

REPORT ON EXAMINATION

OF

SECURITY HEALTH INSURANCE COMPANY OF AMERICA,

NEW YORK, INC.

AS OF

DECEMBER 31, 2012

DATE OF REPORT

FEBRUARY 19, 2015

EXAMINER

FROILAN L. ESTEBAL

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

February 19, 2015

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30961, dated February 22, 2013, attached hereto, I have made an examination into the condition and affairs of Security Health Insurance Company of America, New York, Inc., a for-profit accident and health insurer licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2012, and respectfully submit the following report thereon.

The examination was conducted at the home office of Security Health Insurance Company of America, New York, Inc. located at 388 Broadway, Schenectady, New York.

Wherever the designations the “Company” or “Security Health” appear herein, without qualification, they should be understood to indicate Security Health Insurance Company of America, 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

This is the first examination of Security Health Insurance Company of America, New York, Inc. An on-organization examination of the Company was conducted as of October 31, 2009. This combined (financial and market conduct) examination of the Company covered the period from November 1, 2009 through December 31, 2012. The financial component of the examination was conducted as a financial examination, as such term is defined in the National Association of Insurance Commissioners (“NAIC”) 2012 *Financial Condition Examiners Handbook* (the “Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2012 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner’s assessment of risk in the Company’s operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate Security Health’s current financial condition, as well as identify prospective risks that may threaten the future solvency of the Company.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined

management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

Information concerning the Company's organizational structure, business approach and control environment were utilized to develop the examination approach. The examiner evaluated the Company'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 Company was audited for the first time for the year ending 2012, by the accounting firm of Ernst & Young LLP ("E&Y"). The Company received an unqualified opinion from E&Y for the year 2012 audit report. Certain audit work papers of E&Y were reviewed and relied upon in conjunction with this examination. A review was also made of the Company's internal audit function and enterprise risk management program.

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

2. EXECUTIVE SUMMARY

The examination revealed certain operational deficiencies from the Company's own operations, as well as from contracted third party administrators (TPAs), which occurred during and subsequent to the examination period. Following are the significant findings included within this report on examination:

- The Company failed to comply with Section 3234(b) of the New York Insurance Law when it did not include all of the requisite information on its explanation of benefits ("EOB") statements.
- The Company failed to comply with Sections 4903(e)(2) and 4904(c)(2) of the New York Insurance Law when it did not include written notification and instruction for the insured's right to a standard, expedited or external appeal.
- The Company failed to comply with Section 4901(a) of the New York Insurance Law when it did not file its utilization review plan with the Superintendent on a biennial basis.
- The Company failed to comply with the Department's Circular Letter No. 9 (1999) when its Board of Directors did not adopt or approve its claims processing procedures.

3. DESCRIPTION OF THE COMPANY

Security Health Insurance Company of America, New York, Inc. is a for-profit stock company that was incorporated in the State of New York on November 12, 2008. The Company received a license, effective December 28, 2009, from the then New York State Insurance Department to operate as an accident and health insurer pursuant to Article 42 of the New York Insurance Law.

A. Corporate Governance

Pursuant to the Company's by-laws, the Board of Directors of the Company shall not be less than seven members. As of December 31, 2012, Security Health's Board of Directors consisted of the following seven members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Brian Keith Smith Eagan, Minnesota	President, Private Capital Management, Inc.
William Carl Peterson Apple Valley, Minnesota	Chairman and Chief Executive Officer, Private Capital Management, Inc.
Scott Lee Becker North Oaks, Minnesota	Managing Partner, Northstar Capital
Michael Timothy Davies Bloomington, Minnesota	Principal – Private Equity Private Capital Management, Inc.
Harold Demary Gordon, Esq. Clifton Park, New York	Attorney, Couch White, LLP
Mark Allen Zesbaugh Eagan, Minnesota	President and Chief Executive Officer, Security Life Insurance Company of America
Daniel Robert Bauer Hopkins, Minnesota	Chief Financial Officer, Security Life Insurance Company of America

The minutes of all meetings of the Company's Board of Directors and committees thereof held during the period under examination were reviewed.

Board of Directors' Meeting Attendance

The Company's by-laws require that the Board of Directors meet at least annually. A review of the Board of Directors' minutes of meetings indicated that the Company held the required annual meetings during the years covered by this examination. However, the review of

attendance by the board members revealed that three of the directors attended less than 50% of the meetings that they were eligible to attend. Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Company. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate decisions may be reached by the board.

It is recommended that board members who are unable or unwilling to attend board meetings consistently resign or be replaced.

Board of Directors Member's Residence

A review of the State of residence for members of the Company's Board of Directors indicated that the number of board members residing in the State of New York as of the year end 2012 was less than two, which is not in compliance with the Company's By-Laws.

Article III, Directors, Section 3.2, of the Company's By-laws states the following:

“...At all times a majority of the directors of the Corporation shall be citizens and residents of the United States, and not less than two directors shall be residents of the State of New York.”

It is recommended that the Company comply with its By-Laws by having no less than two board members maintain residences in the State of New York.

Minutes of the Board of Directors' Meetings

A review of the minutes of the Company's Board of Directors meetings revealed that a certain significant event affecting the Company's business was not reflected in the minutes.

This event involved the acquisition of a significant and material block of dental business from Presidential Life Insurance Company. The acquisition which was effective January 1, 2013, resulted in a significant increase in the Company's business in 2013.

It is recommended that significant business decisions be brought to the Board's attention and discussed thoroughly by the Board in order that the Board's approval and appropriate directions can be achieved and conveyed to the Company's management.

It is further recommended that such key significant events involving the Company be reflected in the minutes of the Board of Directors.

Conflict of Interest Statements

The Board of Directors' conflict of interest statements during the period under examination were reviewed. It was noted that two questions were missing from five of the seven conflict of interest statements. The signed conflict of interest statements of the five directors were missing the following questions:

Check here and list or describe exceptions. Give enough information so that a judgment as to the extent of any conflict can be made. Use additional pages as necessary

Check here if you have sent your concerns regarding any perceived conflict of interest directly to:

Mr. Brian Smith, Chairman
Audit Committee..."

It is recommended that the Company require its directors to use the same form and affirm the same questions when completing their Conflict of Interest Statements.

The principal officers of the Company as of December 31, 2012, were as follows:

<u>Name</u>	<u>Title</u>
Mark Allen Zesbaugh	Chief Executive Officer
Daniel Robert Bauer	Chief Financial Officer
Thomas Joseph Bauer	Chief Operations Officer

Internal Controls / Enterprise Risk Management

The Company's internal audit function, as well as the enterprise risk management ("ERM") function for the Company is provided by its parent company, Security America Financial Enterprise, Inc. ("SAFE"), which serves as the management company. Due to its low premium volume, the Company is not required to comply with certain sections of Department Regulation No. 118. The Company is also not subject to Sarbanes Oxley Act ("SOX"), though as a proactive measure, the parent Company's internal auditor performed a general risk identification and assessment of the Company operations in 2013, as part of an initiative to create an enterprise risk management function.

However, the Company did not document its internal control processes. Additionally, the Company did not formally document strategies used to mitigate its identified risks. Although the Company is not required to formalize the internal control and risk assessment process, it would be beneficial to formulate an enterprise risk management structure.

It is recommended, that as a good business practice, the Company formalize and document its internal controls processes for key activities.

It is further recommended that the Company continue to develop and formalize its general risk assessment process and develop and document strategies that mitigate identified risks. Further, such assessments and strategies should be reviewed and approved by the Company's Board of Directors.

B. Territory and Plan of Operation

Security Health is licensed pursuant to the provisions of Article 42 of the New York Insurance Law and is authorized to conduct business only within the State of New York. Security Health reported premiums written totaling \$397,969 during the period January 1, 2010 through December 31, 2012. There were no premiums generated in 2009. Below is a summary of the Company's total written premiums during the examination period:

<u>Year</u>	<u>Premiums</u>
2010	\$ 15,930
2011	75,664
2012	<u>306,375</u>
Total	<u>\$397,969</u>

The following is a summary of the Company's total premiums written by line of business during the period January 1, 2010 through December 31, 2012:

<u>Line of Business</u>	<u>Premiums</u>
Dental	\$395,343
Vision	<u>2,626</u>
Total	<u>\$397,969</u>

The Company is primarily engaged in underwriting ancillary benefit health insurance, such as dental and vision. The largest line of business is dental, which comprised over 99% of the Company's net premiums earned during the examination period. The Company's current business strategy to increase membership is to acquire existing blocks of business and contract with its current third party administrators. The Company also makes use of agents on a limited basis for the procurement of business.

Below is the Company's membership enrollment during the period covered by this examination:

	<u>Members</u>	<u>Increase from prior year</u>
2010	76	-----
2011	182	139% increase
2012	689	278% increase

C. Reinsurance

The Company did not have any reinsurance in effect as of December 31, 2012. No premiums were assumed or ceded to/from other carriers.

D. Significant Underwriting Ratios

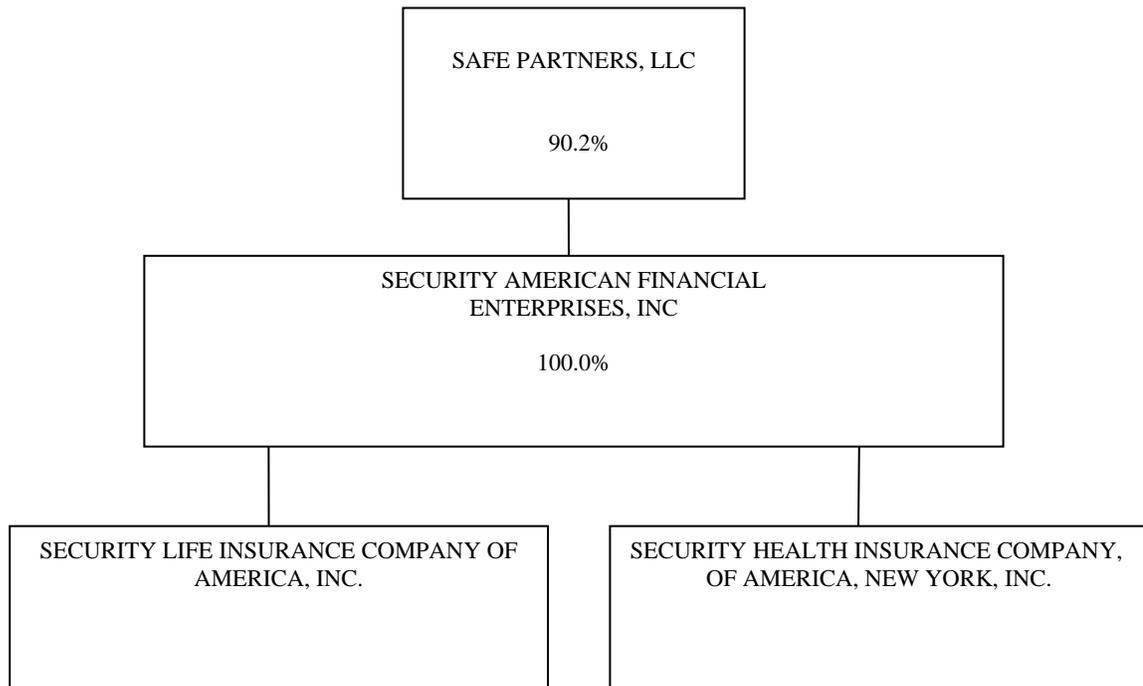
The following ratios to premiums earned have been computed as of December 31, 2012, based upon the results of this examination. The ratios presented below are on an earned-incurred basis and encompass the period covered by this examination:

	<u>Amounts</u>	<u>Ratios</u>
Claims	\$266,880	67.05%
General administrative expenses	283,515	71.23%
Net underwriting loss	<u>(152,386)</u>	<u>(38.29%)</u>
Premiums earned	<u>\$398,009</u>	<u>100.00%</u>

E. Holding Company System

The Company is a wholly-owned subsidiary of Security American Financial Enterprises, Inc. (“SAFE”) a privately held corporation which in turn, is a wholly-owned subsidiary of Safe Partners, LLC. The Company has one affiliate, Security Life Insurance Company of America, Inc., (“Security Life”), which is also a wholly-owned subsidiary of SAFE.

The following chart depicts the Company’s relationship with members of its holding company system. The percentages included in the chart reflect each entity’s proportionate ownership as of December 31, 2012.



The Company’s holding company chart in its filed 2012 Annual Statement indicated that the ultimate parent, Safe Partners, LLP owned 90.2% of the Company. The other 9.8% was

owned by various individuals. However this information was omitted from the Company's filed annual statements and holding company filings covering the examination period.

It is recommended that the Company include complete information regarding holding company entity ownership within its filed annual statements and holding company filings with the Department.

Holding Company Agreements

As of the examination date, the Company had the following agreements with members of its holding company system:

1. A Management and Service Cost Sharing Agreement, dated June 8, 2009, between Security American Financial Enterprises, Inc. and the Company whereby Security American Financial Enterprises, Inc. performs various services on behalf of the Company, including personnel, managerial, accounting, legal, investment management, administrative and IT personnel services. According to the agreement, the Company agrees to reimburse SAFE for the full cost of all services provided under the agreement, including the salaries of the personnel utilized by the Company. According to the agreement, allocated costs and expenses are to be established in conformity with Insurance Regulation No. 30 (11 NYCRR 105-109).
2. A Tax allocation agreement, dated June 8, 2009, between Security American Financial Enterprises, Inc. and the Company, whereby the Company agreed to join in the consolidated filing of the Security American Financial Enterprises, Inc. Group's federal income tax return for each taxable year for which the Company is eligible to join in such filing. The Security American Financial Enterprises, Inc. Group consists of Security American Financial Enterprises, Inc., Security Life Insurance of America, Inc. and Security Health Insurance Company of America, New York, Inc.

According to the consolidated tax allocation agreement, the Company's reported federal tax liability is to be the same amount the Company would have had if it had filed a separate tax return.

The above two agreements have been approved by the Department.

F. Third Party Administrators (“TPAs”)

The Company utilizes third party administrators to provide general administrative services to the Company’s dental business as follows:

1. Meritain Health (“Meritain”) – is a third party administrator located in Plymouth, Minnesota. The Agreement has been in effect since March 1, 2000.
2. Azeros Health Plans (“NOVA”) – is a third party administrator located in Williamsville, New York. This agreement went into effect on June 1, 2010.
3. Pro Benefits Administrators (“Pro-Benefits”) – is a contracted third party administrator that provides similar administrative services (similar to Meritain and NOVA) to the Company. Pro-Benefit’s office is located in Amherst, New York. This agreement went into effect on January 1, 2013.

Key services provided by all three TPAs include enrollment, eligibility, claims processing, premium collection and billing, commissions, reporting, underwriting, sales, information technology services, etc. The majority of the Company’s overall premiums and claims are administered by the TPAs. The TPAs each administer claims that cover specific provider groups.

G. Accounts and Records

During the course of the examination, it was noted that the Company’s treatment of certain items were not in accordance with specified Statements of Statutory Accounting Principles (SSAP) of the *NAIC Accounting Practices and Procedures Manual*, *NAIC Financial Condition Examiners Handbook*, *NAIC annual statement instructions*, or certain rules and

regulations of the New York State Department of Financial Services. A description of such items is as follows:

1. Representation Letter to the External Auditors

The representation letter signed by the Company's management which was disclosed to the external auditors contained a section with regard to subsequent events. The statement indicates that no material transactions occurred subsequent to December 31, 2012. However, on January 1, 2013 the Company acquired a significant block of dental business from Presidential Life Insurance Company (which is administered by its contracted TPA, Pro-Benefits). See Section 6 of this report for further details.

The Subsequent Events section of the representation letter states:

“Subsequent to December 31, 2012 no events or transactions have occurred or are pending that would have a material effect on the financial statements at that date or for the period then ended, or that are of such significance in relation to the Company's affairs to require mention in a note to the financial statements to make them not misleading regarding the financial position, results of operations or cash flows of the Company.”

It is recommended that the Company disclose all events and transactions within the representation letters to the external auditors that have a significant or material effect on its financial statements.

2. Primary Location of the Company's Books and Records

The Company indicated in its annual statements filed with the Department during the examination period that the primary location of its books and records was Schenectady, New York.

However, the primary location of officers/staff, decision makers and other personnel handling the majority of the Company's applications, books and records are located in Minnetonka, Minnesota.

It is recommended that the Company change the reported primary location of its books and records location to its Minnesota address within its filings with the Superintendent of Financial Services.

Further, the Company did not file with the Superintendent a request to keep its books and records outside the State of New York, (nor received permission to do so) as per Section 325(b) of the New York Insurance Law.

Section 325(b) of the New York Insurance Law states:

“(b) A domestic insurer and a licensed United States branch of an alien insurer entered through this state may keep and maintain its books of account without this state if, in accordance with a plan adopted by its board of directors and approved by the superintendent.”

It is recommended that the Company not maintain its books of accounts outside of New York State, unless it receives permission to do so by the Department.

3. Underwriting and Investment Exhibit - Part 3

A review of the Company's Underwriting and Investment Exhibit - Part 3 (Analysis of Expenses) of its annual statement filings made during all years of the examination period revealed that total expenses paid were reported under general administrative expenses and

investment expenses in the Underwriting and Investment Exhibit (“U&I”). No amounts were allocated to the Company’s claims adjustment expenses.

Paragraph 5 of Statement of Statutory Accounting Principles (SSAP) No. 70 of the *NAIC*

Accounting Practices and Procedures Manual states:

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

It is recommended that the Company comply with the requirements of Paragraph 5 of SSAP No. 70 of the *NAIC Accounting Practices and Procedures Manual* by reporting allocated management expenses between claims cost containment expenses, claims adjustment expenses and general administrative expenses within the appropriate areas of its Underwriting and Investment Exhibit of its filed annual statements.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following statements show the assets, liabilities, capital and surplus as of December 31, 2012, as contained in the Company's 2012 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2012 filed annual statement.

The firm of Ernst & Young LLP ("E&Y") was retained by the Company to audit the Company's statutory basis statements of financial position as of December 31st of 2012, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended.

E&Y concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company as of December 31, 2012. Balances reported in this audited financial statement were reconciled to the December 31, 2012 annual statement, except for a minor discrepancy described in Section 6 of this draft report. No examination changes were made relative to the Company's filed annual statement.

<u>Assets</u>	<u>Examination</u>	<u>Company</u>
Bonds	\$351,117	\$351,117
Cash and short term investments	714,652	714,652
Investment income due and accrued	2,492	2,492
Uncollected premiums and agents' balances in course of collection	32,919	32,919
Current federal and foreign income tax recoverable and interest thereon	<u>23,129</u>	<u>23,129</u>
Total admitted assets	<u>\$1,124,309</u>	<u>\$1,124,309</u>
 <u>Liabilities</u>		
Claims unpaid	\$58,011	\$58,011
General expenses due or accrued	13,353	13,353
Remittances and items not allocated	29,486	29,486
Amounts due to parent, subsidiaries and affiliates	721	721
Aggregate write-ins for other liabilities	<u>7,218</u>	<u>7,218</u>
Total liabilities	<u>\$108,789</u>	<u>\$108,789</u>
 <u>Capital and Surplus</u>		
Common capital stock	\$425,000	\$425,000
Gross paid in and contributed surplus	675,000	675,000
Unassigned funds surplus	<u>(84,480)</u>	<u>(84,480)</u>
Total capital and surplus	<u>\$1,015,520</u>	<u>\$1,015,520</u>
Total liabilities and capital and surplus	<u>\$1,124,309</u>	<u>\$1,124,309</u>

Note 1: The Internal Revenue Service has not conducted any federal income tax audits of the Plan through tax year 2012. The examiner is unaware of any potential exposure by the Company to any tax assessment and no liability has been established herein relative to any contingency.

Note 2: The Company adjusted the 2012 balance sheet and income statement subsequent to its original filing to adjust for errors noted regarding premiums received from newly acquired business. No examination changes were made to the financial statements due to the immaterial amount.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus decreased by \$84,777 during the examination period, November 1, 2009 through December 31, 2012, as detailed below:

Revenue

Total revenue		\$398,009
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Expenses

Claims and claims adjustment expenses	266,880	
General administration expenses	283,515	
Total underwriting deductions		<u>\$550,395</u>
Net underwriting losses		(152,386)
Net investment gain		25,380
Net loss before federal income taxes		<u>\$(127,006)</u>
Federal income taxes		42,952
Net loss		<u>\$(84,054)</u>

Capital and Surplus

Capital and surplus, per report on organization, as of October 31, 2009		\$ 1,100,297
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	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>
Net Income (loss)		\$ 84,054
Change in non-admitted assets		730
Change in net deferred income tax	\$ 304	
Unassigned Funds		<u>297</u>
Net decrease in capital and surplus		<u>\$(84,777)</u>

Capital and surplus, per report on examination, as of December 31, 2012		<u>\$ 1,015,520</u>
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5. CLAIMS UNPAID

The examination liability of \$58,011 is the same as the amount reported by the Company in its filed annual statement as of December 31, 2012.

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 Company's internal records and in its filed annual statements. 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 Company's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2012.

However, during the review it was noted that the Company's reported claims unpaid amount included amounts relative to its claims unpaid liability and its claims adjustment expense liability. The two components should be separated as per NAIC Annual Statement instructions.

The Company's filed Statement of Actuarial Opinion for the year ended 2012, as reported by Milliman, Inc., also indicated that the Company's claim liability included an explicit provision for claims adjustment expenses of \$1,740, which was erroneously included in the annual statement as part of the total unpaid claim liability.

It is recommended that, for subsequent filings, the Company report separate liabilities for its unpaid claims adjustment expenses and its unpaid claims expenses in its filed annual statements with the Superintendent of the Department of Financial Services.

6. SUBSEQUENT EVENTS

The Company acquired a significant amount of dental business from Presidential Life Insurance Company effective January 1, 2013. The Company's external auditors, E&Y, adjusted the Company's year end 2012 balance sheet and income statement in its 2012 Annual Report for errors noted regarding the accounting year for premiums received from this newly acquired business. Premiums collected were erroneously reflected in the 2012 annual statement, which was prior to the effective acquisition date of January 1, 2013. The net impact was a reduction in the Company's surplus in the amount of \$16,914. No examination changes were made to the financial statements contained herein, due to the immaterial amount.

It is recommended that the Company reflect the correct balances in its annual and quarterly statement filings with this Department.

7. MARKET CONDUCT ACTIVITIES

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

- A. Utilization review
- B. Explanation of benefits statements
- C. Claims Processing
- D. New York Prompt Pay Law

A. Utilization Review

A review of the Company's Utilization Review process indicated that the first and final adverse determination notices did not contain the required instructions for further appeal and external appeal review rights as required by Sections 4903(e)(2) and 4904(c)(2) of the New York Insurance Law.

New York Insurance Law Section 4903(e)(2) states in part:

“(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
(2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to Section four thousand nine hundred fourteen of this article;”

Further, New York Insurance Law Section 4904(c)(2) states in part:

“...The notice of the appeal determination shall include:
 2) a notice of the insured’s right to an external appeal together with a description, jointly promulgated by the Superintendent and the Commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.”

It is recommended that the Company comply with Sections 4903(e)(2) and 4904(c)(2) of the New York Insurance Law by including the required appeal wording within its determination letters.

In addition, a review of the Company’s, as well as its TPA’s Utilization Review (“UR”) process revealed that the UR review agent did not file the Company’s “Utilization Review Plan” on a biennial with the Superintendent of Financial Services, as required by Section 4901(a) of the New York Insurance Law.

Section 4901(a) of the New York Insurance Law states in part:

“(a) Every utilization review agent shall biennially report to the Superintendent of Financial Services, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section. (b)Such report shall contain a description of the following: (1) The utilization review plan;...”

It is recommended that the Company, as well as its TPA’s, utilization review agent file the Company’s utilization review plan on a biennial basis with the Superintendent of Financial Services, as required by Section 4901(a) of the New York Insurance Law.

B. Explanation of Benefits Statements

A review of the explanation of benefits statements (“EOBs”) issued by the Company, as well as its TPAs revealed that such EOBs did not comply with the requirements of Section 3234(b) of the New York Insurance Law. Section 3234(b) of the New York Insurance Law requires that a notification regarding the time limitation, and the place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate be included in the EOB statements.

Section 3234(b) of the New York Insurance Law states in part:

“(b) The explanation of benefits form must include at least the following:
(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.”

It is recommended that the Company, as well as its TPAs, comply with Section 3234(b) of the New York Insurance Law by including all required information on its explanation of benefits statements.

C. Claims Processing

1. Claims procedure manual

During the review of the Company’s TPA, NOVA’s claims processing procedures, it was revealed that NOVA does not have a documented claims processing manual.

It is recommended that the Company obtain from NOVA a written claims processing policies and procedures manual, which should be updated periodically as changes are made.

Further, the Company's as well as NOVA's procedure manual had not been adopted or approved by the board of directors of the Company as of the examination date. Department Circular Letter No. 9 (1999) describes the responsibilities of the board of directors of health insurers with regard to the management and control of claims processing.

Department Circular letter Number 9 (1999) states in part:

“In order to fulfill its responsibility to oversee the claims adjudication process it is critical that the board adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations. One way for the board to ensure itself that such procedures are in place is to direct the officers responsible for claims adjudication to (i) issue, and up-date as necessary, a claims manual which sets forth the company's claims adjudication procedures; (ii) distribute the claims manual and necessary up-dates to all persons responsible for the supervision, processing and settlement of claims and obtain an acknowledgement of receipt; and (iii) provide the training necessary to ensure the claim manual's implementation including a formal educational program and periodic re-training. It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.”

It is recommended that the Company's board of directors adopt and approve the Company's and its TPA's claims processing procedures manual as required by Department Circular Letter No. 9 (1999), “Adoption of Procedure Manuals”.

2. Paper Claim Files Security

It was noted that active and inactive paper claim files at Pro-Benefits were stored in unlocked cabinets, which are located in an unlocked room, thus leaving sensitive and confidential documents unsecured and vulnerable to unauthorized access.

It is recommended that the Company ensure that claim files, including those files maintained by its TPAs, be kept in a safe and secure manner at all times, ensuring that only authorized staff have access to the files.

3. Paper Claim Files Backup

Pro-Benefits did not have a process in place to create electronic backups for its paper claim files. The TPA did not photocopy, image, scan, nor microfilm claims received in paper format. The TPA does not process electronic claims; therefore all claims are kept in its original paper format. Unsecured paper claim files are vulnerable to theft, misplacement, and unauthorized access.

It is recommended that the Company ensure that its paper claim files are backed-up in an appropriate manner.

4. Unsecured Servers

Pro-Benefits' servers and other sensitive electronic equipment are kept in an unlocked cabinet, in an unlocked room which is easily accessible to unauthorized personnel. Further it was observed that the cabinet that houses the server appeared to have a broken lock.

It is recommended that the Company ensure that its TPA's servers and other sensitive electronic equipment are maintained in a safe and secure manner, accessible only by authorized personnel.

5. Claims Payment Tied to Premiums Receipt

During the review of the Company's in-house claims processing, as well as its TPAs claims processing policies and procedures, it was disclosed that the general policy is to deny or pend payment of claims whenever premium from the member's policy is overdue, uncollected and past the grace period. The Company uses various methods to pend or deny such claims. For Pro-Benefits, the policy is to deny undisputed claims as soon as the premiums are past the grace period. For NOVA, the policy is to suspend the claims indefinitely until overdue premiums are received. For the Company's in-house claims operations, the policy is to deny the claim after 45 days of receipt, if the premiums are in arrears.

It is recommended that the Company and its TPAs change their policy to deny undisputed claims upon the termination of its policy, instead of premiums being in arrears.

D. New York Prompt Pay Law – Monitoring Procedures

During the site review of claims operations of the TPA NOVA, it was noted that NOVA does not have internal control procedures in place to monitor compliance with Section 3224-a of the New York Insurance Law.

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

“...(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy (“covered person”) or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim... within 45 days of receipt of a claim or bill for services rendered.”

Additionally, NOVA does not have internal control procedures in place to monitor the claims unpaid more than 30 days. New York Insurance Law Section 3224-a(b) states in part:

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

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

Further, NOVA also does not have internal control procedures in place to monitor the payment of interest for claims paid over 45 days. New York Insurance Law Section 3224-a(c) states in part:

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

It is recommended that the Company ensure that its TPA, NOVA, maintain adequate controls to monitor the Company's claims for compliance with Sections 3224-a(a), 3224-a(b), and 3224-a(c) of the New York Insurance Law.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Corporate Governance</u>	
<u>Board of Directors</u>	
i. It is recommended that board members who are unable or unwilling to attend meetings consistently resign or be replaced.	6
ii. It is recommended that the Company comply with its By-Laws by having no less than two board members maintain residences in the State of New York.	6
iii. It is recommended that significant business decisions be brought to the Board's attention and discussed thoroughly by the Board in order that the Board's approval and appropriate directions can be achieved and conveyed to the Company's management.	7
iv. It is further recommended that such key significant events involving the Company be reflected in the minutes of the Board of Directors.	7
B. <u>Conflict of Interest Statements</u>	
It is recommended that the Company require its directors to use the same form and affirm the same questions when signing their Conflict of Interest Statements.	7
C. <u>Internal Controls</u>	
i. It is recommended that, as a good business practice, the Company formalize and document its internal controls processes for key activities.	8
ii. It is further recommended that the Company continue to develop and formalize its general risk assessment process and develop and document strategies that mitigate identified risks.	9
Further, such assessments and strategies should be reviewed and approved by the Company's Board of Directors.	9

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Holding Company System</u>	
It is recommended that the Company include complete information regarding holding company entity ownership within its filed annual statements and holding company filings with the Department.	12
E. <u>Accounts and Records</u>	
i. It is recommended that the Company disclose all events and transactions within the representation letters to the external auditors that have a significant or material effect on its financial statements.	14
ii. It is recommended that the Company change the reported primary location of its books and records location to its Minnesota address within its filings with the Superintendent of Financial Services.	15
iii. It is recommended that the Company not maintain its books of accounts outside of New York State, unless it receives permission to do so by the Department.	15
iv. It is recommended that the Company comply with the requirements of Paragraph 5 of SSAP No. 70 of the NAIC Accounting Practices and Procedures Manual by reporting allocated management expenses between claims cost containment expenses, claims adjustment expenses and general administrative expenses within the appropriate area of its Underwriting and Investment Exhibit of its filed annual statement.	16
F. <u>Claims Unpaid</u>	
It is recommended that, for subsequent filings, the Company report separate liabilities for its unpaid claims adjustment expenses and its unpaid claims expenses in its filed annual statement with the Superintendent of the Department of Financial Services.	21
G. <u>Subsequent Events</u>	
It is recommended that the Company reflect the correct balances in its annual and quarterly statement filings with this Department.	21

<u>ITEM</u>	<u>PAGE NO.</u>
H. <u>Utilization Review</u>	
i. It is recommended that the Company comply with Sections 4903(e)(2) and 4904(c)(2) of the New York Insurance Law by including the required appeal wording within its determination letters.	23
ii. It is recommended that the Company as well as its TPA’s utilization review agent file the Company’s utilization review plan on a biennial basis with the Superintendent of Department of Financial Services, as required by Section 4901(a) of the New York Insurance Law.	23
I. <u>Explanation of Benefits Statements</u>	
It is recommended that the Company as well as its TPAs, comply with Section 3234(b) of the New York Insurance Law by including all required information on its explanation of benefits statements.	24
J. <u>Claims Processing</u>	
i. It is recommended that the Company obtain from NOVA a written claim processing policies and procedures manual, which should be updated periodically as changes are made.	25
ii. It is recommended that the Company’s board of directors adopt and approve the Company’s and its TPA’s claims processing procedures manual as required by Department Circular Letter No. 9 (1999), “Adoption of Procedure Manuals”.	25
iii. It is recommended that the Company ensure that claim files, including those files maintained by its TPAs, be kept in a safe and secure manner at all times, ensuring that only authorized staff have access to the files.	26
iv. It is recommended that the Company ensure that its paper claim files are backed-up in an appropriate manner.	26
v. It is recommended that the Company ensures that its TPA’s servers and other sensitive electronic equipment are maintained in a safe and secure manner, accessible only by authorized personnel.	27

<u>ITEM</u>	<u>PAGE NO.</u>
K. <u>Claims Processing (Continued)</u>	
vi. It is recommended that the Company and its TPAs change their policy to deny undisputed claims upon the termination of its policy, instead of premiums being in arrears.	27
L. <u>New York Prompt Pay Law – Monitoring Procedures</u>	
It is recommended that the Company ensures that its TPA, NOVA, maintain adequate controls to monitor the Company’s claims for compliance with Sections 3224-a(a), 3224-a(b), and 3224-a(c) of the New York Insurance Law.	29

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, **BENJAMIN M. LAWSKY**, 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:

Froilan Estebal

as a proper person to examine the affairs of the

Security Health Insurance Company of America, New York, Inc.

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

Company

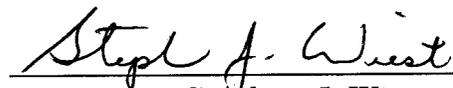
with such other information as he shall deem requisite.

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

this 22nd day of February, 2013

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Stephen J. Wiest
Deputy Bureau Chief
Health Bureau

