau or by a member/provider or other source.

Furthermore a review of complaints revealed that the Plan does not have a formal policy to respond to complaints. In one particular example, the Plan did not send a copy of its response to the member, which was the original complainant, but rather the response to the complaint was sent to the Department. The Plan's policy indicates that:

> "The Plan will commence the appeal process within 30 days of receiving the required information. A written response will be issued within 5 days of the determination."

It was noted when reviewing complaint files received from the Department that the Plan does not always respond to the person appealing in writing.

It is recommended that the Plan follows its own documented procedures when handling consumer complaints.

D. Claims Processing Review

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

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

Further, New York Insurance Law, Section 3224-a(b) states in part:

> "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…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."

In 2009 and 2010, the Plan experienced an unusually high volume of submitted claims. The Plan could not conclude definitively upon the reason for this. In addition, the Plan's claims group leader and main claims processor were unable to work for an extended period of time due to personal reasons. During that time, claims processing was severely backlogged and claims remained unprocessed for over a month. The Plan was caught unprepared for such events and did not have a plan in place to compensate for such events. To compound the problem, the delayed processing resulted in a substantial increase of duplicate claims, as well as customer complaints and inquiries. The result is that claims sat unprocessed for an extended period, leading to violations of the New York Prompt Pay Law, Sections 3224-(a)(a) and 3224-a(b) as described further below.

It is recommended that the Plan develops a replacement and training plan for the Plan's key claims processors that would provide practical alternatives to minimizing delays during times of claims processing and business interruption.

A claims review to determine compliance with the New York Prompt Pay Law could not be achieved systematically by the examiner due to the way certain dates are accounted for in the Plan's claims system. The claims system does not distinguish the date whereby the claim is eligible for payment. Therefore the "clock start date" can not be utilized to determine the number of days from claim receipt date to the date of adjudication of the claim. Since the Plan is a secondary insurer, requests for documents and coordination of benefits takes place for the majority of its claims. The "clock start

date" or "clock restart date" is essential to determine the number of days taken to adjudicate claims.

It is recommended that the Plan's claims processing system be revised to capture the date a claim becomes eligible for payment, thereby allowing the Plan, as well as the Department examiners, to determine Prompt Pay Law compliance.

A claims review was performed by the examiner using a random sampling methodology covering the claims adjudicated in calendar year 2010, in order to evaluate the overall accuracy and compliance environment of the Plan's claims processing. The sampling process, which was performed using ACL for Windows, an auditing software program, was devised to test various attributes deemed to be necessary for proper processing of claims and compliance with the New York Prompt Pay Law. The sample size comprised of 50 claims.

The review of the 50 claims selected for review revealed that a large percentage were in violation of the Prompt Pay Law. Of the 50 claims, 31 (62%) were in violation of New York Insurance Law Section 3224-a(a). Additionally 16 of the 50 (32%) claims were in violation of New York Insurance Law Section 3224-a(b). These results are reflective of problems encountered by the Plan as described above.

It is recommended that the Plan complies with Sections 3224-a(a) and (b) of the New York Insurance Law.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2007, contained the following nine (9) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO		PAGE NO.
1.	Description of the Plan	
	It is recommended that the Plan report the proper date of its incorporation and commencement of business within its future statutory filings with this Department.	4
	The Plan has complied with this recommendation.	
2.	Management and Controls	
	It is recommended that the Plan amend its by-laws to reflect compliance with Section 4301(k)(1) of the New York Insurance Law. It is further recommended that the Plan's board be constructed to comply with Section 4301(k)(1) of the New York Insurance Law.	7
	The Plan has complied with these recommendations.	
3.	Limitation of Expenses	
	It is recommended that the Plan comply with the requirements of Section 4309(a)(2) of the New York Insurance Law relative to the limitation of expenses.	11
	The Plan has not complied with this recommendation. A similar recommendation is included in this report.	
4.	Approval of Investments	
	It is recommended that the Plan comply with the investment approval requirements of Section 1411(a) of the New York Insurance Law.	11
	The Plan has complied with this recommendation.	

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CPA Contracted Duties

5. It is recommended that the Plan incorporate the principle of segregation of duties and cease the practice of having its CPA firm perform accounting and ancillary functions on the Plan's books of account that such CPA firm also audits. 13

6. It is also recommended that the Plan's board of directors review the practice of having its CPA firm conduct duties which appear to be in conflict with AICPA .01 Rule 101. 13

The Plan has not complied with these recommendations. Similar recommendations are included in this report on examination.

Claims Processing

7. It is recommended that the Plan adopt procedures to complete the adjudication of all claims within twelve months from the date the claim is received. 19

The Plan has complied partially to this recommendation.

8. In addition, it is recommended that the Plan deny claims for which information necessary to process the claim was requested but not received, and issue an EOB to the subscriber in compliance with Section 3234 of the New York Insurance Law. 19

The Plan has complied with this recommendation.

Explanation of Benefits Statements (EOBs)

9. It is recommended that the Plan issue EOBs that include all of the requisite information required by Sections 3234(a) and (b) of the New York Insurance Law. A similar recommendation was included in the prior Report on Examination. 21

The Plan has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

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F. Disaster Response Plan

ii. It is recommended that the Plan re-evaluate and amend its Disaster Response Plan by developing and incorporating the following enhancements and procedures: 18

- Re-evaluate and update the outdated vendor contact list to include current IT hardware and programming consultants to be used in the event of a disaster or disruption to its computer systems and other essential operations.

- Determine alternate (disaster recovery) sites that will provide for necessary IT equipment, as well as space for employees to continue their functions.

- Assess and incorporate steps necessary to continue or regenerate its IT business applications and claims processing in the event of a disaster that disable the Plan's claims processing equipment and facilities.

- Incorporate within the Plan's Disaster Response Plan the processes and procedures related to the Plan's operations and periodically test claims data which has been backed-up on-line or incorporated in a data warehouse for access, accuracy and effectiveness.

- Periodically test existing disaster recovery/business continuity plans and make improvements as deemed necessary.

- Incorporate the guidelines of Department Circular Letter No. 2 (February 17, 2011) within the Plan's Disaster Response Plan.

G. Agents and Brokers

It is recommended that the Plan complies with the provisions of Section 2102(a)(1) of the New York Insurance Law. 23

H. Advertising

It is recommended that the Plan complies with Department Regulation No. 34 (11 NYCRR 215.17(a)) and maintain a log of all advertisements. 23

Appointment No. **30723**

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:

Froilan Estebal

as a proper person to examine into the affairs of the

Pupil Benefits Plan, Inc.

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

Plan

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 8th day of June, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR