REPORT ON EXAMINATION

OF

HIP INSURANCE COMPANY OF NEW YORK

AS OF DECEMBER 31, 2016

EXAMINER: **EDOUARD MEDINA**

DATE OF REPORT: **July 11, 2023**

TABLE OF CONTENTS

July 11, 2023

Honorable Adrienne A. Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance, with the instructions contained in Appointment No. 31659 dated August 17, 2017, and annexed hereto, an examination has been made into the financial condition and affairs of the HIP Insurance Company of New York, an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2016, and the following report thereon is respectfully submitted.

The examination was conducted at the home office of the HIP Insurance Company of New York, located at 55 Water Street, New York, NY.

Whenever, the designations the "Company" or "HIPIC" appear herein, without qualification, they should be understood to indicate HIP Insurance Company of New York

Wherever the designation "HIP" appears herein, without qualification, it should be understood to indicate Health Insurance Plan of Greater New York.

Wherever the designation "EmblemHealth" appears herein, without qualification, it should be understood to indicate EmblemHealth, Inc., the ultimate Parent of HIPIC.

Wherever the designation "GHI" appears herein, without qualification, it should be understood to indicate Group Health Incorporated, an affiliate of HIPIC.

Wherever the designation "GHI HMO" appears herein, without qualification, it should be understood to indicate GHI HMO Select, Inc., an affiliate of HIPIC.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

A separate market conduct examination reviewing the manner in which HIPIC conducts its business practices and fulfills its contractual obligations to policyholders and claimants was conducted as of December 31, 2016. A separate report was submitted thereon.

A concurrent examination was made of HIP, a not-for-profit health insurance company licensed pursuant to the provisions of Article 43 of the New York Insurance Law, and the Parent of HIP Holdings, Inc. and GHI. A separate report thereon has been submitted.

1. SCOPE OF THE EXAMINATION

The Company was previously examined as of December 31, 2011. This examination of the Company was a combined (financial and market conduct) examination and covered the period January 1, 2012, 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 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 organization 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 calendar years 2012 through 2016, by the accounting firm of Deloitte. The Company received an unqualified opinion in each of those years.

EmblemHealth, Inc., the parent of both HIP and HIPIC, maintained an Internal Audit Department until September 8, 2016. Effective September 8, 2016, the organization entered into

an outsourcing arrangement with KPMG, LLP to take over the internal audit functions and develop financial reporting internal controls beginning with the 2017 internal audit plan.

The examiner reviewed the corrective actions taken by the Company with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiner's review are contained in Item 5 of this report.

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

2. DESCRIPTION OF THE COMPANY

HIPIC was incorporated under the laws of the State of New York as a for-profit health insurance company on September 7, 1994. On January 12, 1995, HIPIC issued 30,000 shares of $10 par value per share common stock to its immediate Parent, HIP Holdings, Inc., for a consideration of $5,000,000, bringing its authorized capital to $300,000 and contributed capital to $4,700,000. On June 5, 1995, the Department granted HIPIC a license to operate as an accident and health insurance company, as defined in paragraphs 3(i) and (ii) of Section 1113(a) of the New York Insurance Law. HIPIC commenced its operations on September 7, 1994.

On November 15, 2006, having received regulatory approval from the Department, HIPIC's intermediate Parent, HIPNY, became an affiliate of GHI. As a result of this transaction EmblemHealth became the sole member and ultimate Parent of HIPNY, GHI and their subsidiaries. HIPNY and GHI named an equal number of Directors to the Board of EmblemHealth. In December 2010, HIPNY replaced EmblemHealth as the sole corporate member and Parent corporation of GHI.

On March 6, 2007, EmblemHealth Services Company, LLC ("EHS") was formed as a joint venture of HIPNY and GHI in order to integrate the operations of these two entities. On January 1, 2008, assets such as vendor agreements and employees were transferred to EHS. HIPNY, HIPIC, GHI, and GHI HMO, controlled by EmblemHealth then began receiving management and other services from EHS. Also on that date, with the approval of the Department, HIPNY and GHI entered into a written guarantee of all liabilities of EHS.

A. Management and Controls

1. 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) and not more than twenty-one (21) members.

As of December 31, 2016, the Company's seven (7) board of directors were as follows:

Name and Residence	Principal Business Affiliation
Christopher W. Chappelear Maplewood, NJ	Chief Actuary, EmblemHealth, Inc
Lorraine Cortes-Vasquez Bronx, NY	SVP, Corporate Relations & Government Affairs, EmblemHealth, Inc.
William Mastro Shelter Island, NY	Consultant, Self-Employed
Susan Marie Mathews Schenectady, NY	Ethicist, Self-Employed
Michael Palmateer Hoboken, NJ	Chief Administrative Officer, EmblemHealth, Inc.
Ronald Ira Platt M.D. Parkland, FL	Retired
Michael Wise Avon, CT	President and Chief Executive Officer, Connecticare, Inc.

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

Name	Title
Frank A. Melaccio	President
Carlos Manalansan	Secretary
Mathew Rubin	Treasurer

Section II (Composition) of HIPIC's Audit Committee charter states in part:

> "The Audit Committee shall comprise three (3) or more directors as determined by the Board..."

Section III (Meetings) of HIPIC's Audit Committee charter states in part:

> "…The Committee shall meet at least two (2) times annually, or more frequently as circumstance dictate."

It was noted during the examination period that the Audit Committee violated Sections II and III of its Audit Committee charter by having only two members and by meeting only once in each of the calendar years 2012 and 2016.

It is recommended that HIPIC's Audit Committee adhere to its charter by ensuring that the committee comprises three (3) or more directors as determined by the board of directors.

It is also recommended that HIPIC's Audit Committee adhere to its charter by meeting no less than twice annually.

A similar recommendation appeared in the Company's prior report on examination.

2. Enterprise Risk Management ("ERM")

The ERM Workgroup, the ERM Executive Committee and the Chief Risk Officer ("CRO") represent the three most important parts of the Company's Enterprise Risk Management mechanism.

As per the Company's 2016 Own Risk Solvency Assessment Report ("ORSA"), the ERM Workgroup would aggregate risks throughout the organization, evaluate the impact and materiality of the risks, and meet monthly with the CRO to discuss risk mitigation strategies.

The Company's ORSA further stated that the CRO would present the risks to the ERM Executive Committee for review and that the ERM Executive Committee would meet at least quarterly and be responsible for providing direction to the CRO and the ERM Work Group.

The examination indicated that the ERM Workgroup, the CRO and the ERM Executive Committee were not meeting as indicated in the ORSA report.

It is recommended that, the ERM Workgroup, the Chief Risk Officer and the ERM Executive Committee, being vital to the ERM communication mechanism, follow the guidelines of the Company's ORSA report by meeting monthly for the ERM Workgroup and quarterly for the ERM Executive Committee as indicated in the report.

It is also recommended that the ERM Workgroup and the ERM Executive Committee establish respective charters which will define the role, the responsibilities and the activities of the ERM Workgroup and the ERM Executive Committee.

Additionally, the CRO, who is the Chairman of the ERM Workgroup also serves as the Company's VP and Controller. As a best practice, the CRO should not hold a position as a business unit leader in the ERM process.

It is recommended, as a good business practice, that the Company not appoint individuals who have management responsibility or financial responsibility, with respect to any operational business lines or revenue generating functions, as its CRO.

3. Internal Audit Department

A review of the reports issued by the Company's Internal Audit Department for the period under examination indicated a lack of oversight on the part of the Audit Committee. When the Internal Audit Department identified issues and submitted recommendations, it was management who decided whether to implement the submitted recommendations and take other appropriate corrective actions. Management also determined whether the issues would be brought to the attention of the Audit Committee.

This practice is not in compliance with Section 1110.A1 of the International Standards for the Professional Practice of Internal Auditing (Standards), which states the following:

> "The internal audit activity must be free from interference in determining the scope of internal auditing, performing work and communicating results. The chief audit executive must disclose such interference to the board and discuss the implications."

To achieve the necessary degree of independence the performance of the Chief Audit Executive must be free from interference in determining the scope of internal auditing, performing the audit work and communicating the audit results.

It is recommended that the Chief Audit Executive report directly to the Audit Committee.

B. Territory and Plan of Operation

HIPIC is an accident and health insurer operating under the provision of Article 42 of the Insurance Law of the State of New York. HIPIC is authorized to write accident and health insurance as defined in paragraphs 3(i) and (ii) of Section 1113(a) of the New York Insurance Law. The Company is licensed to do business in New York State only.

HIPIC was formed to market insurance products, primarily the out-of-network component of POS products, to members of HIP, and, as a result, it is economically dependent on HIP.

Total enrollment declined by 81% during the examination period due to decreases in its experience and community rated large groups. The following shows the number of members enrolled and corresponding net premiums written at the end of each year of the five-year examination period:

Year	Enrollment	Net Premiums Written
2012	36,572	$ 170,533,961
2013	28,121	$ 147,015,827
2014	8,035	$ 60,654,486
2015	10,022	$ 19,927,099
2016	6,915	$ 8,007,945

As of December 31, 2016, the total number of members reported by the Company was 6,915 which is a decrease of 29,657 members over the examination period, especially between 2013 and 2014 due to a decline in its EPO/PPO membership.

C. Holding Company System

HIPIC is part of the Emblem Health holding company system. HIPIC is a wholly-owned subsidiary of HIP Holdings, Inc., a for-profit Delaware holding corporation. HIP Holdings is a wholly owned subsidiary of HIP, a not-for-profit health insurer licensed under the provisions of Article 43 of the New York Insurance Law. The Ultimate parent of these Companies is EmblemHealth, Inc., formerly HIP Foundations, Inc.

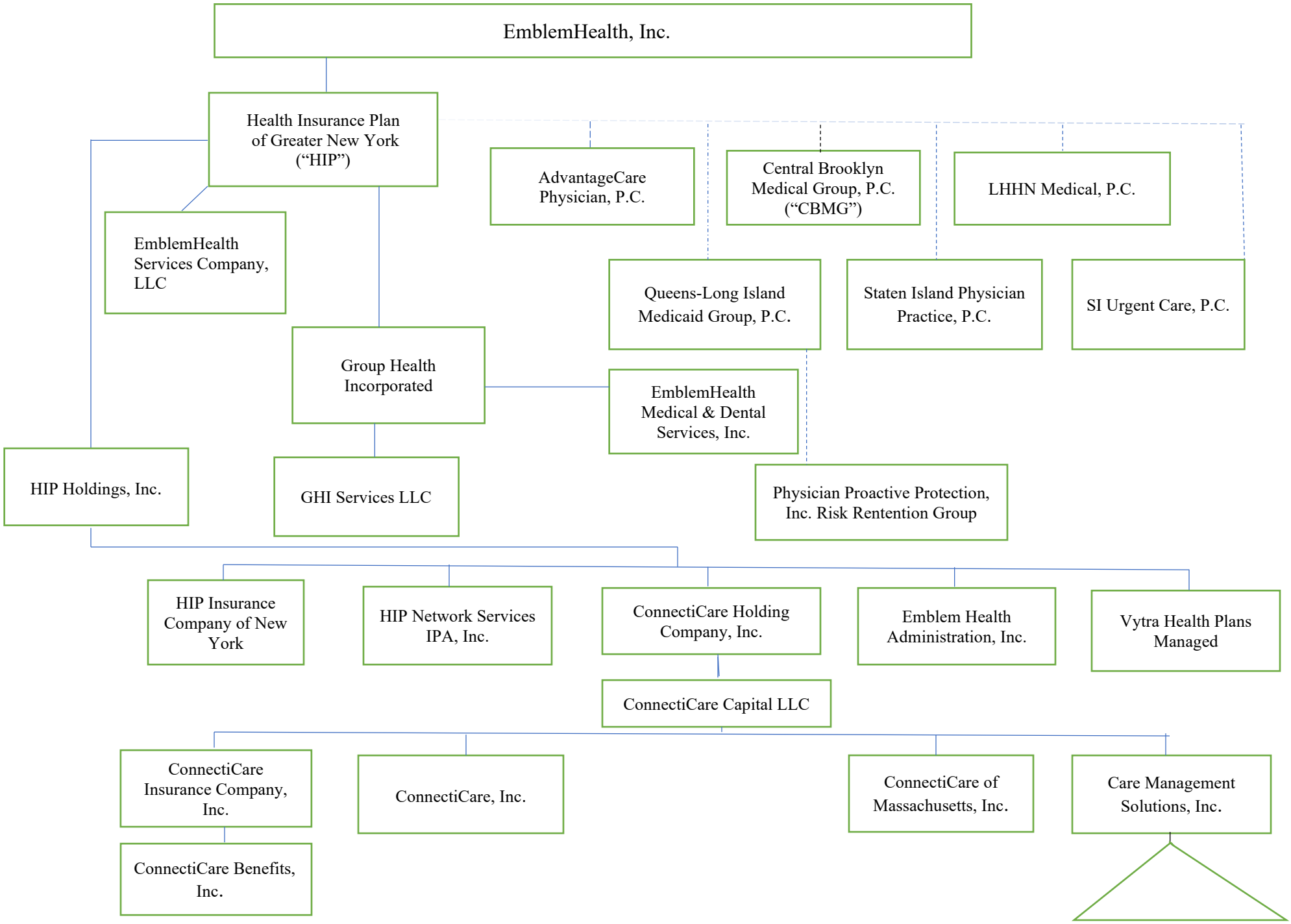
Health Insurance Plan of Greater New York wholly owns Group Health Incorporated and HIP Holdings, Inc., a downstream Delaware holding corporation. In turn, HIP Holdings Inc. owns HIP Insurance Company of New York and ConnectiCare Holding Company Inc.

In March 2005, HIP, through its subsidiary HIP Holdings Inc., acquired ConnectiCare, Inc. ("ConnectiCare"), which included ConnectiCare of Massachusetts, ConnectiCare of New York and ConnectiCare Insurance Company. On January 26, 2011, ConnectiCare of New York was merged into GHI HMO, a subsidiary of GHI.

In January 2006, HIP, through its subsidiary HIP Holdings Inc., acquired Perfect HealthInsurance Company, which merged into GHI on December 31, 2009.

HIP and GHI became affiliated in November 2006. Through an organizational change in 2010, HIP became the parent company of GHI. GHI HMO Select, a subsidiary of GHI, was merged into HIP on June 26, 2013.

An organizational chart depicting the relationship between the Company and significant entities in its holding company system as of December 31, 2016, is as follows:


EmblemHealth, Inc.
Health Insurance Plan of Greater New York ("HIP")
EmblemHealth Services Company, LLC
AdvantageCare Physician, P.C.
Central Brooklyn Medical Group, P.C. ("CBMG")
LHHN Medical, P.C.
Queens-Long Island Medicaid Group, P.C.
Staten Island Physician Practice, P.C.
SI Urgent Care, P.C.
Group Health Incorporated
EmblemHealth Medical & Dental Services, Inc.
HIP Holdings, Inc.
GHI Services LLC
Physician Proactive Protection, Inc. Risk Rentention Group
HIP Insurance Company of New York
HIP Network Services IPA, Inc.
ConnectiCare Holding Company, Inc.
Emblem Health Administration, Inc.
Vytra Health Plans Managed
ConnectiCare Capital LLC
ConnectiCare Insurance Company, Inc.
ConnectiCare, Inc.
ConnectiCare of Massachusetts, Inc.
Care Management Solutions, Inc.
ConnectiCare Benefits, Inc.

Effective January 1, 2008, HIP entered into a management services agreement with EmblemHealth Services, LLC ("EHS") and other health benefit providers controlled by EmblemHealth for the purpose of exchanging services and the use of certain personnel, facilities, equipment, personal property, licenses, and contracts owned or leased by each company. On the same date, EHS became the sponsor of pension plans for management employees. As of December 31, 2016, HIP reported a receivable due from EHS in the amount of $174.5 million.

In 2016, the Department approved HIP's reclassification of some receivables due from AdvantageCare Physicians, P.C. ("ACPNY"), an affiliate, as an additional investment. As a result, HIP's cost of its investment in ACPNY increased from $184.1 million as of December 31, 2015, to $373.2 million as of December 31, 2016.

As mentioned above, HIPIC primarily provides the out-of-network component of POS products to members of HIP. HIP administers the collection of premiums and claim payments on behalf of HIPIC.

Emblem Health Administration, Inc. ("EHA") provides claims processing and certain member services for HIP's members. For the year ended 2016 EHA charged HIP approximately $15.4 million for these services.

EHS' Master Services Agreement ("MSA")

On April 14, 2016, EHS entered into an agreement with Cognizant Healthcare Services LLC, TriZetto Corporation and Medicall collectively ("CTS"), known as the Master Services Agreement ("MSA"), to provide services to EHS including information technology, membership and benefits configuration, billing and claims processing functions. The initial term of the MSA

is for seven years, with EHS having three extension opportunities to extend the term for up to one year with each extension opportunity.

The MSA includes average minimum amounts payable to CTS of approximately $225,000,000 annually over the initial seven-year term.

EHS' Asset Purchase Agreement ("APA")

On April 14, 2016, EHS, HIP and GHI (collectively, "Seller") entered into an Asset Purchase Agreement ("APA") with Cognizant Healthcare Services LLC. The agreement indicates that Emblem sold almost all its hardware to Cognizant Healthcare Services LLC ("Buyer"). Proceeds from the sale were approximately $22.7 million and the net book value of the assets was $18.8 million. EmblemHealth retained the hardware used for the GHI and HIP Medicare Services Government program.

The Examination found that most of the agreements with HIPIC, its affiliates and CTS provide similar services as noted below:

- Accounting and financial services;
- Banking and treasury operations;
- Investment services;
- Underwriting;
- Forms and rates;
- Claims processing;
- Quality management, assessment and utilization;
- Credentialing;
- Member services;
- Fraud and abuse;
- Marketing and planning;
- Agency development;
- Personnel services;
- Information services;
- Legal proceedings; and
- Government and public relations.

The above services may be delegated to CTS or retained internally.

It is recommended that the Company monitor the service agreements as to their use and necessity and terminate them when they are no longer needed.

D. Reinsurance

The Company did not have any ceded or assumed reinsurance program in 2015 and 2016. In 2014, the Company did have ceded reinsurance and reported ($69,229) in Part 1 Line 1.9 for its large group segment in the 2014 MLR report. This reinsurance was ceded with RGA Reinsurance Company and ended after 2014. In addition, HIPIC assumed reinsurance through an inter-company agreement with ConnectiCare. The agreement ended in January 2013. It was noted that the inter-company agreement with ConnectiCare was not approved by the Department, in violation of Section 1505(d)(2) of New York Insurance Law.

Section 1505(d)(2) of New York Insurance Law states, in part:

> "The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least 30 days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period…
> (2) reinsurance treaties or agreements"

It is recommended that HIPIC comply with Section 1505(d)(2) of the New York Insurance Law by ensuring that all reinsurance agreements with the entities within the holding company system be submitted to the Department in writing at least 45 days prior to the execution of such agreement.

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

E. Significant operating ratios

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

	Amounts	Percentage
Claims	$356,471,654	88.0%
Claims adjustment expenses	15,647,287	4.0%
General administrative expenses	49,912,909	2.0%
Net underwriting loss	(17,197,873)	(4.0%)
Net premium earned	$406,139,318	100.0%

3. MEDICAL LOSS RATIO

The Company's 2016 Medical Loss Ratio ("MLR") Annual Reporting Form was examined to determine compliance with Title 45 CFR Part 158. Title 45 CFR Part 158 implements Section 2718 of the Public Health Service Act ("PHS Act"). Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance companies to submit to the Secretary of the US. Department of Health and Human Services (HHS") an annual report on their Medical Loss Ratio. The MLR is the proportion of premium revenue expended by a company on clinical services and activities that improve health care quality in a given state and market. Section 2718 of the PHS Act also requires a company to provide rebates to consumers if it does not meet the MLR standard (generally, 82% in the New York individual and small group markets and 85% in the large group market). The Company writes only large group business.

This is the first examination of the Company's MLR Annual Reporting Form. The examination covered the reporting period January 1, 2014, through December 31, 2016.

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

The examination included evaluating the reasonableness of expense allocations, determining compliance with relevant statutory accounting standards, MLR regulations and guidance.

Title 45 CFR§158.110(b) requires that a report for MLR reporting year be submitted to the Secretary of the U.S. Department of Health and Human Services ("HHS") by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary of HHS. Based on the examiner's review, HIPIC filed an acceptable form for 2016 reporting year.

Title 45 CFR §158.210(a), (b) and (c) require that an issuer must provide a rebate to enrollees if the issuer has an MLR below the required amount (less than 82% in the individual and small group markets and 85% in the large group market for the state of New York). During the examination period the Company only wrote business in the Large Group Market. The Company's MLR and rebate calculations, as reported on the 2016 MLR Annual Reporting Form were as follows:

HIP INSURANCE COMPANY OF NEW YORK

MLR Components	Individual	Small Group	Large Group
Adjusted Incurred Claims			$ 8,253,517
Plus: Quality Improvement Expenses			89,620
Less: Cost-Sharing Reduction			
Less: Federal Transitional Reinsurance Program payments expected from HHS			
Less: Federal Risk Adjustment Program net payments expected from HHS			
Less: Federal Risk Corridors Risk Program net payments			
MLR Numerator			**$ 8,343,137**
Premium Earned			8,211,038
Less: Federal & State Taxes and Licensing/Regulatory Fees			747,707
MLR Denominator			**$ 7,463,331**
Preliminary MLR before credibility adjustment			111.8 %
Credibility Adjustment			0 %
Credibility–Adjusted MLR			**111.8 %**
MLR Standard	82%	82%	85%
Rebate Amount	**$0**	**$0**	**$0**

A. Medical Loss Ratio Numerator

According to Title 45CFR §158.221(b), the numerator of the MLR calculation is comprised of incurred claims, as defined in 45 CFR §158.140, plus expenditures for activities that improve health care quality, as defined in Title 45 CFR §158.150, and Title 45 CFR §158.151. The examiner determined that HIPIC included appropriate adjusted incurred claims in its MLR numerator.

Quality Improvement Activities ("QIA")

The examiner reviewed the reasonableness of the health care quality improvement expenses including confirming that the methodology complies with the narrative provided within Part 4 – Expense Allocation portion of the MLR Reporting Form and conforms to the definition of Healthcare Quality Improvement Expenses as defined by 45 CFR §158.150, and 45 CFR §158.151.

It was determined that HIPIC's allocation methodology and health care quality improvement expenses reported in its MLR numerator were reasonable and conformed to the regulations.

Cost Sharing Reductions ("CSR")

The Company did not report any advanced payments of CSR received from HHS as a deduction from incurred claims.

Federal Premium Stabilization Programs

The examiner reviewed the accuracy of the amounts reported in connection with the Federal Transitional Reinsurance and Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR §158.140(b)(4)(ii), including the verification of amounts to HHS program summary reports and the Company's transactional records. The Company did not report any Federal Risk Corridor Program amounts as a deduction from incurred claims.

Based on the procedures performed, the Company's Federal premium stabilization programs amounts were accurately reported.

B. Medical Loss Ratio Denominator

According to 45 CFR §158.22(c), the denominator of the MLR calculation is comprised of premium revenue, as defined in 45 CFR §158.130, minus federal and state taxes and licensing and regulatory fees, described in 45 CFR §158.161(a), and 45 CFR §158.162(a)(1) and (b)(1).

It was determined that HIPIC included appropriate premiums earned in its MLR denominator.

Additionally, it was determined that HIPIC's allocation methodology and federal and state taxes and regulatory fees reported in its MLR denominator is reasonable and conforms to the regulations.

C. Credibility Adjustment

According to 45 CFR §158.232, the credibility adjustment is the product of the base credibility factor multiplied by the deductible factor. The examiner determined that the large group

market segment was fully credible; therefore, there was no credibility adjustment calculated for this segment.

D. Credibility-Adjusted MLR

According to 45 CFR §158.221(a), the calculation of MLR is the ratio of the numerator to the denominator, subject to the applicable credibility adjustment if any. The examiner determined that HIPIC appropriately calculated the medical loss ratio for each of its market segments.

E Rebate Disbursement and Notice

According to Title 45 CFR §158.240, a rebate is required to be paid, no later than September 30th, if an insurer's MLR is less than the minimum MLR standard. It was determined that HIPIC's MLR exceeded the minimum percentage for each of its market segments and as a result, no rebates were warranted during the examination period.

F. Impact on Risk-Based Capital

According to Title 45 CFR §158.270(a), rebate payments having any adverse impact to the Company's Risk Based Capital ("RBC") level requires notification by the Department to the Secretary of the HHS. The Company's MLRs exceeded the minimum percentage for all market segments, and no rebates were issued, therefore there was no impact on the RBC level and no notification to the Secretary of HHS was warranted.

4. 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, 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 will affect the Company's financial results presented in its financial statements contained in the December 31, 2016, filed annual statement.

Independent Accountants

The Company was audited annually, for the years 2012 through 2016, by the accounting firm of Deloitte. The Company received an unqualified opinion in each of those years.

Deloitte 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 these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets

Bonds	$ 49,598,696
Cash, cash equivalents and short-term investments	1,979,468
Receivables for securities	379
Investment income due and accrued	370,140
Uncollected premiums and agents' balance in course of collection	120,725
Federal income tax recoverable and interest thereon	1,028,936
Receivables from parent, subsidiaries and affiliates	646,084
Total assets	$ 53,744,428

Liabilities

Claims unpaid	$ 1,152,950
Unpaid claims adjustment expenses	26,273
Aggregate health policy reserves	356,127
General expenses due or accrued	88,965
Amounts due to parent, subsidiaries and affiliates	10,528,602
Total liabilities	$ 12,152,917

Capital and Surplus

Common capital stock	$ 300,000
Gross paid in and contributed surplus	62,100,000
Unassigned funds (surplus)	(20,808,489)
Total capital and surplus	$ 41,591,511
Total liabilities, capital and surplus	$ 53,744,428

Note: The IRS conducted examinations of HIP Holdings and its subsidiaries for tax years 2007, 2008, and 2009 tax returns in conjunction with carryback claims filed by HIP Holdings. The tentative determination of the IRS for tax years 2007, 2008, and 2009 was that there was no tax due or payable with respect to these years. In 2013, the IRS conducted a limited audit of HIP Holdings and its subsidiaries, including HIPIC for tax years 2010 and 2011. As of December 31, 2016, the Company reported federal income tax in the amount of $40,099. 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 increased by $29,338,378 during the five-year examination period, January 1, 2012, through December 31, 2016, detailed as follows:

Revenue	
Net premium income	$ 406,139,318
Change in unearned premium reserves and reserve for rate credits	(1,305,340)
Total revenue	$ 404,833,978
Hospital and Medical Expenses	
Hospital/medical benefits	$ 302,674,178
Prescription drugs	54,515,950
Incentive pool, withhold adjustments	1,010,220
Net reinsurance recoveries	(1,728,694)
Total hospital and medical	356,471,654
Claims adjustment expenses	15,647,287
General administrative expenses	49,912,909
Total underwriting expenses	422,031,850
Net underwriting loss	$ (17,197,872)
Net investment income earned	6,138,942
Net realized capital gains or (losses)	314,488
Net investment gains (losses)	6,453,430
Net gain or (loss) from agents' premium balances charged off	(799,951)
Aggregate write-ins for other income or expenses	(431,903)
Net income (loss) before federal income taxes	(11,976,296)
Federal and foreign income taxes incurred	(3,248,842)
Net loss	$ (8,727,454)

Changes in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2011			$ 12,253,134
	Gains in Surplus	Losses in Surplus	
Net loss		$ (8,727,454)	
Change in net deferred income tax		(355,216)	
Change in non-admitted assets	356,914		
Surplus adjustments: paid-in capital	40,000,000		
Aggregate write-ins for gains or (losses) in surplus		(1,935,866)	
Net increase in capital and surplus			29,338,378
Capital and surplus, per report on examination, as of December 31, 2016			$ 41,591,512

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2011, contained four (4) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Management and controls	
1.	It is recommended that the Company take corrective action by developing a policy to evaluate whether Board members who are unable or unwilling to attend meetings consistently should resign or be replaced. Furthermore, in selecting prospective Board members, a key criterion should be their willingness and commitment to attend meetings and participate in the Board's responsibility to oversee the operations of the Company. *The Company has complied with this recommendation*	9
2.	It is recommended that the HIPIC Audit Committee adhere to its charter and meet no less than twice annually. *The Company has not complied with this recommendation. A similar recommendation appears in this report.*	10
	Reinsurance	
3.	It is recommended that HIPIC comply with the requirements of Section 1505(d)(2) of the New York Insurance Law. *The Company has complied with this recommendation.*	16
	Insurance Regulation No. 118 (11 NYCRR 89) - Model Audit Rule	
4	It is recommended that HIPIC comply with the requirement of Part 89.5(e)(2) of Insurance Regulation No. 118 (11 NYCRR 89) by attaching the required statement to its filed audited financial statements. *The Company has complied with this recommendation.*	16

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO.		PAGE NO.
C.	Reinsurance	
	It is recommended that HIPIC comply with Section 1505(d)(2) of the New York Insurance Law by ensuring that all reinsurance agreements with the entities within the holding company system be submitted to the Department in writing at least 45 days prior to the execution of such agreement.	16

Respectfully submitted,

_____

Edouard Medina
Financial Services Manager 1

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

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

_____

Edouard Medina
Financial Services Manager 1

Subscribed and sworn to before me
this ____ day of _____ 2023.

APPOINTMENT NO. 31659

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

HIP Insurance Company of New York

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 17th day of August, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau