REPORT ON EXAMINATION

OF

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2014

DATE OF REPORT **FEBRUARY 8, 2017**

EXAMINER **KENNETH I. MERRITT**

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February 8, 2017

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

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31086, dated January 24, 2015, attached hereto, I have made an examination into the condition and affairs of Capital District Physicians' Health Plan, Inc., a not-for-profit health maintenance organization (HMO), certified pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2014, and submit the following report thereon.

The examination was conducted at the home office of Capital District Physicians' Health Plan, Inc. located at 500 Patroon Creek Boulevard, Albany New York, 12205.

Wherever the designations the "HMO" or "CDPHP" appear herein, without qualification, they should be understood to indicate Capital District Physicians' Health Plan, Inc.

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

A separate Market Conduct examination reviewing the manner in which the HMO conducted its business practices and fulfilled its contractual obligations to policyholders and

claimants was also conducted as of December 31, 2014. A separate report thereon will be submitted.

1. SCOPE OF THE EXAMINATION

We have performed our single state examination of Capital District Physicians' Health Plan, Inc. The previous examination covered the period January 1, 2005 through December 31, 2009. This examination of the HMO was a financial examination as defined in the *National Association of Insurance Commissioners ("NAIC") Financial Condition Examiners Handbook 2015 Edition* ("Handbook") and it covered the period from January 1, 2010 through December 31, 2014. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2014 were also reviewed.

The examiner planned and performed the examination to evaluate the HMO's current financial condition, as well as identify prospective risks that may threaten the future solvency of the HMO.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and annual statement instructions.

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

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

The examination also evaluated the 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

The HMO was audited annually for the years 2010 through 2013 by the accounting firm of PricewaterhouseCoopers LLP ("PwC") and for the year 2014, by Deloitte and Touche ("D&T"). The HMO received an unmodified opinion in each of those years. Certain audit work papers of D&T were reviewed and relied upon in conjunction with this examination. The HMO has an internal audit department which has been given the task of assessing CDPHP's internal control

structure. A review was also made of the HMO's Enterprise Risk Management program / Own Risk Solvency Assessment.

As part of this examination, an information systems review was made of the HMO's computer systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

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. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies and departures from the New York Public Health Law during the examination period. The most significant findings of this examination include the following:

- Certain operational deficiencies were noted within CDPHP's internal audit function ("IA") due to the integration of IA with the management functions of Information Technology Security ("ITS") and Enterprise Risk Management ("ERM"). During the examination period, the supervision of CDPHP's IA function as well as its ITS, was delegated to the same employee with the job title of Director of Audit Information and Assurance and Information Security Officer ("DAIA" and "ISO"). Additionally, it was also noted that the DAIA and ISO reported directly to management (Senior Vice-President and General Counsel) and that management was responsible for ultimate approval of the DAIA and ISO's annual job performance evaluation and compensation and salary adjustment. Subsequent to the examination period, the DIAA and ISO positions were upgraded in 2015 to Vice President, Audit and Assurance/CISO/CRO (with CISO and CRO being Chief Information Security Officer and Chief Risk Officer, respectively). Among the best practice standards of the Institute of Internal Auditors are the following requirements: (i) that the internal audit should be independent and have no supervisory roles in management; (ii) the chief audit executive ("CAE") of a company should have a direct reporting line to the Audit Committee ("AC") of the Board of Directors and a dotted line reporting to

management; and (iii) the AC should be responsible for reviewing and approving the CAE's annual performance evaluation and compensation and salary adjustment.

- CDPHP did not comply with paragraph 3 of Section (b) of Insurance Regulation No. 118 (Title 11 NYCRR 89) when it failed to file within the mandated fifteen day timeframe, the requisite CPA attestation stating whether the firm agrees with the HMO's representation there was no disagreement between the HMO and the former CPA within the previous two years on any matter of accounting principles or practices, or financial statement disclosure, or auditing scope or procedure that might or could have been referenced in the CPA opinions rendered in the CPA Reports of the prior two reporting years.

3. DESCRIPTION OF THE HMO

The HMO was formed as a membership corporation on February 27, 1984, under Section 402 of the Not-for-Profit Corporation Law, and subsequently incorporated within the State of New York on April 13, 1984. The members consist of physicians licensed by the State of New York. CDPHP, a health maintenance organization (HMO), certified pursuant to Article 44 of the New York Public Health Law, obtained its certificate of authority to operate as an independent practice association ("IPA") model HMO from the New York State Department of Health ("DOH"), effective April 30, 1984. The HMO commenced business on July 12, 1984.

As of December 31, 2000, membership in the HMO was opened to physicians licensed by the State of New York, who applied for membership and met the criteria required by the HMO's by-laws and were accepted as member physicians.

The HMO is a not-for-profit health insurer which is exempt from income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code.

CDPHP is authorized to operate in twenty-four (24) geographic counties in New York State, as detailed in Section B of this report. The HMO reported the following for its surplus at December 31 for the years 2010 through 2014:

Account	**2014**	**2013**	**2012**	**2011**	**2010**
NYS contingency reserve	$178,544,153	$162,914,203	$154,885,684	$125,045,318	$107,109,309
2015 ACA Tax	13,286,494	0	0	0	0
Other than special surplus funds	$191,830,647	$162,914,203	$154,885,684	$125,045,318	$107,109,309
Unassigned funds	57,092,467	137,573,692	170,124,206	190,942,544	163,232,847
Total year-end surplus	$248,923,114	$300,487,895	$325,009,890	$315,987,862	$270,342,156
Percent change	(17.2)%	(7.5)%	2.9%	16.9%	

CDPHP's total surplus of $248,923,114 through December 31, 2014 decreased during the examination period due primarily to the HMO providing cash funds of $240,000,000 to its Universal Benefits, Inc. ("UBI") subsidiary during the period. The cash funding provided by CDPHP to UBI was the result of the following transactions that were subject to the approval of New York State Department of Financial Services ("DFS") and New York State Department of Health ("DOH"):

CDPHP's investment/conversion of UBI's Section 1307 Loans

By a letter dated December 17, 2012 to the Department, UBI requested the Department's approval for UBI to (i) repay CDPHP for its outstanding New York Insurance Law Section 1307 loan in the amount of $48.5 million and (ii) receive from CDPHP, debt forgiveness of the associated $11.9 million of accumulated interest payable to CDPHP due to the inability of UBI to pay these debts. UBI's repayment of these outstanding loans was subject to review in accordance

with Section 1307 of the New York Insurance Law, including approval by the Superintendent. Simultaneous to UBI's repayment of the loans, CDPHP proposed to: (i) convert the $48.5 million in surplus notes into investments in UBI and (ii) to make an additional $31.5 million investment in UBI, which included the debt forgiveness to UBI for $11.9 million of accrued interest previously due to CDPHP. The net effect of these approvals was that CDPHP contributed $80 million into UBI ($48.5 million plus $31.5 million). These transactions were subsequently approved by the DFS and the DOH effective May 2, 2013.

Cash Contributions

i). Effective October 18, 2013 and December 4, 2013, the DFS and the DOH, respectively, approved CDPHP's proposal to make a $100 million investment in UBI pursuant to the terms of CDPHP's letter to the DFS and the DOH dated September 24, 2013.

ii). Effective December 18, 2014, the DFS and the DOH each approved CDPHP's proposal to invest $60 million in UBI pursuant to the terms of CDPHP's letter to the DFS and the DOH dated November 4, 2014.

A. Corporate Governance

The HMO is a physicians' controlled corporation. The participating physicians, who are members in good standing with the corporation, constitute a majority of the corporation's board of directors.

Pursuant to the HMO's charter and by-laws, management of the HMO is to be vested in a Board of Directors ("BOD") consisting of fifteen members. Eight of the fifteen members of the BOD include CDPHP's physicians/members and the remaining seven directors comprise individuals who are non-physician members of the HMO.

Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (Title 10 NYCRR 98-1) also imposes the following requirement:

> "…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 …"

The following fifteen directors served on CDPHP's BOD as of December 31, 2014:

Name and Residence	Principal Business Affiliation
Catherine R. Bartholomew, MD Albany, New York	Medical Doctor, Albany Medical Center
Bruce E. Coplin, MD* Delmar, New York	Medical Doctor, Albany Associates in Cardiology
Gennaro A. Daniels,MD* Troy, New York	Surgeon, Capital District Colon & Rectal Surgery Associates, PC
Joseph L. Dudek, MD* Delmar, New York	Medical Doctor, NY Oncology Hematology, PC
Richard E. Grant Glenmont New York	Retired Managing CPA Partner, PricewaterhouseCoopers , LLP
Robert C. Griffin* Albany, New York	Principal of local Business, Griffin Financial Group
Gerald D. Jennings Albany, New York	Retired/Former City Mayor, Albany, NY
Amy M. Johnson Loudonville, New York	President of Local Business, Capstone, Inc.
Richard E. Lavigne, MD* Albany, New York	Medical Doctor, Prime Care Physicians, PC
Anthony J. Marinello, MD* Guilderland, New York	Medical Doctor, Capital Care Family Practice
Thomas J. Marusak* Loudonville., New York	President of Local Business, Comfortex Corporation

Name and Residence	Principal Business Affiliation
Henry M. Neilley, MD* Clifton Park, New York	Medical Doctor, Shaker Pediatrics
William P. Phelan* Loudonville, New York	Chief Executive Officer of Local Business, Bright Hub, Inc.
Joseph M. Polito, II, MD* Albany, New York	Albany Gastroenterology Consultants, PLLC.
Susan C. Scrimshaw, PhD* Troy, New York	President of Local College, The Sage Colleges

*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)).

During the examination period, at least twenty percent of the members of CDPHP's BOD were enrollees of the HMO, in compliance with the requirements of Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1).

The HMO implemented the following amendments to the BOD's by-laws during the examination period:

(i). Effective March 18, 2011, the DOH approved the following amendment to Article IV, Section 4.04, Paragraph (c) of the by-laws:

> "In order to assure continuity of leadership and provide for orderly succession planning and notwithstanding the term limits of paragraphs "a" and "d" of this section, the Board of Directors may extend the term of one or more sitting directors, without the necessity of re-election to the position of director by the members, for the period not to exceed two years upon finding by the board that additional service by a particular director is in the best interests of the corporation because (i) the director possesses needed experience and his or her extended services is necessary for the orderly succession of leadership of the Board of Directors of the Corporation or (ii) to ensure that no more than four seats on the Board of Directors are up for election at any single Annual Meeting. The Board of Directors shall not extend the term of any individual director pursuant to this paragraph more than once."

The above amendment permits a sitting director after reaching his or her term limitation of two consecutive four year terms on the board to remain on the board for an additional period of up two years subject to the need to assure continuity of leadership and orderly succession planning.

(ii) Effective July 2, 2012, the DOH issued its approval of the following amendment to the HMO's by-laws:

> "Not more than one director from any practice group may hold office at the same time. A "practice group" means the professional staff (whether as members/owners, employees, or independent contractors) of (1) a single professional corporation, professional limited liability corporation, or similar practice entity; (2) two or more such entities that control, or are controlled by, a common corporate entity; or (3) two or more such entities that are held out to the public as a partnership, joint venture, single service entity or cooperative or co-branded service entity. This subsection shall not apply to any director holding office as of April 1, 2012."

The minutes of all meetings of the Board of Directors and sub-committees thereof held during the examination period were reviewed. The BOD met at least six times during each calendar year within the examination period, and the sub-committees also met at various times annually on a regular basis throughout the examination period. A review of the minutes of the HMO's BOD and sub-committees' meetings evidenced that the meetings were generally well attended, with all BOD and sub-committee members attending at least one half of all the meetings they were eligible to attend.

The following sub-committees of the BOD were in place during the examination period:

Audit Committee	Governance Committee
Compensation Committee	Investment Committee
Executive Committee	Finance Committee

The principal officers of the HMO as of December 31, 2014 were as follows:

Name	Title
John D. Bennett, M.D.	President and Chief Executive Officer
Neil Brandmaier	SVP, Chief Information Officer
Barbara Downs	SVP, Chief Operating Officer
Fred Galt	SVP, General Counsel
Robert Hinckley	SVP, Chief Strategy Officer
Scott Klenk	SVP, Human Capital Management
Brian Morrissey	SVP, Chief Marketing Officer
Bruce Nash	SVP, Chief Medical Officer
Bethany Smith	SVP, Chief Financial Officer

In disclosure number 26 in the General Interrogatories of the HMO's Annual Statement filings during the examination period, CDPHP disclosed that its investments and other securities owned over the course of the examination years were held in a bank depository account pursuant to a custodial agreement with a qualified bank which was compliant with the enumerated provisions indicated in the *NAIC Financial Condition Examiners Handbook*. However, it was noted that such agreement between the HMO and Key Bank was originally dated May 6, 1992 and was never updated. The agreement fails to include any of the provisions required by the Handbook.

It is recommended that the HMO amend its current Key Bank custodial agreement to include the required protective safeguard provisions detailed in the Handbook.

Enterprise Risk Management ("ERM") and Internal Audit ("IA") Functions

Commencing in 2014, the dual supervision of CDPHP's IA and Information Technology Security ("ITS") functions were delegated to the Director of Audit and Information Assurance and Information Security Officer ("DAIA and ISO"), with the DIA and ISO, being the most senior level position within CDPHP's internal audit department. Organizationally, the DAIA and ISO

reported on a direct basis to management (Executive Vice-President, General Counsel). Simultaneously, management also reviewed and approved annually both the job performance evaluation and compensation and annual salary adjustment of the DAIA and ISO. In accordance with the job/position description of the DAIA and ISO, such employee was responsible for the oversight, coordination and management of several governance functions including: audit, consulting, information assurance, breach readiness and management and business resumption planning. The following were also included among the DAIA's and ISO's essential job duties:

I. Develop technology risk and security standards and procedures that support strategic, tactical and operational objectives.

II. Develop an enterprise program to determine compliance with the HIPAA Security Rule and the HITECH legislation.

III. Develop and maintain security metrics to continually measure information security performance in relation to goals and governance standards.

IV. Facilitate change within the organization whether indicated by corporate needs, industry and technology changes or regulatory requirements.

It was further noted that during 2015 the DAIA and ISO position was upgraded to the title of the Vice-President of Internal Audit Assurance/ Chief Information Security Officer/ Chief Risk Officer, with the Chief Information Security and Chief Risk Officer comprising management positions.

Per guidance from the Information Systems Audit and Control ("ISACA"),

> "Audit independence is a critical component if a business wishes to have an audit function that can add value to the organization. The [internal] audit report and opinion must be free of any bias or influence if the integrity of the audit process is to be valued and recognized for its contribution to the organization's goals and objectives."

The IIA website states the following:

> "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 the 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."

Furthermore, the HMO's Corporate Internal Audit Charter states the following:

> "Internal auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair internal auditor's judgment…"

Based on the above best practices of the ISACA and IIA, as well as the HMO's Corporate Internal Audit Charter, the following comments and recommendations hereby apply:

It is recommended that the HMO assess its current organizational and staffing structure with consideration given to segregating responsibilities for internal audit, information security governance, risk management and internal testing. This assessment should consider all aspects of ERM, internal audit, information security governance and operations, and administrative responsibilities related to management's ERM testing of controls. Such recommendation is also consistent with the same requirement indicated in CDPHP's Corporate Internal Audit Charter.

It is noted that a similar recommendation was made in the HMO's prior report on examination.

It is recommended that as a best practice CDPHP restructure the organizational reporting structure of its internal audit department by having its top supervisory employee in charge of that department report directly to the Audit Committee and on a dotted line basis to management.

It is recommended that the HMO's Audit Committee be responsible for reviewing and approving the performance evaluation and the salary and variable compensation of the Director of Audit Information and Assurance.

It is noted that a similar recommendation was made in the HMO's prior report on examination.

Based on CDPHP's existing corporate Internal Audit Charter, the following applies relative to the requirement of a periodic external assessment of the HMO's internal audit activities:

> "…the Chief Audit Executive will communicate to senior management and the Audit Committee on the internal audit activity's quality assurance and improvement program, including results of ongoing internal assessments and external assessments conducted at least every five years."

In 2014, a third-party performed its annual assessment of a certain operational security function. The examiner noted there was no evidence that the results were communicated outside of the immediate IT Security Department, and to other senior management and the Audit Committee.

It is recommended that CDPHP comply with its Internal Audit Charter by communicating to senior management and the Audit Committee, all significant matters of operational security.

As of the examination date, the last internal audit function assessment and report issued by an external quality assurance reviewer was dated December 31, 2006.

It is recommended that CDPHP comply with the requirement of its Internal Audit Charter by ensuring that an external quality assurance review and assessment of CDPHP's internal audit activities are conducted at least every five years by an independent reviewer.

Subsequent to the examination date, CDPHP had an external quality assurance assessment of its internal audit activities performed in 2015 and a corresponding report issued thereon dated October 2015.

B. Territory and Plan of Operation

The HMO is certified to operate business in New York State only. The HMO's service area, as authorized in its Certificate of Authority, includes the following twenty-four (24) counties in the State of New York:

Albany	Essex	Montgomery	Schenectady
Broome	Fulton	Oneida	Schoharie
Chenango	Greene	Orange	Tioga
Columbia	Hamilton	Otsego	Ulster
Delaware	Herkimer	Rensselaer	Warren
Dutchess	Madison	Saratoga	Washington

The HMO provides a comprehensive prepaid health program by means of a network of participating physicians. Subscribers to the HMO select a participating physician who acts as their primary care physician. This physician refers members to other participating HMO physicians when particular medical specialties are required. Except for services specifically excluded or limited in the HMO's contracts or riders, there is no limit to duration, frequency or type of health care provided, as long as the care is directly provided or pre-authorized by the HMO's medical director and/or the primary care physician.

Inpatient hospital services are rendered as directed by the HMO's participating physicians. The HMO pays hospital charges through direct hospital billing. Out-of-area emergency care is provided for in the subscriber contracts.

The chart below illustrates the HMO's annual year-end member enrollments and premium writings during the examination period.

CDPHP Year-end Annual Enrollment

Line of Business	2014	2013	2012	2011	2010
Direct Pay	4,035	394	351	308	355
Large Group	81,853	87,323	92,929	92,546	93,764
Small Group	6,283	13,980	17,428	19,020	21,001
Healthy New York	1,894	6,458	7,482	8,374	9,310
Medicare Advantage Part. D	36,999	30,478	26,097	22,146	21,304
Medicaid	96,539	73,059	68,745	61,903	57,244
Child Health Plus	12,669	14,249	15,558	18,404	18,727
Family Health Plus	242	6,970	6,159	5,325	5,438
Total	240,514	232,911	234,749	228,026	227,143

During the examination period 2010 through 2014, the HMO's overall annual enrollment increased by approximately 6.0% from 227,143 total enrollees as of December 31, 2010 to 240,514 enrollees as of year-end 2014. Increases of 68.6% and 73.7% respectively in the Medicaid and Medicare (including Part D) lines of business, contributed most to the aforementioned growth in the HMO's member enrollment while that growth was simultaneously offset by decreases in CDPHP's large and small groups business of 12.7% and 70.1%, respectively. As of December 31, 2014, the HMO's total Medicaid and Medicare Advantage enrollment represents 55.5% of CDPHP's total membership, up from 34.6% as of December 31, 2010.

CDPHP Year-end Annual Premiums (000 omitted)

Line of Business	2014	2013	2012	2011	2010
Direct Pay	$ 22,136	$ 4,250	$ 3,518	$ 3,828	$ 3,908
Large Group	467,793	466,531	460,135	456,879	446,079
Small Group	44,746	74,072	82,000	87,546	91,546
Healthy New York	7,966	24,516	26,148	25,824	25,546
Medicare Adv./Pt. D	397,809	331,848	309,288	246,282	226,518
Medicaid	438,056	337,615	295,954	206,850	168,997
Child Health Plus	34,229	35,849	39,073	42,304	42,249
Family Health Plus	16,068	29,088	23,366	18,298	15,696
Total Gross Premiums	$1,428,803	$1,303,769	$1,239,488	$1,087,811	$1,020,538
Total Net Premiums	$1,426,900	$1,302,163	$1,237,874	$1,085,543	$1,018,425
Percentage Change in Gross Writings	9.6%	5.2%	13.9%	6.6%	

CDPHP's reported total gross annual premium increased from $1,020,538,088 as of December 31, 2010 to $1,428,803,217 as of December 31, 2014, representing an overall percentage increase of 40% for the period. This increase in gross annual premiums is largely attributable to Medicaid business. In addition, Medicare Advantage gross annual premium increased by 75.6% from year end 2010 through December 31, 2014. The Medicare and Medicaid business lines collectively comprised 48.7% of the HMO's total overall gross premium writings during the examination period.

C. Reinsurance

As of December 31, 2014, CDPHP held ceded reinsurance agreements with Carter Insurance Company Ltd. of Hamilton Bermuda ("Carter"), a wholly owned subsidiary of CDPHP, and also with Atlantic Specialty Insurance Company, a nonaffiliated and New York authorized insurer. The two agreements comprised the following reinsurance coverage:

Carter Insurance Company Cession:
1st Layer (Specific/Excess Retention)

CDPHP's retention	Reinsurer's obligation
CDPHP retains 100% of the first $600,000 and 15% above $600,000 of incurred losses per covered member, each per covered line of business, up to a maximum of $1,000,000.	Reinsurer pays 85% of CDPHP's incurred losses above $600,000 up to a maximum limit of $1,000,000 per each covered member.

Atlantic Specialty Insurance Company Cession:
2nd Layer (Excess of Loss Coverage

CDPHP's retention	Reinsurer's obligation
CDPHP retains 10% of all hospital losses incurred losses per member above $1,000,000 up to a maximum limit of $3,000,000.	Reinsurer pays 90% of CDPHP's incurred losses above $1,000,000 up to a maximum limit of $3,000,000.

The HMO's ceded reinsurance program applied to all CDPHP's commercial business, and all government Medicare and New York State products excluding Medicaid business.

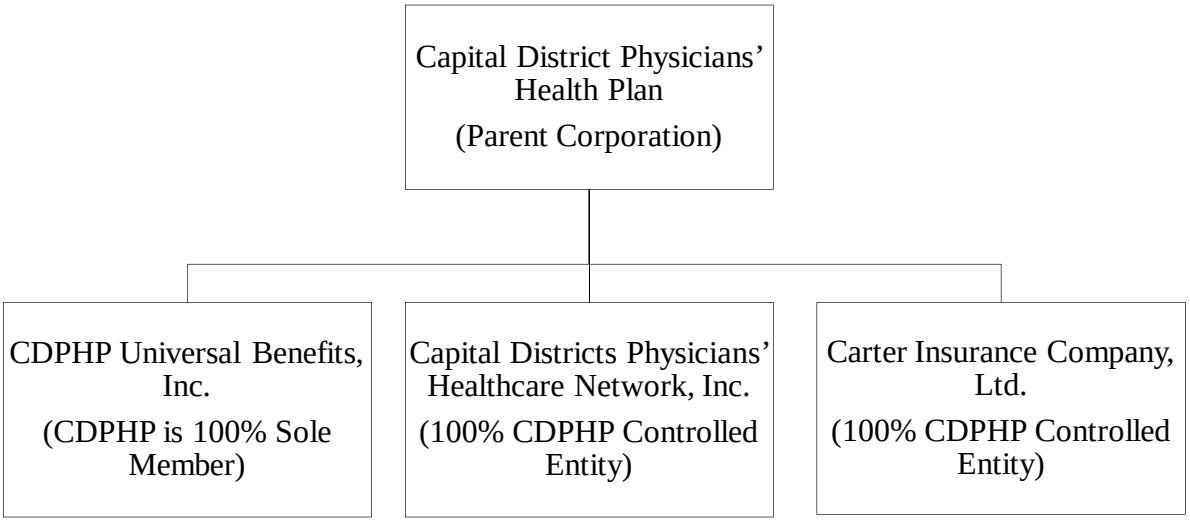
As noted above, CDPHP's first layer reinsurance cession program with Carter called for Carter to reinsure CDPHP's inpatient hospital services at 85% of the total hospital payments by the HMO beginning at the attachment point above $600,000 of paid losses per covered member, up to a maximum of $1,000,000. The second layer cession program with Atlantic Specialty

Insurance Company, calls for the reinsurer to cover 90% of the HMO's inpatient hospital services paid commencing at the attachment point excess of $1,000,000 per member, up to a maximum of $3,000,000.

The insolvency clauses as contained in each of the HMO's reinsurance cession agreements complied with the provisions of Section 1308(a)(2)(A)(i)and(ii) of the New York Insurance Law.

D. Holding Company System

Below is an organizational chart of the HMO and its holding company members, as of December 31, 2014.



Following are descriptions of the individual entities within the holding company system including the ultimate parent.

I. CDPHP, the ultimate parent company of the holding company system, is a not-for-profit corporation organized under Section 402 of the Business Corporation Law of the State of New York to operate as an Individual Practice Association (IPA) Health Maintenance Organization (HMO), pursuant to Article 44 of the New York Public Health Law.

II. Capital District Physicians' Healthcare Network ("CDPHN"), which was incorporated in 1991, provides managed care and administrative support services to the self-insured employer groups under the HMO's administrative services organization ("ASO") contracts. As an investment in CDPHN, CDPHP reported a book/adjusted carrying value in the amount of $3,471,195 as of December 31, 2014.

III. CDPHP Universal Benefits, Inc. (UBI) was incorporated in 1997, as a not-for-profit membership corporation, with the Plan being the sole member. UBI has been granted a license pursuant to the provisions of Article 43 of the New York State Insurance Law. The HMO reported its subsidiary, UBI, as "other invested asset", in the amount of $77,505,720 at December 31, 2014.

IV. Carter Insurance Company, Ltd, ("Carter"), which was formed in November 2003, is the HMO's wholly owned Bermuda based reinsurance affiliate. Carter is a non-New York authorized insurer. The HMO's investment in Carter is carried at cost, which is adjusted for undistributed earnings or losses and changes in the market value of investments. CDPHP's investment in Carter comprised a book/adjusted carrying value in the amount of $5,581,256 as of December 31, 2014.

The HMO maintained the following inter-company agreements with its affiliates as of December 31, 2014:

1. Administrative Services Agreement with UBI

   The captioned agreement, which took effect on June 15, 2006 subsequent to the Department's approval on February 2, 2006, calls for CDPHP to provide UBI with consultative/administrative services and also support services to UBI's customers, including but not limited to: financial, legal, internal operations, information technology, marketing consultation, health care services, including the development, revision and refinement of new health care service products, systems, policies, procedures and software to support and enhance the business of UBI.

2. Administrative Services Agreement with CDPHN

   The captioned agreement, which took effect on January 1, 2004, was approved by the Department of Financial Services and the Department of Health on May 27, 2004 and June 2, 2004, respectively. This agreement calls for CDPHP to provide CDPHN with consultative, administrative and support services including, but not limited to: financial, legal, internal operations, information technology, marketing consultation, health care

services, including the development, revision and refinement of new health care service products, systems, policies, procedures and software to support and enhance the business of CDPHN.

3. Reinsurance Agreement with Carter Insurance Company, Ltd.

The HMO and Carter maintained the captioned agreement whereby CDPHP ceded healthcare business in connection with in-patient hospital services covered under the HMO's enrollee contracts. The agreement, which covered the twelve month period January 1 through December 31, was renewed annually by the HMO and Carter during the examination period.

Part 98-1.10(c) of the administrative rules and regulations of the Department of Health (10 NYCRR 98-1.10(c)) states in part:

> (c) The commissioner's and, except in the case of a PHSP, HIV SNP or PCPCP, the superintendent's prior approval … is required before entering into the following transactions between a controlled MCO and any person in its holding company system: a reinsurance agreement or an agreement for rendering services on a regular or systematic basis, other than medical or management services that require prior approval under this Subpart. Such transactions may become effective unless the commissioner or the superintendent has disapproved the transaction within such period.

The examiner noted that the Plan's affiliated reinsurance agreement with Carter has never been submitted for approval to the Department, as required pursuant to Part 98-1.10(c) of the administrative rules and regulations of the Department of Health.

It is recommended that CDPHP comply with Part 98-1.10(c) of the administrative rules and regulations of the Department of Health by filing with the Department for approval, its inter-company reinsurance agreement with its affiliate, Carter Insurance Company of Hamilton, Bermuda.

E. Significant Operating Ratios

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

Account	Amount	Ratio
Claims incurred	$5,296,445,061	87.2%
Claims adjustment expenses incurred	331,547,419	5.5%
General expenses incurred	310,625,272	5.1%
Increase for reserve for A & H contracts	16,300,000	.3%
Underwriting gain	115,987,674	1.9%
Premiums earned	$6,070,905,426	100.0%

As of December 31, 2014, the HMO reported total adjusted capital and authorized control level risk-based capital in the amounts of $248,923,114 and $54,320,394, respectively, which resulted in a Risk Based Capital ratio of 458%.

F. Medical Loss Ratio ("MLR") Review

The Affordable Care Act (ACA) requires insurers to spend a minimum percentage of premium dollars on medical services and activities designed to improve health care quality and submit an MLR report to present this information. The Department reviewed the components of the MLR Report filings by utilizing the MLR Procedures Spreadsheet provided by the Center for Consumer Information and Insurance Oversight to review and test, as deemed appropriate, the following items in accordance with 45 CFR Part 158:

- Validity of the data regarding expenses and premiums that the issuer reported to the Secretary, including the appropriateness of the allocations of expenses used in such reporting;
- Whether the activities associated with the issuer's reported expenditures for quality improving activities meet the definition of such activities; and

- The accuracy of rebate calculations, and the timeliness and accuracy of rebate payments as applicable.

The Department's review did not uncover any exception or finding that requires additional disclosure, regarding the HMO's MLR reporting.

G. Insurance Regulation No. 118 (Title 11 NYCRR 89)

In the designation of a CPA for purposes of an audit engagement, Insurance Regulation No. 118 (11 NYCRR 89), Sections 4(a) and 4(b), state the following:

> "(a) Every company that files an annual audited financial report shall provide to the superintendent in writing the name, address, telephone number and email address of its CPA by March 1, 2010, and except as otherwise provided in this section, provide updated information within 60 days of any change in CPA thereafter."
>
> "(b) The company shall obtain a letter from the CPA, and file a copy with the superintendent, stating that the CPA is aware of the provisions of the insurance law and the regulations thereunder of the state of domicile that relate to accounting and financial matters and affirming that the CPA will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as the CPA may believe appropriate."

In connection with the HMO's appointment of Deloitte & Touche ("D&T") as its newly appointed external auditor on November 19, 2014 to audit CDPHP's financial statements as of December 31, 2014, the HMO failed to comply with the aforementioned Section of Insurance Regulation No. 118, by neglecting to file with the Department, in a timely manner, the requisite CPA awareness letter from D&T, indicating that D&T is aware of the provisions of New York's insurance law and regulations and also affirming that D&T will express an opinion on CDPHP's financial statements based on the statutory accounting practices prescribed or permitted by New York State Department of Financial Services.

It is recommended that the HMO comply with Parts (a) and (b) of Section 4 of Insurance Regulation No. 118 (Title 11 NYCRR 89) when appointing a new CPA for purposes of the annual audit of its financial statements by filing with the Superintendent, within sixty days of the CPA's appointment by the HMO, the requisite CPA letter stating that the firm is aware of the provisions of New York State insurance laws and regulations relative to accounting and financial matters of this State.

Insurance Regulation No. 118 (Title 11 NYCRR 89), Section 89.4(c), states the following:

"If the CPA is dismissed or resigns:

1. the company shall notify the superintendent within five business days of the event,

2. the company shall submit a letter to the superintendent within fifteen business days of the event detailing with specificity the nature and extent of any disagreements at the decision-making level with the former CPA within the previous two years (whether or not resolved to the CPA's satisfaction) on any matter of accounting principles or practices, or financial statement disclosure, or auditing scope or procedure that might or could have been referenced in the CPA's opinion attached to the audited financial report.

3. the company shall submit, with the letter required by paragraph (2) of this subdivision, a letter from the former CPA to the superintendent stating whether the CPA agrees with the statements contained in the company's letter and, if not, stating the reasons for which the CPA does not agree."

CDPHP notified the Department on November 19, 2014 of PricewaterhouseCoopers LLP ("PwC's") replacement by Deloitte and Touche as the HMO's external auditor effective November 19, 2014. However, CDPHP failed to obtain from PwC and file with the Department, within fifteen business days of its replacement, the requisite PwC letter indicated in paragraph 3 of Section 89.4(c) above stating whether or not the CPA agreed with the HMO that within the previous two years that it had no disagreement with the firm on any matter of accounting principles or practices,

or financial statement disclosure, or auditing scope or procedure that might or could have been referenced in the CPA's opinions rendered by PwC attached to the 2012 and 2013 CPA reports.

Subsequent to the mandatory fifteen business day deadline under which CDPHP was to obtain the mandated attestation letter from PwC, CDPHP's management provided the letter from the former CPA, which was dated August 27, 2015.

It is recommended that CDPHP comply with the requirements of paragraph 3 of Section (b) of Insurance Regulation No. 118 by filing within the specified fifteen business day timeframe the requisite CPA attestation, stating whether the firm agrees with the HMO's representation that it had no disagreement with the former CPA within the previous two years on any matter of accounting principles or practices, or financial statement disclosure, or auditing scope or procedure that might or could have been referenced in the CPA opinions rendered in the CPA Reports of the prior two reporting years.

4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities and surplus as of December 31, 2014, as reported in the HMO's 2014 filed annual statement, a condensed summary of operations and reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the HMO's financial condition as presented in the December 31, 2014 filed annual statement.

Independent Accountants:

The firm PwC was retained by the Plan to audit CDPHP's consolidated combined statements of financial condition as of December 31st for each of the years 2010 through 2013 within the examination period, and the related statements of operations, surplus, and cash flows for the year then ended, with such audits having been conducted on the basis of statutory accounting principles ("SAP"). For the 2014 reporting year, the Plan retained D&T to audit the aforementioned financial statements of CDPHP for the 2014 year then ended, the statements were also audited by D&T on a SAP basis.

PwC and D&T concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the HMO 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	Examination
Bonds	$208,246,749
Common stocks	9,052,451
Cash, cash equivalents and short-term investments	24,165,035
Other invested assets	77,505,720
Receivables for assets	82
Investment income due and accrued	1,298,033
Uncollected premiums and agents' balances in the course of collection	94,054,594
Deferred premiums, agents' balances and installments booked but deferred and not yet due	61,708
Accrued retrospective premiums	(1,346,658)
Amounts recoverable from reinsurers	4,621,535
Electronic data processing and software	1,433,755
Receivable from parent, subsidiaries and affiliates	521,489
Healthcare and other amounts receivable	21,069,428
Total assets	$440,683,921
Liabilities	
Claims unpaid	$114,296,933
Accrued medical incentive pool and bonus amounts	3,849,120
Unpaid claims adjustment expenses	2,676,950
Aggregate health policy reserves	16,300,000
Premiums received in advance	16,488,880
General expenses due and accrued	37,406,643
Ceded reinsurance premiums payable	193,550
Amount due to parent, subsidiaries and affiliates	548,731
Total liabilities	$191,760,807
Surplus	
Aggregate write-ins for other special surplus funds	191,830,647
Unassigned funds	57,092,467
Total surplus	$248,923,114
Total liabilities and surplus	$440,683,921

B. Statement of Revenue and Expenses and Surplus

Surplus decreased $18,613,089 during the five year examination period, January 1, 2010 through December 31, 2014, detailed as follows:

Revenue		
Total premium income		$6,070,905,426
Hospital and medical expenses		
Hospital/medical benefits	$3,769,672,164	
Other professional services	294,229,129	
Emergency room and out-of-area	157,452,423	
Prescription drugs	947,735,925	
Aggregate write-ins for other hospital and medical costs	141,249,030	
Incentive pool, withhold adjustments and bonus amounts	23,095,903	
Total hospital and medical expenses	$5,333,434,574	
Less: Net reinsurance recoveries	36,989,513	
Sub-total	$5,296,445,061	
Claims adjustment expenses	331,547,419	
General administrative expenses	310,625,272	
Increase in reserves for accident and health contracts	16,300,000	
Total underwriting deductions		5,954,917,752
Net underwriting gain		$ 115,987,674
Net investment income earned	40,682,380	
Net realized capital gains	19,659,371	
Net investment gains less capital gain taxes ($0)		60,341,751
Aggregate write-ins for other income		(598,240)
Net income after capital gain and before federal income taxes		175,731,185
Less: Federal and foreign income taxes incurred		0
Net income		$ 175,731,185

Change in Surplus

	Gains in Surplus	Losses in Surplus	
Surplus, per report on examination, as of December 31, 2009			$230,310,025
Net income	$175,731,185		
Change in net unrealized capital losses		$164,583,817	
Change in nonadmitted assets	7,465,721	0	
Net decrease in capital and surplus			$ 18,613,089
Surplus, per report on examination, as of December 31, 2014			$248,923,114

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2009, contained five (5) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO,		PAGE NO.
	Corporate Governance	
1.	It is recommended that the Audit Committee be responsible for reviewing and approving the performance evaluation and the salary and variable compensation of the Internal Audit Manager. The AC should also consider reviewing and approving the salary and variable compensation of the Information Security Officer, since this role is responsible for performing Information Technology ("IT") internal audits. The HMO has not complied with the recommendation.	9
2.	In line with industry best practices, it is recommended that the IAD change its guidelines to require high risk areas be audited annually, instead of every two years. Concurrent with this change, it is recommended that the HMO begin conducting a corporate-wide risk assessment on an annual basis and ensure that high risk areas are audited annually. The HMO has complied with this recommendation.	10
3.	It is recommended that the IAD plan its audits to involve both financial and operational internal auditors along with IT internal auditors so that the entire process has clearly defined common goals. This method of integrated planning will help ensure that the efforts of the operational and IT internal auditors support each other from the inception of the internal audit. The HMO has complied with this recommendation.	10

ITEM NO,		PAGE NO.
	Corporate Governance	
4.	It is recommended that the HMO assess its current organizational and staffing structure with consideration given to segregating responsibilities for information security governance, IT internal audit, and management of internal testing. This assessment should consider all aspects of information security governance and operations, IT internal audit and administrative responsibilities related to management's testing of controls. The HMO has not complied with this recommendation.	11
	Surplus Notes Receivable	
5.	It is recommended that the HMO record its Surplus Notes Receivable on Schedule BA of its Annual Statement on a going forward basis. The HMO has complied with this recommendation.	23

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO.		PAGE NO.
B.	Holding Company System	
	It is recommended that CDPHP comply with Part 98-1.10(c) of the administrative rules and regulations of the Department of Health by filing with the Department for approval, its inter-company reinsurance agreement with its affiliate, Carter Insurance Company of Hamilton, Bermuda.	22
C.	Insurance Regulation No. 118 (Title 11 NYCRR 89)	
i.	It is recommended that the HMO comply with Parts (a) and (b) of Section 4 of Insurance Regulation No. 118 (Title 11 NYCRR) when appointing a new CPA for purposes of the annual audit of its financial statements by filing with the Superintendent, within sixty days of the CPA's appointment by the HMO, the requisite CPA letter stating that the firm is aware of the provisions of New York State insurance laws and regulations relative to accounting and financial matters of this State.	25
ii.	It is recommended that CDPHP comply with the requirements of paragraph 3 of Section (b) of Insurance Regulation No. 118 by filing within the specified fifteen day timeframe the requisite CPA attestation, stating whether the firm agrees with the HMO's representation that it had no disagreement with the former CPA within the previous two years on any matter of accounting principles or practices, or financial statement disclosure, or auditing scope or procedure that might or could have been referenced in the CPA opinions rendered in the CPA Reports of the prior two reporting years.	26

Respectfully submitted,

_____
Kenneth Merritt
Principal Insurance Examiner

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

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

_____
Kenneth Merritt

Subscribed and sworn to before me
this _____ day of_____2017.

APPOINTMENT NO. **31086**

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:*

Kenneth Merritt

as a proper person to examine the affairs of

Capital District Physicians Health Plan

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

Plan

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 24th day of January, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau