Commonwealth of Puerto Rico
OFFICE OF THE COMMISSIONER OF INSURANCE

FIRST MEDICAL HEALTH PLAN, INC.

Examination Report
as of December 31, 2012

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Examiner

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Table

COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE

October 11, 2013

Ángela Weyne Roig
Commissioner of Insurance
Guaynabo, Puerto Rico

Dear Commissioner:

In compliance with your instructions and pursuant to the Order Number EX-2013-06, dated April 11, 2013, and the Puerto Rico Insurance Laws and Regulations, a comprehensive risk focused examination and financial affairs examination was made of the books, records, and financial condition of:

First Medical Health Plan, Inc.
530 Marginal Buchanan
Guaynabo, PR 00966

Wherever the designations "the Company" or "Organization" appear herein without qualification, it should be understood to indicate the First Medical Health Plan, Inc. Wherever the designation "Department" appears herein without qualification, it should be understood to indicate the Puerto Rico Insurance Department. The examination was conducted at the Organization's main administrative office located at 530 Marginal Buchanan, Guaynabo, Puerto Rico.

SCOPE OF EXAMINATION

This examination covered the period from January 1, 2008, through December 31, 2012. Also, transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2012. The examination included a review of income, disbursements and company records deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Organization's independent certified public accountants ("CPA").

This report was a statutory financial examination conducted in accordance with the Financial Condition Examiners Handbook, Accounting Practices and Procedures Manual and Annual Statement Instructions promulgated by the NAIC, with due regard to the statutory requirements of the insurance laws and rules of the Commonwealth of Puerto Rico.

The Financial Condition Examiners Handbook requires that the examination be planned and performed to evaluate the financial condition and identify prospective risks of the Organization by obtaining information about the Organization including corporate governance, identifying and assessing inherent risks within the Organization, and evaluating system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation and management's compliance with Statutory Accounting Principles and Annual Statement

Instructions when applicable to domestic state regulations. A review was also made to ascertain the actions, if any, were taken by the Organization with regard to comments and recommendations in the prior report on examination.

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

HISTORY

The Organization was incorporated on February 1, 1977, under the provisions of the Insurance Code of Puerto Rico and it's authorized to provide services related with health care services in the Commonwealth of Puerto Rico. A substantial portion of the Organization's business activity is with government employees with are contracted annually.

The Organization provides Medicare Advantage Plan (MA Plan) coverage to residents of Puerto Rico who are eligible for Medicare benefits. The Organization offers its MA Plan pursuant to a contract with the United States Centers for Medicare and Medicaid Services (CMS), a federal agency within the U.S. Department of Health and Human Services. The contract is for a period of one year commencing January 1 and ending on December 31, and can be renewed for periods of one year, as defined in the contract.

Stockholders

As of December 31, 2012, the stockholders of the Organization were:

Name	(%)
Mr. Eduardo Artau Gómez	25%
Mrs. Carmen Feliciano Vargas	25%
Mr. Francisco J. Artau Feliciano	23.50%
Mr. Eduardo Artau Feliciano	26.50%

Ruling Letter No. 2009-104-AF dated September 22, 2009, states that no later than March 31st of every year all health services organizations shall submit a list of its stockholder as of December 31st of the previous year. The aforementioned list shall be sworn to by the same persons who swear to the annual statement - Jurat Page.

The Organization's stockholder's relation was not sworn by the same people that swear the annual statement - Jurat Page. The Organization failed to meet Ruling Letter No. 2009-104-AF dated September 22, 2009.

MANAGEMENT AND CONTROL

Board of Directors

Pursuant to Section 29.160 of the Insurance Code of Puerto Rico, the Board of Directors shall be held annually at the annual meeting of stockholders. Upon review of the corporate book, it was noted that the Organization did not maintain records of its directors' election. It is require that the Organization maintain records supporting the board of directors' elections.

As of the examination date, the directors of the Organization were as follows:

Name	Title
Eduardo Artau Gómez	Chairman
Francisco J. Artau Feliciano	Vice-President
Carmen Feliciano Vargas	Secretary
Eduardo Artau Feliciano	Vocal
Juan L. Domínguez	Treasurer
José Pagán	Sub-Treasurer

Name	Title
Ángel Morales Yulfo	Vocal
Marcos Feliciano	Vocal
Dr. Samuel Sostre	Vocal

Officers

Pursuant to the Section 29.210 of the Insurance Code of Puerto Rico and the Organization's by-laws, the Board of Directors (Board) appointed the officers. At December 31, 2012, the officers are comprised of the following:

Name	Title
Francisco J. Artau Feliciano	President
Carmen Feliciano Vargas	Vice President - Marketing
Juan L. Domínguez	Vice President - Finance
José Pagán	Vice President - Administrative
César Ramírez	A Vice President - Finance
Carlos Santana	Executive Director First Plus
Xiomara Rosado	Human Resources Director
William Ramírez	Grievances and Appeals Director
Carlos Fournier	Legal Affairs Director
Eddie Ortiz	Senior Medical Director
Niurka Adorno	Corporate Compliance Director
Federico Pagán	IT Director

CORPORATE RECORDS

The Board of Directors is responsible for providing general oversight over corporate governance matters, including the development and implementation of the appropriate governance policies and procedures. The Organization is not a publicly traded corporation and, therefore, is not subject to the Sarbanes-Oaxley Act of 2002.

Minutes

The minutes of the Board, shareholder and certain internal committees were reviewed for the period under examination. In the review of the Organization's Board

of directors' minutes, it was noted that the Board did not approve the purchases and sales of securities. Section 6.040(2) of the Insurance Code of Puerto Rico provides that the board of directors shall certify in writing, through a formal resolution to be adopted at least once a year that all investments have been made pursuant to the delegation, standards, limitations and investment goals established by the board. The Organization failed to comply with Section 6.040(2) of the Insurance Code of Puerto Rico.

Investment Plan

Section 6.040(1) of the Insurance Code of Puerto Rico provides, among other things, that the Board of Directors of the insurer shall adopt a written plan to acquire and maintain investments, and to outline investment practices. The Organization adopted an investment plan, which was approved by its board of directors.

However, Organization's investment plan does not establish the professional qualifications of the persons who will make routine decisions to ensure investment competence and ethical conduct pursuant to Section 6.040(1) of Insurance Code[1].

Section 6.040(3) of the Insurance Code of Puerto Rico states that at least every three months, or more often if necessary, the board of directors of the insurer or a duly authorized committee shall receive and review a summary report of the investment portfolio of the insurer, its investment activities and the investment practices and review and update the written plan, as appropriate. Similarly, Section 4(C)(2)(d) of

[1] During the course of this examination, the investment plan was reviewed and amended by the Organization pursuant to Section 6.040 of Insurance Code of Puerto Rico.

Rule No. 66 of the Regulation of Insurance Code stipulates that the board of directors or an investment committee shall review its written plan annually.

In the review of the Organization's board of directors' minutes, it was noted that the board or an authorized committee did not review and update the written plan. Therefore, the Organization did not comply with Section 6.040(3) of the Insurance Code and Section 4(C)(2)(d) of Rule No. 66 of Regulation of Insurance Code of Puerto Rico.

Others Committee

As of December 31, 2012, the Organization had not established an audit committee as defined in Section 4(D) of Rule XIV-A of Regulation of Insurance Code[2].

The Organization failed to comply with Section 7(I) of Rule XIV-A of Regulation of Insurance Code. All auditing services and other services provided to Organization by the independent certified public accountant of the Organization had not been preapproved by its audit committee.

Action Plan - Antifraud

Section 27.230(3) of the Insurance Code of Puerto Rico states that the Board of Directors of every insurer shall adopt a written action plan to detect, prevent and fight fraudulent acts in the insurance business. Such action plan shall contain at least a description of the personnel hired or employed by the Antifraud Investigations Unit to execute the procedures established to detect and investigate acts of fraud and the functions assigned to each. The Organization has complied with provisions of Section 27.230(3) of Insurance Code.

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[2] During examination process, the Organization established referred Committee.

Conflict of Interest

The Organization adopted a policy statement without requiring annual disclosure of conflict of interest questionnaires. The Organization require its directors, officers, and key employees to sign conflict of interest forms concerning items that could have an impact on the way the Organization conducts business in accordance with Section 29.230 of the Insurance Code of Puerto Rico.

TERRITORY AND PLAN OF OPERATION

As of December 31, 2012, the Organization was licensed to write business in Puerto Rico. As of the examination date, the Organization was authorized to transact health insurance.

An insurer or health services organization shall appoint and contract a producer or general agent to represent the insurer in Puerto Rico to carry out those functions consistent with the Insurance Code of Puerto Rico.

Section 9.063(2) of the Insurance Code of Puerto Rico, requires that the appointment of a producer as authorized representative of an insurer shall be notified to the Commissioner in the manner prescribed by the latter within the fifteen (15) days following the date on which the contract is subscribed for such a purpose. The Organization has complied with Section 9.063(2) of the Insurance Code of Puerto Rico.

Section 19.050(2)(a) of the Insurance Code stipulates that a health services organization, before exercising any of the powers conferred such as lease, construction or renewal for related property as may be reasonably required for its main office or for

such other purposes as may be necessary for the organization, shall furnish to the Commissioner the adequate information to justify the exercise of said powers.

The Organization did not comply with the provisions of the Section 19.050(2) of the Insurance Code of Puerto Rico.

Statutory Deposit

Pursuant to Section 19.140 of the Insurance Code of Puerto Rico, $600,000, is deposited with the Department in trust as a guarantee of compliance with the obligations towards subscribers, providers and creditors, as required by the respective Insurance Code.

RELATED PARTY

International Medical Card (IMC)

The Organization and IMC are related parties under common control and ownership. IMC is engaged in processing claims and payment to health care providers contracted by the Organization. During 2012, the Organization made payments to IMC in the total amount of $6,296,086, to cover administrative services.

First Medical Health Plan of Florida (FMFL)

FMFL has contracted with the Organization for various administrative and consulting services. In exchange for the Organization's services, FMFL will pay a fixed overhead administration fee as defined in the agreement. The administrative fee was waived by the Organization for the examination period.

It is noted that the Organization's financial statements did not include a disclosure about theses related party transactions. SSAP No. 25, Paragraph 19 of the NAIC Accounting Practices and Procedures Manual states that the financial statements shall

include disclosures of all material related party transactions, a description of the transactions for each period for which financial statements are presented, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements.

The Organization failed to comply with Paragraph 19 of the SSAP No. 25 of the NAIC Accounting Practices and Procedures.

Other Related Party Transaction

There are certain entities related to the Organization which provide several services such as Three A. Engineering and Construction, Inc. As of December 31, 2013, the Organization did not have a written agreement with the aforementioned entity.

The Ruling Letter N-E-9-109-99 dated September 15, 1999, states that in all matters that the Insurance Code keeps silence, the principles, practices and accounting procedures stipulated in the Accounting Practices and Procedures Manual shall constitute the only source of authority.

Pursuant to the provision in Paragraph 7 of SSAP No. 25 of the Accounting Practices of Procedures, transactions between related parties must be in the form of a written agreement.

The Organization should formalize a written agreement with its related party pursuant to the provisions of SSAP No. 25 Paragraph 7 of the NAIC Accounting Practices and Procedures Manual and settle its obligations under the agreement.

At the same time, paragraph 19 (d) of SSAP No. 25, sets that amount due from or to related parties as of the date of each balance sheet presented shall be disclosed. And

paragraph 19(f) of the referred SSAP No. 25 establishes that a description of material management or service contracts involving the reporting entity and any related party shall be disclosed.

As of December 31, 2012, the Organization failed to fulfill paragraph 19(d) and 19 (f) of SSAP No. 25[3].

Holding Company

The Organization is a member of an insurance holding company system as defined by Rule No. 83 of the Regulation of the Insurance Code of Puerto Rico. However, it had not filed a holding company registrations statement (Form B and C) with the Commissioner of Insurance of Puerto Rico as required by Sections 13 and 14 of Rule No. 83; and Ruling Letter No. 2011-126-AF dated June 1, 2011[4].

SURPLUS NOTES

As of December 31, 2012, the Organization was obligated to Eduardo Artau Gómez for surplus notes in the amount of $20,765,860, as follows:

Dated Issued	Interest Rate	Face Amount
5-21-2008	3.75%	$7,385,725
7-28-2009		13,380,135
	Total	$20,765,860

On June 15, 2008, the Organization issued surplus notes in exchange for cash to Mr. Artau Gómez in amount of 9,858,725. In a subsequent determination by the Commissioner, the amount of $2,500,000 was determined to be considered as paid in

[3] It is noted that the Organization developed procedures for prospective compliance with SSAP No. 25 of the Accounting, Practices and Procedures Manual.

[4] The Organization subsequently complied with Rule No. 83.

capital and the remainder $7,358,725 to constitute surplus notes. On 2009, Mr. Artau Gomez made additional cash contributions in the amount of $13,380,135 in surplus notes.

These notes were approved by the Organization's board of directors and the Commissioner. Also both notes will earn interest at a rate of 3.75% annually but are subject to certain restrictions imposed by the Commissioner.

RETIREMENT BENEFITS

The Organization sponsors a defined contribution plan (Plan) which provides retirement benefits to eligible employees. The Plan is administered by the Organization and is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Organization's contributions to the Plan for the years ended December 31, 2012 and 2011 amounted to approximately $127,236 and $90,932, respectively. As part of the examination, the Plan's audit reports were reviewed.

FIDELITY BONDS

The Organization maintained fidelity bond coverage up to $500,000, which adequately covered the suggested minimum recommended by the NAIC. The Organization also maintained Directors and Officers (D&O) liability insurance coverage.

The Organization had other property and liability insurance coverage necessary for the operation of the business.

ACCOUNTS AND RECORD

The Organization maintained its principal operational offices in San Juan, Puerto Rico, where this examination was conducted. An independent CPA audited the Organization's statutory basic financial statements for the year 2012, in compliance with

Rule XIV-A of the Regulations of the Insurance Code of Puerto Rico. Supporting work papers were provided by the CPA as required by Rule XIV-A of the Regulations of the Insurance Code of Puerto Rico. It was noted that the Organization was not filing the audited financial statement with the Commissioner on or before June 1 for the year of operations ended December 31 immediately preceding pursuant to Section 4(A) of Rule XIV-A of the Regulation of the Insurance Code. The following information was not included on Organization's audited financial statements:

- Statement of changes in capital and surplus as required by Section 5(E) of Rule XIV-A of the Regulation of the Insurance Code.
- Communication of internal controls related matters noted in an audit as required by Section 11(A) of Rule XIV-A of the Regulation of the Insurance Code.
- The Letter of Qualifications of the external auditors as required by Section 12 of Rule XIV-A of the Regulation of the Insurance Code.
- Managements report of internal controls for audited financial reports as required by Section 16 of Rule XIV-A of the Regulation of the Insurance Code.

On the other hand, Organization's audited financial statements did not meet the following sections of Rule XIV-A of the Regulation of the Insurance Code:

- The Organization failed to comply Section 5(F) of Rule XIV-A. Notes of the Organization's audited financial statements were not carried out in accordance with Accounting Practices and Procedures Manual and the Annual Statement Instructions promulgated by the NAIC.
- The Organization failed to meet Section 5(G) of Rule XIV-A. The Organization's audited financial statements were not comparative with the previous year.
- The Organization failed to fulfill Section 6(A) of Rule XIV-A. The Organization did not file with the Commissioner in writing the name and address of independent certified public accountant.
- The Organization failed to meet Section 6(B) of Rule XIV-A. The Organization did not file with the Commissioner a certification that establishes its accountant is

aware of the provisions related to accounting and financial matters in the insurance code and that opinion on the financial reports according to the statutory accounting practices prescribed or permitted[5].

The actuarial study and opinion for the period under examination was prepared by Mr. Uriel G. Candelas Agosto. Rule No. 95 of the Regulation of the Insurance Code states requirements for actuarial opinion. As of December 31, 2012, the Organization's actuarial opinion was submitted to the Commissioner, but the opinion did not comply with the following sections of Rule No 95:

- Section 6(C) - the Organization did not notify the Commissioner with the name, title and manner of appointment or retention of each person appointed or retained by the Organization as an appointed actuary.
- Section 7(A)(1) - the identification section did not indicate the appointed actuary's qualification.
- Section 7(A)(2) - the identification section did not include a summary of the reserves, in a table format.
- Section 7(B)(1) - the identification section did not indicate the appointed actuary's relationship to the Organization, qualifications for acting as appointed actuary.
- Section 7 B(2) & (3) - the scope section did not contain a statement required or prescribe wording.
- Section 7(B)(6) - the opinion section did not contain a statement or prescribed wording. Also the actuarial opinion did not provide the date when the opinion was rendered and the signature of the appointed actuary did not appear in the established format.

However, the Organization developed procedures for prospective compliance with Rule No. 95 of the Regulation of Insurance.

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[5] Subsequently, the Organization filed with the Commissioner all required documents pursuant to Rule XIV-A of Regulation.

Prompt Payment

In order to test the Organization's compliance with Rule No. 73, "Standards to Regulate the Punctual Payment of Claims to Health Care Providers" and Chapter 30 of the Insurance Code of Puerto Rico, a sample was drawn from the population of claims paid between January 1, 2012 and April 2013.

The Organization encourages its providers to submit claims electronically, instead of through the US Mail. The Organization paid several claims after of the thirty (30) calendar days term for payment of a claim. The Organization failed to comply with Section 30.030 of the Insurance Code and Section 5(B) of Rule No. 73 of Regulation of Insurance Code.

Pursuant to Section 7 of Rule No. 76 of the Regulation of the Insurance Code, all health services organization using an electronic storage system will be required to get an opinion of certified information system auditor and the chief financial officer or the person in charge of the information systems area must certify that the information on which the auditor based his opinion is correct and complete. Required certifications must be initially presented to the Commissioner within 90 days of the date when the electronic storage system started to operate.

As of December 31, 2012, the aforementioned certifications had not been submitted to the Commissioner[6].

[6] The Organization subsequently filed the certification with the Commissioner.

Complaints System

Section 19.120(1) of the Insurance Code states that every health services organization shall establish and maintain a complaint procedure that include the designation of a Grievance Committee which shall not exceed five (5) members and on which the subscribers of individual contracts, the subscribers of the different group plans and the providers shall be represented. For the years 2010 and 2011, the Organization Grievance Committee did not include providers representatives.

FINANCIAL STATEMENTS

Ruling Letter No. 2010-118-AF dated December 13, 2010, states that every health maintenance organization must submit to the Commissioner, their annual statement and these statement must follow the NAIC's Annual Statements Instructions. The Organization failed to fulfill aforementioned Ruling Letters and Annual Statements Instruction. As of December 31, 2012, the Organization's annual statement did not include:

- Underwriting and Investment Exhibit Part 2-C: Section A, B & C.
- Exhibit of Net Investment Income
- Schedule Y – Information Concerning Activities of Insurer Members of a Holding Company Group
- Schedule Y – Part 1A - Detail of Insurance Holding Company System
- Schedule Y - Part 2 - Summary of Insurer's Transactions with any Affiliates
- Exhibit 3 – Health Care Receivables

Furthermore, Ruling Letter No. NE-3-74-94 dated April 12, 1994, stipulates that all health maintenance organization that opt to partially or fully amend its annual statement, shall include with the amended a statement explaining in detail what is the change with respect to the original report. The aforementioned statement must be

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[7] See Circular Letter No. E-2-I394-95 dated August 11, 1995

sworn with at least two (2) senior officials of the Organization, preferably the same that appear in the annual report originally filed. Further Ruling Letter provides that it shall not be considered as having filed the amended report if it does not comply with the above mentioned.

The Organization amended its annual report for the year 2011, but did not submit to the Commissioner a statement, sworn in with at least two (2) of its senior officials, explaining in detail what is the change with respect to the report originally filed.

The following pages contain financial statements showing the Organization's financial position and results of its operations. These statements are the same filed in the annual statement as of December 31, 2012 and 2011:

First Medical Health Plan, Inc.

Balance Sheet

As of December 31, 2012 and 2011

	YEARS 2012	2011
ASSETS		
Bonds	$21,465,000	$11,000,000
Real Estate	246,990	224,800
Cash and Cash Equivalents	40,943,680	31,221,581
Uncollected Premiums	58,892,976	57,641,027
Electronic Data Processing	337,407	283,868
Aggregate write-ins for other than invested	7,749,332	4,290,100
Total Assets	$129,635,385	$104,661,376
LIABILITIES		
Claims Unpaid	$95,543,964	$81,136,549
General Expenses due or Accrued	9,735,226	8,071,986
Aggregate write-ins for Liabilities	608,095	662,830
Total Liabilities	$105,887,285	$89,871,365
CAPITAL		
Common Capital Stock	$1,875	$1,875
Surplus Notes	20,738,860	20,738,860
Gross Paid and Contributed Surplus	2,960,400	2,960,400
Unassigned Funds	46,965	(8,911,124)
Capital and Surplus	$23,748,100	$14,790,011
Total Liabilities, Surplus and other Funds	$129,635,385	$104,661,376

First Medical Health Plan, Inc.
Statement of Revenue and Expense
As of December 31, 2012 and 2011

	2012	2011
Net Premiums earned	$614,656,900	$585,703,965
Total Revenues	$614,656,900	$585,703,965
Hospital and Medical:		
Hospital/medical benefits	418,207,817	407,787,126
Other Profesional Services	9,840,184	4,426,795
Aggregate write-ins for other Hospital and Medical	118,628,884	113,241,294
Subtotal	$546,676,885	$525,455,215
Less		
Total Hospital and Medical	546,676,885	525,455,215
General Administrative Expenses	60,796,144	58,346,821
Total underwriting deductions	$607,473,029	$583,802,036
Net Underwriting Gain or (Loss)	7,183,871	1,901,929
Aggregate write-ins for other income or expenses	817,417	306,609
Net Income or (loss) before Income Taxes	8,001,288	2,208,538
Federal and foreign income taxes incurred	1,550,359	472,209
Net Income	$6,450,929	$1,736,329

First Medical Health Plan, Inc.
Cash Flows
As of December 31, 2012 and 2011

	2012	2011
CASH FROM OPERATIONS		
Premium Collected Net of Reinsurance	$611,104,967	$605,173,119
Net Investment Income	0	0
Miscellaneous Income	986,295	335,509
	$612,091,262	$605,508,628
Commissions, Expenses paid for Deduction	590,319,750	593,794,689
Federal and Foreign Income Taxes Paid	42,162	28,682
	590,361,912	593,823,371
Net Cash from Operations	**$21,729,350**	**$11,685,257**
CASH FROM INVESTMENTS		
Cost of Investments Acquired		
Bonds	10,465,000	11,000,000
Other Invested Assets	1,487,516	707,591
Total Investments Acquired	11,952,516	11,707,591
Net Cash from Investments	**($11,952,516)**	**($11,707,591)**
CASH FROM FINANCING & MIS. SOURCE		
Other Cash Provided	(54,735)	(184,928)
Net Cash from Financing & Mis. Source	**($54,735)**	**($184,928)**

First Medical Health Plan, Inc.

Balance Sheet Amended[8]

As of December 31, 2012

	A/S 12/31/2012	Adjustment/Reclass Debit	Adjustment/Reclass Credit	Examination Balance
ASSETS				
Bonds	$21,465,000			$21,465,000
Real Estate	246,990			246,990
Cash and Cash Equivalents	40,943,680			40,943,680
Investment Income due and Accrued	0	(R) $43,989		43,989
Uncollected Premiums	58,892,976			58,892,976
Electronic Data Processing	337,407			337,407
Health Care and other amount Receivable	0	(R) 7,493,078	(A) $2,109,273	5,383,805
Aggregate write-ins for other than Invested	7,749,332		(R) 7,537,067	212,265
Total Assets	$129,635,385	$7,537,067	$9,646,340	$127,526,112
LIABILITIES				
Claims Unpaid	$95,543,964			$95,543,964
General Expenses Due or Accrued	9,735,226	(R) 2,358,626		7,376,600
Amounts withheld or Retained for Other	0		(R) $1,122,727	1,122,727
Amount due to Parent and Subsidiaries	0		(R) $1,235,899	1,235,899
Aggregate write-ins for Liabilities	608,095			608,095
Total Liabilities	$105,887,285		$2,358,626	$105,887,285
CAPITAL				
Common Capital Stock	$1,875			$1,875
Surplus Notes	20,738,860			20,738,860
Gross Paid and Contributed Surplus	2,960,400			2,960,400
Unassigned Funds	46,965		(A) $2,109,273	(2,062,308)
Capital and Surplus	$23,748,100		$2,109,273	$21,638,827
Total Liabilities, Surplus and other Funds	$129,635,385			$127,526,112

[8] Certain reclassifications have been made to the 2012 annual statement to conform to Annual Statement Instructions and Accounting Practices and Procedures Manual. Such reclassifications had no effect on the reported results of operations or total net assets.

First Medical Health Plan, Inc.
Comparative Analysis of Changes in Surplus
As of 31 de diciembre de 2012

The following is a reconciliation of Unassigned Funds between that reported by the Organization and as determined by the examination.

	Examination Adjusted Decrease	BALANCE
Unassigned Funds per Annual Statement		$46,965
ASSETS:		
Health care and Other Amount Receivable	$2,109,273	
	$2,109,273	
Total		(2,109,273)
Unassigned Funds per Examination		($2,062,308)

COMMENTS ON THE FINANCIAL STATEMENTS

Aggregate write-ins for Other than Invested Unassigned Surplus

The Organization improperly reported amount from pharmaceutical rebates receivable. These balances should have been reported as non-admitted assets as required SSAP No. 84, Paragraph 10(b) of the NAIC Accounting Practices and Procedures Manual. The Organization failed to comply with Section 5.030 of Insurance Code and aforementioned Paragraph 10(b) of SSAP No. 84, recognizing non-admitted assets as part of its annual statement. Even, paragraph 24 of SSAP No. 84 states that the financial statements shall disclose the method used by the reporting entity to estimate pharmaceutical rebate receivables. The Organization failed to fulfill paragraph 24 of SSAP No. 84.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

MANAGEMENT & CONTROL

- The Organization failed to comply with Ruling Letter No. 2009-104-AF dated September 22, 2009. The Organization's stockholder's relation was not sworn by the same people that swear the annual statement Jurat Page.
- The Organization did not comply with Section 6.040(1) of the Insurance Code. The Organization investment plan does not establish the professional qualifications of the persons who will make routine decisions to ensure investment competence and ethical conduct.
- The Organization failed to comply with Section 6.040(2) of the Insurance Code. The Board did not certify in writing, through a formal resolution the investment activities of the Organization.
- The Organization did not comply with Section 6.040(3) of the Insurance Code and Section 4(C)(2)(d) of Rule 66 of Regulation of Insurance Code. The Board or a duly authorized committee did not review or update the written plan.

- The Organization failed to comply with Section 4(D) of Rule XIV-A of the Regulations of the Insurance Code. As of December 31, 2012, the Organization did not designate its audit committee pursuant to referred Rule.

- The Organization did not meet with Section 7(I) of Rule XIV-A of the Regulations of the Insurance Code. All auditing services and other services provided to Organization by the independent certified public accountant were not preapproved by its audit committee.

- The Organization failed to comply with Section 19.050(2) of the Insurance Code of Puerto Rico.

RELATED PARTY

- The Organization failed to comply with paragraph 19 of the SSAP No. 25 of Accounting Practices and Procedures Manual.

- The Organization failed to comply with Paragraph 7 of the SSAP No. 25 of Accounting Practices and Procedures Manual.

- The Organization failed to fulfill Paragraph 19(d) and 19(f) of the SSAP No. 25 of Accounting Practices and Procedures Manual.

- The Organization failed to submit Form B and Form C pursuant to Rule No. 83 of Regulation of Insurance Code. The Organization did not comply with Sections 13 and Section 14 of referred Rule No. 83 of the Regulation of Insurance.

- The Organization failed to meet Ruling Letter No. 2011-126-AF dated June 1, 2011.

ACCOUNTS AND RECORDS

- The Organization's audited financial statement were not filed with the Commissioner on or before June 1 for year of operations ended December 31 immediately preceding pursuant to Section 4(A) of Rule XIV-A of the Regulation of Insurance.

- The Organization did not file a statement of changes in capital and surplus pursuant Section 5(E) of Rule XIV-A of the Regulation of Insurance.

- The Organization did not file a communication of internal controls related matter noted in an audit as required by Section 11(A) of Rule XIV-A of the Regulation of Insurance.

- The Organization did not submit its Letter of Qualifications of the external auditors as required by Section 12 of Rule XIV-A of the Regulation of Insurance.

- The Organization did not submit its Managements report of internal controls for audited financial reports as required by Section 16 of Rule XIV-A of Regulation of Insurance Code.

- The Organization failed to comply with Section 5(F) of Rule XIV-A of Regulation of Insurances. Notes of the Organization's audited financial statements were not carried out in accordance with Accounting Practices and Procedures Manual and the Annual Statement Instructions promulgated by the NAIC.

- The Organization failed to meet Section 5(G) of Rule XIV-A. The Organization's audited financial statements were not comparative to the previous year.

- The Organization failed to fulfill Section 6(A) of Rule XIV-A. The Organization did not file with the Commissioner in writing the name and address of independent certified public accountant.

- The Organization failed to meet Section 6(B) of Rule XIV-A. The Organization did not file with the Commissioner a certification that establishes its accountant is aware of the provisions related to accounting and financial matters in the insurance code and that opinion on the financial reports according to the statutory accounting practices prescribed or permitted.

- The Organization did not notify the Commissioner of the name, title and manner of appointment or retention of each person appointed or retained by the Organization as an appointed actuary. The Organization failed to comply with Section 6(C) of Rule No. 95 of the Regulation of Insurance.

- The Organization failed to fulfill Section 7(A)(1) of Rule No. 95 of the Regulation of Insurance. Its Actuarial Opinion "Identification Section" did not indicate the appointed actuary's qualification.

- The Organization did not comply Section 7(A)(2) of Rule No. 95 of the Regulation of Insurance. Its Actuarial Opinion "Identification Section" did not include a summary of the reserves, in a table format.

- The Organization did not comply with Section 7(B)(1) of Rule No. 95 of the Regulation of Insurance. Its Actuarial Opinion "Identification Section" did not indicate the appointed actuary's relationship to the Organization and qualifications for acting as appointed actuary.

- The Organization did not meet Section 7(B)(2) and (3) of Rule No. 95 of the Regulation of Insurance. Its Actuarial Opinion "Scope Section", did not contain a statement required or prescribed wording.

- The Organization failed to comply with Section 7(B)(6) of Rule No. 95 of the Regulation of Insurance. The Opinion Section of the Actuarial Opinion did not contain a statement or prescribed wording. Also the Actuarial Opinion did not provide the date when the opinion was rendered and the signature of the appointed actuary did not appear in the established format.

- The Organization failed to meet Section 30.030 of the Insurance Code and Section 5(B) of Rule No. 73 of Regulation of Insurance.

- The Organization did not meet Section 7 of Rule No. 76 of Regulation of Insurance. As of December 31, 2012, an opinion of certified information auditor and the chief financial officer had not been submitted to the Commissioner.

- The Organization's grievance committee did not include providers' representatives for years 2010 and 2011, pursuant to Section 19.120(1) of Insurance Code.

FINANCIAL STATEMENTS

- The Organization failed to comply with Ruling Letter No. 2010-118-AF dated December 13, 2010 and the NAIC's Annual Statements Instructions.

- The Organization failed to comply with Ruling Letter No. NE-3-74-94 dated April 12, 1994. The Organization amended its annual report for the year 2011, but did not submit to the Commissioner a statement, sworn in with at least two (2) of its senior officials, explaining in detail what was the change with respect to the report originally filed.

PHARMACEUTICAL REBATES RECEIVABLES

- The Organization failed to fulfill with Section 5.030 of Insurance Code. The Organization improperly reported as admitted assets pharmaceutical rebates receivables.

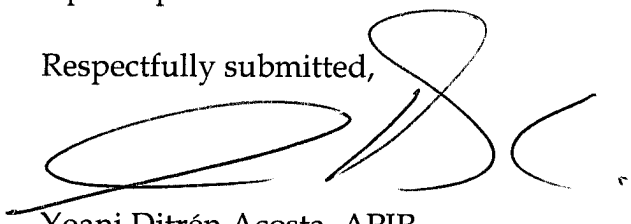
- The Organization did not comply with Paragraphs 10(b) and 24 of SSAP No. 84 of the Accounting Practices and Procedures Manual.

CONCLUSION

The insurance examination practices and procedures as promulgated by the NAIC have been followed in ascertaining the financial condition of First Medical Health Plan, Inc., as of December 31, 2012, consistent with the insurance laws of Puerto Rico.

Per examination finding, the Organization Unassigned Funds was ($2,062,308), in compliance with Insurance Code of Puerto Rico. In addition to the undersigned, Mrs. Yajaira Torres Martínez, Examiner Technician, who participated in the examination.

Respectfully submitted,



Yoani Ditrén Acosta, APIR
Examiner