REPORT ON EXAMINATION

OF

MANAGED HEALTH, INC.

AS OF

DECEMBER 31, 2010

DATE OF REPORT	**DECEMBER 4, 2013**
EXAMINER	**PEARSON GRIFFITH**

TABLE OF CONTENTS

December 4, 2013

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

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 30648, dated January 26, 2011, attached hereto, I have made an examination into the condition and affairs of Managed Health, Inc., d/b/a Healthfirst New York, a not-for-profit health maintenance organization (HMO) licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2010. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Managed Health, Inc., located at 25 Broadway, New York, New York. On September 19, 2011, the Plan relocated its home office to 100 Church Street, New York, New York.

Wherever the designations "MHI" or the "Plan" appear herein, without qualification, they should be understood to indicate Managed Health, Inc.

Wherever the designations the "Parent," or "HFI" appear herein, without qualification, they should be understood to indicate Healthfirst, Inc., a not-for-profit holding company.

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

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2006. This examination of the Plan was a combined (financial and market conduct) examination and covered the four-year period from January 1, 2007 to December 31, 2010. 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, 2010* 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, 2010 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as to identify prospective risks that may threaten the future solvency of Managed Health, Inc.

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 Plan's organizational structure, business approach, and control environment were utilized to develop the examination approach. The examination 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

The Plan was audited for the year 2007 by the accounting firm of Deloitte & Touche LLP, whereas the audits for the years 2008 through 2010 were performed by the accounting firm of Ernst & Young LLP ("E&Y"). The Plan received an unqualified opinion in each of those years. Certain audit work papers of E&Y were reviewed and relied upon in conjunction with this examination.

During the years 2006 through 2009, the Plan's internal audit activities were managed in-house, while in February 2010, the Plan's internal audit activities, along with those of members of its holding company, were outsourced to KPMG, LLP. A review was also made of the Plan's compliance with the provisions of Department Regulation No. 118 (11 NYCRR 89), "Audited Financial Statements". The examiner also reviewed the corrective actions taken by the Plan with respect to the recommendations contained in the prior report on examination.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which require explanation or description.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicate areas of weakness and/or directly impacted the Plan's compliance with the New York Insurance Law and related Regulations, New York Public Health Law and New York State Department of Health Regulations. Significant findings relative to this examination include the following:

- The Plan failed to ensure that the board of directors authorize and approve its investment transactions as required by the provisions of Section 1411(a) of the New York Insurance Law, and that documentation supporting the board's actions in this regard be appended to the minutes of its meetings.

- Among the 19 hospital representatives on HFI's board, seventeen (17) sit simultaneously on the board of the Manager, HF Management Services ("HFMS"). For this reason, the Department desires to

monitor the financial relationship between the two entities as if an affiliation exists. Accordingly, the Department has requested that within five days of execution, MHI provide the Department with copies of any executed agreements involving transactions where pre-notice for affiliated entities would be required under Parts 98-1.10 and 98-1.11 of the Administrative Rules and Regulations of the New York State Department of Health Regulation (10 NYCRR 98-1.10, 98-1.11), as well as other sections of Part 98-1 and Public Health Law Article 44, effective upon the filing of this report. MHI has agreed with this request.

- The Department will continue to review the relationship between MHI and HFMS.

- The Plan failed to ensure that the proper fee schedule for claim remuneration was implemented within the contractual time frame.

- The Plan failed to ensure that claims processed using an improper fee schedule were re-adjudicated and that additional payments, including prompt pay interest were made, where appropriate, in accordance with the provisions of Section 3224-a of the New York Insurance Law.

3. DESCRIPTION OF THE PLAN

Managed Health, Inc., d/b/a Healthfirst New York, is a not-for-profit group model health maintenance organization ("HMO") that was incorporated under Section 402 of the New York Not-For-Profit Corporation Law, and was issued a Certificate of Authority pursuant to the provisions of Article 44 of the New York Public Health Law. On August 1, 1998, Healthfirst, Inc., ("Healthfirst") a not-for-profit non-insurance entity, which was controlled in equal portions by each of the twenty-one hospitals that comprise its corporate members, was granted approval by the New York State Department of Health to acquire control of Managed Health, Inc. and such control transaction was closed on that date.

During the conduct of the examination, MHI's home office was located at 25 Broadway, New York, New York. At this location, the functions of administration, membership services, operations and all other services were performed; with the exception of claims processing and enrollment, which were performed at MHI's office located at 123 William Street, New York, New York. On September 19, 2011, the Plan relocated all of its operations to 100 Church Street, New York, New York.

MHI contracts with various healthcare providers for the provision of certain medical services to its enrollees. These healthcare providers principally consist of hospitals which are corporate members of Healthfirst ("Members") or their affiliates, together with physicians who are associated with the Members.

MHI compensates and shares risk with Members and certain contracted hospital providers who are not Members in accordance with the terms of a healthcare services agreement entered into with each Member or provider. The agreement provides for an allocation of premiums to the Member's or hospital provider's services pool based on a percentage of the premium revenue received by MHI under its agreements to service Medicare enrollees. These percentages of premium primarily range from 85% to 90%.

MHI, its members, and certain contracted providers assume the risk for healthcare service costs in the hospital services pool. To the extent there is a deficit (estimated medical expense in excess of pool funding) in the hospital services pool of a member or contracted provider, MHI records a receivable from the member or contracted provider.

These receivables are collected through reductions of future surpluses in the hospital services pool at the time the quarterly reconciliations are prepared. Management periodically evaluates the likelihood of collecting receivables from members and contracted providers. The agreements with members and contracted providers do not relieve MHI of its obligation to pay claims to providers for healthcare services.

Certain contracted providers have elected not to take risk on their membership for certain product lines. For these providers, MHI fully accepts the risk.

The Plan's authorized control level Risked Based Capital ("RBC") was $43,180,779, as of December 31, 2010. Its total adjusted capital was $160,089,090, yielding an RBC ratio of 370.70% for 2010.

In addition, as of December 31, 2010, the Plan's Contingent Reserve was $136,220,289. Parts 98-1.11(e) and (f) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(e) and (f)), require the Plan to maintain a Contingent Reserve and an escrow account with a custodian, for which a deed of trust has been approved by the Superintendent. The Plan was in compliance with said Regulation, as of December 31, 2010.

A. Corporate Governance

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board of directors consisting of five (5) individuals, at least twenty percent (20%) of whom shall be comprised of individuals ("enrollee-representatives") who are

enrolled in the prepaid health care program operated by the Plan, and at least one-third (33%) of whom shall be persons who reside in New York State. A majority of the MHI directors shall be persons nominated to serve on the board by the board of directors of its parent, Healthfirst, Inc.

As of December 31, 2010, the members of the board of directors and their principal business affiliations were as follows:

Name and Residence	Principal Business Affiliation
Richard Murcotte * Glen Cove, NY	Retired, Community Representative
Stephen Rosenthal Teaneck, NJ	President, Contract Management, Montefiore Medical Center
Donald Scanlon Commack, NY	Chief Financial Officer, Mt. Sinai Medical Center
Jay Schectman Scarsdale, NY	Senior Vice-President, Chief Medical Officer, Healthfirst, Inc.
Elizabeth St. Clair New York, NY	Senior Vice-President, General Counsel, Healthfirst, Inc.

*Enrollee representative – Part 98-1.11(g) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)), requires that a minimum of twenty percent (20%) of the board of directors of a health maintenance organization be comprised of enrollee representatives. The Plan was in compliance with said Regulation, as of 12/31/10.

Section 3.07(a) of the Plan's by-laws states, in part:

> "Meetings of the Board of Directors shall be held regularly, at least four (4) times per year, at the office of the Corporation or at such other place as the Board may from time to time fix or as specified in the respective notice or waivers of notice thereof…" [Emphasis added]

During a review of meetings of the Plan's board of directors, the examiner noted that the Board did not comply with the provisions of Section 3.07(a) of its by-laws when it failed to convene the required number of meetings during calendar year 2008. When this condition was brought to management's attention, the Plan indicated that the situation was due to personnel turnover, which resulted in an inability to obtain a quorum.

It is recommended that MHI comply with the provisions of Section 3.07(a) of its by-laws and convene the requisite number of meetings of its board of directors during each year.

A review of the minutes of the board of director meetings that had been held during the period under examination indicated that one director failed to attend at least fifty percent (50%) of the meetings he was eligible to attend. The examiner noted that such board member only attended one of the four meetings that he was eligible to attend during his 2009-2010 tenure.

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

It is recommended that board members who are unable or unwilling to attend board meetings consistently resign or be replaced. Furthermore, in selecting prospective members of the board, a key criterion should be an assessment of their willingness and

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

Section 1411(a) of the New York Insurance Law states in part:

> "No domestic insurer shall make any loan or investment... unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting."

A review of the Plan's investment transactions and the minutes of meetings of its board of directors indicated that there was no evidence that investment actions taken by the Plan's management were authorized or approved by the board of directors. In addition, the Plan answered "yes" to Question 15 of the General Interrogatories in all of its filed Annual Statements for the period under examination. This question relates to whether the Plan's purchase and sale of all investments were passed upon by either its board of directors or a subordinate committee thereof.

It is recommended that the board of directors comply with New York Insurance Law 1411(a) by authorizing and approving the Plan's investment transactions, and that documentation supporting the board's actions in this regard be appended to the minutes of its meetings.

It is also recommended that the Plan respond accurately to Question 15 of the "General Interrogatories" of the Plan's filed Annual Statements.

The following were the principal officers of MHI as of December 31, 2010:

Name	Title
Pat Wang	Chief Executive Officer
Nahum Kianovsky	Secretary
Marybeth Tita	Senior Vice-President and Chief Financial Officer

B. Territory and Plan of Operation

Managed Health, Inc. was granted a certificate of authority pursuant to the provisions of Article 44 of the New York Public Health Law to serve the commercial population in the five boroughs of New York City ("NYC") and the counties of Nassau and Suffolk.

MHI has been approved to provide only Medicare products in Westchester County. The sale of any other products by MHI in that county would require that MHI submit an application to the Department of Health for approval at least 90 days prior to the proposed implementation date.

Furthermore, contingent upon the execution of a Medicaid Advantage contract, Managed Health, Inc. was approved by the New York State Department of Health, effective January 1, 2010, to serve the dual eligible population, i.e., seniors and persons with disabilities who are covered by both Medicaid and Medicare, through the Medicaid Advantage program in the Bronx, Brooklyn, Manhattan, Nassau, Queens, Richmond and Westchester Counties.

As of December 31, 2010, MHI's total enrollment of 93,811 consisted of 1 direct pay member, 402 Healthy New York members, 71 Medicaid Advantage members and 93,337 Medicare members.

The following table displays MHI's net admitted assets, capital and surplus, net premium income, and net income during the period under examination:

(in thousands)				
	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income
2007	$ 227,366	$ 109,686	$ 741,080	$ 20,513
2008	$ 286,579	$ 116,806	$ 1,038,756	$ (5,680)
2009	$ 373,727	$ 132,722	$ 1,215,596	$ 7,281
2010	$ 367,304	$ 160,089	$ 1,295,113	$ 16,487

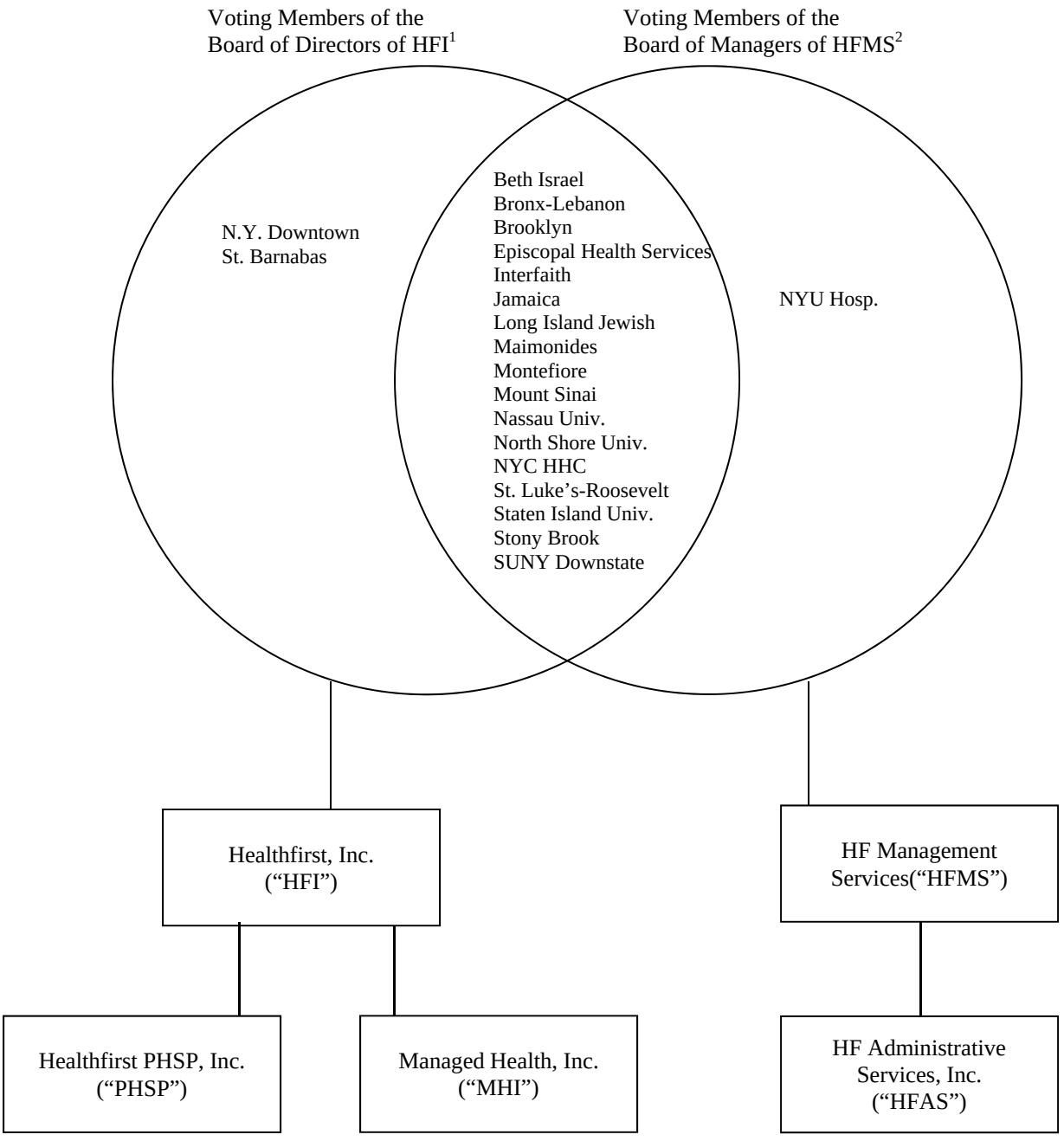
During 2008, the Plan's net worth increased to $116.8 million. This increase was a result of capital contributions of $10.8 million from member hospitals that was offset by a net loss of ($5.7 million) and an increase of $2.0 million in non-admitted assets. In addition, the Plan's net worth increased to $132.7 million during 2009. The increase was a result of capital contributions of $9.7 million from member hospitals and net income of $7.3 million. Furthermore, the Plan's net worth increased to $160.1 million during 2010. The increase was primarily a result of capital contributions of $10.7 million from member hospitals and net income of $16.5 million.

C. Holding Company System

During the period under examination, HFI submitted all holding company filings pursuant to the applicable provisions of Part 98 of the Administrative Rules and Regulations of the Department of Health (10 NYCRR § 98-1.1 and 98-1.16).

For purposes of its holding company filings, HFI has not treated the Plan and HF Management Services, LLC as part of the same holding company system.

As of December 31, 2010, the Plan's organizational structure as determined by this examination was as follows:



[1] Lennox Hill hospital is a non-voting member of HFI. NYU Hospital was suspended from membership effective September 1, 2009.

[2] New York Downtown hospital is a non-voting member of HFMS.

The following is a description of the Plan's affiliations as of December 31, 2010:

Healthfirst, Inc.

Healthfirst, Inc. ("HFI"), the sole corporate member of Managed Health, Inc. ("MHI" or the "Plan"), is a not-for-profit membership corporation incorporated in the State of New York. HFI has 20 member hospitals, of which 19 hospitals appoint one director each to HFI's Board of Directors. The New York City Health and Hospitals Corporation, which is also a member, appoints five directors, and one hospital member appoints no directors.

HF Management Services, LLC

HF Management Services, LLC ("HFMS") was formed under the provisions of Section 203 of the New York Limited Liability Company Law on April 15, 1999 by HFI, its sole member. Effective January 1, 2002, HFI entered into an "Exchange Agreement" with HFMS by which, as a capital contribution, HFI transferred to HFMS all rights, title and interest in:

(i) the assets and operations relating to HFI's business of providing administrative and management services to HFI's Managed Care Organization subsidiaries, Healthfirst PHSP, Inc. and Managed Health, Inc.; and

(ii) all of the shares of common stock of HF Administrative Services, Inc.

Immediately following the capital contribution transfer, HFI transferred its sole ownership of HFMS to the charter hospital members of HFMS in satisfaction of certain repayment obligations due from HFI to those hospital members. The Exchange Agreement and the related transactions were approved by the Department and the

Department of Health. As of December 31, 2010, HFMS had 19 member hospitals, of which 18 appoint one member each to HFMS's Board of Managers.

MHI's Management Services Agreement (the "Agreement") with HFMS requires HFMS to provide management and administrative services, including: all marketing and enrollment services, provider recruitment and provider relations services, accounting and financial services support, claims processing, financial reporting appropriate to member hospitals, maintenance of utilization and quality review programs and all data processing.

For a period of less than one year, prior to the existence of HFMS, HFI contracted directly with MHI to provide MHI with management services.

Healthfirst PHSP, Inc.

Healthfirst PHSP, Inc. ("HFPHSP") is a not-for-profit corporation that was incorporated on August 24, 1994, by Healthfirst, Inc. (its sole corporate member) as a licensed, prepaid health services plan that provides comprehensive prepaid health care coverage to Medicaid, Child Health Plus and Family Health Plus recipients. HFPHSP received a Certificate of Authority from the New York State Department of Health ("DOH") to operate in the City of New York, and Nassau and Suffolk Counties, effective August 30, 1994. HFPHSP holds contracts with DOH to provide health insurance coverage to Medicaid, Family Health Plus and Child Health Plus beneficiaries.

HF Administrative Services, Inc.

HF Administrative Services, Inc. is a New York for-profit business corporation whose purpose is to provide certain administrative and management services and to

operate a preferred provider organization.

During 2008, two affiliate companies, Healthfirst HMO, Inc. and Healthfirst IPA, Inc. were dissolved. Prior to Healthfirst HMO, Inc.'s dissolution, it was inactive and never conducted any business.

1. Control of the Plan

As stated earlier in this section of the report, the Plan is a member of HFI's holding company system. The Department reviewed the relationships among HFI, MHI, and HFMS, the applicable provisions of 10 NYCRR subpart 98-1, the borrowed money transaction described below, and materials submitted by the Plan, and, based on this assessment, the Department questioned whether HFI, MHI, and HFMS are part of the same holding company system. The Department solicited the opinion of the Department of Health, which is the agency that issues the holding company regulations applicable to MHI. The Department of Health advised the Department that it does not believe MHI and HFMS are part of the same holding company system under 10 NYCRR subpart 98.1.

Nonetheless, the examiner noted that among the 19 hospital representatives on HFI's board, 17 representatives sit simultaneously on the board of HFMS. For this reason, the Department desires to monitor the financial relationship between the two entities as if an affiliation exists. Accordingly, the Department has requested that within five days of execution, MHI provide the Department with copies of any executed agreements involving transactions where pre-notice for affiliated entities would be required under Parts 98-1.10 and 98-1.11 of the Administrative Rules and Regulations of

the New York State Department of Health Regulation (10 NYCRR 98-1.10, 98-1.11), as well as other sections of Part 98-1 and Public Health Law Article 44, effective upon the filing of this report. MHI has agreed with this request.

2. Borrowed Money

Note 11 of MHI's 2010 filed Annual Statement, under the caption "Borrowed Money," indicated that on January 27, 2009, HFMS made an advance payment of $11,258,931 to MHI to pay to MHI-contracted hospitals accrued Additional Medical Compensation ("AMC"), as defined in an HFMS Board of Managers resolution, in return for a note payable by MHI to HFMS. The note payable bears interest at prime plus 1%, which was 4.25% for the term of the loan. As of December 31, 2010, accrued interest thereon was $952,937.

The minutes of meetings of MHI's board of directors failed to show any supporting evidentiary material to indicate that the "Borrowed Money" transaction executed by the Plan's management was authorized or approved by MHI's board of directors. However, the transaction was approved by the board of directors of MHI's corporate parent, HFI.

The examiner notes that in a similar scenario, in 2005, the former Insurance Department and the New York State Department of Health declined to allow MHI to make a payment of Additional Compensation to designated member hospitals and HFMS because the transaction would have further reduced the Plan's March 2005 net worth

below the 12.5% level mandated by Section 98-1.11(e) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1).

3. Expense Allocation

Parts 98-1.10(a) and (b) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1) states, in part:

> "(a) Transactions within a holding company system to which a controlled MCO is a party shall be subject to the following guidelines:
>
> (1) the terms of the financial transaction shall be fair and equitable to the MCO at the time of the transaction;
> (2) charges or fees for services performed shall be reasonable; and
> (3) expenses incurred and payments received shall be allocated to the MCO on an equitable basis in conformity with customary accounting practices consistently applied.
>
> (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."

The NAIC's Statement of Statutory Accounting Principles (SSAP) No. 70, Allocation of Expenses, states the following:

> "Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios."

A review of MHI's filed annual statements for the period under examination indicated that it failed to allocate expenses in the (annual statement,) "Underwriting and Investment Exhibit Part 3-Analysis of Expenses", in accordance with the provisions of Part 98-1.10(a) of the Administrative Rules and Regulations of the New York Health

Department (10 NYCRR 98-1), SSAP No. 70 and the NAIC's annual statement instructions.

It is the Department's policy to apply Department Regulation No. 30 (11 NYCRR 105), *Operating Expense Classifications for Annual Statement Purposes,* that sets forth the reporting requirements of income and expense allocations for HMOs. While Department Regulation 30 does not apply to HMOs, the Department has used it as a guide in evaluating the expense allocation methods set forth in HMO services agreements. HMOs may submit other expense allocation methods that satisfy the criteria set forth in Section 98-1.10 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1) to the Department for review and approval. In addition, the Department requires HMOs to include a clause in their management agreements that describes a methodology for cost allocation that is in accordance with the provisions of Section 98-1.10 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.)

It is recommended that MHI include a clause in its management agreement that describes a methodology for cost allocation that is in accordance with the provisions of Section 98-1.10 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.)

D. Significant Operating Ratios

The following ratios have been computed as of December 31, 2010 based upon the results of this examination:

Description	Ratio
Net change in capital and surplus	20.62%
Current liabilities to liquid assets & receivables	74.61%
Premium and risk revenue to capital and surplus	9.51 to 1
Medical loss ratio	87.1%
Combined loss ratio	99.0%
Administrative expense ratio	11.89%

The above ratios fall within the benchmark ranges set forth in the Fast Analysis Solvency Tools (FAST) scoring ratios of the NAIC.

The underwriting ratios presented below are on an earned-incurred basis and encompass the four-year period covered by this examination:

	Amounts	Ratios
Total hospital and medical expenses	$3,681,081,606	85.80%
Claim adjustment expenses	20,851,963	0.49%
Cost containment expenses	27,536,683	0.64%
General administrative expenses	549,064,051	12.80%
Net underwriting gain	12,010,105	0.28%
Net premium income	$4,290,544,408	100.00%

E. Internal Controls, Model Audit Rule and Department Regulation No. 118

HFI's board of directors and its Audit and Compliance Committee provide governance and oversight over related entities' activities, including MHI. The Audit and Compliance Committee was established to provide assistance to the board with matters related to the financial reporting process and the Company's compliance program. Unless otherwise noted below, references to HFI are also applicable to MHI.

HFI has adopted the provisions of Department Regulation No. 118, "Audited Financial Statements" (11 NYCRR 89) and the NAIC's Annual Financial Reporting Model Audit Rule ("MAR") framework for proactively addressing and mitigating risks, including prospective business risks. It has established a co-sourced internal audit department that works with a third party (KPMG, LLP) to perform internal audit functions. Exhibit M (*Understanding the Corporate Governance Structure*) of the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* (the "Handbook") was utilized by the examiner as guidance for assessing MHI's Corporate Governance. The examiner determined that the Plan's corporate governance structure was satisfactory, set an appropriate "tone at the top", supported a proactive approach to operational risk management, and contributed to an effective system of internal controls.

F. Evaluation of Controls in Information Technology

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

The objective of the review was to assess the Plan's IT general controls and procedures through the identification of inherent risk, mitigating controls and residual risk. Substantive testing was performed where deemed appropriate, including the use of work performed by the Plan's Internal Audit Department and external CPA auditors. 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 Plan. As such, appropriate controls and documentation of control assessment initiatives within IT are critical to the evaluation of risks to the Plan. A lack of appropriate controls associated with certain risks may be deemed a material weakness.

The examiner identified a number of risks in HFI's Information Technology ("IT") control environment where the documentation to support adequate controls was not maintained in a manner that would show that such controls were implemented effectively. In addition, the examiner identified a number of IT common controls for which the documentation provided in the Plan's response to the Department's standard IT questionnaire did not adequately demonstrate the effective implementation of such controls to mitigate the associated risks.

The examination revealed that the Plan failed to consistently utilize Best Practices in its application of Information Technology controls. This failure may have resulted in several risks being unmitigated. Some of the risks that may not have been fully mitigated include:

- Risk that the Plan is not performing proper analysis prior to the acquisition or creation of new applications or functions.
- Risk that the Plan implements change requests that are incomplete, unauthorized or untested.
- Risk that the Plan's IT strategic plan is not aligned with business objectives and does not meet business needs.
- Risk that the Plan's IT budget is not representative of the organization's goals and business needs and IT expenses are not properly allocated.
- Risk that the Plan's risk management framework has not been created or maintained, leading to a lack of a common and agreed upon level of IT risks, mitigation strategies and procedures for addressing residual risks.

During the course of this examination, the examiner presented details of the above noted IT deficiencies to MHI's management for its input/response thereon. While the Plan did provide some documentation in an effort to demonstrate satisfaction with the required elements, satisfactory and complete explanations were not provided in a timely manner to support the Department's conclusions in this review.

As a result, the Plan was unable to demonstrate the conclusive mitigation of several risks.

It is recommended that the Plan adopts best practices in its application of IT controls in order to ensure that the supporting documentation of controls are consistently implemented to mitigate all IT risks.

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

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following statements show the assets, liabilities, capital and surplus as of December 31, 2010, as contained in the Company's 2010 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for the years under review:

Assets

Bonds	$ 170,178,427
Cash	106,364,071
Investment income due and accrued	1,325,927
Uncollected premiums and agents' balances in the course of collection	78,391,973
Deferred premiums, agents' balances and installments booked but deferred and not yet due	1,374,626
Accrued retrospective premiums	14,755
Reinsurance: Amounts recoverable from reinsurers	538,230
Health care and other amounts Receivable	9,115,786
Total assets	$ 367,303,795

Liabilities	
Claims unpaid	$ 177,728,839
Unpaid claims adjustment expenses	1,447,085
Aggregate health policy reserves	16,238
General expenses due or accrued	2,275,907
Borrowed money and interest	12,211,868
Amounts due to parent, subsidiaries and affiliates	147,618
Liability for amounts held under uninsured plans	6,293,731
Aggregate write-ins for other liabilities	7,093,419
Total liabilities	$ 207,214,705
Capital and surplus	
Gross paid in and contributed surplus	87,621,675
Aggregate write-ins for other than special surplus	136,220,289
Unassigned funds (surplus)	(63,752,874)
Total capital and surplus	$ 160,089,090
Total liabilities, capital and surplus	$ 367,303,795

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2010. The Plan is a not-for-profit HMO which falls under IRC 501(C)(4), which exempts the Plan from federal income tax. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus increased $78,071,099 during the four-year examination period, January 1, 2007 through December 31, 2010, detailed as follows:

Revenue		
Net premium income	$ 4,290,524,398	
Changes in unearned premium reserves	20,010	
Total revenue		$ 4,290,544,408
Hospital and Medical Expenses		
Hospital and medical benefits	$ 2,371,852,805	
Other professional services	31,646,333	
Emergency room and out-of-area	25,385,516	
Prescription drugs	369,813,637	
Other medical expenses	373,876,637	
Risk pool balance adjustment	168,739,500	
True-up adjustment	259,800,567	
Chiropractic capitation payments	71,903	
Dental payments	9,066,273	
Mental health payments	28,535,517	
Non-FFS med payments (manual check)	5,013,051	
Drug card	43,978,313	
Net reinsurance recoveries	(6,698,446)	
Total hospital and medical benefits	$ 3,681,081,606	
Administrative expenses		
Claims adjustment expenses	20,156,886	
Cost containment expenses	27,536,683	
General administrative expenses	549,064,051	
Total administrative expenses	596,757,620	
Total underwriting deductions		4,277,839,226
Net underwriting gain		12,705,182
Net investment income earned	27,702,538	
Net realized capital gains/losses	(1,336,853)	
Net investment gains/losses		26,365,685
Other income		
Miscellaneous income	37,722	
Interest expense on additional medical Compensation	(507,251)	
Total other income/(loss)		(469,529)
Net income		$ 38,601,338

Change in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination, as of December 31, 2006			$ 82,017,991
Net income	$ 38,601,338		
Change in non-admitted assets		588,217	
Surplus adjustments, paid-in	40,057,978		
Net change in capital and surplus			78,071,099
Capital and surplus, per report on examination, as of December 31, 2010			$ 160,089,090

5. AGGREGATE RESERVES AND CLAIMS UNPAID

The examination liability of $177,728,839 is the same as the amount reported by the Plan as of the examination date.

The examination analysis of the unpaid claims reserve 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 filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2010.

6. UNPAID CLAIM ADJUSTMENT EXPENSES

The examination liability of $1,447,085 is the same as the amount reported by the Plan as of the examination date. The examination analysis 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 its filed annual statements as verified during the examination.

7. MARKET CONDUCT ACTIVITIES

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

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

A. Agents and brokers
B. Underwriting and rating
C. Claims processing
D. Utilization review

A. Agents and Brokers

During the period under examination, MHI contracted with licensed agents and brokers to sell its various health insurance products. MHI also utilized salaried employees in its internal sales department to generate business and enroll members in its Medicare and commercial products.

A review of MHI's sales practices, agents' and brokers' licensing and related processes was performed. In addition, as part of the follow-up to the prior report on examination and the Stipulation entered thereto, a review specifically related to whether there were payments of commissions to unlicensed and non-appointed agents was also performed. The examiner noted no exceptions.

B. Underwriting and Rating

The Plan has a very limited book of commercial business, with only one (1) direct pay subscriber as of December 31, 2010. The Plan also has four hundred two (402) Healthy New York subscribers.

The Plan made all of its filings, in compliance with Section 4308(h) of the New York Insurance Law, during the examination period. The filings support the Plan's rates, with a loss ratio of approximately 85%, for the commercial products, for each filing.

The examiner reviewed the Healthy New York rates listed on the Plan's website and found that they did not coincide with the rates approved by the Department and included on the State's Healthy NY web portal. The examiner was unable to determine the year from which the Plan's posted rates were derived.

After the issue was brought to the attention of the Plan's management, the website was updated to reflect the current rates.

It is recommended that the Plan ensure that the posted rates on its website are the same as those approved by the Department and in agreement with those on the New York State Healthy New York website.

C. Claims Processing

A review of MHI's claims practices and procedures was performed by using a sample covering claims paid during the period of January 1, 2010 through December 31, 2010, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 120 claims, comprised of 100 randomly selected claims from the "commercial" and Healthy New York claims population of both hospital and medical claims, and an additional 20 randomly selected hospital claims.

The random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually, or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each claim in the sample.

The term "claim" can be defined in a myriad of ways. For the purpose of this report, a "claim" as defined by the Plan, is a grouping of all line items (i.e., procedures or services) on any one claim form as entered into its claims processing system. It was possible, through the computer program used for this examination, to match or "roll-up" all procedures on the claim form into one item, which was the basis of the Department's statistical sample of claims or the

sample unit. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by the Plan for the period January 1, 2010 through December 31, 2010.

The following represents errors that were identified by the examiner during the abovementioned claims review:

1. MHI has a policy of updating its Commercial and Healthy NY provider fee schedules within forty-five (45) days of receipt of new Medicare fee schedules from the Center for Medicare & Medicare Services ("CMS"). MHI's fee schedules are based on a percentage of the Medicare fee schedule. The examiner noted that in one instance, MHI failed to update its fee schedules within forty-five (45) days of receipt of the new Medicare fee schedules from CMS.

   The Plan's management informed the examiner that on May 18, 2010, a CMS fee schedule was released retroactive to and effective on January 1, 2010. Based on the Plan's procedures, this fee schedule should have been implemented on July 2, 2010, but in fact, it was not implemented until July 25, 2010. As a result, a number of claims were adjudicated and paid at incorrect amounts. When asked to quantify these errors, the Plan indicated that there were 210 instances where claims were underpaid and 8 cases where claims were overpaid. It is noted that where the claims were underpaid, these are violations of Section 3224-a of the New York Insurance Law ("Prompt Pay Law").

It is recommended that the Plan implement the proper fee schedule within the time frame required by the Plan's provider contracts.

It is recommended that the Plan re-adjudicate affected claims processed between July 2, 2010 and July 25, 2010 for dates of service between January 1, 2010 and July 25, 2010, and make additional payments, including prompt pay interest, if required, in accordance with the provisions of Section 3224-a of the New York Insurance Law.

2. During the claims review, the examiner determined that the Plan incorrectly denied certain claims as duplicates when, in fact, they were not duplicate claims. The reason for the incorrect denials results from claim system logic that establishes criteria for which aspects of a claim submission should be checked to determine whether or not such submissions are, in fact, duplicates of a previously submitted claim. Examples of aspects that were not checked by the claim system include changes to the billed amount and to the modifier code. Also not reviewed was whether the re-submitted claim included an authorization number that may have been neglected on the original submission.

It is recommended that the Plan review the claims system logic to ensure adequate criteria is used to establish whether an auto-adjudicated denied claim is the duplicate of a previously submitted claim.

It is also recommended that the Plan enhance its duplicate claims review process to identify any claims that may have been denied incorrectly and correct any claims denied in error; including complying with the provisions of Section 3224-a of the New York Insurance Law. In the event that management identifies claims denied in error, it is recommended that the Plan devote sufficient resources to minimize such errors in the future.

D. Utilization Review

Section 4903(2) of the New York Public Health Law states in pertinent part:

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

The examiner reviewed fifteen (15) Utilization Review ("UR") cases, of which twelve (12) were prospective and three (3) concurrent reviews. The examiner determined that there was one prospective case where MHI violated Section 4903(2) of the New York Public Health Law for having failed to provide timely written notice of an adverse determination to the enrollee or the enrollee's designee, and the enrollee's health care provider, although it did provide timely notice by telephone.

It is recommended that the Plan comply with the provisions of Section 4903(2) of the New York Public Health Law by providing notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of the receipt of necessary information.

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2006, contained twenty-three recommendations, as follows (page number refers to the prior report):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that MHI complies with its by-laws by having the required number (five) of board members, the majority of whom shall be persons nominated to serve on the board by the board of directors of its parent. *MHI has complied with this recommendation.*	6
2.	While noting that about ninety-five percent (95%) of the Plan's enrollees are Medicare members and though not required by statute, MHI should consider including representation from other components of its enrolled population in the Council. *MHI has complied with this recommendation.*	7
3.	It is recommended that MHI complies with its by-laws and holds the requisite number of board meetings. *MHI has not fully complied with this recommendation of having four (4) meetings in the calendar year; in 2008, only two (2) meetings were held. A similar recommendation is included in this report.*	7
	Conflict of Interest	
4.	It is recommended that MHI complies with its conflict of interest policy by having its board members complete the applicable conflict of interest questionnaire. It is also recommended that completed questionnaires be maintained for all board members. *MHI has complied with this recommendation.*	10

ITEM NO.		PAGE NO.
	Holding Company System	
5.	It is recommended that MHI continue to submit its holding company filings required by Section 80-1.4 of Department Regulation 52 on a timely basis. *MHI has complied with this recommendation.*	11
	Fidelity Bonds	
6.	It is recommended that MHI increase its fidelity bond coverage to at least $1,750,000, in order to meet the terms of the Examiners Handbook of the National Association of Insurance Commissioners. *MHI has complied with this recommendation.*	12
	Accounts and Records	
7.	It is recommended that the Plan establish and maintain an effective internal audit unit staffed with an adequate number of qualified personnel appropriate to its size. Subsequent to the examination date, MHI's parent, Healthfirst, Inc., formed an internal audit department ("IAD") that is anticipated to cover MHI. However, the examiner did not review any aspect of the IAD's functions, particularly those purported to cover the operations of MHI. *MHI has complied with this recommendation.*	13
	Agents and Brokers	
8.	It is recommended that MHI ensure that its employees who earn a commission or fee based on sales/enrollments obtain the requisite license in compliance with Section 2102(a)(1) of the New York Insurance Law, and that the Plan act in compliance with Section 2114(a)(3) of the New York Insurance Law by ensuring that commissions (sales based compensation) are only paid to licensed agents. *MHI has complied with this recommendation.*	19

ITEM NO.		PAGE NO.
9.	It is recommended that the Plan provide complete and accurate information when communicating with this Department. *MHI has complied with this recommendation.*	21
10.	The Plan's management and board of directors are reminded of their fiduciary responsibility to provide proper oversight of the Plan's operations and to determine that they are being conducted in accordance with applicable statutes, rules and regulations. *MHI has complied with this recommendation.*	21
11.	It is recommended that MHI complies with the requirement of Section 2112(a) of the New York Insurance Law and file certificates of appointment for its insurance agents with the Department. It is also recommended that the Plan maintain evidence of such filings. *MHI has complied with this recommendation.*	22
12.	It is recommended that MHI complies with the requirements of Section 2112(d) of the New York Insurance Law by reporting its terminated agents to the Department. *MHI has complied with this recommendation.*	22
	Underwriting and Rating	
13.	It is recommended that MHI complies with the requirements of Section 4308(b) of the New York Insurance Law by charging rates that have been filed with and approved by the Department. *MHI has complied with this recommendation.*	23
	Claims Processing	
14.	It is recommended that MHI review its controls in regard to errors that were determined to be occurring on a frequent basis. *MHI has complied with this recommendation.*	27

ITEM NO.		PAGE NO.
21.	It is recommended that MHI complies with Section 243.2(b)(4) of Department Regulation 152 by retaining all documentation necessary to verify its compliance with Section 3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer. *MHI has complied with this recommendation.*	33
22.	It is also recommended that MHI complies with the requirements of Section 216.11 of Department Regulation 64 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction. *MHI has complied with this recommendation.*	33
23.	It is recommended that the Plan update its complaint log to include all complaints received through the Insurance Department. *MHI has complied with this recommendation.*	34

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____/S/_____
Pearson A. Griffith
Associate Insurance Examiner

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

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

_____/S/_____
Pearson A. Griffith

Subscribed and sworn to before me

this _____day of _____2014.

Appointment No. **30648**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine into the affairs of the

Managed Health, Inc.

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

HMO

with such other information as he shall deem requisite.

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

This 26th day of January, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR