REPORT ON EXAMINATION

OF

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2009

DATE OF REPORT	**DECEMBER 12, 2011**
EXAMINERS	**DOUGLAS BARTLETT, CFE**
	KENNETH MERRITT

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December 12, 2011

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 Letter 22402, dated August 20, 2010, attached hereto, we have made an examination into the condition and affairs of Capital District Physicians' Health Plan, Inc., a health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2009, and submit the following report thereon.

The examination was conducted at the home office of Capital District Physicians' Health Plan, Inc. located at 500 Patroon Creek Boulevard, Albany, New York.

Wherever the designations "CDPHP" or the "HMO" appear herein, without qualification, they should be understood to indicate Capital District Physicians' Health Plan, Inc.

A concurrent examination was made of CDPHP Universal Benefits, Inc. ("UBI"), a direct subsidiary of the HMO, which is a not-for-profit medical and indemnity and hospital service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law. A separate report thereon has been submitted. In addition, separate market

conduct examinations into the manner in which CDPHP and UBI conduct their business practices and fulfill their contractual obligations to policyholders and claimants were conducted as of December 31, 2009. Separate reports will be submitted thereon.

Wherever the designation "UBI" appears herein, without qualification, it should be understood to indicate CDPHP Universal Benefits, Inc.

Whenever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services. On October 3, 2011, the New York State Insurance Department merged with the New York State Banking Department to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The HMO was previously examined as of December 31, 2004. This examination of the HMO is a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2009 Edition* (the "Handbook") and it covers the five-year period from January 1, 2005 through December 31, 2009. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2009 were also reviewed.

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 examiners' assessment of risk in the HMO'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 for the HMO. The examiners planned and performed the examination to evaluate the HMO's current financial condition, as well as identify prospective risks that may threaten the future solvency of CDPHP.

The examiners 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 HMO's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the HMO'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 HMO was audited annually for the years 2005 through 2009, by the accounting firm PricewaterhouseCoopers LLP ("PwC"). The HMO received an unqualified opinion in each of those years. Certain audit workpapers of PwC were reviewed and relied upon in conjunction with this examination. A review was also made of CDPHP's Corporate Governance structure, which included its Internal Audit function and Enterprise Risk Management program.

The examiners reviewed the corrective actions taken by the HMO with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiners' review are contained in Item 6 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 HMO

The HMO was formed as a membership corporation on February 27, 1984, under Section 402 of the Not-for-Profit Corporation Law, and incorporated within the State of New York on April 13, 1984. The members consist of physicians licensed by the State of New York. The HMO was licensed as a health maintenance organization pursuant to Article 44 of the New York Public Health Law and obtained its certificate of authority to operate as an independent practice association ("IPA") model HMO, effective April 30, 1984.

As of December 31, 2000, membership in the HMO was opened to physicians licensed by the State of New York, who apply for membership and meet the criteria required by the HMO's by-laws and are accepted as member physicians.

The HMO is exempt from income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code.

A. Management and Controls

The HMO is a physician-controlled corporation. The participating physicians, who are members in good standing with the corporation, constitute a majority of the corporation's board of directors.

Pursuant to the HMO's by-laws, management of the HMO is to be vested in a board of directors ("BOD") consisting of fifteen members. Eight of the fifteen members shall be members of the corporation. The remaining seven directors shall not be members of the corporation. At least three of such non-member directors shall be enrollees of the HMO.

As of the examination date, the board of directors was comprised of fifteen (15) members. The composition of the BOD was in compliance with the HMO's by-laws and Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98). Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98) states, in part:

> *"… no less than one third of the members of the governing authority of an MCO shall be composed of residents of New York State. Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO …"*

The directors of the HMO as of December 31, 2009 were as follows:

Name and Residence	Principal Business Affiliation
James M. Brennan Slingerlands, New York	President, Albany Truck Sales
Peter T. Burkart, MD Averill Park, New York	Hematologist, Capital District Hematology/Oncology
M. Bruce Cohen Albany, New York	Retired, Former PwC Partner
Bruce E. Coplin, MD * Albany, New York	Cardiologist, Albany Associates in Cardiology
Gennaro A. Daniels, MD Troy, New York	Surgeon, Capital District Colon & Rectal Surgery Associates, PC
Daniel Frasca * Valatie, New York	Retired, Executive Director, Finance and Administration, New York State United Teachers
Robert C. Griffin Albany, New York	Principal, Griffin Financial Group
Douglas P. Larsen, DO Voorheesville, New York	Pediatrician
Richard E. Lavigne, MD * Albany, New York	Internal Medicine/Endocrinology, Prime Care Physicians, PC
James C. Leyhane, MD * East Greenbush, New York	Internist, Community Care Physicians, PC
Anthony J. Marinello, MD * Albany, New York	President, Family Care Practitioner, Family Care Practice
William P. Phelan Loudonville, New York	Chief Executive Officer, Bright Hub, Inc.
Martha H. Pofit * Slingerlands, New York	Healthcare Consultant

Name and Residence	Principal Business Affiliation
Stuart A. Rosenberg, MD Albany, New York	Urologist, Capital District Urologic Surgeons, LLP
Kelly A. Waters Rockford, Illinois	President and CEO, IBDG-UK

*Enrollee representative per Part 98-1.11(g) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11(g)).

A review of the minutes of the HMO's BOD meetings held during the period under examination evidenced that the meetings were generally well attended, with all board members attending at least one-half of the meetings they were eligible to attend.

The principal officers of the HMO as of December 31, 2009 were as follows:

Name	**Title**
Peter T. Burkart, MD	Chairman of the Board of Directors
Gennaro A. Daniels, MD	Vice Chairman
John D. Bennett, MD	President and Chief Executive Officer
James M. Brennan	Secretary
Barbara Downs	Senior Vice President, Corporate Administration
Bruce Nash, MD	Senior Vice President, Chief Medical Officer
Linda Navarra	Senior Vice President, Chief Information Officer
Rolando Portocarrero	Senior Vice President, Chief Financial Officer
Robert Hinckley	Senior Vice President, Government/External Relations
Frederick B. Galt	Senior Vice President, General Counsel

B. Corporate Governance

CDPHP has adopted some elements of an Enterprise Risk Management ("ERM") framework for proactively addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*) was utilized by the examiners as guidance for assessing the HMO's corporate governance.

Overall, it was determined that the HMO's corporate governance structure is adequate, sets an appropriate "tone at the top", and supports a proactive approach to operational risk management, including prospective business risk. Additionally, it was noted that CDPHP's BOD and key executives encourage integrity and ethical behavior throughout the organization.

CDPHP has an established Internal Audit Department ("IAD") function, which is independent of management, to serve CDPHP's Audit Committee of the BOD (the "Audit Committee" or "AC"). The AC is comprised entirely of independent directors. The IAD assists all levels of management by reviewing and testing financial and operational controls and processes established by management to ensure compliance with laws, regulations and CDPHP's policies.

During the course of this examination, consideration was given to the significance and potential impact of certain IAD findings. To the extent possible, the examiners relied upon the work performed by the IAD, as prescribed by the Handbook.

The examination noted the following reportable items related to Corporate Governance, IAD and ERM:

1. Internal Audit Manager – Compensation Approval

During the examination period and into calendar year 2010, the Audit Committee reviewed and approved the performance evaluation of the Director of Risk Management, but had no direct role in reviewing and approving the compensation of the Internal Audit Manager. Based upon the Institute of Internal Auditors ("IIA") Standard 1110, at least once a year, the AC should review the performance of the Chief Audit Executive ("CAE") and

approve this individual's annual compensation and salary adjustment. As CDPHP presently does not have a designated CAE, the examiners looked to apply this standard to the highest level IAD supervisor, noting the Internal Audit Manager's position constituted the most senior level IAD resource. It was noted that the responsibilities over the HMO's IT related audits did not lie with the Internal Audit Manager, but are duties that are delegated to CDPHP's Information Security Officer. CDPHP could not provide evidence documenting the approval of the Internal Audit Manager's compensation in the 2009 CDPHP AC minutes.

It is recommended that the Audit Committee be responsible for reviewing and approving the performance evaluation and the salary and variable compensation of the Internal Audit Manager. The AC should also consider reviewing and approving the salary and variable compensation of the Information Security Officer, since this role is responsible for performing Information Technology ("IT") internal audits.

2. Internal Audit Department – Risk Assessment

Historically, the IAD conducted an annual overall risk assessment of the HMO based on nine (9) factors, as detailed in CDPHP's IAD Manual. However, the risk assessment process was not conducted for 2009, which conflicts with CDPHP's existing IAD standards.

The annual risk assessment is a requirement of one of the IIA's Performance Standards, which states the following:

> *"PS 2010.A1 – The internal audit activity's plan of engagements must be based on a documented risk assessment, undertaken at least annually. The input of senior management and the board must be considered in this process."*

In addition, areas that are rated by the IAD as "high" risk are not audited on an annual basis. The guidelines documented by CDPHP's IAD require "high" risk areas to be audited every two years; however, this condition has not been met.

In line with industry best practices, it is recommended that the IAD change its guidelines to require high risk areas be audited annually, instead of every two years. Concurrent with this change, it is recommended that the HMO begin conducting a corporate-wide risk assessment on an annual basis and ensure that high risk areas are audited annually.

3. Integrated Audits with IT

There is no coordination and/or integration of internal audits between the financial and operational internal auditors and the IT internal auditors. Integrated audits are considered a best practice because they not only generally save time and money, but they also address business risk in terms of more integrated findings.

It is recommended that the IAD plan its audits to involve both financial and operational internal auditors along with IT internal auditors, so that the entire process has clearly defined common goals. This method of integrated planning will help ensure that the efforts of the operational and IT internal auditors support each other from the inception of the internal audit.

4. Segregation of Duties Within IT Security, IT Internal Audit and Internal Model Audit Rule (MAR) Testing

The HMO's organizational structure places responsibility for information security governance and IT internal audit with a single individual. In addition, this individual has

considerable responsibility for managing the HMO's readiness efforts of Department Regulation No. 118 (11 NYCRR 89) ("Regulation 118"), which serves as the Department's implementation of the NAIC's Annual Financial Reporting Model Regulation ("Model Audit Rule", or ("MAR") for purposes of this report). This structure creates the potential for a conflict of interest across responsibilities. It was noted that operational aspects of information security lie outside of this organizational structure.

Per guidance from the Information Systems Audit and Control Association ("ISACA"):

> *"Audit independence is a critical component if a business wishes to have an audit function that can add value to the organization. The [internal] audit report and opinion must be free of any bias or influence if the integrity of the audit process is to be valued and recognized for its contribution to the organization's goals and objectives."*

This position is supported throughout the audit industry, including specific guidance from organizations such as the American Institute of Certified Public Accountants ("AICPA") and The Institute of Internal Auditors ("IIA"). Per the IIA website,

> *"The internal auditor occupies a unique position, he or she is employed by management but is also expected to review the conduct of management which can create significant tension since the internal auditor's independence from management is necessary for the auditor to objectively assess the management's action, but the internal auditor's dependence on management for employment is very clear; and to maintain objectivity, internal auditors should have no personal or professional involvement with or allegiance to the area being audited; and should maintain an un-biased and impartial mindset in regard to all engagements."*

It is recommended that the HMO assess its current organizational and staffing structure with consideration given to segregating responsibilities for information security governance, IT internal audit, and management of internal testing. This assessment should

consider all aspects of information security governance and operations, IT internal audit and administrative responsibilities related to management's testing of controls.

C. Reinsurance

The HMO utilized two excess-of-loss reinsurance agreements, in order to limit its exposure to losses from catastrophic inpatient claims. At December 31, 2009, these reinsurance agreements were as follows:

(i) Excess of loss reinsurance agreement with Carter Insurance Company, LTD ("Carter") of Hamilton, Bermuda, which is a 100% wholly-owned subsidiary of the HMO. Carter, which is not licensed or accredited as an authorized reinsurer in the State of New York, was organized and began operations on January 1, 2004, for the purpose of providing reinsurance coverage to the HMO and UBI. Carter assumes 85% of the inpatient hospital services up to $725,000, in excess of $400,000, for claims paid under CDPHP and UBI contracts.

(ii) A second layer excess-of-loss reinsurance agreement with HCC Life Insurance Company ("HCC"), an unaffiliated accredited reinsurance carrier, which covers the Commercial HMO and Medicare Choice line of business. With certain exclusions and limitations, HCC assumes 90% of the inpatient hospital services after a $725,000 deductible, subject to a maximum of $2,000,000 of covered expenses, per member, per contract period.

Both reinsurance agreements contained the insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

D. Territory and Plan of Operation

The HMO's service area, as stated in its Certificate of Authority, as revised May 25, 2001, includes the following twenty-four (24) counties in the State of New York:

Albany	Essex	Montgomery	Schenectady
Broome	Fulton	Oneida	Schoharie
Chenango	Greene	Orange	Tioga
Columbia	Hamilton	Otsego	Ulster
Delaware	Herkimer	Rensselaer	Warren
Dutchess	Madison	Saratoga	Washington

The HMO provides a comprehensive prepaid health program by means of a network of participating physicians. Subscribers to the HMO select a participating physician who acts as their primary care physician. This physician refers members to other participating HMO physicians when particular medical specialties are required. Except for services specifically excluded or limited in the HMO's contracts or riders, there is no limit to duration, frequency or type of health care provided, as long as the care is directly provided or pre-authorized by the HMO's medical director and/or the primary care physician.

Inpatient hospital services are rendered as directed by the HMO's participating physicians. The HMO pays hospital charges through direct hospital billing. Out-of-area emergency care is provided for in the subscriber contracts.

The HMO's member enrollment as of December 31 for the years under examination was as follows:

	2005	2006	2007	2008	2009
Members	254,265	260,170	250,793	249,461	241,086
% change	(14.44%)	+2.32%	(3.60%)	(0.53%)	(3.36%)

In addition to its Commercial HMO coverage offered to employer groups and non-subsidized individuals, the HMO offers Medicare Advantage, Medicaid, Family Health Plus, Healthy New York and Child Health Plus. The enrollment that corresponds to these various lines of business during the examination period was as follows:

	2005	2006	2007	2008	2009
Medicare	10,444	11,663	13,626	19,620	21,276
Medicaid	36,907	35,548	40,968	43,889	52,048
Family Health Plus	6,130	6,665	6,500	5,517	4,786
Child Health Plus	14,925	18,425	18,230	17,729	18,673
Healthy New York	6,197	5,888	6,723	8,379	9,083
Commercial, HMO only	179,662	181,981	164,746	154,327	135,220
Totals	254,265	260,170	250,793	249,461	241,086

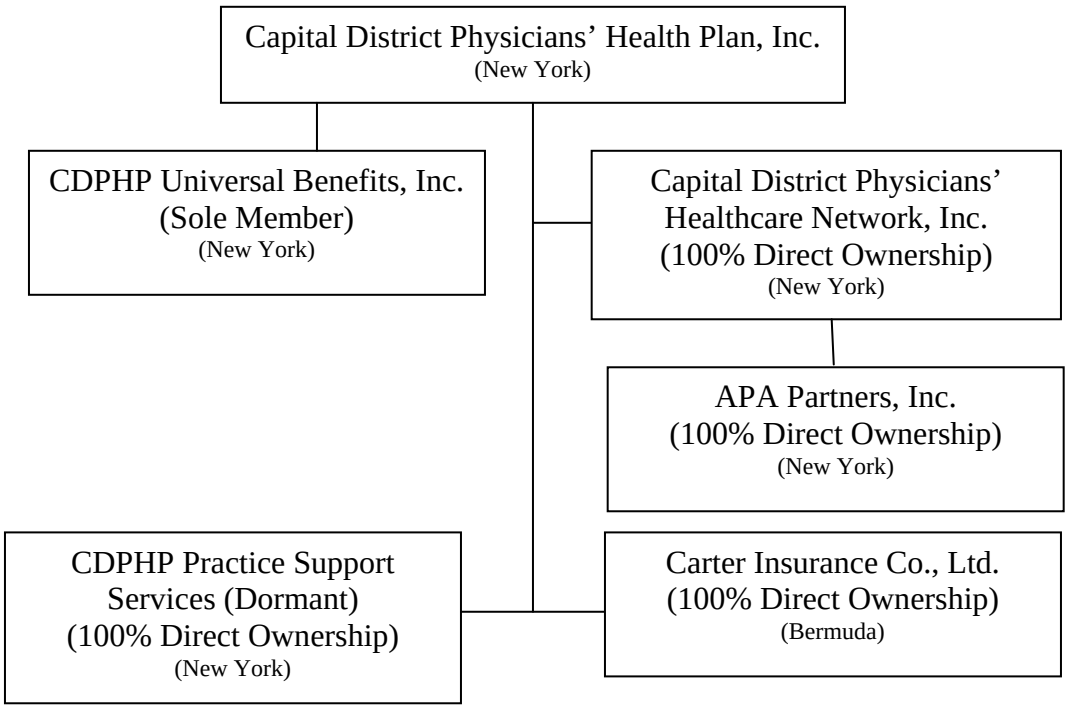
The HMO does business through the use of an internal sales force, as well as through the utilization of independent agents and brokers. Community rated premiums, as such term is defined in Section 4317(a) of the New York Insurance Law, and as filed with the Superintendent, are applicable to all enrollees.

