REPORT ON EXAMINATION

OF

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN

AS OF

JUNE 30, 2004

DATE OF REPORT **SEPTEMBER 27, 2006**

EXAMINER **VICTOR ESTRADA**

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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

September 27, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 22362, dated May 3, 2005, attached hereto, I have made an examination into the condition and affairs of State-Wide Schools Cooperative Health Plan ("the Plan"), a municipal cooperative health benefit plan certified under the provisions of Article 47 of the New York Insurance Law, as of June 30, 2004, and submit the following report thereon.

The examination was conducted at the offices of Wright Risk Management Company ("WRM"), the administrator of the Plan. The main office of WRM is located at 333 Earle Ovington Boulevard, Uniondale, New York. Additional financial and administrative functions were also conducted at WRM's Albany, New York office, located at 24 Aviation Road.

Wherever the terms "SWSCHP" or "the Plan" appear herein, without qualification, they should be understood to indicate State-Wide Schools Cooperative Health Plan.

1. SCOPE OF EXAMINATION

A report on organization as of March 31, 2003 was issued July 2003. This examination covered the period from April 1, 2003 through June 30, 2004. Where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2004 were also reviewed. The Plan's fiscal year is July 1st to June 30th.

The examination comprised a verification of assets and liabilities as of June 30, 2004, in accordance with Statutory Accounting Principles ("SAP"), as adopted by the Department, 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 controls
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
Business in force
Reinsurance
Accounts and records
Financial statements
Market conduct activities

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.

2. DESCRIPTION OF PLAN

The Plan is a multi-employer self-funded health benefits program operated exclusively for the benefit of the employees/retirees and their dependents of member City School Districts ("CSD") and Union Free School Districts ("UFSD"). The Plan has been in existence since 1986 and is composed of twenty-three separate school districts. It was issued a Certificate of Authority on October 1, 2003 by this Department, pursuant to the provisions of Article 47 of the New York Insurance Law, to operate as a municipal cooperative health benefit plan in accordance with its approved Cooperation Agreement in the State of New York, including the county of Westchester, where it originated as the Southern Westchester Schools Cooperative Health Plan.

The Plan participants as of the examination date were as follows:

Ardsley UFSD
Bronxville UFSD
Byram Hills CSD
Dobbs Ferry UFSD
Eastchester UFSD
Edgemont UFSD
Greenburgh #11 UFSD
Greenburgh Central Schools #7
Harrison CSD
Hastings-on-Hudson UFSD
Hawthorne-Cedar Knolls UFSD
Irvington UFSD
Mt. Pleasant-Blythdale UFSD
Mt. Pleasant Central Schools
Mt. Pleasant Cottage School
Mount Vernon CSD
Pelham UFSD
Portchester-Rye UFSD
Rye City School District
Rye Neck UFSD
Tarrytown UFSD
Tuckahoe UFSD
White Plains CSD

As of June 30, 2004, the Plan had the following service agreements in place:

1) Wright Risk Management Company – Plan management and administrative services;
2) Empire HealthChoice Assurance Inc. – claims processing and related functions, including utilization review, in regard to hospital and medical claims;
3) Medco Health Solutions – prescription drug claims processing;
4) Milliman Consultants – actuarial services and rate making.

A. Management

Pursuant to its Municipal Cooperation Agreement, the management of the Plan is vested in a Board of Governors. The Municipal Cooperation Agreement of the Plan specifies that the Board of Governors shall select from among them, an Executive Committee consisting of a minimum of seven Governors.

As of the examination date, the Executive Committee was comprised of the following seven members:

Name and Residence	Principal Business Affiliation
Dr. Kimberly Bucci Hawthorne, NY	Assistant Superintendent-Business, Rye Neck UFSD
Dr. Norman Freimark Yonkers, NY	Superintendent, Mount Pleasant Cottage School
Josephine Moffett Bronx, NY	Superintendent, Greenburgh Central Schools # 7
James Reese Holmes, NY	Assistant Superintendent-Business, Irvington UFSD

Name and Residence	Principal Business Affiliation
Terrence Schruers Greenwich, CT	Assistant Superintendent-Business, White Plains CSD
Dr. Edward Shine Easton, CT	Superintendent, Rye CSD
Dr. Robert Siebert Briarcliff Manor, NY	Superintendent, Eastchester UFSD

A review of the minutes of the Executive Committee meetings conducted during the examination period indicated that the meetings were generally well attended. However, Josephine Moffett attended less than fifty percent (50%) of the meetings she was eligible to attend.

Members of the Executive Committee have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that Executive Committee members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached. Executive Committee members, who fail to attend at least fifty percent (50%) of the Committee's meetings, unless appropriately excused, do not fulfill such criteria. Executive Committee members who are unable or unwilling to attend meetings consistently should resign or be replaced.

It is recommended that the Board of Governors take corrective action by developing a policy to evaluate whether Executive Committee members who are unable or unwilling to attend meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the Executive Committee, a key criterion should be

their willingness and commitment to attend meetings and participate in the Committee's responsibility to oversee the operations of the Plan.

The principal officers of the Plan as of June 30, 2004, were as follows:

Name	Title
Dr. Robert Siebert	President
Dr. Edward Shine	Vice President
James Reese	Chief Financial Officer

The Plan has a Conflict of Interest policy in place for members of its board. The policy requires that each board member annually complete a questionnaire regarding activities or interests that might impair or have the appearance of impairing independence of judgment. The examiners reviewed the declarations for the examination period and no issues were noted.

In accordance with the requirements of Section 4703(b)(2) of the New York Insurance Law, the Plan maintains adequate fidelity bond coverage for its Chief Financial Officer.

B. Territory and Plan of Operation

As of June 30, 2004, the Plan's Certificate of Authority, authorized by §4704 of the New York Insurance Law, allowed it to operate the business of a municipal cooperative health benefit plan in the State of New York, including the county of Westchester.

The Plan's enrollment consisted of 10,194 members at June 30, 2004, which represented an approximate twenty percent (20%) increase from the prior year-end when the enrollment level was 8,435 members. This increase in enrollment was primarily due to the addition of the Mount Vernon City School District in January 2004.

C. Stop-Loss Coverage

In accordance with the requirements of Sections 4707(a)(1) and (2) of the New York Insurance Law, the Plan had stop-loss coverage in effect from Highmark Life Insurance Company of New York, as of the examination date. The contract was renewed subsequent to the examination date, on July 1, 2004.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of June 30, 2004. This statement is the same as the balance sheet filed by the Plan in its annual statement as of June 30, 2004:

Assets	Examination	Plan
Cash	$29,096,258	$ 29,096,258
Premiums receivable	175,036	175,036
Aggregate write-ins:		
claim credits	1,100,000	1,100,000
Total assets	$30,371,294	$30,371,294
Liabilities		
Accounts payable	$ 1,558,306	$ 1,558,306
Claims payable	8,083,000	8,083,000
Additional reserve	2,869,105	2,869,105
Aggregate write-ins:		
escrow	2,082,977	2,082,977
Total liabilities	$14,593,388	$14,593,388
Net Worth		
Contingency reserves	$ 3,582,473	$ 3,582,473
Retained earnings (fund balance)	12,195,433	12,195,433
Total net worth	15,777,906	15,777,906
Total liabilities and net worth	$30,371,294	$30,371,294

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2004. Recognizing that the Plan is a municipal cooperative health benefit plan which falls under IRC Section 115(1), which exempts the Plan from federal income tax, 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

A report on organization was conducted as of March 31, 2003. This examination covered the period from April 1, 2003 through June 30, 2004. Net worth increased by $12,441,825 during the examination period, April 1, 2003 through June 30, 2004, detailed as follows:

Revenue		
Premiums	$86,194,301	
Net investment income	271,046	
Total revenue		$86,465,347
Expenses		
Total medical and hospital expenses	71,886,583	
Administration expenses	7,073,218	
Total expenses		78,959,801
Net Income		$ 7,505,546

Changes in Net Worth

Net worth per report on organization as of March 31, 2003			$ 3,336,081
	Gains in Net Worth	Losses in Net Worth	
Net income	$7,505,546		
Decrease in health claims payable	692,683		
Changes in retained earnings	4,243,596		
Net increase in net worth			$12,441,825
Net worth per report on examination as of June 30, 2004			$15,777,906

4. CLAIMS PAYABLE

The reserves reported under this caption are required to be established pursuant to §4706(a)(1) of the New York Insurance Law, which states:

> "(a) Notwithstanding any provision of law, the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan's chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:
>
> (1) a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount will be adequate."

The liability established by the Plan as of the examination date was below the above-mentioned twenty-five percent (25%) reserve requirement. In June 2003, the Plan requested, and was granted permission by this Department, to reduce its reserves for claims and related expenses to 17% ($8,083,000 claims payable and a $2,869,105 additional reserve, which are reflected in the balance sheet contained herein as liabilities) of the current year's expected incurred claims and expenses.

In February 2004, the Plan reached a settlement of two million dollars ($2,000,000) with its third party administrator ("TPA") for hospital and medical claims, Empire HealthChoice Assurance, Inc. ("Empire"), an accident and health insurer licensed under the provisions of Article 42 of the New York Insurance Law. The Plan's settlement with Empire was deemed restitution for claims payment issues, in regard to

assertions by the Plan that Empire failed to properly administer SWSCHP's claims. The settlement reached applied to all claims as of November 1, 2003.

The settlement resulted in Empire crediting the Plan with five hundred thousand dollars ($500,000) on its bill for the month of March 2004; subsequent credits of one hundred thousand dollars ($100,000) were made on each of the next fifteen (15) monthly bills, ending June 2005. The two million dollar ($2,000,000) settlement was deemed complete financial resolution for all claims payment issues and errors relating to the Plan's claims incurred as of November 1, 2003. The examiner was able to substantiate amounts credited to the Plan.

It was noted that the Plan did not reflect the $2 million claim "adjustment" in its "lag tables" containing historical claims payment information. However, its actuary (Milliman Consultants) was made aware of these amounts and the transaction was noted in the notes to its financial statements.

In addition to the above observation, the examiner determined that the Plan failed to report a liability pertaining to its prescription drug expense in its filed annual statement as of June 30, 2004. While the amount is deemed immaterial for the purposes of this report, such liability should be reported in the financial statements filed with this Department in accordance with the requirements of Statement of Statutory Accounting Principles (SSAP) No. 55 (Unpaid Claims, Losses, and Loss Adjustment Expenses) and §4706(a)(1) of the New York Insurance Law.

It is recommended that the Plan record and report all of its claims liabilities in its financial statements filed with this Department in accordance with the requirements of Statement of Statutory Accounting Principles (SSAP) No. 55 and §4706(a)(1) of the New York Insurance Law.

5. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The review was directed at the practices of the Plan in the following major areas:

A. Claims processing
B. Utilization review

The following are the examiner's findings:

A. Claims Processing

The examination included a review of the Plan's claims settlement practices and oversight of the claims adjudication process by Plan management. As noted above, Empire HealthChoice Assurance, Inc. ("Empire"), an accident and health insurer licensed under the provisions of Article 42 of the New York Insurance Law, is the Plan's third party administrator ("TPA") of hospital and medical claims. As such, Empire is

responsible for most aspects of claims settlement, including utilization review and the issuance of explanation of benefits statements. Certain recommendations to Plan management, included herein under the Claims Processing section, resulted from Empire's failure to process claims in full compliance with the Plan's offered benefits and applicable statutes. Therefore, these recommendations included herein also apply to Empire in its role as TPA, and as an entity regulated by this Department.

The Plan's management demonstrated thorough oversight of the claims processing activities. Since the management of the Plan retains the ultimate responsibility for compliance with the applicable provisions of the New York Insurance Law and related Regulations, its management must remain diligent in its oversight of the claims settlement function.

A review of Empire's claims practices and procedures was performed by using a statistical sample covering claims adjudicated during the period of July 1, 2003 through June 30, 2004, in order to evaluate the overall accuracy and compliance environment of its claims processing.

The claim populations for the Plan were divided into Medical and Hospital claim segments, respectively. The sample size for each segment was comprised of 167 randomly selected unique claim transactions. Thus, in total, three hundred and thirty-four (334) claims were selected for this review.

The 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 claim in the sample.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report; "claim" is defined by the Plan as a grouping of all line items (e.g., procedures or services) on any one claim form. It is possible, through the computer program used for this examination, to match or "roll-up" all procedures into one line, which is 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 were accumulated and reconciled to the paid claims data reported by the Plan for the period July 1, 2003 through July 30, 2004.

The examination review of the Plan's claims determined a financial error rate of 7.19% for medical claims and 2.99% for hospital claims, respectively. Thus, overall claims processing financial accuracy levels were 92.81% for medical claims and 97.01% for hospital claims. Procedural error rates were determined to be 19.76% for medical claims and 7.78% for hospital claims, respectively. Thus, overall claims processing procedural accuracy levels were 80.24% for medical claims and 92.22% for hospital claims.

The financial claims accuracy level is defined as the percentage of times the dollar value of the claim payment was correct. The procedural claims accuracy level is defined as the percentage of times a claim transaction was processed in accordance with the Plan's (Empire'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 as both a financial error and a procedural error. In summary, of the one hundred and sixty-seven (167) medical claims reviewed, twelve (12) contained financial errors and there were thirty-three (33) procedural errors; of the one hundred and sixty-seven (167) hospital claims reviewed, five (5) contained financial errors and there were thirteen (13) procedural errors.

The following charts illustrate the financial and procedural claims accuracy noted above:

Summary of Financial Claims Accuracy

	Medical Claims	Hospital Claims
Total claim population	822,443	31,694
Sample size	167	167
Number of claims with financial errors	12	5
Calculated error rate	**7.19%**	**2.99%**
Upper error limit	11.10%	5.58%
Lower error limit	3.27%	0.41%
Calculated claims in error	**59,097**	**948**
Upper limit claims in error	91,291	1,769
Lower limit claims in error	26,894	130

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

	Medical Claims	Hospital Claims
Total claim population	822,443	31,694
Sample size	167	167
Number of claims with procedural errors	33	13
Calculated error rate	**19.76%**	**7.78%**
Upper error limit	25.80%	11.85%
Lower error limit	13.72%	3.72%
Calculated claims in error	**162,515**	**2,466**
Upper limit claims in error	212,190	3,756
Lower limit claims in error	112,839	1,179

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).

During the process of reviewing the claim transactions within the above claim samples, the following was noted:

- Various claim overpayments/underpayments
- Incorrect reimbursement rates used
- Payment of claim for terminated member
- Misapplication of co-payments
- Incorrect coordination of benefits ("COB") information provided

Empire stated that it is aware of system problems with regard to the misapplication of co-payments and it is currently working to remedy this situation.

It is recommended that Empire correct its claim processing errors in regard to the misapplication of co-payments, whether related to system problems or manual intervention.

It is also recommended that Empire share overpayment reports with SWSCHP to apprise them of any outstanding overpayment amounts and the current status of recovery activity. Additionally, Empire should consider the reduction of future benefit payments by the outstanding amounts due.

The examiner noted numerous instances where information regarding coordination of benefits ("COB") was not processed in a timely fashion, resulting in the Plan paying claims as primary instead of secondary. In addition, there was one instance where termination of a member was not made timely, which resulted in payment of claims for the terminated member.

It is recommended that Empire and SWSCHP implement adequate controls in regard to system updates on coordination of benefits (COB) and membership information, in order to avoid overpayment of claims where other coverage or no coverage may exist.

It is also recommended that Empire take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider retraining individuals who process claims.

B. Utilization Review

§4901, §4902, §4903 and §4904 of the New York Insurance Law set forth the minimum program standards and requirements for utilization review determinations and appeals of adverse determinations by utilization review agents.

The examiner reviewed medical utilization reviews performed during the six month period ending June 30, 2004, all of which were administered by Empire. The Plan is not required to report utilization review cases in its filed annual or quarterly statements, nor its data requirements filings. Per the examiner's request, Empire provided the examiner with a listing of cases requiring utilization review determinations covering the period January 1, 2004 through June 30, 2004. Twenty (20) cases were selected for review by the examiner.

Twelve (12) of the cases selected for review pertained to "prospective" utilization review determinations, which are subject to the provisions of §4903(b) of the New York Insurance Law, which states:

> "(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the health care provider by telephone and in writing within three business days of receipt of the necessary information."

For the Plan files reviewed, it was determined that two prospective utilization review cases failed to provide a notice of determination within three business days as required by §4903(b) of the New York Insurance Law.

It is recommended that in regard to prospective utilization reviews, the Plan (Empire) comply with the requirements of §4903(b) of the New York Insurance Law by providing notices of determination within three business days, by telephone and in writing, to the insured or the insured's designee and the provider.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on organization, as of March 31, 2003, contained one recommendation, as follows (page number refers to the prior report):

ITEM NO.		PAGE NO.
1.	Claims Settlement and Grievances	
	It is recommended that the Plan maintain a complaint log with which to monitor complaints that are forwarded by the Insurance Department's Consumer Services Bureau.	8
	The Plan has complied with this recommendation.	

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Management	
	It is recommended that the Board of Governors take corrective action by developing a policy to evaluate whether Executive Committee members who are unable or unwilling to attend meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the Executive Committee, a key criterion should be their willingness and commitment to attend meetings and participate in the Committee's responsibility to oversee the operations of the Plan.	5
B.	Claims Payable	
	It is recommended that the Plan record and report all of its claims liabilities in its financial statements filed with this Department in accordance with the requirements of Statement of Statutory Accounting Principles (SSAP) No. 55 and §4706(a)(1) of the New York Insurance Law.	12
C.	Claims Processing	
i.	It is recommended that Empire correct its claim processing errors in regard to the misapplication of co-payments, whether related to system problems or manual intervention.	17
ii.	It is also recommended that Empire share overpayment reports with SWSCHP to apprise them of any outstanding overpayment amounts and the current status of recovery activity. Additionally, Empire should consider the reduction of future benefit payments by the outstanding amounts due.	17
iii.	It is recommended that Empire and SWSCHP implement adequate controls in regard to system updates on coordination of benefits (COB) and membership information, in order to avoid overpayment of claims where other coverage or no coverage may exist.	18
iv.	It is also recommended that Empire take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider retraining individuals who process claims.	18

ITEM **PAGE NO.**

D. Utilization Review

It is recommended that in regard to prospective utilization reviews, the Plan (Empire) comply with the requirements of §4903(b) of the New York Insurance Law by providing notices of determination within three business days, by telephone and in writing, to the insured or the insured's designee and the provider. 19

Appointment No. *22362*

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Victor Estrada

as a proper person to examine into the affairs of the

State-Wide Schools Cooperative Health Plan

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

Company

with such information as he shall deem requisite.

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

this *3rd* day of *May 2005*

Howard Mills
Acting Superintendent of Insurance