REPORT ON EXAMINATION

OF

SENIOR WHOLE HEALTH OF NEW YORK, INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT **APRIL 7, 2011**

EXAMINER **KENNETH I. MERRITT**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

April 7, 2011

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 30349, dated September 21, 2009, attached hereto, I have made an examination into the condition and affairs of Senior Whole Health of New York, Inc., a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the home office of Senior Whole Health of New York, Inc. located at 200 South Pearl Street, Albany, New York and also at 58 Charles Street, Cambridge, Massachusetts, its main administrative office and primary accounts and records location.

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

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

1. SCOPE OF THE EXAMINATION

This is the first examination of Senior Whole Health of New York, Inc. This examination covers the two-year period from January 1, 2007, the date of the HMO's initial start of operations, through December 31, 2008. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

This examination comprised a verification of assets and liabilities as of December 31, 2008, in accordance with Statutory Accounting Principles (SAP), as adopted by the Department, a review of income and disbursements to the extent deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants. A review or audit was also made of the following items as called for in the *Examiners Handbook, 2008 Edition* (the "Handbook") *of the National Association of Insurance Commissioners* ("NAIC"):

History of the HMO
Management and controls
Corporate records
Fidelity bonds and other insurance
Reinsurance
Territory and plan of operation
Growth of the HMO
Accounts and records
Loss experience
Financial statements

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

2. DESCRIPTION OF THE HMO

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

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

A. Management and Controls

Pursuant to the HMO's By-Laws, the Board of Directors ("Board") of the HMO shall not be less than one (1) or more than ten (10) members.

As of December 31, 2008, Senior Whole Health's Board of Directors consisted of the following five (5) members:

Name and Residence	Principal Business Affiliation
John W. Baackes, Jr. Menands, New York	Chief Executive Officer, Senior Whole Health of New York, Inc.
Charles E. Glew, Jr. Wilmette, Illinois	Principal Owner, Flexpoint Fund, LP
Allen S. Moseley Atlanta, Georgia	General Partner, Noro-Moseley Partners V
James K. Outland Birmingham, Alabama	Partner, New Capital Partners Private Equity Fund, LP
Richard C. Skevington Saratoga Springs, New York	Chief Executive Director, Flow Management Technologies

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

The principal officers of the HMO as of December 31, 2008, were as follows:

Name	Title
John W. Baackes, Jr.	Chief Executive Officer
Camille M. Bressler	Corporate Secretary
Michael K. Wyman	Chief Financial Officer

In October 2009, Clarissa Neubig replaced Camille M. Bressler as Senior Whole Health's Corporate Secretary.

It is noted that none of the HMO's directors were enrollees of the HMO or enrollee designated representatives, in violation of Section 3.3.1 of the HMO's By-Laws, which states the following:

> "Within one year of the Corporation becoming operational, no less than twenty percent (20%) of the members of the Board of Directors shall be enrollees of the Corporation or enrollee representatives."

Similarly, Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11) states in part:

> "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 except that… (iii) an HMO, PHSP, PCPCP or MLTCP may, as an alternative to or in addition to subparagraphs (i) and (ii) above, establish an enrollee advisory council which is representative of the HMO's, PHSP's, PCPCP's or MLTCP's enrollment and which has direct input to the governing authority…"

It is recommended that the HMO comply with Section 3.3.1 of its By-Laws and Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Department of Health by including the requisite number of enrollees or enrollee representatives as members of Senior Whole Health's Board of Directors.

Section 2.2 of the HMO's By-Laws states the following:

> "The Corporation shall hold annual meetings of shareholders, commencing with the year 2006, on such date and at such time as shall be designated from time to time by the Board of Directors or any officer appointed by the Board to make this decision. At the meeting, shareholders shall elect members of a Board and transact such other business as may be properly brought before the meeting."

It was noted that no such shareholders' meetings were held during the examination period.

It is recommended that the HMO comply with Section 2.2 of its By-Laws and hold annual shareholders' meetings.

B. Territory and Plan of Operation

Pursuant to Senior Whole Health's Certificate of Authority, as of December 31, 2008, the HMO was authorized to operate in the following six counties of New York State:

Albany	Saratoga
Duchess	Schenectady
Rensselaer	Ulster

Senior Whole Health reported premiums written totaling $11,268,980 during the two-year period, January 1, 2007 through December 31, 2008. Below is a summary of the HMO's total written premiums by county:

New York County	2007	2008	Total
Albany	$ 1,298,985	$ 4,099,636	$ 5,398,621
Dutchess	77,248	117,671	194,919
Rensselaer	84,490	1,256,665	1,341,155
Saratoga	7,242	107,905	115,147
Schenectady	33,796	910,938	944,734
Ulster	708,509	2,565,895	3,274,404
Total	$ 2,210,270	$ 9,058,710	$ 11,268,980

Below is a summary of the HMO's total premiums written by individual lines of business for the two-year examination period:

Line of Business	Total
Medicare Advantage (including Part D)	$ 3,662,101
Medicaid Advantage (including Part D)	5,973,408
Medicaid Advantage Plus	1,633,471
Total	$ 11,268,980

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

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

Effective January 1, 2010, the HMO ceased offering new policies to persons under the age of 65.

Senior Whole Health's 2008 enrollment totaled 669 members compared to the prior year total of 353 enrollees, an increase of 89.5% between the two years.

C. Reinsurance

The HMO held the following ceded reinsurance coverage in effect with an authorized reinsurer at December 31, 2008:

Effective Period	HMO's Retention	Reinsurer's Liability
7/1/08 thru 6/30/09	$150,000 annually per member	$2 million per member, per contract year in excess of $150,000 annually per member. $2 million per member, per lifetime.

As of December 31, 2008, the following coinsurance limits applied relative to eligible expenses net of the reinsurer's liability and the HMO's retention limits:

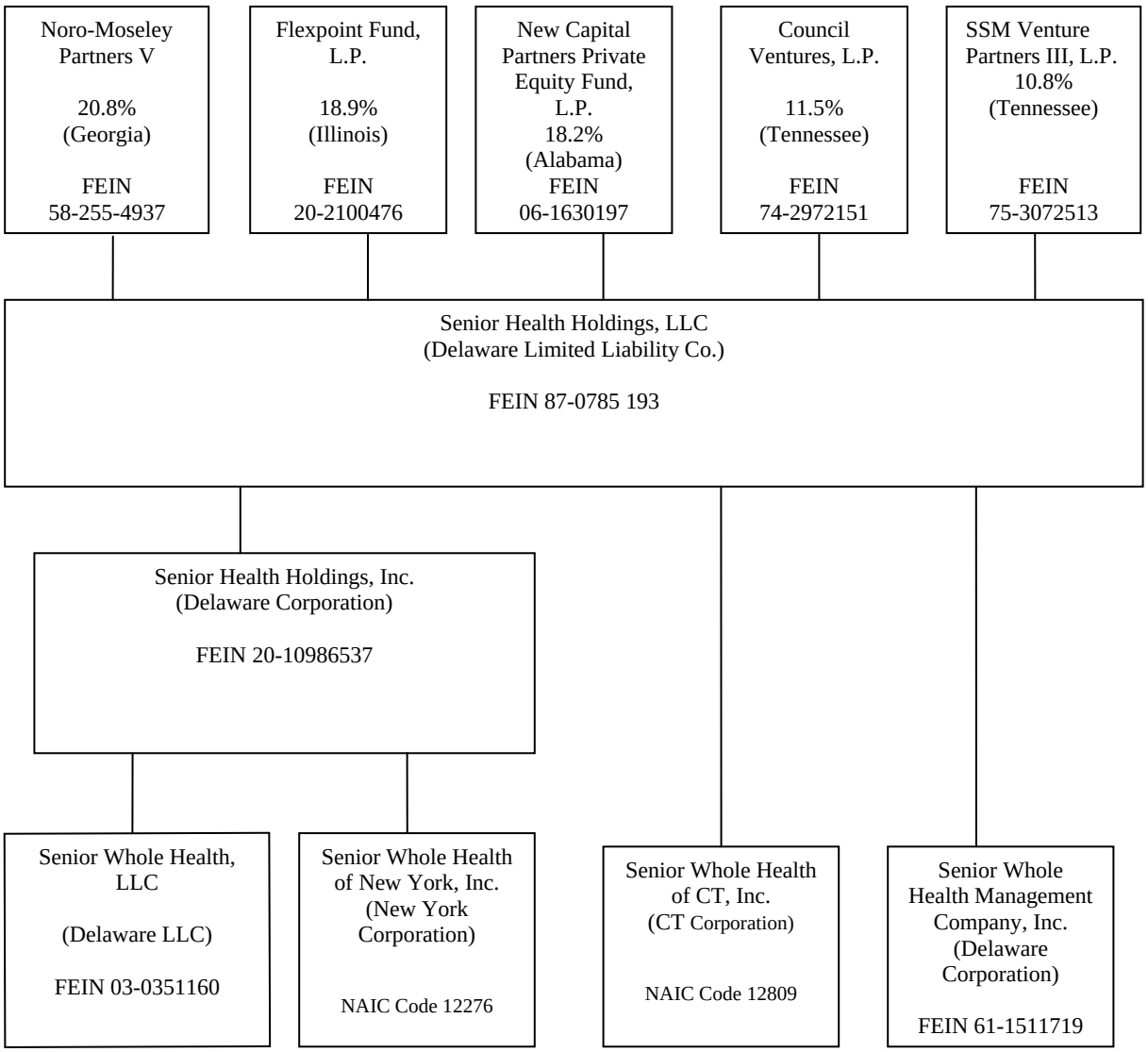
Type of Expense	Coinsurance
Services other than transplant services	90%
Approved transplants	90%
Non-approved transplants	50%

Not to exceed the reinsurance limits, eligible expenses are reimbursed to the HMO at the lesser of: (a) the amount paid, (b) a reinsurer-negotiated amount, or (c) the HMO's arrangement that is approved and on file with the reinsurer.

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

D. Holding Company System

The following chart depicts the HMO's relationship with members of its holding company system. The percentages included in the chart reflect each entity's proportionate ownership as of December 31, 2008.



Senior Health Holdings, LLC (SHH-LLC)

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

Senior Health Holdings, Inc. (SHH-INC)

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

Senior Whole Health, LLC (SWH-LLC)

SWH-LLC was organized on February 19, 2003, as a Delaware limited liability company. SWH-LLC's principal business activity is to provide a new model of health care that expands the provision of Medicaid and Medicare managed care services to the elderly population in Massachusetts. Such care is provided under a Senior Care Organization ("SCO") contract with CMS in partnership with the Commonwealth of Massachusetts.

Senior Whole Health of Connecticut, Inc. (SWH-CT)

SWH-CT was incorporated on May 23, 2006, as a Connecticut corporation. The Company was licensed as a health center facility. It was noted that SWH-CT ceased doing business in January 2009.

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

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

At December 31, 2008, the HMO had the following inter-company agreements in effect with SWH-MGT:

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

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

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

The Department accepted the original agreement on November 8, 2008.

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

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

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

3. Consolidated Tax Allocation Agreement

This agreement was executed September 5, 2006, between the HMO and Senior Health Holdings, Inc., the HMO's direct Parent. The direct Parent and all subsidiaries

agreed to the filing of consolidated Federal income tax returns by Senior Health Holdings, Inc. for every Federal income tax year.

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

It was noted that the management fee schedules appended to the Joint Services and the E&P New York Agreements only covered the monthly fee amounts through December 31, 2007. The Joint Services Agreement is a five-year contract and the E&P New York Agreement remains in effect each year, unless terminated by either the HMO or SWH-MGT, upon either party providing 30 days prior notice to the other party.

It is recommended that the HMO update the management fee schedules related to the Joint Services and E&P New York Agreements to cover the time periods indicated for each agreement.

The HMO's Schedule Y (Information Concerning Activities of Insurer Members of a Holding Company Group) included within its filed December 31, 2008 annual statement incorrectly disclosed SHH-LLC as the HMO's ultimate parent. However, as noted above, several individuals of record owned over 10% of SHH-LLC. Collectively, these individuals held a total of 81% control of such holding company, with the remaining 19% controlled by individuals who each have less than 10% ownership.

The HMO amended its Schedule Y within its second quarter of the 2009 statement filing to include the aforementioned controlling members. However, it was noted that in amending Schedule Y, the HMO omitted certain requirements listed in the 2008 NAIC Annual Statements Instructions ("NAIC Instructions"). Per the NAIC Instructions, page 185, Paragraph 3, the following requirements apply:

> "Attach a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and reporting entities and other affiliates, identifying all insurers and reporting entities as such and listing the Federal Employer's Identification Number of each. The NAIC company code and two-letter state abbreviation of the state of domicile should be included for all domestic insurers. The relationships of the holding company group to the ultimate controlling person (if such person is outside the reported holding company) should be shown. No non-insurer (excluding the parent company) need be shown if it does not have any activities reported in Schedule Y, Part 2 and its total assets are less than one-half of one percent of the total assets of the largest affiliated insurer or reporting entity. Only those companies that were a member of a holding company group at the end of the reporting period should be shown on Schedule Y, Part 1, Organizational Chart."

The HMO failed to list the Federal Employer Identification Number for each holding company member, and the NAIC company code and two-letter state abbreviation of the domiciliary state of each insurance company member. However, the HMO filed an amendment to its Schedule Y as of December 31, 2008, on October 15, 2009, to comply with the NAIC instructions above, in response to a Department letter dated October 2, 2009.

It is recommended that the HMO comply fully with the NAIC Annual Statement Instructions in regard to completing Schedule Y of its quarterly and annual statement filings.

E. Allocation of Expenses

Based on the Joint Services Agreement which applies to the joint/indirect charges allocated, SWH-MGT billed Senior Whole Health charges totaling $878,322 and $438,322 for 2007 and 2008, respectively. The charges for 2007 were net of a $650,000 overcharge refund received by the HMO from SWH-MGT. Such refund resulted from a change that occurred in SWH-MGT's method of allocating joint expenses among its affiliates and also the fact that the HMO's initial reimbursement fees and financial projections were overstated relative to the HMO's actual operating performance. For 2008 and 2009, SWH-MGT allocated joint expenses on the basis of premium income, which resulted in even lower joint expenses being charged to Senior Whole Health. For 2008, the HMO reported total management fees of $438,322, versus the prior year adjusted down total of $878,322.

The aforementioned $650,000 overcharges were subsequently accounted for as a capital contribution in the quarter ended March 31, 2008. Such capital contribution was approved by the Department.

It was further determined by the examiner that SWH-MGT overcharged on the payroll taxes and employee benefits costs allocated to Senior Whole Health. The methodology utilized in the determination of these costs included SWH-MGT applying a flat 27.5% rate against the salaries of the management employees. The flat rate calculated costs were higher than actual costs.

The same scenario described above also applied to Senior Whole Health's E&P New York Agreement (applicable to the direct charges billed to the HMO).

Based on the examiner's review of the two agreements with affiliates, it was determined that Senior Whole Health was overcharged a total of $229,319 in management fees for the two-year period covered by this examination. In addition, Senior Whole Health was overcharged $71,350 in the first nine months of 2009. Below is a breakdown of the total overcharges by agreement and corresponding annual amount.

	2007	2008	Exam. Period Total	2009
Joint Services Agreement	$6,655	$11,845	$18,500	$5,292
E&P New York Agreement	108,351	102,468	210,819	66,058
Total overcharges	$115,006	$114,313	$229,319	$71,350

It is recommended that Senior Whole Health recoup from SWH-MGT the full amount of the management fee overcharges with applicable interest. In addition, it is recommended that the HMO take the steps necessary to ensure that SWH-MGT changes its methodology of calculating the employee benefit charges to actual costs.

Commencing in 2008, Senior Whole Health began allocating joint expenses on the basis of premium income. Such practice is questionable considering that not all expenses necessarily have a direct relationship to premiums (e.g., costs of investigating and processing claims, payroll taxes, fringe benefits, rent, etc.).

It is recommended that the HMO refrain from its current expense allocation of an across-the-board premium income methodology and consider as a guide the detailed procedures outlined in Parts 105.25, 106.2 and 109.2 of Department Regulation No. 30. It is further recommended that the HMO recalculate its expense allocation and make

appropriate adjustments to such expenses charged to the HMO, including adjustments applicable to prior years.

In addition, the following reporting discrepancies were noted in the Underwriting and Investment Exhibit, Part 3 (Analysis of Expenses) of the HMO's 2007 and 2008 annual statement filings:

a) Total joint expenses which were reported entirely to the management allocation account (an expense account) in the trial balance were reported simultaneously to the outsourced services account line item under general administrative expenses in the Underwriting and Investment Exhibit ("U&I"). In the U&I, no amounts were allocated to and subsequently reported within the HMO's claims adjustment and/or investment expenses business lines.

Paragraph 5 of Statement of Statutory Accounting Principles (SSAP) No. 70 of the NAIC Accounting Practices and Procedures Manual states:

> "Allocable expenses for health insurers shall be classified as claim adjustment expenses; general administrative expenses; or investment expenses which are netted against investment income on the Statement of Revenue and Expenses."

Also, in the 2008 NAIC Annual Statement Instructions, Part 3 of the Underwriting and Investment Exhibit, the following requirements apply:

> "Costs for managed care activities must be allocated between claim adjustment expenses and general administrative expenses. Claim adjustment expenses should be allocated to either cost containment expenses, in accordance with SSAP No. 85, Claim Adjustment Expenses, Amendments to SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses. Allocate claim adjustment expenses to (either cost containment expenses, Column 1 or other claim adjustment expenses, Column 2)."

It is recommended that the HMO comply with the requirements of Paragraph 5 of SSAP No. 70 of the NAIC Accounting Practices and Procedures Manual and the 2008 NAIC Quarterly and Annual Statements Instructions, by reporting allocated management expenses from SWH-MGT between claims cost containment expenses, claims adjustment expenses and general administrative expenses, respectively.

b) Additionally, as indicated in (a) above, management expenses were allocated and reported entirely to a management company allocation account in a lump sum total. Such expenditures should have been allocated and reported into each specified expense account (i.e., salaries, payroll taxes, etc.).

Part 105.25(b) of Department Regulation No. 30 (11 NYCRR 105.25(b)) states:

> "(b) *Expenses for account of another:* Whenever expenses are paid by one company for account of another, the payments shall not appear among the expenses reported by the former, and shall be included by the latter in the same expense classifications as if originally paid by it."

The following 2008 NAIC Annual Statement Instructions apply to Part 3 of the Underwriting and Investment Exhibit:

> "A reporting entity that pays any affiliated entity (including a managing general agent) for the management, administration, or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification item (salaries, rent, postage, etc.) as if these costs had been borne directly by the company. Do not report management, administration, or similar fees as one-line expenses. The reporting entity may estimate these expense allocations based on a formula or other reasonable basis."

It is recommended that the HMO follow the NAIC Annual Statement Instructions and Part 105.25(b) of Department Regulation No. 30, by allocating and reporting

management expenses from SWH-MGT into each individual expense account item, as if these expenses had been borne directly by the HMO.

F. Significant Operating Ratios

The following underwriting ratios include the examination financial adjustments as discussed within Item 2E of this report. The HMO amended its December 31, 2008 annual statement on October 15, 2009, to reflect the aforementioned financial adjustments recommended by the examiner.

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

	Amounts	Ratios
Claims	$16,709,776	148.3%
Claims adjustment expenses	1,471,115	13.1%
General administrative expenses	5,768,103	51.2%
Net underwriting loss	(12,680,014)	(112.5%)
Premiums earned	$11,268,980	100.0%

The HMO's significant net underwriting losses are the result of the large disparity between Senior Whole Health's low premium volume versus higher claims costs and operating expenses.

G. Accounts and Records

During the course of the examination, it was noted that the HMO's treatment of certain items were not in accordance with specified Statements of Statutory Accounting Principles (SSAP) of the NAIC Accounting Practices and Procedures Manual, NAIC Financial Condition Examiners Handbook, NAIC annual statement instructions, or the Administrative Rules and Regulations of the New York Department of Health.

A description of such items is as follows:

a) Numerous aged outstanding checks were listed on the December 31, 2008 cash reconciliation of the HMO's Century Bank checking account. A portion of the checks were issued in excess of six months from the examination date, including checks dating back as early as 2007. Management indicated that the HMO did not have internal procedures to follow up with those payees who have checks outstanding, in order to comply with Section 1316 of the New York Abandoned Property Law, or procedures to move long-outstanding checks from its HMO cash account into a contra liability account.

Section 1316 of the New York Abandoned Property Law states the following:

> "1. Any amount issued and payable on or after July first, nineteen hundred seventy-four payable to a resident of this state on or because of a policy of insurance other than life insurance, which is held or owing by a domestic insurer or a foreign insurer authorized to do business in this state or by an agent or agency of such insurer, shall be deemed abandoned property if unclaimed for three years by the person entitled thereto. Where such amount is held or owing by a domestic insurer for an unknown person or a person whose address is unknown, such amount is presumed to be payable to a resident of this state.
>
> 2. Such abandoned property shall be reported to the comptroller annually on or before the first day of April. Such report shall be in such form and manner as the comptroller may prescribe.

> 3. Within thirty days following the filing of the report of abandoned property with the comptroller pursuant to subdivision two of this section, the insurer shall cause to be published a list of such abandoned property in the same manner as that prescribed for life insurance companies by section seven hundred two of this chapter.
>
> 4. Such abandoned property shall be paid or delivered to the comptroller within the first ten days of September of each year."

It is recommended that the HMO establish procedures to follow-up with the payees relative to its outstanding checks and to comply with Section 1316 of the New York Abandoned Property Law. Additionally, it is recommended that Senior Whole Health establish an accounting procedure to move long-outstanding check items from the HMO's cash account into an appropriate liability account.

b) The HMO did not comply with the requirement of the Statements of Statutory Accounting Principles (SSAP) No. 2 and No. 45 of the NAIC Accounting Practices and Procedures Manual, when it reported as "Cash" its money market funds and a repurchase agreement. The SSAPs, require money market funds and repurchase agreements to be classified as short-term investments. In addition, the HMO failed to complete Schedule DA as outlined in the NAIC Health Annual Statement Instructions.

Paragraph 10 of SSAP No. 2 states in part:

> "…Short-term investments include, but are not limited to, bonds, commercial paper, money market instruments, and collateral and mortgage loans which meet the above criteria."

Paragraph 4 of SSAP No. 45 states in part:

> "Repurchase agreements shall be accounted for as collateralized lendings. The underlying securities shall not be accounted for as investments owned by the reporting entity. The amount paid for the securities shall be reported as a short-term investment…"

Although no examination change was made to this account within this report on examination, it is recommended that the HMO report its cash and short-term investments on its filed statements with this Department, in accordance with Paragraph 10 of SSAP No. 2 and Paragraph 4 of SSAP No. 45 of the NAIC Accounting Practices and Procedures Manual and the NAIC Health Annual Statement Instructions.

c) It was noted that Senior Whole Health, in regard to its existing repurchase agreement does not have in place many of the suggested internal procedures indicated in the NAIC's Financial Condition Examiners Handbook, including the following: (i) Board of Directors approved written plan for repurchase transactions; (ii) maintenance of written agreements with the parties that specify the duties and responsibilities of each party, including acceptable types of collateral, standards for collateral custody and control, collateral valuation and initial margin, accrued interest, market tracking, margin calls, methods for transmitting/receiving coupon or dividend payments, conditions which will trigger the termination of the repurchase agreement (including events of default), and acceptable methods of delivery for securities and collateral.

It is recommended that Senior Whole Health implement, at a minimum, the relevant internal control procedures included in the NAIC Financial Condition Examiners Handbook relative to its existing repurchase agreement account.

d) The HMO's cash and short-term investment accounts were comprised of twelve (12) general ledger accounts which represent a considerable number of accounts and account activities. Therefore, it is important for the HMO to have strong internal controls

and an effective reconciliation function. A review of the HMO's reconciliations revealed that the function needs improvement. The reconciliations included extraneous details that created difficulty in understanding the HMO's processes. The information and the reconciliation schedules did not reflect a true balancing of the cash accounts between the HMO's book balance and the bank's records for each account.

It is recommended that the HMO improve its reconciliation function by streamlining the process to include only relevant details necessary to reconcile the cash accounts. It is further recommended that the HMO reconcile its cash accounts between the HMO's book balance and the bank's records for each cash account.

e) The HMO reported investment income due and accrued totaling $57,355 as of the examination date. The actual account balance should have been reported in the amount of $4,561. The difference of $52,794 was derived from the HMO improperly reporting into this account a health care receivable amount. This receivable pertained to pharmaceutical rebates due to Senior Whole Health from its pharmacy benefits administrator, Express Script, Inc.

It is recommended that the HMO follow the NAIC Health Annual Statement Instructions when reporting its investment income due and accrued account by only including earned income items pertaining to cash and other invested assets held.

The HMO amended its 2008 annual statement on October 15, 2009, and reported $4,561 as income due and accrued as of December 31, 2008.

f) As indicated in item (e) above, the HMO incorrectly reported rebates which had not been collected as investment income due and accrued. Such rebates should have been reported as pharmaceutical rebate receivables pursuant to Paragraph 8 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual.

Paragraph 8 of SSAP No. 84 states in part:

> "Pharmaceutical rebate receivables…meet the definition of assets as set forth in SSAP No. 4 and are admitted assets to the extent that the requirements for admission defined in this statement are met…"

It is recommended that the HMO comply with the requirements of Paragraph 8 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual when reporting its pharmaceutical rebate receivables.

The HMO amended its 2008 annual statement on October 15, 2009, and reported the $52,794 within the Health Care Receivables caption of its balance sheet as of December 31, 2008.

g) As also indicated in item (e) above, Senior Whole Health failed to make certain disclosures in connection with its pharmaceutical rebates as required by Paragraph 24 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual, which states:

> "The financial statements shall disclose the method used by the reporting entity to estimate pharmaceutical rebate receivables. Furthermore, for the most recent three years and for each quarter therein, the reporting entity shall also disclose the following: (a) Estimated balance of pharmacy rebate receivable as reported on the financial statements; (b) Pharmacy rebates as invoiced or confirmed in writing; and (c) Pharmacy rebates collected."

It is recommended that Senior Whole Health comply with the requirements of Paragraph 24 of SSAP No. 84 of the NAIC Accounting Practices and Procedures Manual by disclosing the requisite information relative to its pharmaceutical rebates into the Notes section of its financial statements.

The HMO amended its 2008 annual statement on October 15, 2009, and disclosed within the Notes section that the HMO maintained $52,794 of rebates receivable from Express Scripts as of December 31, 2008.

h) A review of the premium reconciliation records revealed that the HMO failed to completely reconcile its members' status in the HMO's enrollment system with CMS and New York State Medicaid records. Such records indicated that only a portion of the differences between expected payments and actual payment amounts received (due to timing differences) were actually reconciled by the HMO. All timing differences should be recognized and reconciled as a monitoring process regarding new member admissions and existing member terminations. In addition, other adjustments and differences were noted each month on a member-by-member basis relative to member status and/or other assigned risk categories.

It is recommended that the HMO reconcile all enrollment differences associated with new member admissions, existing members' terminations and members' assigned risk categories between the Senior Whole Health Medicare and Medicaid enrollment systems.

i) Deficiencies in the HMO's claims processing environment included the claims system's inability to generate: (a) a summary log or edit report documenting

changes/modifications to provider fee schedule records and (b) a change notice involving retroactive adjustments to individual paid claim files. As noted in the 2008 CPA management letter, the system is currently designed to record adjustments and changes to existing claims (individual claim files) only. Without change notice reports, the overall potential effect on the business is that changes to payment codes and or claim totals, which are not regularly reviewed, could lead to instances of overpayment or underpayment to providers and/or difficulties in producing accurate management estimates.

It is recommended that the HMO consider the following enhancements to its existing claims processing system: (i) improving its data warehousing capabilities, (ii) implementing an internal policy and procedures to ensure regular and efficient claims data analysis by the HMO's management, and (iii) maintaining an electronic log of edits to its claims data in order to improve management's ability to track changes to processed claims.

j) The HMO failed to file with the New York State Insurance Department, its CPA management letters dated July 7, 2008 and June 12, 2009, which were issued in conjunction with KPMG's audit of the consolidated financial statements of the Ultimate Parent, SHH-LLC, as of December 31, 2007 and December 31, 2008, respectively. The management letters contained several comments in regard to significant internal control deficiencies applicable to the HMO.

Part 98-1.16(c) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.16) requires the following:

> "Every MCO (Managed Care Organization) shall submit annual financial statements together with an opinion of an independent certified public accountant of the financial statement of such MCO, and an evaluation by such accountant of the accounting procedures and internal control systems of the MCO, by April 1 of each year."

The NAIC Health Annual Statement Instructions, page 16, Paragraph 11, states the following under the captioned heading, "Report on Significant Deficiencies in Internal Controls":

> "…If significant deficiencies are noted, the written report shall be filed annually by the insurer with the domiciliary Department within sixty (60) days after the filing of the annual audited financial statements. The insurer is required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report."

While the HMO did file the stand-alone CPA audited financial statements, together with unqualified opinion reports of Senior Whole Health of New York, Inc. for 2007 and 2008 with the Department, it failed to file the management letters that contained the CPA reported internal control deficiencies.

It is recommended that the HMO fully comply with the requirements of Part 98-1.16(c) of the Administrative Rules and Regulations of the Department of Health and the NAIC Health Annual Statement Instructions by reporting all matters involving the HMO's internal control deficiencies to the Department.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with those reported by the HMO in its December 31, 2008 annual statement (as amended on October 15, 2009):

Assets	Examination	HMO	Surplus Increase/ Decrease
Cash and short term investments	$5,487,305	$5,487,305	
Investment income due and accrued	4,561	4,561	
Uncollected premiums and agents' balances in course of collection	892,941	892,941	
Health care and other amounts receivable	52,794	52,794	
Aggregate write-ins for other than invested assets	(3,974)	(3,974)	
Total admitted assets	$6,433,627	$6,433,627	
Liabilities			
Claims unpaid	$1,798,000	$1,798,000	
Aggregate health policy reserves	2,762,000	2,762,000	
Premiums received in advance	62,249	62,249	
General expenses due or accrued	463,664	463,664	
Amounts due to parent, subsidiaries and affiliates	65,737	295,056	$229,319
Total liabilities	$5,151,650	$5,380,969	$229,319
Capital and Surplus			
Common capital stock	$ 1,000	$ 1,000	
Gross paid in and contributed surplus	14,430,269	14,430,269	
NYS contingent reserve	588,816	588,816	
NYS escrow deposit	83,967	83,967	
Unassigned funds surplus	(13,822,075)	(14,051,394)	229,319
Total capital and surplus	$1,281,977	$1,052,658	$229,319
Total liabilities and capital and surplus	$ 6,433,627	$ 6,433,627	

Note: The Internal Revenue Service is presently conducting an audit of the HMO's 2007 consolidated federal income tax return concurrent with its parent, Senior Health Holdings, Inc. The examiner is unaware of any potential exposure by the HMO to any tax assessment and no liability has been established herein relative to any contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus decreased by $6,162,733 during the period under this examination from January 1, 2007 through December 31 2008, as detailed below:

Revenue		
Total revenue		$ 11,268,980
Expenses		
Hospital/medical benefits	$ 3,200,296	
Other professional services	3,106,068	
Emergency room and out-of-area	389,895	
Prescription drugs	2,913,452	
Aggregate write-ins for other hospital and medical	4,338,065	
Claims adjustment expenses	1,471,115	
General administration expenses	5,768,103	
Increase in reserves for accident and health contracts	2,762,000	
Total underwriting deductions		$ 23,948,994
Net underwriting losses		(12,680,014)
Net investment gain		397,545
Net loss before federal income taxes		$ (12,282,469)
Federal income taxes incurred		248,307
Net loss		$ (12,530,776)

Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per annual statement, as of December 31, 2006			$ 7,444,710
Net loss		$ 12,530,776	
Change in non-admitted assets		25,134	
Cumulative effect in accounting principle change		6,826	
Change in paid in capital		8,030,269	
Paid in surplus	$ 14,430,272		
Net decrease in capital and surplus			$ 6,162,733
Capital and surplus, per report on examination, as of December 31, 2008			$ 1,281,977

4. CLAIMS UNPAID AND AGGREGATE HEALTH POLICY RESERVES

The examination liability of $4,560,000 for the above captioned account is the same amount reported by the HMO in its filed annual statement as of the December 31, 2008.

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

5. UNPAID CLAIMS ADJUSTMENT EXPENSES

The HMO reported no reserve under this caption as of December 31, 2008.

Paragraph 7, of Statement of SSAP No. 55, states in part:

> "The following costs relating to managed care contracts as defined in SSAP No. 50 shall be considered in determining the claims unpaid and claims adjustment expenses…
>
> b. Claim Adjustment Expenses for Managed Care Reporting Entities: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in 7a of this statement. Examples of expenses incurred in these activities are estimating the amounts of losses, disbursing loss payments, maintaining records, general clerical, secretarial, office maintenance, occupancy costs, utilities, computer maintenance, supervisory and executive duties, supplies and postage…"

It is recommended that the HMO comply with the requirements of Paragraph 7 of SSAP No. 55 of the NAIC Accounting Practices and Procedures Manual by establishing an adequate reserve for unpaid claims adjustment expenses.

6. AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

The examination liability of $65,737 is $229,319 less than the $295,056 reported by the HMO as of December 31, 2008.

Such account change reflected the amount of allocated expense overcharges which were billed to the HMO by SWH–MGT during the examination as indicated within Item 2E, "Allocation of Expenses", of this report on examination.

7. CLAIMS PROCESSING

In 2007, Senior Whole Health retained an outside consultant, Blue Slate Solutions, Inc. ("Consultant") to review the HMO's claims processing practices for possible overpayment of claims. Based on an undated letter that was written to the Department by Senior Whole Health's Chief Financial Officer, the HMO stated that it would book at the end of 2008, a $1 million plus surplus increase due to an initial determination by the Consultant that the HMO was entitled to overpaid claims recoveries from various providers.

The Consultant's review concentrated on the following areas of the HMO's claims processing activities:

i. Identifying New York claims paid from November 1, 2007 through October 31, 2008, for Medicare Advantage eligibles who had received Medicare Advantage Plus reimbursement.

ii. Identifying paid New York Medicaid claims between the service dates of January 1, 2007 and October 31, 2007, a period wherein the HMO was only licensed to write Medicare coverage.

iii. Identifying paid New York Medicaid claims processed between the service dates of November 1, 2007 and October 31, 2008, for members whose coverage and dual-eligible memberships were pending and subject to review during a 90 day hold period.

An analysis by the HMO of the Consultant's initial review revealed material discrepancies with both, Blue Slate's total estimate of the HMO's overpaid claims and the supporting source documentation utilized. The problem stemmed from the Consultant using faulty program logic, wherein certain relevant conditions that should have been incorporated into Blue Slate's review were neglected; such as its failures to: (i) limit results

set based on a members-rating category (a key component to identifying improper Medicaid services that may have been delivered); and (ii) the selection and application of all of Senior Whole Health's Medicare fee schedules. Such oversight resulted in the Consultant's findings having both improper application procedure codes between Medicare and Medicaid services and duplicate claims data. As a result of Senior Whole Health having identified and communicated to the Consultant the errors in its program, the Consultant subsequently retested the data. This resulted in a reduction of the initial overpayment estimate from over $1 million, to $250,000. However, according to management, as additional discrepancies and skepticism surrounding the Consultant's revised data evolved, the HMO thereafter deemed the Consultant's reports entirely flawed and unreliable.

The HMO subsequently made a business decision to forego pursuing any potential recoveries against those providers the HMO may have overpaid. Additionally, the HMO concluded that the ultimate exposure was insignificant relative to the findings.

As indicated by the HMO, a reason for the failed review was that the HMO's internal management did not provide appropriate monitoring of the project.

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

8. SUBSEQUENT EVENTS

Effective May 14, 2009, Senior Whole Health received approval for an amended Certificate of Authority to expand Medicare-only business into the following six (6) additional counties:

Columbia County	Orange County
Green County	Warren County
Montgomery County	Washington County

Concurrent with the Department of Health's approval of the aforementioned expansion, the New York State Insurance Department, in a letter dated May 14, 2009, issued a conditional non-objection, which included the following requirements:

1. Senior Whole Health will not market or enroll prospective enrollees into the expansion counties until the HMO receives confirmation from the Department that it has complied with all of the Department's requirements regarding adequate capitalization of the HMO. The HMO's May 12, 2009 letter, signed by Michael Wyman, Chief Financial Officer, agreed to this condition.

2. Sufficient funds are to be immediately infused into the HMO so that it is not impaired as of March 31, 2009.

The HMO subsequently complied with the above requirements. According to management, Senior Whole Health began operations in the above new counties in January 2010.

As of the HMO's June 30, 2009 quarterly statement filing, Senior Whole Health's surplus was insolvent in the amount $649,865 and its contingency reserve fund was impaired in the amount of $1,658,056, in violation of the operating requirements of Part

98-1.8(a) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.8), which states in part:

> "Continuance of a certificate of authority shall be contingent upon satisfactory performance by the MCO of delivery, continuity, accessibility and quality of the services to which an enrolled member is entitled, compliance of the MCO with the provisions of Article 44 of the Public Health Law and this Subpart, the continuing fiscal solvency of the MCO…"

In addition, Part 98-1.11(e)(2) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.8) states in part:

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

During September 2009, Senior Whole Health received a $6 million cash infusion from its parent, Senior Health Holdings, Inc. In addition to addressing the aforementioned insolvency and impairment, such infusion also covered, in part, the financial requirements imposed on the HMO by the New York State Departments of Health and Insurance, in connection with Senior Whole Health's expansion into the additional counties in January 2010.

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

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

The HMO reported capital and surplus in the amount of $2,989,505 as of December 31, 2010, in its latest filed annual statement with the Department. Such amount exceeded the HMO's minimum surplus requirement of $1,793,965 as of such date. It is noted that the HMO reported capital and surplus in the amount of $2,781,935 as of January 31, 2011, in an unaudited balance sheet filed with the Department.

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. **30349**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Kenneth Merritt

as a proper person to examine into the affairs of the

Senior Whole Health of New York, Inc.

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

HMO

with such other information as he shall deem requisite.

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

this 21st day of September, 2009

James J. Wrynn
Superintendent of Insurance