REPORT ON EXAMINATION

OF

SENIOR WHOLE HEALTH OF NEW YORK, INC.

AS OF

DECEMBER 31, 2014

DATE OF REPORT **JULY 20, 2017**

EXAMINER **TOMMY KONG, CFE**

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

July 20, 2017

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and New York Public Health Law, and acting in accordance with the instructions contained in Appointment Number 31353, dated May 27, 2015, attached hereto, I have made an examination into the condition and affairs of Senior Whole Health of New York, Inc., a for-profit health maintenance organization certified pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2014, and respectfully submit the following report thereon.

The examination was conducted at the home office of Senior Whole Health of New York, Inc. located at 58 Charles Street, Cambridge, Massachusetts.

Wherever the designation the "HMO" appears herein, without qualification, it should be understood to indicate Senior Whole Health of New York, Inc.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

Senior Whole Health of New York, Inc. was previously examined as of December 31, 2011. This examination of the HMO was a combined (financial and market conduct) examination and covered the three-year period from January 1, 2012 through December 31, 2014. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2015 Edition* (the "Handbook"). The financial examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2014 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the HMO's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the HMO.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

Information concerning the HMO's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the HMO's risks and management activities in accordance with the NAIC's nine branded risk categories. These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The examination also evaluated the HMO's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

The HMO was audited annually, for the years 2012 through 2014, by the accounting firm PricewaterhouseCoopers LLP ("PwC"). The HMO received an unmodified opinion from PwC for each of those years. Certain audit workpapers of PwC were reviewed and relied upon in conjunction with this examination.

The examiner reviewed the corrective actions taken by the HMO with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 6 of this report.

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 an explanation or description.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain material deficiencies during the examination period. The most significant findings of this examination include the following:

- The HMO and TA Associates US Holding Company failed to comply with Part 98 of New York State Department of Health ("DOH") Regulation (10 NYCRR 98-1.9(a)) when they did not obtain approval from DOH prior to the implementation of a change in control of the HMO.
- The HMO failed to comply with Section 3224-a(a) of the New York Insurance Law ("Prompt Pay Law") with regard to its non-Medicare claims.
- The HMO failed to comply with Section 3224-a(b) of New York Insurance Law ("Prompt Pay Law") with regard to the denial of its non-Medicare claims.

3. DESCRIPTION OF THE HMO

The HMO is a for-profit stock company that was incorporated in the State of New York on August 1, 2006. The HMO received a Certificate of Authority ("Certificate"), effective August 17, 2006, from the New York State Department of Health ("DOH") to operate as a health maintenance organization pursuant to Article 44 of the New York State Public Health Law. In addition, the Certificate also empowered the HMO to enroll members covered under the

Medicare program. Subsequent to the HMO commencing business on January 1, 2007, DOH granted the HMO an amended Certificate, effective September 15, 2007, which permitted the HMO to participate in New York State's Medicaid Advantage Program.

The HMO provides managed health care services to dual-eligible members who qualify to receive Medicare and Medicaid. The HMO also received authorization from the Centers for Medicare and Medicaid Services to operate as a "Special Needs Plan" ("SNP") to its members. SNPs were created by the United States Congress within the Medicare Modernization Act of 2003 as a new type of Medicare managed care plan which focus on certain groups of Medicare beneficiaries: the institutionalized, dual-eligible (Medicare and Medicaid) and beneficiaries with severe or disabling chronic conditions. Beginning in October 2012, DOH granted the HMO approval to write Managed Long Term Care Plan insurance.

A. Corporate Governance

Pursuant to the HMO's by-laws, the board of directors of the HMO shall not be fewer than one (1) nor more than ten (10) members. As of December 31, 2014, the directors of the HMO were as follows:

Name and Residence	Principal Business Affiliation
Wayne Brian Lowell Irvine, California	Chairman and Chief Executive Officer, Senior Whole Health of New York, Inc.
Scott Latimer, M.D. Cambridge, Massachusetts	Chief Medical Officer, Senior Whole Health of New York, Inc.
David Kleinhanzl Stoneridge, New York	President, Senior Whole Health of New York, Inc.

The minutes of all meetings of the board of directors and committees thereof held during the examination period were reviewed. The HMO's by-laws require that the board of directors

meet at least quarterly. The review indicated all board and committee meetings were well attended, with all board members attending at least one-half of the meetings they were eligible to attend. However, it was noted that the board members failed to "sign off" on the prior report on examination.

Section 312(b) of the New York Insurance Law states:

> "(b) A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report."

It is recommended that the HMO comply with Section 312(b) of the New York Insurance Law by requiring each member of its board of directors to sign a statement, which shall be retained in the insurer's files, confirming that such board member received and read the prior report on examination issued by the Department.

A similar recommendation was included in the prior report on examination.

Subsequent to the examination date, the HMO provided signed statements from each board member confirming they have received and read the Department's issued prior report on examination, as required of Section 312(b) of the New York Insurance Law.

As of December 31, 2014, the principal officers of the HMO were as follows:

Name	Title
Wayne Brian Lowell	Chairman and Chief Executive Officer
David Kleinhanl	President
Thurman Rae Justice, CPA	Chief Financial Officer
Carissa Neubig	Chief Administrative Officer and Corporate Secretary

B. Internal Audit

As of December 31, 2014, the HMO did not staff an internal audit function. Given the significant growth of the HMO over the past several years and as a best practice, the HMO's board members should periodically review the requirements for an internal audit function and document their decision in their meeting minutes. Any internal audit function should be independent of management and adhere to the guidance promulgated under the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing ("Standards"). Consistent with the Standards, the internal audit function should be aligned under the direct supervision of the audit committee, with administrative reporting to management. In addition, the audit committee should take the responsibility for reviewing the performance of the internal audit director, including details of the internal audit director's compensation. Documentation of this review should be maintained by the audit committee.

As a best business practice, it is recommended that the HMO ensures that its board members periodically review the requirements for an internal audit function and document their decision in their meeting minutes. It is also recommended, in the event that the HMO establishes an internal audit function, such internal audit function be maintained under the direct supervision of the audit committee, with administrative reporting to management. It is further recommended that the HMO's audit committee should take the responsibility of reviewing the internal audit director's performance and compensation.

C. Territory and Plan of Operation

The HMO obtained its Certificate from the New York State Department of Health as a Medicaid Advantage Plan on September 15, 2007. The Certificate was later amended to allow the HMO to offer Medicaid Advantage Plus on July 1, 2008, and Managed Long Term Care on

October 1, 2012. In 2012, the HMO was authorized to conduct business in the following twelve (12) counties in Upstate New York:

Albany	Montgomery	Schenectady
Columbia	Orange	Ulster
Dutchess	Rensselaer	Warren
Greene	Saratoga	Washington

As of June 1, 2012, the HMO was also authorized to conduct business in the following four (4) counties in New York City:

New York	Bronx	Kings	Queens

As of December 31, 2012, the HMO discontinued operations in all twelve (12) counties in Upstate New York. Effective January 1, 2013, the HMO only operated in the aforementioned four (4) counties in New York City.

The HMO reported premiums written totaling $98,489,943 during the three-year period under examination, from January 1, 2012 through December 31, 2014. Below is a summary of the HMO's total written premiums by county during the examination period.

County	2012	2013	2014	Total
Albany	$ 8,466,966			$ 8,466,966
Bronx	1,176,694	$ 4,611,047	$13,186,622	18,974,363
Columbia	537,074			537,074
Dutchess	965,243			965,243
Greene	134,085			134,085
Kings	166,219	7,442,896	20,679,082	28,288,197
Montgomery	412,991			412,991
New York	547,023	3,576,153	10,027,877	14,151,053
Orange	1,384,192			1,384,192
Queens	14,908	2,132,956	9,276,180	11,424,044
Rensselaer	3,910,674			3,910,674

Saratoga	1,408,522			1,408,522
Schenectady	2,583,627			2,583,627
Ulster	4,660,153			4,660,153
Warren	701,210			701,210
Washington	487,549			487,549
Total	$27,557,130	$17,763,052	$53,169,761	$98,489,943

The following is a summary of the HMO's total premiums written by line of business for the three-year period under examination:

Line of Business	Total
Medicare Advantage (including Part D)	$ 14,772
Medicaid Advantage (including Part D)	9,186,310
Medicaid Advantage Plus and Managed Long Term Care	89,288,861
Total	$98,489,943

The HMO utilizes in-house New York licensed agents that are direct employees of the HMO's affiliate, Senior Whole Health Management Company, Inc. Based on the requirements of the Centers for Medicare and Medicaid Services ("CMS") and the New York State Department of Health, such agents are precluded from making personal contact and a direct solicitation with prospective individual members. Instead, the agents must direct their efforts towards CMS and the local Social Services Departments within each geographic county where the HMO conducts its business. The HMO provides a Special Needs Plan available to citizens 65 years of age or older and other low income adults who are dual eligible (Medicare and Medicaid) recipients. The HMO's health insurance program combines traditional health care services with social support services to accommodate members' collective health, independence and home living needs.

The chart below depicts the total HMO enrollment and the decrease or increase for the periods covered by this examination:

Year	Enrollment	Increase / Decrease
2012	798	
2013	632	20.8% decrease
2014	1,812	186.7% increase

D. Significant Operating Ratios

The following ratios have been computed, as of December 31, 2014, based upon the results of this examination. The ratios presented below are on an earned-incurred basis and encompass the three-year period covered by this examination:

	Amounts	Ratios
Claims	$87,540,793	88.88%
Claims adjustment expenses	6,914,853	7.02%
General administrative expenses	17,403,465	17.67%
Increase in reserves for accident and health contracts	(1,836,000)	(1.86%)
Net underwriting loss	(11,533,168)	(11.71%)
Premiums earned	$98,489,943	100.00%

E. Reinsurance

The HMO held the following ceded reinsurance coverage in effect with Highmark Life Insurance Company, an authorized reinsurer, at December 31, 2014:

Effective Period	HMO's Retention	Reinsurer's Liability
7/1/2014 thru 6/30/2015	$200,000 annually per member	$2 million per member, per contract year, in excess of $200,000 annually per member; $2 million per member, per lifetime.

The reinsurance agreement noted above contained the required clauses, including the insolvency clause, prescribed by Section 1308 of the New York Insurance Law.

F. Disaster Response Plan

It was noted that the HMO failed to file the Department's Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire with the Department by June 1, 2015, as required by Insurance Circular Letter No. 4 (2015).

It is recommended that the HMO complete and file the Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire with the Department, as required by Insurance Circular Letter No. 4 (2015).

Subsequent to the due date of June 1, 2015, the HMO submitted to the Department its Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire.

G. Holding Company System

On December 9, 2015, subsequent to the examination date, the HMO provided the New York State Department of Health ("DOH") and the Department with written notice that in February 2012, TA Associates, Inc., the ultimate parent of the HMO, had converted to a Delaware limited partnership known as TA Associates L.P., the general partner of which is TA Associates US Holding Corp. ("TAUS").

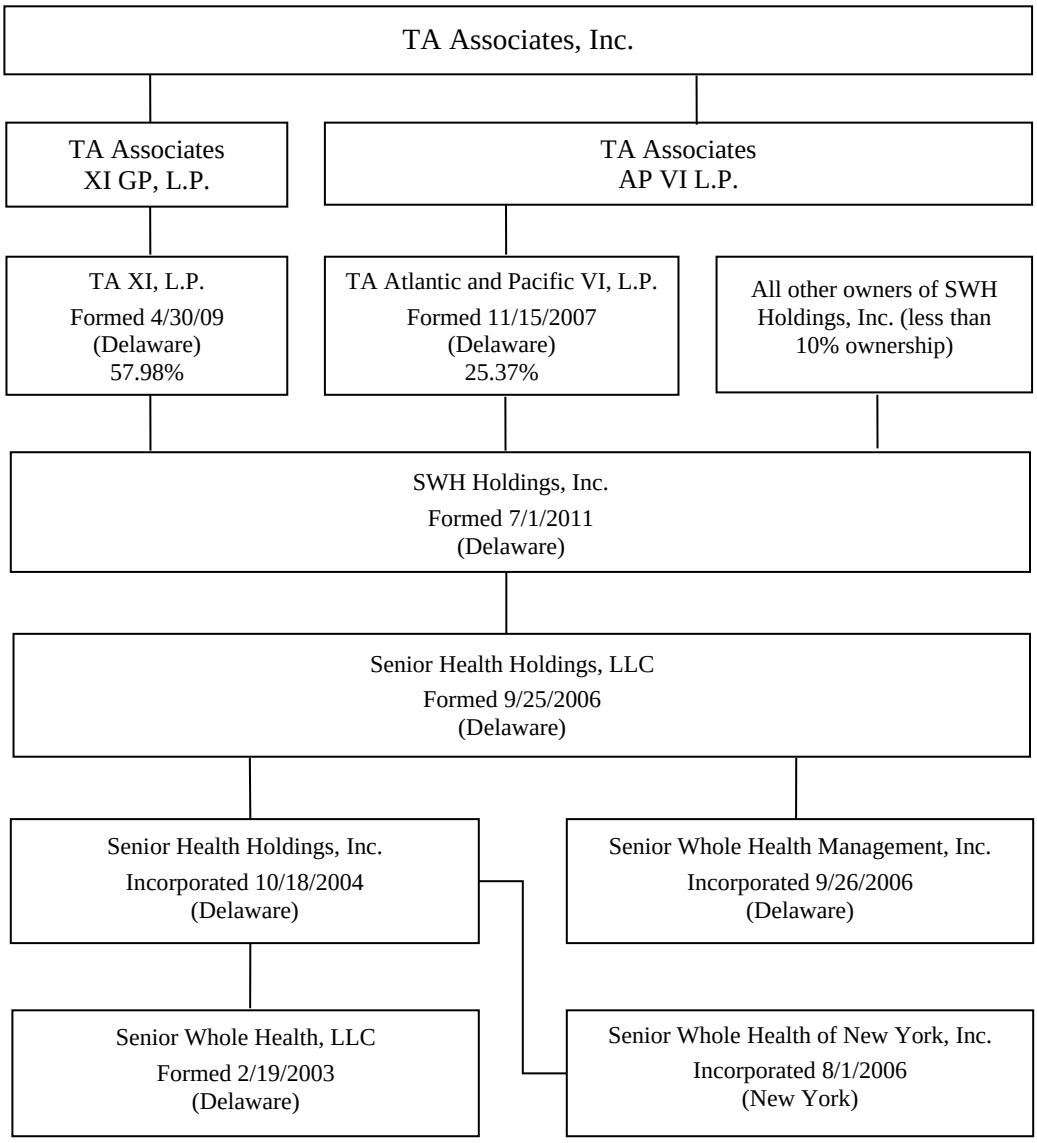
Part 98 of DOH Regulation 10 NYCRR 98-1.9(a) states:

> "No person shall acquire control of any New York State-certified MCO, whether by purchase of its securities or otherwise, unless it receives the commissioner's prior approval, which shall not be issued until the commissioner has consulted with the superintendent, as appropriate."

TAUS did not receive approval for the acquisition of control of the HMO, and appeared to have violated Part 98 of DOH Regulation 10 NYCRR 98-1.9(a), which required prior approval from the commissioner of DOH for such acquisition. On January 29, 2016, TAUS submitted an application to DOH for the acquisition of the HMO to which determination and handling of such matter has been addressed by DOH.

It is recommended that if there is a change in control of the HMO, the potential controlling person and the HMO obtain approval from DOH prior to the implementation of such control change, as required by 10 NYCRR 98-1.9(a).

The following chart depicts the HMO's reporting of the relationship with members of its holding company system as of December 31, 2014. The percentages included in the chart reflect each entities' proportionate ownership.



Note: The board of directors of TA Associates, Inc. had established an investment committee and had delegated to that committee the authority to exercise control over the funds with regard to TA Associates, Inc.'s investments in SWH Holdings and over SWH Holdings or any of the entities owned or controlled by SWH Holdings. If DOH approves TAUS's acquisition of the HMO, the investment committee will no longer have that authority.

Description of Ownership as of December 31, 2014

Senior Health Holdings, LLC ("SHH-LLC") was organized to act as a holding company for Senior Health Holdings, Inc. ("SHH-INC"). SHH-INC is the immediate parent company of the HMO and Senior Whole Health, LLC, a Delaware LLC, organized to provide Medicare and Medicaid benefits in Massachusetts.

On July 27, 2011, the Department received an application from SWH Holdings, Inc. for the acquisition of the HMO, by obtaining control of SHH LLC. A Department investigation revealed that TA Associates, Inc. controlled SWH Holdings, Inc.

TA Associates, Inc. ("TA")

TA, founded in 1968 as a Delaware limited partnership, headquartered in Boston, Massachusetts, with satellite offices in Menlo Park, New Jersey; London, England; Mumbai, India; and Hong Kong, China, is an international private equity firm specializing in acquisitions, capital growth, financing, and initial public offerings. TA had investments that are spread across a range of industries, including technology, healthcare, consumer products, financial services and business services.

The ultimate control of the HMO would reside with the members of TA Associates, Inc.'s investment committee. TA's control of the HMO was determined by virtue of TA's position as a general partner of the intermediate entities.

Senior Health Holdings, LLC ("SHH-LLC")

SHH-LLC was organized on September 25, 2006 as a Delaware limited liability company. SHH-LLC's principal business activities are to: (i) act as a direct holding company for Senior Health Holdings, Inc. and Senior Whole Health Management, Inc.; and (ii) provide capital indirectly to Senior Whole Health of New York, Inc., via Senior Health Holdings, Inc.

Senior Health Holdings, Inc. (“SHH-INC”)

SHH-INC, initially organized on April 30, 2004 as a Delaware limited liability company, was reorganized on October 18, 2004 to a Delaware corporation. SHH-INC’s principal business activity is to act as a direct holding company for the following two affiliated entities: Senior Whole Health, LLC and Senior Whole Health of New York, Inc.

Senior Whole Health, LLC (“SWH-LLC”)

SWH-LLC was organized on February 19, 2003 as a Delaware limited liability company. SWH-LLC’s principal business activity is to provide a new model of health care that expands the provisions of Medicaid and Medicare managed care services to the elderly population in Massachusetts. Such managed care services are provided under a Senior Care Organization contract with Centers for Medicare and Medicaid in partnership with the Commonwealth of Massachusetts.

Senior Whole Health Management Company, Inc. (“SWH-MGT”)

SWH-MGT was incorporated on September 29, 2006 as a Delaware corporation. Its principal business function is to provide administrative and management services to SWH-LLC and Senior Whole Health of New York, Inc. by entering into Outsourced Service agreements and Equipment and Personnel Lease agreements with the aforementioned affiliates.

At December 31, 2014, the HMO had the following inter-company agreements in effect with SWH-MGT:

Outsourced Services Agreement effective October 1, 2006 (Joint Services Agreement)

SWH-MGT provides the HMO with various services, including: accounting/auditing, claims processing, legal compliance, marketing/public relations, information network and software systems, provider credentialing, etc. Reimbursement is on an allocated cost basis with monthly fees payable. Personnel costs charged for services rendered in connection with said agreement pertain only to those used in common (joint expenses) between Senior Whole Health of New York Inc. and any other entities within the holding system.

This agreement, which was amended effective October 1, 2011, was filed with the New York State Department of Health ("DOH") and approved on May 30, 2013. The submission of the original agreement was approved by DOH on August 17, 2006, concurrent with DOH's approval of the HMO's initial certificate of authority. The Department accepted the original agreement on November 8, 2008.

Equipment and Personnel Lease Agreement

SWH-MGT leases to the HMO the services of SWH-MGT's employees and all equipment necessary for the operation of the HMO. Personnel costs charged for services rendered in connection with said agreement shall pertain only to those employees whose time is wholly dedicated to the business and affairs of Senior Whole Health of New York, Inc. Reimbursement is on a cost basis with monthly charges paid monthly.

This initial agreement, effective October 1, 2006, was approved by DOH on August 17, 2006. The Department accepted the initial agreement for filing on November 8, 2008. This agreement was amended, effective June 19, 2009, and approved by DOH on June 2, 2009.

Consolidated Tax Allocation Agreement

This agreement was executed on September 5, 2006 between the HMO and its immediate parent, Senior Health Holdings, Inc. ("SHH-INC"). SHH-INC and its subsidiaries, the HMO and Senior Whole Health, LLC, agreed to the filing of a consolidated Federal income tax return by SHH-INC. This agreement was submitted to DOH with the HMO's initial application for a certification of authority and was approved by DOH on August 17, 2006. The Department accepted the original agreement on November 8, 2008.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following statements show the assets, liabilities, and capital and surplus as of December 31, 2014, as contained in the HMO's 2014 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review.

PricewaterhouseCoopers LLP ("PwC") was retained by the HMO to audit the HMO's statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended.

PwC concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the HMO at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

Assets	
Cash and short-term investments	$22,559,069
Investment income due and accrued	103
Uncollected premiums in course of collection	176,241
Other amounts receivable under reinsurance contracts	3,392
Amounts receivable relating to uninsured plans	12,000
Receivables from parent, subsidiaries and affiliates	250,427
Health care and other amounts receivable	4,984
Aggregate write-ins for other than invested assets	78,309
Total assets	$23,084,525

Liabilities	
Claims unpaid	$12,749,221
Unpaid claims adjustment expenses	130,599
Aggregate health policy reserves	2,000
General expenses due or accrued	3,259,721
Amounts due to parent, subsidiaries and affiliates	1,204,094
Liability for amounts held under uninsured plans	1,000
Aggregate write-ins for other liabilities	115,146
Total liabilities	$17,461,781
Capital and Surplus	
Aggregate write-ins for special surplus funds	$ 20,738
Common capital stock	1,000
Gross paid in and contributed surplus	41,980,725
Aggregate write-ins for other than special surplus funds	2,658,488
Unassigned funds	(39,038,207)
Total capital and surplus	$ 5,622,744
Total liabilities, capital and surplus	$23,084,525

Note: The Internal Revenue Service has not conducted any audits of the federal income tax return filed on behalf of the HMO through tax year 2014. The examiner is unaware of any potential exposure of the HMO to any tax assessments, and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased $4,802,203 during the three-year examination period, January 1, 2012 through December 31, 2014, detailed as follows:

Revenue		
Premium	$98,489,943	
Total revenue		$ 98,489,943
Expenses		
Claims	$56,183,920	
Other professional services	4,741,311	
Outside referrals	3,720,850	
Emergency room and out-of-area	3,634,047	
Prescription drugs	4,775,674	
Aggregate write-ins for other hospital and medical	14,484,991	
Claims adjustment expenses	6,914,853	
General administrative expenses	17,403,465	
Increase in reserves for accident and health contracts	(1,836,000)	
Total underwriting deductions		110,023,111
Net underwriting loss		$(11,533,168)
Net investment income earned		3,210
Net loss		$(11,529,958)

Change in Capital and Surplus

	Gain in Capital and Surplus	Losses in Capital and Surplus	
Capital and surplus, per report on examination, as of December 31, 2011			$ 820,541
Net loss		$11,529,958	
Change in non-admitted assets		434,106	
Paid in surplus	$16,766,265		
Rounding adjustment	2		
Net change in capital and surplus			$4,802,203
Capital and surplus, per report on examination, as of December 31, 2014			$5,622,744

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO 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 HMO in the following major areas:

A. Record Retention Policy
B. Prompt Pay Law

A. Record Retention Policy

During the examination period, the HMO did not maintain a record retention policy. This is not in compliance with Part 243.3(c) of Insurance Regulation No. 152 (11 NYCRR 243.3(c), which requires that:

> "(c) An insurer shall establish and maintain a records retention plan. The plan shall include a description of the types of records being retained, the method of retention, and the safeguards established to prevent alteration of the records. Such plan shall be provided to the superintendent upon request. The insurer shall certify the accuracy of any records that are provided in accordance with its record retention plan."

The above mentioned regulation requires the HMO to have a record retention policy that describes the types of records being retained, method and period of retention, and safeguards established to prevent alteration of listed records.

It is recommended that the HMO establish and maintain a record retention policy, as required by Part 243.3(c) of Insurance Regulation No. 152 (11 NYCRR 243.3(c)).

B. Prompt Pay Law

To determine the HMO's compliance with New York's Prompt Pay Law (Section 3224-a of the New York Insurance Law), a population consisting of all non-Medicare claims received between January 1, 2014 and December 31, 2014 that were not paid within the time frames prescribed by Section 3224-a of the New York Insurance Law were identified and tested. The result of this review revealed that from the total population of 345,601 claims received in 2014 (of which 305,616 were dual-eligible (Medicare and Medicaid) claims, 37,234 were Managed Long Term Care Plan claims, and 2,751 were pharmacy claims), there were 32,120 paper and 38,768 electronic claims that took longer than forty-five (45) days and thirty (30) days to pay, respectively, and 37,132 claims that were denied more than thirty (30) days after receipt of the claim.

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

> "(a) Except in a case where the obligation of an insurer…to pay a claim submitted by a policyholder or person covered under such policy ("covered person") 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…shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

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

> "(b) In a case where the obligation of an insurer…to pay a claim…is not reasonably clear…, an insurer…shall pay any undisputed portion of the claim…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."

A sample of 167 paper claims was extracted from the above population of 32,120 possible violations and reviewed. Of this sample, there were 167 confirmed violations of Section 3224-a(a) of the New York Insurance Law. A sample of 167 electronic claims was extracted from the population of the above 38,768 possible violations and reviewed. Of this sample, there were 167 confirmed violations of Section 3224-a(a) of the New York Insurance Law.

The following chart illustrates the HMO's compliance with Section 3224-a(a) of the New York Insurance Law, as determined by this examination:

Total claims population	345,601
Population of paper claims paid after 45 days of receipt	32,120 *
Sample size	167
Number of claims with violations	167
Calculated violation rate	100%
Lower violation limit	100%
Upper violation limit	100%
Calculated claims in violation	32,120
Lower limit transactions in violation	32,120
Upper limit transactions in violation	32,120

Note: The lower and upper 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).

* Population of paper claims paid after 45 days of receipt represented 9.3% of the total claims population.

Total claims population	345,601
Population of electronic claims paid after 30 days of receipt	38,768 *
Sample size	167
Number of claims with violations	167
Calculated violation rate	100%
Lower violation limit	100%
Upper violation limit	100%
Calculated claims in violation	38,768
Lower limit transactions in violation	38,768
Upper limit transactions in violation	38,768

Note: The lower and upper 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).

* Population of electronic claims paid after 30 days of receipt represented 11.2% of the total claims population.

It is recommended that the HMO comply with Section 3224-a(a) of the New York Insurance Law by making appropriate payment of all claims within the time frames prescribed by the aforementioned section of the Insurance Law.

A sample of 167 denied claims was extracted from the above population of 37,132 possible violations and reviewed. Of this sample, there were 167 confirmed violations of Section 3224-a(b) of the New York Insurance Law.

The following chart illustrates the HMO's compliance with Section 3224-a(b) of the New York Insurance Law, as determined by this examination:

Total claims population	345,601
Population of claims denied after 30 days of receipt	37,132 *
Sample size	167
Number of claims with violations	167
Calculated violation rate	100%
Lower violation limit	100%
Upper violation limit	100%
Calculated claims in violation	37,132
Lower limit transactions in violation	37,132
Upper limit transactions in violation	37,132

Note: The lower and upper 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).

* Population of claims denied after 30 days of receipt represented 10.7% of the total claims population.

It is recommended that the HMO takes step to ensure compliance with Section 3224-a(b) of the New York Insurance Law.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained the following fourteen (14) recommendations (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Corporate Governance	
1.	It is recommended that the HMO's Board of Directors be made aware of all significant events and reports affecting the HMO, so that the Board is afforded the necessary information to enhance its ability to make appropriate decisions and provide knowledgeable direction to the HMO management. *The HMO has complied with this recommendation.*	7
2.	It is further recommended that such key significant events and reports be reflected in the minutes of the Board of Directors. *The HMO has complied with this recommendation.*	7
3.	It is recommended that the HMO maintains and attaches significant presentations, reports, and other detailed documents presented during the board of directors meetings to the board minutes. *The HMO has complied with this recommendation.*	7
4.	It is recommended that each member of the Board of Directors review and sign-off on the report on examination issued by the Department in compliance with Section 312(b) of the New York Insurance Law. *The HMO has complied with this recommendation subsequent to the examination date.*	8
	Enterprise Risk Management	
5.	It is recommended that as good business practice, the Management Company establish a Risk Committee accountable for the overall ERM function. The RC should report directly to the Board of Directors of the HMO. *The HMO has complied with this recommendation.*	9

ITEM NO.		PAGE NO.
6.	It is recommended that the Management Company perform a general risk assessment of the HMO's operations, implement and document strategies that mitigate such risk. Such assessments and strategies should be reviewed and approved by the HMO's Board. *The HMO has complied with this recommendation.*	9
7.	It is recommended that the HMO formalize and document its internal controls review processes and procedures. *The HMO has complied with this recommendation.*	10
	Internal Audit Department	
8.	It is recommended that the internal audit director's reporting process be revised so that the internal audit reporting structure allows direct reporting to the Audit Committee of the Management Company. It is also recommended that the Audit Committee be assigned primary responsibility for the performance evaluation and compensation of the internal audit director. *An internal audit function, including an internal audit director position, was not established during the current or prior examination period. Therefore, the HMO was not required to comply with these recommendations.*	11
9.	It is also recommended that the HMO's Audit Committee maintain documentation to support the Audit Committee's review of the Internal Audit Department ("IAD") director's performance. Details for the IAD director's compensation should also be included. *An internal audit function, including an internal audit director position, was not established during the current or prior examination period. Therefore, the HMO was not required to comply with this recommendation.*	11
	Holding Company System	
10.	It is recommended that the HMO apply for a renewal or extension amendment of the Joint Services Agreement with the New York State Department of Health retroactive to the date the contract expired. In this regard, it is also recommended that such renewal or extension amendment be filed with the Department. *The HMO has complied with this recommendation.*	19

ITEM NO.		PAGE NO.
	Allocation of Expenses	
11.	It is recommended that the HMO refrain from using its current joint expense allocation of premium income methodology as described above and consider as a guide the detailed procedures outlined in Parts 105.25, 106.2 and 109.2 of Department Regulation No. 30. *Pursuant to a New York State Department of Health letter of approval dated May 30, 2013, the HMO was granted approval to use its current allocation methodology.*	20
12.	Further, it is recommended that the HMO recalculate its expense allocations in accordance with Department Regulation No. 30 and make appropriate adjustments to such expenses charged to the HMO, including adjustments applicable to prior years. *Pursuant to a New York State Department of Health letter of approval dated May 30, 2013, the HMO was granted approval to use its current allocation methodology.*	20
	Subsequent Events	
13.	It is recommended that the HMO develop a strategic plan that incorporates the HMO's long and short term goals and objectives which should be updated periodically as strategies are revised and objectives achieved. It is also recommended that such plan be documented, reviewed and approved by the board of directors and provided to this Department. *The HMO has complied with this recommendation.*	27
14.	It is recommended that the HMO at all times, maintain its contingent reserve in compliance with the requirements of Part 98-1.11(e)(2) of the Administrative Rules and Regulations of the New York State Department of Health. *The HMO has complied with this recommendation.*	28

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____
Tommy Kong, CFE
Senior Insurance Examiner

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

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

_____
Tommy Kong, CFE

Subscribed and sworn to before me
this _____ day of _____ 2017

APPOINTMENT NO. 31353

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Tommy Kong

as a proper person to examine the affairs of

Senior Whole Health of New York, Inc.

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

HMO

with such other information as he shall deem requisite.

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

this 27th day of May, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau