REPORT ON EXAMINATION

OF

EMPIRE HEALTHCHOICE HMO, INC.

AS OF

DECEMBER 31, 2013

DATE OF REPORT	**AUGUST 15, 2016**
EXAMINERS	**JERRY EHLERS, CFE**
	SYLVIA D. LAWSON, AINS, ARM, CLU

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August 15, 2016

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

Madam:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31233, dated October 9, 2014 attached hereto, we have made an examination into the condition and affairs of Empire HealthChoice HMO, Inc., a for-profit health maintenance organization issued a certificate of authority under the provisions of Section 4403 of the New York Public Health Law, as of December 31, 2013, and submit the following report thereon.

The examination was conducted at the home office of Empire HealthChoice HMO, Inc. located at One Liberty Plaza, New York, NY.

Empire HealthChoice HMO, Inc. is a wholly-owned subsidiary of Empire HealthChoice Assurance, Inc. ("EHCA"). EHCA is an indirect wholly-owned subsidiary of WellPoint, Inc. ("WellPoint").

Wherever the designations "EHC HMO" or the "Plan" appear herein, without qualification, they should be understood to indicate Empire HealthChoice HMO, Inc.

Wherever the designation "EHCA" appears herein, without qualification, it should be understood to indicate Empire HealthChoice Assurance, Inc.

Wherever the designations "WellPoint Holding Corporation" or "WHC" appear herein, without qualification they should be understood to indicate WellPoint Holding Corporation, the Parent of EHCA.

Wherever the designation "WellPoint" appears herein, without qualification, it should be understood to indicate WellPoint, Inc., the ultimate Parent of WHC. On December 2, 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc.

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

Wherever the designation the "Companies" appear herein, without qualification, it should be understood to indicate Empire HealthChoice Assurance, Inc., and Empire HealthChoice HMO, Inc., collectively.

A concurrent examination was made of Empire HealthChoice Assurance, Inc., EHC HMO's immediate parent, a stock insurance company, licensed pursuant to provisions of Article 42 of the New York Insurance Law. A separate report thereon has been submitted.

A separate market conduct examination into the manner in which EHC HMO and its parent, EHCA, conducted their business practices and fulfilled their contractual obligations to policyholders and claimants was conducted as of December 31, 2014. A separate report thereon will be submitted.

1. SCOPE OF THE EXAMINATION

EHC HMO was previously examined as of December 31, 2010. This examination of the Plan was a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2014 Edition* ("the Handbook") and it covered the period January 1, 2011 through December 31, 2013. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2013 were also reviewed.

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 examiners' assessment of risk in EHC HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiners planned and performed the examination to evaluate EHC HMO's current financial condition, as well as identify prospective risks that may threaten the future solvency of EHC HMO.

The examiners 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 Annual Statement Instructions.

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

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

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

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

EHC HMO was audited annually for the years 2011 through 2013, by the accounting firm of Ernst & Young, LLP ("E&Y"). EHC HMO received an unmodified opinion in each of those years. Certain audit workpapers of E&Y were reviewed and relied upon in conjunction with this examination. A review was also made of WellPoint, Inc.'s Internal Audit function, Sarbanes-Oxley/Model Audit Rule ("SOX/MAR") function, and Enterprise Risk Management program, as they relate to the Plan.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook (an examination of one insurer or a group of insurers performed by examiners from more than one state whereby the participating states share resources and allocate work among the examiners), of the insurance subsidiaries of WellPoint, Inc. The examination was led by the state of Indiana with participation from twelve (12) other states: New York, California, New Hampshire, Maryland, Maine, Missouri, Ohio, Texas, Virginia, West Virginia, Washington and Wisconsin. Since the lead and participating states are accredited by the NAIC, all states deemed it appropriate to rely on each other's work. The examination team, representing the participating states, identified and assessed the risks for key functional activities across all of the WellPoint, Inc. insurance subsidiaries. The examination team also assessed the relevant prospective risks as they related to the insurance entities.

Additionally, as part of this coordinated examination and in accordance with the provisions of the Handbook, an information systems review was made on a risk-focused basis, of WellPoint's computer systems and operations that support EHC HMO.

The examiners reviewed the corrective actions taken by the Plan with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiners' review are contained in Item 5 of this report.

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

2. DESCRIPTION OF THE PLAN

EHC HMO is a for-profit HMO certified pursuant to Article 44 of the New York Public Health Law. EHC HMO was originally incorporated on March 5, 1996, as Family HealthChoice, Inc., a health maintenance organization licensed in the State of New York. Family HealthChoice, Inc. commenced business on March 19, 1996. Family HealthChoice, Inc. was granted a certificate of authority under the provisions of Article 44 of the New York Public Health Law, effective March 7, 1996. Effective June 10, 1996, Family HealthChoice, Inc., changed its name to Empire HealthChoice HMO, Inc.

EHC HMO is a licensee of the Blue Cross and Blue Shield Association ("BCBSA") and markets its product under the Blue Cross Blue Shield name. EHC HMO has been in operation for over 17 years and offers HMO, point-of-service, Medicare Advantage and state-sponsored products to individual and group accounts in the greater New York metropolitan area and select upstate counties. As a BCBSA licensee, EHC HMO participates in the BlueCard program. BlueCard is a BCBSA nationwide program that enables members who need health care services while traveling or living in another Plan's service area to access their benefits through local BCBSA Plan's providers. It also allows the cost of service to be calculated in accordance with the local Plan's contract with providers. EHC HMO is a wholly-owned subsidiary of Empire HealthChoice Assurance, Inc., which is an indirect wholly-owned subsidiary of WellPoint, Inc., a publicly traded company and one of the largest health benefits Plans in terms of membership in the United States, serving approximately 35.7 million medical members as of December 31, 2013.

In a letter dated October 14, 2011, WellPoint Holding Corporation filed an application for approval for the acquisition of Rayant Insurance Company of New York ("Rayant"). This application was filed pursuant to Section 1506 of the New York Insurance Law and Subpart 80-

1.6 of Insurance Department Regulation No. 52 (11 NYCRR 80-1.6) – Holding Companies. Pursuant to the purchase agreement, WHC purchased 100% of the capital stock of Rayant, a dental insurance Plan that was wholly owned by Horizon Healthcare Plan Holding Company, Inc. Rayant became a party to the WellPoint inter-plan Federal Income Tax Sharing Agreement and the Amended and Restated Master Administrative Services Agreement. On December 30, 2013, Rayant was merged into EHCA.

During the examination period, EHC HMO took the following measures as a result of financial losses:

- On November 11, 2011, EHC HMO discontinued certain Small Group and commercial market products. EHC HMO discontinued prescription drug cost sharing options that affected approximately 200,000 insureds; and
- On April 1, 2012, the Companies discontinued their Small Group Commercial and Health Maintenance Organization ("HMO") products. Subsequently, the Companies discontinued all remaining small group plans/ options in the Commercial and HMO markets with the exception of its HMO option, Preferred Provider Organization ("PPO") option, Exclusive Provider Organization ("EPO") option and its Consumer Directed Health Plan ("CDHP") option.

A. Management and Controls

The EHC HMO Board of Directors ("BOD") is comprised of internal management and external independent directors. As required by Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11(g)), a minimum of twenty percent (20%) of the Board of Directors of the Plan must be comprised of enrollee representatives.

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

> "(g) Except in the case of an HMO operated by a corporation licensed under article 43 of the Insurance Law which also operates a Public Health Law article 44 line of

> business, no less than one third of the members of the governing authority of an MCO shall be composed of residents of New York State.
>
> (1) Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO…"

EHC HMO complied with this requirement during the examination period.

Pursuant to the Plan's By-laws, management of the Plan is to be vested in a Board of Directors consisting of not less than three (3) and not more than ten (10) Directors. As of December 31, 2013, EHC HMO's Board of Directors ("BOD") was comprised of five (5) Directors. The Audit Committee for WellPoint, Inc. ("WellPoint"), the Companies' ultimate parent, which is composed of outside Directors, assumes responsibility for all entities in the holding company structure. With the independent auditors, internal auditors, and the Risk Assessment and Controls group, the WellPoint Audit Committee reviews the effectiveness of the accounting and financial controls and elicits recommendations that may improve controls. The WellPoint Audit Committee meets each quarter and minutes of the meetings are prepared and retained.

The five (5) Directors and their principal business affiliation as of December 31, 2013, were as follows:

Name and Residence	Principal Business Affiliation
Lois S. Freedman* East Norwich, NY	Member, Empire HealthChoice HMO, Inc.
Brian T. Griffin Allenhurst, NJ	President, Chairperson and CEO – New York Market, Empire HealthChoice Assurance, Inc.
Grace H. McCabe New York, NY	Retired
Chrystal L. Veazey- Watson West Caldwell, NJ	Associate General Counsel, New York Market, WellPoint, Inc.
Richard D. Watson New York, NY	Regional Vice-President, Finance, WellPoint, Inc.

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

The principal officers of the Plan as of December 31, 2013, were as follows:

Name	Title
Timothy P. Deno	Valuation Actuary
Brian T. Griffin	President, Chairperson and CEO
Eric K. Noble	Treasurer
Vincent E. Scher	Assistant Treasurer
Chrystal L. Veazey-Watson	Assistant Secretary
Jay H. Wagner	Secretary

B. Corporate Governance

WellPoint, Inc. is a publicly traded, diversified health plan subject to the Sarbanes-Oxley Act of 2002. EHC HMO is required to be compliant with Insurance Department Regulation No. 203 – Enterprise Risk Management and Own Risk and Solvency Assessment. Controls are identified by management and testing managed and monitored by the WellPoint Controls and Assurance group that reports up through the WellPoint, Inc. Internal Audit Department ("IAD"). Shared services are managed by WellPoint, Inc. and include information technology, risk management, investments, accounting, and internal audit.

i. Enterprise Risk Management

WellPoint has adopted an Enterprise Risk Management ("ERM") framework for proactively addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*) was utilized by the examiners as guidance for assessing corporate governance. It appears that the Plan's BOD and key executives maintain an effective control environment.

ii. Internal Audit Department

WellPoint assumed the Internal Audit Department ("IAD") function, which is independent of management, to serve the WellPoint Audit Committee of the BOD ("the Audit Committee" or "AC"). In addition, WellPoint has established an Audit Council to address the requirements of Insurance Regulation No. 118 (11 NYCRR 89) – Audited Financial Statements, New York's version of the NAIC's Model Audit Rule, and assist management at the local level with any insurance regulatory reviews.

During the course of this examination, consideration was given to the significance and potential impact of certain IAD and Risk Control and Assurance ("RCA") findings. To the extent possible, the examiners relied upon the work performed by the IAD, as prescribed by the Handbook.

No exceptions relative to the Plan's corporate governance were noted.

C. Territory and Plan of Operation

EHC HMO is a licensee of the Blue Cross and Blue Shield Association ("BCBSA") and markets its products under the Blue Cross Blue Shield trade name. EHC HMO has been in operation for over seventeen (17) years and offers HMO, Point of Service, Medicare Advantage and state-sponsored products to individuals and groups in the greater New York metropolitan area and select upstate counties.

As set forth in its certificate of authority, EHC HMO is permitted to serve the following twenty-eight (28) counties in the State of New York.

New York Region

Bronx	Dutchess	Kings	Nassau
New York	Putnam	Queens	Richmond
Rockland	Suffolk	Westchester	

Albany Region

Albany	Clinton	Columbia	Delaware
Essex	Fulton	Greene	Montgomery
Orange	Rensselaer	Saratoga	Schenectady
Schoharie	Sullivan	Ulster	Warren
Washington			

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

	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income
2013	$750,553,176	$477,261,490	$1,549,699,961	$22,301,609
2012	850,095,319	548,842,074	1,688,198,549	83,798,732
2011	969,027,174	495,712,723	1,867,357,777	104,568,697

The change in net income from 2012 to 2013 is primarily due to premiums decreasing approximately $138.5 million or 8.2%. It should be noted that total medical and hospital expenses also decreased $96.8 million or 6.63% during the same period. These changes were due to declining membership. The change in net income from 2011 to 2012 was primarily due to declining Child Health Plan membership. This resulted in premiums decreasing $179.2 million or 9.6% from 2011 to 2012. In addition, all lines of business except Medicare Advantage decreased significantly during this period. Contributing to the decline was the Plan's strategy to exit the small group point of service market.

As of December 31, 2013, health care services were provided to 164,290 members. The following chart shows annual membership changes during the examination period by number and percentage:

	2010	**2011**	**2012**	**2013**
Members	284,922	258,348	219,165	164,290
Change %	(15.98%)	(9.33%)	(15.17%)	(25.04%)

D. Risk-Based Capital

Risk-Based Capital ("RBC") measures the minimum amount of capital appropriate for the Plan to support its overall business operations in consideration of its size and inherent risks. The Plan's RBC for the examination period was 792%, 950% and 882% for calendar years 2011, 2012, 2013, respectively.

E. Dividends

Part 98-1.11(c) of the Administrative Rules and Regulations of the Health Department states in part:

> "(c) No HMO which is organized as a stock corporation shall declare or distribute any dividend on its capital stock, except out of earned surplus unless upon prior application therefore, the commissioner, with the advice of the superintendent, approves such distribution. No such company shall declare or distribute any dividend to shareholders which, together with all such dividends declared or distributed by it during the prior twelve month period, exceeds the lesser of ten percent of its capital and surplus (net worth), as shown by its last statement on file with the commissioner, or 100 percent of adjusted net investment income for such period unless, upon prior application therefore, the commissioner, with the advice of the superintendent, approves a greater dividend payment based upon his/her finding that the insurer will retain sufficient surplus to support its obligations and writings…"

EHC HMO, Inc. declared and paid a dividend November 20, 2011, to its sole shareholder EHCA. It should be noted that a finding was made in the prior report on examination when it was determined that the aggregate amount of the dividend had exceeded 10% of the Plan's prior twelve month period's capital and surplus and that the commissioner's approval (nor the superintendent's advice) was not obtained before the payment of the dividend. It should be further noted that the Plan rectified this matter.

F. Small Group Business

During the examination period, EHC HMO experienced a loss of its profits in its small group business. EHC HMO has limited its writings of small business accounts in New York. The

decline was predominately due to some of the Plan's small group subscribers making a switch from the Plan to an affiliated Preferred Provider Organization ("PPO") plan or some other HMO competitor and also the economic downturn.

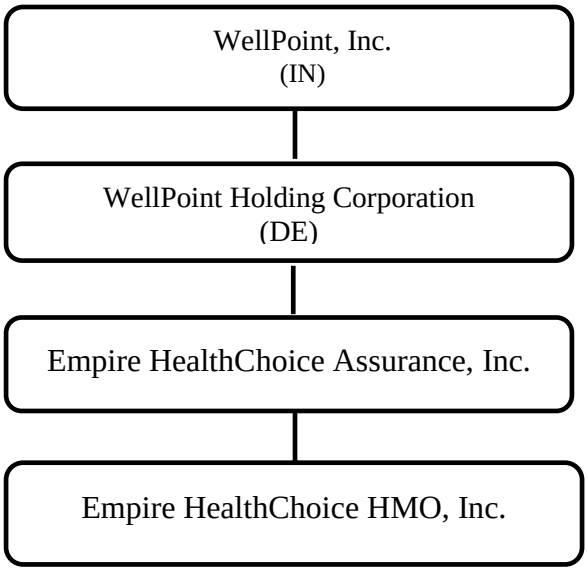
On September 2, 2011, the Department met with representatives from EHCA and EHC HMO to discuss a plan for the discontinuance of small group policy forms and options which were to become effective January 1, 2012. Early in 2011, EHCA and EHC HMO submitted a plan to discontinue certain products relative to their small group and commercial markets, which were mostly associated with prescription drug plans.

On April 1, 2012, EHCA and EHC HMO discontinued their small group commercial and HMO market business. EHCA and EHC HMO discontinued all remaining small group plans/options in the commercial and HMO markets except for the HMO option, the Preferred Provider Organization ("PPO") option, the Exclusive Provider Organization ("EPO") option, and the Consumer Directed Health Plan ("CDHP") option and Healthy New York ("HNY").

G. Holding Company System

EHC HMO is a wholly-owned subsidiary of Empire HealthChoice Assurance, Inc. ("EHCA"). As of the examination date, EHCA was a wholly-owned subsidiary of WellPoint Holding Corporation ("WHC"). WHC was a wholly-owned subsidiary of WellPoint, Inc. ("WellPoint"), which is a publicly traded company and the largest health benefits plan in terms of memberships in the United States, serving approximately 35.7 million medical members as of December 31, 2013.

The following chart depicts the Plan's abbreviated holding company system as of December 31, 2013:



The Plan, during the examination period, was a party to inter-company agreements with its affiliates, which were subject to the New York Department of Health and the Department's review and approval. These agreements involved activities such as administrative services, cash management, investment management, and tax allocation.

Inter-company agreements and amendments for EHC HMO that were in place as of December 31, 2013, include the following:

- Amended and Restated WellPoint Master Administrative Services Agreement – The Companies entered into an Amended and Restated Master Administrative Services Agreement, effective August 1, 2007, with WellPoint, Inc. ("WellPoint"), and its subsidiaries and affiliates. This agreement was submitted to the Department on April 3, 2006 and was approved by the Department on July 3, 2008.

- Federal Income Tax Allocation Agreement – The Companies entered into an Amended Consolidated Federal Income Tax Agreement, effective December 15, 2006, with WellPoint and its subsidiaries. This agreement was submitted to the Department on September 28, 2006, and a letter of no objection was sent to the Companies on October 4, 2006.

H. Reinsurance

There was no reinsurance assumed or ceded during the period under examination.

I. Internal Controls

The NAIC Risk Surveillance approach to financial examinations relies on the review of mitigating controls applicable to the inherent risks of the companies examined. In the case of WellPoint and EHC HMO, the mitigating controls are housed in "Open Pages," a vendor purchased software package. Controls related to the WellPoint Sarbanes-Oxley ("SOX") and Department Regulation No. 118 (11 NYCRR 89) are tested and monitored by WellPoint's Risk Control and Assurance ("RCA") group. Within WellPoint's SOX records, the internal controls applicable to EHC HMO were identified by its management.

A thorough review of WellPoint's SOX controls documentation and the Plan's MAR internal controls were an important component of the examination process. There were no identified material weaknesses or significant deficiencies identified by E&Y, the Plan's Auditor. Additionally, there were no material control deficiencies or internal control observations noted during the review of WellPoint's and the Companies' internal controls that warranted attention.

The information technology ("IT") environment for EHC HMO is managed in a shared services model by WellPoint, Inc. Under this model, WellPoint manages all aspects of information technology for the entire holding company.

IT infrastructure and operations for the financially significant systems identified were managed at the data centers located in Richmond, Virginia, and in St. Louis, Missouri.

The examination encompassed a review of the controls for financially significant applications, systems and infrastructure. The IT portion of the examination was performed in accordance with the Handbook and utilized applicable procedures found in Exhibit C – *Evaluation of Controls in Information Technology* – of the Handbook.

Controls for financially significant applications, systems, and underlying infrastructure in each of the NAIC Exhibit C Information Technology Work Program areas listed below represent the framework for the scope of this examination. The following control areas were reviewed:

- Align, Plan and Organize;
- Build, Acquire and Implement;
- Deliver, Service and Support; and
- Monitor, Evaluate, and Assess.

It was determined that the overall assessment of the Plan's IT general controls ("ITGC") environment for the key financial systems that supported the preparation of the Plan's financial statements supported an ITGC reliance-based financial examination. The IT examiners assessed the ITGC for EHC HMO as effective.

J. Facilitation of the Examination

Section 310(a)(3) of the New York Insurance Law states:

> "The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so."

Various requests were made by the examiners to management of the Plan. It should be noted that management of the Plan failed to provide the examiners with the requested documentation regarding many of these requests in a timely manner. Failure to provide the documentation in a timely manner led to numerous delays in the examination process. It should be further noted that a similar comment was made in the Plan's prior report on examination.

It is recommended that the Plan comply with the requirements of Section 310(a)(3) of the New York Insurance Law by providing all requested documentation in a timely manner.

K. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles, Annual Statement Instructions, and/or Department guidelines. The examiners also noted several deficiencies with the Plan's system of accounts and records. A description of such items is as follows:

1. The 2013 NAIC Health Annual Statement Instructions, with regard to a Plan's Actuarial Memoranda, state in part:

> *"...This technical component must show the analysis from the basic data, (e.g., claim lags) to the conclusions..."*

Upon review it was noted that none of the Actuarial Memoranda included claim lag triangles. While the technical component of each of the Actuarial Memoranda did include a significant amount of information and exhibits, it was also not indexed or organized in a way that one could easily follow the analysis from the data to the conclusions.

It is recommended that the Appointed Actuary's technical component of the Actuarial Memoranda include the analysis from the basic data, (e.g., claim lags) to the conclusions, as is required by the NAIC Health Annual Statement Instructions.

It is also recommended that the Appointed Actuary organize the technical appendices in a manner such that the analysis can be followed from data to conclusions.

It is further recommended that the Plan establish and implement a control to prevent the omission of required components during the preparation of the Actuarial Memoranda.

2. The 2013 NAIC Health Annual Statement Instructions also require that the Actuarial Memoranda include, "An exhibit which ties to the Annual Statement and compares the actuary's

conclusions to the carried amounts." The required exhibit was not included in the Actuarial Memoranda for any of the Companies. An inquiry was made to the Plan and the examiners were told that, "The actuarial team does currently perform the checks via notes in our reconciliations, but that information isn't currently included in the memo itself."

It is recommended that the Appointed Actuary include in all Actuarial Memoranda, an exhibit that reconciles the Annual Statement and compares the Actuary's conclusions to the carried amounts as is required by the NAIC Health Annual Statement Instructions.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2013, as contained in EHC HMO's 2013 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. The examiners' review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in the financial statements contained in the December 31, 2013 filed annual statement.

The firm of Ernst and Young, LLP ("E&Y") was retained by WellPoint to audit EHC HMO's combined statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended.

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

A. Balance Sheet

Assets

Bonds	$	563,252,383
Cash and short-term investments		(14,047,680)
Securities lending reinvested collateral assets		26,398,641
Aggregate write-ins for invested assets		765,921
Investment income due and accrued		5,446,411
Uncollected premiums in the course of collection		45,407,289
Accrued retrospective premiums		935,089
Amounts receivable relating to uninsured plans		528,390
Net deferred tax asset		16,611,518
Receivables from parent, subsidiaries and affiliates		46,483,347
Healthcare and other amounts receivable		7,064,017
Aggregate write-ins for other than invested assets		51,707,850
Total assets	$	750,553,176

Liabilities

Claims unpaid	$	162,091,893
Accrued medical incentive pool and bonus amounts		1,477,180
Unpaid claims adjustment expenses		3,289,497
Aggregate health policy reserves		39,780,195
Aggregate health claim reserves		2,221,766
Premiums received in advance		9,592,745
General expenses due or accrued		2,787,843
Federal and foreign income tax payable and interest thereon		489,135
Amounts withheld or retained for the account of others		404,568
Remittance and items not allocated		2,984,635
Amounts due to parents, subsidiaries and affiliates		7,445,865
Payable for securities		738,165
Payable for securities lending		26,398,641
Aggregate write-ins for other liabilities		13,589,558
Total liabilities	$	273,291,686

Capital and Surplus

Gross paid-in and contributed surplus	$	71,999,998
Aggregate write-ins for other than special surplus funds		192,451,710
Unassigned funds		212,809,780
Total capital and surplus	$	477,261,490
Total liabilities, capital and surplus	$	750,553,176

NOTE: The Internal Revenue Service ("IRS") routinely conducts a Compliance Assurance evaluation of tax returns for WellPoint and its affiliates. There were no known IRS findings reported from the Compliance Assurance completed for December 31, 2011, December 31, 2012 or December 31, 2013. The examiners are unaware any potential exposure of issues related to the EHC HMO for any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus decreased $82,165,686 during the three-year examination period, January 1, 2011 through December 31, 2013, detailed as follows:

Revenue		
Premium income	$ 5,105,256,287	
Change in unearned premium reserve	(2,836,086)	
Total revenue		$ 5,102,420,201
Hospital and medical expense		
Hospital/medical benefits	$ 3,566,907,178	
Other professional services	103,225,085	
Outside referrals	157,663,799	
Emergency room and out-of-area	184,494,567	
Prescription drugs	622,667,083	
Aggregate write-ins for other hospital and medical	(223,307,824)	
Incentive pool, withhold adjustments, and bonus amounts	4,543,699	
Total hospital and medical expenses	$ 4,416,193,587	
Claims adjustment expenses	139,820,004	
General administrative expenses	299,554,641	
Increase in reserves for life and accident and health contracts	13,062,014	
Total underwriting expenses		4,868,630,246
Net underwriting gains		$ 233,789,955
Net investment income		68,555,006
Net realized capital gains less capital gains tax		17,170,866
Net gain from agents' premium balances charged-off		467,235
Aggregate write-ins for other income or expense		(13,001,880)
Net income before federal and foreign income taxes		$ 306,981,182
Federal and foreign income taxes incurred		96,312,144
Net income		$ 210,669,038

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination, as of December 31, 2010			$ 559,427,176
Net Income	$ 210,669,038		
Net change in unrealized capital gains	51,879		
Change in net deferred income tax		$ 10,975,506	
Change in non-admitted assets	12,875,977		
Cumulative effect of change in accounting principles	7,165,622		
Dividends to shareholders		301,952,696	
Net change in capital and surplus			$ (82,165,686)
Capital and surplus, per report on examination, as of December 31, 2013			$ 477,261,490

4. SUBSEQUENT EVENTS

On December 3, 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc., and started trading on the New York Stock Exchange under the ticker symbol "*ANTM*". Shareholders approved the name change at a special shareholders meeting on November 5, 2014.

On February 5, 2015, Anthem, Inc. communicated to its current and former members that Anthem had been the subject of a very sophisticated external cyber-attack. The attackers gained unauthorized access (in mid-December 2014) to Anthem Inc.'s IT system and obtained personal information from approximately 80 million current and former members.

It should be noted that following the discovery of this cyber breach, the National Association of Insurance Commissioners ("NAIC") requested that a multi-state examination of Anthem, Inc. and its subsidiaries be conducted. A separate report of their findings will be issued at a later date.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2010, contained the following three (3) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Dividends	
1.	It is recommended that the Plan comply with the requirements of Section 4207(b)(1) of the New York Insurance Law by obtaining the Superintendent's approval before declaring and distributing any dividends exceeding the lesser of 10% of its capital and surplus or 100% of its adjusted net income earned, as shown by its last statement on file with the Superintendent. *EHC HMO has complied with this recommendation.*	11
	Facilitation of the Examination	
2.	It is recommended that the Plan comply with the requirements of Section 310(a)(3) of the New York Insurance Law by providing all requested documentation in a timely manner. *EHC HMO has not complied with this recommendation. A similar recommendation appears in this report.*	17
	Premium refunds and Department Regulation No. 146 (11 NYCRR 361) - Specified Medical Conditions ("SMC") Pools	22
3.	It is recommended that the Plan properly accrue for all monies received from the SMC pools that remain undistributed to the policyholders. *EHC HMO has complied with this recommendation.*	

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____
Jerry Ehlers, CFE
Insurance Examiner

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

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

_____
Jerry Ehlers, CFE

Subscribed and sworn to before me
this _____ day of_____2016.

Respectfully submitted,

_____
Sylvia D. Lawson, AINS, ARM, CLU
Principal Insurance Examiner

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

Sylvia D. Lawson, being duly sworn, deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

_____
Sylvia D. Lawson, AINS, ARM, CLU
Principal Insurance Examiner

Subscribed and sworn to before me
this _____ day of_____2016.

APPOINTMENT NO. **31233**

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:*

Noble Consulting Services, Inc.

as a proper person to examine the affairs of the

Empire HealthChoice HMO, Inc.

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

HMO

with such other information as they 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 9th day of October, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau