REPORT ON EXAMINATION

OF

SENIOR WHOLE HEALTH OF NEW YORK, INC.

AS OF

DECEMBER 31, 2011

DATE OF REPORT **MARCH 12, 2014**

EXAMINER **FROILAN ESTEBAL**

TABLE OF CONTENTS

March 12, 2014

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

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 30847, dated April 27, 2012, attached hereto, I have made an examination into the condition and affairs of Senior Whole Health of New York, Inc., a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York State Public Health Law, as of December 31, 2011, and respectfully submit the following report thereon.

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

Wherever the designations “Senior Whole Health” or the “HMO” appear herein, without qualification, they should be understood to indicate Senior Whole Health of New York, Inc.

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

The HMO's contingent reserve of $1,788,078 was impaired in the amount of $1,573,219 as of December 31, 2011. On March 5, 2012, Senior Health Holdings, Inc. infused $7.5 million into the HMO, which cured the impairment.

1. SCOPE OF THE EXAMINATION

The HMO was previously examined as of December 31, 2008. This examination of the HMO is a combined (financial and market conduct) examination as such term is defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook* (the "Handbook"). The examination covered the three-year period from January 1, 2009 through December 31, 2011. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2011, were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007. Thus, the current examination was the first such type of examination of the HMO. The examiner planned and performed the examination to evaluate Senior Whole Health'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 examiner 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 2009 through 2011, by the accounting firm of Pricewaterhouse Coopers LLP ("PwC"). The HMO received an unqualified opinion from PwC in each of those years. Certain audit work papers of PwC were reviewed and relied upon in conjunction with this examination.

A review was also made to ascertain what action was taken by the HMO with regard to comments and 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 examination revealed several operational deficiencies that occurred during the examination period. Following are the significant findings included within this report on examination:

- The HMO at times was not in compliance with the contingent reserve requirement set forth in Part98-1.11(e) of the Administrative Rules and Regulations of the Department of Health.

- The minutes of the Board of Directors did not include discussions of certain significant events and reports to the board of directors during its meetings.

  Key events that were not reflected include:

  - Authorizations of capital infusions provided by the parent company
  - Replacement of the Company's external auditors
  - Significant deficiencies noted by the Company's external auditors
  - Report on examination issued by the Department

- The HMO did not have a formal internal control review process in place. The HMO also did not assess risk in a systemic fashion nor did it adequately document strategies used to mitigate identified risk.

- The HMO operated under a service agreement with SWH Management Co. Inc., which expired on November 1, 2011.

3. DESCRIPTION OF THE HMO

Senior Whole Health of New York, Inc. is a for-profit stock company that was incorporated in the State of New York on August 1, 2006. The HMO received a Certificate of Authority ("Certificate"), effective August 17, 2006, from the New York State Department of Health ("Department of Health") to operate as a health maintenance organization pursuant to Article 44 of the New York State Public Health Law. In addition, the Certificate also empowered the HMO to enroll members covered under the Medicare program. Subsequent to the HMO commencing business on January 1, 2007, the Department of Health granted the HMO an amended Certificate, effective September 15, 2007, which permitted the HMO to participate in New York State's Medicaid Advantage Program.

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

A. Corporate Governance

Pursuant to the HMO's by-laws, the Board of Directors ("Board") of the HMO shall not be less than one (1) or more than ten (10) members. As of December 31, 2011, Senior Whole Health's Board of Directors consisted of the following four (4) members:

Name and Residence	Principal Business Affiliation
John W. Baackes, Jr. Menands, New York	President and Chief Executive Officer, Senior Whole Health of New York, Inc.
Mark Howard Carter Boston, Massachusetts	Director, TA Associates
Jonathan Mark Goldstein Boston, Massachusetts	Managing Director, TA Associates
Richard Craig Skevington Saratoga Springs, New York	Business Owner, Flow Management Technologies

The minutes of all meetings of the Board of Directors and committees thereof held during the examination were reviewed. The HMO's by-laws require that the Board of Directors meet at least quarterly. The review indicated all board and committee meetings were well attended, with all members attending at least one-half of the meetings they were eligible to attend.

A review of the minutes of the HMO's Board of Directors meetings, however, revealed that certain significant events and reports affecting the HMO were not reflected in the minutes of meetings. Such significant events include the following:

- Discussion and authorization of capital infusions received from the parent company.
- Discussion of ongoing impairment and financial solvency issues.
- The previous report on examination issued by the Department containing numerous comments and recommendations.
- Management Letters issued by the Company's external auditors containing significant deficiencies.
- Replacement of Company's external auditors.

It is recommended that the HMO's Board of Directors be made aware of all significant events and reports affecting the HMO, so that the Board is afforded the necessary information to enhance its ability to make appropriate decisions and provide knowledgeable direction to the HMO management.

It is further recommended that such key significant events and reports be reflected in the minutes of the Board of Directors.

Additionally, the minutes of the Board of Directors of the HMO did not maintain presentations, reports, and other detailed documents discussed during the meetings of the Board of Directors. The minutes frequently made reference to significant reports and documents discussed, however none of the documents were attached.

It is recommended that the HMO maintains and attaches significant presentations, reports, and other detailed documents presented during the board of directors meetings to the board minutes.

Further, the minutes of the Board of Directors did not make reference or include a statement that each member of the Board of Directors reviewed or signed off on the prior report on examination issued by the Department.

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

> *"(b) A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report. The superintendent may require that a copy of the report shall also be furnished by such insurer to the supervising insurance official of each state in the United States in which such insurer is authorized to do an insurance business".*

It is recommended that each member of the Board of Directors review and sign-off on the report on examination issued by the Department in compliance with Section 312(b) of the New York Insurance Law.

The principal officers of the HMO as of December 31, 2011, were as follows:

Name	Title
John Williams Baackes, Jr.	President and Chief Executive Officer
Michael Kent Wyman	Chief Financial Officer
Carissa Neubig	Corporate Secretary

On May 3, 2012, the following changes took place with regard to the officers of the Company:

- Wayne Brian Lowell replaced John Williams Baackes as the President and Chief Executive officer.
- Robert Paul Fallon replaced Michael Kent Wyman as the Chief Financial Officer.

- Michael Kent Wyman became the Chief Operating Officer (a newly created officer position).

Enterprise risk management and internal audit department ("IAD") processes for the HMO are provided by its affiliate, Senior Whole Health Management Company, Inc. ("Management Company"). An evaluation of such processes is provided below:

Enterprise Risk Management ("ERM")

The Management Company, at the time of examination, had not adopted an ERM framework for proactively addressing and mitigating key current and prospective risks. It is prudent for the Management Company to consider establishing the services of a risk management specialist and also establish a Risk Committee ("RC").

Further, the HMO does not have a formal internal control review process in place. The Management Company did not assess risk in a systemic fashion, nor did it adequately document strategies used to mitigate identified risk.

It is recommended that as good business practice, the Management Company establish a Risk Committee accountable for the overall ERM function. The RC should report directly to the Board of Directors of the HMO.

It is recommended that the Management Company perform a general risk assessment of the HMO's operations, implement and document strategies that mitigate such risk. Such assessments and strategies should be reviewed and approved by the HMO's Board.

It is recommended that the HMO formalize and document its internal controls review processes and procedures.

Internal Audit Department

The HMO's affiliate, Senior Whole Health Management Company, Inc., at the time of this examination, hired an internal audit director to serve all the affiliates within its holding company system, including the HMO.

The Company's internal audit reporting process is limited in that the internal audit director does not report directly to the Company's Audit Committee. Instead the internal audit director reports directly to the Director of Financial Operations of the Management Company. This reporting format puts into question the auditor's independence and ability to report freely with regard to certain observed issues.

Preferred corporate governance protocols call for the responsibilities and performance of the internal audit department director to be measured by the Audit Committee of the Management Company to ensure independence from senior management.

The importance of both independence and an audit committee's active involvement within the internal audit function is a widely supported position throughout the audit industry, including the support from the Institute of Internal Auditors ("IIA"). Below is the related guidance, as listed on the website of the IIA:

(a) "The internal auditor occupies a unique position, he or she is employed by management but is also expected to review the conduct of management which can create significant tension since the internal

auditor's independence from management is necessary for the auditor to objectively assess management's action, but the internal auditor's dependence on management for employment is very clear; and to maintain objectivity, internal auditors should have no personal or professional involvement with or allegiance to the area being audited; and should maintain an un-biased and impartial mindset in regard to all engagements."

(b) "A critical activity of the audit committee is to be involved in the hiring of the CAE of the organization. Because the CAE reports to the audit committee, the committee should be responsible for ensuring that the CAE receives fair and timely performance reviews. The audit committee should have an active role in determining the annual salary adjustment for the CAE. The audit committee should be the decision-making party in any decision to terminate the CAE."

Note: The acronym, "CAE", as noted above, refers to Chief Audit Executive.

It is recommended that the internal audit director's reporting process be revised so that the internal audit reporting structure allows direct reporting to the Audit Committee of the Management Company. It is also recommended that the Audit Committee be assigned primary responsibility for the performance evaluation and compensation of the internal audit director.

It is also recommended that the HMO's Audit Committee maintain documentation to support the Audit Committee's review of the Internal Audit Department ("IAD") director's performance. Details for the IAD director's compensation should also be included.

B. Territory and Plan of Operation

Pursuant to Senior Whole Health's Certificate of Authority, as of December 31, 2011, the HMO was authorized to conduct business in the following twelve counties of New York State:

Albany	Montgomery	Saratoga
Bronx	New York	Schenectady
Columbia	Orange	Ulster
Duchess	Queens	Warren
Greene	Rensselaer	Washington
Kings		

Senior Whole Health reported premiums written totaling $64,146,847 during the three-year period under examination from January 1, 2009 through December 31, 2011. Below is a summary of the HMO's total written premiums by county:

New York County	2009	2010	2011	Total
Albany	$ 6,709,951	$ 6,740,744	$ 8,020,429	$ 21,471,124
Columbia		403,348	565,787	969,135
Dutchess	236,653	744,843	965,065	1,946,561
Greene		108,273	149,283	257,556
Montgomery		72,589	268,393	340,982
Orange		634,653	1,208,653	1,843,306
Rensselaer	4,194,844	4,215,698	3,973,796	12,384,338
Saratoga	293,260	741,121	1,064,488	2,098,869
Schenectady	1,781,551	2,192,544	2,677,059	6,651,154
Ulster	4,926,891	4,944,949	5,028,945	14,900,785
Warren		292,957	678,782	971,739
Washington		13,746	297,552	311,298
Total	$18,143,150	$21,105,465	$24,898,232	$ 64,146,847

The following is a summary of the HMO's total premiums written by individual lines of business for the three years period under examination:

Line of Business	Total
Medicare Advantage (including Part D)	$ 488,079
Medicaid Advantage (including Part D)	29,292,419
Medicaid Advantage Plus	34,366,349
Total	$64,146,847

The HMO utilizes in-house New York licensed agents that are the direct employees of the HMO's affiliated management company, Senior Whole Health Management Company, Inc. which, at the time of examination, had contracted with Senior Whole Health to provide administrative services to the HMO. Based on the requirements of the Centers for Medicare and Medicaid Services ("CMS") and the New York State Department of Health, such agents are precluded from making personal contact and direct solicitation with the individual members. Instead, agents must direct their efforts towards CMS and the local Social Services Departments within each geographic county where Senior Whole Health conducts its business.

Senior Whole Health provides a special needs plan available to senior citizens 65 years of age or older and other low income adults who are dual eligible Medicare and Medicaid recipients. The HMO's health insurance program combines traditional health care services with social support services to accommodate members' collective health, independence and home living needs.

Below is the HMO's enrollment chart that depicts the increases during the period covered by this examination:

	Enrollment	**Increase from prior year**
2008	669	
2009	761	13.75% increase
2010	783	2.89% increase
2011	835	6.64% increase

C. Reinsurance

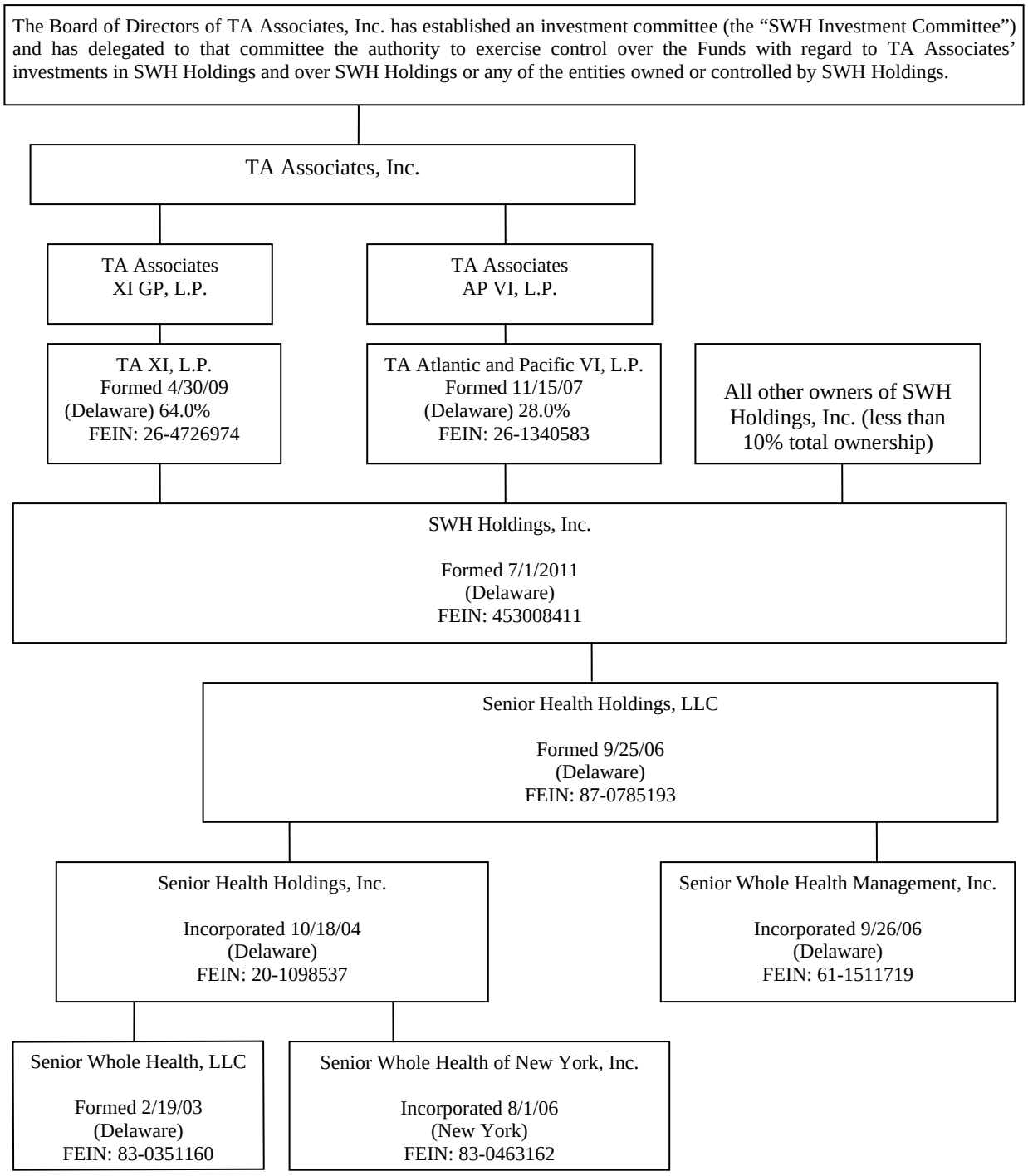
The HMO held the following ceded reinsurance coverage in effect with an authorized reinsurer at December 31, 2011:

Effective Period	HMO's Retention	Reinsurer's Liability
7/1/11 thru 6/30/12	$200,000 annually per member.	$2 million per member, per contract year, in excess of $200,000 annually per member. $2 million per member, per lifetime.

It was noted that the agreement contained all of the required clauses prescribed by the Department, including the insolvency clause required in Section 1308 of the New York Insurance Law.

D. Holding Company System

The following chart depicts the HMO's relationship with members of its holding company system. The percentages included in the chart reflect each entity's proportionate ownership as of December 31, 2012.



Change of Ownership

On July 28, 2011, the Department received an application from SWH Holdings, Inc., owned by five private equity firms, d/b/a TA Associates for the acquisition of Senior Health Holdings, LLC (SHH-LLC).

SHH-LLC was organized as a Delaware LLC to act as a holding company for SHHINC. SHHINC is the parent company of the HMO and Senior Whole Health, LLC, a Delaware LLC, organized to provide Medicare and Medicaid benefits in Massachusetts.

On November 1, 2011 SWH Holdings, Inc. completed the acquisition by acquiring all the outstanding Common and Preferred Units of SHH-LLC from its members. As consideration, SWH Holdings, Inc. paid SHH-LLC $134,680,903 in cash and 207,447 shares of preferred stock.

Senior Health Holdings, LLC (SHH-LLC)

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

Senior Health Holdings, Inc. (SHH-INC)

SHH-INC was organized on October 18, 2004, as a Delaware corporation. SHH-INC's principal business activity is to act as a direct holding company for the affiliated entities, Senior Whole Health, LLC (SWH-LLC) and Senior Whole Health of New York, Inc.

Senior Whole Health, LLC (SWH-LLC)

SWH-LLC was organized on October 22, 2003, as a Delaware limited liability company. SWH-LLC's principal business activity is to provide a new model of health care that expands the provisions of Medicaid and Medicare managed care services to the elderly population in Massachusetts. Such care is provided under a Senior Care Organization ("SCO") contract with CMS in partnership with the Commonwealth of Massachusetts.

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

SWH-MGT was incorporated on September 29, 2006, as a Delaware corporation. Its principal business function is providing administrative and employee leasing services to SWH-MA, the HMO and SWH-CT by entering into Outsourced Service agreements and Equipment and Personnel Lease agreements with the aforementioned affiliates.

At December 31, 2011, the HMO had the following inter-company agreements in effect with SWH-MGT:

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

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

This agreement which was amended effective January 1, 2009 was filed with the New York State Department of Health ("DOH"). The submission of the original agreement was approved by the DOH on August 17, 2006 concurrent with the DOH's approval of the HMO's initial certificate of application. The HMO's subsequent amended agreement was approved by the DOH on March 18, 2009. The Department accepted the original agreement on November 8, 2008.

According to the terms of the agreement, the contract is valid for five years beginning with the effective date and may be renewed only when authorized by the DOH. Further, the terms of the agreement states that any request to renew shall be submitted to the New York State Department of Health at least ninety (90) days prior to the expiration of the agreement. The effective date of the contract is October 1, 2006. Therefore this agreement was no longer valid as of November 1, 2011; however, the contract was still being used as of the time of examination.

It is recommended that the HMO apply for a renewal or extension amendment of the Joint Services Agreement with the New York State Department of Health retroactive to the date the contract expired. In this regard, it is also recommended that such renewal or extension amendment be filed with the Department.

2. Equipment and Personnel Lease effective October 1, 2006 ("E&P New York Agreement")

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

This agreement which was amended effective April 10, 2009, was filed with the DOH. DOH approved the initial agreement on August 17, 2006 and the amended agreement effective May 15, 2008. The Department accepted the initial agreement for filing on November 8, 2008.

3. Consolidated Tax Allocation Agreement

This agreement was executed on September 5, 2006, between the HMO and Senior Health Holdings, Inc., the HMO's direct Parent. The direct Parent and all subsidiaries agreed to the filing of consolidated Federal income tax returns by Senior Health Holdings, Inc. for every Federal income tax year.

The agreement was submitted by Senior Whole Health to the DOH along with the HMO's submission of its initial application for a certification of authority which was approved by the DOH on August 17, 2006.

E. Allocation of Expenses

Commencing in 2008, Senior Whole Health began allocating joint expenses on the basis of premium income, whereby expenses charged to the HMO by the Management Company are charged at the same percentage as the percentage of the HMO's premiums written relate to the total premiums written by all entities of the Holding Company System. The prior report on examination included a recommendation that the HMO refrain from using this methodology.

A review of the current joint expense allocation methodology used by the HMO revealed that the HMO continues to implement this methodology and fails to comply with the prior examination recommendations.

It is recommended that the HMO refrain from using its current joint expense allocation of premium income methodology as described above and consider as a guide the detailed procedures outlined in Parts 105.25, 106.2 and 109.2 of Department Regulation No. 30.

Further, it is recommended that the HMO recalculate its expense allocations in accordance with Department Regulation No. 30 and make appropriate adjustments to such expenses charged to the HMO, including adjustments applicable to prior years.

Similar recommendations were included within the prior report on examination.

F. Significant Operating Ratios

The following ratios have been computed as of December 31, 2011, based upon the results of this examination. The ratios presented below are on an earned-incurred basis and encompass the three-year period covered by this examination:

	Amounts	Ratios
Claims	$60,635,811	94.53%
Claims adjustment expenses	4,991,277	7.78%
General administrative expenses	10,220,124	15.93%
Net underwriting loss	(11,700,366)	(18.24%)
Premiums earned	$64,146,846	100.00%

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities as determined by this examination and as reported by the HMO in its filed Annual Statement as of December 31, 2011.

Assets	Examination	HMO	Difference
Cash and short term investments	$2,969,864	$2,969,864	
Investment income due and accrued	58	58	
Uncollected premiums and agents' balances in course of collection	1,379,762	1,379,762	
Other amounts receivable under reinsurance contracts	22,128	22,128	
Amounts receivable relating to uninsured plans	423,383	423,383	
Receivables from parent, subsidiaries and affiliates	282,129	282,129	
Health care and other amounts receivable	101,639	101,639	
Aggregate write-ins for other than invested assets	739	739	
Total admitted assets	$5,179,702	$5,179,702	
Liabilities			
Claims unpaid	$2,061,196	$2,061,196	
Unpaid claims adjustment expenses	100,000	16,319	83,681
Aggregate health policy reserves	2,358,000	1,836,000	522,000
General expenses due or accrued	445,479	445,479	
Amounts due to parent, subsidiaries and affiliates	168	168	
Total liabilities	$4,964,843	$4,359,162	605,681
Capital and Surplus			
Common capital stock	$1,000	$1,000	
Gross paid in and contributed surplus	25,714,460	25,714,460	
NYS contingent reserve	1,788,078	1,788,078	
Unassigned funds surplus	(27,288,679)	(26,682,998)	(605,681)
Total capital and surplus	$214,859	$820,540	(605,681)
Total liabilities and capital and surplus	$5,179,702	$5,179,702	

Note: 1. The HMO's contingent reserve of $1,788,078 was impaired in the amount of $1,573,219 as of December 31, 2011.

Note: 2. The Internal Revenue Service has not conducted any federal income tax audits of the HMO through tax year 2011. The examiner is unaware of any potential exposure by the HMO to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus decreased by $1,067,118 during the three-year examination period, January 1, 2009 through December 31 2011, as detailed below:

Revenue		
Total revenue		$64,146,846
Expenses		
Hospital/medical benefits	$32,782,809	
Other professional services	2,720,782	
Outside Referrals	6,957,757	
Emergency room and out-of-area	2,689,843	
Prescription drugs	11,286,429	
Aggregate write-ins for other hospital and medical	5,124,191	
Claims adjustment expenses	4,991,277	
General administration expenses	10,220,124	
Increase in reserves for accident and health contracts	(926,000)	
Total underwriting deductions		$75,847,212
Net underwriting losses		(11,700,366)
Net investment gain		8,462
Net loss before federal income taxes		$(11,691,904)
Federal income taxes		0
Net loss		$(11,691,904)

Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per examination, as of December 31, 2008			$ 1,281,977
Net loss		$ 11,691,904	
Change in non-admitted assets		137,405	
Deficiency in aggregate health policy Reserve		522,000	
Paid-in surplus	$ 11,284,191		
Net decrease in capital and surplus			$ 1,067,118
Capital and surplus, per report on examination, as of December 31, 2011			$ 214,859

5. CLAIMS UNPAID

The examination liability of $2,061,196 is the same as reported by the HMO on its annual statement as of December 31, 2011.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements as verified during the examination.

The examination reserve was based upon actual payments made through a period in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2011.

6. UNPAID CLAIMS ADUSTMENT EXPENSES

The examination liability of $100,000 is $83,681 more than the $16,319 reported by the HMO in its December 31, 2011 annual statement. Unpaid claims adjustment expenses are reserves for administrative expenses associated with unpaid health claims that are in the process of settlement, as well as those that have been incurred but not reported yet as of December 31, 2011. The examination calculation of unpaid claims adjustment expenses is based on the HMO's historical financial data of the relationship between claims handling expenses and incurred claims.

7. AGGREGATE HEALTH POLICY RESERVES

The examination liability of $2,358,000 is $522,000 more than the $1,836,000 amount reported by the HMO in its December 31, 2011 annual statement. The examination estimate is developed by reviewing the financial experience in calendar years 2010 and 2011 and projecting the underwriting gains in calendar year 2012, for the period from January 1, 2012, to the renewal dates in calendar year 2012.

8. SUBSEQUENT EVENTS

Termination of Upstate Business / Start of the Downstate Operations

By the letter dated June 13, 2012, the New York State Department of Health and New York State Department of Financial Services were notified by the HMO's plan to withdraw contracts C027208 (MA), C027762 (MAP) and C027750 (MLTCP) from the following upstate

counties effective January 1, 2013: Albany, Dutchess, Rensselaer, Saratoga, Schenectady, Ulster, Warren, Washington, Montgomery, Greene, Columbia and Orange. As a result of this withdrawal, there were no longer any policies in effect in the aforementioned upstate counties as of January 1, 2013. The HMO continued to process and pays all claims relative to such withdrawn contracts within the aforementioned counties that were incurred as of December 31, 2012.

As a result of the HMO's withdrawal, as of December 31, 2012, all of the HMO's business was written within the counties of the Bronx, Kings, New York and Queens. As of January 1, 2013 the HMO's total enrollment was reduced to a total of 798 members. Most are enrolled in Medicaid Advantage Plus ("MAP") and Managed Long Term Care Plan ("MLTCP").

The HMO projected that enrollment will increase by between 800 and 1,000 members by year-end 2013. The projection is based on the New York State mandatory enrollment for certain managed long term care populations and the HMO's open enrollment programs for the aforementioned lines of business which were implemented on July 2, 2012.

Deteriorating Financial Condition

As noted earlier in this report on examination, the HMO has experienced significant underwriting losses during the examination period and subsequent period. The HMO's significant net underwriting losses during the examination period are the result of the large disparity between Senior Whole Health's low premium volume versus higher claims costs and operating expenses.

The HMO's continued underwriting losses dating back to its inception have required frequent capital infusions from its parent company to avoid insolvency. Below is a summary of the capital infusions received by the HMO since it commenced business:

Date of Infusion	Amount
2/29/2008	$3,100,000
5/13/2009	1,429,191
9/29/2009	6,000,000
3/29/2010	2,155,000
5/20/2011	1,700,000
3/02/2012	7,500,000
2/28/2013	2,000,000
3/21/2013	275,000
3/28/2013	2,000,000
Total	$26,159,191

The HMO does not have a formal strategic plan that includes the HMO's short and long term goals and objectives. In conjunction with an assessment of the HMO's continued solvency and enrollment issues, the HMO's plans to improve its operations to achieve profitability should be documented and presented to the board of directors.

It is recommended that the HMO develop a strategic plan that incorporates the HMO's long and short term goals and objectives which should be updated periodically as strategies are revised and objectives achieved. It is also recommended that such plan be documented, reviewed and approved by the board of directors and provided to this Department.

Further, Part 98-1.11(e)(2) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11) states in part:

> *"…any applicant for certification as an MCO must establish a contingent reserve in an amount equal to 5 percent of projected net premium income…For each subsequent year…it must increase its contingent reserve according to the schedule set forth above…"*

The HMO's contingent reserve of $1,788,078 was impaired in the amount of $1,573,219 as of December 31, 2011. On March 5, 2012, Senior Health Holdings, Inc. infused $7.5 million into the HMO, which cured the impairment.

It is recommended that the HMO at all times, maintain its contingent reserve in compliance with the requirements of Part 98-1.11(e)(2) of the Administrative Rules and Regulations of the New York State Department of Health.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2008, contained the following twenty-two (22) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that the HMO comply with Section 3.3.1 of its By-Laws and Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Department of Health by including the requisite number of enrollees or enrollee representatives as members of Senior Whole Health's Board of Directors. *The HMO has complied with this recommendation.*	5
2.	It is recommended that the HMO comply with Section 2.2 of its By-Laws and hold annual shareholders' meetings. *The HMO has complied with this recommendation.*	6
	Holding Company System	
3.	It is recommended that the HMO update the management fee schedules related to the Joint Services and E&P New York Agreements to cover the time periods indicated for each agreement. *The HMO has complied with this recommendation.*	14
4.	It is recommended that the HMO comply fully with the NAIC Annual Statement Instructions in regard to completing Schedule Y of its quarterly and annual statement filings. *The HMO has complied with this recommendation.*	15
	Allocation of Expenses	
5.	It is recommended that Senior Whole Health recoup from SWH-MGT the full amount of the management fee overcharges with	17

ITEM NO.		PAGE NO.
	applicable interest. In addition, it is recommended that the HMO take the steps necessary to ensure that SWH-MGT changes its methodology of calculating the employee benefit charges to actual costs. *The HMO has complied with this recommendation.*	
6.	It is recommended that the HMO refrain from its current expense allocation of an across-the-board premium income methodology and consider as a guide the detailed procedures outlined in Parts 105.25, 106.2 and 109.2 of Department Regulation No 30. It is further recommended that the HMO recalculate its expense allocation and make appropriate adjustments to such expenses charged to the HMO, including adjustments applicable to prior years. *The HMO has not complied with both recommendations. A similar recommendation is contained within this report on examination.*	17
7.	It is recommended that the HMO comply with the requirements of Paragraph 5 of SSAP No. 70 of the NAIC Accounting Practices and Procedures Manual and the 2008 NAIC Quarterly and Annual Statements Instructions, by reporting allocated management expenses from SWH-MGT between claims cost containment expenses, claims adjustment expenses and general administrative expenses, respectively. *The HMO has complied with this recommendation.*	19
8.	It is recommended that the HMO follow the NAIC Annual Statement Instructions and Part 105.25(b) of Department Regulation No. 30, by allocating and reporting management expenses from SWH-MGT into each individual expense account item, as if these expenses had been borne directly by the HMO. *The HMO has complied with this recommendation.*	19
	Accounts and Records	
9.	It is recommended that the HMO establish procedures to follow-up with the payees relative to its outstanding checks and to comply with Section 1316 of the New York Abandoned Property Law. Additionally, it is recommended that Senior Whole Health establish an accounting procedure to move long-	22

ITEM NO.		PAGE NO.
	outstanding check items from the HMO's cash account into an appropriate liability account. *The HMO has complied with this recommendation.*	
10.	It is recommended that the HMO report its cash and short-term investments on its filed annual statements with this Department, in accordance with Paragraph 10 of SSAP No. 2 and Paragraph 4 of SSAP No. 45 of the NAIC Accounting Practices and Procedures Manual and the NAIC Health Annual Statement Instructions. *The HMO has complied with this recommendation.*	23
11.	It is recommended that Senior Whole Health implement, at a minimum, the relevant internal control procedures included in the NAIC Financial Condition Examiners Handbook relative to its existing repurchase agreement account. *The HMO has complied with this recommendation.*	24
12.	It is recommended that the HMO improve its reconciliation function by streamlining the process to include only relevant details necessary to reconcile the cash accounts. It is further recommended that the HMO reconcile its cash accounts between the HMO's book balance and the bank's records for each cash account. *The HMO has complied with this recommendation.*	24
13.	It is recommended that the HMO follow the NAIC Health Annual Statement Instructions when reporting its investment income due and accrued account by only including earned income items pertaining to cash and other invested assets held. *The HMO has complied with this recommendation.*	24
14.	It is recommended that the HMO comply with the requirements of Paragraph 8 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual when reporting its pharmaceutical rebate receivables. *The HMO has complied with this recommendation.*	25

ITEM NO.		PAGE NO.
15.	It is recommended that Senior Whole Health comply with the requirements of Paragraph 24 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual by disclosing the requisite information relative to its pharmaceutical rebates into the Notes section of its financial statements. *The HMO has complied with this recommendation.*	26
16.	It is recommended that the HMO reconcile all enrollment differences associated with new member admissions, existing members' terminations and members' assigned risk categories between the Senior Whole Health Medicare and Medicaid enrollment systems. *The HMO has complied with this recommendation.*	26
17.	It is recommended that the HMO consider the following enhancements to its existing claims processing system: (i) improving its data warehousing capabilities, (ii) implementation of an internal policy and procedures to ensure regular and efficient claims data analysis by the HMO's management, and (iii) maintaining an electronic log of edits to its claims data in order to improve management's ability to track changes to processed claims. *The HMO has complied with this recommendation.*	27
18.	It is recommended that the HMO fully comply with the requirements of Part 98-1.16(c) of the Administrative Rules and Regulations of the Department of Health and the NAIC Health Annual Statement Instructions by reporting all matters involving the HMO's internal control deficiencies to the Department. *The HMO has complied with this recommendation.*	28
	<u>Unpaid Claim Adjustment Expenses</u>	
19.	It is recommended that the HMO comply with the requirements of Paragraph 7 of SSAP No. 55 of the NAIC Accounting Practices and Procedures Manual by establishing an adequate reserve for unpaid claim adjustment expenses. *The HMO has complied with this recommendation*	32

ITEM NO. **PAGE NO.**

Claims Processing

20. It is recommended that the HMO's senior management provide appropriate monitoring of Senior Whole Health's projects that are managed by outside consultants. 34

The HMO has complied with this recommendation.

Subsequent Events

21. It is recommended that Senior Whole Health comply fully with the requirements of Part 98-1.8(a) of the Administrative Rules and Regulations of the Department of Health by maintaining continued fiscal solvency. 36

The HMO has not complied with this recommendation. A similar recommendation is contained within this report on examination.

22. It is further recommended that the HMO at all times maintain its contingent reserve fund in compliance with the requirements of Part 98-1.11(e)(2) of the Administrative Rules and Regulations of the New York Department of Health. 37

The HMO has not complied with this recommendation. A similar recommendation is contained within this report on examination.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO. **PAGE NO.**

C. Internal Audit Department

i. It is recommended that the internal audit director's reporting process be revised so that the internal audit reporting structure allows direct reporting to the Audit Committee of the Management Company. It is also recommended that the Audit Committee be assigned primary responsibility for the performance evaluation and compensation of the internal audit director. 11

ii. It is also recommended that the HMO's Audit Committee maintain documentation to support the Audit Committee's review of the Internal Audit Department ("IAD") director's performance. Details for the IAD director's compensation should also be included. 11

D. Holding Company System

i. It is recommended that the HMO apply for a renewal or extension amendment of the Joint Services Agreement with the New York State Department of Health retroactive to the date the contract expired. In this regard, it is also recommended that such renewal or extension amendment be filed with the Department. 19

E. Allocation of Expenses

i. It is recommended that the HMO refrain from using its current joint expense allocation of premium income methodology as described above and consider as a guide the detailed procedures outlined in Parts 105.25, 106.2 and 109.2 of Department Regulation No. 30. 20

ii. Further, it is recommended that the HMO recalculate its expense allocations in accordance with Department Regulation No. 30 and make appropriate adjustments to such expenses charged to the HMO, including adjustments applicable to prior years. 20

F. Subsequent Events

i. It is recommended that the HMO develop a strategic plan that incorporates the HMO's long and short term goals and objectives which should be updated periodically as strategies are 27

ITEM NO.		PAGE NO.
	revised and objectives achieved. It is also recommended that such plan be documented, reviewed and approved by the board of directors and provided to this Department.	
ii.	It is recommended that the HMO at all times, maintain its contingent reserve in compliance with the requirements of Part 98-1.11(e)(2) of the Administrative Rules and Regulations of the New York State Department of Health.	28

Respectfully submitted,

_____/S/_____
Froilan Estebal
Senior Insurance Examiner

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

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

_____/S/_____
Froilan Estebal

Subscribed and sworn to before me
this _____ day of _____2014

APPOINTMENT NO. 30847

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:*

Froilan Estebal

as a proper person to examine the affairs of the

Senior Whole Health of New York, Inc.

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

HMO

with such other information as he shall deem requisite.

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

this 27th day of April, 2012

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: Stephen J. Wiest

Stephen J. Wiest
Deputy Bureau Chief
Health Bureau