REPORT ON EXAMINATION

OF

HEALTH INSURANCE COMPANY OF AMERICA, INC.

AS OF

DECEMBER 31, 2016

DATE OF REPORT	**SEPTEMBER 22, 2020**
EXAMINER	**EDOUARD MEDINA**

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NEW YORK STATE OF OPPORTUNITY.
Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Superintendent

September 22, 2020

Honorable Linda A. Lacewell
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31562, dated January 12, 2017, attached hereto, I have made an examination into the condition and affairs of Health Insurance Company of America, Inc., an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2016, and submit the following report thereon.

The examination was conducted at the home office of Health Insurance Company of America, Inc. located at 2363 James Street, Syracuse, New York.

Wherever the designations the "Company" or "HICA" appear herein, without qualification, they should be understood to indicate Health Insurance Company of America, 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 Health Insurance Company of America, Inc. An "on organization" examination was conducted as of September 30, 2010. This examination of the Company was a combined (financial and market conduct) examination and covered the period from October 1, 2010 through December 31, 2016. 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, 2017 Edition* ("the Handbook"). The financial examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2016 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 the Company's current financial condition as well as to 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 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 examination also evaluated the Company's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

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

The Company was audited annually, for the years 2011 through 2013, by the accounting firm Testone, Marshall and Discenza, LLP, merged with Bonadio and Company, LLP, with

Bonadio and Company, LLP becoming the surviving entity. The Company was audited annually, for the years 2014 through 2016 by Bonadio and Company, LLP.

The Company received an unmodified opinion in each of the years 2011 through 2016.

During this examination, an information systems review was made of the Company's computer systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

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

2. DESCRIPTION OF THE COMPANY

The Company is licensed under Article 42 of the New York Insurance Law to write accident and health insurance as defined in New York Insurance Law, Section 1113(a)(3)(i). The Company was incorporated on February 24, 2010 and became licensed on November 15, 2010.

A. Corporate Governance

Pursuant to the Company's charter and by-laws, management of the Company is vested in a board of directors consisting of not less than seven (7) members nor more than fifteen (15) directors. As of the examination date, the board of directors was comprised of nine (9) members.

The Company's directors as of December 31, 2016, were as follows:

Name and Residence	Principal Business Affiliation
Donald Christian Doerr Syracuse, NY	Vice President of Compliance, POMCO, Inc.
Terrence Charles Dowd, Jr. Baldwinsville, NY	Chief Financial Officer, POMCO, Inc.
Vanessa Stello Flynn Liverpool, NY	Vice President Client Services, POMCO, Inc.
Kathleen Elaine Lamb Jamesville, NY	Secretary and General Counsel, POMCO, Inc.
Donald Peter Napier Manlius, NY	Chief Operating Officer, POMCO, Inc.
Steven Daniel Solomon Marblehead, MA	Managing Director, QBE Insurance Company
Lawrence Francis Thompson Fresno, CA	President, POMCO, Inc.
Timothy Charles Whelan Baldwinsville, NY	Controller, POMCO, Inc.
Jeffrey Alan Winchell Cicero, NY	Retired

As of December 31, 2016, the principal officers of the Company were as follows:

Name	Title
Lawrence Francis Thompson	President
Terrence Charles Dowd, Jr.	Treasurer
Kathleen Elaine Lamb	Secretary and General Counsel

The 2015 NAIC Health Annual Statement Filing Instructions for Actuarial Opinions require that the Company's appointed Actuaries report to the board of directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion and that the actuarial opinion and the actuarial memorandum be made available to the board of directors. With regard

to Actuarial Opinions submitted to the Department for the years 2014 and 2015, there was no evidence that those Actuarial Opinions were discussed during the board meetings, therefore, the Actuarial Opinions were not in compliance with the requirements of the 2015 NAIC Health Annual Statement Filing Instructions for Actuarial Opinions.

It is recommended that the Company comply with the 2015 NAIC Health Annual Statement Filing Instructions for Actuarial Opinions by having its appointed Actuaries report to the board of directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion; ensuring that the actuarial opinion and the actuarial memorandum be made available to the board of directors and that the minutes of the board of directors' meetings indicate that the appointed Actuary has presented such information to the board of directors or the Audit Committee.

Part 89.8(a) of New York Insurance Regulation 118 (11 NYCRR 89), states in part:

> "(a) Every company required to furnish an annual audited financial report shall require the CPA to submit written notification to the superintendent, the board of directors and the company's audit committee within five business days of any determination by the CPA that the company has materially misstated its financial condition as reported to the superintendent as of the balance sheet date currently under audit …"

During the course of the examination, certain account balances required adjustments to correct errors related to claims incurred during the years under examination, due to inaccuracies in HICA's reported share of QBE Insurance Corporations ("QBE") reinsured claims in relation to the reinsurance contracts described below in Section F. The adjustments were reflected as an increase in the unassigned funds. Bonadio and Company, LLP the Company's certified public accountants ("CPAs"), found the errors during the 2016 audit but did not report such misstatement to the Department as required by Part 89.8(a) of New York Insurance Regulation 118 (11 NYCRR 89).

It is recommended that the Company comply with Part 89.8(a) of New York Insurance Regulation 118 by requiring the CPA to submit written notification to the Department, the board of directors and the audit committee within five business days of any determination by the CPA that the Company has materially misstated its financial condition.

B. Enterprise Risk Management

Circular Letter No. 14 (2011) states, in part:

> "…the Department of Financial Services expects every insurer to adopt a formal Enterprise Risk Management ("ERM") function. An effective ERM function should identify, measure, aggregate, and manage risk exposures within predetermined tolerance levels, across all activities of the enterprise of which the insurer is part, or at the company level when the insurer is a stand-alone entity…"

The Company submitted an enterprise risk management report for each of the years 2014 through 2016. However, the reports did not indicate if the Company had a framework in place to identify, measure, mitigate or manage risk exposures across the activities of the Company.

Furthermore, it was determined that the Company did not have an Internal Audit Department, or any comparable department to perform its internal audit functions. The only audits conducted were those of the Company's claims processes.

It should be noted that if enterprise risks are not handled properly or remedied promptly, they will likely have material adverse effects on a company's financial condition or liquidity.

It is recommended that the Company comply with Insurance Circular Letter No. 14 (2011) by adopting a formal Enterprise Risk Management function which will assist the Company in identifying, measuring, mitigating or managing risk exposures within predetermined tolerance levels across all activities of the entity.

C. Territory and Plan of Operation

Health Insurance Company of America, Inc. is a domestic accident & health insurer licensed pursuant to Article 42 of the New York Insurance Law ("NYIL"). The Company provides dental and medical stop-loss products to mid-market and large employer in New York State.

The following chart shows the direct premiums written by the Company for the period under examination:

Year	Total Direct Premiums
2011	-
2012	$ 122,903
2013	260,102
2014	300,495
2015	297,820
2016	294,774

For the period under examination, the Company experienced a decrease of 9,080 members, as shown in the chart below:

	2011	2012	2013	2014	2015	2016
Membership	26,190	18,982	27,674	20,680	16,862	17,110
Growth	-	(27.52)%	45.79%	(25.27)%	(18.46)%	1.47%

D. Conflict of Interest Statement

Section 6 of the Company's conflict of interest policy states:

