REPORT ON EXAMINATION

OF

THE HEALTH CARE PLAN, INC.

AS OF

SEPTEMBER 30, 2000

DATE OF REPORT **JANUARY 31, 2002**

EXAMINER **ROBERT W. McLAUGHLIN, CFE, CIE**

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August 17, 2001

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 21524 dated April 10, 2000, attached hereto, I have made an examination into the condition and affairs of The Health Care Plan, Inc., as of September 30, 2000, and submit the following report thereon.

The examination was conducted at the Company's home office located at 205 Park Club Lane, Buffalo, New York 12221

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Whenever the designations "HCP", "Univera – WNY" or "the Plan" appear herein without qualification, they should be understood to mean Health Care Plan, Incorporated.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1996. This examination covers the period from January 1, 1997, through September 30, 2000. Where deemed appropriate, transactions occurring subsequent to this period were also reviewed. The examination comprised a complete verification of assets and liabilities as of September 30, 2000, a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items called for in the Examiners Handbook of the National Association of Insurance Commissioners:

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

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations 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 are deemed to require explanation or description.

A systems review was also made of the Plan's computer system and processes. A separate Report on Examination as of November 17, 2000 was made relative to the findings of the systems review.

2. DESCRIPTION OF PLAN

Health Care Plan, Inc. is a health maintenance organization (HMO) which offers prepaid comprehensive health care benefits to subscribers. The Plan was incorporated on September 30, 1976. Effective August 31, 1978, HCP became federally qualified. HCP received authority to operate pursuant to Article 44 of the New York State Public Health Law and Article 43 of the New York Insurance Law on September 1, 1978, and September 8, 1978, respectively.

In 1999, the Plan filed a Certificate of an assumed name, Univera Healthcare – WNY, with the New York Department of State.

A. Management

The sole member of the Plan is Univera Healthcare Foundation, Inc. (UHF), a corporation as defined in Section 102(a)(5) of the Not-For-Profit Corporation Law. Univera Healthcare Foundation, Inc. formerly known as HCP Foundation, Inc., was formed in 1989 for the principal purposes of advancing research in the organization and delivery of medical, health and hospital services, and medical research.

In 1998, UHF's Certificate of Incorporation was amended to change the corporate purposes to include that of a supporting organization under Section 509(a)(3) of the U.S. Internal Revenue Code of 1986 and to specifically identify The Health Care Plan, Inc., Health Services Medical Corporation of Central New York (Univera Healthcare – CNY, Inc.) and Health Services Association of Central New York, Inc. as supported organizations.

As of September 30, 2000, pursuant to UHF's Certificate of Incorporation and by-laws, its members consisted of two groups. The Class A member group was comprised of six (6) individuals who

were directors of Univera Healthcare – CNY, Inc. The Class B member group was comprised of seven (7) individuals, who are directors of The Health Care Plan, Inc.

As of September 30, 2000, the Plan's board of directors was comprised of eleven (11) members and one (1) vacancy. In accordance with its by-laws, the board meets at least once in each calendar quarter.

The directors as of September 30, 2000, were as follows:

Name and Residence	**Principal Business Affiliation**
Provider Representatives	
James P. Nolan M.D.* Snyder, NY	Chairman-Department of Medicine Erie County Medical Center
Arthur R. Goshin, M.D.* East Amherst, NY	President and CEO, The Health Care Plan, Inc.
Public Representatives	
Steven C. Ames Williamsville, NY	Retired
George Deptula Syracuse, NY	Hiscock & Barclay, LLP

Name and Residence	**Principal Business Affiliation**
Louis P. Dudek Orchard Park, NY	Retired
Bertha S. Laury* Buffalo, NY	Retired Associate Dean of Community Affairs, School of Social Work,
James L. Magavern, Esq. Buffalo, NY	Attorney, Magavern, Magavern, & Grimm
Thomas J. Mulvey West Seneca, NY	Retired
Geraldine Ochocinska Amherst, NY	Assistant Director, Region 9 United Auto Workers
Theodore Scallon Syracuse, NY	Vice President, M&T Bank
Vacancy	
Officer/Employee Frederick F. Yanni Baldwinsville, NY	Chairman, The Health Care Plan, Inc.

* Executive Committee Member

As noted above, the Plan's board at September 30, 2000 consisted of eleven (11) members with one (1) vacancy. The by-laws of the Company provide that the corporation shall be managed by a board of directors comprised of not more than fifteen (15), nor less than seven (7) voting directors. However, Section 1201(a)(5)(B)(v) of the New York Insurance Law) establishes that the charter must fix the number of directors at no less than thirteen. Section 1201(a)(5)(B)(v) of the New York Insurance Law states as follows:

> " *The corporation's proposed charter shall state:*
>
> (*v) the number of directors, or that it shall be not less than a stated minimum nor more than a stated maximum. Except as provided in section six thousand four hundred two of this chapter the number of directors shall not be less than thirteen, ...*"

It is recommended that the Plan comply with Section 1201(a)(5)(B)(v) of the New York Insurance Law and amend its charter and by-laws in order to fix the number of board members at not less than thirteen (13).

At September 30, 2000, the Plan's board consisted of eight (8) public representatives, two (2) provider representatives, one of which was also an officer/employee member, zero (0) subscriber representatives and one (1) designated officer employee representative.

Section 4301(k)(1)(A)&(B) of the New York Insurance Law provides for equal representation, as nearly as possible, relative to subscriber and public representatives on the board of directors.

It is thus recommended that the number of directors on the Plan's board representative of subscribers and the number of directors representative of the public be as equal as possible in compliance with Section 4301(k)(1)(A)&(B) of the New York Insurance Law.

The minutes of all meetings of the Board of Directors and committees thereof held during the examination period were reviewed. All board meetings held during the examination period were well attended.

During the examination period, investment purchases were not acted upon or approved by the Plan's board of directors. Section 1411(a) of the New York Insurance law requires all investment purchases be authorized or approved by the Plan's board of directors.

It is recommended that the Plan comply with the investment authorization or approval requirements of Section 1411(a) of the New York Insurance Law.

It was noted that minutes of the Plan's Committee meetings were not taken in all instances during the examination period.

It is recommended that the Plan maintain minutes of all Committee meetings held by the Plan.

The prior report on examination noted that four vacancies existed on the Plan's Executive Committee and recommended that the Plan fill the vacancies. In September, 1998, the Plan revised its by-laws to provide for an Executive Committee composed of five (5) or more members consisting of the Chair, President and three (3) or more additional directors. As of September 30, 2000, the Plan's Executive Committee consisted of four (4) members.

It is recommended that the Plan comply with Section 5.02 of its by-laws and fill all vacancies on its Executive Committee.

The principal officers of the Plan, at September 30, 2000, were as follows:

Name	**Title**
Frederick F. Yanni	Chair, Board of Directors
Bertha S. Laury	*Vice Chair, Board of Directors
Theodore Scallon	*Vice Chair, Board of Directors
Arthur R. Goshin, MD	President and CEO
James P. Nolan, MD	Treasurer
Stephen C. Ames	Secretary
Timothy J. Finan	Executive Vice President & COO
Samuel S. Rabkin	Sr. Vice President, General Counsel & Assistant Secretary
Lesleylinda K. Lannan	Sr. Vice President, Marketing
Robert L. Ludwig	Sr. Vice President, Information Systems
Paul H. Huefner	Vice President, Finance
Marcia Metcalfe	Vice President, Health Insurance Development
Ronald S. Mornelli	Vice President, Program Operations
Virginia E. Parysek	Vice President, Human Resources
Thomas W. Smith	Vice President, Budget and Strategic Development

*The position of Vice Chair, Board of Directors is a shared position.

A review of the Plan’s minutes of meetings indicated that, since 1998, the Plan’s Secretary and Treasurer were not elected on an annual basis. Article IV, Section 4.01(4) of the Plan’s by-laws states in part,

" The Secretary and Treasurer shall be elected at the annual meeting of the Board. Each officer shall hold office until the next annual meeting of the Board..."

It is recommended that the Plan elect its Secretary and Treasurer on an annual basis in compliance with its by-laws.

B. Territory and Plan of Operation

The Plan is licensed to do business as a non-profit health service corporation within this State pursuant to the provisions of Article 43 of the New York Insurance Law.

The Plan also holds a Certificate of Authority to operate as a health maintenance organization pursuant to Article 44 of the New York State Public Health Law within the following eight counties of New York State:

Allegany	Genesee
Cattaraugus	Niagara
Chautauqua	Orleans
Erie	Wyoming

The Plan offers its subscribers a choice of two delivery systems for its HMO business. The Medical Centers Option provides prepaid comprehensive health care primarily through the Plan's seven medical centers supplemented by arrangements with outside specialists and hospitals. The Network Option provides the same prepaid comprehensive health care through independent participating community

physicians and providers. Both delivery systems utilize a primary care physician (PCP) to coordinate medical care.

The Plan, during the examination period, instituted a contract termed “Univera Access” whereby a member in the Network Option may obtain treatment for necessary medical care without a primary care physician’s approval.

The Plan provides Medicare benefits to eligible recipients. By agreement with the Health Care Financing Administration, a division of the United States Department of Health and Human Services, HCP provides a Medicare cost reimbursement program and a Medicare risk reimbursement program under its Medical Centers Option. Network Option coverage is available under the Plan’s “Senior Choice” contract.

Non-subscribers are able to utilize the medical centers subject to a fee for service charge.

Risk Sharing

Services are provided to Plan subscribers choosing the Medical Centers Option by Promedicus Health Group (formed through the merger of Medical Partners, L.L.P. and another physician practice group, Buffalo Family Practice). A copy of an executed agreement, effective January 1, 1997, between the Plan and Medical Partners, L.L.P (MP) provided to the examiners by

the Plan did not include the terms and conditions regarding compensation of MP (now PHG) by the Plan for services provided. This agreement expired on December 31, 1999 and provided for renewal for five (5) years. Negotiations between the Plan and PHG for the renewal period subsequent to 1999 have continued through September 30, 2000 without a signed renewal agreement in place.

The Plan has continued to pay a capitation to PHG based on an estimated cost of services performed by PHG for the Plan's subscribers at the Plan's' medical centers. In addition, the Plan did not present evidence of approval of the existing contract by the New York Department of Health or this Department.

It is recommended that the Plan maintain an executed contract with the Promedicus Health Group, approved by the New York Department of Health or this Department, relative to the services provided by PHG to the Plan and its subscribers.

At September 30, 2000, the Plan maintained agreements with its participating physicians, which provided for specified percentage withholds of fees due these physicians. A 10% withhold applied to primary care physicians (PCPs) with a 12% withhold applicable to specialists. At the end of each year, a settlement is made according to a formula that details performance criteria.

Incentive Fund Withhold Summary
For the Years 1997 - 2000

Year	Retained	Payout

1997	$ 626,512	$ 3,358,945
1998	1,119,352	3,467,811
1999	1,216,874	5,226,890
2000	3,677,396	5,295,637

The withhold amounts are based on physician services only in accordance with a network risk model. A network risk model has been defined by the Plan as a grouping (panel) of five (5) to twenty (20) physicians in which member allowances and claims experience are pooled. The experience of the physician grouping is used as a basis for physician financial incentives. Services such as mental health, vision, pediatric, preventive care and pediatric immunizations are carved out of the risk model and do not have a withhold taken. Facility inpatient and facility outpatient are included in the model but do not have a withhold taken.

Individual providers are grouped into panels (groups of PCPs that aggregate their budget and costs together to share risk). Individual providers receive their withhold pay outs based on a formula which multiplies each of the panel's withhold return percentages for the services rendered to members of the respective panel to each of the individual providers. For individual PCPs, an incentive pay out is based on the proportion of each individual PCP's individual member credits (budget left after debits/costs below stop-loss coverage) to total panel member credits (panel surplus minus total panel withhold below stop loss adjusted for outstanding claims liability).

IPA, Network and Intermediary Capitation Arrangements

The Plan also maintains capitation arrangements with Individual Practice Associations and medical groups. It was noted that the Plan did not maintain contracts with all entities with which it maintains capitation arrangements. At the examination date, the Plan maintained a Letter of Agreement(LOA) with the Catholic IPA. The aforementioned LOA was developed as an interim agreement until a signed contract was negotiated. However, as of the date of this report, the Plan continued its contractual relationship with the Catholic IPA under the LOA which had not been approved by the New York Department of Health or this Department.

The Plan did not provide evidence of prior approval of its IPA and network agreements by the New York Department of Health as required by Part 98-1.8 (10 NYCRR 98-1.8) of the Department of Health Administrative Rules and Regulations.

In addition, the Plan failed to include the required balance sheet and statement of operations for each Independent Practice Association (IPA) with which it contracted in its filed 1997 through 2000 Annual New York Data Requirements Statements.

It is recommended that the Plan maintain complete contracts with all of its capitated providers along with documentation of approval of such contracts by the New York Department of Health.

It is further recommended that the Plan include the required balance sheet and statement of operations for each Independent Practice Association (IPA) with which it has contracted in its filed 1999 and 2000 New York Data Requirements Statements.

Article 43 business

The Plan provides hospital, medical and other health services through indemnity contracts issued pursuant to its authority under Article 43 of the New York Insurance Law. These contracts are issued to large groups and are experience rated.

ASO contracts

The Plan also offers Administrative Services Only contracts (ASO) to self insured groups, for an administrative service fee.

Enrollment

The Plan markets its contracts to both groups and individuals. Enrollment during the period under review was as follows:

	HMO Membership	Article 43 Membership	Total Membership
December 31, 1997	135,150	15,363	150,513
December 31, 1998	145,635	14,008	159,644
December 31, 1999	171,866	14,048	185,914
December 31, 2000	102,179	72,525	174,704

It is noted that the Plan's Article 43 membership increased from 10.2% to 41.5% of the total membership between December 31, 1997 and December 31, 2000.

C. Reinsurance

At September 30, 2000, the Plan had the following reinsurance program in effect with an authorized reinsurer for its HMO business including Medicare and Point of Service (POS) in and out of network business with an accredited reinsurer:

Hospital Expenses and other eligible expenses

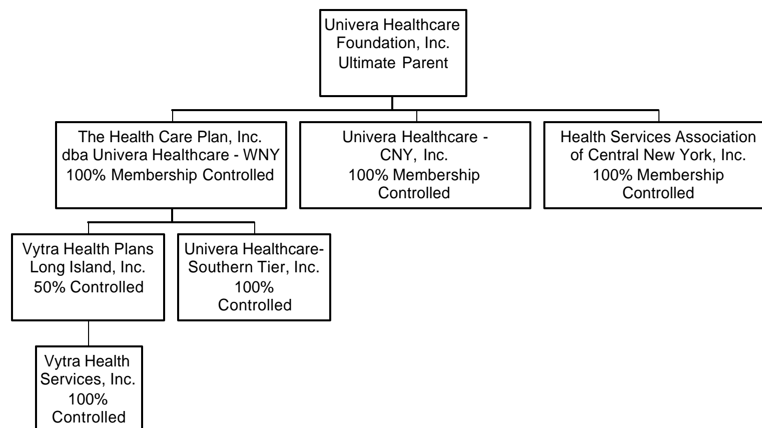
Type	Limits
Excess of loss two layers	
Covered acute care:	80% -90% of $500,000 excess of $200,000 of loss per member, per contract year for approved transplant rates dependent on the type of transplant
	50% of $500,000 excess of $200,000 of loss per member, per contract year for all other transplant rates
Sub-acute care:	
Home health care:	75% of $500,000 excess of $200,000 of loss per member, per contract year
Rehabilitation facility services and skilled nursing facility services:	90% of $500,000 excess of $200,000 of loss per member, per contract year
	100% excess of $700,000 of loss per member, per contract year

The maximum lifetime reinsurance indemnity payable under the contract for eligible hospital services for each member is $2,000,000. Continuation of benefits and out of area conversion benefits provisions are also included in the contracts.

All ceded reinsurance contracts effected during the examination period were reviewed. The contracts contained the standard clauses including insolvency clauses required by Section 1308 of the New York Insurance Law.

D. Holding Company System

The following abbreviated chart depicts the Plan and its relationship to its major affiliates as of September 30, 2000:



Univera Healthcare Foundation, Inc. (UHF)

UHF was the ultimate holding company and sole corporate member of the Plan as of September 30, 2000

UHF, was originally established by The Health Care Plan, Inc., under the name, HCP Foundation, Inc., as a tax exempt charitable foundation in 1989, for the principal purposes of advancing research in the organization and delivery of medical, health and hospital services, and scientific medical research.

In 1998, the HCP Foundation, Inc. Certificate of Incorporation was restated and amended under Section 805 of the New York Not-For-Profit Law to change the corporate purpose of the HCP Foundation, Inc to include that of a supporting organization under Section 509(a)(3) of the United States Internal Revenue Code of 1986 and to specifically identify The Health Care Plan, Inc., Health Services Medical Corporation of Central New York (now known as Univera Healthcare – CNY, Inc.) and Health Services Association of Central New York, Inc. as supported organizations.

In 1999, the Certificate of Incorporation of HCP Foundation, Inc. was amended in order to change its name to Univera Healthcare Foundation, Inc., its current name.

As noted above, the Plan is a controlled insurer of UHF As such, this Department has mandated that the UHF board of directors be determined in accordance with the provisions of Section 4301(k) of the New York Insurance Law.

In 1999, the Plan's board of directors authorized a $600,000 contribution to UHF.

Univera Healthcare – CNY, Inc. (U-CNY)

Univera Healthcare – CNY, Inc. is organized pursuant to the provisions of both Article 43 of the New York Insurance Law and Article 44 of the New York State Public Health Law as a health maintenance organization. On December 3, 1998, U-CNY entered into a merger agreement with Health Services Association of Central New York, Inc. (HSA), The Health Care Plan, Inc.(d/b/a Univera Healthcare – WNY, Inc.) and Univera Healthcare Foundation, Inc. (formerly HCP Foundation, Inc.).

As part of the agreement, UHF became the ultimate parent of each of the three aforementioned organizations as sole corporate member of each organization. As of September 30, 2000, HCP and Univera Healthcare – CNY, Inc. were jointly operated by the Univera Healthcare Foundation, Inc. board of directors and senior officers. Several directors and senior officers of HCP and Univera Healthcare – CNY, Inc. held similar positions in both plans.

During the examination period, Univera - WNY granted a total of $4,500,000 in New York Insurance Law Section 1307 loans to Univera Healthcare – CNY, Inc. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to the approval of the Superintendent of Insurance of the State of New York

In 2000, Univera Healthcare – WNY made a non-subordinated loan in the amount of $1,700,000 to Univera Healthcare, CNY, Inc. In 2001, Univera Healthcare – WNY made additional non-subordinated loans aggregating $5,800,000 to U-CNY.

Section 1505(c)of the New York Insurance Law states:

"The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year end.

Section 1505(d)(1) of the New York Insurance Law states in part:

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

1) sales, purchases, exchanges, loans or extensions of credit, or investments, involving more than one-half of one percent but less than five percent of the insurer's admitted assets at last year end.

With regard to the aforementioned 2000 loan (non-Section 1307), both Univera – WNY and Univera – CNY, as controlled insurers, exceeded the limitation prescribed by Section 1505(d)(1) of the New York Insurance Law by not notifying the Superintendent of Insurance of such transaction at least thirty days prior to making such loan.

With regard to the aforementioned 2001 loans (non-Section 1307), U-CNY and U-WNY violated Section 1505(c) of the New York Insurance Law by not obtaining the Superintendent of Insurance's prior approval for said loans.

It is recommended, pursuant to Section 1505(c) of the New York Insurance Law, that the Plan obtain the approval of the Superintendent of Insurance for its loans made in 2001 to U-CNY. In addition, it is recommended that the Plan, in the future, comply with the notification and prior approval requirements of Section 1505(c) and (d) of the New York Insurance Law.

The Department's examination of Univera HealthCare – CNY found that the HMO was insolvent in the amount of $9.2 million as of September 30, 2000. Further, as of March 31, 2001, Univera Healthcare – CNY, Inc. reported itself insolvent in the amount of $14.7 million.

Health Services Association of Central New York, Inc. (HSA)

Health Services Association of Central New York, Inc. is incorporated as a not for profit corporation under the not for profit laws of this State. As indicated above, the sole member of HSA is Univera Healthcare Foundation, Inc. Pursuant to an agreement with the Plan, HSA provides comprehensive outpatient medical and physician services for Univera Healthcare – CNY subscribers on a capitated basis.

HSA reported itself insolvent in the amount of $7,933,376 and $13,890,261 at December 31, 1999 and December 31, 2000, respectively.

Univera Healthcare – Southern Tier, Inc. (U-ST)

Univera Healthcare – Southern Tier, Inc., formerly known as North American Healthcare, Inc., is a for profit New York Corporation which was issued a certificate of authority on October 4, 1995 to operate an HMO pursuant to Article 44 of the New York State Public Health Law .

On December 30,1999, 100% of the North American Healthcare, Inc.'s capital stock was purchased by The Health Care Plan, Inc. (d/b/a Univera Healthcare – WNY, Inc.). On October 2, 2000, the Plan changed its name to Univera Healthcare – Southern Tier, Inc.

During the examination period, Univera –WNY made a Section 1307 loan in the amount of $1.800,000 to Univera Healthcare – Southern Tier, Inc. As provided in Section 1307, repayment of

principal and interest shall only be made out of free and divisible surplus, subject to the approval of the Superintendent of Insurance of the State of New York

The Department's examination of U– ST found that the HMO was insolvent in the amount of $1.6 million as of September 30, 2000. Further, as of March 31, 2001, U – ST reported itself insolvent in the amount of $357,912.

Vytra Health Plans, Long Island, Inc. (VLI)

This New York Article 44 of the Public Health Law not-for-profit corporation operates as a health maintenance organization from corporate offices located in Melville, New York. It previously operated under the names, Vytra Healthcare, Long Island, Inc. and ChoiceCare Long Island, Inc.

It was formed by the Plan and Winthrop University Hospital through contributions of $1,333,000 and $2,333,000, respectively.

The Plan, during the examination period made aggregate Section 1307 loans to VLI in the amount of $5.5 million. One of the Section 1307 loans, in the amount of $4.5 million was subsequently converted by the parties as a $2 million capital contribution and a $2.5 million Section 1307 loan. The aforementioned conversion, approved by this Department, brought the Plan's net outstanding Section 1307 loans to VLI to $3.5 million at September 30, 2000.

In 1995, the Plan changed its valuation method for VLI from a cost basis to the equity method. The prior Report on Examination contained a recommendation that the Plan comply with the requirements of Regulation 59 which required the approval of the Superintendent prior to changing a subsidiary's valuation methodology.

In 1997 the Plan used the equity method for valuation. This valuation methodology resulted in the Plan carrying an asset on its books that was in excess of the Section 1307 loans granted to Vytra.

In 1998, the Plan valued its investment in VLI on a cost basis (i.e. capital contributions). The Plan continued this method of valuation through December 31, 2000. During this period, the cost-based valuation was in excess of the Plan's "ownership" proportion of VLI's net worth.

Section 1414(c)(2) of the New York Insurance Law requires a subsidiary that is an insurance company *…" to be valued at the lesser of market value or book value as shown by its last annual statement or the last Report on Examination, whichever is more recent"*. Based upon that Section, the Plan's carrying value should have been equal to the lower of the amounts contributed or the Plan's share of the VLI's surplus.

The limitation in the valuation of VLI described above is reflected herein under item 3, Financial Statements.

Subsequent to the examination date VLI was sold for consideration in excess of the value carried by the Plan.

Vytra Health Services Corporation (formerly CCLI Health Services Corporation)

This New York not-for-profit health services corporation is a wholly owned subsidiary of Vytra Health Plans, Long Island. It is licensed to do business pursuant to Article 43 of the New York Insurance Law.

Vytra Healthcare Managed Systems, Inc. (formerly ChoiceCare Managed Systems, Inc.)

On March 26, 1991, ChoiceCare Managed Systems, Inc., (CCMS) was formed as a New York general business corporation by the Plan and Winthrop University Hospital. This for profit corporation is engaged in the business of providing managed health care administrative services. The Plan and Winthrop University Hospital each contributed $50,000 in capital to CCMS.

HealthMed Development, Inc.

This wholly-owned subsidiary, is a New York For-Profit Corporation, formed in 1994, to provide Managed Information System (MIS) consulting, marketing and administrative support services for managed care programs.

The Plan dissolved this subsidiary in June, 2001.

Buffalo Community Health, Inc.(BCH)

The Plan, together with two area hospitals, is a member of this not-for-profit corporation formed in 1996, to establish and operate a prepaid health services plan to serve Medicaid recipients in Erie County, New York. The operations of BCH were expanded, during the examination period, to include the Child Health Plus program. The Plan provided $250,000 in initial capital in 1996.

The Plan provides claims paying and accounting services to Buffalo Community Health. for a monthly fee.

During the prior examination period the Plan formed the following:

1. The Plan and Buffalo General Hospital formed Integrated Care, Inc. in 1993. Integrated Care Inc. is discussed at item 6 of this section of the Report on Examination.

2. In 1994 the Plan formed HealthMed Development Inc., a wholly owned subsidiary, for $1,500,000 in capital contributions.

Subpart 81-2 of the New York Codes, Rules and Regulations (Regulation 115) requires filings to be made to this Department by parent corporations relative to the initial investment in or acquisition of an institution. Regulation 115 also provides for annual information reports (Form IR) to be filed for each subsidiary owned directly or indirectly. The prior examination noted the Plan’s failure to file and

recommended that it do so. In its response to the prior recommendation, the Plan indicated that it would make the required filings.

During the period under review, with the exception of the Plan's Regulation 115 controlled company filing for calendar year 1998, the Plan did not make any of the required Regulation 115 filings.

It is again recommended that the Plan comply with the requirements of Regulation 115 and file the required reports.

E. Significant Operating Ratios

The following ratios have been computed for the period, January 1, 2000 to September 30, 2000 based on the results of this examination:

Premiums written to total reserves and unassigned funds	12:1
Premiums receivable to total reserves and unassigned funds	45.6%
Liabilities to liquid assets	264.2%
Claims and expenses incurred to premiums earned	106.3%

The Plan exceeded the Department's benchmarks for all of the above ratios.

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

	Amounts	Ratios
Premiums earned	$1,275,165,993	
Medical expenses	$1,151,368,875	90.30%

Administrative expenses	164,238,900	12.88%
Underwriting gain (loss)	$ (40,441,782)	(3.18)%

F. Abandoned property

During the period covered by this examination, the Plan still had not established procedures to comply with the provisions of Section 1315 and 1316 of the New York State Abandoned Property Law. No reports were filed by the Plan during the period under review even though the prior two reports on examination contained recommendations to file reports. The Abandoned Property Law requires filings to be made to the Office of the Comptroller of the State of New York each year even if there are no checks to report.

It is recommended that the Plan comply with the reporting requirements of Section 1315 and Section 1316 of the New York State Abandoned Property Law. A similar recommendation was made in the prior two reports on examination.

G. Accounts and Records

A review of the Plan's accounts and records revealed the following:

1. Reporting inaccuracies:

A review of the Plan's Substitute Schedule H filed with the Plan's September 30, 2000 quarterly statement and the Schedule H filed with its December 31, 2000 annual statement, indicated that the Plan did not file all of the required data accurately. The Plan did not report capitation payments as the exhibit

requires, nor amounts withheld, under the appropriate captions within its aforementioned filed Substitute Schedules.

It is recommended that the Plan correctly complete its Schedule H in future filings with this Department.

A review was made of the Plan's Schedule M as filed with the Plan's annual statement as of December 31, 1999. The data included in said schedule reflects data relative to grievances filed under Section 4408-a of the Public Health Law as well as appeals filed pursuant to Article 49 of the Public Health Law.

The review encompassed an examination of the underlying support data used in compiling Schedule M which was included in the Plan's filed December 31, 1999 annual statement. The Plan did not maintain underlying detail which fully supported all data included within said schedule. Several of the amounts included in the Plan's Schedule M did not reconcile to the Plan's supporting data.

In light of the above, it is recommended that the Plan maintain adequate detail records to support the amounts reported in its filed Schedules M.

The Plan failed to complete Report No. 4 – Year to Date Statement of Revenue and Expenses Healthy New York in its filed March 31, 2001 New York Data Requirements quarterly statement.

It is recommended that the Plan comply with the New York Data Requirements statement instructions and complete Report No. 4 – Year To Date Statement of Revenue and Expenses Healthy New York in future filed New York Data Requirements statements.

A review of the Plan's filed 1999 and 2000 New York supplements indicated that the Schedules P included therein did not include all required amounts. The Plan indicated in correspondence to this Department that limitations in its database resulted in the Plan's inability to include data in every cell of Schedule P.

It is recommended that the Plan maintain an appropriate data base relative to its claims history and that Schedule P be properly completed within future statements to this Department.

2. Annual and Quarterly Statement Reports:

The examination review of the Plan's 1999 filed annual statement and September 30, 2000 quarterly statements indicated that the Plan's numerous reporting errors, misclassifications of liability, income and expense items, as outlined in the previous examination, had decreased.

However, annual statement filing errors continued during the examination period that caused the Plan to submit revisions to previously filed schedules and exhibits relative to its 1997, 1998 and 1999 annual statements and the Plan's September 30, 2000 quarterly statement.

In light of the above, it is again recommended that the Plan comply with the annual and quarterly statement instructions and exercise greater care in the preparation of its filed financial statements to this Department.

The Plan made late filings of its December 31, 1999 annual statement and its March 31, 2000 and June 30, 2000 quarterly statements. The Plan reported that the primary reason for the above late filings was reporting problems because of the implementation of its new data processing system. The Plan did subsequently make timely filing of its September 30, 2000 quarterly statement and its December 31, 2000 annual statement.

In order to appraise the Plan's new system and evaluate the procedures that the Plan's management has taken or proposed to take to remediate the problems that have occurred because of the Plan's implementation of its new system, a systems review was conducted as part of the examination. A concurrent systems and processes report, dated February 13, 2001, was made relative to the Plan's systems and processes.

H. Investments and Custodial Agreements

Securities

The Plan, at December 31, 1999, reported three securities which had not been submitted to the NAIC's Security Valuation Office (SVO). The aforementioned securities subsequently matured and are not currently held by the Plan.

It is recommended that the Plan obtain values for all of its securities from the SVO. It is further recommended that the Plan submit all securities which do not have an SVO valuation to the SVO for valuation or dispose of same.

Section 1404(a)(10)(b)(i) of the New York Insurance Law limits the investments in a mutual fund to 10% of admitted assets as shown by the last statement on file with the superintendent. As of December 31, 1999, the Plan had a total of $ 46,770,974 invested in one money market mutual fund. The Plan's investment in excess of the aforementioned limitation was $32,227,745.

The Plan subsequently disposed of this excess investment as required by Section 1212(a).

It is recommended that the Plan closely monitor its investment activity in order to maintain compliance with the applicable sections of Article 14 of the New York Insurance Law.

Custodial Agreements

The review of the Plan's custodial agreements for the safeguarding of securities indicated that the following protective covenants and provisions, which the Department regards as indicative of prudent business practices, were not included in said custodial agreements:

a. The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the insurer 60 days written notice of any material change in the form or amount of such insurance or termination of this coverage.

b. The bank will at all times give the securities held by the bank thereunder the same care the bank gives its own property of a similar nature.

c. The bank shall furnish the insurer (at least quarterly) with a list of such securities showing a complete description of each issue, which shall include the number of shares or par value of bonds so held at the end of each quarter.

d. The bank shall maintain records sufficient to verify information insurers are required to report in the annual statement blanks of the Insurance and Health Departments of the State of New York.

e. The bank shall furnish the insurer with the appropriate affidavits in the form as may be acceptable to the bank and to the New York Insurance Department in order for the securities referred to in such affidavits to be recognized as admitted assets of the insurer.

f. Access shall be during the bank's regular hours and specifying those persons who shall be entitled to examine on the bank's premises securities held by the bank and the bank's records regarding securities held, but only upon furnishing the bank with written instructions to that effect from any specified authorized officer.

g. Written instructions hereunder shall be signed by any two of the insurer's authorized officers specified in a separate list for this purpose which will be furnished to the bank from time to time signed by the treasurer or an assistant and certified under the corporate seal by the secretary or the assistant secretary.

h. In connection with any situation involving registration of securities in the name of a nominee of a bank custodian, the custodian agreement should empower the bank to take such action.

i. The agreement should have a provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal control, pertaining to custodian record keeping, issued by internal control, pertaining to custodian record keeping, issued by internal or independent auditors.

It is recommended that the Plan include the enumerated protective covenants and provisions in all custodial agreements in which the Plan participates.

I. Real Estate

The Plan, in 1999, exceeded the limitations prescribed by Section 1404(a)(5) by $1,139,754 relative to the amounts expended for additions and permanent improvements without the approval of the Superintendent of Insurance relative to three of its medical centers.

Section 1404(a)(5)(v) states in part:

" Except with the superintendent's approval, no domestic insurer shall:…(II) with respect to any building which was acquired under items (i) and(ii) of subparagraph (A) of this paragraph, make any improvement which should be capitalized according to generally accounting principles if the annual expenditure for such improvements for any such building will exceed the greater of ten percent of its book value or one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent."

It is recommended that the Plan obtain the approval of the Superintendent of Insurance relative to any building improvements which exceed the limitations of Section 1404(a)(5)(v) of the New York Insurance Law.

J. Records Retention Plan

At the time of examination, the Plan did not maintain a formal corporate-wide records retention plan. Part 243.3(c) of Insurance Department Regulation 152 (11 NYCRR 243.3) states the following:

" An insurer shall establish and maintain a records retention plan. The plan shall include a description of the types of records being maintained,

the method of retention, and the safeguards established to prevent alteration of the records..."

In light of the above, it is recommended that the Plan establish and implement a formal records retention plan in compliance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243.3).

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination, and as reported by the Plan as of September 30, 2000.

ASSETS	EXAMINATION	PLAN	SURPLUS INCREASE (DECREASE)
Current assets			
Cash and cash equivalents	$(8,942,200)	$(8,942,200)	$ 0
Short-term investments	21,412,958	21,412,958	0
Premiums receivable	12,135,542	12,135,542	0
Investment income receivable	121,696	121,696	0
Health care receivables	14,626,515	14,626,515	0
Amounts due from affiliates	2,076,578	3,655,058	(1,578,480)
Supply inventory	141,483	141,483	0
Pharmacy inventory	1,684,026	1,684,026	0
Prepaid expense	1,021,783	1,021,783	0
Total current assets	$44,278,381	$45,856,861	$ (1,578,480)
Other assets			
Bonds	$16,840,252	$16,840,252	$ 0
Other long-term assets	3,523,911	6,008,000	(2,484,089)
Amounts due from affiliates	3,820,830	10,541,406	(6,720,576)
Deferred charges – net	29,841	29,841	0
Software	4,554,526	4,554,526	0
Goodwill	3,595,521	0	3,595,521
Total other assets	$32,364,881	$37,974,025	$(5,609,144)
Property and equipment			
Land, building and improvements	$17,195,718	$17,195,718	$ 0
Furniture and equipment	3,496,748	3,496,748	0
Leasehold improvements	0	2,434,936	(2,434,936)
Vehicles and other equipment	3,920,941	3,920,941	0
Total property and equipment	$24,613,407	$27,048,343	(2,434,936)

Total assets	$101,256,669	$110,879,229	$(9,622,560)

LIABILITIES	EXAMINATION	PLAN	SURPLUS INCREASE (DECREASE)
Current liabilities			
Accounts payable	$ 1,185,693	$ 1,185,693	$ 0
Claims payable	43,688,275	43,688,275	0
Accrued medical incentive pool	8,076,814	8,076,814	0
Unearned premiums	(88,532)	(88,532)	0
Loans and notes payable	247,599	247,599	0
Payroll/employee benefits	6,293,949	6,293,949	0
Accrued professional fees	2,389,775	2,389,775	0
Other accrued liabilities	8,929,758	8,929,758	0
Federal tax	182,438	182,438	0
Total current liabilities	$70,974,301	$70,974,301	$ 0
Other liabilities			
Loans and notes payable	$2,588,388	$2,588,388	$ 0
Deferred revenue	1,172,774	1,172,774	0
Total other liabilities	$3,761,162	$3,761,162	$ 0
Net Worth			
Statutory reserve	$22,057,610	$22,057,610	$ 0
Unassigned funds	4,552,127	14,174,687	(9,622,560)
Total net worth	$26,609,737	$36,232,297	$(9,622,560)
Total liabilities and net worth	$101,256,669	$110,879,220	

Note 1: The Internal Revenue Service has not audited 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.

Note 2: The Balance Sheet shown above includes no provision for distributions from the Demographic and Specified Medical Condition Pools. For Pool Year 1999, the Pool's administrator's calculation indicates the Plan would receive $571,787 from the Pools based on the demographic calculation. Based on this calculation, and review by the Examiner, it appears that the Plan may receive Pool distributions in excess of the amount recorded above for pool years 1999 and 2000. However, the amount of such distributions cannot be fully determined at this time.

B. Statement of Revenue and Expenses

Total net worth decreased $4,602,479 during the examination period, January 1, 1997 through September 30, 2000, detailed as follows:

Revenue

Premiums (Basic) Community rated		$682,287,685
Premiums (Drugs)		128,587,067
Premiums- (Other riders)		38,735,491
Premiums – Article 43 business		35,180,842
Title XVIII-Medicare		391,634,610
Title XIX-Medicaid		0
Reinsurance premiums		(1,259,702)
Fee for service		43,803,016
Investment income		11,317,959
Other revenue		9,889,490
ASO revenue		910,965
Total revenue		$1,341,087,423

Expenses

Medical and hospital:

Physicians services		$339,023,355
Other professional services		106,071,383
Outside referrals		90,510,984
Emergency room, and out-of-area		64,591,675
Occupancy, depreciation and amortization		17,994,373
Inpatient		321,714,393
Incentive pool and withhold adjustments	(5,282,091)	
Other medical and hospital expenses		42,713,311
Demographic pool expense		483,460
Drug expenses		189,093,985
Subtotal		$1,168,636,646
Less:		
Reinsurance recoveries		176,450
Copayments		17,091,321
Subtotal		17,267,771
Total medical and hospital expenses		$1,151,368,875

Administration:

Compensation	$ 70,306,154
Interest expense	1,614,598
Occupancy, depreciation and amortization	23,380,515
Marketing	26,264,526
Commissions	543,314
Other administrative expenses	42,050,075
ASO expenses	79,718
Total administration expenses	$164,238,900
Total expenses	$1,315,607,775
Income before taxes	$ 5,042,671
Provision for federal income taxes	(22,590)
Net income	$ 5,020,081

C. Net Worth

	Increase in Net worth	Decrease in Net worth	
Net worth per examination as of December 31, 1996			$31,212,216
Net income	$ 5,020,081		
Net change in not-admitted		$(9,622,560)	
	$ 5,020,081	$(9,622,560)	
Net decrease in net worth			4,602,479
Net worth per examination as of September 30, 2000			$26,609,737

4. PREMIUMS IN COURSE OF COLLECTION

No change per examination was made relative to the $12,135,542 reported for this item in the Plan's filed September 30, 2000 quarterly statement.

As of the examination date the Plan used Generally Accepted Accounting Principles (GAAP) guidance to value this asset. Subsequent to the examination date, the Department adopted SSAP No. 6 in the NAIC Accounting Practices and Procedures Manual. SSAP No. 6 establishes an over 90 day not admitted rule and provides that if one installment is overdue, all subsequent installments are to be reported overdue. The Plan should now calculate its 90-day not admitted premiums for all groups according to the annual statement instructions and in accordance with SSAP No. 6 in the NAIC Accounting Practices and Procedures Manual. Also, problems associated with the Plan's conversion to its new billing and premium system contributed to the Plan's underestimation of its not admitted asset relative to this receivable.

It is recommended that the Plan abide by the annual statement instructions and SSAP No. 6 in calculating its not admitted over 90-day premiums.

5. AMOUNTS DUE FROM AFFILIATES

The examination amount of $2,076,578 is $1,578,480 less than the $3,655,058 reported by the Plan in its September 30, 2000 quarterly statement.

The major examination change relative to this item is the disallowance as an admitted asset of $1,577,705 in receivable amounts due from the Plan's wholly owned subsidiary, Univera Healthcare – Southern Tier, Inc. (U-ST) in reimbursement for administrative services provided by U-WNY. U-ST was determined to be insolvent per examination as of September 30, 2000 in the amount of $1.6 million. The $1,577,705 carried by the Plan was net of a bad debt reserve established by U-WNY at September 30, 2000.

A review of the Plan's general ledger indicated that U-ST had not made any payments on this account throughout 2000. Department Circular Letter 15 (1975) states in part,

"1. Inter-company balances.

Any such receivable over 90 days should be deducted as a not admitted asset."

Thus based on U-ST's aforementioned insolvent position and its apparent inability to make payments on the amounts due the Plan, this receivable has been classified a not –admitted asset in this Report on Examination.

6. OTHER LONG TERM ASSETS

The examination amount of $3,523,911 is $2,484,090 less than the $6,008,000 reported by the Plan in its September 30, 2000 quarterly statement.

The examination amount represents the subsidiary valuations as described earlier herein under item 2D.

Vytra Health Plans Long Island, Inc.

The examination subsidiary value of $1,879,023 is $1,178,978 less than the $3,058,000 reported by the Plan under this caption in its filed September 30, 2000 quarterly statement. The Plan, at September 30, 2000, had valued its investment in VLI at the amount of capital contributions which the Plan had made to this subsidiary.

As noted earlier in this report, Section 1414(c)(2) of the New York Insurance Law requires a subsidiary that is an insurance company…*"to be valued at the lesser of market value or book value as shown by its last annual statement or the last Report on Examination, whichever is more recent"*. There generally is no carrying value for a not-for-profit subsidiary (e.g. VLI) other than the amounts contributed or loaned to the entity (up to the parent company's share of the entity's surplus).

Thus the examination subsidiary value, of Vytra Health Plans Long Island, Inc. (VHL) represented the Plan's portion of VHL's book value (surplus) adjusted for the value of the Section 1307 loans made to Vytra Health Services, Inc.as reported on the books of VHL at September 30, 2000 and further adjusted for the carrying value of Section 1307 loans made by the Plan to VHL as included herein under item 7.

Univera Healthcare – Southern Tier, Inc.(U-ST)

The examination subsidiary value of Univera Healthcare – Southern Tier, Inc. of $ 0 is $1,200,000 less than the $1,200,000 reported by the Plan under this caption in its filed September

30, 2000 quarterly statement. Upon examination, U–ST was found to be insolvent at September 30, 2000. Thus, the examination value of this subsidiary was determined to be $0 for purposes of this report.

Healthmed Development, Inc.

The examination subsidiary value of Healthmed Development, Inc. of $1,394,888 is $105,112 less than the $1,500,000 reported by the Plan in its filed September 30, 2000 quarterly statement. Pursuant to Department Reg. 59, the examination amount represented the book value (net equity) of said subsidiary at September 30, 2000.

It is recommended the Plan now value all non-insurance company subsidiaries according to the provisions of SSAP 46 in the NAIC Accounting Practices and Procedures Manual. The Plan should value all insurance company subsidiaries in accordance with the provisions of Section 1414(c)(2) of the New York Insurance Law, adjusted for the value of the Section 1307 loans made to such subsidiaries.

7. AMOUNTS DUE FROM AFFILIATES

The examination amount of $3,820,830 is $6,720,576 less than the $10,541,406 reported by the Plan in its September 30, 2000 quarterly statement.

The two examination changes which make up the above aggregate examination change are (1) the disallowance of Sections 1307 loans and interest due from Univera – CNY in the amount of $4,706,826 and (2) the disallowance of Section 1307 loans and interest due from Univera – ST in the amount of $2,013,750. Both of the aforementioned affiliates were found, per examination to be insolvent as of September 30, 2000. Thus, the Plan's carried asset amounts for the above Section 1307 loans and interest thereon due the Plan are classified as not admitted as of September 30, 2000.

8. GOODWILL

The examination admitted asset of $ 3,595,521 is $3,595,521 more than the $ 0 reported by the Plan in its filed September 30, 2000 quarterly statement. This asset, represents the adjusted net deficit and the purchase price of North American Healthcare, Inc. as of December 31, 1999, the date the latter entity was purchased by The Health Care Plan, Inc. Plan management originally established an asset for Goodwill on the books of North American Healthcare, Inc. (now Unvera Healthcare, – Southern Tier, Inc.) subsequent to the its purchase.

However, this accounting treatment was found not to be in conformance with GAAP or statutory accounting reporting principles. Thus, this asset is established on the books of Univera – WNY, the purchasing company.

9. LEASEHOLD IMPROVEMENTS

The examination amount of $ 0 is $2,434,936 less than the $2,434,936 reported by the Plan in its September 30, 2000 quarterly statement.

The Plan made leasehold improvements in 2000 in the amount of $2,299,592.

Section 4310(h) of the New York Insurance Law requires the Plan to obtain the prior approval of the Superintendent of Insurance for leasehold improvements. The Plan did not obtain Department approval for these leasehold improvements nor did it obtain approval for prior period leasehold improvements.

Thus, the above unapproved leasehold improvements have been deducted as a not admitted in this Report on Examination.

10. SUBSEQUENT EVENTS

Effective January 1, 2001, the Plan became subject to new statutory accounting rules established by the National Association of Insurance Commissioners (NAIC), as modified by Department Regulation 172 {11NYCRR83} These accounting rules may result in changes in the way certain assets and liabilities are to be reported.

In its March 31, 2001 Quarterly Financial Statement submitted to the Department, the Plan did not report its accounting changes relative to the aforementioned new statutory accounting rules. The following changes were reported by the Plan in its June 30, 2001 Quarterly Financial Statement submitted to the Department:

Page 2, Assets – Increase (Decrease) in Not admitted Assets

1. Line 6 – Other long term investments	
Investment in U-ST	$ 1,200,000
Goodwill	(2,761,106)
2. Line 11 – Health care receivables	3,433,348
3. Line 15 – Amounts due from parent, subsidiaries and affiliates	13,971,077
4. Line 17 – Furniture and fixtures	2,876,524
5. Line 20 – EDP equipment and software	4,932,537
6. Line 21 - Other non-admitted assets: Leasehold improvements	2,076,266
7. Line 22 -Aggregate write-ins for other than invested assets –	
Prepaid expenses	550,090
Increase in non-admitted assets	$26,278,735

The Plan reported total capital and surplus of $16,276,175 as of March 31, 2001. As of March 31, 2001, the Plan's required statutory reserve of $22,893,890 was impaired in the amount of $6,617,715.

The Plan reported total capital and surplus of $26,982,729 as of June 30, 2001. However, the Plan included $6,300,000 in Section 1307 loans to insolvent affiliates as an admitted asset as of said date. After classifying the aforementioned $6,300,000 as a not admitted asset, the Plan's reported capital and surplus was reduced to $20,682,729 as of June 30, 2001. After the above adjustment the Plan's required statutory reserve of $25,365,428 was impaired in the amount of $4,682,699 as of June 30, 2001 per examination.

The Plan requested approval of the Superintendent of Insurance for a reduction of its required surplus and approval for a plan of restoration. The plan of restoration provided for the Plan to restore its required surplus by means of sufficient 2001 net income.

On October 1, 2001, the Plan merged with Excellus Health Plan, Inc. The above impairment was addressed by such merger.

11. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was directed at the practices of the Plan in the following major areas:

1. Sales and advertising
2. Underwriting
3. Rating
4. Claims

Underwriting

Forms and Rates

A review of the Plan's contract forms and riders in effect at the time of examination revealed the following riders and rates thereon which had not received prior approval of the Superintendent of Insurance as required by Section 4308(a) of the New York Insurance Law:

RX$5/$20/$45-44-W (2001)	Prescription Drug Schedule of Copayments $5/$20/$45
PDS $10G/$20B/50%	Non- Formulary Drugs
HCP-PFD-6	Low Option-$15 Copay

It is recommended that the Plan obtain approval of contracts, and riders prior to issuance as required by Section 4308 of the New York Insurance Law.

A similar recommendation was made in the previous two reports on examination.

Rating

Experience Rating - Article 43 contracts

The Plan rated four groups on an experience rated basis. It was noted that the contract with SUNY at Buffalo, effective August 1993 did not contain experience rating wording. Two other contracts did contain experience rating language, however, the methodology used by the Plan was inconsistent with the language and the Plan did not provide evidence of Department approval for the experience rating

methodology being used for those contracts. The Plan was not able to provide a copy of the fourth contract.

The Plan's experience rating methodology provides for establishing a rate stabilization reserve where premiums in excess losses for each experience period are identified for each group. Fifty percent (50%) of the established rate stabilization reserve is then carried forward to adjust future renewal rates. However, with this methodology there is no provision for settlement of surpluses or deficits at the time of cancellation. Also, as noted above, the Plan did not provide the examiners with a specific Department approved experience rating contract, rider or separate relative to its experience rated groups.

Part 52.40 of Department Regulation 62 (11 NYCRR 52.40) states the following:

> *"(1) Contracts of master group insurance may be experience rated only in accordance with a formula or plan previously furnished to the department. Such formula or plan shall include a retention designed to provide for a contribution to surplus.*
>
> *Any such plan or formula of experience rating may include provision for a rate stabilization reserve provided that the terms under which the rate stabilization reserve is created are included in the master group contract or separate written agreement previously approved by the department and which upon termination of the group contract impose an obligation on the plan in respect to the application of the funds represented by such reserve."*

It is recommended that the Plan file for approval with this Department a contract, rider or separate agreement relative to its experience rating methodology which complies with the requirements of Part 52.40 of Department Regulation 62 (11 NYCRR 52.40).

Guaranteed Rates - Article 44 contracts

Section 52.42(b)(3)(ii)(a) of Part 52 of Department Regulation 62 (11 NYCRR 52.42) allows an HMO to guarantee rates if it has an approved rider or remitting agent agreement.

A review of the Plan's level premium guaranteed rating program revealed that the Plan did not maintain a signed level premium agreement for the majority of groups receiving guaranteed rates The Plan could produce only one signed level premium agreement relative to ten sample groups.

It is recommended that the Plan comply with the requirements of Part 52.42 of Department Regulation 62 (11 NYCRR 52.42) by obtaining signed copies of a Department approved rider or remitting agent agreement with all groups receiving guaranteed rates. A similar recommendation was included in the prior two reports on examination.

Claims Settlement Practices

Explanation of Benefits Forms

A review of the Plan's Explanation of Benefits forms indicated that said forms did not fully comply with the requirements of Section 3234(b) of the New York Insurance Law

Section 3234(b) of the New York Insurance Law states in part,

"(b) The explanation of benefits form must include at least the following:

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply

with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

A review of the Plan's explanation of benefits forms indicated that said forms did not include the wording, that "failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made".

It is recommended that the Plan include within its explanation of benefits forms all wording required by Section 3234(b) of the New York Insurance Law.

<u>Section 3224-a of the New York Insurance Law – Prompt Payment Law</u>

A review was made of the Plan's compliance with Section 3224-a of the New York Insurance Law (Prompt Payment Law).

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

"Except 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 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 services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policy-holder or covered person or make a payment to a health care provider within forty-five days of receipt of claim or bill for services rendered."

Section 3224-a(b) of the New York Insurance Law states the following:

"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 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."*

In addition, Section 3224-a(c) states the following:

"Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, 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…to be computed from the date the claim or health care payment was required to be made…"

In this regard, a sampling of paid claims for calendar year 2000 was made. The claims were reviewed for compliance with said sections of the New York Insurance Law. The results of the review were then projected for the population of claim payments made during the aforementioned period. The following schedule (Column 1) quantifies the Plan's projected violations of Section 3224-a of the New York Insurance Law based on the results of this examination's claims payment review.

The following schedule shows the range of projected violations of Section 3224-a of the New York Insurance Law:

Column 1 shows the total projected Section 3224-a violations.
Column 2 shows those violations for which interest was not due or, if due, was paid correctly.
Column 3 shows those violations for which interest was due but not paid or not paid correctly.

(1)	(2)	(3)
Section 3224-a(a) of the NYIL	Section 3224-a(c) of the NYIL	Section 3224-a(c) Of the NYIL
Upper Limit 31,731	29,007	2,724
Lower Limit 15,734	15,059	675

Projected violations listed in the preceding schedule under the heading, Column 2, "Section 3224-a(c) of the NYIL", relate to claim payments made in excess of forty-five (45) days of receipt for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a) or (b) of the New York Insurance Law and interest was either not due or, if due, was paid correctly.

It is noted that Section 3224-a(c) of the New York Insurance Law indicates the following relative to the non-payment of interest:

"…When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

Any classification noted as "no interest due" in the following schedule refers to the interest calculated on said paid claim being less than $2.00.

Projected violations listed in the preceding schedule under the heading, Column 3, "Section 3224-a(c) of the NYIL", relate to claim payments made in excess of forty-five (45) days of receipt for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a) or (b) of the New York Insurance Law and interest payments due have been calculated over $2.00 and were not paid to the provider or subscriber.

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 Section 3224-a(a) and (b) of the New York Insurance Law.

It was noted that the original request for the Plan's claims data was made in October, 2000. The examiners did not receive complete, reconciled claims data until April, 2001. It was noted that during the interim period, the Plan provided a series of data runs which were not complete or included serious errors. The delay in receiving complete, reconciled claims data contributed to the length of this examination.

Regulation 64 Compliance

A review was made of the Plan's claims files in order to determine compliance with Regulation 64 promulgated by the New York State Insurance Department. A review was also made of subscriber complaints in order to determine compliance with the requirements of Department Circular Letter No. 11(1978).

The review indicated that copies of Regulation 64 were not distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of said regulation.

The prior examination noted a similar deficiency in the Plan's claims settlement practices.

In addition, the review noted that many of the Plan's electronic claims files did not contain any or complete documentation as to the reason for delay in payment. Also, the Plan, did not record the date in

which a communication was sent relative to a request for additional information on a claim. The Plan documented only the date such information was received from the subscriber or provider.

Part 216.11 of Department Regulation 64 (NYCRR 216.11) states, in part,

> *"…all insurers…must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants."*

It is recommended that copies of Regulation 64 be distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of said regulation.

It is recommended that the Plan comply with Part 216.11 of Department Regulation 64 (NYCRR 216.11) and maintain its claims files in such a manner so that all events relating to a claim can be reconstructed by the Insurance Department examiners, including the maintaining of all pertinent claim information relative to communications made to providers and subscribers.

12. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included eleven recommendations detailed as follows (The page numbers refer to the prior report on examination):

ITEM		PAGE NO.
A.	**Executive Committee Vacancies** It is again recommended that the Plan comply with the provisions of its by-laws and fill all vacancies on its Executive Committee. As of September 30, 2000, there remained one vacancy on the Plan's Executive Committee. A similar recommendation is included in this report.	**5**
B.	**Officers** It is recommended that the Plan abide by Article IV Section 2(a) of its by-laws or formally amend them. Although the Plan restated its by-laws during the examination period, the Plan failed to comply with Article 4.01 by not electing its Secretary and Treasurer on an annual basis.	**7**
C.	**Statutory Reserve Fund** It is recommended that the Plan include all premium income in the statutory reserve calculation. The Plan has complied with this recommendation.	12

ITEM		PAGE NO.
	Holding Company System	
D.	It is recommended that the Plan comply with the requirements of Regulation 115 and file the required reports.	15
	The Plan did not fully comply with this recommendation. A similar recommendation is included within this report.	
	It is recommended that the Plan comply with the requirements of Regulation 59.	16
	The Plan did not comply with this recommendation. A similar recommendation is included within this report.	
	It is recommended that the Plan report its investments in subsidiaries under the proper annual statement caption in all future filed statements	17
	The Plan has complied with this recommendation.	
	It is recommended that the Plan execute an administrative services agreement with Vytra Healthcare Managed Systems detailing the terms of the servicing arrangement regarding hospital contracts.	18
	The Plan discontinued the service arrangement with Vytra Healthcare Managed Systems during the examination period.	
	It is recommended that the Plan value its investment in Healthmed in accordance with Regulation 59 and properly report this asset as an investment in all future statements with this Department.	20
	The Plan did not fully comply with this recommendation. As of September 30, 2000, the Plan valued this subsidiary at cost. However, in April, 2001, Healthmed Development, Inc. was dissolved.	

ITEM		PAGE NO.
	It is recommended that the Plan comply with the requirements of Section 1705(a)(2) and seek approvals for any subsidiary investment in excess of the 1% limitation.	20
	The Plan complied with this recommendation during the examination period.	
	It is again recommended that the Plan comply with the instructions to the Annual Statement and properly complete Schedule M.	22
	The Plan has complied with this recommendation with regard to Schedule Y.	
E.	**Abandoned Property**	23
	It is again recommended that the Plan comply with the reporting requirements of Section 1315 and Section 1316 of the New York State Abandoned Property Law.	
	The Plan has not complied with this recommendation. A similar recommendation is included within this report.	
F.	**Leasehold Improvements**	24
	It is again recommended that the Plan obtain approval from the Superintendent of Insurance for its leasehold improvements as required by Section 4310(h) of the New York Insurance Law.	
	The Plan has not complied with this recommendation. A similar recommendation is included within this report.	
G.	**Accounts and Records**	26
	It is recommended that the Plan comply with the Annual Statement instructions and exercise greater care in the preparation of its future financial statements.	
	The Plan has not fully complied with this recommendation. A similar recommendation is included within this report.	

ITEM | **PAGE NO.**

H. **Investments** — 27

It is recommended that the Plan closely monitor its investment activity in order to maintain compliance with the applicable sections of Article 14 of the New York Insurance Law.

The Plan has not fully complied with this recommendation. A similar recommendation is included within this report.

I. **Unpaid Claims Reserves** — 32

It is again recommended that the Plan review its reserving practices and reduce its reserves to a level that more nearly reflects actual developments.

The Plan has complied with this recommendation.

J. **Contract Approvals** — 35

The Plan violated Section 4308 of the New York Insurance Law when it failed to obtain approval of contracts and riders prior to issuance of such contracts.

The Plan issued three riders during the examination period which had not been approved prior to issuance.

K. **Guaranteed Rates** — 38

The Plan violated Section 4308 of the Insurance Law when it failed to abide by the requirements of Regulation 62, Section 52.42 and obtain signed copies of the approved rider with all groups receiving guaranteed rates and settle variances between guaranteed and approved rates in compliance with Regulation 62.

The Plan did not obtain signed copies of the approved rider with all groups receiving guaranteed rates during the examination period.

ITEM		PAGE NO.
L.	**Claims Settlement Practices**	39

It is again recommended that the Plan maintain a central log to monitor complaint activity as required by Circular Letter No. 11 (1978).

The Plan has complied with this recommendation.

Copies of Regulation 64 should be distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of said regulation.

The Plan has not complied with this recommendation. A similar recommendation is included within this report.

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

The following is a summary of the comments and recommendations made in the body of this report:

ITEM		PAGE NO.
A.	**Statutory Reserve**	44
	As of March 31, 2001, the Plan's required statutory reserve of $22,893,890 was impaired in the amount of $6,617,715.	
	.	
B.	**Board of Directors**	
	It is recommended that the Plan comply with Section 1201(a)(5)(B)(v) of the New York Insurance Law and amend its charter and by-laws in order to fix the number of board members at no less than thirteen (13).	6
	It is recommended that the number of directors on the Plan's board representative of subscribers and the number of directors representative of the public be as equal as possible in compliance with Section 4301(k)(1)(A)&((B) of the New York Insurance Law.	6
	It is recommended that the Plan comply with the investment authorization or approval requirements of Section 1411(a) of the New York Insurance Law.	7
	It is recommended that the Plan maintain minutes of all Committee minutes held by the Plan.	7
	It is recommended that the Plan comply with Section 5.02 of its by-laws and fill all vacancies on its Executive Committee	7

ITEM		PAGE NO.
	It is recommended that the Plan elect its Secretary and Treasurer on an annual basis in compliance with its by-laws.	8
C.	**Medical Centers**	11
	It is recommended that the Plan maintain an executed contract with the Promedicus Health Group, approved by the New York Department of Health or this Department, relative to the services provided by PHG to the Plan and its subscribers.	
	.	
D.	**IPA, Network and Intermediary Capitation Arrangements**	
	It is recommended that the Plan maintain complete contracts with all of its capitated providers along with documentation of approval of such contracts, by the New York Department of Health.	13
	It is further recommended that the Plan include the required balance sheet and statement of operations for each Independent Practice Association (IPA) with which it has contracted in its filed 1999 and 2000 New York Data Requirements Statements.	13
E.	**Loans to Univera Healthcare – CNY, Inc.**	19
	It is recommended, pursuant to Section 1505(c) of the New York Insurance Law, that the Plan obtain the approval of the Superintendent of Insurance for its loans made in 2001 to Univera Healthcare – CNY, Inc.	
	It is recommended that the Plan, in the future, comply with the notification and prior approval requirements of Section 1505(c) and (d) of the New York Insurance Law.	

ITEM		PAGE NO.
F.	**Regulation 115 Holding Company Reports**	25
	It is recommended that the Plan comply with the requirements of Regulation 115 and file all required reports with this Department.	
G.	**Abandoned Property**	26
	It is recommended that the Plan comply with the reporting requirements of Section 1315 and Section 1316 of the New York State Abandoned Property Law.	
H.	**Accounts and records**	
	It is recommended that the Plan correctly complete its Schedule H in future filings with this Department.	27
	It is recommended that the Plan maintain adequate detail records to support the amounts reported in its filed Schedule M.	27
	It is recommended that the Plan comply with the instructions to the New York Data Requirements statements and complete Report 4 – Year to Date Statement of Revenue and Expenses Healthy New York in future filed New York Data Requirements statements.	28
	It is recommended that the Plan maintain an appropriate data base relative to its claims history and that Schedule P be properly completed within future statements to this Department.	28
	It is recommended that the Plan comply with the annual and quarterly statement instructions and exercise greater care in the preparation of its filed financial statements to this Department.	29

ITEM		PAGE N0.
I.	**Securities**	30
	It is recommended that the Plan obtain values for all of its securities from the SVO.	
	It is further recommended that the Plan submit all securities which do not have an SVO valuation to the SVO for valuation or dispose of same.	
	It is recommended that the Plan closely monitor its investment activity in order to maintain compliance with the applicable sections of Article 14 of the New York Insurance Law.	
J.	**Custodial Arrangements**	31
	It is recommended that the Plan include the enumerated protective covenants and provisions in all custodial agreements in which the Plan participates.	
K.	**Real Estate**	32
	It is recommended that the Plan obtain the approval of the Superintendent of Insurance relative to any building improvements which exceed the limitations of Section 1404(a)(5)(v) of the New York Insurance Law.	
L.	**Records Retention Plan**	32
	It is recommended that the Plan establish and implement a formal records retention plan in accordance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243.3).	
M.	**Premiums In Course of Collection**	37

It is recommended that the Plan abide by the annual statement instructions and SSAP No. 6 in calculating its not admitted over 90 day premiums.

ITEM		PAGE NO.
N.	**Other Long Term Assets** It is recommended that the Plan now value all non-insurance company subsidiaries according to the provisions of SSAP 46 in the NAIC Accounting Practices and Procedures Manual. The Plan should value all insurance company subsidiaries in accordance with the provisions of Section 1414(c)(2) of the New York Insurance Law, adjusted for the value of the Section 1307 loans made to such subsidiaries.	40, 41
O.	**Contracts and riders** It is recommended that the Plan obtain approval of contracts and riders prior to issuance as required by Section 4308 of the New York Insurance Law.	45
P.	**Experience Rating** It is recommended that the Plan file for approval with this Department a contract, rider or separate agreement relative to its experience rating methodology which complies with the requirements of Part 52.40 of Department Regulation 62 (11 NYCRR 52.40).	46
Q.	**Guaranteed Rating** It is recommended that the Plan comply with the requirements of Part 52.42 of Department Regulation 62 (11 NYCRR 52.42).	47
R.	**Explanation of Benefits Forms** It is recommended that the Plan include within its explanation of benefits forms all wording required by Section 3234(b) of the New York Insurance Law.	48

ITEM **PAGE NO.**

S.. **Section 3224-a of the New York Insurance Law – Prompt Payment Law** 51

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 Section 3224-a(a) and (b) of the New York Insurance Law.

T. **Regulation 64** 53

It is recommended that copies of Regulation 64 be distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of said regulation.

It is recommended that the Plan comply with the provisions of Part 216.11 of the New York Codes, Rules and Regulations and maintain within its claims files all pertinent information as required by Part 216.11 of Department Regulation 64 (11 NYCRR 216.11).

Respectfully submitted,

____

Robert W. McLaughlin, CFE, CIE
Principal Insurance Examiner

STATE OF NEW YORK)
)SS.
)
COUNTY OF ERIE)

ROBERT W. MCLAUGHLIN, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

____

Robert W. McLaughlin

Subscribed and sworn to before me

this______day of ____________________2001.

Appointment No. 21524

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Robert W. McLaughlin

as a proper person to examine into the affairs of the

The Health Care Plan
DBA Univera Healthcare – WNY, Inc.

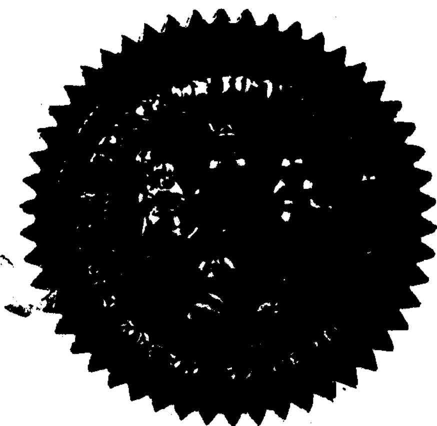
and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

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

this 10th *day of* April 2000



NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent