REPORT ON EXAMINATION

OF

RAYANT INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 2009

DATE OF REPORT **APRIL 24, 2013**

EXAMINER **VICTOR ESTRADA**

TABLE OF CONTENTS

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

April 24, 2013

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

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30586, dated August 31, 2010, annexed hereto, I have made an examination into the condition and affairs of Rayant Insurance Company of New York, a for-profit accident and health insurance company licensed pursuant to of Article 42 of the New York Insurance Law, as of December 31, 2009, and submit the following report thereon.

The examination was conducted at the home office of Rayant Insurance Company of New York, located at 3 Penn Plaza, Newark, New Jersey.

Wherever the designations "the Company" or "RICNY", appear herein, without qualification, they should be understood to indicate to Rayant Insurance Company of New York.

Wherever the designation "the Parent" or "HHPHC" appear herein, without qualification, they should be understood to indicate Horizon Healthcare Plan Holding Company, Inc., the Company's parent.

Wherever the designations “the Ultimate Parent” or “BCBSNJ” appear herein, without qualification, they should be understood to indicate Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, the Company’s ultimate parent.

Wherever the designation “the Department” appears herein, without qualification, it should be understood to indicate the New York State Insurance Department. On October 3, 2011, the New York State Insurance Department merged with the New York State Banking Department to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2005. This examination of the Company was a combined financial and market conduct examination and covered the period January 1, 2006, through December 31, 2009. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners (“NAIC”) *Financial Condition Examiners Handbook, 2010 Edition* (“the Handbook”). The examination was conducted observing the guidelines and procedures in the Handbook and transactions occurring subsequent to December 31, 2009, were reviewed where deemed appropriate by the examiner.

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 examiners planned and performed the examination to evaluate the Company’s current financial condition, as

well as identify prospective risks that may threaten the future solvency of RICNY. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Company.

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 annual statement instructions.

Information concerning the Company's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination 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 annually for the years 2006 through 2009, by the accounting firm of Pricewaterhouse Coopers ("PwC"). The Company received an unqualified opinion in each of those years. Certain audit workpapers of PwC were reviewed and relied upon in conjunction

with this examination. A review was also made of the Ultimate Parent's Internal Audit function and Enterprise Risk Management program, as they relate to the Company.

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

2. DESCRIPTION OF THE COMPANY

Rayant Insurance Company of New York, formerly known as Horizon Healthcare Insurance Company of New York ("HHICNY"), was initially incorporated under New York State Law on January 6, 1998, under the name, Medigroup Insurance Company (NY), a for-profit corporation licensed pursuant to Article 42 of the New York Insurance Law. On August 16, 1998, the Company's Articles of Incorporation were amended to change the name of the corporation from Medigroup Insurance Company (NY) to Horizon Healthcare Insurance Company of New York. The Company commenced business on February 22, 1999. HHICNY was established to transact and carry out the business of accident and health insurance, as defined in Section 1113(a)(3)(i) of the New York Insurance Law.

According to the Company's Articles of Incorporation, the number of shares issued and outstanding shall be one hundred (100), having a par value of two thousand dollars ($2,000) each for a total common capital stock of two hundred thousand dollars ($200,000). Ownership of the Company was divided between Horizon Healthcare Holding Corporation ("HHHC"), formerly known as Medigroup Holding Company, Inc. and Horizon Healthcare of New York, Inc. ("HHNY"), a domestic health maintenance organization ("HMO"); each of which owned fifty

(50) shares of common stock purchased at one hundred fifty thousand dollars ($150,000) for an initial total capital of three hundred thousand dollars ($300,000 - $200,000 capital and $100,000 paid-in and contributed surplus). Both entities are in turn owned by the Ultimate Parent, Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey ("BCBSNJ").

Due to excessive underwriting losses, BCBSNJ made a business decision to discontinue offering HMO business through HHNY, and these corporations went through a reorganization process to withdraw and liquidate HHNY. On March 31, 2005, as part of the restructuring plan, the New York Insurance and Health Departments approved a proposal by Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey to (1) consolidate the ownership of the two intermediate holding companies within the holding company system and (2) restructure the ownership interests of the Company.

The pre-approved reorganization was effective April 15, 2005 and consisted of the following steps: (1) Horizon Healthcare Holding Company, LLC merged with and into Horizon Healthcare Plan Holding Company, Inc. ("HHPHC"), with HHPHC as the surviving intermediate holding company; and thereafter, (2) HHPHC (a) purchased HHNY's 50% ownership interest in the Company for $3,000,000; and (b) issued a guaranty of all of HHNY's financial obligations, including any financial obligations to covered persons, throughout the withdrawal process as additional consideration to HHNY for transferring its 50% ownership interest in the Company to HHPHC.

Effective August 7, 2006, the Company entered into agreements to sell the renewal rights of the Company's insured medical enrollment to a major New York health insurer and its uninsured enrollment to a large third party administrator ("TPA"). The Company withdrew its

health insurance products in New York over a transition period of 180 days, ending on February 28, 2007. Effective as of June 8, 2007, Horizon Healthcare Insurance Company of New York changed its name to Rayant Insurance Company of New York, and it continues to offer dental business.

A. Management and Controls

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of no less than thirteen, nor more than nineteen members, of which no less than two shall be New York residents.

As of December 31, 2009, the Company's Board of Directors consisted of the following thirteen members:

Name and Residence	Principal Business Affiliation
Christy W. Bell Chester, NJ	Senior Vice-President, Horizon Blue Cross Blue Shield of New Jersey
Margaret M. Coons Montvale, NJ	Vice President, Human Resources Horizon Blue Cross Blue Shield of New Jersey
Charles R. Dees, Jr., PhD Seaside, NJ	Vice President for University Advancement, New Jersey Institute of Technology
William D. Georges New York, NY	Vice President, Investor Relations Horizon Blue Cross Blue Shield of New Jersey
Vincent J. Giblin Spring Lake, NJ	President, International Union of Operating Engineers
John G. Hansbury Titusville, NJ	Life Insurance and Financial Planner, Hansbury Associates

Name and Residence	Principal Business Affiliation
William J. Marino Morris Plain, NJ	President and Chief Executive Officer, Horizon Blue Cross Blue Shield of New Jersey
Robert A. Marino West Caldwell, NJ	Senior Vice President, Horizon Blue Cross Blue Shield of New Jersey
Michael R. McGarvey, MD New York, NY	Retired
Robert E. Meehan Randolph, NJ	Vice President, Consumer & Senior Markets Horizon Blue Cross Blue Shield of New Jersey
Robert J. Pures River Vale, NJ	Senior Vice-President, Horizon Blue Cross Blue Shield of New Jersey
James A. Skidmore, Jr. Berkeley Heights, NJ	Chairman, President and Chief Executive Officer, Science Management Corporation
Peter G. Stewart, Esq. Caldwell, NJ	Partner, Carella, Byrne, Bain, Gilfillan, Cecchi, Stewart & Olstein

The principal officers of the Company as of December 31, 2009 were as follows:

Name	Title
Robert A. Marino	Chief Executive Officer
William Frantel	Treasurer
Linda Anne Willett	Secretary

During the period under examination, the Board of Directors met nineteen times. A review of the attendance records at Board of Directors' meetings held during the examination period revealed that meetings were generally well attended; all members attended at least 50% of the meetings for which they were eligible to attend.

The Company has a policy in place for all directors, officers, and employees that requires them to complete a conflict of interest questionnaire, and annually disclose all interests or

activities which are, or might be, in conflict with their duties at the Company. The following states in part the aforementioned policy known as the "Officer and Employee Code of Business Conduct and Conflict of Interest Questionnaire":

> "Under our Corporate Code of Business Conduct all directors, officers and employees have a continuing obligation to fully and accurately disclose any and all interest or activities which are in conflict with or may potentially conflict with or which may create the appearance of a conflict with their obligations and responsibilities to Horizon… Annually, we require all officers, employees and associates to respond to this questionnaire in order to determine whether any such conflicts, or potential conflicts, exist and to certify such officer's, employee's and associate's compliance with the Corporate Code of Business Conduct and Ethics."

It was noted that the Company responded "Yes" to question number 16 contained in the general interrogatories of its 2009 filed annual statement which states as follows:

> "Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?"

The examination revealed that nine directors, five directors, five directors and twelve directors, in 2006, 2007, 2008 and 2009, respectively, did not submit the required conflict of interest statements.

It is recommended that all of the Company's directors and officers comply with the Corporate Code of Business Conduct and Ethics and that conflict of interest questionnaires be completed on an annual basis.

B. Territory, Plan of Operation and Enrollment

Rayant Insurance Company of New York is licensed to operate in the entire state of New York as an accident and health insurer pursuant to Article 42 of the New York Insurance Law. Accordingly, it is authorized to write the kind of business set forth in Section 1113(a)(3)(i) of the New York Insurance Law. Based upon the lines of business for which the Company is licensed, and pursuant to the requirements of Articles 13 and 42 of the New York Insurance Law, the Company is required to maintain minimum capital of $200,000. The Company met the minimum capital and Risk-Based Capital requirements throughout the examination period.

Effective August 7, 2006, the Company entered into agreements to sell the renewal rights of the Company's insured medical enrollment to a major New York health insurer and its uninsured enrollment to a large third party administrator ("TPA"). The Company withdrew its health insurance products in New York over a transition period of 180 days, ending on February 28, 2007. Effective June 8, 2007, Horizon Healthcare Insurance Company of New York changed its name to Rayant Insurance Company of New York, and it continues to write only dental business.

Written premium by line of business for each year under examination were as follows:

	Hospital & Medical	Dental	Total
2006	$161,296,428	$6,865,233	$168,161,661
2007	9,675,889	6,979,608	16,655,497
2008	24,619	7,540,838	7,565,457
2009	-	7,848,078	7,848,078

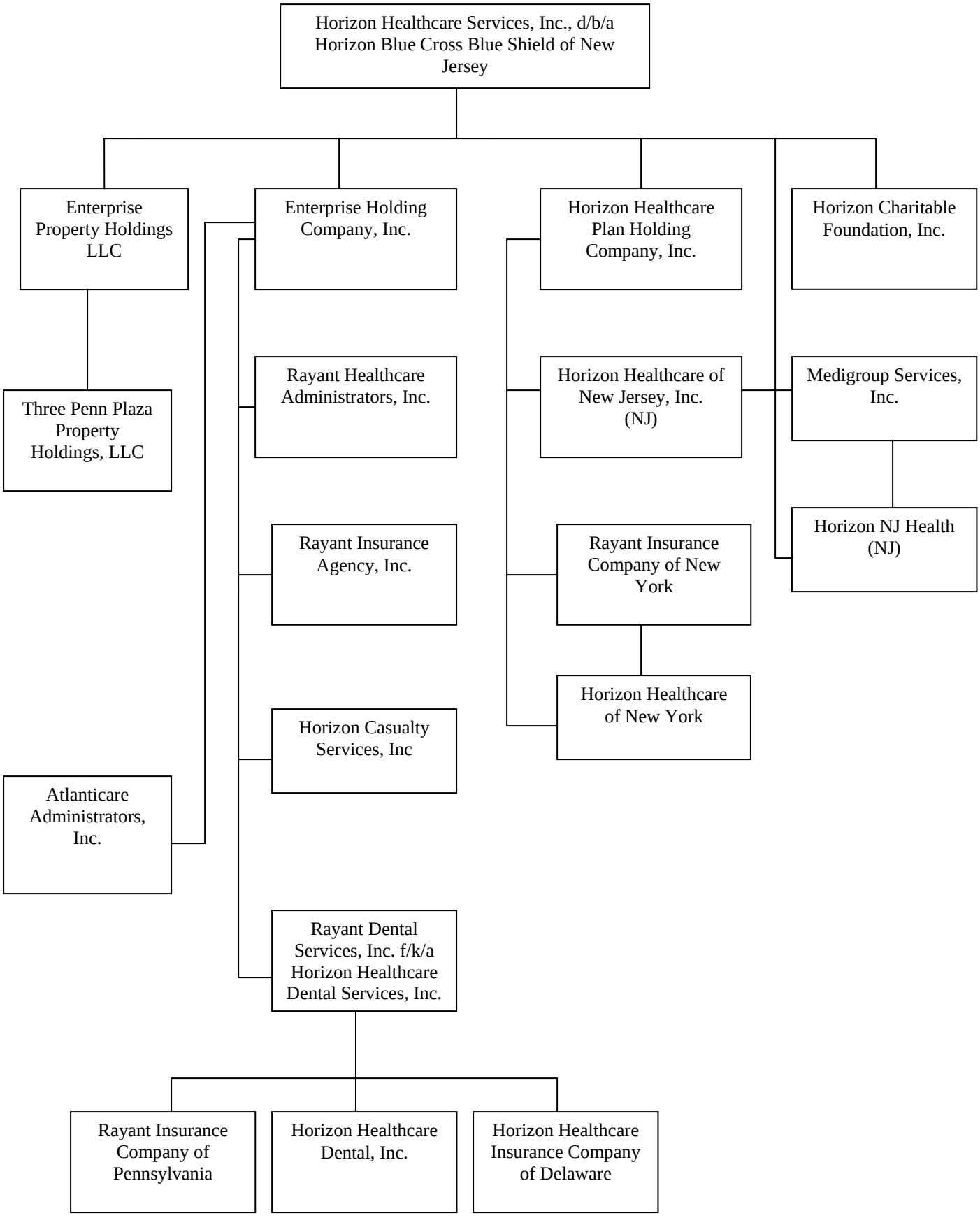
During the period January 1, 2006 through December 31, 2009, the Company experienced a net decrease in policyholders of 56,976 due to the discontinuance of its hospital and medical writings. An analysis of this decrease in enrollment is set forth below:

	2006	2007	2008	2009
Enrollment, January 1	76,969	52,430	20,519	21,361
Net gain/(loss)	(24,539)	(31,911)	842	(1,368)
Enrollment at December 31	52,430	20,519	21,361	19,993

C. Holding Company System

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

The following chart depicts the Company and its relationship with members of its holding company system as of December 31, 2009:


Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey
Enterprise Property Holdings LLC
Enterprise Holding Company, Inc.
Horizon Healthcare Plan Holding Company, Inc.
Horizon Charitable Foundation, Inc.
Three Penn Plaza Property Holdings, LLC
Rayant Healthcare Administrators, Inc.
Horizon Healthcare of New Jersey, Inc. (NJ)
Medigroup Services, Inc.
Rayant Insurance Agency, Inc.
Rayant Insurance Company of New York
Horizon NJ Health (NJ)
Horizon Healthcare of New York
Horizon Casualty Services, Inc
Atlanticare Administrators, Inc.
Rayant Dental Services, Inc. f/k/a Horizon Healthcare Dental Services, Inc.
Rayant Insurance Company of Pennsylvania
Horizon Healthcare Dental, Inc.
Horizon Healthcare Insurance Company of Delaware

i. Horizon Healthcare of New Jersey, Inc.

During the examination period, the Company operated under two service agreements with members of its holding company system, specifically Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), and Horizon Healthcare Dental Services, Inc. ("HHDS"). These agreements were previously approved by the Department pursuant to Article 15 of the New York Insurance Law.

Under the BCBSNJ agreement, BCBSNJ performs numerous services related to general managerial and administrative functions, including actuarial, rating and underwriting, preparation of all benefit contracts and certificates, provider network services, and additional subscriber and provider support.

The HHDS agreement provides the Company with dental claims related services, including network administration, provider directories, claims processing and claims adjudication, underwriting and actuarial, sales and marketing services.

On January 1, 2010, subsequent the examination date, both agreements were revised to reflect services to be provided to Rayant Insurance Company of New York, f/k/a, Horizon Healthcare Insurance Company of New York, by Horizon Blue Cross Blue Shield of New Jersey ("BCBSNJ") and Rayant Dental Services, Inc., ("RDSI"), formerly known as Horizon Healthcare Dental Services, Inc. respectively. Both agreements were approved by the Department on January 25, 2011, pursuant to Article 15 of the New York Insurance Law.

ii. Cash Accounts

The examiners' review of the settlement of certain financial accounts such as uncollected premiums, advanced premiums and claims liabilities revealed that there was no evidence that premiums were deposited in the Company's bank account(s) and that claims were paid out of the Company's bank account. The examination indicated that all premiums were deposited in a New Jersey checking account titled solely in the name of the Ultimate Parent, Horizon Blue Cross Blue Shield of New Jersey. Premiums are allocated to the Company on a monthly basis solely in the form of a journal entry.

It is recommended that the Company establish a separate operating account so that it can maintain adequate control over its cash.

iii. Custodian Agreements

The Company's investment accounts were maintained in four trust accounts for the examination period. Three trust accounts (balance of $29,594,404; $448,646; $28,240, respectively) were maintained with JP Morgan Chase and the short-term investments ($5,648,794) were maintained by SEI Investment (d/b/a TreasuryPoint.com). The Company provided the examiners with copies of two custodian agreements, which encompassed all four trust accounts. The JP Morgan Chase agreement had no effective date, but it was executed on June 15, 2004. The agreement indicated that it will remain in force until expressly revoked in writing by either party. The SEI Investment agreement was executed on November 22, 2002. Both agreements were executed between the Ultimate Parent and the aforementioned institutions. Without an effective agreement under RICNY's name, the Company does not appear to have an effective control over its assets maintained by these institutions.

A similar finding was cited in the previous report on examination.

It was also noted that the Company responded "No" to question number 21.1 contained in the general interrogatories of its 2009 filed annual statement:

> "21.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity?"

Since the Company had investments residing in various institutions under a custodian agreement that it was not party to, the right and proper answer for the above question should have been "Yes".

It is recommended that the Company execute all custodian agreements in its corporate name and that such agreements include all the appropriate protective covenants as required by the Handbook.

It is also recommended that the Company provide accurate responses to the general interrogatories contained in its sworn annual statements.

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

D. Accounts and Records

During the course of the examination, it was noted that the Company's treatment of certain items was not in accordance with Statutory Accounting Principles ("SSAP") as adopted by Department Regulation No. 172 or annual statement instructions. Paragraph 8 of SSAP No. 70 states:

> "8. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the

> expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios."

Shared expenses under the terms of the Horizon Healthcare Services, Inc. agreement, was not apportioned to RICNY as if it had paid those expenses, for example, information systems and real estate. Additionally, many expense categories captioned in the underwriting and investment exhibit were blank, as if no expenses were incurred.

It is recommended that the Company properly apportion its expenses in compliance with Paragraph 8 of SSAP No. 70.

E. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the four-year period covered by this examination:

	Amounts	Ratio
Claims incurred	$198,996,022	97%
Claims adjustment expenses incurred	9,251,673	5%
General administrative expenses incurred	32,931,478	16%
Net underwriting loss	(37,188,553)	(18)%
Premiums earned	$203,990,620	100%

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus as determined by this examination with those reported by the Company as of December 31, 2009. This statement is the same as the balance sheet filed by the Company in its filed annual statement as of December 31, 2009:

Assets	Examination	Company
Bonds	$28,837,013	$28,837,013
Cash and short-term investments	5,868,987	5,868,987
Investment income due & accrued	159,996	159,996
Uncollected premiums	118,903	118,903
Net deferred tax asset	69,911	69,911
Receivable from parent and affiliates	81,114	81,114
Healthcare receivable	596,617	596,617
Total assets	$35,732,541	$35,732,541
Liabilities		
Claims unpaid	$3,965,381	$3,965,381
Unpaid claims adjustment expenses	10,000	10,000
Aggregate health policy reserves	20,617	20,617
Premiums received in advance	213,251	213,251
General expenses due and accrued	1,670,973	1,670,973
Current federal income tax payable	33,881	33,881
Amounts due parent, subsidiaries and affiliates	79,102	79,102
Total liabilities	$ 5,993,205	$ 5,993,205

Capital and Surplus

Common capital stock	$ 200,000	$ 200,000
Gross paid-in and contributed capital	175,100,000	175,100,000
Unassigned funds (surplus)	(145,560,664)	(145,560,664)
Total capital and surplus	$ 29,739,336	$ 29,739,336
Total liabilities, capital and surplus	$ 35,732,541	$ 35,732,541

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2009. The examiner is unaware of any potential exposure of the Company to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus decreased by $8,222,970 during the examination period, January 1, 2006 through December 31, 2009, detailed as follows:

Revenue		
Net premium income	$ 200,230,693	
Change in unearned premium reserves	1,111,674	
Total revenue		$ 201,342,367
Expenses		
Hospital/Medical benefits	$ 136,813,893	
Other professional services	36,183,021	
Prescription drugs	25,999,108	
Net reinsurance recoveries	(2,648,253)	
Claim adjustment expenses	9,251,673	
General administrative expenses	32,931,479	
Total underwriting expenses		238,530,921
Net underwriting loss		(37,188,554)
Net investment gains		7,046,823
Sales proceeds-renewal rights membership		3,394,700
Net income before federal income taxes		(26,747,031)
Federal and foreign income taxes incurred		5,584,113
Net loss		$ (21,162,918)

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus per report on examination as of December 31, 2005			$ 21,516,366
Net loss		$ 21,162,918	
Change in net deferred tax assets		758,069	
Change in non admitted assets	$ 2,843,957		
Change in aggregate health policy reserves	7,300,000		
Paid-in surplus	20,000,000		
Net increase in capital and surplus			8,222,970
Capital and surplus per report on examination as of December 31, 2009			$ 29,739,336

4. CLAIMS UNPAID

The examination liability of $3,965,381 is the same as that reported by the Company in its filed annual statement as of December 31, 2009.

The examination analysis of the unpaid claims reserve 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 as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Company's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2009.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Company 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 investigation. The review was directed at the practices of the Company in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Explanation of benefits statements
D. Complaints
E. Appointment of agents

A. Claims Processing

The examination included a review of the Company's claims settlement practices and oversight of the claims adjudication process by the Company's management. The Company receives its claims through both electronic submissions and the US Post Office. Approximately 56% of all claims were electronically submitted in 2009. All claims received are assigned a 13 digit Image Control Number ("ICN"), which is subsequently used as the claim number in order to enter the claim into the system or for subsequent retrieval.

A review of the Company's claims settlement practices and oversight of the claims adjudication process was performed by using a statistical sampling methodology covering claims adjudicated during the period January 1, 2009 through December 31, 2009, in order to evaluate the overall accuracy and compliance of RICNY's claims processing environment. The examiner selected a sample of 50 claims for review.

The statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually, or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be made for each claim in the sample.

For the purpose of this report, a "claim" as defined by the Company is the total number of items submitted by a single provider with a single claim form, as received and entered into its claims processing system. A claim may consist of various lines, procedures or service dates. It was possible, through the computer systems used for this examination, to match or "roll up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by the Company for the period January 1, 2009 through December 31, 2009. No material exceptions were noted.

It was noted that the Parent performs quality control reviews or audits to check the accuracy of recorded claims transactions (e.g., payment dollar, payment incidence, coding, procedural and total claim accuracy) on a monthly basis, in order to identify and correct errors that may be occurring on an ongoing basis.

B. Prompt Pay Law

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt

Pay Law"), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer…to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

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

> "… 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."

In order to test the Company's compliance with the Prompt Pay Law, a statistical sample of 167 claims processed during the period January 1, 2009 through December 31, 2009 was selected from claims not adjudicated within 45 days of submission to the Company. A determination was then made regarding whether the timeliness of the payment was in violation of the timeframe requirement of Section 3224-a(a) of the New York Insurance Law, and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law.

There were 1,039 claims processed in 2009 that took the Company more than 45 days after receipt to pay. Accordingly, all claims that were not paid within 45 days of receipt (Section 3224-a(a)) during 2009 were segregated. A sample of 167 claims were reviewed to determine whether the claims were in violation of Section 3224-a(a) of the New York Insurance Law and whether they were subject to interest as required by Section 3224-a(c) of the New York Insurance Law.

Of the 167 claims paid after 45 days of receipt, nine (9) claims were deemed to be violations of Section 3224-a(a) of the New York Insurance Law and five (5) of these claims were determined to be interest eligible. Interest was paid by RICNY for these five claims. The remaining four (4) claims were not interest eligible.

The following chart illustrates RICNY's compliance with Section 3224-a(a) as determined by this examination:

Summary of Violations of Section 3224-a(a) of the New York Insurance Law

Total claim population	34,942
Population of claims adjudicated after 45 days of receipt	1,039
Sample size	167
Number of claims with violations	9
Calculated violation rate	5.39%
Upper violation limit	8.81%
Lower violation limit	1.96%
Calculated transactions in violation	56
Upper limit transactions in violation	91
Lower limit transactions in violation	20

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

It should be noted that the violations above relate to the population of 1,039 claims used for the review, which consisted of only claims adjudicated in 2009 that were not paid within forty-five days of receipt. The total population of claims pertaining to RICNY that were processed during calendar year 2009 was 34,942.

It is recommended that the Company implement the necessary procedures in order to ensure its compliance with the requirements of Section 3224-a(a) of the New York Insurance Law.

Section 3224-a(b) of the New York Insurance Law 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 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…"

During the examination of RICNY, the examiner selected a sample of one hundred and sixty-seven (167) claims to review compliance with Section 3224-a(b) of the New York Insurance Law. The review was established through the isolation of all claims that took the Company more than thirty (30) days to either deny or to seek additional information for claims adjudicated during the period January 1, 2009 through December 31, 2009.

The following chart illustrates RICNY's compliance with Section 3224-a(b) of the New York Insurance Law as determined by this examination:

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

Total claim population	34,942
Population of claims adjudicated after 30 days of receipt	615
Sample size	167
Number of claims with violations	9
Calculated violation rate	5.39%
Upper violation limit	8.81%
Lower violation limit	1.96%
Calculated transactions in violation	33
Upper limit transactions in violation	54
Lower limit transactions in violation	12

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

It is recommended that RICNY comply with the requirements of Section 3224-a(b) of the New York Insurance Law and send out requisite notification within 30 days, where applicable.

It is also recommended that the Company review and revise its procedures in order to improve its compliance with Section 3224-a(b) of the New York Insurance Law.

Additionally, the Company did not retain sufficient information (i.e., supporting documentation of request for additional information) on the claims denied after 30 days. In fact, RICNY was unable to demonstrate that any such correspondence was sent out on all of the claims reviewed by the examiner.

Section 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2(b)(4)) states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received."

Further, Section 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) states in part:

> "…to enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants."

It is recommended that RICNY comply with Part 243.2(b)(4) of Department Regulation No. 152 by retaining all necessary documentation pertaining to a claim file, for the required period of time.

It is also recommended that RICNY comply with the requirements of Section 216.11 of Department Regulation No. 64 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.

C. Explanation of Benefits

As part of the review of RICNY's claims practices and procedures, an analysis of the Explanation of Benefits ("EOBs") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and Company. It should clearly communicate to the subscriber and/or provider that RICNY has processed a claim and how that

claim was processed. The EOB should also clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other carriers.

Section 3234(b)(7) of the New York State Insurance Law states in part:

> "(b) The explanation of benefit statement form must include at least the following…
>
> (7)…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 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 should be noted that RICNY did not include the aforementioned requisite information on its EOBs. Accordingly, subscribers and/or providers are not being properly informed of their appeal rights.

It is recommended that RICNY modify its EOBs to comply with Section 3234(b)(7) of the New York Insurance Law.

D. Circular Letter No. 11 (1978) – Establishment of Internal Consumer Services Department for Insurance Companies

Department Circular Letter No. 11 (1978) – Establishment of Internal Consumer Services Department for Insurance Companies- provides that all licensed insurance companies establish an internal department specifically designated to investigate and resolve complaints filed by its subscribers, with the Insurance Department's Consumer Services Bureau and that these insurance companies take action, as necessitated as a result of the complaint investigation findings.

Circular Letter No. 11 (1978) provides guidelines for the Complaint Departments of all licensed insurance companies. Additionally, the Circular Letter requires that all insurers maintain an ongoing central log to register and monitor all complaint activity. The examiners were provided with a complaint listing by the Department's Consumer Services Bureau that indicated 587 closed complaints filed during the examination period.

The examiners requested the complaint logs from the Company for the examination period, however, the Company was unable to provide the complaint logs for calendar years 2006-2008. Therefore, examiners were unable to determine the number of complaints received by the Company for the same period. The Company provided the examiners with the 2009 complaint log, which listed 151 closed complaints.

It is recommended that the Company maintain complete complaint logs as required by Department Circular Letter No. 11 (1978).

Department Circular Letter No. 11 (1978) states in part:

> *"As part of its complaint handling function, the company's consumer services department will maintain an ongoing central log to register and monitor all complaint activity. The log should be kept in a columnar form and list the following:*
>
> 1. *The date the complaint was received in-house.*
> 2. *The name of the complainant and the policy or claim file number.*
> 3. *The New York State Insurance Department file number.*
> 4. *The responsible internal division, i.e., personal lines underwriting, property damage claims, etc.*
> 5. *The person in the company with whom the complainant has been dealing.*
> 6. *The person within the company to whom the matter has been referred for review.*
> 7. *The date of such referral.*
> 8. *Bearing in mind the appropriate regulation mandating timely substantive replies, the dates of correspondence to the Insurance Department's Consumer Services Bureau.*
> 9. *The subject matter of the complaint.*
> 10. *The results of the complaint investigation and the action taken.*
> 11. *Remarks about internal remedial action taken as a result of the investigation."*

The examination revealed that among the listing of the above required items, the Company's complaint log did not contain the information relative the items 2, 5, 6, 9, 10 and 11.

It is recommended that all items required by Department Circular Letter No. 11 (1978) be included in the Company's complaint log.

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

E. Appointment of Agents

The examiner reviewed a sample of agent appointment files selected from a listing of agents utilized during the examination period. The current agent appointment process requires that insurers make the agent appointment "on-line" via the internet. When the process is complete, a confirmation is generated that indicates the date of appointment, as well as a confirmation number. When the examiner requested copies of such confirmation, the Company was unable to produce such documentation.

Part 243.2(b)(5) of Department Regulation No. 152 (11 NYCRR 243.2) states in part:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (5) A licensing record for six calendar years after the relationship is terminated for each Insurance Law licensee with which the insurer establishes a relationship. Licensing records shall be maintained so as to show clearly the dates of appointment and termination of each licensee."

Rayant did not maintain a licensing record, which details the dates of appointment and/or termination, of any of its agents.

It is recommended that the Company comply with Part 243.2(b)(5) of Department Regulation No. 152 by maintaining a licensing record of all its agents and/or terminated agents, for the prescribed period of time.

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

6. SUBSEQUENT EVENTS

In a letter dated October 14, 2011, Wellpoint Holding Corporation filed an application for approval of acquisition of control of RICNY. Wellpoint Holding Corporation purchased from Horizon Healthcare Plan Holding Company Inc., all (100%) outstanding capital stock of RICNY. The Department approved Wellpoint Holding Corporation's acquisition of control of Rayant on December 31, 2011.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The previous report on examination as of December 31, 2005 contained thirty (30) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that the Company comply with Section 2.07 of the Company's by-laws and have the Board of Directors appoint a Nominating Committee, of no fewer than three Directors, prior to the annual shareholders' meeting in compliance with Section 2.07 of the Company's by-laws. Further, the Nominating Committee shall file, in writing with the Secretary of the Company, a list of nominees for election to the Board of Directors of the Corporation. *The Company has complied with these recommendations.*	7
2.	It is recommended that all directors and officers comply with the Corporate Code of Business Conduct and Ethics and that conflict of interest questionnaires be completed on an annual basis. *The Company has not complied with this recommendation. A similar recommendation is included in this report.*	8
	Adoption of Procedure Manual – Circular Letter No. 9 (1999)	
3.	It is recommended that the Company's Board comply with the requirements of Circular Letter No. 9 (1999) by obtaining the required certifications. *The Company has complied with this recommendation.*	9

ITEM NO. **PAGE NO.**

Holding Company System

4. It is recommended that the Company comply with Section 1505(c) of the New York Insurance Law by executing a formal written agreement with Horizon Healthcare of New Jersey, Inc. It is further recommended that the Company comply with Section 1505(d)(3) of the New York Insurance Law and submit this agreement to the Superintendent of Insurance for his non-disapproval. 16

   Due to the Company's discontinuance of its healthcare operations, as detailed in Item 7 herein, Horizon Healthcare of New Jersey ceased providing services to the Company on June 14, 2007, therefore, this comment is no longer applicable.

5. It is recommended that the Company comply with the requirements of Sections 1505(a) and (b) of the New York Insurance Law by executing a formal written agreement with Horizon Healthcare of New Jersey, Inc. in which the terms are fair and equitable and that the books, accounts and records of all such transactions be maintained as to clearly and accurately disclose the nature and details of the transactions. 17

   Due to the Company's discontinuance of its healthcare operations, as detailed in Item 7 herein, Horizon Healthcare of New Jersey ceased providing services to the Company on June 14, 2007, therefore, this comment is no longer applicable.

6. It is recommended that the Company execute a custodian agreement in its corporate name which includes all the appropriate protective covenants required by the Department. 18

   The Company has not complied with this recommendation. A similar recommendation is included in this report.

7. It is also recommended that the Company provide accurate responses to the general interrogatories contained in its sworn to annual statements. 18

   The Company has not complied with this recommendation. A similar recommendation is included in this report.

ITEM NO. **PAGE NO.**

8. It is recommended that the Company comply with Section (a) of Department Regulation 152 and amend its Record Retention Policy to include that documents be maintained for six calendar years, or until after the filing of the report on examination in which the record was subject to review, whichever is longer. 20

The Company has not complied with this recommendation. A similar recommendation is included in this report.

Disaster Response Filing

9. It is recommended that the Company comply with Insurance Department Circular Letter No. 23 (2005) and file with the Department its Disaster Response Plan, Disaster Response Questionnaire, and Business Continuity Plan and Questionnaire. 20

The Company has complied with this recommendation.

Accounts and Records

10. It is recommended that the Company properly classify its expenses. 20

The Company has not complied with this recommendation. A similar recommendation is included in this report.

11. It is again recommended that the Company properly classify its expenses. 20

The Company has complied with this recommendation. A similar recommendation is included in this report.

12. It is recommended that the Company comply with the requirements of Insurance Department Circular Letter No. 33 (1979) and settle the tax credit within the time frame set forth in the Circular Letter and in accordance with the terms of the written agreement. 21

The Company has complied with this recommendation.

Aggregate Health Policy Reserve

13. It is recommended that the Company comply with the provisions of Paragraph 18 of the Statements of Statutory Accounting Principles No. 54 by establishing the requisite liability for each line of business where a premium deficiency exists. 25

This recommendation is no longer applicable.

Holding Company System (cont'd.)

ITEM NO. **PAGE NO.**

Claims Processing

Prompt Pay Law

ITEM NO. **PAGE NO.**

Prompt Pay Law (cont'd.)

Complaints

ITEM NO. **PAGE NO.**

Complaints (cont'd.)

25. It is recommended that the Company complete the required form for complaints referencing Prompt Pay issues. 41

The Company has complied with this recommendation.

26. It is recommended that the Company comply with Section 4904(b) of the New York Insurance Law and revise its utilization review policy in regard to its expedited appeals process, as well as all materials distributed to its members. 42

This recommendation is no longer applicable.

27. It is recommended that the Company comply with Department Regulation 152 and maintain all appeal records for at least six calendar years from their creation. 43

As noted in Item 2F herein, the Company revised its record retention policy subsequent to the examination date.
The Company has complied with this recommendation.

28. It is recommended that the Company report the correct number of appeals cases in its filings with this Department. 43

The Company has complied with this recommendation.

Notice of Policy Terminations

29. It is recommended that the Company comply with the requirements of Section 3221(p)(3)(A)(i) of the New York Insurance Law and provide notices to all members when such policies are discontinued. 44

The Company has complied with this recommendation.

Appointment of Agents

30. It is recommended that as a good business practice the Company should print screen confirmations of its agent submission to this Department and maintain such documentation under its record retention policy. 45

The Company has not complied with this recommendation. A similar recommendation is included in this report.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____

Victor Estrada

Senior Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

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

_____/S/_____

Victor Estrada

Subscribed and sworn to before me

this _____ day of _____2013.

Appointment No. **30586**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Victor Estrada

as a proper person to examine into the affairs of the

Rayant Insurance Company of New York

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

Company

with such other information as he shall deem requisite.

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

this 31st day of August, 2010

James J. Wrynn
Superintendent of Insurance