The following table displays CDPHP's net admitted assets, capital and surplus, net premium income and net income during the period under examination:

Year	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income
2009	$404,455,968	$230,310,025	$1,025,074,140	$30,698,334
2008	345,855,556	206,531,049	960,443,043	14,377,246
2007	338,340,592	209,319,373	886,673,853	38,348,766
2006	301,525,096	179,882,607	844,040,951	34,450,486
2005	259,708,741	147,193,124	772,746,626	24,638,084

E. Holding Company System

The following chart depicts the HMO's holding company system as of December 31, 2009:



Below is a description of each entity's organizational structure and operating activities:

(i) CDPHP Universal Benefits, Inc. ("UBI")

UBI was incorporated on February 28, 1997, under Section 402 of the Not-for-Profit Corporation Law and was licensed on August 14, 1997, pursuant to the provisions of Article 43 of the New York Insurance Law. UBI is an indemnity carrier, initially offering the out-of-network portion of the Point-of-Service product for which CDPHP provides in-network benefits. UBI also offers stand-alone indemnity coverage such as Preferred Provider Option and Exclusive Provider Option contracts.

(ii) Capital District Physicians' Healthcare Network, Inc. ("CDPHN")

CDPHN, a wholly-owned subsidiary of CDPHP, was incorporated on June 14, 1991. CDPHN was organized for the purpose of providing managed care and administrative support services to self-insured employers. The reported net equity for CDPHP in its CDPHN subsidiary as of December 31, 2009 was $806,877.

(iii) APA Partners, Inc. ("APA")

During 2004, CDPHN acquired APA Partners, Inc., which provides third-party administrative services. During 2008, the HMO's BOD approved management's plan that beginning in 2010, APA would no longer accept new contracts for dental or vision insurance benefits or third-party administrators services under the APA Brand. During the transition and thereafter, the operations and future offerings of dental and vision benefits will be transferred to CDPHN, parent of APA. Third-party administrator benefits will no longer be offered beginning in 2010, with the potential of some benefits terminating during 2011.

(iv) CDPHP Practice Support Services ("PSS")

PSS is a wholly-owned subsidiary of CDPHP, which was incorporated on May 9, 1994. PSS was organized for the purpose of providing management support services to participating providers. PSS became dormant in 1997; therefore, it did not conduct business during the examination period.

(v) Carter Insurance Company, Ltd. ("Carter")

Carter, an unauthorized reinsurer, was incorporated in November 2003, in Bermuda as a for-profit corporation and began operations on January 1, 2004. The HMO made a capital contribution of $1,000,000 in this subsidiary during November 2003 and received in return 120,000 shares of stock, which represents 100% of common stock issued. At the examination date, Carter was valued at $1,903,474 by the HMO, which represented the net equity of Carter at such date.

The HMO maintains administrative service agreements with its subsidiaries, CDPHP Universal Benefits, Inc. ("UBI") and Capital District Physicians' Healthcare Network, Inc. ("CDPHN"), whereby various services are provided to the subsidiaries by the HMO. These services include, but are not limited to: financial, legal, internal operations, management information systems, marketing, consultation, utilization review services, claims administration, developing, revising, and refining new health care services products, systems, policies and overall administration. The aforementioned agreement between CDPHP and UBI, was approved by the Department on February 2, 2006.

As established by the administrative service agreements, premiums for the subsidiaries are collected by CDPHP and disbursed to the subsidiaries on a monthly basis. The agreements also establish the requirement that the HMO be reimbursed monthly for actual costs incurred. The inter-company payables and receivables were settled in a timely manner.

F. Accounts and Records

Per the 2009 NAIC Handbook, in order to complete an examination under the risk-focused examination ("RFE") approach, examiners must consider and evaluate the HMO's established risk management processes. Understanding how the HMO identifies, controls, monitors, evaluates and responds to risks enhances the examiner's consideration of current and prospective risk areas and assists with the appropriate determination of detailed examination procedures that should be performed in Phase 5 (Substantive Examination Procedures) of the RFE approach.

Under the RFE approach, and in compliance with the Sarbanes-Oxley Act of 2002, for public companies and in accordance with the new risk assessment standards (in particular Statement of Auditing Standards ("SASs") 109 and 110), and Department Regulation No. 118, required for private companies, documentation of the internal controls must be available for review. The extent of documentation pertaining to a company's risk mitigation strategies varies based on the size and structure of the company and of its holding company group.

Further under the RFE approach, all available information should be considered and evaluated for each examination. Examiners are not expected to create internal control documentation if it is not present at the company at the onset of the examination.

Regardless of the documentation available, the examiner should determine whether effective controls are in place and adequately mitigate the identified risks. In instances where the examiner can preliminarily determine and document that effective controls do not exist, or would be inefficient to test, no control testing would be required.

The examiners considered the HMO's internal control environment, including the Information Technology General Controls ("ITGC"). In particular, the examiners considered certain ITGC control weaknesses and gaps, identified by the HMO during calendar year 2010, as part of its Department Regulation No. 118 compliance efforts, which were determined to likely have existed as of December 31, 2009 and prior. 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 HMO's key functional areas for the examination period. Accordingly, the examination team took a non-controls reliance strategy for the current financial examination period that covers January 1, 2005 through December 31, 2009. Therefore, the examiners did not test controls in Phase 3 (Risk Mitigation Strategy/Controls Assessment) of the RFE and, for the purposes of determining residual risk, concluded that the internal control environment for the key functional activities (e.g., significant processes) could not be relied upon.

During 2010, the HMO began implementing changes to strengthen its internal control environment in order to mitigate the risks in the key functional activities as part of the HMO's compliance with Department Regulation No. 118.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with those reported by CDPHP in its filed annual statement as of December 31, 2009:

	Examination	HMO	Surplus Increase/ (Decrease)
Assets			
Bonds	$199,373,872	$199,373,872	
Common stocks	7,064,169	7,064,169	
Cash and cash equivalents	65,300,116	65,300,116	
Short-term investments	6,896,095	6,896,095	
Other invested assets	22,330,910	0	$ 22,330,910
Interest income due and accrued	1,950,398	1,950,398	
Uncollected premiums and agents' balances in the course of collection	46,264,182	46,264,182	
Deferred premiums, agents' balances and installments booked but deferred and not yet due	596,507	596,507	
Accrued retrospective premiums	(375,698)	(375,698)	
Amounts recoverable from reinsurers	915,312	915,312	
Electronic data processing equipment and software	43,188,413	43,188,413	
Amounts due from parents, subsidiaries and affiliates	1,600,021	1,600,021	
Healthcare and other amounts receivable	9,351,671	9,351,671	
CDPHP-UBI surplus notes receivable	0	22,330,910	(22,330,910)
Total assets	$404,455,968	$404,455,968	

	Examination	HMO	Surplus Increase/ (Decrease)
Liabilities			
Claims unpaid	$ 101,703,454	$101,703,454	
Accrued medical incentive pool and bonus amounts	3,538,415	3,538,415	
Unpaid claims adjustment expenses	2,147,283	2,147,283	
Premiums received in advance	14,660,592	14,660,592	
General expenses due and accrued	34,473,392	34,473,392	
Amounts due to parent, subsidiaries and affiliates	17,622,807	17,622,807	
Total liabilities	$ 174,145,943	$174,145,943	
Capital and Surplus			
New York State contingency reserves	$ 97,581,656	$ 97,581,656	
Unassigned funds	132,728,369	132,728,369	
Total capital and surplus	$ 230,310,025	$ 230,310,025	
Total liabilities, capital and surplus	$ 404,455,968	$ 404,455,968	

Note 1: The HMO is not subject to audits by the Internal Revenue Service based on its existing tax exempt status, which will continue as long as, its business of providing health insurance coverage remains as CDPHP's predominant business operation. Accordingly, the HMO has never undergone any IRS audits since its inception. The examiners are unaware of any potential exposure of the HMO to any tax 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 $106,552,246 during the five-year examination period, January 1, 2005 through December 31, 2009, detailed as follows:

Revenue		
Premium income		$ 4,488,978,613
Hospital and medical expenses		
Hospital / medical benefits	$ 2,907,399,366	
Other professional services	153,148,816	
Emergency room and out of area	102,217,874	
Prescription drugs	634,006,603	
Regulatory charges	122,391,309	
Incentive pool, withheld adjustments and bonus amounts	19,496,741	
Net reinsurance recoveries	(29,591,139)	
Total hospital and medical benefits	$ 3,909,069,570	
Claims adjustment expenses	191,369,851	
General administrative expenses	291,745,607	
Increase in reserves for life and accident and health contracts	(1,643,634)	
Total underwriting deductions		$ 4,390,541,394
Net underwriting gain		$ 98,437,219
Net investment income earned	46,418,610	
Net realized capital gains	(2,342,913)	
Net investment income		44,075,697
Net income before federal and foreign income taxes		$ 142,512,916
Federal and foreign income taxes incurred		0
Net income		$ 142,512,916

Changes in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2004			$ 123,757,779
	Gains in Surplus	Losses in Surplus	
Net income	$ 142,512,916		
Net change in unrealized capital gains and (losses)		$ 14,798,124	
Change in non-admitted assets		22,528,467	
Aggregate write-ins for gains (or losses) to surplus	1,365,921		
Net change in capital and surplus			$ 106,552,246
Capital and surplus, per report on examination, as of December 31, 2009			$ 230,310,025

4. SURPLUS NOTES RECEIVABLE

The examiners have reclassified the HMO's investment in UBI's Surplus Notes Receivable ("CDPHP-UBI surplus notes receivable"). CDPHP recorded the Surplus Notes as an "aggregate write-in for other than invested assets" in its balance sheet as of December 31, 2009. According to the NAIC Annual Statement Instructions, the Surplus Notes should have been recorded in Schedule BA: Other Invested Assets.

It is recommended that the HMO record its Surplus Notes Receivable on Schedule BA of its Annual Statement on a going forward basis.

5. CLAIMS UNPAID

The examination liability of $101,703,454 for the above captioned account is the same as the $101,703,454 amount reported by the HMO in its filed annual statement as of December 31, 2009.

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 HMO's internal records and in its filed annual statements as verified by the examiners.

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 HMO's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2009.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2004, contained twenty (20) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Management	
1.	It is recommended that the HMO revise its compensation program to eliminate profitability as a factor in the compensation package offered to its officers and employees.	7
	The HMO has complied with this recommendation.	
	Reinsurance	
2.	It is recommended that, in future statements, the HMO report reinsurance recoverable balances as a non-admitted asset from an unauthorized reinsurer unless the HMO maintains appropriate credit in compliance with SSAP No. 61, Paragraph 42.	11
	The HMO has complied with this recommendation.	
	Holding Company System	
3.	It is recommended that the HMO comply with New York State Insurance Law 1307(d) and obtain Superintendent approval for the two loans it made to its subsidiary, UBI, during 2004. It is further recommended that the HMO desist from making further such loans until the Superintendent approval has been obtained.	17
	The HMO has complied with this recommendation.	

ITEM NO.		PAGE NO.
	Investments	
4.	It is recommended that CDPHP's Office of General Counsel must review each contract with a financial advisor, consultant, broker, dealer, custodian agent or auditor, or with any other financial intermediary of financial service provider concerning the information, implementation, monitoring, management or review of any investment activity. Each contract must accurately state all material items and conditions of the contract and state clearly the respective material duties and obligations of each party to that contract. CDPHP, its directors, officers, employees, or agents may execute any such contract only after CDPHP's General Counsel has approved such contract. *The HMO has complied with this recommendation.*	17
5.	The Department will not deem to be a contract, any letter of intent or functionally similar document that provides, in any form, that the parties intend to enter into a contract at some other date or by some other instrument. *The HMO has complied with this recommendation.*	17
6.	These requirements are in addition to, and not in lieu of, any other requests or demands that the Department is otherwise authorized to make regarding CDPHP's contracts, book, or records. CDPHP's General Counsel will make and maintain a record of the review and approval of each contract by means of a review and approval log, email, or similar physical, written, or electronic record. This record must be available to New York Insurance Department examining personnel immediately upon request. CDPHP will deliver all contracts and records, or copies of such contracts and records, to a New York Insurance Department examiner within the time established by such examiner after a New York Insurance Department request for those or similar items. In no event shall such established time for response or delivery be less than ten (10) business days. If the examiner has not established a time within which contracts, records, or copies thereof are to be delivered, all contracts, records, or copies thereof must be delivered to an examiner no more than twenty (20) business days after the date on which the Department has requested those items. *The HMO has complied with this recommendation.*	17

ITEM NO.		PAGE NO.
7.	It is recommended that the HMO must provide the Department's Capital Markets Bureau (CMB) with the initial investment advisory reports produced by Wells, Canning in 2006 or an outline of services rendered in 2006. *The HMO has complied with this recommendation.*	18
8.	It is recommended that the HMO require Wells, Canning to produce written reports detailing its review of CDPHP's Investment managers periodically during the year. *The HMO has complied with this recommendation.*	18
9.	It is recommended that, subsequent to changes implemented in the investment policy and associate benchmarks, that CDPHP provide these revisions in writing to CMB for its review. *The HMO has complied with this recommendation.*	18
10.	It is recommended that any amended investment management agreements between CDPHP and its investment managers, BlackRock and Conning Asset Management, be furnished to CMB for its review. *The HMO has complied with this recommendation.*	18
	Provider/TPA Arrangements	
11.	It is recommended that the HMO clarify within its provider contracts the methodology to be utilized in the calculation of withhold. *The HMO has not complied with this recommendation.* However, the HMO will implement the recommendation the next time CDPHP amends its participating physician agreement templates and moves its providers to that template. CDPHP will amend its participating physician's agreements accordingly when a new template is filed which is expected to occur in year 2011 after the Department of Health amends its provider contracting guidelines.	19

ITEM NO.		PAGE NO.
	Accounts and Records	
12.	It is recommended that the HMO's board of directors establish a dollar level at which claim checks must be personally signed by an authorized signatory.	20
	The HMO has complied with this recommendation.	
13.	It is recommended that the HMO comply with SSAP No. 70 and properly allocate investment expenses within its Annual Statement, Underwriting and Expense Exhibit, Part 3, Analysis of Expenses.	21
	The HMO has complied with this recommendation.	
14.	It is recommended that the HMO comply with SSAP No. 84 and 64 and report assets and liabilities separately unless otherwise permitted.	22
	The HMO has complied with this recommendation.	
15.	It is recommended that the HMO comply with SSAP No. 84, Paragraph 16 and report as admitted assets only those provider advances for which it has formal agreements.	22
	The HMO has complied with this recommendation.	
16.	It is recommended that the HMO comply with SSAP No. 54, Paragraph 18 and establish premium deficiency reserves for the appropriate contract term.	22
	The HMO has complied with this recommendation.	
17.	It is recommended that the HMO ensure that those sums recorded as advance premiums only represent premiums not yet due.	22
	The HMO has complied with this recommendation.	

ITEM NO.		PAGE NO.
18.	It is recommended that the HMO comply with SSAP No. 6, Paragraph 9(a) in calculating non-admitted assets. *The HMO complied with this recommendation.*	24
19.	It is recommended that the HMO comply with the annual statement instructions and appropriately report its gross premiums receivables and non-admitted asset premium receivable on the annual statement. *The HMO has complied with this recommendation.*	22
20.	It is recommended that the HMO report the proper aging of its premium receivable on its annual statement Exhibit 3 - Accident and Health Premiums Due and Unpaid. *The HMO has complied with this recommendation.*	24

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	**Corporate Governance**	
i.	It is recommended that the Audit Committee be responsible for reviewing and approving the performance evaluation and the salary and variable compensation of the Internal Audit Manager. The AC should also consider reviewing and approving the salary and variable compensation of the Information Security Officer, since this role is responsible for performing Information Technology ("IT") internal audits.	9
ii.	In line with industry best practices, it is recommended that the IAD change its guidelines to require high risk areas be audited annually, instead of every two years. Concurrent with this change, it is recommended that the HMO begin conducting a corporate-wide risk assessment on an annual basis and ensure that high risk areas are audited annually.	10
iii.	It is recommended that the IAD plan its audits to involve both financial and operational internal auditors along with IT internal auditors so that the entire process has clearly defined common goals. This method of integrated planning will help ensure that the efforts of the operational and IT internal auditors support each other from the inception of the internal audit.	10
iv.	It is recommended that the HMO assess its current organizational and staffing structure with consideration given to segregating responsibilities for information security governance, IT internal audit, and management of internal testing. This assessment should consider all aspects of information security governance and operations, IT internal audit and administrative responsibilities related to management's testing of controls.	11
B.	**Surplus Notes Receivable**	
	It is recommended that the HMO record its Surplus Notes Receivable on Schedule BA of its Annual Statement on a going forward basis.	23

Appointment No. **22402**

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:

RSM McGladrey, Inc.

as a proper person to examine into the affairs of the

Capital District Physicians Health Plan, Inc.

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

Plan

with such other information as it 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 20th day of August, 2010

James J. Wrynn
Superintendent of Insurance