

REPORT ON EXAMINATION

OF

MVP HEALTH PLAN, INC.

AS OF

DECEMBER 31, 2019

DATE OF REPORT

OCTOBER 15, 2021

EXAMINERS:

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Department of Financial Services

KATHY HOCHUL
Governor

ADRIENNE A. HARRIS
Acting Superintendent

October 15, 2021

Honorable Adrienne A. Harris
Acting 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 32179, dated December 21, 2020, 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, 2019. The following report is respectfully submitted.

The examination was conducted remotely due to the restrictions relating to the COVID-19 pandemic.

Wherever the designations “MVPHP” or the “HMO” appear herein, without qualification, they should be understood to indicate MVP Health Plan, Inc.

Wherever the designation “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, 2019, 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.

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 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, 2016. This examination of the HMO was a financial examination as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2020 Edition* (the “Handbook”) and covered the three-year period January 1, 2017 through December 31, 2019. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2019 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 risk 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 2017 through 2019 by the accounting firm KPMG, LLP ("KPMG"). The HMO received an unmodified 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 No. 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 No. 118 (11 NYCRR 89).

Additionally, as part of this examination and in accordance with the provisions of the Handbook, a review was made of MVPHP's computer systems and operations that support MVPHP, on a risk-focused basis. Compliance with the provisions of the Financial Services Regulation Part No. 500 (23 NYCRR 500) – "Cybersecurity Requirements for Financial Services Companies" was also assessed.

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 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 issued a non-objection letter to the NYSDOH on August 29, 2013, relative to this acquisition. MVPHP is the sole corporate member of HHP, 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 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 NYSDOH's Regulation 10 NYCRR §98-1.11(b)(1).

2. 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, 2019, the HMO has expenditures for health care services in the amount \$2,423,759,535 and an escrow deposit requirement of \$121,187,977. Pursuant to the provisions of 10 NYCRR 98-1.11(f) of the Administrative Rules and Regulations of the NYSDOH, the HMO established an escrow account in the amount of \$151,589,361 (book/adjusted carrying value), as of December 31, 2019.

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 nine (9) and not more than fourteen (14) directors. As required by Part 98-1.11(g) of the Administrative Rules and

Regulations of the NYSDOH, 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 ten (10) independent directors.

As of December 31, 2019, 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	Retired, Ortho NY
David Spalding Pratt, M.D., MPH Rexford, NY	Retired
<u>Enrollee Representatives*</u>	
Burt Danovitz, Ph.D. Clinton, NY	Self-employed, Danovitz Consulting
Alan Paul Goldberg Albany, NY	Retired, First Albany Securities
William Reddy Rochester, NY	Retired, Veterans Outreach Center, Inc.
<u>Community Representatives</u>	
Lindsay Carroll Farrell Ossining, NY	CEO/President, Open Door Family Medical Center
Meng-Ling Hsiao, Ph.D. Schenectady, NY	Executive Chief Engineer, GE Power and Water
Curtis Lloyd Albany, NY	Vice Chancellor for Human Resources State University of New York – System Administration

Name and ResidencePrincipal Business Affiliation

Kevin O'Connor
Albany, NY

Director of Economic Development,
Albany County Executive's Office

Kimberly A. Zeoli
Needham, MA

CPA / Management Consulting,
Deloitte Risk & Financial Advisory

*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 NYSDOH Regulation 10 NYCRR 98-1.11(g) as of December 31, 2019.

The Board met at least four times during each calendar year within the examination period. A review of the Board's meeting minutes for meetings 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.

The principal officers of the HMO as of December 31, 2019 were as follows:

<u>Name</u>	<u>Title</u>
Christopher Del Vecchio*	President and Chief Executive Officer
Monice Barbero, Esq.	Secretary
Karla Ann Austen	Treasurer and Chief Financial Officer

*On September 1, 2019, President Christopher Del Vecchio assumed the position of Chief Executive Officer upon the retirement of Denise V. Gonick Esq.

Enterprise Risk Management

The HMO is required to be compliant with Insurance Regulation No. 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.

MVP also established multiple management committees that oversee various aspects of its operations, such as the Enterprise Risk Management Committee, Corporate Compliance Committee, and Quality Improvement Committee and its subcommittees. Each of these committees were implemented and are monitored by executive management of MVP in accordance with their charters / governing documents. These management committee charters/ governing documents reflect the Committees' respective purposes.

In October 2019, a Board level committee, the Compliance and Risk Oversight Committee (the "CROC") replaced the Cybersecurity Committee and assumed, in addition to oversight of cybersecurity, certain oversight responsibilities previously held by other Board committees, such as Enterprise Risk Management, and Corporate Compliance, as well as a new oversight responsibility, vendor management. The CROC is responsible for risk and controls and monitoring and reporting on the MVP Companies' overall ERM program.

Additionally, MVP 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 potential impact to 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 relative to emerging issues.

Information Technology (“IT”)

MVP and its subsidiaries have more than 485,000 members across New York and Vermont. MVP manages and maintains a set of computerized application systems to support the Company’s business processes. In addition, the Company 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. The IT review’s conclusions were based on inquiry, observation, inspection of documentation, independent research, and a review of third-party workpapers.

The IT examination team also assessed MVP’s compliance with the provision of the Financial Services Regulation Part 500 (23 NYCRR 500) - Cybersecurity Requirements for Financial Services Companies. It was concluded that MVP was compliant with the sections of the

Cybersecurity Regulation that were in effect during the examination period. 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 MVPHP's corporate governance were noted.

Insurance Regulation No. 118 (11 NYCRR 89)

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 No. 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 No. 118 (11 NYCRR 89) 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. Through 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 includes the HMO. As part of its Insurance Regulation No. 118 (11 NYCRR 89) 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, 2019, included the following fifty-five (55) counties in New York State:

Albany	Essex	Oneida	Seneca
Allegany	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	Schuyler	

As of the examination date, the HMO contracted with fourteen (14) Independent Practice Associations (“IPA”) 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 an HMO 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. It should be noted that these two risk sharing agreements are no longer active due to the dissolution of VMC and United Health Alliance, as of April 2014 and October 2020, respectively.

The HMO’s enrollment, by line of business, as of December 31st of each year under examination and 2020 was as follows:

	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
HMO	320,103	330,634	333,000	349,595
PPO	23,812	25,330	31,032	52,201
POS	19,942	14,802	9,699	896
Aggregate Write-Ins	<u>422</u>	<u>216</u>	<u>213</u>	<u>198</u>
Total	<u>364,279</u>	<u>370,982</u>	<u>373,944</u>	<u>402,890</u>

During the examination period, the HMO's membership increased from 365,240 at December 31, 2016, to 373,944 at December 31, 2019. The membership further increased to 402,890 in 2020, marking a 10.3% increase over the four-year period.

MVPHP's growth from calendar year 2017 to 2020 is attributable to increases in government programs and commercial products in Vermont which are offset by the withdrawal from the Federal Employee Health Benefit Plan in 2020.

The HMO's direct written premiums for each year under examination and 2020 were as follows:

	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
NY	\$ 2,446,137,020	\$ 2,509,772,447	\$ 2,487,880,004	\$ 2,526,784,851
VT	<u>72,025,646</u>	<u>144,242,684</u>	<u>191,463,429</u>	<u>250,783,919</u>
	<u>\$ 2,518,162,666</u>	<u>\$ 2,654,015,131</u>	<u>\$ 2,679,343,433</u>	<u>\$ 2,777,568,770</u>

C. Reinsurance

Assumed Reinsurance

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

Ceded Reinsurance

On December 31, 2019, the HMO had a stop-loss reinsurance agreement with The North River Insurance Company ("NRIC"), a New York licensed insurer. The agreement requires the

reinsurer to pay a percentage of the eligible benefit related expenses paid by MVPHP during the contract year. Any amounts due to MVPHP pursuant to this agreement, as detailed below, are recorded as amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

Excess-of-loss coverages:

Retention:

\$800,000 of eligible expenses per member per agreement year for the Commercial, Individual, MVP Employees & Individual Exchange.

\$550,000 of eligible expenses per member per agreement year for Medicare members.

\$500,000 of eligible expenses per member per agreement year for Child Health Plus and Essential 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.

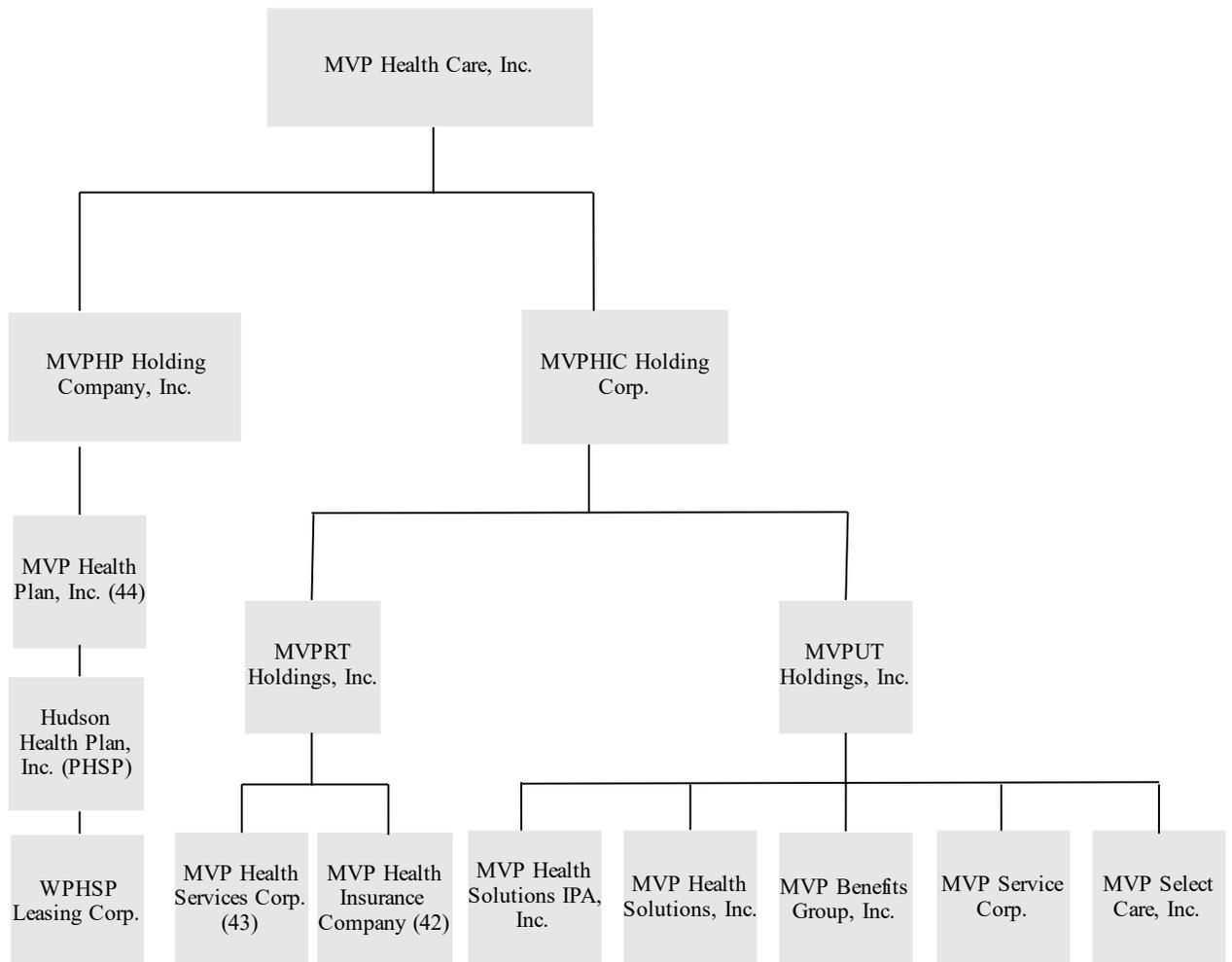
The reinsurance agreement contained all the required standard clauses, including the insolvency clause required by Section 1308(a)(2)(A) of the New York Insurance Law.

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, 2019:



The following is a summary of MVPPHP’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.
- MVP Health Services, Corp. (“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 business 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.
- MVP Health Insurance Company (“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 Accident and Health 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 as follows:

Staffing Services Agreement

The HMO has a staffing services agreement with MVP Service Corp. (“MVPSC”) dated May 25, 2016. MVPSC is wholly-controlled by MVPUT Holdings, Inc. MVPSC’s employees perform all 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 replaced the previously expired management services agreement which was effective on May 26, 2011. The NYSDOH approved this agreement on January 10, 2018.

Office Facilities, Equipment and Supplies Agreement

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

1. MVP Health Insurance Company
Agreement was approved by the Department on March 14, 2008. First amendment to this agreement was approved on January 1, 2011. Second amendment to this agreement was approved on October 29, 2013.
2. MVP Health Insurance Company of New Hampshire, Inc. (Dissolved March 31, 2017)
Agreement was approved by the Department on March 14, 2008. First amendment to this agreement was approved on January 1, 2011. Second amendment to this agreement was approved on October 29, 2013.
3. MVP Health Services Corp.
Agreement was approved by the Department on January 1, 2011. First amendment to this agreement was approved on October 29, 2013. Second amendment to this agreement was approved on April 17, 2015.

4. MVP Select Care, Inc.
Agreement was approved by the Department on January 1, 2011. First amendment to this agreement was approved on October 29, 2013.
5. MVP Benefit Group, Inc.
Agreement was approved by the Department on January 1, 2011. First amendment to this agreement was approved on October 29, 2013.
6. Genesee Region Preferred Health Network IPA, Inc. (Dissolved February 28, 2017)
Agreement was approved by the Department on January 1, 2011. First amendment to this agreement was approved on October 29, 2013. Second amendment to this agreement was approved on April 17, 2015.
7. MVP Service Corp.
Agreement was approved by the Department on January 1, 2011. First amendment to this agreement was approved on October 29, 2013.
8. Hudson Health Plan, Inc.
Agreement was approved by the Department on October 23, 2014. First amendment to this agreement was approved on April 17, 2015.

Administrative Services Agreement

MVPHP entered into an administrative services agreement with 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, outreach, management information and legal. The 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.

On April 1, 2017, the parties to this agreement executed an amendment to this agreement. The purpose of the amendment was to remove the New Hampshire entities since they were no longer active. The HMO did not file this amendment with the Department for review; thereby failing to comply with Section 1505(d) of the New York Insurance Law

Sections 1505(d)(3) and (4) of the New York Insurance Law state, in part:

“The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or with regard to reinsurance treaties or agreements at least forty-five days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within such period... (3) rendering of services on a regular or systematic basis; or (4) any material transaction, specified by regulation, that the superintendent determines may adversely affect the interests of the insurer’s’ policyholders or shareholders.”

It is recommended that the HMO implement practices and procedures to ensure that the superintendent is properly notified of its intent to enter into and/or amend any form of services or cost-sharing agreement with an affiliated company as required by Section 1505(d) of the New York Insurance Law.

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 expenses	\$ 7,087,756,180	90.43%
Other claim adjustment expenses	32,916,462	0.42%
Cost containment expenses	145,989,581	1.86%
General administrative expenses	515,191,104	6.57%
Increase in reserves	10,149,294	0.13%
Net underwriting gain	<u>45,858,613</u>	<u>0.59%</u>
Total revenue	\$ <u>7,837,861,234</u>	<u>100.00%</u>

F. Affirmation of Prior Report on Examination

Section 312(b) of New York Insurance Law states, in part:

“A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer’s files confirming that such member has received and read such report...”

Although the HMO provided the examiners with a copy of a letter addressed to the Department dated September 30, 2020, indicating that a copy of the report on examination was provided to each member of its Board and that each member signed a statement of receipt and reading of the report, the HMO failed to produce the actual signed statements. As a result, it was determined that the HMO failed to comply with Section 312 (b) of the New York Insurance Law.

It is recommended that the HMO comply with Section 312(b) of the New York Insurance Law by obtaining and retaining signed statements from each of its board members verifying that they have received and read a copy of the report on examination.

G. New York Supplement

Part 101.9 of Insurance Regulation No. 164 (11 NYCRR 101.9(a)(2) and (3)), states, in part:

“(2) the health care provider agrees that the superintendent, and the insurer, shall have the right, from time to time, to inspect the health care provider’s books and records and that the superintendent may examine under oath any officer or agent of such provider with respect to its use of the in-network capitation funds received from the insurer and the provider’s compliance with the terms and conditions of the financial risk transfer agreement and the provisions of this Part;

(3) the health care provider agrees that on an annual basis, it will submit within 120 days of the close of its fiscal year, to the insurer and the superintendent, a financial statement in a form prescribed by the superintendent, sworn to under

penalty of perjury by the health care provider's chief financial officer, showing the health care provider's financial condition at the close of its fiscal year, together with an opinion of an independent certified public accountant (CPA) on the financial statement of such health care provider.”

The HMO is required to summarize and provide the financial information submitted by the health care provider through the completion of Report #15 to the NY Supplement. Upon reviewing the NY Supplements filed over the course of the examination period, it was noted that the HMO did not provide the required information (Parts A through D) for numerous risk-bearing entities. This has been a recurring and ongoing issue with the HMO.

It should be noted that the HMO was unable to properly oversee and monitor the health care providers in order to obtain the required financial information needed to complete the NY Supplement. It was also noted, after a review of a sample of risk-bearing agreements, that the agreements did not include appropriate language which would enable the HMO to compel the health care providers to provide the information necessary to facilitate its compliance with the above cited requirements. In addition, the HMO was unable to provide evidence of the Department's approval of the agreements. The HMO has failed to comply with Insurance Regulation No. 164 (11 NYCRR 101.9).

It is recommended that the HMO comply with the Part 101.9(a)(2) and (3) of Insurance Regulation No. 164 and file with the Department, its risk-bearing agreements with all the required provisions.

Additionally, it is recommended that the HMO enhance its oversight and monitoring practices and procedures to ensure its ability to obtain the information needed to complete Report #15 Parts A through D of the New York Supplement for each of its health care providers with which it has entered into a risk-sharing agreement.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2019, as contained in the HMO's 2019 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, 2019 filed annual statement.

Independent Accountants

KPMG was retained by the HMO to audit the HMO's GAAP basis statements of financial position as of December 31, 2019, as well as the related statements of operations and changes in net assets, and cash flows for the year then ended. A GAAP to statutory footnote was presented within the financial statements of the HMO for each of the years audited for the changes in capital and surplus.

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.

A. Balance SheetAssets

Bonds	\$ 268,148,522
Common stocks	34,781,841
Cash, cash equivalents and short-term investments	103,668,637
Receivables for securities	15,797
Aggregate write-ins for invested assets	116,504,477
Investment income due and accrued	1,484,093
Uncollected premiums and agents' balances in the course of collection	33,193,229
Accrued retrospective premiums and contracts subject to redetermination	2,519,906
Amounts recoverable from reinsurers	25,494,912
Electronic data processing equipment and software	2,076,912
Furniture and equipment	63,241
Receivables from parent, subsidiaries and affiliates	16,492,287
Health care and other amounts receivable	119,781,848
Aggregate write-ins for other than invested assets	<u>885,821</u>
Total assets	\$ <u>725,111,523</u>

Liabilities

Claims unpaid	\$ 203,988,633
Accrued medical incentive pool and bonus amounts	18,864,115
Unpaid claims adjustment expenses	5,277,000
Aggregate health policy reserves	42,583,532
Premiums received in advance	19,719,549
General expenses due or accrued	21,489,485
Current federal and foreign income tax payable	319,617
Net deferred tax liability	2,056,896
Amounts due to parent, subsidiaries and affiliates	316,530
Payable for securities	659,587
Aggregate write-ins for other liabilities: Due to CMS	<u>5,850,319</u>
Total liabilities	\$ <u>321,125,263</u>

Capital and Surplus

Aggregate write-ins for special surplus funds	\$ 26,601,026
Aggregate write-ins for other than special surplus funds	267,592,255
Unassigned funds (surplus)	<u>109,792,979</u>
Total capital and surplus	\$ <u>403,986,260</u>
Total liabilities capital and surplus	\$ <u>725,111,523</u>

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

B. Statement of Revenue and Expenses and Changes to Capital and Surplus

The HMO's capital and surplus increased by \$60,500,491 during the three-year examination period, January 1, 2017 through December 31, 2019, detailed as follows:

Revenue

Net premium income	\$ 7,821,362,224	
Change in unearned premium reserves and reserve for rate credits	<u>16,499,010</u>	
Total revenue		\$ 7,837,861,234
<u>Hospital and Medical Expenses</u>		
Hospital/medical benefits	\$ 5,019,674,257	
Other professional services	420,561,623	
Emergency room and out-of-area	187,581,450	
Prescription drugs	1,182,420,298	
Aggregate write-ins for other hospital and medical	149,074,438	
Incentive pool, withhold adjustments and bonus amounts	177,251,845	
Net reinsurance recoveries	<u>(48,807,731)</u>	
Total hospital and medical expenses	\$ 7,087,756,180	
Claims adjustment expenses, including \$145,989,581 cost containment expenses	178,906,043	
General administrative expenses	515,191,104	
Increase in reserves for life and accident and health contracts	<u>10,149,294</u>	
Total underwriting deductions		\$ <u>7,792,002,621</u>
Net underwriting gain		\$ 45,858,613
Net investment income earned		25,711,184
Net realized capital gain		8,441,417
Net investment gain		34,152,601
Aggregate write-ins for other income or expenses		<u>1,263,287</u>
Net income before all other federal income taxes		\$ 81,274,501
Federal and foreign income taxes incurred		<u>2,344,593</u>
Net income		\$ <u><u>78,929,908</u></u>

Changes in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2016			\$ 343,485,769
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$ 78,929,908		
Change in net unrealized capital gains		\$ 12,892,774	
Change in non-admitted assets		<u>5,536,643</u>	
Net change in surplus			\$ <u>60,500,491</u>
Capital and surplus, per report on examination, as of December 31, 2019			\$ <u>403,986,260</u>

4. CLAIMS UNPAID

The examination liability of \$203,988,633 for the above captioned account is the same as the amount reported by the HMO as of December 31, 2019.

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 experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2019.

5. SUBSEQUENT EVENTS

On March 11, 2020, the World Health Organization declared the spreading coronavirus (COVID-19) outbreak a pandemic. On March 13, 2020, the coronavirus pandemic was declared a

national emergency in the United States. The epidemiological threat posed by COVID-19 continues to have disruptive effects on the economy, including disruption of the global supply of goods, reduction in the demand for labor, and reduction in the demand for U.S. products and services, resulting in a sharp increase in unemployment. The economic disruptions caused by COVID-19 and the increased uncertainty about the magnitude of the economic slowdown has also caused extreme volatility in the financial markets.

The full effect of COVID-19 on the U.S. and global insurance and reinsurance industry is still unknown at the time of releasing this report. The New York Department of Financial Services expects the COVID-19 outbreak to impact a wide range of insurance products resulting in coverage disputes, reduced liquidity of insurers, and other areas of operations of insurers. The New York Department of Financial Services and all insurance regulators, with the assistance of the National Association of Insurance Commissioners (“NAIC”), continue to monitor the situation through a coordinated effort and will continue to assess the impacts of the pandemic on U.S. insurers.

6. **COMPLIANCE WITH PRIOR REPORT ON EXAMINATION**

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

7. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Holding Company System</u>	
It is recommended that the HMO implement practices and procedures to ensure that the superintendent is properly notified of its intent to enter into and/or amend any form of services or cost-sharing agreement with an affiliated company as required by Section 1505(d) of the New York Insurance Law.	21
B. <u>Affirmation of Prior Report on Examination</u>	
It is recommended that the HMO comply with Section 312(b) of the New York Insurance Law by obtaining and retaining signed statements from each of its board members verifying that they have received and read a copy of the report on examination.	22
C. <u>New York Supplement for Health Maintenance Organizations</u>	
i. It is recommended that the HMO comply with the Part 101.9(a)(2) and (3) of Insurance Regulation No. 164 and file with the Department, its risk-bearing agreements with all the required provisions.	23
ii. Additionally, it is recommended that the HMO enhance its oversight and monitoring practices and procedures to ensure its ability to obtain the information needed to complete Report #15 Parts A through D of the New York Supplement for each of its health care providers with which it has entered into a risk-sharing agreement.	23

Respectfully submitted,

_____/S/_____
James B. Morris, CPA, CFE

Examiner in Charge

STATE OF MARYLAND)

) SS.

)

COUNTY OF BALTIMORE)

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

_____/S/_____
James B. Morris, CPA, CFE

Examiner in Charge

Subscribed and sworn to before me

This ____ day of _____ 2021

Respectfully submitted,

_____/S/_____
Jeffrey Usher, CFE

Supervising Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

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

_____/S/_____
Jeffrey Usher, CFE

Subscribed and sworn to before me

This ____ day of _____ 2021

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, LINDA A. LACEWELL, 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:

Baker Tilly US, LLP.

as a proper person to examine the affairs of the

MVP Health Plan, Inc.

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

HMO

with such other information as they shall deem requisite.

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

this 21st day of December, 2020

LINDA A. LACEWELL
Superintendent of Financial
Services

By:

Alice W. McKenney

Alice McKenney
Bureau Chief
Health Bureau