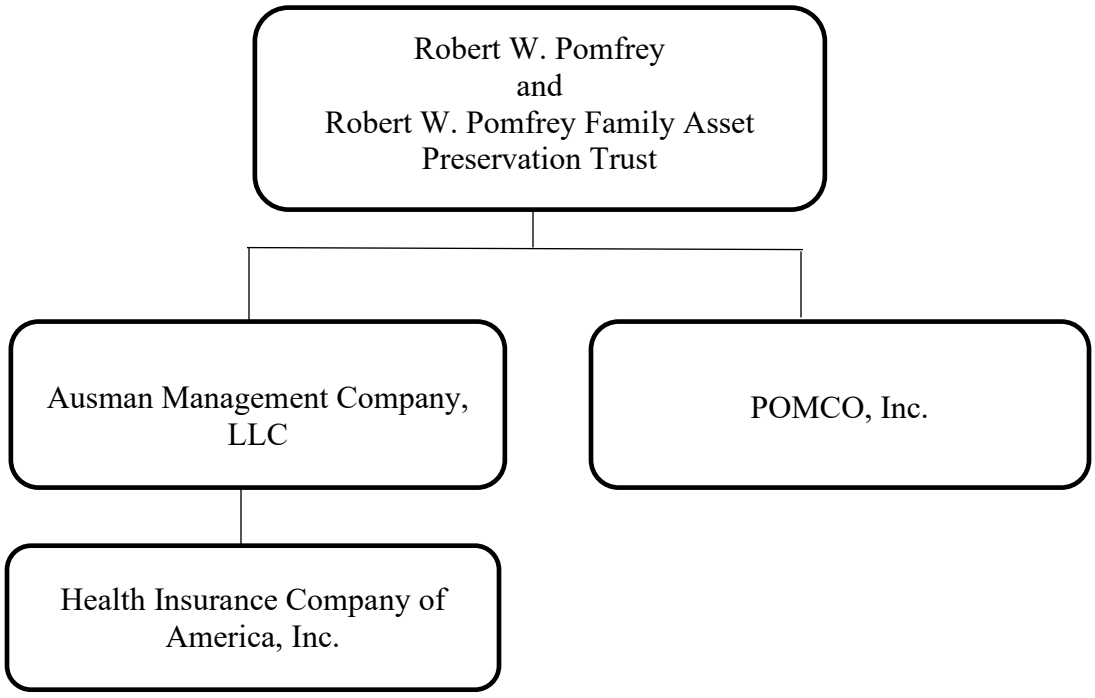
> *"6. Upon commencement of employment and annually thereafter, all employees/ board members must complete a "Conflict of Interest Questionnaire." Employees/ board members are also required to update the Conflict of Interest Questionnaire whenever there has been a change in the individual's affiliations. Employees/board members must disclose all of their affiliations, as requested by the form, even if there is no current conflict of interest."*

A review of the Company's conflict of interest policy indicated that, during the years under examination, apart from 2014, the Company did not obtain signed conflict of interest statements from its board members, officers and key employees. Therefore, the Company was not in compliance with Section 6 of its conflict of interest policy.

It is recommended that the Company comply with Section 6 of its conflict of interest policy by requiring board members, officers and key employees to complete and sign a conflict of interest statement in accordance with the stated timeframes.

E. Holding Company System

The following chart depicts the Company's holding company system as of December 31, 2016.



- Effective July 1, 2010, the Company entered into a Management/ Service Agreement with POMCO, Inc. ("POMCO") whereas POMCO provides the following services to HICA: (a) access and use of general office equipment; (b) access and use of designated personnel to handle general administrative and secretarial tasks; and (c) access and use of office space.

- Effective July 1, 2010, HICA entered into a Claim Adjudication Services Agreement with POMCO whereas POMCO acts as HICA's agent for the payment of certain medical plan benefits and furnishes certain administrative services related to such benefit plans.

  HICA agreed to pay POMCO's fees monthly upon remittances within fifteen (15) days of receipt of an invoice. Reimbursements for services rendered are on a cost basis, but no greater than what HICA would expend in providing such services itself. This agreement was approved by the Department on July 1, 2010.

- Effective March 26, 2013, HICA entered into a Business Associate Agreement with POMCO whereas POMCO establishes and implements appropriate safeguards (including certain administrative requirements) for "Protected Health Information" ("PHI") that POMCO may create, receive, use, or disclose in connection with certain functions, activities, or services (collectively "services") to be provided by POMCO to HICA.

- Effective July 14, 2010, HICA entered into a Tax Allocation Agreement with Ausman Management Company, Inc. ("Parent") whereas HICA and the Parent participated in a consolidated filing of federal income tax returns. This agreement was approved by the Department.

- Effective July 1, 2010, HICA entered into a Managing General Underwriting Agreement with POMCO whereas POMCO acts as an independent contractor for the underwriting and servicing of accident and health insurance, and any such products as may be added from time to time, with the consent of both parties.

  Reimbursement to POMCO for the services rendered was made on a cost basis, but no greater than what HICA would expend in providing such services for itself. This agreement was approved by the Department.

F. Reinsurance

During the examination period, HICA had two reinsurance contracts in effect. The first, effective July 1, 2011, with QBE Insurance Corporation written on QBE paper, with HICA as the "Reinsurer" sharing a 20% quota share. This agreement was amended with addendums effective July 1, 2011, July 1, 2013 and July 1, 2016. The maximum exposure (to HICA) on all risks attaching at a $300,000 risk cap. HICA, as the Reinsurer, allowed QBE (as the reinsured) a ceding commission on all premiums ceded as per the agreement and addendums.

The second agreement is effective January 1, 2012 with QBE Reinsurance Corporation as the "Reinsurer" and HICA as the "Reinsured". This agreement was amended with addendums effective January 1, 2012 and January 1, 2013. For this agreement, the Reinsured (HICA) ceded to the Reinsurer (QBE) 80% of the risk with HICA again having a 20% quota share with a maximum exposure (to HICA) on all risks attaching at a $300,000 risk cap. This agreement ended on or about December 31, 2015, and there are no active stop-loss policies on this agreement.

The purpose of the second reinsurance contract was to start building up the HICA brand and business. While the risk remained the same, the goal was to start writing stop-loss insurance on HICA paper (HICA as the insurer) as opposed to being just a simple reinsurer. It should be noted that the costs of maintaining both agreements became cost prohibitive and a decision was made to have only one contract (treaty) with QBE starting in 2016.

In either agreement, the reinsurer acknowledges and agrees that the reinsurance contract provides for the establishment and maintenance of a Working Fund which may be drawn from in the event the balances due the insureds under the policies for any one underwriting year exceed the funds available.

For each underwriting year, a portion of the balances otherwise payable to the reinsurer in accordance with the provisions of the agreement, shall be deposited in the Working Fund account until the accumulated balance in the Working Fund for the underwriting year equals $500,000. As of December 31, 2015, and 2016 this account had $494,751 and $382,722, respectively.

Furthermore, Articles II and III of HICA's by-laws state, in part, respectively:

> *"Article II…The affairs and business of the Corporation shall be controlled and managed by a board of directors…*
>
> *Article III…The President shall have general charge and control of the business and affairs of the Corporation."*

Upon the examiner's review of the contracts, the following was noted:

1. Both reinsurance contracts described above require that QBE furnish a monthly report summarizing the gross premium collected during the month along with the commissions, ceded losses, loss adjustment expenses, ceded subrogation and the net balance due to either party. The Company was unable to provide evidence that such report was being furnished by QBE during the examination period and subsequent.
2. Article 9 of the first contract, with HICA as the reinsurer, states that a ceding commission shall be paid to QBE on all premiums ceded. The examination indicated that the ceding commission charged to HICA was calculated on the gross premium before the 20/80 allocation.
3. Article 9 of the same contract indicates that the ceding commission paid to QBE on all ceded premiums should equal the sum of the following: (1) actual agent commissions, (2) a management fee of up to 1.1%, (3) issuing company fee of 4.5% and (4) premium taxes and assessments of 2.5%. The management fee amount was later increased to 9% without any board discussions.
4. At the conclusion of a reinsurance treaty period, the premiums due to HICA is retained in a Working Fund up to $500,000 for no more than 30 months. The amount of the premiums in the Working Fund is offset against subsequent years' expenses. It should be noted that since the inception of the reinsurance contracts HICA has not received any money from QBE.
5. The Company was unable to indicate what amounts were due to/ or from QBE under the second contract when it ended on or about December 31, 2015.

The failure of the Company to implement the requirements of the reinsurance contracts indicate that the Company was not in compliance with Articles II and III of its by-laws.

It is recommended that HICA's management comply with Articles II and III of its by-laws by enhancing controls over QBE's review procedures to mitigate the risk of material misstatement,

including but not limited to (1) implementation of a formal monthly reconciliation process of premium revenue allocated to HICA to QBE's records of policyholders billed for that month; (2) a formal review of QBE records of claims processed for the month; (3) assessment of the plausibility of the rates underlying the calculation of the ceding commission; and (4) enforcement of the terms of the reinsurance contract.

G. Accounts and Records

Upon review of the Company's operations, the following deficiencies were indicated:

1. Certain estimates, such as claims unpaid which are essential to the Company's operations, are prepared by the actuaries of QBE which acts as both a reinsured/ reinsurer to HICA. The Company was not able to provide documentation to support the claims unpaid amounts filed with the Department and therefore, not in compliance with Articles II and III of the Company's by-laws.

It is recommended that the Company comply with Articles II and III of its by-laws by requiring that management perform reviews of estimates, including assumptions, and maintain documentation supporting the claims unpaid amounts filed with the Department.

2. During the years under examination, due to inaccuracies in determining HICA's share of claims incurred by QBE, certain account balances required adjustments to correct errors related to claims incurred. The adjustments were reflected in the unassigned funds account - line 31, page 3-Liabilities Page of the NAIC 2015 annual statement. The CPA found the errors during the 2016 audit.

It is recommended that the Company's management comply with Articles II and III of its by-laws by ensuring that amounts reported to the Company by vendors and third-party administrators be reconciled to the Company's underlying supporting records and that the Company management gain an understanding of the different aspects of the transactions conducted between the Company and those parties.

3. HICA failed to comply with the requirements of Part 106.6 of New York Insurance Regulation 30 (11 NYCRR 106) when it did not maintain and use an expense allocation procedure to allocate joint expenses.

Part 106.6 of New York Insurance Regulation 30 (11 NYCRR 106) states, in part:

> "(a) The methods followed in allocating joint expenses shall be described, kept and supported as set forth under "detail of allocation bases"…
> (b) The effects of the application, to each operating expense classification of all bases of allocation shall be shown on records kept in clear and legible form. Such records shall be readily available for examination."

The abovementioned management service agreement with POMCO, allowed HICA the access and use of POMCO's general office equipment, designated personnel and office space. The examiner's review indicated that POMCO allocated and charged expenses to HICA arbitrarily, without an expense allocation procedure.

It is recommended that the Company comply with Part 106.6 of New York Insurance Regulation 30 by adopting an expense allocation procedure that will delineate the methods to be followed in allocating joint expenses.

Additionally, as part of the process of Form HC1 Registration Statement filing, financial statements for Ausman Management Company, LLC and Robert and Kellie Pomfrey, were prepared by Bonadio & Co., LLP, and submitted to the Department. The cost of preparation for

these financial statements were paid entirely by HICA; Ausman Management Company, LLC and Robert and Kellie Pomfrey or their ultimate controlling entity, should have been responsible for paying their individual shares.

Section 1217 of the New York Insurance Law states, in part:

> "No domestic insurance company shall make any disbursement of one hundred dollars or more unless evidenced by a voucher… and correctly describing the consideration for the payment."

HICA failed to comply with Section 1217 of the New York Insurance Law when it failed to obtain an invoice for the expenses before making payment.

Furthermore, Section 8 of the management agreement states that reports, with supporting details of service charges, are to be furnished monthly to HICA from POMCO and remittance to POMCO will be within 15 days of the date of the report. During the examination, HICA paid POMCO for such services without such report, therefore, HICA reimbursed POMCO without a voucher, a report or any other documents signed by or on behalf of POMCO, which is in violation of Section 1217 of the New York Insurance Law.

It is recommended that HICA review any charges prior to issuing payment to ensure it is liable for the payment.

It is also recommended that the Company comply with Section 1217 of the New York Insurance Law by making sure that any disbursement of one hundred dollars or more is evidenced by a voucher, signed by or on behalf of the payee as compensation for goods or services rendered to the Company.

4. It was noted that the Company did not have a written investment guideline / policy. Although the Company's investments as of the examination date consisted mainly of U.S.

Treasury bonds, the Company should develop, as a prudent business practice, an investment guideline/ policy authorized by its board.

It is recommended that the Company adopt and abide by formal written investment guidelines that have been approved by its board.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2016, as contained in the Company's 2016 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 December 31, 2016 filed annual statement.

Independent Accountants

Bonadio & Company, LLP was retained by the Company to audit the Company's combined statutory basis statements of financial position for calendar years 2014 through 2016, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

The independent accountants concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audit dates. Balances reported in the audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets

Bonds	$ 210,571
Cash, cash equivalents and short-term investments	925,949
Investment income due and accrued	659
Uncollected premiums and agents' balances	58,598
Funds held by or deposited with reinsured companies	382,722
Total assets	$ 1,578,499

Liabilities

Claims unpaid	$ 508,863
General expenses due and accrued	173,083
Total liabilities	$ 681,946

Capital and Surplus

Common capital stock	$ 200,000
Gross paid in and contributed surplus	1,980,500
Unassigned funds (surplus)	(1,283,947)
Total capital and surplus	$ 896,553
Total liabilities, capital and surplus	$ 1,578,499

Note 1: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2016. 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.

Note 2: The Company had deferred income tax assets which do not qualify for admission under accounting practices or permitted by the New York State Department of Financial Service for the years ended December 31, 2016 and 2015.

B. Statement of Revenue, Expenses and Capital and Changes in Capital and Surplus

Capital and surplus decreased by $252,972 during the examination period, October 1, 2010 through December 31, 2016, detailed as follows:

Revenue		
Net premium income	$ 3,912,125	
Aggregate write-ins for other health related revenues	18,180	
Aggregate write-ins for other non-health revenues	4,325	
Total revenue		$ 3,934,630
Expenses		
Hospital and medical benefits	$ 1,069,721	
Net reinsurance recoveries	(2,705,140)	
Claims adjustment expenses	47,933	
General administrative expenses	1,559,953	
Total expenses		5,382,747
Net underwriting loss		$ (1,448,117)
Net investment income earned		5,532
Net loss before income taxes		(1,442,585)
Federal income taxes		0
Net loss		$ (1,442,585)

Changes in Capital and Surplus

Capital and surplus, as of October 1, 2010			$ 1,149,525
	Gains in Surplus	Losses in Surplus	
Net income (loss)		$ 1,442,585	
Change in non-admitted assets		1,168	
Paid-in capital	$ 1,030,500		
Capital and surplus adjustment	160,281*	0	
Net decrease in capital and surplus			(252,972)
Capital and surplus per report on examination, as of December 31, 2016			$ 896,553

*Unassigned funds balance as of January 1, 2015, have been restated to correct an error of $160,281 related to claims incurred in years 2014 and earlier.

4. CLAIMS UNPAID

The examination liability of $508,863 is the same as the amount reported by the Company in its filed annual statement as of December 31, 2016.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in HICA'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 HICA's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2016.

5. SUBSEQUENT EVENTS

On March 31, 2017, United Healthcare Group acquired POMCO, United HealthCare Group will use POMCO's current location to serve as one of its Northeast third-party claim's administration service hubs.

As of June 1, 2017, POMCO no longer provided claims processing services to HICA through an agreement. Additionally, as of June 1, 2017, POMCO cancelled the contracted dental coverage for its employees with HICA.

On July 21, 2017, pursuant to Section 1105 of the New York Insurance Law and New York Insurance Regulation 109 (11 NYCRR 88), the Company submitted its plan to voluntarily cease to maintain its New York State accident and health insurance license. The Department subsequently approved the plan and the Company no longer has any policies in effect.

The Company entered into Commutation and Release Agreements, effective October 18, 2018, with QBE Insurance Corporation and QBE Reinsurance Corporation for the reinsurance contracts noted in Section F of this report. On October 31, 2018, QBE North America confirmed that payment for the settlements under both contracts had been received. It should be noted that because of the commutations, the Company is no longer carrying amounts for "Funds Held by Or Deposited with Reinsured Companies" and "Claims Unpaid" in its financial statements.

In the 2018 annual statement, HICA has indicated that, as of October 31, 2018, the Company paid all outstanding obligations in accordance with the "Communication & Release Agreements" with QBE. As a result, the Company does not have any outstanding claims liabilities or obligations.

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Company conducts its business 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 Company in the following major areas:

A. Prompt Pay Law
B. Utilization Review
C. Grievances
D. Complaints

A. Standards For Prompt, Fair and Equitable Settlement Of Claims For Health Care And Payments For Health Care Services ("Prompt Pay Law")

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

A review of the Company's claims practices and procedures was performed by using a statistical sample covering claims adjudicated during the period January 1, 2016 through December 31, 2016, in order to evaluate the overall accuracy and compliance environment of its claims processing.

The examiner selected a sample of 167 claims for review and reviewed the claims on a stop and go basis. It should be noted that although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material findings were noted.

B. Utilization Review

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

> "(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."

It should be noted that for the period under examination, the Company violated Section 4901(a) of the New York Insurance Law, when it failed to file with the Department, its biennial utilization review report.

It is recommended that the Company comply with Section 4901(a) of the New York Insurance Law by filing with the Department, its biennial utilization review report.

Further, Section 4902(a)(2) of the New York Insurance Law states:

> "(a) Each utilization review agent shall adhere to utilization review program standards consistent with the provisions of this title which shall, at a minimum, include:
>
> (2) Development of written policies and procedures that govern all aspects of the utilization review process and a requirement that a utilization review agent shall maintain and make available to insureds and health care providers a written description of such procedures including procedures to appeal an adverse determination 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 appeals."

During the years under examination, the Company did not maintain written utilization review policy and procedures. Therefore, the Company did not adhere to utilization program standards consistent with above Section of the New York Insurance Law.

It is recommended that the Company comply with Section 4902(a)(2) of the New York Insurance Law by developing written utilization review policies and procedures that can be used to govern all aspects of the utilization process.

C. Grievances

Section 3217-d(a) of the New York Insurance Law states:

> "(a) An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall establish and maintain a grievance procedure consistent with the requirements of section four thousand eight hundred two of this chapter."

During the years under examination, the Company did not maintain a grievance procedure, which violated Section 3217-d(a) of the New York Insurance Law.

It is recommended that the Company comply with Section 3217-d(a) the New York Insurance Law by establishing and maintaining grievance program standards consistent with the captioned Section of the New York Insurance Law and by assuring adherence to the established standards.

D. Complaints

Part 216.4(c) of New York Insurance Regulation 64 (11 NYCRR 216) states:

> "Every insurer shall establish an internal Department specifically designated to investigate and resolve complaints filed with the Department of Financial Services and to take action necessitated as a result of its complaint investigation findings."

The Company did not establish procedures to process internal and external complaints, thereby violating the provisions of Part 216.4(c) of New York Insurance Regulation 64 (11 NYCRR 216).

It is recommended that the Company comply with Part 216.4(c) of New York Insurance Regulation 64 by establishing an internal department specifically designated to investigate and resolve complaints filed with the Company and with the Department.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Corporate Governance	
i.	It is recommended that the Company comply with the 2015 NAIC Health Annual Statement Filing Instructions for Actuarial Opinions by having its appointed Actuaries report to the board of directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion; ensuring that the actuarial opinion and the actuarial memorandum be made available to the board of directors and that the minutes of the board of directors' meetings indicate that the appointed Actuary has presented such information to the board of directors or the Audit Committee.	6
ii.	It is recommended that the Company comply with Part 89.8(a) of New York Insurance Regulation 118 by requiring the CPA to submit written notification to the Department, the board of directors and the audit committee within five business days of any determination by the CPA that the company has materially misstated its financial condition.	7
B.	Enterprise Risk Management	
	It is recommended that the Company comply with Insurance Circular Letter No. 14 (2011) by adopting a formal Enterprise Risk Management function which will assist the Company in identifying, measuring, mitigating or managing risk exposures within predetermined tolerance levels across all activities of the entity.	7
C.	Conflict of Interest Statement	
	It is recommended that the Company comply with Section 6 of its conflict of interest policy by requiring board members, officers and key employees to complete and sign a conflict of interest statement in accordance with the stated timeframes.	9

ITEM **PAGE NO.**

Respectfully submitted,

_____
Edouard Medina
Financial Services Examiner 3

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

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

_____
Edouard Medina

Subscribed and sworn to before me

This _____ day of _____2020.

APPOINTMENT NO. **31562**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

Edouard Medina

as a proper person to examine the affairs of

Health Insurance Company of America, 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 12th day of January, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau