REPORT ON EXAMINATION

OF

VNS CHOICE

AS OF

SEPTEMBER 30, 2005

DATE OF REPORT	**OCTOBER 30, 2006**
EXAMINER	**WAI WONG**

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

George E. Pataki
Governor

Howard Mills
Superintendent

October 30, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with instructions contained in Appointment Number 22241, dated July 29, 2004, attached hereto, I have made an examination into the condition and affairs of VNS CHOICE, a not-for-profit managed long-term care plan (MLTCP) incorporated under the provisions of Article 4403-f of the New York Public Health Law, as of September 30, 2005, and submit the following report thereon.

The examination was conducted at the home office of VNS CHOICE, located at Five Penn Plaza, New York, New York 10001.

Wherever the terms “the Plan” or “VNS” appear herein, without qualification, they should be understood to mean VNS CHOICE.

1. SCOPE OF EXAMINATION

This examination covered the period from January 1, 1998 through September 30, 2005. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner. This was the first examination of VNS CHOICE.

The examination comprised a verification of assets and liabilities as of September 30, 2005 in accordance with generally accepted accounting principles (GAAP) and as such included 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 as called for in the *Examiners' Handbook of the National Association of Insurance Commissioners (NAIC)*:

History of the Plan
Management and control
Corporate records
Fidelity bond and other insurance
Territory and plan of operation
Growth of the Plan
Business in force
Loss experience
Accounts and records
Financial statements

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

2. DESCRIPTION OF PLAN

VNS CHOICE is a not-for-profit corporation incorporated under the provisions of Article 4403-f of the New York Public Health Law, and is an affiliated organization of Visiting Nurse Service of New York. VNS CHOICE is under contract to the New York State Department of Health as a risk-bearing managed long-term care (MLTC) program. New York State's MLTC program is designed to provide services to Medicaid and nursing home eligible populations who require long-term care, but choose to reside at home. The plans which participate in the MLTC program are financed by Medicaid for each member enrolled through a fixed monthly capitation payment calculated on a per member per month basis. VNS CHOICE began enrolling members on January 1, 1998 and operates in the five boroughs of New York City.

A Certificate of Incorporation for VNS CHOICE was filed with the Public Health Council and the Department of State on May 30, 1997, under Section 402 of the Not-for-Profit Corporation Law. An amended Certificate of Incorporation was filed with the Public Health Council and the Department of State on March 3, 2003, under Section 803 of the Not-for-Profit Corporation Law.

On May 1, 2003, VNS CHOICE established a subsidiary, VNS CHOICE Community Care ("VNS-CCC"), in order to better serve its members under a more cost efficient regulatory framework. VNS-CCC operates as a licensed home care services agency, which provides VNS CHOICE enrollees with care management and home care services. Prior to the formation of VNS-CCC, VNS CHOICE purchased home health aide and professional support services from another affiliated company, VNS Home Care, a certified home health care provider.

VNS CHOICE had been operating as a demonstration program under a contract with the Department of Health since it began operations in 1998. Prior to the completion of the revisions to Part 98 of the Codes, Rules and Regulations of New York State (10 NYCRR 98-1), which were effective June 2005, Managed Long Term Care Plans were not included as a type of "Managed Care Organization", as defined under Part (Regulation) 98.

This revised Regulation requires all Managed Long Term Care Plans to obtain a certificate of authority within one year of the promulgation of the revised Part 98. VNS CHOICE submitted a certificate of authority application with the Department of Health and was approved on June 9, 2006, subsequent to the date of examination.

VNS CHOICE files its annual and quarterly cost reports with the New York State Department of Health and the New York State Department of Insurance on a consolidated basis, with its subsidiary VNS CHOICE Community Care. Inter-company account balances between VNS CHOICE and VNS CHOICE Community Care are reported as "net" amounts on the cost report filings.

A. Management

Pursuant to its by-laws, the management of VNS CHOICE is to be vested in a board of directors consisting of not less than five members; at least one of whom shall be a director of Visiting Nurse Service of New York. At least twenty percent (20%) of the directors shall be either enrollees of VNS CHOICE or their representatives, and no less than one-third of the directors shall be residents of New York State.

A review of the meetings held during the period covered by this examination indicated that board meetings were generally well attended, however, one director, Robert C. Daum, failed to attend either of the two meetings he was eligible to attend, since his election to the board in February of 2005. Subsequent to the examination date, Mr. Daum attended all of the five VNS CHOICE board meetings held.

At September 30, 2005, the Plan's board consisted of the following eight members:

Name and Residence	Principal Business Affiliation
Phyllis Mills New York, NY	Trustee, Mary Flagler Cary Charitable Trust
*Rose Dobrof New York, NY	Professor Gerontology, Brookdale Center on Aging
*Mary Jane Koren, MD, PhD New York, NY	Senior Program Office, The Commonwealth Fund
Kwan-Lan (Tom) Mao Darien, CT	Retired, Citibank Executive
David O. Wicks New York, NY	Retired, Cablevision Executive
Andrew Schiff New York, NY	Managing Director, Perseus-Soros Biopharmaceutical Fund
Robert Daum New York, NY	Managing Director, Gross Capital Partners
Peter Hutchings New York, NY	Retired

*Enrollee representative – Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)), requires that a minimum of twenty percent (20%) of the board of directors of a Managed Care Organization be comprised of enrollee representatives.

In addition to the above statutory requirement, the Plan is also in compliance with the requirements of its by-laws which require: that at least one third of its directors be residents of New York State, and at least one of its directors be a director of Visiting Nurse Service of New York ("VNSNY"). All of the Plan's directors, other than the two enrollee representatives noted above, are members of VNSNY's board.

The principal officers of VNS CHOICE as of September 30, 2005 were as follows:

Name	Title
Roberta Brill	Executive Director
Eric Price	Director of Finance

B. Territory and Plan of Operation

VNS CHOICE was granted a certificate of authority to operate a MLTCP in Manhattan, Bronx, Kings, Queens and Richmond counties, under the provisions of Article 4403-f of the New York Public Health Law. VNS CHOICE contracted with the New York State Department of Health to participate in New York State's partially capitated long-term care program. The contract defines the services that must be provided and the capitation rate to be paid per member per month.

VNS CHOICE enrolls only those individuals eligible for Medicaid that are over 65 years of age and are nursing home eligible, but choose to stay at home. Services are provided by nurses, physical therapists, and home health aides, as well as a network of physicians providing health services such as vision, dental and podiatry care. VNS CHOICE does not provide hospital or basic medical healthcare coverage.

VNS CHOICE's subsidiary, VNS CHOICE Community Care, employs nurses and other physical therapists to provide services to its members. Home health aide services are provided by VNS CHOICE Community Care's affiliate, Partners in Care, and with various other vendors that VNS CHOICE Community Care contracts with. VNS CHOICE maintains a network of

providers to provide various medical services to its members. These providers are compensated on a fee-for-service basis by the Plan.

During the examination period VNS CHOICE also provided a drug benefit to its members, but this benefit was no longer available in 2006, with the advent of the Medicare prescription (Part D) drug coverage.

C. Enrollment

VNS CHOICE began enrolling members on January 1, 1998. As of September 30, 2005, VNS CHOICE's total enrollment was 3,869 members. An analysis of the enrollment during the examination period is set forth below:

	1998	1999	2000	2001	2002	2003	2004	9/30/05
Enrollment Jan. 1	0	466	1,647	2,561	2,509	2,858	3,439	3,718
Net gain/(loss)		1,181	914	(52)	349	581	279	151
Enrollment Dec. 31	466	1,647	2,561	2,509	2,858	3,439	3,718	3,869

D. Holding Company System

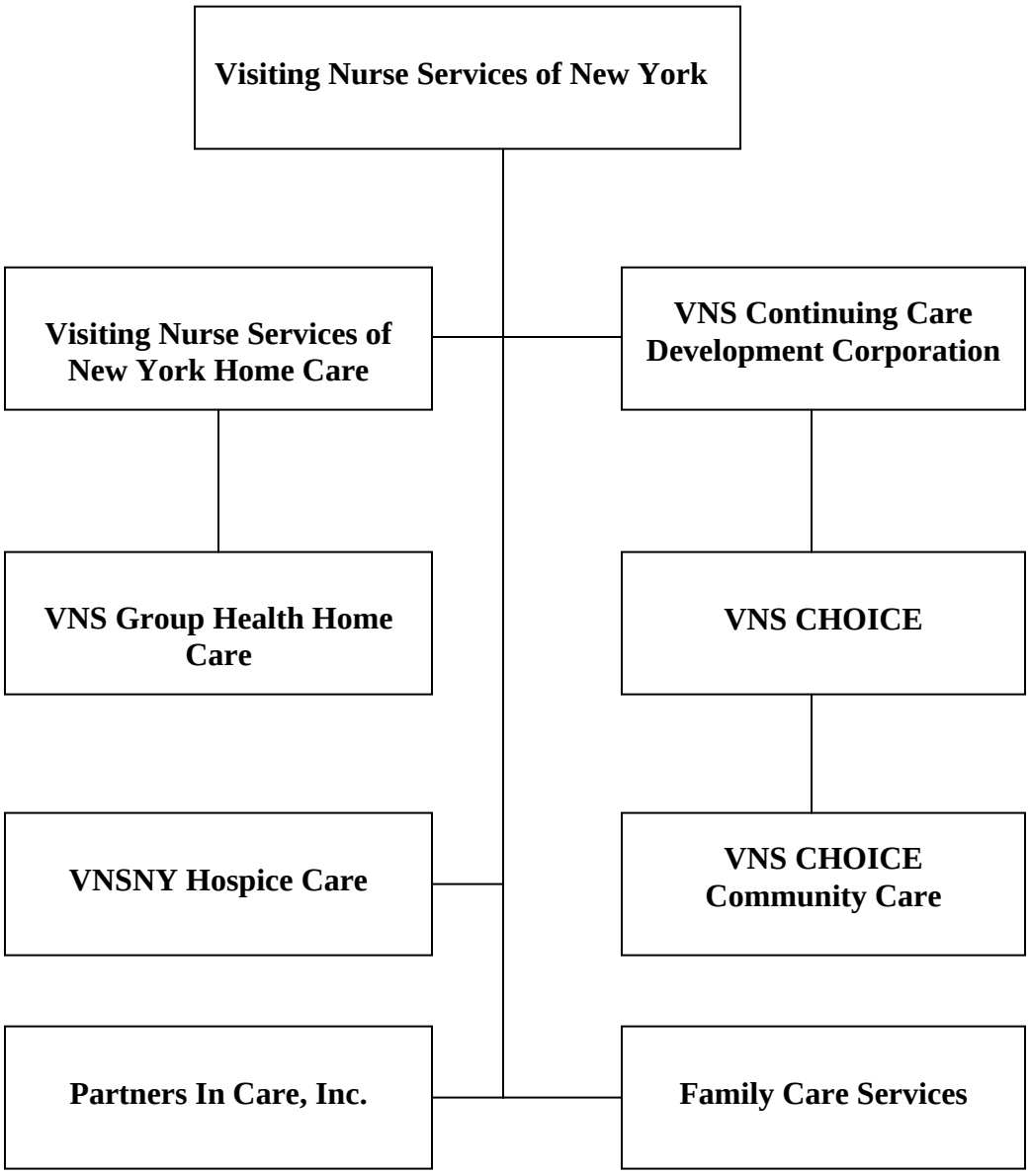
VNS CHOICE is a wholly-owned subsidiary of VNS Continuing Care Development Corporation. VNS Continuing Care Development Corporation was established as the corporate parent for all of Visiting Nurse Service of New York's (VNSNY) ventures in the long-term care

arena and is not licensed by any government entity. VNS Continuing Care Development Corporation in turn, is a wholly-owned subsidiary of VNSNY, a not-for-profit home health care agency licensed by the Department of Health, and the ultimate parent in the VNS holding company system.

VNS CHOICE is the parent of VNS CHOICE Community Care (VNS-CCC), a licensed home care service agency which provides VNS CHOICE enrollees with care management and home care services.

Partners in Care is a wholly-owned subsidiary of Visiting Nurse Service of New York. It is a licensed home health care agency that provides home health aide services on a contractual basis to VNS CHOICE Community Care and other affiliated companies.

The following chart depicts VNS CHOICE's relationship with members of its holding company system as of the examination date:


Visiting Nurse Services of New York
Visiting Nurse Services of New York Home Care
VNS Continuing Care Development Corporation
VNS Group Health Home Care
VNS CHOICE
VNSNY Hospice Care
VNS CHOICE Community Care
Partners In Care, Inc.
Family Care Services

E. Contingent Reserve Fund

A certified operating Managed Care Organization such as VNS CHOICE is required to maintain a minimum net worth pursuant to Sections 98-1.11(e) and (f) of Part 98-1 of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11). The required net worth is calculated as the greater of:

1. A reserve fund designed as the contingent reserve fund, which during each calendar year is increased in an amount equal to one percent of premium revenue until it reaches an overall maximum of five percent of the most recent year's net premium income; and

2. An escrow deposit account consisting of five percent of the estimated expenditures for health care services for the year.

During the examination period, VNS CHOICE requested and received approval from the New York State Department of Insurance ("Department") to lower the Plan's Escrow Deposit requirement to 2.5% (rather than 5%) of estimated expenditures for health care services for the year. Subsequently, VNS CHOICE's net worth increased so that from 2001 through September 30, 2005, the Plan's net worth exceeded 5% of the estimated expenditures for healthcare services for each year.

The Plan's Contingent Reserve Fund as of December 31, 2004 was $7,653,176, and was calculated throughout the examination period as follows:

1998 Initial Reserve Amount ($1,000,000 X 5%)	$ 50,000
1998 Premium Revenue ($7,790,000-$1,000,000) X (1%)	$ 67,900
1998 Contingent Reserve	$ 117,900
+ 1999 Premium Revenue ($ 49,066,573 X 1%)	$ 490,666

+ 2000 Premium Revenue ($104,437,080 X 1%)	$1,044,371
+ 2001 Premium Revenue ($115,534,417 X 1%)	$1,155,344
+ 2002 Premium Revenue ($132,751,140 X 1%)	$1,327,511
+ 2003 Premium Revenue ($155,048,283 X 1%)	$1,550,483
+ 2004 Premium Revenue ($196,690,134 X 1%)	$1,966,901
= Contingency Reserve as of December 31, 2004	$7,653,176

The Plan's Contingent Reserve Fund requirement as of December 31, 2004 was $7,653,176. This amount was VNS CHOICE's required net worth as of December 31, 2004, because it is greater than the escrow deposit requirement of $4,897,837 (2.5% of $195,907,837 (estimated healthcare expenses)).

F. Inter-Company Agreements

VNS CHOICE has inter-company agreements with its parent, Visiting Nurse Service of New York ("VNSNY"), and its subsidiary, VNS Choice Community Care. Pursuant to its agreement with VNS CHOICE, VNSNY is responsible for providing administration services to the Plan, including: legal services, government and public relations, corporate compliance, and research and other analytical support to aid the ongoing development of the program. VNS CHOICE reimburses VNSNY in an amount equal to the direct and indirect costs VNSNY incurs in providing the services, in compliance with the terms of their Agreement.

VNS CHOICE's agreement with VNS Choice Community Care ("VNS-CCC") specifies that VNS-CCC will provide care management and professional home health care services to VNS CHOICE members. The terms of this Agreement require VNS CHOICE to reimburse VNS-CCC on a cost reimbursement basis. Among the care management services VNS-CCC

provides are: the assignment of a professional staff member as the primary care manager, ensuring that all medically necessary covered services are provided to the member as part of the member's plan of care and assisting members in obtaining needed services in support of the plan of care; regardless of whether they are VNS CHOICE covered services.

The agreement with VNS-CCC received oral approval from the Department of Health, and the agreement with VNSNY was submitted to the Department of Health in May 2004 for approval, but a response has not yet been received by the Plan.

Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.10) states:

> (c) The commissioner's and, except in the case of a PHSP, HIV SNP or PCPCP, the superintendent's prior approval shall be required for the following transactions between a controlled MCO and any person in its holding company system: sales, purchases, exchanges, loans, extensions of credit or investments the aggregate of which involves five percent or more of the MCO's admitted assets at last year-end. Thirty days prior notice to the commissioner and, except in the case of a PHSP, HIV SNP or PCPCP, the superintendent, is required before entering into the following transactions between a controlled MCO and any person in its holding company system: a reinsurance agreement or an agreement for rendering services on a regular or systematic basis, other than medical or management services that require prior approval under this Subpart. Such transactions may become effective unless the commissioner or the superintendent has disapproved the transaction within such period.

It is recommended that VNS CHOICE comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department by getting written (prior) approval from the New York State Departments of Health and Insurance for all inter-company agreements entered into.

G. Conflict of Interest Policy

Visiting Nurse Service of New York, the parent company of VNS CHOICE, has a corporate-wide written Compliance Plan and Code of Conduct for its employees and directors. It describes what standards of behavior are required of its employees, including what activities or practices constitute a conflict of interest for its directors and employees.

VNS CHOICE generally follows the standards, policies, and procedures of its parent, however, at times VNS CHOICE's legal requirements as a MLTCP differ from those of its parent. In order to ensure that VNS CHOICE is in compliance with all legal requirements, the Plan has developed its own conflict of interest program to supplement the VNSNY plan.

Conflict of interest statements are required to be filed by members of the Plan's board of directors on an annual basis, while employees are required to file the forms on a semi-annual basis. A review of the conflict of interest filings for the years 2003, 2004, and 2005 was performed by the examiner. This review revealed the following:

- For calendar years 2003 and 2004, two members of the board of directors failed to file conflict of interest forms with VNS CHOICE.

- In 2003 and 2005, a board of director member filed an incomplete conflict of interest form with VNS CHOICE.

- One employee failed to return her conflict of interest form until five months after the disclosure form was sent to her (it is due within one month of receipt).

It is recommended that all conflict of interest statements be fully completed, signed, and returned by each applicable board member/employee, and that they be returned within the required timeframe.

It is also recommended that all conflict of interest forms be reviewed by an officer of the Plan designated by the Plan's board of directors.

H. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles or Annual Statement (Cost Report) instructions. A description of such items is as follows:

1. VNS CHOICE did not report its claim adjustment expense liability or its administrative expense liability separately on its cost reports filed with the Department. The amounts for the claim adjustment and administrative expense liabilities were included with the claim expense liability in its filed cost reports. The instructions for the cost report details that these liabilities should be shown as separate balance sheet line items.

It is recommended that the Plan comply with the cost report instructions by reporting its liabilities for claim adjustment expenses and administrative expenses separately from claim expenses on its cost report filings.

2. A review of the claim “lag triangles” for medical supply expenses found that the Plan failed to record the proper expenses for certain transactions. Certain medical suppliers provided discounts to the Plan on their medical supply purchases, however, the Plan recorded these purchases at the full price on the claim “lag triangles”, rather than the discounted amount actually paid.

   It is recommended that the Plan record the actual expenses paid on its claim lag tables.

3. The Plan reported an asset of $54,814 as “leasehold improvements” in its September 30, 2005 cost report filing. The examination determined that the total was actually $49,068, or $5,746 less than the reported amount. The asset amount reported was reduced because the Plan included some items such as garbage cans, refrigerators, and coffee makers purchased for the office that did not meet the definition of a leasehold improvement per FASB Statement of Financial Accounting Concepts No. 6. There was no change to the financial statements contained herein due to the immaterial amount of the difference.

   It is recommended that the Plan comply with the requirements of FASB Statement of Financial Accounting Concepts No. 6, and record only those assets that comply with the definition of a leasehold improvement as an admitted asset in its cost report filings with this Department.

   In addition, the Plan failed to keep invoices documenting the amounts spent for items classified as leasehold improvements. The examiners could not determine what all the items were without the invoices.

Section 243.2(b)(8) of Department Regulation 152 (11 NYCRR 243) sets forth standards of retention of records by an insurer and states that an insurer shall maintain:

> "Except as otherwise required by law or regulation, an insurer shall maintain:
>
> Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

It is recommended that the Plan comply with the requirements of Section 243.2(b)(8) of Department Regulation 152, by maintaining all source documents for six calendar years from their creation, or until after the filing of the report on examination in which the record was subject to review, whichever is longer.

4. VNS CHOICE has a services agreement with VNSNY's investment committee to manage VNS CHOICE's investments. The funds are managed according to the guidelines developed by VNSNY's investment subcommittee and approved by the VNS CHOICE board. The assets remain in a separate account as an asset in the name of VNS CHOICE, however, the custodial agreement effective July 1, 1999, is between Visiting Nurse Service of New York and Chase Manhattan Bank ("Chase"). VNS Choice should be a party to the agreement with Chase.

Further, a review of the custodian agreement with Chase also revealed that it does not contain all of the safeguards and protections recommended by the Department and the NAIC. The following provisions were missing from the agreement:

- 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 of termination of this coverage.
- A statement that the custodian will give the securities it holds the same care it provides its own property of a similar nature.
- A statement that the custodian will furnish VNS CHOICE with the appropriate affidavits in the form acceptable to the Plan and the New York Insurance Department for the securities referred to in such affidavits to be recognized as admitted assets of the Plan.
- 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 and/or issued by internal or independent auditors.

It is recommended that the aforementioned custodial agreement be revised to make VNS CHOICE and Chase Manhattan Bank the principal parties.

It is recommended that the Plan then amend the custodial agreement with Chase Manhattan Bank to include the abovementioned provisions requiring: the bank to maintain in-force Bankers Blanket Bond Insurance, that the custodian will give the securities it holds the same care as its own property, that the custodian will furnish VNS CHOICE with appropriate affidavits, and that the custodian will allow the insurer the opportunity to obtain the most recent report on the review of the custodian's system of internal controls.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of September 30, 2005. This is the same as the balance sheet filed by the Plan in its September 30, 2005 cost report:

Assets	Examination	Plan
Cash – on hand or in bank	$ 40,183,308	$ 40,183,308
Premiums receivable – net	1,254,102	1,254,102
Prepaid expenses	19,381	19,381
Total current assets	41,456,791	41,456,791
NYS escrow account balance	4,909,007	4,909,007
Other restricted funds	834,111	834,111
Long-term investments	44,378,645	44,378,645
Total other assets	50,121,763	50,121,763
Furniture and equipment – net	554,590	554,590
Leasehold improvements - net	54,814	54,814
Total property and equipment	609,404	609,404
Total assets	$ 92,187,958	$ 92,187,958

Liabilities	Examination	Plan
Accounts payable	$ 8,238,861	$ 8,238,861
Claims payable	3,716,409	3,716,409
Accrued other medical	16,187,062	16,187,062
Amounts due to affiliates	372,080	372,080
Total current liabilities	28,514,412	28,514,412
Deferred expenses	94,247	94,247
Total non-liabilities	94,247	94,247
Total liabilities	28,608,659	28,608,659
Net Worth		
NYS contingency reserve	7,664,488	7,664,488
Net assets – all other	55,914,811	55,914,811
Total net worth	63,579,299	63,579,299
Total liabilities and net worth	$ 92,187,958	$ 92,187,958

Note 1: VNS CHOICE files its annual and quarterly cost reports with the New York State Departments of Health and Insurance on a consolidated basis, with its subsidiary VNS Community Care. Inter-company account balances between VNS CHOICE and VNS Community Care are reported as "net" amounts on the cost report filings.

Note 2: The Plan is a tax exempt organization. The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2004. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Net Worth

Net worth increased $63,579,299 during the examination period, January 1, 1998 through September 30, 2005, detailed as follows:

Revenue and Expense Statement

Revenue		
Medicaid premium revenue		$ 895,896,093
Spend-down and NAMI		11,883,482
Total premium revenue		$ 907,779,814
Net investment income		10,811,195
Other income		1,872,741
Total revenue		$ 920,463,750
Medical and Hospital Expenses		
Nursing facility	$ 69,798,237	
Pharmacy	71,124,717	
Home health aide	429,364,386	
Durable medical equipment & supplies	12,863,737	
Other services	104,076,647	
Total medical and hospital expenses		$ 687,227,724
Care management		96,907,303
Administrative Expenses		
Allowable administrative expense		66,259,852
Total expenses		$ 850,394,879
Underwriting income		70,068,871
Less: Non-allowable administrative expenses		2,121,585
Operating income		67,947,286
Aggregate write-ins for other expenses		1,867,987
Net income		$ 66,079,060

Change in Net Worth

Net worth of VNS CHOICE at inception January 1, 1998			$ 239
	Gains in Net Worth	Losses in Net Worth	
Net income	$ 66,079,060		
Equity transfer to Parent Company		$ 2,500,000	
	$ 66,079,060	$ 2,500,000	
Net increase in net worth			$ 63,579,060
Net worth per report on examination as of September 30, 2005			$ 63,579,299

4. CLAIMS PAYABLE

The examination liability of $28,514,412 is the same as the amount reported by the Plan on its September 30, 2005 cost report filing.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based upon statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through December 31, 2005, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan’s past experience in projecting the ultimate cost of claims incurred.

5. MARKET CONDUCT

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 general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at the practices of the Plan in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Denied claims
D. Explanation of benefits statements
E. Grievances
F. Utilization Review

A. Claims Processing

A review of the Plan's claims practices and procedures was performed by using a statistical sampling methodology covering claims adjudicated during the period January 1, 2005 through September 30, 2005, in order to evaluate the overall accuracy and compliance of VNS CHOICE's claims processing environment.

The claim population for the Plan consisted only of network provider claims. Some of the claims reviewed included items such as: transportation services, prescription drug, and durable medical equipment claims. The random statistical sample detailed below included claims from each of the aforementioned segments.

A sample of 167 randomly selected unique claim transactions was selected for review. Additional random samples were generated as "replacement items" in the event it was determined a particular claim transaction selected in the sample should be excluded. Accordingly, various replacement items were appropriately utilized.

This statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each item in the sample.

For the purpose of this report, a "claim" as defined by VNS CHOICE is the total number of items submitted by a single provider with a single claim form, as reviewed and entered into its claims processing system. This claim may consist of various lines, procedures or service dates. It was possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims, or the sample unit. To ensure the completeness of the claims population being tested, the total dollars paid during the period January 1, 2005 through September 30, 2005 were accumulated and reconciled by the examiner to the paid claims data reported by VNS CHOICE in its cost reports filed with the Department.

The examination review revealed a calculated Financial error rate of 1.2%, thus overall claims processing accuracy levels were 98.8%. In addition, the examination review revealed a calculated Procedural error rate of 1.8%, thus overall claims processing procedural accuracy levels were 98.2%. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with the Plan's claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy**.** However, a financial error is caused by a procedural error and as such, it is counted both as a financial error and a procedural error. In summary, of the 167 claims reviewed, there were three (3) procedural errors, two (2) of which resulted in financial errors.

The following charts illustrate the financial and procedural claims accuracy findings determined by the examination as detailed above:

Summary of Financial Claims Accuracy

Total Population	16,919
Sample size	167
Number of claims with errors	2
Calculated error rate	**1.20%**
Upper error limit	2.85%
Lower error limit	0.0%
Calculated claims in error	**203**
Upper limit claims in error	482
Lower limit claims in error	0

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

Summary of Procedural Claims Accuracy

Total Population	16,919
Sample size	167
Number of claims with errors	3
Calculated error rate	**1.80%**
Upper error limit	3.81%
Lower error limit	0.0%
Calculated claims in error	**305**
Upper limit claims in error	645
Lower limit claims in error	0

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

B. Prompt Pay Law

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

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

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

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

> "(c) 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 or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

In order to test the Plan's compliance with the Prompt Pay Law, a statistical sample of 167 claims processed during the period January 1, 2005 through September 30, 2005 was drawn from claims not adjudicated within 45 days of submission to the Plan. A determination was then made regarding whether the timeliness of the payment was in violation of the timeframe requirement of Section 3224-a(a) of the New York Insurance Law, and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law.

The following charts illustrate Prompt Pay compliance as determined by this examination:

Summary of Violations of Section 3224-a(a) of the New York Insurance Law

Total Population	16,919
Eligible population of claims adjudicated past 45 days of receipt	430
Sample size	167
Number of claims with errors	161
Calculated error rate	**96.41%**
Upper error limit	99.23%
Lower error limit	93.58%
Calculated claims in error	**415**
Upper limit claims error	427
Lower limit claims in error	402

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

Summary of Violations of Section 3224-a(c) of the New York Insurance Law

Total Population	16,919
Eligible population of claims adjudicated past 45 days of receipt	430
Sample size	167
Number of claims with errors	25
Calculated error rate	**14.97%**
Upper error limit	20.38%
Lower error limit	9.56%
Calculated claims in error	**64**
Upper limit claims in error	88
Lower limit claims error	41

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

It should be noted that the extrapolated number of violations relates only to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt, based upon the examiner's calculation for claims adjudicated by the Plan during the period January 1, 2005 through September 30, 2005.

The population of network claims adjudicated after forty-five days from the date of receipt for the Plan consisted of 430 claims, out of 16,919 claims processed by it during the period January 1, 2005 through September 30, 2005.

It is recommended that the Plan take steps to ensure that the provisions of Section 3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with.

It is also recommended that the Plan implement the necessary procedures and training in order to ensure compliance with Section 3224-a(a) of the New York Insurance Law.

It is further recommended that the Plan comply with the requirements of Section 3224-a(c) of the New York Insurance Law by calculating interest due on all claims paid after 45 days of receipt, and remitting interest due on all applicable claims.

Section 3224-a(b) of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (Prompt Pay Law) requires all insurers to issue claim denials or request all additional information needed to determine liability to pay the claim within 30 days of receipt of the claim.

Section 3224-a(b)(1) of the New York Insurance Law states:

> "In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim.
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment."

Network claims on the claims data file provided to the examiners that were not paid, and for which the Plan had not issued a denial or sent a request for additional information within 30 days of receipt were segregated. There were 170 claims that were identified as within this category. A sample of 25 of these claims was selected for review and the following was noted:

- The review found that 23 of the 25 claims were denied, and that VNS CHOICE failed to issue the denial letter within 30 days of receipt of the claim as is required by the above statute. Approximately half of these claims were denied because they were duplicate submissions, or they were paid as part of another claim; the balance were denied for various other reasons.

- The review found that 2 of the 25 claims required additional information to pay the claim. VNS CHOICE failed to send a letter, for either claim, requesting the additional information within 30 days of receipt of the claim.

It is recommended that VNS CHOICE comply with the requirements of Section 3224-a(b)(1) of the New York Insurance Law by issuing denials, or requesting additional information needed to adjudicate claims, within 30 days of receipt of the claim.

C. Utilization Review

VNS CHOICE provided the examiners with a log containing 52 utilization review files covering the period January 1, 2005 through September 30, 2005. A sample of 15 cases was selected for review by the examiners.

Section 4903(2) of the New York Public Health Law states:

> "A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date."

For three of the fifteen files reviewed, VNS CHOICE failed to maintain documentation on when the letter of determination was issued to the enrollee.

It is recommended that the Plan implement the necessary procedures and training to ensure that determination letters are sent to enrollees, in compliance with the requirements of Section 4903(2) of the New York Public Health Law.

Further, Section 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243) which sets forth standards of retention of records by an insurer states:

> "Except as otherwise required by law or regulation, an insurer shall maintain:
>
> Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

It is recommended that the Plan comply with the requirements of Section 243.2(b)(8) of Department Regulation 152 and retain all required documentation for its utilization review files for 6 calendar years, or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review.

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. *22241*

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, *GREGORY V. SERIO*, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Wai Wong

as a proper person to examine into the affairs of the

VNS Choice

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

Company

with such information as he shall deem requisite.

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

this *29th* day of *July* *2004*

Gregory V. Serio
Superintendent of Insurance