

REPORT ON EXAMINATION

OF

TOUCHSTONE HEALTH HMO, INC.

AS OF

DECEMBER 31, 2012

DATE OF REPORT

MARCH 4, 2015

EXAMINER

ANDRE BLACKMAN

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

March 4, 2015

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30884 dated September 25, 2012, attached hereto, I have made an examination into the condition and affairs of Touchstone Health HMO, Inc., a for-profit health maintenance organization (“HMO”) certified under Article 44 of the New York Public Health Law, as of December 31, 2012, and submit the following report thereon.

The examination was conducted at the administrative office of Touchstone Health HMO, Inc., located at 1 North Lexington Avenue, White Plains, NY.

Wherever the designations “Touchstone” or the “Plan” appear herein, without qualification, they should be understood to indicate Touchstone Health HMO, Inc.

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

Wherever the designations “THP” or the “Parent” appear herein, without qualification, they should be understood to indicate Touchstone Health Partnership Inc., the Parent of Touchstone Health HMO, Inc.

Touchstone is a member of a holding company system. Touchstone Health Partnership Inc. is the parent company. Touchstone Health Partnership is owned by private equity partners and individual investors, and holds 100% of the outstanding shares of Touchstone Health HMO, Inc.

Part 98-1.11(e) of the Administrative Rules and Regulations of the New York Department of Health 10 NYCRR 98-1.11 require the Plan to maintain a Contingent Reserve. As of December 31, 2012, the Plan's Contingent Reserve was \$14,890,125. However, as of December 31, 2012, Touchstone's capital and surplus was only \$880,876; the required Contingent Reserve was therefore impaired in the amount of \$14,009,249.

The Plan's financial condition had deteriorated in 2013 and was insolvent in the amount of \$(549,191) as of year-end 2013. The Plan's required Contingent Reserve at December 31, 2013 was \$15.9 million, and it was therefore impaired by \$16.4 million, as of that date. The Plan was still impaired as of June 30, 2014, although the magnitude of the impairment decreased to \$6,811,168, as of that date.

The Plan was instructed to submit a capital plan to cure the impairment in accordance with the Departments guidelines, and as required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the New York Department of Health (10 NYCRR 98-1.11).

1. EXECUTIVE SUMMARY

The examination revealed certain operational deficiencies that occurred during the examination period. New York Insurance Law and Department Regulations were applied except in those instances where the laws and regulations of the Center for Medicare and Medicaid Services (“CMS”) supersede New York Law. The following are the significant findings included within this report on examination:

Significant findings related to this examination include the following:

- Touchstone was determined to be impaired in the amount of \$14,009,249, with a capital and surplus of \$880,876 as of December 31, 2012, but subsequently reduced their impairment to \$6,811,168.
- Touchstone does not verify financial information produced by outside vendors on behalf of the Plan in the process of preparing its financial statements.
- In the absence of an internal audit department, Touchstone’s audit and compliance resources are insufficient to address the full range of Touchstone’s internal audit and compliance needs.
- Touchstone’s controls relating to functions delegated to its vendors are lacking. In order to improve Touchstone’s operating effectiveness and the financial results affected by failed controls, the Plan needs to strengthen its processes, procedures, and oversight for these vendors.
- Touchstone failed to secure an outside auditor’s evaluation, such as SOC-1 or SSAE-16 reports for certain critical IT vendors housing and securing the Plan’s financial data.
- Touchstone lacks a process for attaining signed conflict of interest attestations from its officers and directors.
- Subsequent to December 31, 2012, Touchstone established a reserve of \$600,000 to settle amounts claimed by Montefiore Medical Center that were the result of disputed claims unpaid by Touchstone’s claims administrator, Healthcare Partners IPA.

The above findings are described in greater detail in the remainder of this report.

2. SCOPE OF THE EXAMINATION

The previous financial examination was conducted as of December 31, 2008. This examination is a financial examination as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook* (“FCEH”), 2013 Edition (the “Handbook”) and it covers the four-year period January 1, 2009 to December 31, 2012. The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2012 were also reviewed. In fact, this report contains a “Subsequent Events” section which details several material transactions that occurred subsequent to the exam date.

This examination was conducted using a risk-focused approach 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 Plan’s operations and utilized that evaluation in formulating the nature and extent of the examination. The examination was performed to evaluate the Plan’s current financial condition, as well as identify prospective risks that may threaten the future solvency of the Plan.

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.

Concurrent with the financial examination of Touchstone, a limited and separate market conduct review was completed. It should be noted that Center for Medicare and Medicaid Services' guidelines for Medicare Advantage plans supersede New York rules and regulations concerning the operations of a Medicare Advantage ("MA") HMO, such as Touchstone; and the manner in which the Plan conducts its business and fulfills its contractual obligations to policyholders and claimants. Where it was found that New York rules apply, a review was performed and exceptions from that review are noted in this report on exam.

In developing the exam approach, the examination considered the Plan's organizational structure and control environment, and also evaluated the Plan'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

A review was also made to ascertain what actions were taken by the Plan with regard to comments and recommendations made in the prior report on examination.

The Plan was audited annually by the CPA firm BDO USA, LLP for the years 2009, 2010, 2011, and 2012. The Plan received an unqualified opinion in each of those years. Certain audit work papers of BDO from their 2012 audit year were reviewed and relied upon in conjunction with this examination. A review was also made of Touchstone's corporate governance structure.

This report contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

3. DESCRIPTION OF THE PLAN

Touchstone Health HMO, Inc. is a for-profit health maintenance organization ("HMO") incorporated on May 31, 2006, and it was issued a certificate of authority on June 21, 2007, pursuant to the provisions of Article 44 of the New York Public Health Law. Touchstone is a wholly-owned subsidiary of Touchstone Health Partnership, Inc.

Touchstone became a "Medicare Only" Public Health Law Article 44 health maintenance organization on September 1, 2007, certified to arrange for the delivery of health care services directly to members of a covered Medicare population. The Plan became operational pursuant to the approval by the Centers for Medicare and Medicaid Services ("CMS") as a Medicare Advantage Organization, and thereby being the successor-in-interest to Touchstone Health Partnership, Inc.'s ("Parent") 2007 pre-existing Medicare Advantage Contract.

From inception through December 31, 2008, Touchstone received capital infusions from its Parent totaling \$12,700,000. An additional capital infusion followed on December 31, 2009 in the amount of \$5,000,000, bringing the total amount of capital infused to \$17,700,000. These foregoing amounts are Surplus Notes according to Section 1307 of the New York Insurance. At December 31, 2012, the accrued and unpaid interest on the surplus notes was \$9,151,733. As of the date of this report, none of the principal balance was paid on the surplus notes. More information on the Company's Surplus Notes is presented in Section F. (iii) and in the Subsequent Events Section below.

During 2010, the Plan benefited from a round of financing through an equity offering by its Parent. Touchstone Health Partnership issued Series D Preferred Shares in the amount of \$26,373,772. The capital from this equity transaction repaid some inter-company balances between the Plan and the Parent, paid legal costs for the equity transaction, and increased the capital and surplus levels of the Plan. This equity transaction involved loans from Healthcare Partners, IPA; an affiliated entity. More information on this transaction and the Company's Surplus Notes is presented in Section F. (iii).

A. Management and Controls

Article III, Section 3.01 of the Plan's by-laws provides that the number of directors which shall constitute the entire Board of Directors shall be as set by the Board of Directors from time to time and shall initially be three (3). Directors shall be elected by plurality vote of the stockholders.

The members of the Plan's Board of Directors as of December 31, 2012 were as follows:

| <u>Name and Residence</u> | <u>Principal Business Affiliation</u> |
|--------------------------------------|--|
| Robert Caione Fairfield, CT | President and CEO, Touchstone Health HMO, Inc. |
| Antonio Lopez Staten Island, NY | Enrollee* |
| Nancy Lopez Staten Island, NY | Enrollee* |
| David Pfaff, MD Staten Island, NY | Physician, David R. Pfaff, MD |
| Martin Sepulveda Southbury, CT | Vice President of Integrated Health Services, IBM |

*Enrollee representatives per Part 98-1.11(g) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11(g)).

A review of the attendance records of the Board of Directors' meetings held during the period under examination revealed that meetings were generally well attended with all Board members attending at least one-half of the meetings for which they were eligible to attend.

The principal officers of the Plan as of December 31, 2012 were as follows:

| <u>Name</u> | <u>Title</u> |
|--------------------|-------------------------------|
| Robert Caione | Chief Executive Officer |
| Edward Fargis | General Counsel and Secretary |
| Mark Sudock | Chief Financial Officer |
| Michael Richmond | Chief Information Officer |

A review of the existence and effectiveness of Touchstone's management is a key aspect of the risk-focused examination approach. The work of an effective internal audit area provides management with important information to perform its operations. Section 2, Part 3 of the Handbook ("Assessing the Adequacy of the Audit Function") states in part:

"Well-planned, properly structured audit programs are essential to a strong corporate risk management process. Effective internal and external audit activities create a critical monitoring control against fraud, provide vital information to the board of directors (or audit committee) about the effectiveness of internal control systems and mitigate operating and financial reporting risk..."

It should be noted that, in addition to the absence of a designated internal audit unit, Touchstone's audit and compliance functions were covered by one unit head, a Chief Compliance Officer, and one additional Director of Audit and Compliance. The activities of the Plan surrounding internal audit, compliance, and delegated entity review indicate the need for more extensive audit and compliance activities.

Additionally, a report from the Centers for Medicare and Medicaid Services ("CMS") indicates that more audit and compliance resources are needed by the Plan. The 2010 CMS Audit and Inspection Report issued for Touchstone's Medicare Advantage contracts stated that the Plan, "*lacks adequate audit and compliance resources to carry out its required functions.*" The report also indicates that additional audit and compliance resources should be employed to effectively perform the internal audit and compliance reviews, and as generally determined for proper oversight of an entity's operations.

It is recommended that the Plan seek to employ additional resources to address the audit and compliance needs of the Plan, including adding personnel to perform internal

audits, to conduct compliance-related activities and to exercise oversight over delegated entities.

It was also noted that the Plan delegates certain operational duties and the delegation of some of these duties involves the financial transfer of risk to third parties. Governance over these delegated duties is the responsibility of the compliance and internal audit functions of the Plan. Touchstone continues to be ultimately responsible for duties assigned under a risk transfer agreement.

The oversight of delegated vendors is a critical function that enhances the Plan's ability to serve its subscribers. Touchstone's delegation of global risk to its third-party vendor Health Care Partners ("HCP") heightens the importance of their oversight of this delegated entity.

Part 101.4(b) of Insurance Regulation No. 164 (11 NYCRR 101.4(b)) – "Standards for Financial Risk Transfer between Insurers and Health Care Providers", states:

"Notwithstanding any agreement to the contrary, the insurer retains full financial risk on a prospective basis for the provision of health care services pursuant to any applicable policy or contract. At all times, the insurer must be able to demonstrate to the satisfaction of the superintendent that the insurer can fulfill its non-transferable obligation to provide coverage for health care services to subscribers in any event, including the failure, for any reason, of a financial risk transfer agreement with a provider."

The audit and oversight by the Plan of its delegated entities provides the information needed to determine that each delegated entity is working to effectively provide health care services on behalf of the Plan.

Touchstone performed one limited review of HCP during the examination period. The examiner found that this one review failed to cover key operational areas involving

the Plan's delegated activities. The audit was designated to cover the "general controls environment" of Health Care Partners. However, the actual audit differed from that scope and only covered a limited compliance review. For this reason, the Plan was advised by the examiner to further develop its internal audit functions, and to devise a corrective action plan that serves its delegated entities and would ensure the services rendered by these entities are the focus of a more comprehensive review by the Plan. A corrective action plan was adopted by Touchstone and presented to the examiner while on site. A review of this corrective action plan deemed it to be inadequate, due to the fact that there was no review of claims, utilization review, grievances or appeals. Development and implementation of such plan is the responsibility of Touchstone's officers and directors.

It is recommended that Touchstone develop a comprehensive corrective action plan to address the oversight needed regarding the activities of Health Care Partners and any other delegated entities on behalf of the Plan.

It is also recommended that such comprehensive corrective action plan include goals, roles and responsibilities of assignees, parameters to measure goal attainment, and steps for remediation of deficiencies when identified for any vendor, now or in the future, who accepts global risk from the Plan.

B. Territory and Plan of Operation

The New York State Department of Health issued a (health maintenance organization) certificate of authority to Touchstone Health HMO, Inc., effective June 21, 2007, pursuant to Article 44 of the New York Public Health Law.

The certificate of authority authorized the Plan to offer Medicare products under its Medicare Advantage contract with CMS in the NYS counties of New York, Richmond, Kings, Queens, Bronx, Manhattan, Westchester, Onondaga, Broome, Chenango, Delaware and Orange. Effective December 31, 2011, the Plan ceased providing services to its members in Onondaga, Broome, and Chenango and Delaware counties. As a result of exiting these four counties, the Plan's membership decreased from 15,366 at December 31, 2011 to 11,451 at December 31, 2012.

C. Enrollment

During the four-year examination period January 1, 2009 through December 31, 2012, the Plan experienced a net increase in enrollment of 175 members. An analysis of the enrollment for the exam period is set forth below:

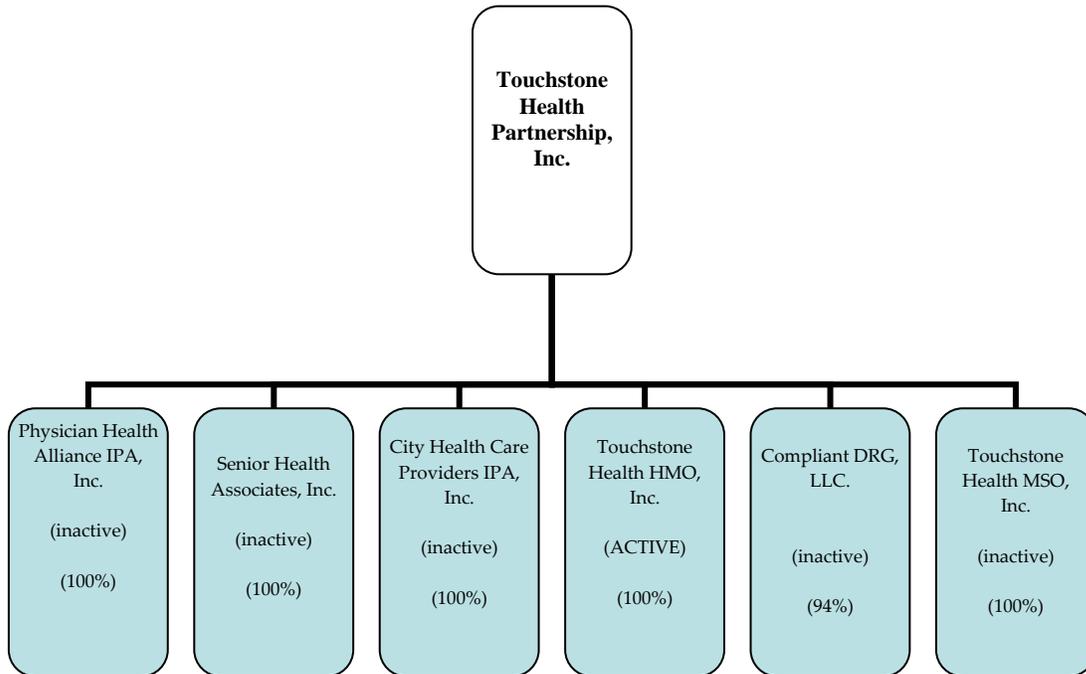
| | <u>2009</u> | <u>2010</u> | <u>2011</u> | <u>2012</u> |
|---|--------------------|--------------------|--------------------|--------------------|
| Enrollment, January 1 st | 11,276 | 14,217 | 16,812 | 15,366 |
| Net gain/(loss) | 2,941 | 2,595 | (1,446) | (3,915) |
| Enrollment at December 31 st | 14,217 | 16,812 | 15,366 | 11,451 |

D. Reinsurance

For the examination period, the Plan did not have any reinsurance in place due to the global capitation arrangement with Health Care Partners which transferred the financial risk for medical care costs. The Plan assumed no reinsurance during the examination period.

E. Holding Company System

The Plan is a wholly-owned subsidiary of Touchstone Health Partnership, Inc. The following chart depicts the Plan’s relationships as of December 31, 2012 to its affiliates within the holding company system:



Touchstone Health MSO, Inc.

As of December 31, 2010, Touchstone Health MSO, Inc. (“MSO”), a wholly owned subsidiary of Touchstone Health Partnership, Inc., ceased operations. MSO was formed to operate as the Plan’s management services organization and accordingly, performed administrative services for the Plan. Subsequently, Healthcare Partners MSO performed these services for the Plan.

Compliant DRG, LLC.

Compliant DRG, LLC was formed to offer hospital coding review services. The business commenced operations during 2011 and ceased operations as of December 31, 2012.

Healthcare Partners Management Services Organization

Effective October 1, 2010, Touchstone entered into a management services agreement with Heritage Northeast Medical Management, Inc., an unaffiliated entity also known as Healthcare Partners Management Services Organization (“HCP MSO”), whereby HCP MSO provides certain operating and customer service activities to Touchstone Health HMO, Inc. The agreement was filed with the Department on August 25, 2010 and provides that Touchstone will pay HCP MSO 3% of its Medicare Part “C” revenues for these services. For the year ending December 31, 2012, these fees amounted to approximately \$4,100,000.

Healthcare Partners IPA

Concurrent with the HCP MSO agreement, Touchstone also entered into an IPA services agreement with Heritage New York IPA also known as Healthcare Partners IPA (“HCP IPA”) for the arrangement and delivery of healthcare services to its subscribers. For the year ending December 31, 2012, the Plan paid capitation to HCP IPA in the amount of \$136,719,644.

Touchstone and HCP IPA are related parties. A principal investor in the Plan’s parent (Touchstone Health Partnership) is also the principal owner of HCP IPA. The common ownership of these two entities makes them related parties.

The October 2010 agreement for the provision of healthcare services between the Plan and HCP IPA was initiated along with two loan agreements between the entities. These loans, in addition to those presented herein under Description of the Plan, are Surplus Notes issued to the Company according to Section 1307 of the New York Insurance. The loan agreements provided Touchstone with the proceeds of \$4,000,000 and \$2,000,000 in October and November 2010, respectively from HCP IPA. The loans are subject to the terms of the agreements between the parties, and are repayable only out of divisible surplus, subject to Department approval. As of the examination date, none of the proceeds were repaid on the loans.

Touchstone pays HCP IPA a capitated rate for the provision of healthcare services to its members according to an IPA services agreement with HCP IPA. A dispute has arisen between the parties surrounding the correct method to calculate capitation payments made to the IPA. As of December 31, 2012, the Plan accrued, as a contingency, an

amount management determined to be the best estimate to settle the dispute. Touchstone had reserved \$1,133,066 out of a disagreed amount that HCP asserts was \$6,300,000 at December 31, 2012. In September 2013, the Plan determined that the disputed amount increased to approximately \$8,000,000 and established a reserve equal to half (\$4,000,000) the estimated disputed amount at December 31, 2013. This legal contingency reserve was reflected in the Plan's financial statements as of December 31, 2013.

F. Accounts and Records

During the course of the examination it was noted that the Plan had certain weaknesses in its operations and controls, and did not comply with certain areas of the New York Insurance Law, Department Regulations, and/or Statements of Statutory Accounting Principles ("SSAP") of the *NAIC Accounting Practices and Procedures Manual*. A description of such items is as follows:

(i) Segregation of Duties

It was noted that certain application level controls were not in place for Touchstone's accounting and reporting software.

Administration of the application is performed by a person from Finance, instead of a person in Information Technology ("IT"). Touchstone's Finance Department purchased, owns, and has administrative and processing rights over the application, while the Plan's IT Division has no access to the application.

Separation of duty controls with regard to the Plan's accounting and reporting application should be developed and implemented. An IT administrator, instead of someone from the Finance Department, should have ownership over application security and program administration.

It is recommended that Touchstone segregates responsibilities for application-level controls surrounding its accounting and reporting application, and assign product ownership and administration to an IT administrator.

It is further recommended that Touchstone establishes roles and responsibilities designed to segregate duties between the IT operations of the Plan and its business units to reduce the possibility that critical processes are compromised.

(ii) Unverified Reports from Vendors

Touchstone delegates certain of its health services to contracted vendors, called "delegated entities" or "first-tier, downstream and related entities" contracted to arrange for the delivery of services such as vision, dental, hearing, and mental health to Touchstone subscribers.

Touchstone is party to such a contract in its global capitation agreement with HCP MSO, a delegated entity. The contract provides that HCP MSO delivers to the Plan, reports on operational outcomes, including operational and statistical data related to the Plan's subscribers. Both the HCP and other IPA agreements of the Plan contain clauses describing the reporting responsibilities of the vendors regarding their activities on behalf of Touchstone.

Section 6.3 “Reporting Requirements” of the HCP contract states:

“In order for Touchstone to monitor MSO’s performance hereunder as it impacts IPA Members, MSO agrees to comply with the reporting requirements and performance standards set forth on the “Delegation Reporting Requirements with Data Definitions” attached hereto as Exhibit 4.1A, as such requirements may be modified by Touchstone from time to time in accordance with section 11.16. MSO agrees to provide Touchstone with all necessary data required to comply with federal or state law or accreditation organization reporting schedules.”

Additionally, Article IV of the IPA services contract “IPA’S OBLIGATIONS AND RESPONSIBILITIES”, Section 4.18.3, subsection (k) states:

“IPA agrees to furnish to Touchstone all of the information necessary for Touchstone to file the New York State Data Requirements for Health Maintenance Organizations annually, including all information to file Report #10 and Report #13. IPA will furnish this information to Touchstone annually, in a timely enough fashion so that the Touchstone [Sic] can file the New York Data Requirements annual filing with the New York Insurance Department and the New York State Department of Health, by the date required by those agencies, pursuant to Section 308 of the New York Insurance Law and 10 NYCRR 98.”

Touchstone prepares and presents an Exhibit in the New York Data Requirements for each of its delegated entities carrying risk on behalf of the Plan. Exhibit #13 – Part B “STATEMENT OF OPERATIONS” for HCP MSO carries the operating results for the vendor (and not the Plan), but documents the capitation amounts received by the vendor from the Plan. During the examination it was found that the amounts reported on Exhibit #13 – Part B “STATEMENT OF OPERATIONS” as capitation revenue received from Touchstone was reported incorrectly. The Plan did not utilize the amount reported in the exhibit for preparing its own annual statement, but used the exhibit as a stand-alone report of HCP’s operations. The amount reported in Exhibit #13 as capitation revenue received from Touchstone by HCP was \$165,879,094, while the amount of capitation reportedly

paid to HCP by Touchstone on its filed annual statement at December 31, 2012 was \$136,719,644.

HCP MSO produced a corrected report of capitation received, and the corrected amount, also shown on a corrected Exhibit #13 – Part B, was \$129,334,866. HCP's corrected amount of capitation revenue still differed from Touchstone's report on capitation revenue paid by an amount of \$7,384,778. Touchstone then provided a reconciliation of this difference, and it was determined that no adjustment to the filed annual statements was needed; except for amending Exhibit #13 as presented herein.

The financial data originally reported in Exhibit #13 – Part B was inaccurate and was unchecked by Touchstone. Touchstone should ensure that it verifies all external vendor-provided financial data on behalf of subscribers covered by the Plan before it includes that data in the statutory annual statements and its exhibits.

It is recommended that Touchstone discloses and presents all financial information completely and accurately in its financial reports and exhibits, including validated financial data received from third-party vendors.

It is also recommended that Touchstone resubmits its December 31, 2012 New York Data Requirements, with the corrected Exhibit #13 – Part B, to the Department.

(iii) Section 1307 Loans

From inception, and in the years following, the Company has been the recipient of loans accounted for as Surplus Notes in accordance with Section 1307 of the New York

Insurance Law. In 2007, the Plan obtained three (3) capital infusions in the form of New York Insurance Law Section 1307 loan agreements from its parent, Touchstone Health Partnership. The initial Section 1307 loan agreements called for a capital infusion of \$7,100,000, followed by subsequent capital contributions of \$5,600,000 and \$5,000,000. These capital infusions were made on September 1, 2007, October 7, 2008, and December 31, 2009, respectively. The Plan obtained additional capital from its Parent, via Section 1307 loans, during 2010 in the amounts of \$16,873,772 and \$9,500,000. These infusions occurred on October 16, 2010 and December 28, 2010, respectively. Other funds were received from Touchstone affiliate, HCP IPA, and are included in the Plan's Section 1307 loans in amounts equaling \$6,000,000, as described above in Section E. under the caption "Healthcare Partners IPA". The total amount of Section 1307 loans at December 31, 2012 was \$50,073,772, and encompasses all Section 1307 loan amounts previously described in this report. As of the date of the filing of this report, the Plan has not sought approval from this Department (as required by NYS Law) to repay any part of its Section 1307 loans. An additional \$6 million of Surplus Notes have been issued, as described in the Subsequent Events Section below.

Section 1307(c) of the New York Insurance Law states:

"Any sum so advanced or borrowed shall not be part of the legal liabilities of such insurer and shall not be a basis of any set-off but until repaid all statements published by such insurer or filed with the superintendent shall show, as a footnote, the amount then remaining unpaid."

During the examination period, it was noted that the Plan's financial statement failed to include a footnote regarding these outstanding Section 1307 loans and their respective interest, as required by Section 1307(c) of the New York Insurance Law.

It is recommended that the Plan complies with the requirements of Section 1307(c) of the New York Insurance Law by including a footnote for all outstanding Section 1307 loans and their respective interest amounts in its filed annual and quarterly statements.

A footnote instruction appeared to be erroneously stated at the bottom of New York Data Requirements' Schedule J – "SURPLUS NOTES" in the Plan's 2012 filed statement. The footnote stated that the figure should agree with page NY3, line 28. However, the footnote should have indicated that the amount of surplus notes, and interest thereon be reported on page NY3 (Report-1, Part-B), line 29 of the New York Data Requirements. This finding and the following recommendation appeared in the previous report on examination as of December, 31 2008.

It is recommended that the Plan revises its footnote at the bottom of Schedule J of the New York Data Requirements so that it accurately corresponds with the information on the Plan's annual statement "Report 1 – Part-B: Liabilities, Capital and Surplus".

(iv) (SSAE 16) - Reporting on Controls at a Service Organization

An attestation standard has been issued by The American Institute of Certified Public Accountants (AICPA) for an auditor's report on the controls of a service

organization. After June 15, 2011, reports on controls at service organizations are required to be captured in accordance with the new standard.

Statement on Standards for Attestation Engagements (“SSAE”) No. 16 is an attestation standard issued by the Auditing Standards Board (“ASB”) of the “AICPA”, and addresses engagements with service organizations for purposes of reporting on the design of controls and their operating effectiveness.

It was noted that the service provider, HeavyWater, LTD (“HeavyWater”), located in New Rochelle, NY, provided network management services to the Touchstone organization. The Plan has not secured an auditor’s attestation concerning the controls and their operating effectiveness for HeavyWater.

It is recommended that Touchstone secure SOC1 (SSAE 16 or its equivalent) reports for all significant external service providers, including HeavyWater, LTD, on an annual basis.

G. Corporate Ethics and Compliance

The Plan has a fiduciary responsibility to uphold a code of ethics for the benefit of its enrolled members to ensure that its directors, officers and responsible employees do not use their official positions to promote an interest which is in conflict with that of the Plan.

Question #18 of the General Interrogatories of the 2012 filed annual statement stated:

Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?

As part of the Plan's corporate ethics and compliance functions, officers and employees receive conflict of interest guidelines upon beginning their employment, and these guidelines are well publicized and available to all staff as part of the Plan's Ethics and Compliance policies and procedures. However, for question #1B of the 2012 filed Annual Statement's General Interrogatories, the Plan answered "yes" as to whether it had an established procedure for disclosing conflicts of interest. However, when the procedures were requested, the policy was general in nature and was directed to all staff without particular reference for the board of directors and trustees.

The Plan has not maintained signed conflict of interest statements from any of its officers or directors for the years under this examination. A recommendation appeared in the prior report on exam for the Plan to have all officers and directors submit conflict of interest statements annually, and that the Plan enforces this as a policy going forward.

It is recommended that all of the Plan's officers and directors submit signed conflict of interest statements during each calendar year and that the Plan establish a procedure for enforcing such policy.

4. FINANCIAL STATEMENTS

The CPA firm of BDO USA, LLP was retained by the Touchstone to audit the Plan's combined 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.

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

A. Balance Sheet

The following shows the assets, liabilities, capital and surplus as of December 31, 2012, as contained in the Plan's 2012 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2012 filed annual statement.

| <u>Assets</u> | <u>Examination</u> | <u>Plan</u> |
|---|----------------------|----------------------|
| Cash and short-term investments | \$ 9,935,993 | \$ 9,935,993 |
| Accounts receivable | 122,729 | 122,729 |
| Health care and other amounts receivable | <u>4,704,263</u> | <u>4,704,263</u> |
| Total assets | <u>14,762,985</u> | <u>14,762,985</u> |
| <u>Liabilities</u> | | |
| Unpaid claims | \$ 1,078,482 | \$ 1,078,482 |
| Unpaid claims adjustment expenses | 16,666 | 16,666 |
| Accounts payable, accrued expenses and other liabilities | 8,786,961 | 8,786,961 |
| Notes payable | <u>4,000,000</u> | <u>4,000,000</u> |
| Total liabilities | <u>13,882,109</u> | <u>13,882,109</u> |
| <u>Capital and Surplus</u> | | |
| Common capital stock | 10 | 10 |
| Surplus notes | 50,073,772 | 50,073,772 |
| NYS contingent reserve fund | 14,890,125 | 14,890,125 |
| Unassigned funds (surplus) | <u>(64,083,031)</u> | <u>(64,083,031)</u> |
| Total capital and surplus | <u>880,876</u> | <u>880,876</u> |
| Total liabilities, capital and surplus | <u>\$ 14,762,985</u> | <u>\$ 14,762,985</u> |

NOTE 1: As of December 31, 2012, the Plan's Contingent Reserve was \$14,890,125. However, as of December 31, 2012, Touchstone's capital and surplus was only \$880,876; the required Contingent Reserve was therefore impaired in the amount of \$14,009,249.

As of December 31, 2013, the Plan was determined to be impaired by \$16.4 million with a minimum capital requirement at December 31, 2013 of \$15.9 million. At this date, the Plan was insolvent with a net worth of \$(549,191). As of June 30, 2014, the Plan continued to be impaired by a diminished amount of \$(6,811,168).

NOTE 2: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2012. 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 Capital and Surplus

Capital and surplus increased by \$977,959 during the four-year examination period, January 1, 2009 through December 31, 2012, detailed as follows:

Revenue

Net premium income \$ 912,966,026

Hospital and medical expenses

| | | |
|-------------------------------------|-----------------------|--------------------|
| Hospital/medical benefits | \$ <u>782,475,116</u> | |
| Total medical and hospital expenses | | <u>782,475,116</u> |

Administrative expenses

| | | |
|---------------------------------|--------------------|--------------------|
| Claims adjustment expenses | 50,187,417 | |
| General administrative expenses | <u>107,725,073</u> | |
| Total administrative expenses | | <u>157,912,490</u> |

Total underwriting deductions (940,387,606)

Net underwriting loss \$ (27,421,580)

Net investment income earned (583,929)

Other losses (4,287,564)

Net loss \$ (32,293,073)

Changes in Capital and Surplus

Capital and surplus, per report on examination,
as of December 31, 2008 \$ (97,083)

| | <u>Gains in Surplus</u> | <u>Losses in Surplus</u> |
|-------------------------------|-----------------------------|------------------------------|
| Net loss | | \$ 32,293,073 |
| Change in non-admitted assets | | 4,102,740 |
| Surplus paid-in | \$ <u>37,373,772</u> | _____ |

Net increase in surplus \$ 977,959

Capital and surplus, per report on examination,
as of December 31, 2012 \$ 880,876

5. UNPAID CLAIMS

The examination liability of \$1,078,482 is the same as the amount reported by the Plan in its filed annual statement as of December 31, 2012. The examination analysis of the unpaid claims liability was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination.

6. CASH AND SHORT-TERM INVESTMENTS

The examination asset of \$9,935,993 is the same amount reported by the Plan in its filed annual statement as of December 31, 2012.

An escrow deposit has been established including the funds held in accordance with the provisions of Part 98-1.11(f) of the Administrative Rules and Regulations of the New York Department of Health (10 NYCRR 98-1.11(f)).

7. LEGAL CONTINGENCIES

On February 2, 2012, Montefiore Medical Center ("Montefiore") began litigation proceeding against Touchstone. The claim alleges Touchstone breached its contract for claims payments to Montefiore in the amount of \$4.4 million.

Touchstone's legal exposure in the Montefiore action is partly mitigated as a result of its risk-transfer agreement with Healthcare Partners, where, after October 1, 2010, Touchstone transfers financial risk for the claims payments alleged in the Montefiore action. Claims arising before October 1, 2010, are the responsibility of Touchstone.

As of December 31, 2012, Touchstone denies any liability related to Montefiore's action and has retained counsel to defend its interests. A reserve related to the Montefiore action had not been established at December 31, 2010, however, a reserve in the amount of \$600,000 (\$450,000 for pending settlement payments and \$150,000 for hospital claims previously denied by HCP) was subsequently established (See Item 8 below).

8. SUBSEQUENT EVENTS

Touchstone has presented the Department with a plan to come into full compliance with the Contingent Reserve requirements of Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the New York Department of Health (10 NYCRR 98-1.11). At June 30, 2014, the Plan remained impaired, and as of that date the impairment was \$6,811,168.

Additionally, it should be noted that Touchstone has, subsequent to this examination date, estimated its legal liability with regard to the Montefiore action to be \$600,000. The estimate is comprised of \$450,000 in pending settlement payments and a separate reserve of \$150,000 for claims subject to an independent party's review of hospital claims previously denied by HCP on behalf of Touchstone.

In November 2013, the Company's Parent issued an additional Section 1307 loan to the Company. In an equity exchange, the Company received a \$6 million Surplus Note according to the terms of an agreement between the Parent, the Company, and an investor.

Subsequent to the examination period, the Plan has seen a change in management. Two key executive officers, the Chief Executive Officer and the Chief Financial Officer, have each resigned, and left the company in 2014. As of this writing, both positions were filled.

9. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior combined financial and market conduct report on examination contained fifty-one (51) comments and recommendations detailed as follows (page numbers refer to the prior report on examination).

| <u>ITEM NO.</u> | <u>PAGE NO.</u> |
|--|-----------------|
| <u>Insolvency</u> | |
| 1. This examination has determined the HMO to be insolvent in the amount of \$(14,111,264), and its contingent reserve fund of \$6,954,197, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department, to be impaired in the amount of \$(21,065,461) as of December 31, 2008. | 1, 27, 44 |
| As of September 30, 2011, subsequent to the examination date, the HMO reported itself solvent in the amount of \$1,608,135, however, its contingent reserve fund of \$16,682,521, required by Parts 98-1.11(d) and (e) of the Administrative Rules and Regulations of the Health Department, remained impaired, in the amount of \$(15,074,386). | |
| <i>The Plan has not complied with this recommendation.</i> | |
| <u>Facilitation of the Examination</u> | |
| 2. It is recommended that the HMO improve its procedures for facilitating the examination process. | 4 |
| <i>The Plan has complied with this recommendation.</i> | |
| 3. It is also recommended that the documentation provided be complete and that it also be provided in a timely manner. | 4 |
| <i>The Plan has complied with this recommendation.</i> | |
| <u>Management and Controls</u> | |
| 4. It is recommended that the HMO comply with its By-Laws and have Board of Directors' meetings at least once a quarter. | 6 |
| <i>The Plan has complied with this recommendation.</i> | |

ITEM NO.**PAGE NO.**Management and Controls (Cont'd)

5. It is recommended that the HMO comply with the investment authorization approval requirements of Section 1411 of the New York Insurance Law. 7

The Plan has complied with this recommendation.

6. It is recommended that the HMO formalize and document the discussion, and the approval of all of its investment decisions. 7

The Plan has complied with this recommendation.

7. It is recommended that the HMO comply with its Investment Policy by submitting it to the Board of Directors annually, for its review and approval. 8

The Plan has complied with this recommendation.

Circular Letter No. 9 (1999) - Adoption of Procedure Manuals

8. It is recommended that the HMO's Board comply with the requirements of Circular Letter No. 9 (1999) by obtaining the required certifications on an annual basis. 9

The Plan has complied with this recommendation.

Holding Company System

9. It is recommended that the HMO accurately report all information in its filed annual statement. 11

The Plan has complied with this recommendation.

10. It is recommended that the HMO comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the New York Department of Health by executing a formal written agreement with any entity within its holding company system and by submitting the agreement to the Commissioner of Health and the Superintendent of Insurance for their prior approval for any transaction with a member of its holding company system involving five percent or more of its admitted assets at last year-end. 13

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Holding Company System (Cont'd)

11. It is recommended that the HMO comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and file its tax allocation agreement with the Superintendent for approval. 14

The Plan has complied with this recommendation.

12. It is also recommended that the HMO comply with the requirements of Department Circular Letter No. 33 (1979) by entering into a formal tax allocation agreement with its Parent, Touchstone Health Partnership, Inc., and other members of its holding company system, by filing such tax allocation agreement with the Department. 14

The Plan has complied with this recommendation.

Section 1307 Loans

13. It is recommended that the HMO comply with the requirements of Section 1307(d) of the New York Insurance Law and by not directly, nor indirectly make any agreement for any borrowing pursuant to this Section unless such agreement has been submitted in writing to the Department and approved by the Superintendent. 15

The Plan has complied with this recommendation.

14. It is recommended that the HMO comply with the requirements of Section 1307(c) of the New York Insurance Law and include a footnote for all outstanding Section 1307 loans and their respective interest amounts in its filed annual statements. 15

The Plan has complied with this recommendation.

15. It is recommended that the HMO accurately report the amount of Surplus Notes in its filed New York Data Requirements. 16

The Plan has not complied with this recommendation. A similar recommendation appears in this report.

ITEM NO.**PAGE NO.**Disaster Response and Business Continuity Plan

16. It is recommended that the HMO comply with the requirements of Circular Letter No. 2 (2008) and file its Disaster Response Plan, Disaster Response Questionnaire, and Business Continuity Plan Questionnaire on an annual basis with the Department. 16

The Plan has complied with this recommendation.

Fraud Plan

17. It is recommended that the HMO comply with Part 98-1.21(a) of the Administrative Rules and Regulations of the Department of Health and implement a plan for the detection, investigation and prevention of fraudulent activities and file such plan with the commissioner of the Department of Health. 17

The Plan has complied with this recommendation.

Abandoned Property Report

18. It is recommended that the HMO comply with the abandoned property filing guidelines of The Handbook for Reporters of Unclaimed Funds and file the respective abandoned property report annually. 18

The Plan has complied with this recommendation.

Record Retention Policy

19. It is recommended that the HMO establish and implement a formal record retention plan in compliance with the requirements of Department Regulation No. 152. 18

The Plan has complied with this recommendation.

20. It is recommended that the HMO comply with the requirements of Department Regulation No. 152 and maintain all required records for a minimum of six calendar years from their creation. 19

The Plan has complied with this recommendation.

| <u>ITEM NO.</u> | <u>PAGE NO.</u> |
|---|------------------------|
| 21. It is again recommended that the HMO comply with the requirements of Department Regulation No. 152 and maintain all required records for a minimum of six calendar years from their creation. | 20 |
| <i>The Plan has complied with this recommendation.</i> | |
| <u>Custodial Agreement</u> | 20 |
| 22. It is recommended that the HMO execute and implement a formal custodial agreement with Barclays Wealth. Subsequent to the examination date, the HMO closed the Barclays Wealth account. | |
| <i>The Plan has complied with this recommendation.</i> | |
| <u>Conflict of Interest Policy</u> | |
| 23. It is recommended that, as a good business practice, all officers and directors of the HMO submit signed conflict of interest forms on an annual basis, and that the HMO establish a procedure for enforcing such policy. | 21 |
| <i>The Plan has not complied with this recommendation. A similar recommendation appears in this report.</i> | |
| <u>Accounts and Records</u> | |
| 24. It is recommended that the HMO accurately report its claim count and prompt payment interest amounts in Schedule H, Section 3 of its filed New York Data Requirements. | 22 |
| <i>For the examination period, the Plan was not required to file Schedule H due to its capitation agreement with HCP.</i> | |
| 25. It is recommended that the HMO accurately report the amounts of its claims paid during the year on Schedule H, Section 3 and on Schedule F, Section 3 of its filed New York Data Requirements. | 22 |
| <i>For the examination period, the Plan was not required to file Schedule H due to its capitation agreement with HCP.</i> | |
| 26. It is recommended that the HMO include all requisite information in Schedule H, Section 3 of its filed New York Data Requirements. | 22 |
| <i>For the examination period, the Plan was not required to file Schedule H due to its capitation agreement with HCP.</i> | |

ITEM NO.**PAGE NO.**Accounts and Records (Cont'd)

- | | | |
|-----|---|----|
| 27. | It is recommended that the HMO incorporate the principle of “segregation of duties” into appropriate job functions in order to ensure that the HMO’s assets are safeguarded and its liabilities are properly authorized and recorded. | 23 |
| | <i>The Plan has not complied with this recommendation. A similar recommendation appears in this report.</i> | |
| 28. | It is recommended that the HMO revise all authorized signature lists to include only those individuals who possess signatory rights. | 23 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 29. | It is further recommended that this list be updated whenever a change of authorized signatories is made. | 23 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 30. | It is recommended that the HMO file its annual statement in accordance with the NAIC Annual Statement Instructions, by completing and attaching Schedule Y to its filed annual statements. | 24 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 31. | It is recommended that the HMO revises the footnote instruction that appears in Schedule J of its New York Data Requirements, so that it provides correct information. | 24 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 32. | It is recommended that the HMO accurately report the amount of Surplus Notes in its filed New York Data Requirements. | 24 |
| | <i>The Plan has not complied with this recommendation. A similar recommendation appears in this report.</i> | |
| 33. | It is recommended that the HMO accurately report all information in its filed annual statement. | 25 |
| | <i>The Plan has complied with this recommendation.</i> | |
| 34. | It is recommended that the HMO accurately report commission expenses in its filed New York Data Requirements. | 25 |
| | <i>The Plan has not complied with this recommendation. A similar recommendation appears in this report.</i> | |

ITEM NO.**PAGE NO.**Accounts and Records (Cont'd)

35. It is recommended that the HMO comply with the requirements of Section 101.4(c) of Department Regulation No. 164 by implementing a contract for all applicable risk-sharing arrangements. 26

The Plan has complied with this recommendation.

36. It is also recommended that the HMO comply with requirements of Section 101.4(c) of Department Regulation No. 164 by filing all applicable risk sharing arrangements with the Department for approval. 26

The Plan has complied with this recommendation.

Cash, Cash Equivalents and Short-Term Investments

37. It is recommended that the HMO closely monitor its investment activity in order to maintain compliance with the applicable section of Article 14 of the New York Insurance Law. 31

The Plan has complied with this recommendation.

38. It is recommended that the HMO withdraw the cash from the Cayman Islands Sweep Account and deposit the same in a bank or financial institution which is under the jurisdiction of the U.S. or State government. 31

Subsequent to the examination date, the HMO provided documentation indicating that the Cayman Island Sweep Account was closed in 2009.

The Plan has complied with this recommendation.

New York State Contingent Reserve Fund

39. It is recommended that the HMO accurately report the amount of contingent reserve in its filed annual statement. 32

The Plan has complied with this recommendation.

Prepaid Expenses

40. It is recommended that the HMO report assets in accordance with the requirements of SSAP No. 29. 33

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Claims Processing

41. It is recommended that the HMO review the accuracy of the paid claims amount as reported in its filed 2008 New York Data Requirements. 35

Due to its global risk capitation contract with HCP, the Plan does not report claims paid amounts.

42. It is again recommended that the HMO improve its procedures to facilitate the examination and provide requested documentation. Subsequent to the examination date, the HMO provided documentation resolving the difference. 35

Due to its global risk capitation contract with HCP, the Plan does not report claims paid amounts.

Prompt Pay Requirements

43. It is recommended that the HMO takes steps to monitor and improve its timely payment of claims, in accordance with the timeframe mandated by CMS. 37

Due to its global risk capitation contract with HCP, the Plan delegates the payment of claims by risk transfer.

44. It is recommended that the HMO revise its methodology for determining interest payment, so that all claims eligible for interest payment are paid regardless of the interest amount to be paid. 37

Due to its global risk capitation contract with HCP, the Plan delegates the payment of claims by risk transfer.

Complaints

45. It is recommended that the HMO establish and maintain a complaint log in compliance with the requirements of Department Circular Letter No. 11 (1978). 38

The Plan has complied with this recommendation.

Explanation of Benefits Statement

46. It is recommended that the HMO revise its explanation of benefits statements to comply with the requirements of Sections 3234(b)(6) and (7) of the New York Insurance Law. 40

The Plan has complied with this recommendation.

ITEM NO.**PAGE NO.**Explanation of Benefits Statement (Cont'd)

47. It is also recommended that the HMO revise its explanation of benefits statements to include the explanation for denials as required by CMS' Medicare and Managed Care Manual. 40

Subsequent to the examination, the HMO reported that with the migration to the new claims platform in June 2009, it has been compliant with the text of denial messages, as well as appeal rights as approved by CMS. The HMO provided the examiner with a revised EOB indicating its compliance with said requirements.

The Plan has complied with this recommendation.

Broker Commissions

48. It is recommended that the HMO include in its broker agreement a provision which reflects the commission limitation mandated by Section 52.42(e) of Department Regulation No. 62. 41

The Plan has complied with this recommendation.

49. It is also recommended that the HMO comply with Section 52.42(e) of Department Regulation No. 62 and limit its payment of commissions to brokers to no more than 4% of premiums. 41

The Plan has complied with this recommendation.

Quality Management Program

50. It is recommended that, as a good business practice, the HMO acquire and maintain required detailed information pertaining to all policies issued by the HMO. 43

The Plan has complied with this recommendation.

51. It is also recommended that, as a good business practice, management of the HMO approve and sign all policies issued by the HMO. 44

The Plan has complied with this recommendation.

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

| <u>ITEM</u> | <u>PAGE NO.</u> |
|--|-----------------|
| 1. <u>Impairment</u> | |
| <p>Parts 98-1.11(e) of the Administrative Rules and Regulations of the New York Department of Health 10 NYCRR 98-1.11 require the Plan to maintain a Contingent Reserve. As of December 31, 2012, the Plan's Contingent Reserve was \$14,890,125. However, as of December 31, 2012, Touchstone's capital and surplus was only \$880,876; the required Contingent Reserve was therefore impaired in the amount of \$14,009,249.</p> <p>The Plan's financial condition deteriorated in 2013 and it was insolvent in the amount of \$(549,191) as of December 31, 2013. The Plan's required Contingent Reserve at December 31, 2013 was \$15.9 million, and it was therefore impaired by \$16.4 million, as of that date. The Plan was still impaired as of June 30, 2014, although the magnitude of the impairment decreased and was \$6,811,168, as of that date.</p> | 2, 25, 28 |
| 2. <u>Management and Controls</u> | |
| <p>i. It is recommended that the Plan seek to employ additional resources to address the audit and compliance needs of the Plan, including adding personnel to perform internal audits, to conduct compliance-related activities and to exercise oversight over delegated entities.</p> | 10 |
| <p>ii. It is recommended that Touchstone develop a comprehensive corrective action plan to address the oversight needed regarding the activities of Health Care Partners and any other delegated entities on behalf of the Plan.</p> | 11 |
| <p>iii. It is also recommended that such comprehensive corrective action plan include goals, roles and responsibilities of assignees, parameters to measure goal attainment, and steps for remediation of deficiencies when identified for any vendor, now or in the future, who accepts global risk from the Plan.</p> | 11 |
| 3. <u>Accounts and Records</u> | |
| <p>i. It is recommended that Touchstone segregates responsibilities for application-level controls surrounding its accounting and reporting application, and assign product ownership and administration to an IT administrator.</p> | 17 |

ITEM**PAGE NO.**Accounts and Records (Cont'd)

- | | | |
|-------|--|----|
| ii. | It is further recommended that Touchstone establishes roles and responsibilities designed to segregate duties between the IT operations of the Plan and its business units to reduce the possibility that critical processes are compromised. | 17 |
| iii. | It is recommended that Touchstone discloses and presents all financial information completely and accurately in its financial reports and exhibits, including validated financial data received from third-party vendors. | 19 |
| iv. | It is also recommended that Touchstone resubmits its December 31, 2012 New York Data Requirements, with the corrected Exhibit #13 – Part B, to the Department. | 19 |
| v. | It is recommended that the Plan complies with the requirements of Section 1307(c) of the New York Insurance Law by including a footnote for all outstanding Section 1307 loans and their respective interest amounts in its filed annual and quarterly statements. | 21 |
| vi. | It is recommended that the Plan revises its footnote at the bottom of Schedule J of the New York Data Requirements so that it accurately corresponds with the information on the Plan's annual statement "Report 1 – Part-B: Liabilities, Capital and Surplus". | 21 |
| vii. | It is recommended that Touchstone secure SOC1 (SSAE 16 or its equivalent) reports for all significant external service providers, including HeavyWater, LTD, on an annual basis. | 22 |
| viii. | It is recommended that all of the Plan's officers and directors submit signed conflict of interest statements during each calendar year and that the Plan establish a procedure for enforcing such policy. | 23 |

Respectfully submitted,

_____/S/_____
Andre Blackman
Associate Insurance Examiner

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

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

_____/S/_____
Andre Blackman

Subscribed and sworn to before me

this _____ day of _____ 2014.

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:

Andre Blackman

as a proper person to examine the affairs of the

Touchstone Health HMO, 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 25th day of September, 2012

*BENJAMIN M. LAWSKY
Superintendent of Financial Services*

By:

Steph J. Wiest

Stephen J. Wiest
Deputy Bureau Chief
Health Bureau

