REPORT ON EXAMINATION
OF
HEALTHNOW NEW YORK INC.
AS OF

DECEMBER 31, 2018

EXAMINER:	**OCTOBER 3, 2022**
DATE OF REPORT:	**SCOTT R. KALNA, CFE**

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October 3, 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 acting in accordance with the instructions contained in Appointment No. 31997, dated August 23, 2019, and annexed hereto, I have made an examination into the financial condition and affairs of HealthNow New York, Inc., a not-for-profit health service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2018, and respectfully submit the following report thereon.

The examination was conducted at the home office of HealthNow New York, Inc. located at 257 West Genesee Street, Buffalo, New York.

Wherever the designations "Plan" or "HealthNow" appear herein, without qualification, they should be understood to indicate HealthNow 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

The previous examination of HealthNow was conducted as of December 31, 2013. This examination of HealthNow was a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2019 Edition* ("the Handbook") and covered the five-year period January 1, 2014 through December 31, 2018. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate, by the examiner, transactions occurring subsequent to December 31, 2018 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 HealthNow's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate HealthNow's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Plan.

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 HealthNow's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination

evaluated HealthNow'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 HealthNow'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

HealthNow was audited annually, for the years 2014 through 2018, by the accounting firm of Deloitte & Touché LLP ("Deloitte"). HealthNow received an unmodified opinion in each of those years. Certain audit work papers of Deloitte were reviewed and relied upon in conjunction with this examination. A review was also conducted of the Internal Audit and Enterprise Risk Management programs, as they relate to HealthNow.

The examiner reviewed the corrective actions taken by the Plan with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiners' review are contained in Item 6 of this report.

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

A separate market conduct examination was conducted as of December 31, 2018, to review the manner in which the Plan conducted its business practices and fulfilled its contractual obligations to policyholders and claimants. A separate report on examination was issued thereon.

2. DESCRIPTION OF THE PLAN

HealthNow New York Inc. is a not-for-profit health service corporation organized under the provisions of the Membership Corporation Law and Article 43 of the New York Insurance Law. The Plan was incorporated in the State of New York on September 9, 1939, and commenced business on March 15, 1940. The Plan is a 100% controlled subsidiary of HealthNow Systems, Inc. ("HNS"), a New York non-profit corporation and a non-operating holding company. HNS is the sole member of the Plan.

The Plan established operations in the Albany, New York area as a separate division pursuant to its merger with Whole Health Insurance Network Inc. on December 30, 1992. Concurrent with the date of the merger, through May 1, 1996, the Plan operated under the corporate name, Blue Cross and Blue Shield of Western New York, Inc. The Plan subsequently effected name changes to New York Care Plus Insurance Company and its present name of

HealthNow New York Inc., on May 2, 1996, and October 1, 1998, respectively.

The Plan, as of December 31, 2008, operated under the names of BlueCross and BlueShield of Western New York, within its Western New York division, HealthNow New York Inc., within its Central New York division, and BlueShield of Northeastern New York, within its Eastern New York division. On August 1, 1985, the Plan began the operations of Community Blue, a health maintenance organization authorized pursuant to Article 44 of the New York Public Health Law. Community Blue, an independent practice association model health maintenance organization, functions as a line of business of the Plan. The Plan's health maintenance operations are marketed under the name "Community Blue" in the Buffalo, New York area and under the name "HealthNow" in the Albany, New York area.

A. Management and Controls

1. Corporate Governance

Pursuant to the Plan's charter and by-laws, management of HealthNow is to be vested in a Board of Directors consisting of not less than ten (10) nor more than twenty-one (21) members, with the exact number of directors fixed by HealthNow Systems, Inc.

As of December 31, 2018, HealthNow's Board of Directors consisted of the following twelve (12) members:

Name and Residence	Principal Business Affiliation
Employee Director	
David W. Anderson Buffalo, New York	President and Chief Executive Officer, HealthNow New York, Inc.

Name and Residence	Principal Business Affiliation
Provider Representatives	
James K. Reed, M.D. Cohoes, New York	President and Chief Executive Officer, St. Peter's Health Partners
Willie Underwood, III, M.D. Buffalo, New York	Associate Professor, Urology and Cancer Prevention, Roswell Park Cancer Institute
Public Representatives	
Gene E. Burleson Atlanta, Georgia	Retired
Jon J. Cooper East Aurora, New York	Retired Chief Executive Officer, Champlain National Bank
Craig A. Duncan Averill Park, New York	Retired
Thomas J. Hook* Frisco, Texas	Chief Executive Officer, Q Holdings
Dennis M. Penman Orchard Park, New York	Owner, Penman Development Partners LLC
Subscriber Representatives	
Gwendolyn O. Acrara Buffalo, New York	President, Executive Dimensions, Inc.
Robert B. Fleming, Jr., Esq. Buffalo, New York	Partner, Hodgson Russ LLP
June W. Hoeflich Williamsville, New York	Retired
Karen L. Howard Snyder, New York	Executive Vice President, Kei Advisors

*Thomas J. Hook is Chairman of HealthNow's Board of Directors

A review of the minutes of HealthNow's Board of Directors' meetings, held during the period under examination, revealed that the meetings were well attended, with all directors attending more than one-half of the meetings they were eligible to attend.

It was noted that the composition of HealthNow's Board of Directors was in compliance with the requirements of Section 4301(k)(1) of the New York Insurance Law throughout the examination period.

As of December 31, 2018, the principal officers of HealthNow were as follows:

Name	Title
David W. Anderson	President and Chief Executive Officer
Stephen T. Swift, CPA	Executive Vice President, Chief Financial Officer
Jared M. Gross, FSA, MAAA	Senior Vice President, Enterprise Initiatives and Analytics
David Busch	Senior Vice President, Chief Sales Officer
Michael J. Edbauer, DO	Senior Vice President, Chief Strategy Officer
Christopher M. Leardini, CPA	Senior Vice President, Operations
Ronald Mornelli	Senior Vice President, Chief Network Officer
Douglas Parks	Senior Vice President, Chief Human Resources Officer
Thomas E. Schenk, MD	Senior Vice President, Chief Medical Officer

2. Enterprise Risk Management ("ERM")

In addition to utilizing the NAIC Model Audit Rule ("MAR") and Own Risk Solvency Assessment ("ORSA"), the Plan developed an ERM framework. ERM oversight falls under the Plan's Audit Committee. Pursuant to the Audit Committee Charter, the Audit Committee will:

- Oversee senior managements establishment of an ERM framework and assess its effectiveness.
- Review the Plans ERM charter, policies and procedures for assessing and managing exposures, and will be familiar with the corporations risk culture, governance, risk identification, prioritization, risk appetite, risk tolerance, risk management, controls, communication and accountability.

- Oversee the Plans risk management function to ensure that the function is staffed and resourced at an appropriate level, and that senior management carries out its risk management responsibilities effectively.
- Review the Plans portfolio of risks focusing on risks applicable to the committees responsibilities and subject matter expertise, as defined in the committee work plan and respective risk information/scorecards produced by management and consider them against the Plans strategy, guiding principles, risk appetite framework, and risk tolerances.

The Executive Leadership Team, comprised of the President and Chief Executive Officer, Chief Financial Officer, all Senior Vice Presidents, and the Vice President of Corporate Relations, is responsible for identifying and managing risks that can impact the ability of their area, or HealthNow, to achieve its objectives. The Senior Vice President and Chief Strategy Officer is responsible for the ERM program and the ORSA filings. It was noted that the Audit Committee approved the ERM reports that were presented to the Committee at the meetings.

3. Internal Audit Department ("IAD")

HealthNow outsourced the Internal Audit function to Freed Maxick, CPAs, P.C. for the examination period 2014 through 2017. During 2018, HealthNow transitioned the Internal Audit function in-house and by January 2019 the IAD was fully in-house. The IAD function has no scope restrictions, is independent of management, and reports to the Audit Committee of the Board of Directors.

During the course of this examination, consideration was given to the significance and potential impact of certain IAD findings. To the extent possible, the examiners relied upon the work performed by the IAD, as prescribed by the Handbook.

The IAD meets with the Audit Committee five (5) times per year. Once a year, the Chief Audit Executive presents the internal audit plan to the Audit Committee for review and approval.

During the remaining Audit Committee meetings, the IAD presents updates to the Audit Committee relating to the status of internal audits being conducted or completed.

B. Territory and Plan of Operation

HealthNow is a not-for-profit health service corporation licensed under the provisions of Article 43 of the New York Insurance Law. HealthNow also operates under the authority of Article 44 of the Public Health Law as a health maintenance organization ("HMO"). HealthNow is licensed to do business in thirty-two (32) counties within New York State.

Buffalo Division

The Buffalo division, doing business as BlueCross and BlueShield of Western New York, conducted business within the following eight (8) counties of New York State:

Allegany	Cattaraugus	Chautauqua	Erie
Genesee	Niagara	Orleans	Wyoming

Albany Division

The Albany division, doing business as BlueShield of Northeastern New York, conducted business within the following thirteen (13) counties of New York State:

Albany	Clinton	Columbia	Essex	Fulton
Greene	Montgomery	Rensselaer	Saratoga	Schenectady
Schoharie	Warren	Washington		

The Albany division was acquired by the Plan through the merger with Whole Health Insurance Network Inc. on December 30, 1992.

Central New York Division

The Central New York division, doing business as HealthNow, operates in the following eleven (11) counties of New York State:

Cayuga	Chemung	Cortland	Livingston	Monroe
Onondaga	Ontario	Oswego	Schuyler	Tompkins
Wayne				

Binghamton Division

The Plan operates the Upstate Medical Division in Binghamton, New York. This division, acquired through the merger with Whole Health Insurance Network Inc., is used solely for the administration of the Plan's Medicare Part B contract. In accordance with a contract with the Centers for Medicare and Medicaid Services, the Plan processes Medicare Part B claims for Medicare recipients in forty-five (45) counties of New York State. The Plan is reimbursed for all administrative costs, in accordance with certain guidelines, in connection with this program.

The following table displays HealthNow's net admitted assets, capital and surplus, net premium income and net income during the years under examination:

	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income
2014	$1,041,284,147	$486,538,550	$2,462,198,309	$ (53,204,297)
2015	1,037,761,658	544,447,512	2,254,845,435	63,816,849
2016	1,062,288,003	541,465,413	2,313,825,356	4,220,596
2017	1,072,495,239	611,746,575	2,485,520,505	54,946,404
2018	1,113,326,232	624,623,850	2,652,249,710	47,038,980

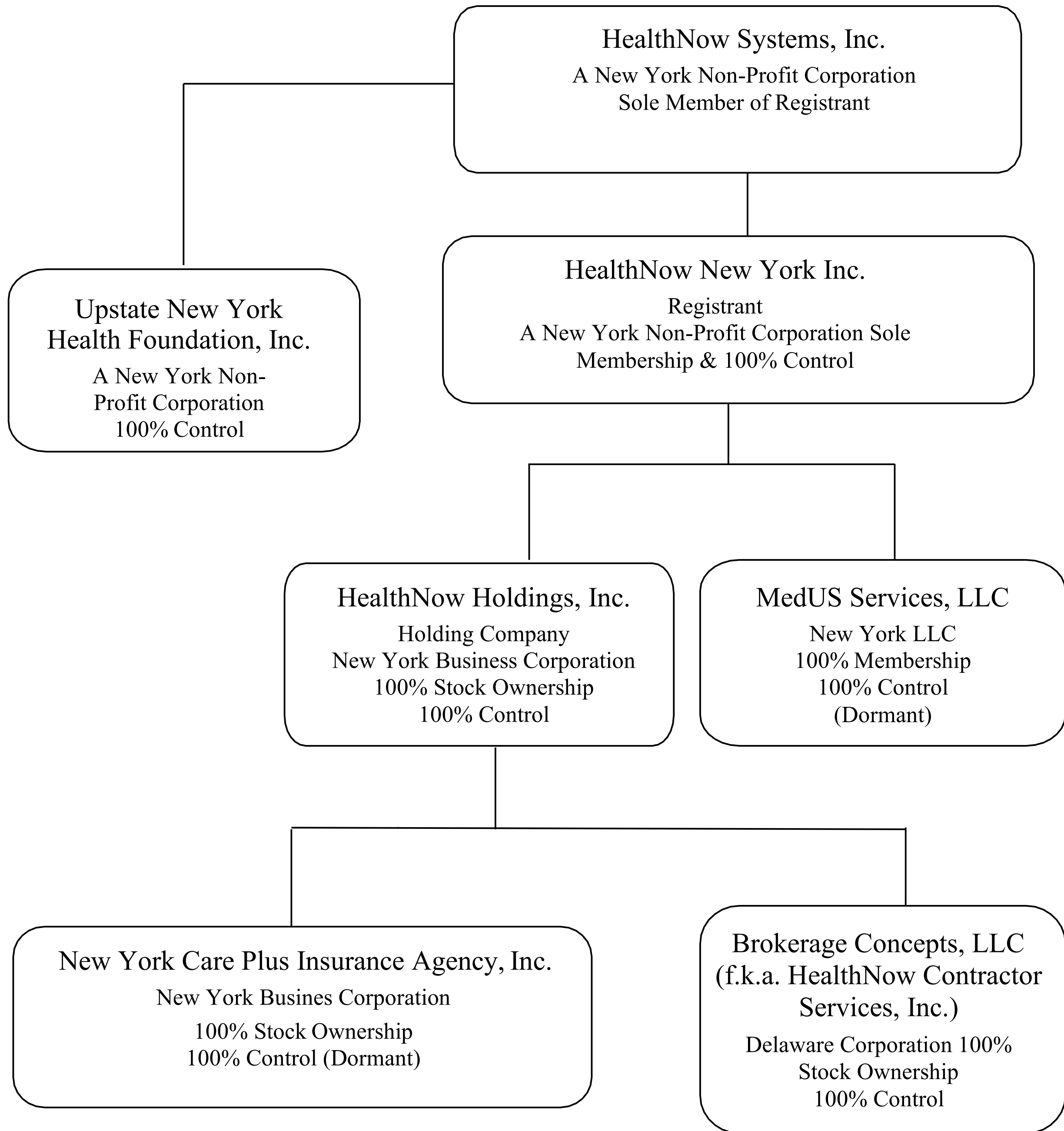
As of December 31, 2018, the Plan provided health care services to 402,277 members. The following chart shows annual memberships changes during the examination period by number and percentage.

	2013	2014	2015	2016	2017	2018
Members	457,869	428,856	398,949	391,898	397,955	402,277
Change (%)	——	(6.34%)	(6.97%)	(1.77%)	1.55%	1.09%

C. Holding Company System

As a member of a holding company system, HealthNow is required to file registration statements pursuant to Article 15 of the New York Insurance Law and Insurance Regulation No. 52 (11 NYCRR 80). All required filings made during the examination period, regarding the aforementioned statute and regulation were reviewed. No problem areas were noted.

An organizational chart depicting the relationship between HealthNow and significant entities in its holding company system as of December 31, 2018 is as follows:



HealthNow Systems, Inc.
A New York Non-Profit Corporation
Sole Member of Registrant
Upstate New York
Health Foundation, Inc.
A New York Non-
Profit Corporation
100% Control
HealthNow New York Inc.
Registrant
A New York Non-Profit Corporation Sole
Membership & 100% Control
HealthNow Holdings, Inc.
Holding Company
New York Business Corporation
100% Stock Ownership
100% Control
MedUS Services, LLC
New York LLC
100% Membership
100% Control
(Dormant)
New York Care Plus Insurance Agency, Inc.
New York Busines Corporation
100% Stock Ownership
100% Control (Dormant)
Brokerage Concepts, LLC
(f.k.a. HealthNow Contractor
Services, Inc.)
Delaware Corporation 100%
Stock Ownership
100% Control

As of the examination date, HealthNow maintained agreements with affiliated entities for administrative services and tax sharing. Inter-company agreements and amendments for HealthNow that were in place as of December 31, 2018, included the following:

- **Administrative Services Agreement:** This agreement, made between HealthNow and Brokerage Concepts, Inc., requires HealthNow to provide specified administrative services, including legal, internal audit, office space, and human resources to Brokerage Concepts, Inc., and for Brokerage Concepts, Inc. to provide third-party administration services relative to HealthNow's Administrative Services Only business.

  Fees relative to services provided by HealthNow to Brokerage Concepts, Inc. were made on a cost basis, which included an allocation methodology for shared expenses. Such payment methodology was based on a "no-gain" and "no-loss" basis. For services provided by Brokerage Concepts, Inc. to HealthNow, such payments were made according to agreed upon fees for individual tasks. This agreement was approved by the Department on April 11, 2013.

- **Tax Allocation Agreement**: HealthNow is party to a federal income tax allocation agreement with its Parent, HealthNow Systems, Inc. and its subsidiaries HealthNow Holdings, Inc. and Brokerage Concepts, Inc. The agreement provided for a federal income tax allocation methodology, which was in compliance with Department Circular Letter No. 33 (1979). This agreement was approved by the Department.

D. Significant Operating Ratios

The Plan's operating ratios, for the examination period January 1, 2014, through December 31, 2018, were as follows:

	Amounts	Ratios
Claims (expenses incurred)	$10,642,591,017	87.75%
Claim adjustment expenses	$ 372,509,699	3.07%
General administrative expenses	$ 1,200,055,877	9.89%
Increase in reserves for health	$ (47,900,000)	(0.39)%
Net underwriting loss	$ (38,517,516)	(0.32)%
Premium earned	$12,128,739,077	100.00%

The underwriting results presented above are on an earned / incurred basis and encompass the five-year period covered by this examination.

E. Medical Loss Ratio Review

HealthNow's 2017 Medical Loss Ratio ("MLR") Annual Reporting Form for the state of New York was examined to assess compliance with the requirements of Title 45 of the Code of Federal Regulations ("CFR"), Part 158, which implements Section 2718 of the Public Health Service Act ("PHS Act"). Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance companies to submit to the Secretary of the U.S. Department of Health and Human Services ("HHS"), an annual report on their MLRs. The MLR is the proportion of premium revenue expended by a company on clinical services and activities that improve health care quality in a given market. Section 2718 of the PHS Act also requires a company to provide rebates to consumers if it does not meet the MLR standard (82% in the New York individual and small group markets, 85% in the New York large group market, and 80% in the student health plans market).

This is the first examination of the Plan's MLR Annual Reporting Form performed by the Department. This examination of the Plan's 2017 MLR Annual Reporting Form covered the reporting period January 1, 2015, through December 31, 2017, including 2015, 2016 and 2017 experience and claims run-out through March 31, 2018.

The examination was conducted in accordance with the NAIC's MLR Examination Reporting Instructions and its 24 MLR Agreed Upon Procedures ("MLR AUPs"). The MLR AUPs set forth the procedures for performing an examination to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Annual Reporting Form, and the accuracy and timeliness of any rebate payments, if applicable. The examination included assessing the principles used and significant estimates made by the Plan, evaluating the reasonableness of expense allocations, and determining compliance with relevant statutory accounting standards, MLR regulations and guidance, and the MLR Annual Reporting Form Filing Instructions.

Title 45 CFR Section 158.110(b) requires that a report for each MLR reporting year be submitted to the Secretary of HHS by July 31st. of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary of HHS. Based on the examiners' review, the 2017 MLR Annual Reporting Form filed by the Plan contains some elements that are not fully compliant with the requirements of Title 45 CFR Section 158, as more fully described in the sections below.

Title 45 CFR Sections 158.210 (a), (b) and (c) require that an issuer must provide a rebate to enrollees if the issuer has an MLR below the required amount (82% in the New York individual and small group markets and 85% in the New York large group market, and 80% in the student health plans market).

The Plan's three-year aggregate numerator and denominator for each market, along with the resulting credibility-adjusted MLR and rebate obligation, for the 2017 MLR Annual Reporting Form, as adjusted during the examination, are shown in the following table:

MLR Components	Individual Market		
	Filed	**Exam**	**Recalculated**
Adjusted Incurred Claims	$ 170,448,044	$(3,442,726)	$167,005,318
Plus: Quality Improvement Expenses	$ 1,731,530	$ (222,695)	$ 1,508,835
Less: Cost-sharing reductions	$ 1,523,374	$ 0	$ 1,523,374
Less: Federal Transitional Reinsurance Program payments expected from HHS	$ 6,815,299	$ 0	$ 6,815,299
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$ 26,417,323	$ 4,797,914	$ 31,215,237
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	$0
MLR Numerator	**$137,423,578**	**$(8,463,335)**	**$128,960,243**
Premium Earned	$130,928,466	$ 0	$130,928,466
Less: Federal and State Taxes and Licensing/Regulatory Fees	$ 2,285,887	$(3,106,295)	$ (820,408)
MLR Denominator	**$128,642,579**	**$ 3,106,295**	**$131,748,874**
Preliminary MLR	106.8%		97.9%
Credibility Adjustment	1.6%	0.0%	1.6%
Credibility–Adjusted MLR	**108.4%**	**(9.0)%**	**99.5%**
MLR Standard Rebate Amount	82%		82%
Rebate Amount	**$0**	**$0**	**$0**

MLR Components	Small Group Market		
	Filed	Exam	Recalculated
Adjusted Incurred Claims	$968,466,580	$(15,868,058)	$952,598,522
Plus: Quality Improvement Expenses	$ 11,944,811	$(1,529,914)	$ 10,414,897
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$ 18,447,540	$ 2,930,620	$ 21,378,160
Less: Federal Risk Corridors Program net payments (charges)	$ 0	$ 0	$ 0
MLR Numerator	**$961,963,851**	**$(20,328,592)**	**$941,635,259**
Premium Earned	$1,057,133,455	$ 0	$1,057,133,455
Less: Federal and State Taxes and Licensing/Regulatory Fees	$ 18,628,522	$(8,359,826)	$ 10,268,696
MLR Denominator	**$1,038,504,933**	**$ 8,359,826**	**$1,046,864,759**
Preliminary MLR	92.6%		89.9%
Credibility Adjustment	0.0%	0.0%	0.0%
Credibility–Adjusted MLR	**92.6%**		**89.9%**
MLR Standard	82%		82%
Rebate Amount	**$0**	**$0**	**$0**

MLR Components	Large Group Market		
	Filed	Exam	Recalculated
Adjusted Incurred Claims	$2,876,359,015	$(44,038,096)	$2,832,320,919
Plus: Quality Improvement Expenses	$19,625,193	$ (1,263,614)	$ 18,361,579
MLR Numerator	**$2,895,984,208**	**$(45,301,710)**	**$2,850,682,498**
Premium Earned	$3,391,514,565	$ 0	$3,391,514,565
Less: Federal and State Taxes and Licensing/Regulatory Fees	$ 103,278,642	$(7,507,208)	$ 95,771,434
MLR Denominator	**$3,288,235,923**	**$ 7,507,208**	**$3,295,743,131**
Preliminary MLR	88.1%		86.5%
Credibility Adjustment	0.0%	0.0%	0.0%
Credibility–Adjusted MLR	**88.1%**	**(1.6)%**	**86.5%**
MLR Standard	85%		85%
Rebate Amount	**$0**	**$0**	**$0**

MLR Components	Student Health Plans Market		
	Filed	**Exam**	**Recalculated**
Adjusted Incurred Claims	$16,550,915	$(1,992,573)	$14,558,342
Plus: Quality Improvement Expenses	$ 129,948	$ (2,288)	$ 127,660
MLR Numerator	**$16,680,863**	**$(1,994,861)**	**$14,686,002**
Premium Earned	$18,410,126	$ 0	$18,410,126
Less: Federal and State Taxes and Licensing/Regulatory Fees	$ 945,680	$ (796,502)	$ 149,178
MLR Denominator	**$17,464,446**	**$ 796,502**	**$18,260,948**
Preliminary MLR	95.5%		80.4%
Credibility Adjustment	2.6%	0.0%	2.6%
Credibility–Adjusted MLR	**98.2%**	**(15.1)%**	**83.1%**
MLR Standard	80%		80%
Rebate Amount	**$0**	**$0**	**$0**

1. <u>Market Classification</u>

According to Title 45 CFR Section 158.103, the applicable definitions of individual market, small group market and large group market according to Section 2791(e) of the Public Health Service Act ("PHS Act") are codified and applicable to the MLR calculation. Section 2791(e) of the PHS Act requires that small and large group market classifications be based on the *average number of employees on the business days of the calendar year preceding the coverage effective date*. Additionally, according to Title 45 CFR Section 158.120, the MLR report must aggregate data for each entity licensed within the state where each health care coverage contract was issued, aggregated separately for the large group market, the small group market and the individual market.

The examiner reviewed a sample of individual and group policies to verify that the appropriate group size and market classification determination was applied by the Plan in accordance with 45 CFR Section 158.103. The samples of all policies, claims and other items tested during the examination appeared to be correctly assigned to the appropriate state, markets and lines of business in accordance with Title 45 CFR Section 158.103 and Title 45 CFR Section 158.120.

2. MLR Numerator

According to Title 45 CFR Section 158.221(b), the numerator of the MLR calculation is comprised of incurred claims, as defined in Title 45 CFR Section 158.140, expenditures for activities that improve health care quality as defined in Title 45 CFR Section 158.150, and Title 45 CFR Section 158.151, Cost Sharing Reductions Program as defined in Title 45 CFR Section 158.140(b)(1)(iii) and Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR Section 158.140(b)(4)(ii), as applicable.

Incurred Claims

The examiner reviewed the accuracy and appropriateness of the amounts reported within incurred claims as defined by Title 45 CFR Section 158.140, including the verification of the data used by the Plan to calculate adjusted incurred claims and the validation of a sample of incurred claims reported by the Plan.

The Plan was unable to provide adequate documentation supporting the amounts reported for 2017 incurred claims for the individual, small group, large group and student health plan markets on its 2017 MLR Annual Reporting Form. The Plan included various categories of

expenses as part of its reconciliation of paid claims on Part 2, Line 2.1b of the 2017 MLR Annual Reporting Form that did not meet the definition of claims in accordance with Title 45 CFR Section 158.140. For example, the Plan included various categories of administrative and access fee expenses paid to third-party vendors, and claims expenses incurred on behalf of other Blue Cross Blue Shield licensees. The Plan also included in its reconciliation an entry to remove cost containment expenses from paid claims that it determined did not meet the definition of incurred claims in accordance with Title 45 CFR Section 158.140. However, the Plan failed to identify the components of the cost containment reclassification entry or otherwise provide evidence that the non-qualifying categories of claims expenses were completely removed. As a result, the examiner was unable to conclusively determine the accuracy of the claims reconciling items and the incurred claims reported on the Plan's 2017 MLR Annual Reporting Form.

It was noted that the Plan inappropriately included as incurred claims the amount paid to its Pharmacy Benefit Manager ("PBM") for pharmacy claims transactions, in an amount that exceeded the total amount the PBM paid the corresponding pharmacy providers. According to Title 45 CFR Section 158.140(b)(3)(ii), if a third-party vendor reimburses the provider at one amount but bills the issuer a higher amount to cover its network development, utilization management costs, and profits, then the amount that exceeds the reimbursement to the provider must not be included in incurred claims. As a result of this error, the Plan overstated its three-year aggregate incurred claims in the 2017 MLR Annual Reporting Form by $3,442,726 in the individual market, $15,868,058 in the small group market, $44,038,096 in the large group market and $1,992,573 in the student health plans market.

It is recommended that the Plan implement policies and procedures to ensure accurate reporting of incurred claims in accordance with Title 45 CFR Section 158.140, including, but not

limited to, ensuring proper reconciliation of incurred claims, that administrative fees paid to third-party-vendors and claims incurred on behalf of other legal entities are not included as a part of incurred claims, and that amounts paid to its PBM in excess of the cost of prescription drugs paid to pharmacies for its enrollees are not included as a part of incurred claims.

Quality Improvement Activities ("QIA")

The examiner reviewed the accuracy and reasonableness of health care quality improvement expenses, including the validation of a sample of the QIA amounts reported, to ensure conformity with the definition of Healthcare Quality Improvement Expenses as defined by Title 45 CFR Section 158.150 and Title 45 CFR Section 158.151, and to confirm that the allocation methodology is reasonable and complies with the requirements set forth by Title 45 CFR Section 158.170.

The Plan did not maintain adequate documentation to support the expenses it reported as QIA, in violation of Title 45 CFR Section 158.502. Title 45 CFR Section 158.502 requires an issuer to maintain all documents and other evidence necessary to enable Center for Consumer Information and Insurance Oversight ("CCIIO") to verify that the data submitted complied with the definitions and criteria set forth in Title 45 CFR Part 158 and that the MLR and any rebates owed were calculated and provided in accordance with the Regulation. In addition, Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.2) states, in part:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
> 8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

The largest category of QIA expenses reported by the Plan was the salaries and related benefits of the employees whose roles and responsibilities included activities that are part of QIA

that meet the definition at Title 45 CFR Section 158.150. The Plan did not provide sufficient time studies of employee activities or other quantifying documentation to substantiate the salary ratios used to allocate salary and other costs to QIA. Accordingly, alternative testing procedures were employed, which included reviewing the title description, job description, allocation percentages, and other information related to employees whose salaries and other expenses were included as QIA. Based on the alternative procedures performed, the examiner concluded that a portion of the activities in the job descriptions provided by the Plan in several cost centers did not qualify as QIA. The examiner was unable to verify the portion of direct salary expenses that were attributable to activities that do meet the definition of QIA due to the lack of a fully developed and documented quantitative analysis of the activities and time spent by staff on these activities. However, the amounts of any misstatement, as a result, were deemed to be immaterial and not to have a significant impact on the MLR calculations. Therefore, no adjustments were made as a result of this finding.

It was also noted that the Plan incorrectly included in its 2017 MLR Annual Reporting Form certain cost centers that included activities and expenses that did not qualify as QIA in accordance with Title 45 CFR Section 158.150. The amounts reported included expenses for administrative fees paid to a third-party vendor for various wellness and nutritional incentive programs, which do not meet the definition of QIA. According to Title 45 CFR Section 158.150(c)(12), costs associated with calculating and administering enrollee or employee incentives must not be included in QIA. In addition, due to a data recording error, the Plan incorrectly included various other expenses that did not qualify as QIA. As a result of these errors, the Plan overstated its three-year aggregate QIA on the 2017 MLR Annual Reporting Form by

$222,695 in the individual market, $1,529,914 in the small group market, $1,263,614 in the large group market, and $2,288 in the student health plans market.

It is recommended that the Plan adopt and implement procedures to ensure that it complies with Title 45 CFR Section 158.502 and Part 243.2 (b)(8) of Insurance Regulation No. 152 by maintaining sufficient quantitative analyses to adequately support the QIA allocation percentages used to allocate salary costs to QIA. The Plan should perform additional analysis to adequately differentiate between activities that do and do not qualify as QIA and perform additional quantitative analysis to ensure that the appropriate percentage of each activity or transaction that qualifies as a QIA pursuant to Title 45 CFR Section 158.150 is reported on its MLR Annual Reporting Form. For salary-related expenses classified as QIA, the Plan should perform time studies of employee activities and/or other quantitative analyses of salary ratios to support allocating any such amounts to QIA. Only salary amounts supported by quantitative analyses regarding allocation of time spent on qualifying QIA activities should be considered as allowable QIA expenses in the future.

Cost Sharing Reductions (“CSR”)

The examiner reviewed the accuracy of the amounts reported in connection with the advance payments of CSR as defined by Title 45 CFR Section 158.140(b)(1)(iii), including the verification of amounts to HHS reconciliation settlement reports and the Plan’s transactional records.

Based upon the procedures performed the Plan correctly reported the advanced payments of CSR received from HHS as a deduction from incurred claims in accordance with Section 158.140(b)(1)(iii).

Federal Premium Stabilization Programs

The examiner reviewed the accuracy of the amounts reported for Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR Section 158.140(b)(4)(ii), including the verification of amounts to HHS program summary reports and the Plan's transactional records.

It was noted that the Plan did not report the appropriate amount as a deduction from incurred claims, the payments expected from HHS for the Federal Risk Adjustment Program, in the CY and PY2 columns on Part 3, Line 1.6 on its 2017 MLR Annual Reporting Form. According to Title 45 CFR Section 158.140(b)(4)(ii), receipts related to the risk adjustment program shall be deducted from incurred claims.

The Plan reported three-year aggregate net payments expected from HHS of $26,417,323 in the individual market and $18,447,540 in the small group market on Part 3, Line 1.6 on its 2017 MLR Annual Reporting Form. However, according to reports issued by HHS, the Plan should have reported $31,215,237 in the individual market and $21,378,160 in the small group market. As a result of this error, the Plan understated the three-year aggregate risk adjustment amount reported on Part 3, Line 1.6 by $4,797,914 in the individual market and $2,930,620 in the small group market.

It is recommended that the Plan implement policies and procedures to ensure that it properly reports Risk Adjustment Program Payments expected to be received from HHS.

Based on the procedures performed it was determined that, the Plan's Federal Transitional Reinsurance and Federal Risk Corridor Program amounts were accurately reported on the MLR

Annual Reporting Form.

3. MLR Denominator

According to Title 45 CFR Section 158.221(c), the denominator of the MLR calculation is comprised of premium revenue, as defined in Title 45 CFR Section 158.130, minus Federal and State Taxes and Licensing / Regulatory Fees, described in Title 45 CFR Section 158.161(a), and 45 CFR Section 158.162(a)(1) and (b)(1).

Earned Premiums

The examiner reviewed the accuracy and appropriateness of the amounts reported within earned premium as defined by Title 45 CFR Section 158.130, including the verification of the data used by the Plan to calculate earned premium and the validation of a sample of policy premium reported by the Plan.

Based upon the procedures performed, the Plan was unable to provide complete and adequate supporting documentation for 20 policies in the sample of 77 policies selected for testing in the individual, small group, large group and student health plans markets.

Policy and/or premium elements that the Plan could not adequately support included the initial or renewal application for coverage, copies of an invoice as well as payment support for premium amounts reported. In addition, a number of premium amounts selected for testing could not be matched to the invoice or payment support provided by the Plan. According to the Plan, these variances were due to retroactive premium adjustments, but the Plan could not provide sufficient support for the differences.

Title 45 CFR Section 158.502 requires an issuer to maintain all documents and other evidence necessary to enable CCIIO to verify compliance with the definitions and criteria set forth in Title 45 CFR Section 158 and that the MLR and any rebates owed are calculated and provided in accordance with Title 45 CFR Section 158. Based on alternative testing procedures, the examiner was able to confirm the existence of each policy. However, due to missing invoices and payment support, the precise impact of the failure to maintain adequate documentation supporting premium amounts cannot be conclusively determined due to the Plan's lack of the information necessary to support its reporting.

It is recommended that the Plan adopt and implement a comprehensive MLR records maintenance program under which it maintains all documentation and evidence necessary to enable CCIIO to verify compliance with each element included in the MLR Annual Reporting Form, as required by Title 45 CFR Section 158.502. The records maintenance program should include storing copies of all applications for coverage, invoices and payment support for policies that the Plan has issued, as well as maintaining adequate documentation, as may be necessary.

Based on the procedures performed, other than the missing documentation noted above, the Plan's earned premium were accurately and appropriately reported on a direct basis and the data elements underlying the 2015, 2016 and 2017 premium as reported on the Plan's 2017 MLR Annual Reporting Form were compliant with Title 45 CFR Section 158.130.

Federal and State Taxes and Licensing / Regulatory Fees

The examiner reviewed the accuracy and appropriateness of Federal and State Taxes and Licensing / Regulatory Fees, including confirmation that the allocation methodology was reasonable and complied with the requirements set forth by Title 45 CFR Section 158.170 and that

taxes were reported in accordance with the provisions of Title 45 CFR Section 158.161 and Section 158.162.

It was noted that the Plan failed to report various taxes and fees in the '3/31' column on Part 1, Lines 3.1a, 3.1b and 3.3b, on its 2017 MLR Annual Filing Form, including Federal income taxes, Patient Centered Outcomes Research Institute ("PCORI") fees and Other Federal and state regulatory authority licenses and fees. The Plan properly reported the appropriate amounts in the '12/31' column for each market but failed to carry forward the amounts to the '3/31' column in completing its MLR form. According to the 2017 MLR Annual Reporting Form Filing Instructions, financial information reported in the '3/31' columns should equal the amount of each element related specifically to experience incurred during the MLR reporting year. As a result of this error, the Plan's three-year aggregate taxes and licensing or regulatory fees reported on Part 3, Line 2.2 on the 2017 MLR Annual Reporting Form were overstated by $1,845,300 in the individual market and $67,813 in the student health plans market, and understated by $325,289 in the small group market and $12,459,489 in the large group market.

It was also noted that the Plan failed to include amounts paid in relation to Affordable Care Act ("ACA") section 9010 fees on Part 1, Line 3.1c on its 2015 MLR Annual Reporting Form. Due to a reporting error, the Plan inadvertently reported its 2015 ACA 9010 fees as a part of non-claims costs on Part 1, Section 5, which is not included in the MLR calculation. As a result of this error, the Plan's three-year aggregate taxes and licensing or regulatory fees reported on Part 3, Line 2.2 on the 2015 MLR Annual Reporting Form was understated by $579,255 in the individual market, $5,405,934 in the small group market, $24,257,969 in the large group market and $155,592 in the student health plans market. However, the Plan corrected the error in the PY2 column on

Part 3, Line 2.2 on its 2017 MLR Annual Reporting Form and therefore there was no impact from this error on the 2017 filing.

Finally, it was noted that the Plan included the expenses related to the Graduate Medical Expense ("GME") surcharge from the state of New York as a part of incurred claims on Part 2, Line 2.1b, as well as a part of state premium taxes reported on Part 1, Line 3.2b of its 2017 MLR Annual Reporting Form. According to Title 45 CFR Section 158.140(b)(2)(i), state surcharges directly tied to claims incurred or census-based assessments shall be reported as a part of incurred claims. As a result of this duplication error, the Plan's three-year aggregate taxes and licensing / regulatory fees were overstated by $1,260,995 in the individual market, $8,685,115 in the small group market, $19,966,697 in the large group market, and $728,689 in the student health plans market.

It is recommended that the Plan implement policies and procedures to ensure that amounts reported as taxes and licensing or regulatory fees, reported as a reduction to earned premium in the MLR calculation, are in accordance with Title 45 CFR Section 158.161 and Title 45 CFR Section 158.162, as well as the MLR Annual Reporting Form Filing Instructions.

Based on the procedures performed, other than the errors noted above, the Plan's allocation methodology is reasonable and the Federal and State Taxes and Licensing /Regulatory Fees were accurately and appropriately reported for each market segment on its MLR Annual Reporting Form.

4. Credibility-Adjustment

According to Title 45 CFR Sections158.232, the credibility-adjustment is the product of the

base credibility factor multiplied by the deductible factor. The examiner reviewed the underlying data utilized in the determination of the base credibility and deductible factors, tested the accuracy of the calculation of the base credibility and deductible factors and the resulting credibility-adjustment for the individual, small group, large group and student health plans markets. The Plan elected to use a deductible factor of 1.0, in lieu of calculating a deductible factor, therefore, eliminating any impact on the Credibility-Adjusted MLR.

Based on the procedures performed, the Plan's base credibility-factor, deductible factor and credibility-adjustment were accurately calculated and reported for each market segment on its MLR Annual Reporting Form.

5. Credibility-Adjusted MLR

According to Title 45 CFR Section 158.221(a), the calculation of the MLR is the ratio of the numerator to the denominator, plus the credibility adjustment. The examiner recalculated the credibility-adjusted MLR in accordance with Title 45 CFR Section 158 and the applicable MLR Annual Reporting Form Filing Instructions and determined the Plan's credibility-adjusted MLR amounts were accurately calculated for each market segment on its MLR Annual Reporting Form.

6. Rebate Disbursement and Notice

According to Title 45 CFR Section 158.240, a rebate is required to be paid no later than September 30th, following the MLR reporting year if an insurer's credibility-adjusted MLR is less than the MLR standard (82% for the individual and small group markets, 85% for the large group market, and 80% for the student health plans market, in the state of New York). According to Title 45 CFR Section 158.250, for each MLR reporting year, an issuer must provide a Notice of Rebate

to each policyholder and/or subscriber who is to receive a rebate.

Based on the examiner's review of the reported credibility-adjusted MLR for each market segment, the Plan exceeded the New York MLR standard of 82% in the individual and small group markets, 85% in the large group market and 80% in the student health plans market in each year under examination. Therefore, the Plan was not required to, and did not, issue any Notices of Rebates for the 2015, 2016 or 2017 reporting years in accordance with Title 45 CFR Section 158.250.

7. Impact on Risk-Based Capital

According to Title 45 CFR Section 158.270(a), rebate payments having any adverse impact on the Plan's Risk-Based Capital ("RBC") level requires notification by the Department to the Secretary of the Health and Human Services ("HHS"). Based on the examiner's review, the Plan's credibility-adjusted MLR exceeded the minimum percentage for the individual, small group, large group and student health plans market segments, and no rebates were issued. Therefore, there was no impact on the RBC level that would warrant notification to the Secretary of HHS.

E. Accounts and Records

1. Income Taxes:

Effective December 22, 2017, the Tax and Jobs Act was signed into law. Effective January 1, 2018, the statutory tax rate changed from 35% to 21%. This resulted in HealthNow net admitted adjusted gross deferred tax assets decreasing by approximately $28 million as reflected in its annual statement filing as of December 31, 2018, due to the statutory rate change.

2. Pension Plan:

HealthNow sponsors two defined benefit pension plans covering substantially all salaried and hourly employees. HealthNow's funding policy is to fund amounts sufficient to meet the minimum funding requirements under government regulations, plus such additional amounts as the Plan may deem appropriate from time to time after consultation with the Plan's Actuary. For the year ending December 31, 2018, HealthNow contributed $0 to its benefit plan.

HealthNow also sponsors two Section 401(k) deferred retirement plans. Under the terms of the HealthNow New York Elective 401(k) Plan, eligible employees of HealthNow may elect to defer up to 75% of gross income, not to exceed Internal Revenue Service ("IRS") limitations. The HealthNow New York Elective 401(k) Plan provides both matching and annual contributions to be made by HealthNow. The matching contribution is an amount equal to 100% of the first 4% of employees' contributions, while the annual contribution is equal to 2% of eligible employees' total compensation. HealthNow may also make annual discretionary contributions of 1.5% of eligible employees' total compensation to the 401(k) Plan. Under the terms of the Brokerage Concepts Elective 401(k) Plan, eligible employees may elect to defer up to 75% of gross income, not to exceed IRS limitations. The matching contribution is an amount equal to 50% of the first 4% of employees' contributions. HealthNow does not provide any annual contributions to this plan.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2018, as contained in HealthNow's 2018 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 reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2018 filed annual statement.

Independent Accountants

The firm of Deloitte was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

Deloitte concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan 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

Bonds	$ 665,139,865
Preferred stocks	7,499,993
Common stocks	144,747,407
Cash and short-term investments	9,261,745
Other invested assets	2,177,093
Aggregate write-ins for invested assets	13,530,971
Investment income due and accrued	5,430,545
Uncollected premiums and agents' balances in the course of collection	79,471,322
Amounts receivable relating to uninsured plans	5,757,320
Current federal and foreign income tax recoverable and interest thereon	14,437,211
Net deferred tax asset	30,991,791
Guaranty funds receivable or on deposit	3,016,617
Electronic data processing equipment and software	5,947,641
Receivables from parent, subsidiaries and affiliates	1,264,576
Healthcare receivables	123,371,114
Aggregate write-ins for other than invested assets	1,281,021
Total assets	$ 1,113,326,232

Liabilities

Claims unpaid	$ 189,634,714
Accrued medical incentive pool and bonus amounts	20,206,245
Unpaid claims adjustment expenses	30,866,219
Aggregate health policy reserves	34,735,761
Premiums received in advance	28,297,792
General expenses due or accrued	47,270,858
Amounts withheld or retained for the account of others	59,332
Amounts due to parent, subsidiaries and affiliates	3,246,000
Aggregate write-ins for other liabilities	134,385,461
Total liabilities	$ 488,702,382

Capital and Surplus

Aggregate write-ins for other than special surplus funds	$ 331,531,214
Unassigned funds (surplus)	293,092,636
Total capital and surplus	$ 624,623,850
Total liabilities, capital and surplus	$ 1,113,326,232

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of Excellus for the tax years 2014 through 2018, in which the Plan filed its returns on a group basis under the consolidated federal income tax returns of its parent, Lifetime Healthcare, Inc. The examiner is unaware of any potential exposure of the Plan to any tax assessment, and no liability has been established herein relative to such a contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased by $32,923,848 from January 1, 2014 through December 31, 2018, detailed as follows:

Revenue		
Premium income	$ 12,168,639,315	
Change in unearned premium reserve	(39,900,238)	
Total revenue		$ 12,128,739,077
Hospital and Medical Expenses		
Hospital / medical benefits	$ 7,337,358,711	
Other professional services	938,307,898	
Emergency room and out-of-area	365,032,319	
Prescription drugs	1,876,516,131	
Aggregate write-ins for other hospital and medical	47,210,471	
Incentive pool, withhold adjustments, and bonus Amounts	81,107,118	
Net reinsurance recoveries	2,941,631	
Total hospital and medical expenses	$ 10,642,591,017	
Claims adjustment expenses	372,509,699	
General administrative expenses	1,200,055,877	
Total underwriting expenses		12,215,156,593
Net underwriting loss		$ (86,417,516)
Net investment income		80,641,243
Net realized capital gains		85,091,937
Aggregate write-ins for other income or expenses		64,044,868
Net income before federal and foreign income taxes		$ 143,360,532
Federal and foreign income taxes incurred		26,542,000
Net income		$ 116,818,532

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and Surplus, per report on examination, as of December 31, 2013			$ 591,700,002
Net income	$116,818,532		
Net change in unrealized capital gains		$ 31,612,704	
Change in net unrealized foreign exchange capital gain or loss		936,095	
Change in net deferred income tax		31,078,336	
Change in non-admitted assets		14,013,651	
Aggregate write-ins for losses in surplus		6,253,898	
Net increase in capital and surplus			$ 32,923,848
Capital and Surplus, per report on examination, as of December 31, 2018			$ 624,623,850

4. UNPAID CLAIMS ADJUSTMENT EXPENSES

The Department examination of the Plan's unpaid claims adjustment expenses of $30,866,219 reported by the Plan in its filed annual statement as of December 31, 2018, was deemed to be excessive.

It was noted that HealthNow's incurred claims adjustment expenses were approximately 4.59% and 4.34% of total medical and hospital expenses during 2018 and 2017, respectively. For the five-year period 2014 to 2018 incurred claims adjustment expenses were approximately 3.50% of total medical and hospital expenses.

HealthNow has set up unpaid claims adjustment expenses at about 16.28% and 7.47% of claims unpaid at December 31, 2018 and 2017 respectively. For the five-year period 2014 to 2018 unpaid claims adjustment expenses were approximately 6.86% of claims unpaid. As compared to

the experience incurred by the Plan from 2014 to 2018, unpaid claims adjustment expenses of $30,866,219 at December 31, 2018 was deemed excessive.

It is recommended that the Plan set unpaid claims adjustment expenses at a more reasonable level to its total unpaid claims.

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 Plan's internal records and in its filed annual and quarterly statements, as well as additional information provided by the Plan.

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 Plan's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2018.

5. SUBSEQUENT EVENTS

On November 11, 2019, HealthNow requested approval from the Department for a capital contribution of $19,250,000 from HealthNow to Brokerage Concepts, LLC. The Department approved the $19,250,000 capital contribution on January 15, 2020.

On March 11, 2020, The World Health Organization declared the spreading coronavirus ("COVID-19") outbreak a pandemic. On March 13, 2020, United States ("U.S.") President Donald J. Trump declared the coronavirus pandemic a national emergency in the U.S. The epidemiological threat posed by COVID-19 is having 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 Department is expecting 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 Department and all insurance regulators, with the assistance of NAIC, are monitoring the situation through a coordinated effort and will continue to assess the impacts of the pandemic on U.S. insurers. The Department has been in communication with the Plan regarding the impact of COVID-19 on business operations and financial position, and no immediate action was deemed necessary at the time of this report.

On April 27, 2020, the Supreme Court issued its decision in *Maine Community Health Options v. United States*. The decision stems from three consolidated cases brought by four insurers over whether insurers are entitled to more than $12 billion in unpaid risk corridors payments from calendar years 2014 to 2016. By a vote of eight to one, the Supreme Court ruled that the government was obligated to make full risk corridors payments. It is undetermined as to what impact this will have on the Plan's financial statements.

On June 19, 2020, pursuant to New York Insurance Law Section 1506, Highmark Inc. and Highmark Health filed an application with the Department and the New York State Department of Health for approval to become affiliated with HealthNow New York Inc. ("Affiliation"). The Department and the New York State Department of Health simultaneously approved the affiliation on February 24, 2021. After the affiliation, HealthNow New York Inc. changed its legal name to

"Highmark Western and Northeastern New York Inc" and its d/b/a names to "Highmark Blue Cross Blue Shield of Western New York" and "Highmark Blue Shield of Northeastern New York."

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2013, contained sixteen (16) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Corporate Governance	
1.	It is recommended that the Plan classify only those board members who are covered under an insured contract as Subscriber Representatives in compliance with Section 4301(k)(1)(A) of the New York Insurance Law and Article IV, Section 2(c)(i) of its by- laws. *The Plan has complied with this recommendation.*	8
2.	It is recommended that the Plan comply with Article IV, Section 2(c)(ii) of its by-laws by having board members noted as "Public Representatives" represent all of the geographic regions served by the Plan. *The Plan has complied with this recommendation.*	8
	Internal Audit Department	
3.	It is recommended that the Plan adhere to the guidance promulgated under the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing by ensuring that its internal audit department is aligned under the direct supervision of the audit committee, with administrative reporting to the Plan's management. *The Plan has complied with this recommendation.*	20
4.	It is recommended that the Plan update its relevant charters to reflect the direct functional reporting line to the audit committee and administrative reporting line to management. *The Plan has complied with this recommendation.*	20

ITEM NO.		PAGE NO.
	Internal Audit Department (Con't.)	
5.	It should also be noted that the contract with Freed Maxick was signed by the Chief Risk Officer. While the selection of Freed Maxick was properly vetted through the audit committee, it is recommended, and the Plan acknowledged, that a best practice would be for such contracts to be signed by the chair of the audit committee. *The Plan has complied with this recommendation.*	21
6.	It is recommended that the Plan review the work performed by Freed Maxick and on an annual basis prepare a report on the results of the audit work for the audit committee's review. *The Plan has complied with this recommendation.*	22
7.	As a best practice, it is further recommended that the Plan perform, on at least an annual basis, a quality assurance and improvement program review of the internal audit function and use such a review to assist the audit committee in assessing the quality and effectiveness of the work performed by Freed *The Plan has complied with this recommendation.*	22
8.	It is recommended that, if it is the intention of the Plan to continue to use an outside firm to provide consulting services relating to ERM, that such outside firm be independent of an outside firm that provides internal audit functions on behalf of *The Plan has complied with this recommendation.*	23
9.	It is recommended that the Plan revise its audit committee and internal audit charters in accordance with the guidance promulgated under Standards 1000 and 1111 of The Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing, respectively, to clarify that internal audit maintain a direct reporting line to the audit *The Plan has complied with this recommendation.*	24
10.	As a best practice, it is recommended that the audit committee membership be restricted to independent directors of the board. *The Plan has complied with this recommendation.*	24
11.	It is recommended that the Chief Audit Executive establish a risk assessment methodology for development of the audit plan that measures the relative risk of all units in the Plan's audit *The Plan has complied with this recommendation.*	25

ITEM NO.		**PAGE NO.**
	Internal Audit Department (Con't.)	
12.	It is recommended that the internal audit plan presented to the audit committee be clear on the risk assessment methodology used and how the results of the risk assessment have been considered in the development of the annual audit plan and that such audit methodology be reviewed and approved by the audit	25
	The Plan has complied with this recommendation.	
13.	It is recommended that the Plan ensure that its internal auditors comply on a consistent basis with the guidance promulgated under Standard 2300 of The Institute of Internal Auditors' International Standards for the Professional Practice of Internal	27
	The Plan has complied with this recommendation.	
14.	It is recommended that the Plan consistently follow a formal audit report structure that adheres to the guidance promulgated under Standard 2410 of The Institute of Internal Auditors' International Standards for the Professional Practice of Internal	28
	The Plan has complied with this recommendation.	
15.	It is recommended that the Plan adhere to the guidance promulgated under Standard 2500 of The Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing by ensuring that a report of open issues be kept current, in consistent format, and be presented to the audit committee on a quarterly basis.	28
	The Plan has complied with this recommendation.	
	Employment Procedures	
16.	It is recommended that the Plan comply with the provisions of United States Code, Title 18, Part 1, Chapter 47, Section 1033 by requesting and obtaining the consent of the Superintendent, prior to the employment of any individual who has been convicted of a felony.	31
	The Plan has complied with this recommendation.	

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Medical Loss Ratio Review	
i.	It is recommended that the Plan implement policies and procedures to ensure accurate reporting of incurred claims in accordance with Title 45 CFR Section 158.140, including, but not limited to, ensuring proper reconciliation of incurred claims, that administrative fees paid to third-party-vendors and claims incurred on behalf of other legal entities are not included as a part of incurred claims, and that amounts paid to its PBM in excess of the cost of prescription drugs paid to pharmacies for its enrollees are not included as a part of incurred claims.	20
ii.	It is recommended that the Plan adopt and implement procedures to ensure that it complies with Title 45 CFR Section 158.502 and Part 243.2 (b)(8) of Insurance Regulation No. 152 by maintaining sufficient quantitative analyses to adequately support the QIA allocation percentages used to allocate salary costs to QIA. The Plan should perform additional analysis to adequately differentiate between activities that do and do not qualify as QIA and perform additional quantitative analysis to ensure that the appropriate percentage of each activity or transaction that qualifies as a QIA pursuant to Title 45 CFR Section 158.150 is reported on its MLR Annual Reporting Form. For salary-related expenses classified as QIA, the Plan should perform time studies of employee activities and/or other quantitative analyses of salary ratios to support allocating any such amounts to QIA. Only salary amounts supported by quantitative analyses regarding allocation of time spent on qualifying QIA activities should be considered as allowable QIA expenses in the future.	23
iii.	It is recommended that the Plan implement policies and procedures to ensure that it properly reports Risk Adjustment Program Payments expected to be received from HHS.	24

ITEM		PAGE NO.
A.	Medical Loss Ratio Review (Con't.)	
iv.	It is recommended that the Plan adopt and implement a comprehensive MLR records maintenance program under which it maintains all documentation and evidence necessary to enable CCIIO to verify compliance with each element included in the MLR Annual Reporting Form, as required by Title 45 CFR Section 158.502. The records maintenance program should include storing copies of all applications for coverage, invoices and payment support for policies that the Plan has issued, as well as maintaining adequate documentation, as may be necessary.	26
v.	It is recommended that the Plan implement policies and procedures to ensure that amounts reported as taxes and licensing or regulatory fees, reported as a reduction to earned premium in the MLR calculation, are in accordance with Title 45 CFR Section 158.161 and Title 45 CFR Section 158.162, as well as the MLR Annual Reporting Form Filing Instructions.	28
B.	Unpaid Claims Adjustment Expenses	
	It is recommended that the Plan set unpaid claims adjustment expenses at a more reasonable level to its total unpaid claims.	37

Respectfully submitted,

____

Scott R. Kalna, CFE, AMCM
Examiner-In-Charge

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

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

____

Scott R. Kalna, CFE, AMCM

Subscribed and sworn to before me
this _____ of _____________, 2022.

APPOINTMENT NO. **31997**

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:

Exam Resources, LLC

as a proper person to examine the affairs of the

HealthNow New York Inc.

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

Company

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 23rd day of August, 2019

LINDA A. LACEWELL
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau