REPORT ON EXAMINATION

OF

SENIOR WHOLE HEALTH OF NEW YORK, INC.

AS OF

DECEMBER 31, 2017

DATE OF REPORT	**FEBRUARY 15, 2022**
EXAMINER	**VICTOR ESTRADA**

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Department of Financial Services

KATHY HOCHUL
Governor

ADRIENNE A. HARRIS
Superintendent

February 15, 2022

Honorable Adrienne A. Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and New York Public Health Law, and acting in accordance with the instructions contained in Appointment Number 31806, dated August 24, 2018, 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 certified pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2017, and respectfully submit the following report thereon.

The examination was conducted at the administrative office of Senior Whole Health of New York, Inc. located at 325 Adams Street, Brooklyn, New York.

Wherever the designations the "HMO" or "SWH" appears 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 Department of Financial Services.

1. SCOPE OF THE EXAMINATION

Senior Whole Health of New York, Inc. was previously examined as of December 31, 2014. This examination of the HMO was a combined (financial and market conduct) examination and covered the three-year period January 1, 2015 through December 31, 2017. The financial component of the examination was conducted as a financial examination, as such term is defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2018 Edition* (the "Handbook"). The financial examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2017 were also reviewed.

The financial portion of 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 examiner's assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner 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 the HMO.

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

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

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

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

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

The HMO was audited annually, for the years 2015 through 2016, by the accounting firm PricewaterhouseCoopers LLP ("PwC"). For the year 2017, the HMO was audited by the accounting firm Ernst and Young LLP ("E&Y"). SWH received an unmodified opinion in each of those years. Certain audit workpapers of E&Y were reviewed and relied upon in conjunction with this examination.

The examiner reviewed the corrective actions taken by the HMO with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item 5 of this report.

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

2. DESCRIPTION OF THE HMO

The HMO 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 ("DOH") to operate as a health maintenance organization pursuant to Article 44 of the New York State 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, DOH 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. The HMO also received authorization from the Centers for Medicare and Medicaid Services to operate as a "Special Needs Plan" ("SNP") to its members. SNPs' were created by the United States Congress within the Medicare Modernization Act of 2003 as a new type of Medicare managed care plan which focus on certain groups of Medicare beneficiaries: the institutionalized, dual-eligible (Medicare and Medicaid) and beneficiaries with severe or disabling chronic conditions. Beginning in October 2012, DOH granted the HMO approval to write Managed Long-Term Care Plan insurance.

A. Corporate Governance

Pursuant to the HMO's by-laws, the board of directors of the HMO shall not be less than one (1) nor more than ten (10) members. As of December 31, 2017, the directors of the HMO were as follows:

Name and Residence	Principal Business Affiliation
Anne McCabe Saratoga Springs, NY	Vice President, Senior Whole Health of New York, Inc.
Jonathan Rubin, West Simsbury, CT	Chief Financial Officer, Senior Whole Health of New York, Inc.
Sam Srivastava Wilton, CT	Chief Executive Officer, Senior Whole Health of New York, Inc.

Subsequently, in 2018, the three-member board was replaced by Jonathan Rubin (Chief Financial Officer of Magellan Health, Inc.) and Sam Srivastava (Chief Executive Officer of Magellan Health, Inc.).

The minutes of all meetings of the board of directors and committees held during the examination period were reviewed. The HMO's by-laws require that the board of directors meet at least quarterly. The review indicated all board and committee meetings were well attended, with all board members attending at least one-half of the meetings they were eligible to attend. However, it was noted that the board members failed to "sign off" on the prior report on examination.

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

> "(b) 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."

It is recommended that the HMO comply with Section 312(b) of the New York Insurance Law by requiring each member of its board of directors to sign a statement, which shall be retained in the HMO's files, confirming that such board member received and read the prior report on examination issued by the Department.

A similar recommendation was included in the prior report on examination.

Subsequent to the examination date, the HMO provided signed statements from each board member confirming they have received and read the Department's issued prior report on examination, as required by Section 312(b) of the New York Insurance Law.

As of December 31, 2017, the principal officers of the HMO were as follows:

Name	Title
David Kleinhanzl	Chief Executive Officer
Juno Paramadevan	Chief Financial Officer
Andrew M. Cummings	Secretary
Anne McCabe	Vice President

Subsequently, in 2018, the principal officers of the HMO were replaced by Sharon Muscarella, (President and Chief Executive Officer), Amanda Jackson, (Chief Financial Officer), Ann McCabe and Margie Smith, (Vice Presidents) and Andrew Cummings, (Secretary). Ms. Muscarella was subsequently replaced by Mary Shinham, as the HMO's President and Chief Executive Officer.

B. Territory and Plan of Operation

The HMO obtained its Certificate from the New York State Department of Health as a Medicaid Advantage Plan on September 15, 2007. The amended Certificate as of October 19,

2017 allowed the HMO to offer Medicare and Medicaid Advantage Plus only, in the following six (6) counties in New York City:

Bronx	Kings	Nassau
New York	Queens	Westchester

As of October 19, 2017, the HMO was also approved to operate a partial capitation Managed Long-Term Care Plan serving the Medicaid population in the following five (5) counties in New York City:

Bronx Kings New York Queens Westchester

As of October 19, 2017, the HMO was also approved to offer the Fully Integrate Duals Advantage ("FIDA") product serving dually eligible population in the following four (4) counties in New York City:

Bronx Kings New York Queens

The HMO reported premiums written totaling $790,904,936 during the three-year period under examination, January 1, 2015 through December 31, 2017. Below is a summary of the HMO's total written premiums by county during the examination period.

County	2015	2016	2017	Total
Bronx	$ 23,709,650	$ 40,620,735	$ 62,953,440	$ 127,283,825
Kings	53,356,703	93,221,478	156,944,462	303,522,643
Nassau	-	-	296,653	296,653
New York	24,542,709	46,285,486	76,096,405	146,924,600
Queens	31,442,083	65,574,999	115,847,704	212,864,786
Westchester	-	-	12,429	12,429
Total	$ 133,051,145	$ 245,702,698	$ 412,151,093	$ 790,904,936

The following is a summary of the HMO's total premiums written by line of business for the three-year period under examination:

Line of Business	Total
Medicare Advantage (including Part D)	$ 24,779,231
Medicaid Advantage (including Part D)	22,488,228
Medicaid Advantage Plus and Managed Long-Term Care	743,637,477
Total	$ 790,904,936

During the three-year period under examination, January 1, 2015 through December 31, 2017, the HMO experienced a net increase in enrollment of 6,056 members. An analysis of the enrollment is set forth below:

Year	Enrollment	Increase
2015	3,773	108.22%
2016	6,936	83.83%
2017	9,829	41.71%

C. Reinsurance

The HMO held the following ceded reinsurance coverage in effect with Highmark Life Insurance Company, an authorized reinsurer, at December 31, 2017:

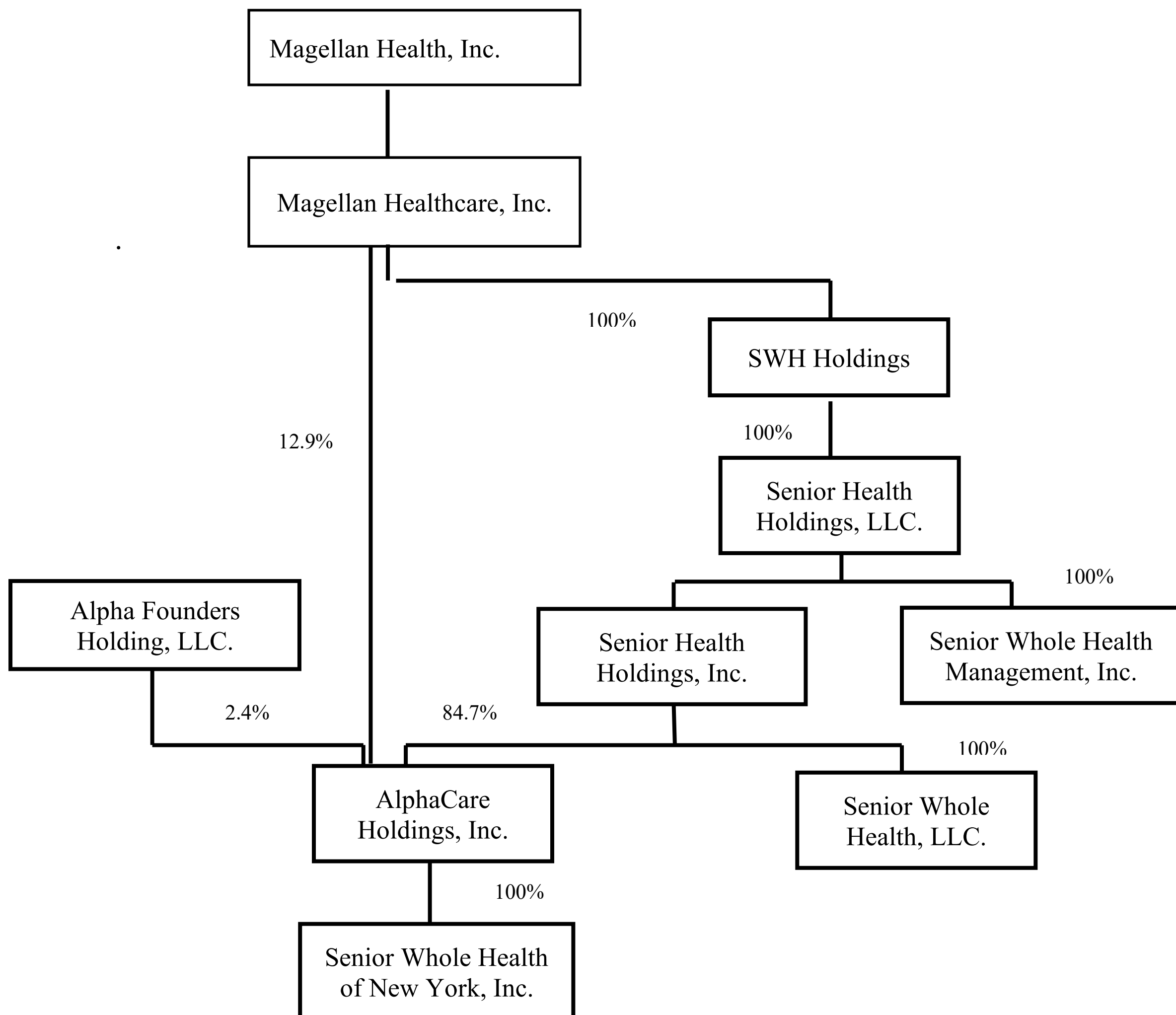
Effective Period	HMO's Retention	Reinsurer's Liability
July 1, 2017 to June 30, 2018	$200,000 annually per member	$2 million per member, per contract year, in excess of $200,000 annually per member; $2 million per member, per lifetime.

The reinsurance agreement noted above contained the required clauses, including the insolvency clause, prescribed by Section 1308 of the New York Insurance Law.

D. Holding Company System

On October 31, 2017, the owners of SWH Holdings, Inc., including TA Associates, Inc. who had controlling interest, sold their stake in SWH Holdings, Inc. to Magellan Health, Inc. ("Magellan"). Magellan acquired the HMO's ultimate parent company, SWH Holdings, Inc. and its subsidiaries, including the HMO in the transaction. Effective January 1, 2018, the HMO and another Magellan subsidiary, AlphaCare of New York, Inc. ("AlphaCare") were merged. The HMO is the surviving entity, and AlphaCare no longer exists.

The following chart, in part, depicts the HMO's reporting of the relationship with members of its holding company system as of December 31, 2017.



Description of Ownership as of December 31, 2017

Senior Health Holdings, LLC ("SHH-LLC") was organized as a holding company for Senior Health Holdings, Inc. ("SHH-INC"). SHH-INC is the immediate parent company of the HMO and Senior Whole Health, LLC, a Delaware LLC, was organized to provide Medicare and Medicaid benefits in Massachusetts.

Senior Health Holdings, LLC ("SHH-LLC")

SHH-LLC was organized on September 25, 2006 as a limited liability company. SHH-LLC's principal business activities include: (i) acting as a direct holding company for Senior Health Holdings, Inc. and Senior Whole Health Management, Inc. and (ii) providing capital indirectly to Senior Whole Health of New York, Inc., via Senior Health Holdings, Inc.

Senior Health Holdings, Inc. ("SHH-INC")

SHH-INC, initially organized on April 30, 2004 as a limited liability company. On October 18, 2004, SHH-INC reorganized to a Delaware corporation. As its principal business activity SHH-INC acts as a direct holding company for Senior Whole Health, 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 limited liability company. SWH-LLC's principal business activity is providing health care that expands the provisions of Medicaid and Medicare managed care services to the elderly population in Massachusetts. Such managed care services are provided under a Senior Care Organization contract with Centers for Medicare and Medicaid in partnership with the Commonwealth of Massachusetts.

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

SWH-MGT was incorporated on September 29, 2006. Its principal business function is to provide administrative and management services to SWH-LLC and Senior Whole Health of New York, Inc. by entering into Outsourced Service agreements and Equipment and Personnel Lease agreements with the aforementioned affiliates.

At December 31, 2017, the HMO had the following inter-company agreements in effect with SWH-MGT:

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, and provider credentialing, etc. Reimbursement is on an allocated 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 October 1, 2011, was filed with the New York State Department of Health ("DOH") and approved on May 30, 2013. This agreement was effective as of June 12, 2013, for a five-year term.

Equipment and Personnel Lease 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 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 invoiced charges paid monthly.

This initial agreement, effective October 1, 2006, was approved by DOH on August 17, 2006. The Department accepted the initial agreement. On June 2, 2009, DOH approved an amendment to the agreement. The amended agreement became effective on June 19, 2009.

Consolidated Tax Allocation Agreement

This agreement was executed on September 5, 2006 between the HMO and its immediate parent, Senior Health Holdings, Inc. ("SHH-INC"). SHH-INC and its subsidiaries, the HMO and Senior Whole Health, LLC, agreed to the filing of a consolidated Federal income tax return by SHH-INC. This agreement was submitted to DOH with the HMO's initial application for a Certification of Authority and was approved by DOH on August 17, 2006. The Department accepted the original agreement on November 8, 2008.

E. Significant Operating Ratios

The following ratios have been computed, as of December 31, 2017, based upon the results of this examination. The ratios presented below are on an earned-incurred basis and encompass the three-year period covered by this examination:

	Amount	Ratio
Claims	$ 696,053,132	88.00%
Claims adjustment expenses	8,571,201	1.10%
General administrative expenses	58,364,279	7.40%
Net underwriting gain	27,916,324	3.50%
Premiums earned	$ 790,904,936	100.00%

F. Abandoned Property Law

Section 1316 of the New York Abandoned Property Law states in part:

> "1. Any amount issued and payable …to a resident of this state on or because of a policy of insurance other than life insurance shall be deemed abandoned property if unclaimed for three years by the person entitled thereto. Such abandoned property shall be reported to the comptroller on or before the first day of April in each succeeding year."
>
> 2. Every insurer shall cause to be published, on or before the first day of May in each year, 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.
>
> 3. Such property…shall be paid or delivered to the comptroller within the first day of September of each year…"

During the examiner's review of cash, it was noted that numerous unclaimed checks of three years or older were listed on the December 31, 2017 cash reconciliation of the HMO's checking account. The HMO's abandoned property reports for the period under examination were requested to determine compliance with the filing requirements of Section 1316 of the New York Abandoned Property Law. SWH was unable to provide the examiner with the applicable abandoned property filings.

It is recommended that the HMO comply with the requirements of Section 1316 of the New York Abandoned Property Law by filing the requisite abandoned property reports with the Office of the New York Comptroller.

It is also recommended that the HMO comply with the requirements of Section 1316 of the New York Abandoned Property Law by annually publishing a list of names with the last known addresses of the persons appearing to be entitled to such abandoned property.

It is further recommended that the HMO file proof of such publication with the Office of the State Comptroller.

G. Disaster Response Plan

Circular Letter No. 5 (2017) states, in part:

> "By June 16, 2017, each addressee must submit to the Department a disaster response plan, a response to the disaster response plan questionnaire, and a response to the business continuity plan questionnaire, pursuant to Insurance Law § 308. The electronic templates for the disaster response plan and business continuity plan questionnaires, and instructions for their completion and submission, are available at http://www.dfs.ny.gov/insurance/iindx.htm#dpr. An addressee should report to the Department as soon as possible any change in the information requested by submitting an updated response to the disaster response plan or business continuity plan questionnaire.
>
> When submitting a disaster response plan, an addressee must document that the disaster response plan was approved by the relevant board of directors, or appropriate committee thereof or, if there is no board of directors, then the governing body. If the current disaster response plan is the same as the last plan filed with the Department, then an addressee need not submit the plan again. Instead, the addressee must submit a statement indicating that the previously filed disaster response plan is still in effect."

It was noted that the HMO failed to file a Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire with the Department as required by Insurance Circular Letter No. 5 (2017).

It is recommended that the HMO complete and file a Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire with the Department, as required by Insurance Circular Letter No. 5 (2017).

A similar recommendation was made in the prior report on exam.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and capital and surplus as of December 31, 2017, as contained in the HMO's 2017 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review.

PricewaterhouseCoopers LLP ("PwC") was retained by the HMO to audit the HMO's statutory basis statements of financial position as of December 31st of the years 2015 and 2016 and Ernst and Young LLP, ("E&Y") was retained to audit the HMO as of December 31st of 2017, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended.

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

A. Balance Sheet

Assets	
Cash and short-term investments	$ 84,876,417
Investment income due and accrued	11,448
Uncollected premiums in course of collection	10,824,326
Accrued retrospective premiums	648,878
Other amounts receivable under reinsurance contracts	14,278
Net deferred tax asset	2,502,376
Amounts receivable relating to uninsured plans	53,880
Health care and other amounts receivable	98,827
Aggregate write-ins for other than invested assets	(424,496)
Total assets	$ 98,605,934

Liabilities	
Claims unpaid	$ 43,508,615
Unpaid claims adjustment expenses	250,162
Premiums received in advance	7,284,970
General expenses due or accrued	11,210,961
Current and foreign income tax payable	569,758
Amounts due to parent, subsidiaries and affiliates	1,455,917
Liability for amounts held under uninsured plans	170,969
Total liabilities	$ 64,451,352

Capital and Surplus	
Aggregate write-ins for special surplus funds	$ 120,457
Common capital stock	1,000
Gross paid-in and contributed surplus	41,980,725
Aggregate write-ins for other than special surplus funds	20,611,688
Unassigned funds (surplus)	(28,559,288)
Total capital and surplus	$ 34,154,582
Total liabilities, capital and surplus	$ 98,605,934

Note: The Internal Revenue Service has not conducted any audits of the federal income tax return filed on behalf of the HMO through tax year 2017. The examiner is unaware of any potential exposure of the HMO to any tax assessments, and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased $28,531,838 during the three-year examination period, January 1, 2015 through December 31, 2017, detailed as follows:

Revenue		
Premium	$ 790,904,936	
Total revenue		$ 790,904,936
Expenses		
Hospital/medical benefits	$ 613,055,753	
Other professional services	35,579,431	
Outside referrals	405	
Emergency room and out-of-area	542,003	
Prescription drugs	4,270,745	
Aggregate write-ins for other hospital and medical	42,644,368	
Claims adjustment expenses	8,571,201	
General administrative expenses	58,364,279	
Net reinsurance recoveries	(39,573)	
Total underwriting deductions		762,988,612
Net underwriting gain		$ 27,916,324
Net investment income earned		82,177
Federal and foreign income taxes incurred		569,758
Net income		$ 27,428,743

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination, as of December 31, 2014			$ 5,622,744
Net income	$ 27,428,743		
Change in net deferred income tax	2,523,750		
Change in non-admitted assets	0	$ 1,420,655	
Net gain in capital and surplus			$ 28,531,838
Capital and surplus, per report on examination, as of December 31, 2017			$ 34,154,582

4. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at the practices of the HMO in the following major areas:

A. Record Retention Policy
B. Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services ("Prompt Pay Law")

A. Record Retention Policy

During the examination period, the HMO did not maintain complaint records forwarded from the Department's Consumer Assistance Unit. This is not in compliance with Part 243.2(b)(6) of Insurance Regulation No. 152 (11 NYCRR 243.2), which states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
> "(6) A complaint record required to be maintained under chapter IX of this Title for six calendar years after all elements of the complaint are resolved and the file is closed."

The above-mentioned regulation requires the HMO to maintain complaint records for six (6) calendar years after the resolution of all the elements of the complaint, and the file is closed. The maintenance of proper records and processes help generate the flow of timely, relevant and reliable information from within and outside the organization.

It is recommended that the HMO comply with Part 243.3(b)(6) of Insurance Regulation No. 152 by maintaining all complaint records for six calendar years after all elements of the complaints are resolved and the file has been closed.

B. Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services ("Prompt Pay Law")

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt of a claim that is transmitted via the internet or electronic mail or 45 days of receipt of a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

In a case where the obligation of an insurer is not reasonably clear the insurer shall (1) pay any undisputed portion of the claim and notify the policyholder, covered person or health care provider, in writing, within 30 calendar days of the receipt of the claim that it is not obligated to pay the claim in whole or in part, stating the specific reasons why it is not liable; or (2) request all additional information needed to determine liability to pay the claim or make the health care payment.

Section 3224-a(a) of the New York Insurance Law states in part:

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article … forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

In addition, Section 3224-a(c)(1) of the New York Insurance Law states:

> "(c)(1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim."

A review was also performed as to the manner in which the HMO handled the denial of its claims.

Section 3224-a(b) of the New York Insurance Law states:

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:(1) that it is not obligated to pay

> the claim or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section."

A statistical sample of claims not adjudicated within 30 days of receipt for claims transmitted via the internet or electronic mail, or paid within 45 days of receipt for claims submitted by other means such as paper or a facsimile by the HMO was reviewed by the examiner to determine whether the claims were processed in compliance with the timeframe requirements of Section 3224-a(a) and 3224-(a)(b) of the New York Insurance Law ("NYIL"), and, if interest was required and appropriately paid pursuant to Section 3224-a(c)(1) of the NYIL. Accordingly, all claims that were not adjudicated within the respective 30/ 45 day time frames during the period, January 1, 2017 through December 31, 2017, were segregated for review.

The review found 115,659 dual-eligible (Medicare and Medicaid) claims of which 5,969 claims took longer than forty-five (45) / thirty (30) days to pay, or longer than thirty (30) days to deny. A statistical sample of 167 claims was selected from this population for review.

The chart below shows the number of violations from the sample which were then extrapolated to the population of claims used for the sample as described above.

The following chart illustrates the HMO's compliance with the Prompt Pay Law, as determined by this examination:

Summary of Violations of Sections 3224-a(a) and (b)of the New York Insurance Law

Total dual eligible claims population	115,659
Population of claims paid after 30/ 45 days or denied after 30 days of receipt	5,969
Sample size	167
Number of claims with violations	158
Calculated violation rate	**94.61%**
Lower violation limit	98.04%
Upper violation limit	91.19%
Calculated claims in violation	**5,647**
Lower limit transactions in violation	5,852
Upper limit transactions in violation	5,443

Note: The lower and upper violation limits represent the range of potential error (e.g., if 100 samples were selected, the rate of error would fall between these limits 95 times).

It is recommended that the HMO pay, deny or request additional information on claims where its obligation to pay is unclear within the time frame requirements of Section 3224-a(a) and (b) of the New York Insurance Law.

A similar recommendation was cited in the prior report on examination.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2014, contained the following nine (9) recommendations (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Corporate Governance	
1.	It is recommended that the HMO comply with Section 312(b) of the New York Insurance Law by requiring each member of the board of directors to sign a statement, which shall be retained in the insurer's files, confirming that such board member received and read the prior report on examination issued by the Department. *Subsequent to the examination date, the HMO provided signed statements from each board member confirming they have received and read the Department's issued prior report on examination, as required of Section 312(b) of the New York Insurance Law.* *The HMO failed to comply with the above recommendation during the exam period under review. A similar recommendation is contained herein.*	6
	Internal Audit	
2.	As a best business practice, it is recommended that the HMO ensures that its board members periodically review the requirements for an internal audit function and document their decision in their meeting minutes. *The HMO will continue to periodically review the requirements for an internal audit function and maintain documentation of such review. As of October 31, 2017, Magellan Health (Magellan) acquired the Company's ultimate parent company, SWH Holdings, Inc. and its subsidiaries which includes the Company. As such, the Company will be subject to review of Magellan's internal audit function.* *The HMO has complied with this recommendation.*	7

ITEM NO. **PAGE NO.**

Internal Audit-Cont'd.

3\. It is also recommended, in the event that the HMO establishes an internal audit function, such internal audit function be maintained under the direct supervision of the audit committee, with administrative reporting to management. — 7

The HMO will continue to periodically review the requirements for an internal audit function and maintain documentation of such review. As of October 31, 2017, Magellan Health (Magellan) acquired the Company's ultimate parent company, SWH Holdings, Inc. and its subsidiaries which includes the Company. As such, <u>Company will be subject to review of Magellan's internal audit function.</u>

The HMO has complied with this recommendation.

4\. It is further recommended that the HMO's audit committee should take the responsibility of reviewing the internal audit director's performance and compensation. — 7

The HMO will continue to periodically review the requirements for an internal audit function and maintain documentation of such review. As of October 31, 2017, Magellan Health (Magellan) acquired the Company's ultimate parent company, SWH Holdings, Inc. and its subsidiaries which includes the Company. As such, the Company will be subject to review of Magellan's internal audit function.

The HMO has complied with this recommendation.

Disaster Response Plan

5\. It is recommended that the HMO complete and file the Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire with the Department, as required by Insurance Circular Letter No. 4 (2015). — 11

Subsequent to the due date of June 1, 2015, the HMO submitted to the Department its Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire.

The HMO has complied with this recommendation.

ITEM NO.		PAGE NO.
	Holding Company System	
6.	It is recommended that if there is a change in control of the HMO, the potential controlling person and the HMO obtain approval from DOH prior to the implementation of such control change, as required by 10 NYCRR 98-1.9(a).	12
	The HMO has complied with this recommendation.	
	Record Retention Policy	
7.	It is recommended that the HMO establish and maintain a record retention policy, as required by Part 243.3(c) of Insurance Regulation No. 152 (11 NYCRR 243.3(c)).	21
	The HMO has complied with this recommendation.	
	Prompt Pay Law	
8.	It is recommended that the HMO comply with Section 3224-a(a) of the New York Insurance Law by making appropriate payment of all claims within the time frames prescribed by the aforementioned section of the Insurance Law.	25
	The HMO has not complied with this recommendation. A similar recommendation was included in the prior report on examination.	
9.	It is recommended that the HMO takes step to ensure compliance with Section 3224-a(b) of the New York Insurance Law.	26
	The HMO has not complied with this recommendation. A similar recommendation was included in the prior report on examination.	

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Corporate Governance	
	It is recommended that the HMO comply with Section 312(b) of the New York Insurance Law by requiring each member of its board of directors to sign a statement, which shall be retained in the HMO's files, confirming that such board member received and read the prior report on examination issued by the Department.	6
	Subsequent to the examination date, the HMO provided signed statements from each board member confirming they have received and read the Department's issued prior report on examination, as required of Section 312(b) of the New York Insurance Law.	
B.	Abandoned Property	
i.	It is recommended that the HMO comply with the requirements of Section 1316 of the New York Abandoned Property Law by filing the requisite abandoned property reports with the Office of the New York Comptroller.	13
ii.	It is also recommended that the HMO comply with the requirements of Section 1316 of the New York Abandoned Property Law by annually publishing a list of names with the last known addresses of the persons appearing to be entitled to such abandoned property.	13
iii.	It is further recommended that the HMO file proof of such publication with the Office of the State Comptroller.	13
C.	Disaster Response Plan	
	It is recommended that the HMO complete and file the Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire with the Department, as required by Insurance Circular Letter 5 (2017).	14
D.	Record Retention Policy	
	It is recommended that the HMO comply with Part 243.3(b)(6) of Insurance Regulation No. 152 by maintaining all complaint records for six calendar years after all elements of the complaints are resolved and the file has been closed.	19

ITEM		PAGE NO.
E.	Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services ("Prompt Pay Law")	
	It is recommended that the HMO pay, deny or request additional information on claims where its obligation to pay is unclear within the time frame requirements of Section 3224-a(a) and (b) of the New York Insurance Law.	22

Respectfully submitted,

____

Victor Estrada
Senior Insurance Examiner

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

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

____

Victor Estrada

APPOINTMENT NO. **31806**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

*I, **MARIA T. VULLO**, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Victor Estrada

as a proper person to examine the affairs of

Senior Whole Health of New York, Inc.

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

HMO

with such other information as he shall deem requisite.

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

this 24th day of August, 2018

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau