REPORT ON EXAMINATION

OF

ORANGE-ULSTER SCHOOL DISTRICTS HEALTH PLAN

AS OF

JUNE 30, 2003

DATE OF REPORT	**JUNE 4, 2004**
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

Gregory V. Serio
Superintendent

June 4, 2004

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the directions contained in Appointment Number 22076, dated July 3, 2003, annexed hereto, I have made an examination into the condition and affairs of Orange-Ulster School Districts Health Plan, a municipal cooperative health benefit plan licensed under the provisions of Article 47 of the New York Insurance Law at its home office located at 163 Harriman Heights Road; Monroe, New York. The following report thereon is respectfully submitted.

Wherever the terms "O-U SDHP" or "the Plan" appear herein, without qualification, they should be understood to refer to Orange-Ulster School Districts Health Plan.

This examination has determined that the Plan was solvent in the amount of $1,261,735, but its contingency reserve of $3,028,008 was impaired in the amount of ($1,766,273) as of June 30, 2003. Refer to item 4 herein.

1. SCOPE OF EXAMINATION

A report on organization was issued as of December 31, 1999. This examination covers the period from January 1, 2000 through June 30, 2003. Transactions subsequent to this period were reviewed where deemed appropriate. It should be noted that the Plan operates on a calendar year basis.

The examination comprised a verification of assets and liabilities as of June 30, 2003, in accordance with Statutory Accounting Principles, 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:

History of the Plan
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
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.

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 school districts ("SD") and the Orange-Ulster Board of Cooperative Educational Services ("BOCES"). The Plan has been in existence since 1982 and is composed of nineteen school districts and the Orange-Ulster BOCES. It was issued a certificate of authority on November 1, 2000, pursuant to the provisions of Article 47 of the New York Insurance Law.

The Plan participants are as follows:

Chester Union Free SD	Middletown City SD
Cornwall Central SD	Minisink Valley Central SD
Eldred Central SD	Monroe-Woodbury Central SD
Florida Union Free SD	Pine Bush Central SD
Goshen Central SD	Marlboro Central SD
Greenwood Lake Union Free SD	Port Jervis City SD
Highland Falls Central SD	Tuxedo Union Free SD
Kiryas Joel Village SD	Valley Central SD
Livingston Manor Central SD	Warwick Valley SD
Orange-Ulster BOCES	Washingtonville SD

The Plan's home office is located at 163 Harriman Heights Road; Monroe, New York 10950. At this location, most administrative functions are performed, except certain claims functions detailed below. In addition, accounting functions are performed at the Orange-Ulster BOCES' office located in Goshen, New York.

The Plan entered into administrative services agreements, whereby certain third party administrators ("TPAs") process health benefit claims submitted. For the fiscal year ended June 30, 2003, the Plan had administrative services agreements with the following:

(1) Independent Employee Consultation Services, Inc. ("INDECS") – Claims processing;
(2) PCS Health Systems – Prescription drugs claims processing.

The Plan is billed an administration fee by the TPAs for services rendered.

During the exam period, medical utilization review was performed by BeechStreet Corporation ("BSC") from January 1, 2003 through March 31, 2003, and HealthCare Strategies ("HCS") since April 1, 2003. INDECS entered into agreements with these entities; the Plan was not a party to these agreements.

The Plan is held to the requirements of Article 49 of the New York Insurance Law (Utilization Review and External Appeal), as a condition of its Insurance Department certification. Article 49 permits delegation of utilization review ("UR") activities by an "insurer" to a contracted UR agent pursuant to Section 4900(i) of the New York Insurance Law.

However, Orange Ulster is not a party to the contract delegating the UR function. The requirements of the above mentioned statute obliges the Plan to be a party to the contract with the UR agent.

It is recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs either directly or indirectly by the Plan.

A. Management

Pursuant to its Municipal Cooperation Agreement, the management of the Plan is vested in a board of directors. The Municipal Cooperation Agreement of the Plan specifies that the board of directors shall consist of the Superintendent of Schools, or his designee, for the aforementioned School Districts, and the Orange-Ulster BOCES.

As of June 30, 2003, the members of the board of directors of the Plan, with their principal business affiliations, were as follows:

Name and Residence	Principal Business Affiliation
Erin Brennan Newburgh, NY	Business Administrator, Chester Union Free SD
James Christie Warwick, NY	Assistant Superintendent-Business, Cornwall Central SD
Elizabeth McKean Jeffersonville, NY	Business Manager, Goshen Central SD
Michael Henery Monroe, NY	Business Administrator, Greenwood Lake Central USFD
Rachell Harmer Cornwall, NY	Business Official, Highland Falls Central SD
Steven Bernardo Bronx, NY	Business Manager, Kiryas Joel Village SD

Name and Residence	Principal Business Affiliation
Neysa Sensenig Grahamsville, NY	Business Administrator, Marlboro Central SD
Tim Conway Goshen, NY	Deputy Superintendent, Middletown City SD
Priscilla Holden Middletown, NY	Assistant Superintendent-Business, Minisink Valley Central SD
Terrence Olivo Central Valley, NY	Superintendent, Monroe-Woodbury Central SD
Deborah Heppes Goshen, NY	Assistant Superintendent-Finance, Orange-Ulster BOCES
Deborah Brush Pine Bush, NY	Assistant Superintendent-Business, Pine Bush Central SD
Larry Lawrence Port Jervis, NY	Assistant Superintendent-Business, Port Jervis City SD
John Staiger Wallkill, NY	Assistant Superintendent-Business, Tuxedo Union Free SD
Peter Roden Montgomery, NY	Assistant Superintendent-Business, Valley Central SD
Tom Gustainis Warwick, NY	Assistant Superintendent-Business, Warwick Valley SD
Janet Barbour Newburgh, NY	Assistant Superintendent-Business, Washingtonville SD
Ivan Katz Eldred, NY	Superintendent, Eldred Central SD
Debra Lynker Livingston Manor, NY	Superintendent, Livingston Manor Central SD
Howard Cohen Florida, NY	Business Official, Florida Union Free SD

A review of the attendance records at board of directors' meetings held during the period under examination revealed that meetings were generally well attended. However, designees from Eldred Central SD, Livingston Manor Central SD and Kiryas Joel Village SD did not attend any of the meetings that were held during 2002. In addition, no attendance at board meetings was noted for the designees of Eldred Central SD, Kiryas Joel Village SD and Livingston Manor Central SD for the six month period ending June 30, 2003. It should be noted, however, that sufficient members were present at the board meetings for a quorum. In addition, Eldred Central SD and Livingston Manor CSD are not located in Orange County, and the Municipal Cooperation Agreement only calls for school districts in Orange County to be entitled to vote.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Board members who fail to attend at least one-half of the board's meetings, unless appropriately excused, do not fulfill such criteria.

It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.

The following were the principal officers of the Plan as of June 30, 2003:

Name	Title
Terrence Olivo	Chairman
Priscilla D. Holden	Secretary
William Ingles	Plan Administrator

Article 4 of the Plan's Municipal Cooperation Agreement and by-laws states in part:

"The officers of this Board of Directors shall be as follows:

1. A Chairperson, elected annually in October.
2. A Secretary, elected annually in October.
3. A Plan Administrator, appointed by the Chairman annually in October.
4. A Chief Fiscal Officer, appointed by the Chairman annually in October through December 2003."

Through December 31, 2003, the Plan still had not elected a Chief Fiscal Officer. In the interim, the Chairperson (Terrence Olivo) serves as the Chief Fiscal Officer.

It is recommended that the Plan complies with its Municipal Cooperation Agreement and by-laws by appointing a Chief Fiscal Officer.

§4705(c)(2) of the New York Insurance Law states:

"(c) A municipal cooperation agreement shall include a provision:

(2) designating one governing board member to have custody of all reports, statements and other documents of the plan."

The Plan was unable to provide the examiner with all the provider contracts between INDECS and BSC and HCS, respectively, on behalf of the Plan.

It is recommended that the Plan complies with §4705(c)(2) of the New York Insurance Law by maintaining custody of all relevant documents in its home office.

Subsequent to the examination date, INDECS provided the Plan Administrator with the provider contracts between INDECS and BSC and HCS.

The minutes of the May 21, 2002 meeting of the Plan's board of directors reflected a motion made and accepted by the board to amend the Plan's administrative services agreement with INDECS. This amendment was for the provision of additional Plan management services, effective July 1, 2002, for an annual fee not to exceed ninety-nine thousand dollars ($99,000).

The $99,000 "fee" amount reflected salary, benefits, and payroll taxes to be made in compensation to the Plan Administrator. The Plan Administrator received a W-2 from the Plan's third party administrator ("TPA"), INDECS.

B. Territory and Plan of Operation

As of June 30, 2003, the Plan held a certificate of authority to operate the business of a municipal cooperative health benefit plan as authorized by §4704 of the New York Insurance Law in the counties of Orange, Sullivan and Ulster.

The Plan obtained stop loss coverage from Standard Security Life Insurance Company of New York, effective January 1, 2003.

The Plan's enrollment consisted of 8,253 members at June 30, 2003, which represents a 3% increase from December 31, 2002, when the enrollment level was 8,034. Enrollment as of December 31, 2001 was 8,109.

C. Conflict of Interest

The Plan disclosed in its responses to the General Interrogatories, Item 3, in all its filed Annual Statements for the period under examination that, "it has an established procedure for disclosure to its Board of Directors, of any material interest or affiliation on the part of its officers, directors, or responsible employees which is in, or is likely to, conflict with the official duties of such person." However, the Plan was unable to provide such policy to the examiners and it was determined that the Plan did not maintain a code of ethics, nor did it require its directors and officers to annually complete conflict of interest disclosures.

It is recommended that the Plan adopts a formal code of ethics and requires that its directors and officers annually sign conflict of interest statements.

It should be noted that subsequent to the examination date, the Plan provided the examiner with a conflict of interest policy adopted by its board in September 2003.

It is also recommended that the Plan provides accurate responses when filling out the General Interrogatories filed with this Department.

D. Accounts and Records

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

1. A review of the cash account indicated that the Plan recorded a liability for "accounts payable" that reflected a negative balance in its claims disbursement bank account after deducting outstanding checks (net account overdraft of $16,324). While no exam change is warranted, such amounts should be reported as a negative "cash" asset in the Plan's filed Annual Statement in accordance with Statement of Statutory Accounting Principles #2, paragraph 5.

It is recommended that the Plan presents its accounts in compliance with the requirements of Statement of Statutory Accounting Principles #2, paragraph 5.

2. A review of the Plan's Schedule F ("Claims Payable Analysis") in its filed annual statement with the Department for the year ending December 31, 2002, revealed that the Plan incorrectly prepared Schedule F. Specifically the following was noted:

   - The Plan incorrectly reported "estimated incurred but unreported claims" in "Schedule F - Claims Payable Analysis, Section II-Analysis of Unpaid Claims-Current". The amounts reported in Section II - "Analysis of Unpaid Claims-Current", for estimated "incurred but unreported" must be calculated in accordance with §4706(a)(1) of the New York Insurance Law (this matter is detailed further in Item 4 of this report). However, it was noted that the annual statement instructions need clarification.

   - The amounts reported in Section II - "Analysis of Unpaid Claims-Current", for total claims payable, must equal the amount reported on Section III, line 4, column D plus column E. These amounts did not equal on the aforementioned Schedule in the Plan's December 31, 2002 filed annual statement.

It is recommended that the Plan takes the necessary steps to complete its Schedule F ("Claims Payable Analysis") in accordance with the annual statement instructions.

3. Certain balance sheet numbers reflected in the Plan's 2000 filed annual statement for the "prior year" column (1999) were different from what the Plan reported in its 1999 filed annual statement.

It is recommended that the Plan exercises due diligence in preparing its annual statement and reports the actual balances from the previous year's annual statement in the "prior year" column in the "current year" annual statement.

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 in its filed June 30, 2003 quarterly statement:

Assets	Examination	Plan	Net Worth Increase (Decrease)
Cash	$ 21,699	$ 21,699	
Short-term investments	18,808,000	18,808,000	
Premiums receivable	207,063	207,063	
Total assets	$19,036,762	$19,036,762	
Liabilities	**Examination**	**Plan**	
Accounts payable	$ 327,948	$ 327,948	
Unearned premiums	5,943,334	5,943,334	
Claims payable (inc. clm. stab.)	11,503,745	13,190,503	$1,686,758
Total liabilities	$17,775,027	$19,461,785	$1,686,758
Net Worth			
Contingency reserves	$ 3,028,008	$ 3,028,008	
Retained earnings (fund balance)	(1,766,273)	(3,453,031)	$1,686,758
Total net worth	1,261,735	(425,023)	$1,686,758
Total liabilities and net worth	$19,036,762	$19,036,762	

This examination has determined that the Plan was solvent in the amount of $1,261,735, but its contingency reserve of $3,028,008 was impaired in the amount of ($1,766,273) as of June 30, 2003. Refer to item 4 herein.

B. Statement of Revenue, Expenses and Net Worth

A report on organization was issued as of December 31, 1999. This examination covers the period from January 1, 2000 to June 30, 2003. Reserves and unassigned funds decreased $8,966,784 during the examination period, January 1, 1999 through June 30, 2003, detailed as follows:

Revenue		
Premiums	$183,088,091	
Net investment income	2,598,747	
Total revenue		$185,686,838
Expenses		
Total medical and hospital expenses	192,131,545	
Administration expenses	8,581,374	
Total expenses		200,712,919
Net Loss		$ (15,026,081)
Changes in Net Worth		
Net Worth as of December 31, 1999, per report on organization		$ 10,228,519

	Gains in Net Worth	Losses in Net Worth	
Net Loss		$(15,026,081)	
Decrease in estimated health claims payable	$1,686,758		
Decrease in claim stabilization reserves	5,449,536		
Decrease in stop loss reserve	31,000		
Aggregate write-ins for other net worth items		(118,001)	
Increase in claims payable		(989,996)	
Total gains and losses	$7,167,294	$(16,134,078)	
Net Decrease in net worth			(8,966,784)
Net Worth as of June 30, 2003, per report on examination			$ 1,261,735

4. CLAIMS PAYABLE (INCLUDING CLAIM STABILIZATION RESERVE)

The examination liability of $11,503,745 is $1,686,758 less than the $13,190,503 reported by the Plan in its filed quarterly statement as of June 30, 2003. 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 was below the above-mentioned 25% reserve requirement, although the Plan had not received permission from the Superintendent to establish a reserve below its statutory requirement. However, subsequent to the date of examination, the Plan submitted a request for a reduction in the reserve to reflect the analysis of its independent actuary.

The examination analysis of this liability was conducted in accordance with generally accepted actuarial standards and practices and utilized statistical information contained in the Plan's internal records and in its filed annual and quarterly statements, as well as additional information provided by the Plan. The Department's analysis confirmed that the reserve could

be lowered from the amount established by the Plan as of the examination date. The entire examination decrease in this liability is based on the Department's actuarial review. The reduction is limited to the reserve liability reported at June 30, 2003.

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.

Although the exam review was focussed on claims settlement practices, it was noted that the Plan's summary plan documents and related forms were not properly amended to include newly mandated benefits. Specifically, the documents needed to be changed to address the benefits for the diagnosis and treatment of infertility under Section 4303(s) of the Insurance Law, as amended by Chapter 82 of the Laws of 2002 and the benefits of the Women's Health and Wellness Act of 2002. The Women's Health and Wellness Act of 2002 amended Sections 4303(p) and 4303(t) and added new Sections 4303(bb) and 4303(cc) to the Insurance Law. Chapter 82 took effect on September 1, 2002 and applied to contracts issued, renewed, modified or amended on and after that date. The Women's Health and Wellness Act took effect on January 1, 2003 and applied to contracts issued, renewed, modified, altered and amended on and after that date.

It is recommended that the Plan modify its contract documents to conform to the aforementioned statutory changes. It is further recommended that the Plan reprocess all claims where such benefits were not properly afforded since the effective date of each respective statute.

The Department and the Plan are involved in ongoing discussions to resolve the issue of compliance with Section 4303(s).

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

A. Claims processing
B. Utilization review
C. Explanation of benefits statements
D. Grievances, appeals and complaints

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. INDECS is the Plan's third party administrator ("TPA") of claims. As such, INDECS is responsible for most aspects of claims settlement, including grievances and appeals and issuance of explanation of benefits statements. Certain recommendations to Plan management included herein under the claims subsection resulted from INDECS' failure to process claims in full compliance with applicable statutes. Therefore, these recommendations included herein also apply to INDECS, in its role as TPA; as well as the entities detailed herein that INDECS contracts with to perform its contractual duties on behalf of the Plan.

However, the management of Orange-Ulster School Districts Health Plan retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related Regulations, and therefore its management must be diligent in its oversight of the claims settlement function.

It is recommended that Plan management fulfills its responsibility for compliance with New York Insurance statutes, rules, and regulations, as regards claims settlement practices, via stronger oversight of its TPA's practices.

It is further recommended that all "claims settlement" recommendations be brought to the attention of INDECS and immediately remedied.

A review of INDECS' claims practices and procedures was performed by using a statistical sample covering claims paid during the period of January 1, 2003 through June 30, 2003, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiners selected a sample of 167 claims, which included both medical claims and hospital claims.

The statistical random sampling process, which was performed using the computer software program ACL, was devised 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. A “claim” is defined by INDECS as groupings of six line items (e.g. procedures or services) on any claim form. Each additional six lines on the claim form are entered into the claims system as a separate claim. This claim may consist of various lines, or procedures. It is possible, through the computer systems used for this examination, to match or “roll-up” all procedures on the six line items 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 financial data reported by the Plan for the period January 1, 2003 through June 30, 2003. In order to further verify the accuracy of the information reported in INDECS’ lag data, the examiners reviewed arbitrarily selected cells from the “lag charts” it provided. The examiners noted data entry errors in cells regarding the claims service date for five (5) of the seventeen (17) claims selected for review**.**

The examination review revealed that the overall claims processing financial accuracy level was 99.4% for Medical and Hospital claims combined. The overall claims processing procedural accuracy level for these claims was 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 INDECS’ claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. If a financial error is caused by a procedural error, it is

counted both as a financial error and a procedural error. In summary, of the 167 claims reviewed, three contained procedural errors and there was one financial error.

Although the error rate was consistent with usual health industry norms, it was noted that INDECS does not perform any formal quality control reviews or audits to check the accuracy of recorded claims transactions (e.g., payment dollar, payment incidence, coding, procedural and total claim accuracy), nor does it have any benchmarks by which to measure accuracy or timeliness of payments made.

The Plan's Certified Public Accountant ("CPA") reviews claims as part of its audit procedures. However, this review is limited in scope and the claims information is only verified to the extent required by the function being reviewed, rather than the claims processing procedure as a whole. Further, subsequent to 2000, the Plan's TPA, INDECS, made a business decision (based on the small amount of errors it uncovered) to discontinue its formal internal audit of its claims processing. INDECS does, however, track claims "exceptions" (calls received from provider or members regarding amount paid and or provider status) as they occur. INDECS provided the examiners with its daily error register, which captures claims that were adjusted, for April, May and June of 2003.

The following represents various errors noted by the examiner:

- "Examiner error" vs. "system error"
- Benefits calculated incorrectly

- Benefits paid "out-of-network" when they should have been paid "in-network"
- Incorrect contract rate used
- Errors by managed health benefits TPA (Quantum - mental health benefits)

It is recommended that INDECS continue to take proactive steps to identify and correct errors that may be occurring on an ongoing basis and consider providing retraining to individuals who consistently appear on the daily error register.

It is recommended that external audits of INDECS' claims processing function(s) be performed on an annual basis and that the results be provided to the Plan's management.

It is also recommended that the Plan obtains periodic reports from INDECS that measure claims processing accuracy, and that it obtains the results of all internal reviews and audits of INDECS' claim processing functions.

INDECS states that it uses the 90th percentile of Ingenix's fee data to establish and maintain their reasonable and customary profiles for out-of-network benefits. Allowances are updated twice a year; however, the claims system does not automatically adjust for the date of service. This application does not ensure that aged claims are held to prior allowances.

It is recommended that INDECS investigate possible system enhancements that will facilitate the application of prior allowances to aged claims to ensure they receive the proper reimbursement of benefits.

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, respectively.

All medical utilization reviews performed during the six months ending June 30, 2003, were administered by BeechStreet Corporation and HealthCare Strategies. The Plan is not required to report cases reviewed in its filed annual statements, quarterly statements, nor data requirements. INDECS provided the examiners with a listing of cases requiring utilization review determinations through June 30, 2003. Twenty-seven cases were selected for review. All files were reviewed to determine compliance with §4901, §4902, §4903 and §4904 of the New York Insurance Law.

§4901(a) and (b)(1) of the New York Insurance Law state:

> "(a) Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to section (b) of this section."
>
> "(b) Such report shall contain a description of the following:
>
> (1) The utilization review plan."

INDECS, acting on behalf of the Plan, was unable to provide the examiner with the filed utilization review plans utilized by HealthCare Strategies ("HCS") and BeechStreet Corporation ("BSC"). INDECS, however, provided the examiners with a certification for HCS from the New York State Department of Health, which was effective August 14, 2003; subsequent to the date of the examination. HCS has not yet filed a report with the Insurance Department per the

requirements of Article 49 of the New York Insurance Law. As of the examination date, INDECS no longer contracted with BSC.

While it was apparent that HCS had filed a plan as required by §4901(1) and §4902(2)(a) of the Public Health Law, which contains similar requirements to the above statute, such plan was not provided to the examiner in its entirety, nor did HCS fully comply with its filing requirements under Article 49 of the New York Insurance Law.

It is recommended that the Plan, in its oversight of the claims settlement function, require that third parties acting on its behalf comply with §4901(a) and (b)(1) of the New York Insurance Law.

It is further recommended that HCS file the required documentation with the Insurance Department.

Subsequent to the examination date, HCS filed its utilization review report with the Insurance Department.

Furthermore, §4903(b) of the New York Insurance Law 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."

It was noted that for all cases reviewed by the examination, HCS and BSC completed their utilization reviews within the required 3 days. However, the examiner found that written notice to the insured and/or the provider for the cases reviewed by HCS was not sent in all instances. It is HCS' policy that a written response be provided when HCS provides a

"determination" (i.e. a response which is made to any issue) or makes an "adverse determination". For certain instances such as pre-certifications or second surgical opinions (i.e. when a "determination" was not made); notifications were only done via telephone.

Should any "determination" be made, then the Plan should provide written notices to insureds and providers regarding utilization review determinations in accordance with §4903(b) of the New York Insurance Law.

Additionally, §4903(e) of the New York Insurance Law states in part:

> "(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
>
> (1) The reasons for the determination including the clinical rationale, if any;
> (2) Instructions on how to initiate standard appeals and expedited appeals …
> (3) Notice of availability, upon request of the insured, or the insured's designee, of the clinical review criteria… Such notice shall also specify what, if any, additional necessary information must be provided…"

Notices reviewed by the examiner stated that claimants had 180 days to file an appeal. This is contrary to the Plan's appeals procedures, which require appeals to be filed within 60 days.

It is recommended that the utilization review notices provided to Plan members agree with the Plan's appeal instructions.

As was noted previously in this report, the Plan was not a party to the agreements that INDECS had with BSC and HCS, in their capacity as third party administrators for the utilization review function.

Therefore, it is recommended that the Plan's agreement with INDECS be amended to include verification that all claims settlement functions contracted out to third parties, by INDECS, be audited, and that the results of these audits be submitted to Plan management for their review.

It is further recommended that the Plan's agreement with INDECS contains performance measurements for the claims settlement functions performed by INDECS, and any other party it contracts with.

C. Explanation of Benefits Statements ("EOB")

As part of the review of the Plan's claims practices and procedures, an analysis of the "EOBs" sent to subscribers and/or providers by INDECS, as the Plan's TPA, was performed. An EOB is an important link between the subscriber, the provider, and the Plan. It should clearly communicate to the subscriber and/or provider that the Plan has processed a claim and how that claim was processed. It should clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed the provider. It should also serve as the documentation necessary to recover any money from coordination of benefits with other carriers.

Overall, the Plan's EOBs are easy to read and understand. However, subsequent to the examination date, in November 2003, the Plan revised its EOBs, and the following was noted:

§3234(b)(7) of the New York Insurance Law states in part:

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

> (7)…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 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."

The Plan does not include the information required by §3234(b)(7) on its EOBs since it does not contain language on potential forfeiture of members' rights.

It is recommended that the Plan modify its EOBs to comply with §3234(b)(7) of the New York Insurance Law.

This recommendation is the result of the failure of the Plan's TPA, INDECS, to issue EOBs in a manner compliant with §3234(b)(7) of the New York Insurance Law.

The Plan provided evidence that its EOBs were amended, in March 2004, to include wording regarding the potential forfeiture of members' appeal rights.

D. Grievances, Appeals and Complaints

§4704(a)(8) of the New York Insurance Law states:

> "(a) The superintendent shall issue a certificate of authority to a municipal cooperative health benefit plan if all of the following conditions, after examination and investigation, have been met to the superintendent's satisfaction:
>
> (8) the municipal cooperative health benefit plan has established a fair and equitable process for claims review, dispute resolution and appeal procedures including arbitration of rejected claims, and procedures for handling claims for benefits in the event of plan dissolution, which are satisfactory to the superintendent."

The Plan has a four step appeals procedure included in its filed Plan Document which appears to be "fair and equitable". The Plan maintains files of grievances submitted to the appeals committee. In addition, INDECS maintains a listing of grievances submitted to the

appeals committee, including grievances that involved a hearing. The examiner selected for review seven (7) files to determine fairness and equity of the outcome of the appeal.

The Plan Document states, "*The Appeals Committee's written response shall cite the reasons for their decisions and the specific Plan provisions upon which their review decision was based.*" Not all written responses reviewed by the examiner cited the specific Plan provisions upon which the Plan decision was based. It does appear, however, that at the time of the appeal, all relevant issues regarding the claim had been discussed. Furthermore, the Plan responded to grievances from insureds, and INDECS, where applicable, made the necessary adjustments to claims as a result of grievances filed.

It is recommended that all Appeals Committee's written responses to members cite the reasons for its decisions, and the specific plan provisions upon which their review decision was based.

In addition, the Plan's complaint log was reviewed to verify compliance with Circular Letter No. 11 (1978). While the Plan does maintain a log in which to track complaints received, it was not in accordance with the requirements of said Circular Letter. The Plan was provided with a copy of Circular Letter No. 11 (1978) and agreed to fully comply with its requirements.

6. CONCLUSION

This examination has determined that the Plan was solvent in the amount of $1,261,735, but its contingency reserve of $3,028,008 was impaired in the amount of ($1,766,273) as of June 30, 2003. Refer to item 4 herein.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained four comments and recommendations as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
1.	It is recommended that the board members be required to sign conflict of interest statements.	4
	The Plan has not complied with this recommendation. A similar recommendation is made in this report.	
2.	It is recommended that the Plan apply to the Superintendent for a waiver of stop-loss insurance coverage if the Plan determines such coverage is not necessary. Alternatively, should the Plan not apply for such waiver, then it is recommended that the stop-loss insurance be purchased.	7
	The Plan has complied with this recommendation.	
3.	It is recommended that the Plan establish its claim reserves and its contingency reserves in a manner to allow it to qualify for waiver of stop-loss coverage.	8
	As of the examination date the Plan had not fully complied with this recommendation. However, subsequent to the examination date, the Plan submitted a request for a reduction in its claim reserve to reflect the analysis of its independent actuary. The Department's actuarial analysis confirmed that the reserve could be lowered from the amount established by the Plan as of the examination date.	
4.	It is recommended that the Plan maintain a log of complaints sent by the Insurance Department.	8
	The Plan has complied with this recommendation.	

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Insolvency	
	This examination has determined that the Plan was solvent in the amount of $1,261,735, but its contingency reserve of $3,028,008 was impaired in the amount of ($1,766,273) as of June 30, 2003. Refer to item 4 herein.	1, 13, 28
B.	Description of Plan	
	It is recommended that the Plan become a signed party to the contract allowing for the delegation of the utilization review function and all other functions that are delegated to TPAs either directly or indirectly by the Plan.	5
C.	Management	
i.	It is recommended that directors who are unable or unwilling to attend board meetings consistently should resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be their willingness and commitment to attend meetings and participate in the board's responsibility to oversee the operations of the Plan.	7
ii.	It is recommended that the Plan complies with its Municipal Cooperation Agreement and by-laws by appointing a Chief Fiscal Officer.	8
iii.	It is recommended that the Plan complies with §4705(c)(2) of the New York Insurance Law by maintaining custody of all relevant documents in its home office.	8
	Subsequent to the examination date, INDECS provided the Plan Administrator with the provider contracts between INDECS and BSC and HCS.	
D.	Conflict of Interest	
i.	It is recommended that the Plan adopts a formal code of ethics and requires that its directors and officers annually sign conflict of interest statements.	10
	It should be noted that subsequent to the examination date, the Plan provided the examiner with a conflict of interest policy adopted by its board in September 2003.	

Respectfully submitted,

_____
Victor Estrada,
Senior Insurance Examiner

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

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

_____
Victor Estrada

Subscribed and sworn to before me

this ____day of _____2004.

Appointment No. ***22076***

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:

Victor Estrada

as a proper person to examine into the affairs of the

Orange Ulster Muni-Coop Health Insurance, Inc.

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 *July 2003*

Gregory V. Serio
Superintendent of Insurance