

REPORT ON EXAMINATION

OF

MVP HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2016

DATE OF REPORT

OCTOBER 22, 2018

EXAMINERS

ALEX QUASNITSCHKA, CFE

JEFFREY USHER, CFE

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

October 22, 2018

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

Madam:

Pursuant to the requirements of the New York Insurance Law and the New York State Public Health Law, and acting in accordance with the instructions contained in Appointment Number 31753, dated April 6, 2018, attached hereto, we have made an examination into the condition and affairs of MVP Health Plan, Inc., a not-for-profit health maintenance organization (“HMO”) issued a certificate of authority by the New York State Department of Health (“NYSDOH”) under the provisions of Article 44 of the New York Public Health Law, as of December 31, 2016. The following report is respectfully submitted thereon.

The examination was conducted at the administrative office of MVP Health Care, Inc., the ultimate parent of MVP Health Plan, Inc., located at 625 State Street, Schenectady, New York.

Wherever the designations “MVPHP” or the “HMO” appear herein, without qualification, they should be understood to indicate MVP Health Plan, Inc. Wherever the designation the “MVP Companies” appears herein, without qualification, it should be understood to indicate MVP Health Plan, Inc., MVP Health Insurance Company and MVP Health Services Corp., collectively.

Wherever the designation “MVP” appears herein, without qualification, it should be understood to indicate MVP Health Care, Inc., the ultimate parent of the MVP Companies. 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 Medical Loss Ratio (“MLR”) examination of MVPHP was conducted as of December 31, 2016, to assess compliance with the requirements of Title 45 of the Code of Federal Regulations, Part 158, which implements section 2718 of the Public Health Service Act. A separate report will be submitted thereon.

Concurrent financial and MLR examinations were made of MVP Health Insurance Company (“MVPHIC”), a New York for-profit insurance company licensed pursuant to the provisions of Article 42 of New York Insurance Law and MVP Health Services Corp. (“MVPHSC”), a not-for-profit corporation licensed pursuant to the provisions of Article 43 of New York Insurance Law. These two companies are affiliates within the MVP holding company system as detailed herein. Separate reports thereon have been submitted for each of the above entities.

1. SCOPE OF EXAMINATION

The prior examination of the HMO was conducted as of December 31, 2013. This examination of the HMO was a financial examination as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2017 Edition* (the “Handbook”) and covered the three-year period from January 1, 2014 through December 31, 2016. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2016 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 the 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 the HMO’s current financial condition, as well as to identify prospective risks that may threaten the future solvency of MVPHP.

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 NAIC annual statement instructions.

Information concerning the HMO’s organizational structure, business approach, and control environment was 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 MVPHP'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 during the years covered by this examination. For the year ended 2014, MVPHP utilized PricewaterhouseCoopers, LLP ("PwC") as its external auditor. For the years 2015 through 2016 and subsequent, MVPHP was audited by the accounting firm KPMG, LLP ("KPMG"). The HMO received an unqualified opinion in each of those years. Certain audit work papers of KPMG were reviewed and relied upon in conjunction with this examination. A review was also made of the ultimate parent's corporate governance structure, which included its Internal Audit function and Enterprise Risk Management program, as they relate to the HMO.

A review was made of the HMO's compliance with the provisions of Insurance Regulation 118 (11 NYCRR 89), "Audited Financial Statements." This regulation is based on the Model Audit Rule ("MAR"), as established by the NAIC, and all references to MAR within this report may be interpreted as reference to Insurance Regulation 118. Additionally, as part of this examination and in accordance with the provisions of the Handbook, a review was made of MVP's computer systems and operations that support MVPHP, on a risk-focused basis.

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. DESCRIPTION OF THE HMO

MVP Health Plan, Inc. is a New York State not-for-profit health maintenance organization incorporated on July 30, 1982, pursuant to Section 402 of the New York Not-For-Profit Corporation Law, for the purpose of operating as a health maintenance organization, as such term is defined in Article 44 of the New York Public Health Law, to deliver health care services in New York and Vermont. MVPHP received its Certificate of Authority from the New York State Department of Health ("NYSDOH") on June 1, 1983. The HMO's incorporators were the board of directors of the Schenectady County Foundation for Medical Care, Inc., a non-profit physicians' association. Simultaneous with the incorporation of the HMO, the incorporators formed Mohawk Valley Medical Associates, Inc., a non-profit independent practice association ("IPA"), pursuant to Section 402 of the New York Not-For-Profit Corporation Law.

MVP Health Plan, Inc. is an IPA model HMO. On March 8, 1982, the HMO and Mohawk Valley Medical Associates, Inc. contracted, through an “Independent Practice Association Service Agreement” to work together to provide for the administration of a comprehensive prepaid program of health care and for the delivery of health services. Subsequently, the HMO made similar arrangements with other independent practice associations to achieve the same goal. These arrangements are detailed further under the “Territory and Plan of Operation” section of this report.

On August 30, 2013, the NYSDOH approved MVPHP’s request to acquire Hudson Health Plan, Inc. (“HHP”). The Department had issued a non-objection letter to the NYSDOH on August 29, 2013, relative to this acquisition. MVPHP is the sole corporate member of Hudson Health Plan, Inc. a Tarrytown, New York based Medicaid managed care organization.

MVPHP maintained the following Surplus Note Agreements (“Executed Loan Agreement”) with affiliates pursuant to Section 1307 of the New York Insurance Law during the examination period:

1. Per the executed loan agreement dated December 23, 2009, MVPHP issued a Surplus Note to MVPHIC in the amount of \$47 million. The loan was approved by the Department on December 23, 2009. On February 23, 2016, MVPHIC received approval from the Department to repay the loan principal of \$47 million and total accrued interest in the amount of \$1,036,704. The repayment occurred on March 23, 2016.
2. Per the executed loan agreement dated December 31, 2014, MVPHP issued a Surplus Note to MVPHSC in the amount of \$40 million. NYSDOH Regulation 10 NYCRR §98-1.11(b), requires Article 44 MCOs to obtain approval from the NYSDOH and the Department. The loan was approved by the Department on December 23, 2014. The NYSDOH approved

the loan on December 24, 2014. MVPHP's net worth after the requested loan exceeded 12.5% of the HMO's annual net premium income as required by 10 NYCRR §98-1.11(b)(1).

3. On February 23, 2016, the Department approved MVPHP's request to issue a \$35 million note payable to MVPHSC. The NYSDOH approved the loan on February 24, 2016. The loan payment was completed on March 24, 2016. MVPHP's estimated surplus continued to meet or exceed 12.5% of annual net premium income, as required by NYSDOH Regulation 10 NYCRR §98-1.11(b)(1).

Under the provisions of Part 98-1.11(f) of the Administrative Rules and Regulations of NYSDOH 10 NYCRR 98-1.11(f), each health maintenance organization initiating operations under the authority of Article 44 of the New York State Public Health Law shall establish a deposit in the form of an escrow account for the protection of enrollees, in an amount equal to the greater of five percent of the estimated expenditures for health care services for the year or \$100,000. As of December 31, 2016, the HMO has expenditures for health care services in the amount \$2,266,208,113 and an escrow deposit requirement of \$111,279,738. Pursuant to the provisions of 10 NYCRR 98-1.11(f) of the Administrative Rules and Regulations of the New York State Department of Health, the HMO had established an escrow account in the amount of \$115,826,512 (book/adjusted carrying value), as of December 31, 2016.

A. Corporate Governance

Pursuant to the HMO's Certificate of Incorporation and by-laws, management of the HMO is to be vested in a board of directors (the "Board") consisting of not less than eleven (11) and not more than fourteen (14) directors. As required by Part 98-1.11(g) of the Administrative Rules and

Regulations of the NYSDOH 10 NYCRR 98-1.11(g), a minimum of twenty percent (20%) of the Board of Directors of the HMO must be comprised of enrollee representatives, and at least one-third (1/3) shall be persons who reside in New York State. As of examination date, the MVPHP Board was comprised of eleven (11) independent directors.

As of December 31, 2016, the Board and their principal business affiliation were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
<u>Provider Representatives</u>	
Richard Joseph D'Ascoli, M.D. Niskayuna, NY	Physician, Ortho NY
Ernest Levy, M.D. Cooperstown, NY	Physician, Self-employed
Michael Schneider, M.D. Rochester, NY	University of Rochester Medical Faculty Group, Physician
David Spalding Pratt, M.D., MPH Rexford, NY	Medical Consultant, Self-employed
<u>Enrollee Representatives*</u>	
Burt Danovitz, Ph.D. Utica, NY	Retired Executive Director and CEO, Resource Center for Independent Living
Alan Paul Goldberg (Vice Chair) Albany, NY	First Albany Securities, Retired President & CEO
Karen Brown Johnson (Chair) Schenectady, NY	Proctors Theater Director Fund Raising
William Reddy Rochester, NY	Veterans Outreach Center, Inc., Retired

Name and ResidencePrincipal Business AffiliationCommunity Representatives

Wallace Altes
Troy, NY

Self-employed,
Consultant

Michael Copeland
Rochester, NY

Alstom Signaling, Inc.,
Human Resource Manager

Lindsay Carroll Farrell
Ossining, NY

Open Door Family Medical Center,
President

Meng-Ling Hsiao, Ph.D
Schenectady, NY

GE Power & Water,
Executive Chief Engineer

Arthur Joel Roth
Loudonville, NY

Tax consultant

Debbie Lynn Sydow, Ph.D.
Abington, VA

Richard Bland College of William &
Mary Petersburg, VA,
President

*Enrollee representative per Part 98-1.11(g) of the Administrative Rules and Regulations of the Department of Health. The composition of the Board meets the requirements of 10 NYCRR 98-1.11(g) as of 12/31/16.

The Board met at least four times during each calendar year within the examination period.

A review of the Board's meeting minutes held during the examination period revealed that the meetings were generally well attended, with all members attending at least one-half of the meetings they were eligible to attend with the exception of one Board member. That Board member retired in 2016.

The principal officers of the HMO as of December 31, 2016 were as follows:

<u>Name</u>	<u>Title</u>
Denise Verfenstein Gonick, Esq.	President and Chief Executive Officer
Dawn Kristen Jablonski, Esq.	Secretary
Karla Ann Austen	Treasurer and Chief Financial Officer

Enterprise Risk Management

The HMO is required to be compliant with Insurance Regulation 203 (11 NYCRR 82) as it relates to Enterprise Risk Management (“ERM”) and Own Risk Solvency Assessment (“ORSA”). The HMO has a formal ERM framework with defined risk appetites and tolerances 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. Overall, it was determined that MVPHP’s Board and key executives maintain an effective control environment.

In addition, MVP has established a government affairs department to address emerging policy issues within the health insurance industry and those facing MVP and all of its affiliates. As issues are identified, MVP establishes leadership teams to gain an understanding of the impact on the MVP Companies. These leadership teams are developed to provide recommendations to the members of the executive team which have the responsibility for MVP’s strategy on emerging issues.

Information Technology (“IT”)

MVP and its subsidiaries have more than 700,000 members across the states of New York and Vermont. MVP manages and maintains a set of computerized application systems to support the HMO’s business processes. MVP has primary and secondary data centers. MVP has hardware located in facilities within the state of Vermont. In addition, MVP has a contract for recovery services for its primary facility.

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.

Overall, the IT examination team concluded that MVP’s IT General Controls (“ITGCs”) are “Effective,” resulting in the conclusion that ITGCs are reliable for the purposes of this financial examination. IT review conclusions were based on inquiry, observation, inspection of documentation, independent research and a review of third-party workpapers.

The IT examination team assessed MVPHP’s compliance with the provision of the Financial Services Regulation Part 500 (23 NYCRR 500) - Cybersecurity Requirements for

Financial Services Companies. MVPHP appears to be in compliance with the sections of the New York Cybersecurity Regulation that have already taken effect through March 2018, and they appear to be ready for the remaining sections as they come due. This conclusion was based on a review of the responses provided by MVP to the Department's Cybersecurity letter, review of prior third-party control assessments, inspection of documentation, observation, and management interviews.

Internal Audit Department

MVP, the ultimate parent, established an Internal Audit Department ("IAD") function, which is independent of management, to serve all the subsidiaries and affiliates within its holding company system, including MVPHP. The IAD reports to the Audit Committee ("AC") of the Board of Directors, which is comprised entirely of members independent of MVP's and MVPHP's internal management.

The IAD assists all levels of management by reviewing and testing financial and operational controls and processes established by management to ensure compliance with laws, regulations and policies. The scope of the IAD program is coordinated with KPMG, MVP's independent certified public accountant, to ensure optimal audit coverage and efficiency.

During the course of this examination, consideration was given to the significance and potential impact of certain IAD findings. No exceptions relative to the MVPHP's corporate governance were noted.

Insurance Regulation 118

The HMO's parent, MVPHP Holding Company, Inc., as well as its ultimate parent, MVP, are both non-publicly traded companies and therefore not subject to the Sarbanes-Oxley Act of 2002. Insurance Regulation 118 (11 NYCRR 89) – “Audited Financial Statements,” is similar to the NAIC's Model Audit Rule (“MAR”), and therefore applies to certain New York regulated insurance entities, including MVPHP. Insurance Regulation 118 became effective January 1, 2010. The Audit Committee for MVPHP, which is composed of outside directors, assumed responsibility for all entities within the holding company structure. With the independent and internal auditors, the MVPHP Audit Committee reviews the effectiveness of the accounting and financial controls and elicits recommendations that may improve controls. The MVPHP Audit Committee met each quarter during the examination period, and meeting minutes were prepared and retained.

MVP's management of general controls is applied to all its subsidiaries and affiliates, which include the HMO. As part of its Insurance Regulation 118 analysis, the risks from various operations were identified and segregated by operational cycles and entity level controls. The IAD performed its own control testing and accumulated its findings. To the extent possible, the examiners relied upon the work performed by the IAD, as prescribed by the Handbook.

B. Territory and Plan of Operation

The HMO's service area, as stated in its certificate of authority as of December 31, 2016, included the following fifty-five (55) counties in New York State:

Albany	Essex	Oneida	Seneca
Alleghany	Franklin	Onondaga	Steuben

Broome	Fulton	Ontario	St. Lawrence
Cattaraugus	Genesee	Orange	Sullivan
Cayuga	Greene	Orleans	Tioga
Chautauqua	Hamilton	Oswego	Tompkins
Chemung	Herkimer	Otsego	Ulster
Chenango	Jefferson	Putnam	Warren
Clinton	Lewis	Rensselaer	Washington
Columbia	Livingston	Rockland	Wayne
Cortland	Madison	Saratoga	Westchester
Delaware	Monroe	Schenectady	Wyoming
Dutchess	Montgomery	Schoharie	Yates
Erie	Niagara	Schulyer	

The HMO contracted with eighteen (18) Independent Practice Associations to provide a comprehensive prepaid program of health care and the delivery of health services. According to the IPA agreements, the HMO provides all administrative, marketing, enrollment, financial, accounting, claims processing, management information and other functions necessary, convenient or appropriate for the administration of a comprehensive prepaid health program. Each IPA is responsible for establishing contractual relationships with physicians, health care professionals and other providers of health care, and for arranging and facilitating the availability and delivery of health services to members of the HMO.

On March 20, 1993, the HMO was issued a certificate of authority to transact the business of a Health Maintenance Organization in the State of Vermont. The HMO entered into risk sharing arrangements/capitation agreements with Vermont Managed Care (“VMC”) and United Health Alliance to provide health care services to its members throughout the State of Vermont.

The Company's enrollment by line of business for each year under examination and 2017 was as follows:

	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
HMO	199,525	188,341	342,112	320,103
PPO	14,252	17,742	17,792	23,812
POS	13,871	5,995	5,336	19,942
Aggregate Write-Ins	-	-	-	422
Total	<u>227,648</u>	<u>212,078</u>	<u>365,240</u>	<u>364,279</u>

During the examination period, the membership of the HMO increased from 227,648 to 365,240. The membership decreased to 364,279 in 2017, marking a 60% increase over the four-year period. A variety of factors have contributed to the membership changes from 2014 to 2017 as noted above. The large increase in 2016 was primarily due to the acquisition of Hudson Health Plan, Inc. members.

The plan's direct written premiums for each year under examination and 2017 were as follows:

	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
NY	\$1,625,683,116	\$1,531,541,250	\$2,483,954,999	\$2,446,137,020
VT	<u>34,621,593</u>	<u>36,034,317</u>	<u>42,134,718</u>	<u>72,025,646</u>
	<u>\$1,660,304,709</u>	<u>\$1,567,575,567</u>	<u>\$2,526,089,717</u>	<u>\$2,518,162,666</u>

The premiums written have a direct relationship to the membership, as noted above.

C. Reinsurance

Assumed Reinsurance

The Company did not assume any business during the examination period.

Ceded Reinsurance

At December 31, 2016, the Company had a stop-loss reinsurance agreement with HM Life Insurance Company of New York (“HM Life”), a licensed insurer in New York. The agreement requires the reinsurer to pay specified amounts of eligible expenses paid by MVPHP during the contract year as follows:

Excess of loss coverages:Retention:

\$675,000 of eligible expenses per member per agreement year for the Commercial, Individual, MVP Employees & Essential Health Plan business.

\$500,000 of eligible expenses per member per agreement year for Medicare members.

\$200,000 of eligible expenses per member per agreement year for Child Health Plus Plan.

Coinsurance:

90% of the approved transplants and services other than transplant services after application of Reinsurance Limits and Retention per agreement year, except non-approved transplants, which are reimbursable at 60%.

Reimbursement maximum:

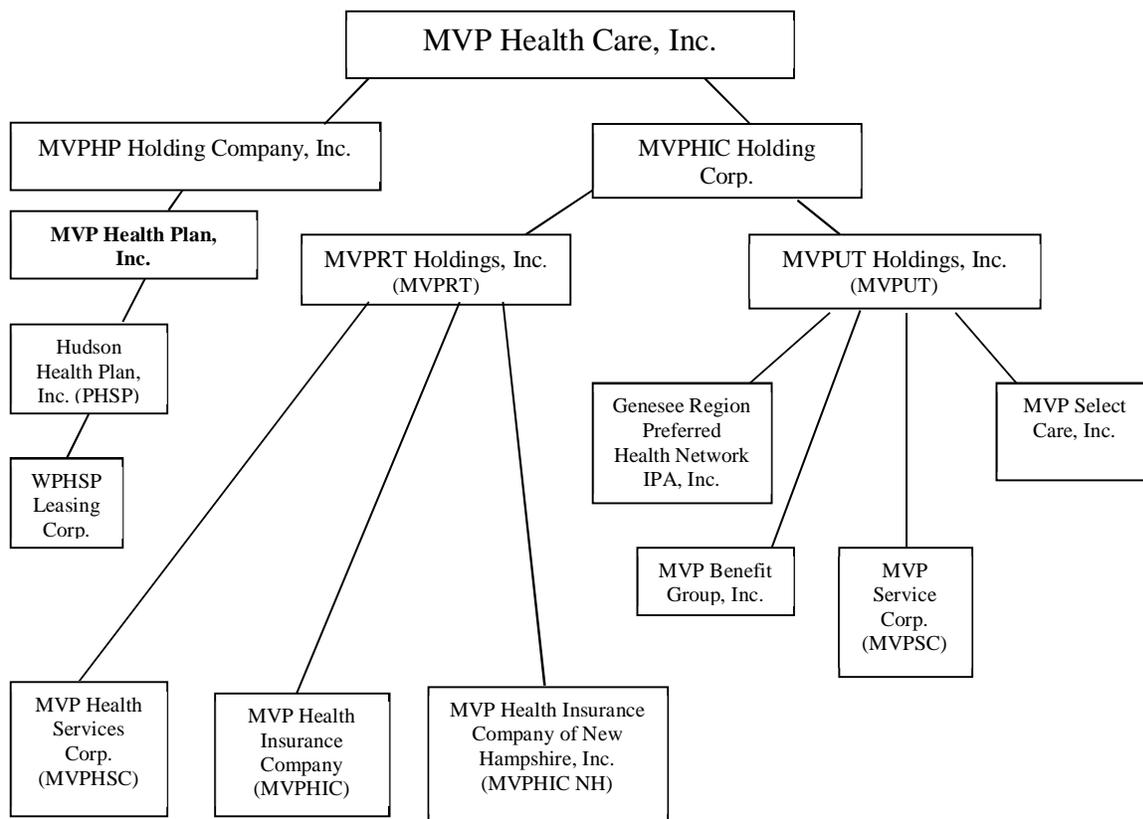
\$3,000,000 per member, per agreement year.

The reinsurance agreement contained all the required standard clauses, including the insolvency clause required by Section 1308(a)(2)(A) of the New York Insurance Law.

D. Holding Company System

MVPHP is a wholly-owned subsidiary of MVPHP Holding Company Inc., which is a wholly-owned subsidiary of MVP, the ultimate parent. As a member of a holding company system, MVPHP is required to file registration statements pursuant to the requirements of Part 98-1.16(e) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.16). All pertinent filings made regarding the aforementioned statutes during the examination period were reviewed, and no exceptions were noted.

The following is the organizational chart of MVP Health Care, Inc. and its subsidiaries as of December 31, 2016:



* Genesee Region Preferred Health Network IPA, Inc. and MVP Health Insurance Company of New Hampshire, Inc. were dissolved on February 28, 2017 and March 31, 2017, respectively.

The following is a summary of MVPHP's significant entities within the holding company system shown above:

- MVPHP Holding Company, Inc. ("MVPHPHC") was formed on December 23, 2005 as a not-for-profit corporation, which is controlled by MVP, the ultimate parent. In 2006, MVPHPHC became the immediate parent of MVPHP.
- MVPHSC is a not-for-profit corporation, licensed under Article 43 of the New York Insurance Law. Prior to January 2002, MVPHSC offered point-of-service health insurance products. MVPHSC began writing small and large group health insurance business in 2014 attributing to its rapid growth. As of the date of examination, MVPHSC is licensed in the State of New York to write health and dental insurance pursuant to Article 43 of the New York Insurance Law. MVPHSC is a subsidiary of MVPRT Holdings, Inc., which is in turn a wholly-owned subsidiary of MVPHIC Holding Corp. MVPHIC Holding Corp. is in turn a wholly-owned subsidiary of MVP.
- MVPHIC was incorporated on April 24, 2000 as a for-profit accident and health ("A&H") insurer, wholly-owned by MVPRT Holdings Inc., which is in turn a wholly-owned subsidiary of MVPHIC Holding Corp. MVP is the ultimate parent. MVPHIC is licensed in the State of New York as an accident and health insurance company pursuant to Article 42 of the New York Insurance Law, and received approval to operate as an A&H insurer in the State of Vermont on May 14, 2002. MVPHIC offers a variety of insurance products, such as a preferred provider option ("PPO"), an exclusive provider option ("EPO"), a point-of-service option ("POS") and a traditional indemnity product.

The HMO maintains significant intercompany agreements with several affiliated organizations listed above as follows:

Staffing Services Agreement

The HMO has a management services agreement with MVP Service Corp. (“MVPSC”) dated May 25, 2016. MVPSC is wholly-controlled by MVPUT Holdings, Inc. MVPSC’s employees perform all the day-to-day operations of the HMO, and charges the HMO for its share of costs based on a contractual cost allocation methodology pursuant to an agreement approved by the Department. This agreement replaces the previous management services agreement effective May 26, 2011. The NYSDOH approved the agreement on January 10, 2018.

Office Facilities, Equipment and Supplies Agreement

During the exam period, MVPHP provided subsidiaries with space, furnishings, equipment, supplies and facilities necessary to operate their businesses. MVPHP bills periodically but not less than quarterly. The affiliates/subsidiaries are as follows:

1. MVP Health Insurance Company
2. MVP Health Insurance Company of New Hampshire, Inc. (Dissolved March 31, 2017)
3. Preferred Assurance Company, Inc. (merged into MVP Health Services Corp. on February 28, 2014)
4. MVP Health Services Corp.
5. MVP Select Care, Inc.
6. MVP Benefit Group, Inc.
7. Genesee Region Preferred Health Network IPA, Inc. (Dissolved February 28, 2017)
8. MVP Service Corp.
9. Preferred Administrative Services, Inc. (merged into MVP Select Care, Inc. on March 31, 2014)
10. Hudson Health Plan, Inc.

Agreements and respective amendments contained all the required approvals from the Department and NYSDOH.

Administrative Services Agreement

MVPHP entered into an administrative services agreement with Hudson Health Plan, Inc. (“HHP”) dated June 1, 2014. Under this agreement, HHP agrees to provide day-to-day administrative services to MVPHP including those related to general, personnel, office facilities, equipment, supplies, outreach, management information and legal. The agreement was approved by the Department on October 23, 2014.

Facilities Agreement

MVPHP entered into a facilities agreement with HHP dated June 1, 2014. Under this agreement, the HMO provides office equipment for HHP including those related to office facilities, equipment and supplies. This agreement was approved by the Department on October 23, 2014.

ACA Fee Allocation Agreement

MVPHP has entered into an ACA Fee Allocation Agreement with MVPHSC, MVPHIC and MVP Health Insurance Company of New Hampshire dated January 1, 2015. Under this agreement, MVPHP agrees to allocate the ACA Fee liability on behalf of various entities within the holding company system. This agreement was approved by the Department on November 24, 2015.

E. Significant Operating Ratios

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

	<u>Amounts</u>	<u>Ratios</u>
Total hospital and medical	\$5,182,564,522	90.62%
Other claim adjustment expenses	40,583,370	0.71%
Cost containment expenses	94,078,596	1.65%
General administrative expenses	426,312,564	7.45%
Increase in reserves	5,007,400	0.09%
Net underwriting gain (loss)	<u>(29,903,005)</u>	<u>-0.52%</u>
 Total revenues	 <u>\$5,718,643,447</u>	 <u>100.00%</u>

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2016, as contained in the HMO's 2016 filed annual statement and restated prior year amounts in the 2017 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 result in any differences which affected the HMO's financial condition as presented in its financial statements contained in the December 31, 2016 filed annual statement or the restated prior year amounts in the 2017 filed annual statement.

KPMG was retained by the HMO to audit the HMO's GAAP basis statements of financial position as of December 31 for 2015 and 2016, with the firm of PricewaterhouseCoopers, LLP retained to audit the HMO's GAAP basis statements of financial position as of December 31, 2014, as well as the related statements of operations and changes in net assets, and cash flows for the years then ended. A GAAP to statutory footnote has been presented within the financial statements of the HMO for each of the years audited for the changes in capital and surplus.

PwC and KPMG concluded that the GAAP financial statements presented fairly, in all material respects, the financial position of the HMO for all years under review. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

On April 10, 2018, MVP advised the Department of a self-identified error in a vendor's proprietary filtering logic used for the Company's Centers for Medicare and Medicaid Services

(“CMS”) Risk Adjustment Processing System (“RAPS”) submissions. The impact of the error resulted in CMS overpayments to the HMO from 2011 through 2016. The restatement as of December 31, 2016 was reflected in the prior period column of the HMO’s financial statements as of December 31, 2017. The restatement for the risk adjustment error was in accordance with Statement of Statutory Accounting Principle No. 3 of the NAIC Accounting Practices & Procedures Manual. The Department did not require the HMO to refile the 2016 annual statement. See the financial statement adjustments detailed below.

A. Balance Sheet

Assets

		Financial Statement Adjustment	<u>Restated</u>
Bonds	\$ 173,267,486		\$ 173,267,486
Common stocks	55,826,376		55,826,376
Cash, cash equivalents and short-term investments	165,295,238		165,295,238
Receivables for securities	16,787		16,787
Aggregate write-ins for invested assets	123,091,312		123,091,312
Investment income due and accrued	903,378		903,378
Uncollected premiums and agents' balances in the course of collection	78,947,640	(13,955,771)	64,991,869
Contracts subject to redetermination	18,112,932		18,112,932
Amounts recoverable from reinsurers	15,589,937		15,589,937
Electronic data processing equipment and software	1,054,788		1,054,788
Furniture and equipment	536,647		536,647
Receivables from parent, subsidiaries and affiliates	11,460,579		11,460,579
Health care and other amounts receivable	105,422,366		105,422,366
Aggregate write-ins for other than invested assets	<u>475,496</u>		<u>475,496</u>
Totals assets	<u>\$ 750,000,962</u>	<u>\$ (13,955,771)</u>	<u>\$ 736,045,191</u>

Note: Financial statement adjustments noted above are the result of the Risk Adjustment Error described above under the “Financial Statements” section of this report.

<u>Liabilities</u>		Financial Statement <u>Adjustments</u>	<u>Restated</u>
Claims unpaid	\$ 216,566,604		\$ 216,566,604
Accrued medical incentive pool and bonus amounts	47,770,638		47,770,638
Unpaid claims adjustment expenses	5,355,000		5,355,000
Aggregate health policy reserves, including the liability of \$14,504,853 for Medical Loss Ratio Rebate for medical loss ratio rebate per the Public Health Service Act	25,494,332		25,494,332
Premiums received in advance	5,438,355		5,438,355
General expenses due or accrued	19,339,845		19,339,845
Current federal and foreign income tax payable	332,086		332,086
Net deferred tax liability	204,516		204,516
Ceded reinsurance premiums payable	1,167,676		1,167,676
Amounts due to parent, subsidiaries and affiliates	3,610,593		3,610,593
Payable for securities	20,305,595		20,305,595
Aggregate write-ins for other liabilities: Due to CMS	<u>564,000</u>	<u>46,410,181</u>	<u>46,974,181</u>
Total liabilities	<u>\$ 346,149,240</u>	<u>\$ 46,410,181</u>	<u>\$ 392,559,421</u>
 <u>Capital and Surplus</u>			
Aggregate write-ins for other than special surplus funds	\$ 255,040,978		\$ 255,040,978
Unassigned funds (surplus)	<u>148,810,744</u>	<u>(60,365,952)</u>	<u>88,444,792</u>
Total capital and surplus	<u>\$ 403,851,722</u>	<u>\$ (60,365,952)</u>	<u>\$ 343,485,770</u>
Total liabilities and surplus	<u>\$ 750,000,962</u>	<u>\$ (13,955,771)</u>	<u>\$ 736,045,191</u>

Note: Financial statement adjustments noted above are the result of the Risk Adjustment Error described above under the “Financial Statements” section of this report.

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the HMO during the period under this examination. The examiner is unaware of any potential exposure of the HMO to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Revenue

Net premium income	\$ 5,736,416,078	
Change in unearned premium reserves and reserve for rate credits	<u>(17,772,631)</u>	
Total revenue		\$ 5,718,643,447

Hospital and Medical Expense

Hospital/medical benefits	\$ 3,940,375,053	
Other professional services	159,831,910	
Emergency room and out-of-area	125,142,143	
Prescription drugs	796,054,396	
Aggregate write-ins for other hospital and medical	126,628,863	
Incentive pool, withhold adjustments and bonus amounts	98,346,738	
Net reinsurance recoveries	<u>(63,814,581)</u>	
Total hospital and medical expenses	\$ 5,182,564,522	
Claims adjustment expenses, incl. \$94,078,596 cost containment expenses	134,661,966	
General administrative expenses	426,312,564	
Increase in reserves for life and accident and health contracts	<u>5,007,400</u>	
Total underwriting deductions		\$ <u>5,748,546,452</u>
Net underwriting gain		\$ (29,903,005)
Net investment income earned		9,552,257
Net realized capital gains less capital gains tax of \$0		<u>8,726,660</u>
Net investment gains		18,278,917
Aggregate write-ins for other income or expenses		<u>1,756,024</u>
Net income before all other federal income taxes		\$ (9,868,064)
Federal and foreign income taxes incurred		<u>(1,657,075)</u>
Net income (loss)		\$ <u>(8,210,989)</u>

Change in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2013			\$ 380,924,248
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net loss		8,210,989	
Change in net unrealized capital gains	112,640,795		
Change in non-admitted assets		1,334,694	
Unassigned Surplus: Risk Adjustment Correction		60,365,952	
Aggregate write-ins for gains or (losses) in surplus		80,167,638	
Net change in surplus			\$ <u>(37,438,478)</u>
Capital and Surplus, per report on examination, as of December 31, 2016			\$ <u>343,485,770</u>

Note: Financial statement adjustment noted above are the result of the Risk Adjustment Error described above under the “Financial Statements” section of this report.

4. AGGREGATE RESERVES AND CLAIMS UNPAID

The examination liability of \$216,566,604 for the above captioned account is the same as the amount reported by the HMO as of December 31, 2016.

The examination analysis of the claims unpaid reserve 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 filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2016.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination did not include comments and/or recommendations.

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

There are no comments and recommendations for this report on examination.

Respectfully submitted,

_____/S/_____
Alex Quasnitschka, CFE

Examiner in Charge

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

Alex Quasnitschka, being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____/S/_____
Alex Quasnitschka, CFE

Subscribed and sworn to before me

This ____ day of _____ 2018

Respectfully submitted,

_____/S/_____
Jeffrey Lonzo Usher, CFE

Principal Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

Jeffrey Lonzo Usher, being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____/S/_____
Jeffrey Lonzo Usher, CFE

Subscribed and sworn to before me

This ____ day of _____ 2018

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, MARIA T. VULLO, 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:

Risk & Regulatory Consulting, LLC.

as a proper person to examine the affairs of

MVP Health Plan, 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 6th day of April, 2018

MARIA T. VULLO
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

