REPORT ON EXAMINATION

OF

QUALITY HEALTH PLANS OF NEW YORK, INC

AS OF

DECEMBER 31, 2012

DATE OF REPORT	**JANUARY 17, 2017**
EXAMINER	**EDOUARD MEDINA**

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NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

January 17, 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 31005, dated June 21, 2013, annexed hereto, I have made an examination into the condition and affairs of Quality Health Plans of New York, Inc., a for-profit health maintenance organization (HMO) certified pursuant to the provisions of 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 home office of Quality Health Plans of New York, Inc., located at 2805 Veterans Memorial Highway, Ronkonkoma, New York.

Wherever the designations the “HMO” or “QHPNY” appear herein, without qualification, they should be understood to indicate Quality Health Plans 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.

Wherever the designations the “Health Department” or “DOH” appear herein, without qualification, they should be understood to indicate the New York State Department of Health.

1. SCOPE OF THE EXAMINATION

This is the first examination of the HMO. The examination of the HMO was a combined (financial and market conduct) examination and covered the three-year period January 1, 2010 through December 31, 2012. 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, 2013 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2012 were reviewed.

The financial portion of the 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 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 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 HMO was audited annually for the years 2010 through 2012, by the accounting firm of Cherry Bekaert & Holland, LLP, Tampa, FL. The HMO received unqualified opinions in 2010 and 2012. However, in 2011, Cherry Bekaert & Holland, LLP expressed a qualified opinion on the HMO's statutory financial statements because the firm was unable to obtain sufficient competent evidential matter to determine whether cash of $5,000,000 (further explained on page 22) as included in the December 31, 2011 statutory statement of admitted assets, liabilities, and capital and surplus was unrestricted and available to the HMO for use in its operations.

For the year ending 2013, the HMO retained a new accounting firm, Waters CPA Group, P.A., Tampa, FL.

2. DESCRIPTION OF THE HMO

Quality Health Plans of New York, Inc. was incorporated in February 2009. The HMO received its Certificate of Authority in May 2009 pursuant to Article 44 of the New York Public Health Law to operate as a health maintenance organization ("HMO") in the counties of Nassau, Queens, Richmond, and Suffolk, for the limited purpose of providing Medicare Advantage program services as authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"). The HMO began writing business in January 2010.

The HMO provides comprehensive health care services on a prepaid basis for Medicare Parts A, B and D to eligible members in New York (Nassau, Queens, Richmond and Suffolk counties).

The HMO has issued 15 surplus notes as of December 31, 2012 to the HMO's parent and sole shareholder QHP Financial Group, Inc., in return for $11,567,000 in cash.

The surplus notes issued are as follows:

Date Issued	Interest Rate	Face Value	Amount Outstanding
7/31/2008	8%	$5,000	$5,000
9/30/2008	8%	$5,000	$5000
12/29/2008	8%	$10,000	$10,000
12/29/2008	8%	$20,000	$20,000
1/8/2009	8%	$35,000	$35,000
2/26/2009	8%	$25,000	$25,000
3/6/2009	8%	$100,000	$100,000

5/7/2009	8%	$9,000,000	$9,000,000
5/7/2009	8%	$500,000	$500,000
5/11/2009	8%	$150,000	$150,000
10/2/2009	8%	$100,000	$100,000
10/28/2009	8%	$72,000	$72,000
11/11/2009	8%	$90,000	$90,000
11/30/2009	8%	$55,000	$55,000
12/1/2009	8%	$1,400,000	1,400,000
Total		$11,567,000	$11,567,000

The above surplus notes have not been approved by the Department of Financial Services, except for the $9,000,000 surplus note issued on May 7, 2009, which was approved by the Department on May 8, 2009.

The aggregate amount of interest outstanding as of December 31, 2012 was $3,319,620. The payment of interest and repayment of principal are subject to the prior approval of the New York State Department of Financial Services. No payments of interest or principal were made during the years under examination.

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

> "(a) Any domestic stock, mutual or co-operative insurance company or reciprocal insurer may, without pledging any of its assets, receive advances or borrow funds to:
>
> (1) conduct its business,
> (2) enable it to comply with any surplus requirement or make good any impairment or deficiency or other requirement of this chapter,
> (3) defray the reasonable expenses of its organization,
> (4) provide any fund to be voluntarily contributed to surplus, or
> (5) organize, acquire or invest in any subsidiaries authorized by this chapter.

> (d) No such insurance company or reciprocal insurer shall directly or indirectly make any agreement for any advance or borrowing pursuant to this section unless such agreement is in writing and shall have been approved by the superintendent as not unfair, misleading or contrary to law."

It is recommended that the HMO comply with Section 1307(d) of the New York Insurance Law by entering into a written agreement that is approved by the superintendent for any advance or borrowing pursuant to this Section.

A. Corporate Governance

Article 6 of the HMO's Certificate of Incorporation stipulates that the number of directors shall be provided in its by-laws, but shall not be less than three (3) nor more than nine (9) members.

Article 3, Section 2 of the HMO's by-laws indicates that the number of directors shall be determined by the directors from time to time by resolution adopted by a majority of the board. The HMO's by-laws, as of the examination date, did not fix the number of directors and, therefore was not in compliance with the HMO's Certificate of Incorporation.

It is recommended that the HMO revise its by-laws in order to fix the number of directors as required by Article 6 of the HMO's Certificate of Incorporation.

The HMO's board members as of December 31, 2012 were as follows:

Name and Residence	Principal Business Affiliation
Richard Joseph Bonnano, MD Bridgewater, NY	Teacher, Southside Hospital
Arain Nawaz, MD Port Jefferson, NY	Private Practice, Dr. Arain Nawaz, MD
Dr. Haider Ali Khan, Port Jefferson, NY	Chief Executive Officer, Quality Health Plans of New York, Inc.

Name and Residence	Principal Business Affiliation
Dr. Safia Haider Khan Tampa, FL	Senior Executive Vice President, Quality Health Plans of New York, Inc.

It was noted that the HMO did not have an enrollee representative on its board of directors as of December 31, 2014.

Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York State Health Department states in part:

> "(1) Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO"

It is recommended that the HMO comply with Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York State Health Department and institute enrollee representation within its board of directors.

Furthermore, the HMO did not hold any shareholders' meetings during the examination period. This is in violation of Article 1, Section 1 of HMO's by-laws, which requires that the HMO hold annual shareholders' meetings for the election of directors and for the transaction of such other business as may properly come before the meeting. This also indicates that none of the HMO's board of directors was elected.

It is recommended that the HMO comply with its by-laws by holding annual shareholders' meetings in order to elect board members and to transact other relevant business.

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

Name	Title
Dr. Haider Ali Khan	Chief Executive Officer
Stacy Lynn Martin	Chief Financial Officer
Dr. Safia Haider Khan	Senior Executive Vice President

Note1: Stacy Lynn Martin resigned as Chief Financial Officer on April 26, 2013. She was replaced by Richard Clark on May 15, 2013.

Note2: Dr. Haider Ali Khan resigned as Chief Executive Officer on June 26, 2014 and was replaced by Dr. Frank Olsen on the same date. See Subsequent Events section of this report on examination for further details.

B. Enterprise Risk Management

The HMO did not obtain a Qualifications Letter from its CPA firm, Cherry Bekaert, LLP to ensure that it acts in conformity with the standards of the accounting profession.

Part 89.10 of Insurance Regulation No. 118 (11 NYCRR 89.10) states:

> "(a) Every company subject to this Part shall retain a CPA who agrees by written contract with such company to comply with the provisions of Insurance Law section 307(b) and this Part. The contract must specify:
>
> (1) that the CPA is independent with respect to the company and is acting in conformity with the standards of the CPA's profession, such as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the New York Board of Public Accountancy, or similar code and meets the definition of a CPA set forth in subdivision (g) of section 89.1 of this Part;
>
> (2) that the CPA understands the annual audited financial report, that the CPA's opinion thereon will be filed in compliance with this Part and that the superintendent will be relying on this information in the monitoring and regulation of the financial condition of the company;
>
> (3) that the CPA consents to the requirements of section 89.11 of this Part and that the CPA consents and agrees to make available the work papers for review by the superintendent; and
>
> (4) that the CPA represents that it is in compliance with the requirements of section 89.5 of this Part.
>
> (b) Every company subject to this Part shall further require that the CPA include, as part of each submission to the Department for which the CPA is responsible, the background and experience in general, and the experience of the staff assigned to the engagement and whether each is a CPA."

It is recommended that the HMO comply with Part 89.10 of Insurance Regulation No. 118 (11 NYCRR 89.10) by obtaining a Qualifications Letter from its CPA ensuring that the CPA it retains is independent and agrees to comply with the provisions of the New York Insurance Law and Insurance Regulations.

The HMO's contracted CPA firm, Cherry Bekaert, LLP provided tax preparation services for the HMO without the approval of the HMO's audit committee. This is a violation of Parts 89.5(e) and (f) of Insurance Regulation No. 118 (11 NYCRR 89.10).

Parts 89.5(e) and (f) of Insurance Regulation No. 118 (11 NYCRR 89.5) state in part:

> "(e)(1) A company may not utilize for any purpose of this Part any work performed or prepared by a CPA if that CPA also contemporaneously provides any of the following non-audit services to that company:
>
> (i) bookkeeping or other services related to the accounting records or financial statements of the company;
>
> (f) A company may permit a CPA who performs the audit to engage in non-audit services, including tax and other services, which are not prohibited by subdivision (e)(1) of this section, but only if the activity is approved in advance by the audit committee, in accordance with subdivision (h) of this section."

It is recommended that QHPNY comply with Parts 89.5(e) and (f) of Insurance Regulation No. 118 (11 NYCRR 89.5) by obtaining the approval of the HMO's audit committee when the CPA who performs the audit is also engaged in non-audit services.

The Audit Committee's Charter states that the Committee will meet twice a year, or more as circumstances dictate. The HMO conducted only one Audit Committee meeting in the years 2011 and 2012, in violation of its Audit Committee's Charter.

Section III – Duties and Responsibilities of the Audit Committee's Charter states in part:

> "Appoint, compensate, retain, and oversee the work performed by the independent auditor retained for the purpose of preparing or issuing an audit report or related work. Review the performance and independence of the independent auditor and remove the independent auditor if circumstances warrant. The independent auditor will report directly to the audit committee and the audit committee will oversee the resolution of disagreements between management and the independent auditor if they arise."

In reviewing the minutes of the Audit Committee's meetings, it was found that the December 31, 2012 meeting minutes (the only meeting in 2012) stated that QHPNY received a proposal from Carr, Riggs & Ingram LLP ("CRI") to perform the independent audit of the HMO's 2012 financial statements. The minutes went on to say that CRI will begin work on the 2012 audit starting in March 2013. However, the December, 31, 2012 financial audit was conducted by Cherry Baekert, LLP not CRI. There was no evidence that management's resolution to reverse the original decision of retaining CRI for the 2012 audit was presented to the Audit Committee for discussion and/or approval and, therefore, the examiner was unable to determine whether or not the HMO was in compliance with Part 89.12(a) of the Insurance Regulation No. 118 (11 NYCRR 89.12(a)) which requires that the Audit Committee be directly responsible for the appointment and oversight of the work of the CPA.

Part 89.12(a) of the Insurance Regulation No. 118 (11 NYCRR 89.12(a)) states:

> "(a) The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any CPA (including resolution of disagreements between management and the CPA regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this Part. The CPA shall report directly to the audit committee."

It is recommended that the HMO comply with Part 89.12(a) of Insurance Regulation No. 118 (11 NYCRR 89.12(a) by maintaining an Audit Committee that is responsible for the appointment, compensation and oversight of the work of the HMO's CPA.

It is recommended that the HMO's Audit Committee revise its Charter to require that the Audit Committee meet on at least a quarterly basis.

It is also recommended that the HMO's management follow the direction of its Audit Committee.

C. Territory and Plan of Operation

The New York State Department of Health issued a Certificate of Authority to Quality Health Plans of New York, Inc., effective May 19, 2009, pursuant to Article 44 of the New York Public Health Law. The certificate authorizes the HMO to offer Medicare products in the following four (4) counties of New York State: Nassau, Queens, Richmond and Suffolk.

The HMO's sole line of business during the examination period was Medicare Advantage. During the examination period January 1, 2010 through December 31, 2013, the HMO experienced a net increase in enrollment of 136 members. An analysis of the enrollment is set forth below:

	2010	2011	2012	2013
Enrollment at January 1	0	13	10	33
Net gain/loss	13	(3)	23	103
Enrollment at December 31	13	10	33	136

D. Reinsurance

As of December 31, 2012, the HMO had an excess of loss reinsurance contract in effect with HCC Life Insurance Company, an authorized reinsurer. The contract's effective date is January 1, 2012. The reinsurance coverage in effect as of December 31, 2012 was as follows:

Covered member type:	Medicare
HMO's deductible:	$175,000 per member per agreement period
Coinsurance:	80%
Policy limit:	$1,500,000 per member, per agreement period

A review of the HMO's accounting practices relative to its reinsurance function was made and the following was noted:

The HMO paid a total of $50,000 for reinsurance to HCC Life Insurance Company in 2012. Of the $50,000, only $6,868 was reported as premium (the $6,868 is the product of the reinsurance rate $25.25 multiplied by the total membership for the year (272)). The remaining balance of $43,132.04 was reported as general administrative expenses.

The examiner's review indicates that the above $6,868 was deducted from the HMO's gross premiums revenue to arrive at the premium revenue amount reported in the 2012 NAIC annual statement ($221,756).

The HMO expensed 86% ($43,132.04) of the reinsurance paid in 2012 ($50,000) to HCC Life Insurance Company. Such accounting procedure resulted in the HMO reducing its reported gross premium revenue by only $6,868.

Such procedure is not in compliance with Paragraph 25 of the NAIC's Statement of Statutory Accounting Principles No. 61R.

Paragraph 25 of Statement of Statutory Accounting Principles (SSAP) No. 61R states:

> "For all reinsurance arrangements, the assuming entity must report premiums under the terms of the reinsurance contract as income and establish any asset or liability consistent with the methods and assumptions used to establish its policy reserves and guidance contained in SSAP No. 51—Life Contracts, SSAP No. 54—Individual and Group Accident and Health Contracts, and SSAP No. 59—Credit Life and Accident and Health Insurance Contracts. The ceding entity shall reduce premium income by the amounts paid or payable to the reinsurers. The ceding entity shall reduce its deferred and uncollected premiums reported as an asset by the corresponding proportionate amount of any deferred and uncollected premium attributable to those insurance policies reinsured. When the ceding entity has collected the premium but has not remitted the proportionate share to the reinsurer, the ceding entity shall establish a liability for the amount due the reinsurer. The assuming entity shall record an asset for premiums receivable from the ceding entity."

It is recommended that the HMO comply with Paragraph 25 of SSAP No. 61R and reduce its premium income by the full amount of reinsurance paid and/or payable to the reinsurers.

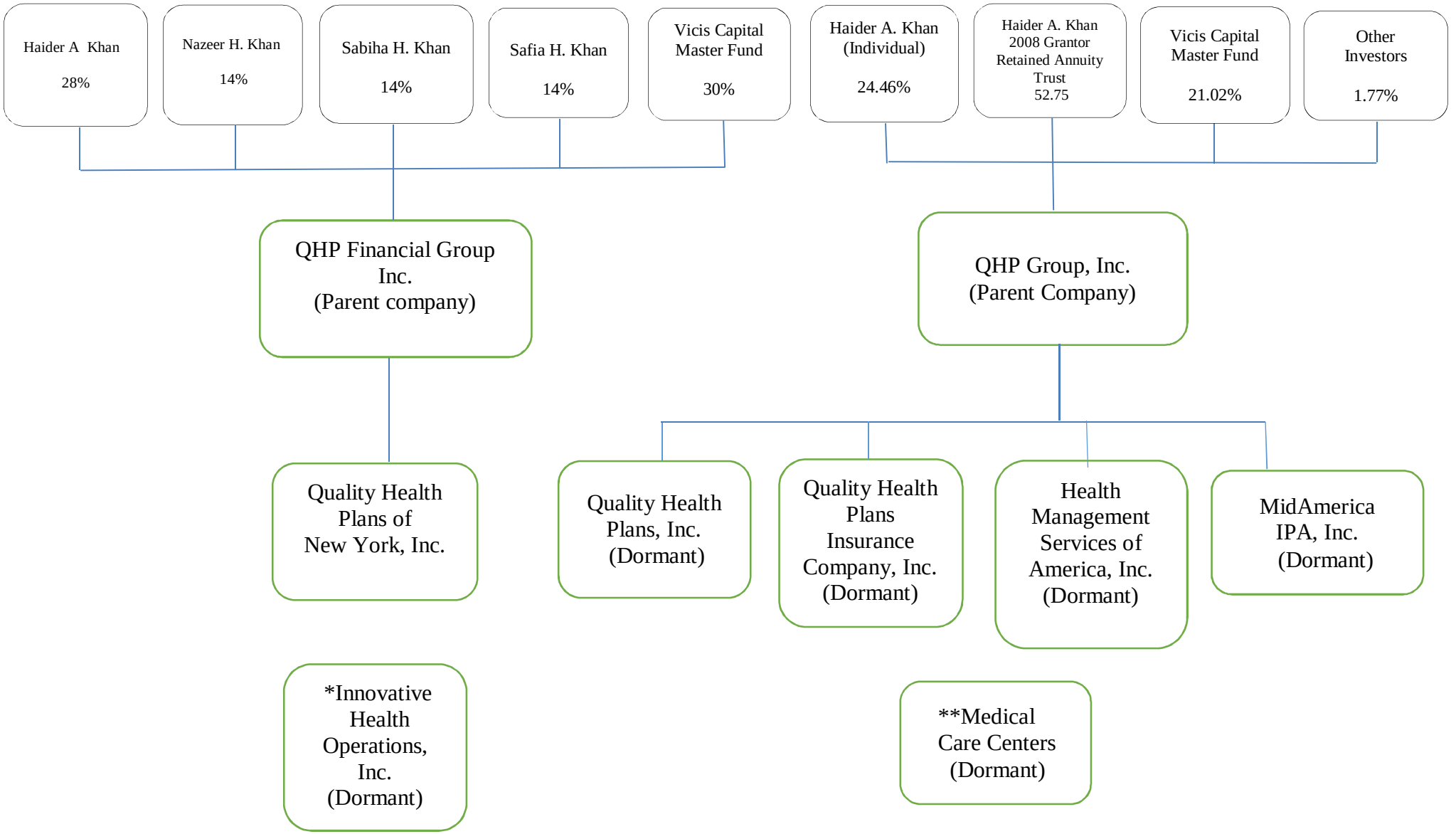
The HMO did not complete an analysis of ceded reinsurance by carrier in Schedule S of its filed 2012 NAIC annual statement. This practice is not in compliance with the NAIC Health Annual Statement Instructions, which states below, in part, the information to be provided in the captioned schedule:

> "Provide an analysis by reinsurance carrier of reinsurance ceded data shown in total in various parts of the statement. Information is included on all reinsurance ceded to other entities authorized as well as unauthorized or certified in the state of domicile of the reporting entity. Additional data for unauthorized companies is displayed in Part 4; additional data for certified reinsurers is displayed in Part 5."

It is recommended that the HMO comply with the NAIC Health Annual Statement Instructions by providing in its Schedule S an analysis, by reinsurance carrier, of the required reinsurance ceded information.

E. Holding Company System

The following chart depicts the HMO's holding company system as of December 31, 2012:



* Owned 100% by Haider A. Khan
** Owned 51% by Haider A. Khan and 49% by Nazeer H. Khan

A review of the HMO's records indicated that, during the period from January 1, 2010 through December 31, 2012, QHPNY conducted business with and/or received services from the following related parties:

- QHP Group, Inc. ("QHPG"), located in Tampa, Florida.
- QHP Financial Group, Inc. ("QHPFG", Parent Company), located in Tampa, Florida.
- Health Management Services of America, Inc. ("HMS"), located in Tampa, Florida. It provides claims and IT services to QHPNY, inactive since September 26, 2014
- Innovative Health Operations ("IHOP"), located in New Port Richey, Florida. It provided IT and employee leasing to QHPNY, inactive since September 26, 2014
- Medical Care Centers ("MCC"), located in Tampa, Florida, inactive since September 26, 2014
- Quality Health Plans Insurance Company, Inc. ("QHPIC"), located in Tampa, Florida, inactive since September 28, 2012
- Quality Health Plans, Inc. (Florida HMO), inactive since September 28, 2012

All the above Companies have common ownership with QHPNY. Also, Health Management Services of America, Inc., Innovative Health Operations, Inc. and Quality Heath Plans, Inc. were providing services to the HMO during the examination period but there were no service agreements in effect during the examination period between such entities and QHPNY, although the services were provided on a regular basis.

Part 98-1.10(a) of the Administrative Rules and Regulations of the New York State Health Department states:

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

> unless the commissioner or the superintendent has disapproved the transaction within such period."

As noted above, several of the entities within the holding company are dormant. If a dormant entity is reactivated and provides services to the HMO, it is recommended that the HMO send a written contract outlining, among other items, the services provided and costs for such services to the New York State Department of Financial Services and the New York State Health Department for review and approval.

On April 16, 2009, the New York State Department of Health approved a management services agreement ("MSA") between QHPNY and DMCNY, LLC, a New York limited liability Company. It should be noted that DMCNY, LLC is not one of the companies listed above. Pursuant to the agreement DMCNY, LLC was contracted to provide administrative services to QHPNY. However, QHPNY later decided not to go forward with the implementation of the agreement.

QHPNY did not notify the New York State Department of Health of this decision, nor did QHPNY provide DOH with a description of how the management functions delegated to DMCNY would be handled without the services of DMCNY.

The HMO did not implement the Management Services Agreement (MSA) that it had with DMCNY. The New York State Department of Health treated that as a default and, consequently, issued a statement of deficiencies to QHPNY on December 26, 2012. In response, QHPNY submitted a Plan of Correction to the New York State Department of Health on January 15, 2013.

The Plan of Correction comprised the following actions:

- "QHPNY's contact repository was enhanced in January 11, 2013 by organizing all scanned, original executed management contracts and implementing a system to

track effective and termination dates, submission to New York State Department of Health and/or Department of Financial Services, and approval dates.

- Applicable QHPNY staff were trained with regard to New York State regulations pertaining to management contracts.

- The Chief Financial Officer (Tracy Martin) was named as the responsible officer for the repository and tracking of the MSAs. The HMO's Compliance Department was assigned to monitor and track the HMO's contracts for adherence to New York State Department of Health regulations including 90 days prior written notice of any termination or non-renewal. The HMO's Compliance Department was also assigned to monitor the plan for how the delegated management functions will be handled subsequent to the discharge."

The above plan of correction was found acceptable by New York State Department of Health on January 18, 2013.

QHPNY, by not notifying New York State Department of Health of its decision not to go forward with the implementation of the above agreement with DMCNY, violated Part 98-1.11(n) of the Administrative Rules and Regulations of the New York State Health Department.

Part 98-1.11(n) of the Administrative Rules and Regulations of the New York State Health Department states:

> "(n) Any termination or non-renewal of a management contract shall require the prior written approval of the commissioner following 90 days prior written notice. The governing authority of the MCO shall, within the terms of the contract, retain the authority to discharge the management contractor for cause or based on mutual agreement between the MCO and the management contractor. The governing authority of the MCO shall provide a plan for the management of the MCO subsequent to the discharge, to be submitted with 90 days prior notification to the department of the MCO's decision to discharge the management contractor. The department shall be given at least 90 days prior written notice by the MCO of all terminations whether initiated by the MCO or the manager. Termination may be upon less than 90 days notice provided it is demonstrated to the satisfaction of the commissioner prior to termination that circumstances exist which justify more immediate termination.."

It is recommended that QHPNY comply with Part 98-1.11(n) of the Administrative Rules and Regulations of the New York State Health Department by obtaining prior written approval on any termination or non-renewal of its management contracts.

F. Holding Company Transactions

During the year ended December 31, 2011, QHPNY loaned approximately $3,132,551 to its Parent, QHP Financial Group, Inc. This note receivable bears interest at 8% per year and matures in November 2012. All principal and accrued interest is due upon maturity. The Department and the HMO's board of directors were not notified of this transaction. Pursuant to a directive from the Department, this loan was paid back to the HMO on October 25, 2012.

On November 25, 2012, the HMO made a loan of $5,000,000 to the HMO's Parent, QHP Financial Group, Inc., without notice to and approval from the New York State Department of Financial Services and the New York State Department of Health.

The Department directed that the HMO reverse the $5,000,000 loan and infuse the $5,000,000 back into the HMO's bank account no later than December 31, 2013. The Department later granted an extension until January 31, 2014 for the reversal of the $5,000,000 loan. From March 31, 2014 to October 22, 2015 a total of $3,154,000 was repaid leaving a balance of $1,846,000

The above transactions are in violation of Part 98-1.11(b) of the Administrative Rules and Regulations of the New York State Health Department.

Part 98-1.11(b) of the Administrative Rules and Regulations of the New York State Health Department states:

> "(b) No funds shall be transferred or loaned from the MCO article 44 business to any other business, function or contractor of the MCO, or to any subsidiary or member of the MCO's holding company system or to any member or stockholder without the prior approval of the commissioner and except in the case of a PHSP, HIV SNP, PCPCP or MLTC, the superintendent. Repayment of any such approved loans, to the extent required, shall be made in accordance with schedules approved by the superintendent and commissioner. Any such transfers or loans shall require a certification by the MCO that such transfer or loan is in compliance with and does not violate any provision of any applicable law or regulation."

It is recommended that the HMO comply with Part 98-1.11(b) of the Administrative Rules and Regulations of the New York State Health Department by seeking the prior approval of the New York State Health Department and the New York State Department of Financial Services when it intends to transfer or loan funds to any other business, function or to any subsidiary or member of the HMO's holding company system or to any member or stockholder.

The HMO, by loaning monies to its parent, also violated Section 1407(a)(4) of the New York Insurance Law.

Section 1407(a)(4) of the New York Insurance Law states:

> "(a) Non-reserve and prohibited investments for property/casualty and certain other insurers. (a) Any insurer that makes investments under the authority of subsection (c) of section one thousand four hundred three of this article and meets the requirements of such subsection (c) and section one thousand four hundred two of this article may invest in, or otherwise acquire or loan upon, directly or indirectly, any of the types of investments described in section one thousand four hundred four of this article, but without having to meet the applicable qualitative standards or quantitative limitations which are set forth in subsection (a) of section one thousand four hundred four of this article, except the following prohibited investments:
>
> (4) Obligations, shares or other securities (including certificates of deposit) issued by a parent corporation or a corporation which is an affiliate or will be an affiliate after direct or indirect acquisition by the insurer..."

It is recommended that the HMO comply with Section 1407(a)(4) of the New York Insurance Law by refraining from making loans to its Parent.

The following four transactions with affiliates are each in violation of Part 98-1.10(a) of the Administrative Rules and Regulations of the New York State Health Department.

The HMO received claims and IT services from Health Management Services of America, Inc. without service agreements.

On a regular basis, the HMO received management and employee leasing services from Innovative Health Operations without agreements.

A review of the HMO's CPA's workpapers and other pertinent documents indicated that the HMO filed consolidated tax return with its Parent, QHP Financial Group, Inc. The HMO did not have a tax allocation agreement in place with QHP Financial Group, Inc.

> Insurance Circular Letter No. 33 (1979) states in part,
>
> "Pursuant to the provisions of Section 27 of the Insurance Law every domestic insurer is directed to notify this Department within 60 days…if it participates in a consolidated tax return and to submit a copy of this tax allocation agreement with such notification"…

It is recommended that the HMO comply with the guidelines of Insurance Circular Letter No. 33 (1979) relative to its tax allocation process and it is also recommended that the HMO comply with Part 98-1.10(a) of the Administrative Rules and Regulations of the New York State Health Department by seeking the approval of the New York State Health Department and the New York State Department of Financial Services before entering into an agreement for rendering

services on a regular or systemic basis between the HMO and any person in its holding company system.

For QHPNY, as of December 31, 2012, the amount due from Parent and other related parties, excluding the above $5,000,000 loan to Parent, was $644,368. Such receivables included $245,094 due from IHOP and 375,581 due from the HMO's Parent. As of September 30, 2013, the receivable increased to $915,011.

The amount due to/from parent, subsidiaries and affiliates in the 2012 NAIC annual statement, includes transactions with the following affiliated entities, previously listed in this report:

- QHP Group, Inc. ("QHPG"), common ownership
- QHP Financial Group, Inc. ("QHPFG") (parent company), common ownership
- Health Management Services of America, Inc. ("HMS"), common ownership
- Innovative Health Operations ("IHOP"), common ownership
- Medical Care Centers ("MCC"), common ownership
- Quality Health Plans Insurance Company ("QHPIC"), common ownership
- Quality Health Plans, Inc. ("Florida HMO"), liquidated on December 1, 2011, common ownership

The HMO erroneously refers to the above companies as vendors. This is not in compliance with Paragraphs 4 & 5 of the NAIC's SSAP No. 25 and Parts 98-1.2(l) and 98-1.2(v) of the Administrative Rules and Regulations of the New York State Health Department.

Paragraphs 4 & 5 of Statement of Statutory Accounting Principles No. 25 state:

> "4. Affiliate is defined as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. An affiliate includes a parent or subsidiary and may also include partnerships, joint ventures, and limited liability companies as defined in SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies (SSAP No. 48). Those entities are accounted for under the guidance provided in SSAP No. 48, which requires an

> equity method for all such investments. An affiliate is any person that is directly or indirectly, owned or controlled by the same person or by the same group of persons, that, directly or indirectly, own or control the reporting entity.
>
> 5. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the investee, whether through the (a) ownership of voting securities, (b) by contract other than a commercial contract for goods or nonmanagement services, (c) by contract for goods or nonmanagement services where the volume of activity results in a reliance
> relationship (d) by common management, or (e) otherwise. Control shall be presumed to exist if a reporting entity and its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting interests of the entity."

It is recommended that the HMO follow the guidelines of Paragraphs 4 & 5 of Statement of Statutory Accounting Principles No. 25 and revise its organizational chart to include all of its related companies.

Parts 98-1.2(j) and 98-1.2(v) of the Administrative Rules and Regulations of the New York State Health Department state, respectively:

> "(j) Control, which shall be synonymous with the terms controlling, controlled by and under common control with, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities or voting rights, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to control another person solely by reason of his or her being an officer or director of such other person. Control shall be presumed to exist if any person directly or indirectly owns, controls or holds the power to vote 10 percent or more of the voting securities or voting rights of any other person, or is a corporate member of a not-for-profit corporation."
>
> "(v) Holding company system means a holding company together with a controlled MCO and/or controlled persons."

The NAIC Annual Statement Instructions – Health state:

> "Attach a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and reporting entities; and other affiliates, identifying all insurers and reporting entities as such and listing the Federal Employer's Identification Number for each. The NAIC company code and two-character state abbreviation of the state of domicile should be included

> for all domestic insurers. The relationships of the holding company group to the ultimate controlling person…should be shown…"

It is recommended that the HMO comply with Parts 98-1.2(j) and 98-1.2(v) of the Administrative Rules and Regulations of the New York State Health Department and the NAIC Annual Statement Instructions - Health and report all of its organizational charts that are reported in all filings made to the New York State Department of Health and the New York State Department of Financial Services.

Parts 98-1.10(c) of the Administrative Rules and Regulations of the New York State Health Department states in part,

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

It is recommended that the HMO comply with Part 98-1.10.1(c) and establish appropriate agreements/contracts for the rendering of services on a regular or systematic basis with any person or affiliate within its holding company structure. It is further recommended that the HMO seek approval for all such regular and systemic transactions and agreements with the Commissioner of Health and Superintendent of Financial Services.

G. Conflict of Interest Policy

The HMO maintains a conflict of interest policy that states, in part:

> "We do not automatically assume that there is a conflict of interest if you have a relationship with another company. However, if you have any influence on transactions involving purchases, contracts, or leases, you must tell an officer of Quality Health Plans of New York as soon as possible. By telling us that there is the possibility of an actual or potential conflict of interest, we can set up safeguards to protect everyone involved..."

The HMO does not require directors, officers and responsible employees to sign a conflict of interest statement on an annual basis. The HMO has a fiduciary responsibility to 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 HMO.

It is recommended that, as a good business practice, the HMO revise its conflict of interest policy to require all officers, directors and responsible employees to sign a conflict of interest statement on an annual basis, and that the HMO establish a procedure for enforcing such policy.

H. Accounts and Records

During the course of the examination, it was noted that the HMO's treatment of certain transactions was not in accordance with NAIC annual statement instructions and/or New York State Departments of Health and Department of Financial Services guidelines. A description of such transactions is as follows:

There were several expenses for auditing and consulting, postage and telephone, occupancy and depreciation, and marketing that were incurred by and for Quality Health Plans, Inc. (Florida domestic HMO), which was liquidated on December 1, 2011), that were paid by the HMO.

The HMO, during the examination, paid the premiums for the personal malpractice insurance policy of the HMO's former Medical Director, Dr. Nazeer Khan. The examiner's review indicated that the 2012 and 2013 malpractice insurance policies were written and billed to Dr. Nazeer Khan. Dr. Nazeer Khan resigned as the HMO's Chief Medical Officer on September 7, 2012.

Several invoices for wages and benefits billed to Innovative Health Operations were paid by the HMO.

In each of the above situations, the HMO violated Part 98-1.10(b) of the Administrative Rules and Regulations of the New York State Health Department.

Part 98-1.10(b) of the Administrative Rules and Regulations of the New York State Health Department states:

> "b) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

It is recommended that the HMO comply with Part 98-1.10(b) of the Administrative Rules and Regulations of the New York State Health Department by refraining from making disbursements on behalf of the HMO unless the books, accounts and records of each party to the transactions can accurately disclose the nature of the transactions, and such items are subject to the HMO's business operations.

Two of the HMO's officers, Dr. Nazeer Haider Khan and Sabiha Haider Khan, effective September 7, 2012, resigned from their positions of Chief Medical Officer and Chief Financial

Officer, respectively of QHPNY. The examination review of the HMO's cash and investments indicated that these two individuals, during a transition period, continued to be authorized to sign checks on behalf of the HMO, and such former officers continued to sign QHPNY checks as of December 31, 2012. However, the HMO's internal controls indicated that the signatories for the HMO's cash accounts are Dr. Haider Ali Khan, President and Dr. Safia Haider Khan, Vice President.

It is recommended that the HMO enhance its cash and investment internal controls by removing from its bank and depository signatory lists all individuals who are no longer officers or employees of the HMO, or are no longer authorized to transact such processes. HMO management has indicated that the aforementioned issue was subsequently corrected.

I. Annual Statements

The examiner's review of the HMO's annual statements filings revealed the following:

Schedule G of the 2012 New York Data Requirements Statement requires the reporting of the salaries paid to each of the ten officers or employees receiving the largest amounts for his/her service to the reporting insurer whether paid directly by the insurer or affiliated companies. The HMO's 2012 N. Y. Schedule G shows only $16,827 paid to Safia H. Khan and $20,829 paid to Stacy Martin. However, there were salaries in the aggregate amount of $284,000 paid by the HMO to several individuals which were allocated to Innovative Health Operations and which were not reported within Schedule G of the HMO's 2012 annual statement in violation of the instructions

of the New York Data Requirements Statement. Those salaries belonged to employees of Innovative Health Operations, an affiliate which is no longer in business.

The HMO filed its 2012 NAIC annual statement and its 2012 New York State Data Requirements for Health Maintenance Organizations, in May 2013.

Part 98-1.16 of the Administrative Rules and Regulations of the New York State Health Department states:

> "(a) Every MCO, other than a PHSP that only serves enrollees eligible for benefits under title XIX, HIV SNPs and PCPCPs, shall file in duplicate with both the commissioner and the superintendent a financial statement on or before April 1 of each year, in the form and containing such information as the commissioner and the superintendent shall prescribe, showing its condition at last year-end and containing information required by section 4408 of the Public Health Law and the following information:"

It is recommended that the HMO comply with Part 98-1.16 of the Administrative Rules and Regulations of the New York State Health Department by filing its annual statements on or before April 1 of each year.

J. Evaluation of Controls - Information Technology

A review was conducted of the HMO's Information Technology ("IT") control environment during the examination, in accordance with the *NAIC Financial Condition Examiners Handbook's Exhibit C* (*Evaluation of Controls in Information Technology*) approach.

The objective of the review was to assess the HMO's IT general controls and procedures through the identification of inherent risk, mitigating controls and residual risk. Key areas targeted during the review included the following:

- IT management and organizational controls
- Application and operating system software change controls
- System and program development controls
- Overall systems documentation
- Logical and physical security controls
- Contingency planning
- Local and wide area networks
- Personal computers
- Mainframe controls

Information Technology is pervasive throughout the entire risk universe and is a key component of the overall corporate governance structure within the HMO. As such, appropriate controls and documentation of control assessment initiatives within IT are critical to the evaluation of risks to the HMO.

The examination revealed that the HMO failed to consistently utilize best practices in its application of Information Technology controls. This failure resulted in several risks being unmitigated. Such unmitigated risks included the following:

- Risk that the HMO's process framework does not ensure transparency, proper internal controls and appropriate level of segregation of duties.

- Risk that the HMO implements change requests that are incomplete, unauthorized or untested.

- Risk that the HMO's IT strategic plan is not aligned with business objectives and does not meet business needs.

- Risk that the HMO's service levels are not managed to ensure that IT services meet business needs and are efficiently utilized.

During the course of this examination, the examiner presented details of the above noted IT deficiencies to HMO's management for its input/response thereon. While the HMO did provide some documentation in an effort to demonstrate the adequacy of mitigating controls, such documentation was not provided in a timely manner and did not adequately mitigate the above risks. Subsequent to the examination period, the HMO adopted policies to ensure that supporting controls are documented and that such controls identify the risks.

It is recommended that the HMO continue to adopt IT best practices in its application of IT controls, in order to ensure that supporting controls are documented and that such controls mitigate identified risks.

It is recommended that the HMO ensure adequate expertise and support is provided to the Department during examinations and that all Department requests are fully responded to in a timely manner.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities and capital and surplus as of December 31, 2012, as contained in the HMO's 2012 filed annual statement, a condensed summary of operations and a reconciliation of the 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 HMO's financial condition as presented in its financial statements contained in the December 31, 2012 filed annual statement.

The firm of Cherry Bekaert & Holland, LLP. ("CB&H") was retained by the QHPNY to audit the HMO's combined financial statements of financial position as of December 31st of each year in the examination period, and the related statements of operations, capital and surplus and cash flows for the year then ended.

CB&H concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the HMO as of December 31, 2010 and December 31, 2012. However, as noted earlier this report on examination, CB&H reported a qualified opinion of the HMO as of December 31, 2011. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements.

A. Balance Sheet

Assets

Cash, cash equivalents and short-term investments	$ 2,359,425
Uncollected premiums and agents' balances	4,858
Amounts receivable relating to uninsured plans	30,150
Health care and other amounts receivable	8,470
Total assets	$ 2,402,903

Liabilities

Unpaid claims	$ 19,674
Unpaid claims adjustment expenses	393
Aggregate health policy reserve	547,222
Premiums received in advance	7,833
General expenses due and accrued	292,003
Amounts due to parent, subsidiaries and affiliates	34,358
Liability for amounts held under uninsured plans	8,215
Specialist payable	1,998
Total liabilities	$ 911,696

Capital and Surplus

Common stock	$ 1,000
Surplus notes	11,567,000
Aggregate write-ins for special funds	100,000
Unassigned funds	(10,176,793)
Total capital and surplus	$ 1,491,207
Total liabilities, capital and surplus	$ 2,402,903

Note : The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the HMO through tax year 2012. 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, Expenses and Capital and Surplus

Capital and surplus increased by $1,491,207 during the three-year examination period, January 1, 2010 through December 31, 2012, detailed as follows:

Revenue		
Net premium income		$ 496,454
Hospital and medical expenses		
Hospital/medical benefits	$ 131,973	
Other professional services	3,113	
Outside professional services	20,228	
Emergency room and out-of-area	3,043	
Prescription drugs	111,173	
Total medical and hospital expenses	$ 269,530	
Administrative expenses		
Claims adjustment expenses	393	
General administrative expenses	3,173,281	
Increase in reserves for life and accident and health contracts	542,109	
Total underwriting expenses		$ 3,985,313
Net underwriting loss		($3,488,859)
Net investment income earned		562,035
Net income (loss)		($2,926,824)

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and Surplus as January 1, 2010			$9,997,052
Net loss		($2,926,824)	
Change in non-admitted assets		($5,579,021)	
Net decrease in capital and surplus			($8,505,845)
Capital and surplus, per report on examination, as of December 31, 2012			$1,491,207

4. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO conducts its business and fulfills its contractual obligations to the 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 practices of the HMO in the following major areas:

A. Claims processing
B. Prompt Pay
C. Grievances and appeals
D. Agents and brokers
E. Fraud prevention and detection
F. Advertising and Marketing
G. Explanation of benefits statements
H. Complaints

Agents and Brokers

In 2010, the HMO maintained five producers. The HMO did not file certificates of appointments for the five agents as required by Sections 2112(a) & (b) of the New York Insurance Law.

Sections 2112(a) & (b) of the New York Insurance Law state:

> "(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."
>
> "(b) To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted."

It is recommended that the HMO comply with Sections 2112(a) & (b) of the New York Insurance Law by filing a certificate of appointment with the superintendent when it appoints agents.

The HMO terminated the above five producers it appointed in 2010 and did not file those terminations with the Department as required by Section 2112(d) of the New York Insurance Law.

Section 2112(d) of the New York Insurance Law states:

> "(d) Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication."

It is recommended that the HMO comply with Section 2112(d) of the New York Insurance Law by filing the termination of its producers with the superintendent and sending notice of those terminations to the terminated agents.

5. SUBSEQUENT EVENTS

The HMO incurred net losses of ($2,587,187) during the year ended December 31, 2012 and ($2,857,084) during the year ended December 31, 2013. Management's plans to remediate the above losses are; 1) to seek release of a portion of the $1,351,698 held in escrow with the Department, 2) generate management fee income in connection with a proposed management contract with an unrelated corporation and 3) obtain additional equity funding from unrelated third parties.

As of December 31, 2015 and August 31, 2016, the HMO reported capital and surplus in the amounts of 746,999 and $749,695, respectively.

While the HMO's capital and surplus, as of such dates, continued to be maintained in excess of its minimum capital requirements, such capital and surplus is being monitored on a monthly basis by this Department.

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____
Edouard Medina
Associate Insurance Examiner

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

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

_____
Edouard Medina

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

APPOINTMENT NO. **31005**

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:*

Edouard Medina

as a proper person to examine the affairs of

Quality Health Plans of New York, Inc.

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

Company

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 21st day of June, 2013

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau