REPORT ON EXAMINATION

OF

CARECONNECT INSURANCE COMPANY, INC.

AS OF

DECEMBER 31, 2015

DATE OF REPORT **NOVEMBER 8, 2018**

EXAMINER **EDOUARD MEDINA**

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November 8, 2018

Honorable Maria T. Vullo
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 31509, dated July 20, 2016, attached hereto, I have made an examination into the condition and affairs of CareConnect Insurance Company, Inc., formerly North Shore-LIJ CareConnect Insurance Company, Inc., an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2015, and submit the following report thereon.

The examination was conducted at the home office of CareConnect Insurance Company, Inc. located at 2200 Northern Boulevard, East Hills, New York 11548.

Wherever the designations the "Company" or "CareConnect" appear herein, without qualification, they should be understood to indicate CareConnect Insurance Company, Inc.

Wherever the designations the "Department" or "DFS" appear herein, without qualification, they should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

We have performed our single state examination of CareConnect Insurance Company, Inc. This examination of the Company was a combined (financial and market conduct) examination and covered the period July 17, 2013 through December 31, 2015. It is the Company's first examination. 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, 2016 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, 2015 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 CareConnect.

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 2014 and 2015, by the accounting firm Ernst & Young LLP. CareConnect received an unmodified opinion in each of those years. A review was also made of the Company's Enterprise Risk Management program.

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 Paragraph (3)(i) of Section 1113(a) of the New York Insurance Law. The Company was incorporated on March 28, 2013 and licensed to write business on July 30, 2013, in New York State. On January 1, 2014, the Company began offering commercial health insurance products to individuals and small business on the New York State Health Insurance Exchange ("Exchange") and to small and large businesses off the Exchange.

On September 30, 2016, the Company's Charter was amended to change the Company's name from North Shore-LIJ CareConnect Insurance Company, Inc. to CareConnect Insurance Company, Inc. The name change was approved on September 30, 2016.

A. Corporate Governance

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of not less than 7 members. As of the examination date, the board of directors was comprised of 8 members.

The directors as of December 31, 2015 were as follows:

Name and Residence	Principal Business Affiliation
Alan B. Bernstein, M.D. Larchmont, NY	Chief Medical Officer, CareConnect Insurance Company, Inc.
Robert W. Brown Ramsey, NJ	Chief Growth Officer, CareConnect Insurance Company, Inc.
Kathryn Howell Pelham, NY	Chief Legal Officer; Secretary CareConnect Insurance Company, Inc.
Emily Leish Brooklyn, NY	Deputy Chief Legal Officer; Assistant Secretary, CareConnect Insurance Company, Inc.
Charles Merz Lewisburg, PA	Chief Actuary Officer, CareConnect Insurance Company, Inc.
Alan J. Murray Syosset, NY	Chief Executive Officer, CareConnect Insurance Company, Inc.
Charles Ottomanelli East Northport, NY	Chief Operating Officer, CareConnect Insurance Company, Inc.
Kevin M. Smolich Huntington, NY	Chief Financial Officer, CareConnect Insurance Company, Inc.

The board met four times in 2014 and three times in 2015. The Company's by-laws are silent with respect to the number of times the board should meet every year. It is important that board meetings are held regularly so that directors can discharge their responsibility to oversee the company's operations, strategies and policies, and so that individual directors can report on their particular areas of responsibility. The minutes of the board meetings indicate that the meetings were generally well attended, with all BOD and sub-committee members attending at least one half of all the meetings they were eligible to attend.

It is recommended that the Company hold board meetings at least every quarter, in addition to an annual meeting, so that directors can discharge their responsibility to oversee the company's operations, strategies and policies, and so that individual directors can report on their particular areas of responsibility.

As of December 31, 2015, the principal officers of the Company were as follows:

Name	Title
Alan J. Murray	President & Chief Executive Officer
Charles Ottomanelli	Chief Operating Officer
Kathryn Howell	Chief Legal Officer & Secretary
Kevin M. Smolich	Chief Financial Officer & Treasurer
Emily Leish	Deputy Chief Legal Officer & Assistant Secretary
Robert W. Brown	Chief Growth Officer
Charles Merz	Chief Actuarial Officer

Section 1110 of the IIA's International Standards for the Professional Practice of Internal Auditing states:

> "Organizational independence is effectively achieved when the chief audit executive reports functionally to the board."

The Company's internal audit unit is comprised of only one individual, the Director of Internal Audit, who reports directly to the (VP and) Compliance Officer. Accordingly, the Company is not acting in accordance with Section 1100 of the Institute of Internal Auditor's ("IIA") International Standards for the Professional Practice of Internal Auditing, which recommends that the Director of Internal Audit report directly to the board.

It is recommended that the Company, to achieve an effective organizational independence for its internal audit function, follow the guidelines of Section 1100 of the IIA's International

Standards for the Professional Practice of Internal Auditing by having the Company's Director of Internal Audit report functionally to the board or Audit Committee and administratively to a C-level officer.

CareConnect's internal audit unit only conducts compliance and business operation audits. The audits results are reported to the Compliance Officer who reports to CareConnect's audit committee.

Northwell Health, Inc. ("Northwell") the Ultimate Parent Company in the Company's holding company system, has an Audit and Compliance committee which reports directly to Northwell's board of directors. Northwell's Audit and Compliance committee is responsible for all entities within the Northwell holding company system, including CareConnect. This Audit and Compliance committee conducts internal financial audits of CareConnect.

A review of Northwell's Audit and Compliance committee meeting minutes indicated that no representatives from CareConnect attended those meetings.

It is recommended that, at a minimum, members of the CareConnect Audit Committee attend Northwell's Audit and Compliance committee meetings, especially when CareConnect related issues and audits are on the agenda.

B. Territory and Plan of Operation

As of July 30, 2013, the Company was licensed to write accident and health insurance as defined in Paragraph (3)(i) of Section 1113(a) of the New York Insurance Law.

The Company offers commercial health insurance products to individuals and small

businesses on the New York State Health Insurance Exchange ("Exchange") and to small and large businesses off the Exchange.

The Company reported annual written premiums of $124,602,052 for the year 2015. The Company's enrollment as of December 31, 2015 was 69,374, compared to 11,662 at December 31, 2014.

As of December 31, 2015, the Company reported capital and surplus in the amount of $20,496,045. As of September 30, 2016, the Company reported capital and surplus of $3,577,066. On November 17, 2016, the Department approved a capital contribution of $69,000,000 from the Northwell Healthcare, Inc., the intermediate Parent of the Company. The Company received the infusion on December 7, 2016. Through December 7, 2016, the Company had received total Paid in Capital Contributions in the amount of $243,453,931 from its parent.

C. Reinsurance

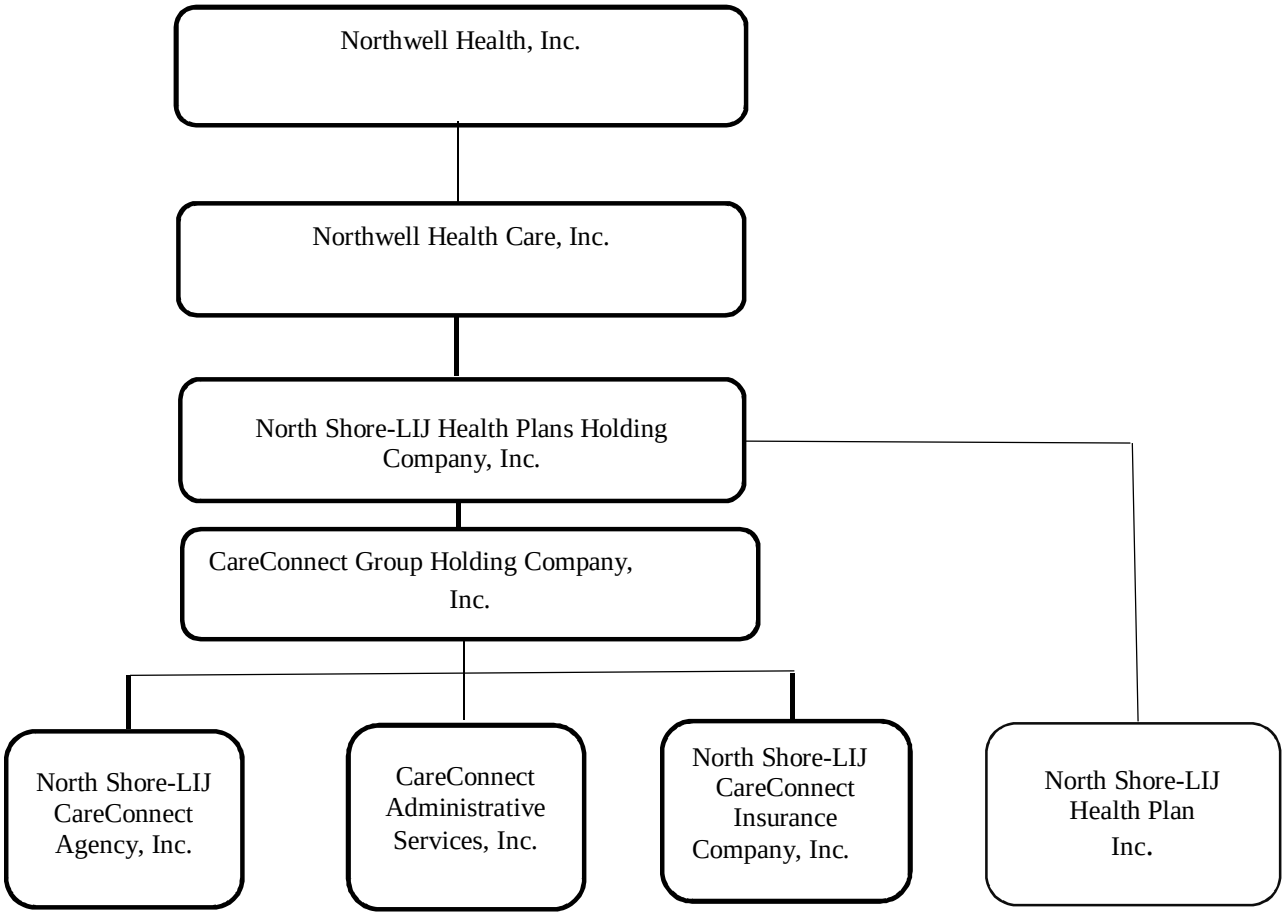
Effective January 1, 2015, the Company entered into a Specific Excess Loss Reinsurance Agreement with PartnerRe America Insurance Company, with an expiration date of January 1, 2016, covering individual, small group and large group business, on and off the Exchange.

The above agreement was replaced by a reinsurance agreement effective January 1, 2016, with Zurich American Insurance Company covering individual and small group business on and off the Exchange and large group business.

D. Holding Company System

The ultimate parent of the Company is Northwell Health, Inc.

The following chart depicts the Company's abbreviated holding company system as of December 31, 2015.



- Effective July 16, 2013, the Company entered into a Management Services Agreement with North Shore-Long Island Jewish Health Care, Inc. ("HCI"), whereby HCI is to provide certain administrative services to the Company through personnel employed or engaged by HCI or the North Shore-LIJ Health System. That agreement was amended, restated,

originally submitted to the Department on May 12, 2015. It was subsequently resubmitted to the Department on July 24, 2015. On December 16, 2015, the Department issued a letter stating that it had no objection to the implementation of the amended and restated agreement. According to the agreement, for fiscal year 2015, CareConnect is to pay $1,500,000 to be allocated between CareConnect and North Shore-LIJ Health Plan, Inc. Subsequent to 2015, the fee for the services for each year within the terms of the agreement are to be agreed upon by the parties no later than November 1 of the preceding year.

- Effective December 17, 2015, CareConnect entered into a Reporting Services Agreement with North Shore-Long Island Jewish Health System, Inc. ("HSI") whereby CareConnect has access to certain hosted software solutions for the purpose of producing analytics, reporting, and related functionality. This Agreement was approved by DFS on December 17, 2015.

- Effective December 17, 2015, CareConnect entered into an Affiliate Agency Agreement with North Shore-LIJ CareConnect Insurance Agency, Inc. ("Agent", a captive licensed insurance agency wholly owned by CareConnect Group Holding Company, Inc. ("CCG"), the parent of CareConnect, and licensed in New York as an accident and health agency) whereby the Agent collects shared commissions from other CareConnect Agents and to provide an approval mechanism for the Agent to sell CareConnect Benefit Plans. This Agreement was approved by DFS on December 17, 2015.

- Effective January 1, 2015, CareConnect Group Holding Company, Inc. ("CCG") entered into an Employee Transfer Agreement with North Shore-Long Island Jewish Health Care, Inc. (HCI), whereby HCI is to transfer certain of its employees to CCG, and HCI shall

provide certain human resources and payroll services in connection with such employees. For 2015, CCG was to pay $250,000 to HCI. Subsequent to 2015, the fees for each year within the term of the agreement shall be agreed upon by the parties no later than September 1 of the preceding year.

The Company is not a party to the Employee Transfer Agreement. However, the fees paid through the agreement are derived from the Company. Therefore, the terms of the agreement should be in accordance with Parts 105-109 of Insurance Regulation No. 30.

Furthermore, the examination indicated that Northwell Health, Inc. is the employer of record for all employees. Northwell Health, Inc. has, however filed the IRS Form 2678 to become a paymaster agent on behalf of CCG, which was approved by the IRS on April 4, 2017.

- Effective January 1, 2015, a Leased Employee Services Agreement was entered into among the Company, North Shore-LIJ Health Plan, Inc. (“HPI”) and CCG, whereby CCG makes its employees available to provide services to the Company and HPI. According to the agreement, the leased employees shall be employees of CCG at all times. Each lessee will pay CCG an amount equal to the percentage allocated to it for each leased employee. The agreement was amended and restated on January 1, 2016.

- Effective April 4, 2013, an original Provider Agreement among HPI, CareConnect and North Shore-LI Jewish Health System, Inc. (“HSI") was executed.

  Effective January 1, 2015, the Company entered into Provider Agreement Amendment #1 with HPI and HSI. CareConnect was removed from the Provider Agreement.

- Effective January 1, 2015, the Company entered into an alternate Provider Agreement with CareConnect Administrative Services, Inc. ("CCAS"), HSI and North Shore-Long Island Jewish Health Care, Inc. ("HCI") whereby the parties wish to create an integrated health care and health insurance experience for members.

  The Second Amendment to the Provider Agreement was effective October 1, 2016, whereby the parties desire to amend the Agreement to compensate North Shore-LIJ Urgent Care, P.C., a Northwell subsidiary, for an additional service.

  There is no First Amendment to the Provider Agreement.

  Effective January 1, 2015, the Company entered into Amendment Number 3 to the Provider Agreement/Termination of Readmission and Reduction and Emergency Room Abatement Services Agreement (Amendment #3) with CCAS, Northwell Health, Inc. ("NHI") and Northwell Health Care, Inc. ("HCI") whereby the parties wished to expand the care management services to CareConnect and memorialize all services in one stand-alone agreement called the "Care Management Services Agreement." Amendment #3 and the Care Management Services Agreement are currently under the Department's review.

- Effective March 1, 2013, the Company entered into the IPA Health Care Services Agreement with HPI, North Shore-LIJ Clinical Integration Network IPA, LLC and North Shore-LIJ Network, Inc. (collectively "IPA").

  Effective January 1, 2016, the Company entered into the IPA Health Services Agreement Amendment, whereas the Parties desired to extend the scope of the Agreement to include

the arrangement by IPA of Services by Providers to individuals enrolled in self-insured employer plans.

As of December 31, 2015, the Employee Transfer Agreement, the Leased Employee Services Agreement, the Amended and Restated Leased Employee Services Agreement, the Provider Agreement, the First Amendment to the Provider Agreement, the alternate Provider Agreement, the Second Amendment to the alternate Provider Agreement, the IPA Health Care Services Agreement and the IPA Health Care Services Amendment were not submitted to the Department for review and approval, in violation of Section 1505(d)(3) of the New York Insurance Law.

Subsequent to the examination period, on October 20, 2016, the Company has filed the following agreements with the Department for approval: The Leased Employee Services Agreement and Amended and Restated Leased Employee Services Agreement. Furthermore, on May 2, 2017, the Company submitted to the Department the Employee Transfer Agreement, the Provider Agreement and alternate Provider Agreement (and all amendments thereto), and the IPA Health Services Agreement and amendment.

Section 1505(d)(3) of the New York Insurance Law states:

> "(d) 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 thirty days prior thereto, or with regard to reinsurance treaties or agreements at least forty-five days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within such period:
> (3) rendering of services on a regular or systematic basis."

It is recommended that the Company comply with the requirements of Section 1505(d)(3) of the New York Insurance Law by submitting the Employee Transfer Agreement, the Leased Employee Services Agreement, the Amended and Restated Leased Employee Services Agreement and the Provider Agreement and all other relevant agreements with affiliates to the Department for its review and approval.

The Company was not able to provide details supporting the number of work hours for the individual employees who provided services to CareConnect in 2015. Also, the salaries allocated to CareConnect were not in compliance with the terms of the 2015 Leased Employee Services Agreement.

It is recommended that the Company use fees that are supported by the respective service agreements when paying its affiliates for services provided in relation to the terms of those agreements to avoid potential violations of Parts 105-109 of Insurance Regulation No. 30.

The Company used premium revenue and claims expenses to allocate expenses among the affiliates, in violation of Parts 109.3(d) and (e) of the Department's Insurance Regulation No. 30.

Parts 109.3(d) and (e) of Insurance Regulation No. 30 state as follows:

> "(d) *Premiums.* (1) Premiums shall not be used as a basis of allocation except when specifically noted as a permissible basis or when the expense is incurred as a percentage of premiums (subject to instructions under commission and allowances in § 107.3(c)(2)), or when the expenses are logically allocable on the basis of premiums. In no event shall premiums be used as a basis of allocation in connection with clerical, technical, secretarial, office maintenance, supervisory and executive activities unless such basis is clearly appropriate and until all other reasonable bases of allocations have been considered and found less appropriate than premiums.
>
> (e) *Dollar volume of losses.* (1) Dollar volume of losses shall be used as a basis of allocation only when the activities resulting in expense are influenced by the dollar amounts of losses, and only when all other reasonable bases of allocation have been considered and found less appropriate than dollar volume of losses."

It is recommended that the Company comply with Parts 109.3(d) and (e) of Insurance Regulation No. 30 by not using premiums or dollar volume of losses as a basis of allocation, except when specifically noted as a permissible basis or when the expense is incurred as a percentage of premiums or when the activities resulting in such expenses are influenced by the dollar amounts of losses.

The invoices for the charges to the Company were not settled within the timeframes prescribed by the service agreements.

It is recommended that the Company comply with the terms of service agreements by settling the charges within the timeframe(s) prescribed by the agreements.

F. Accounts and Records

The day-to-day functions of CareConnect involve extensive use of third party vendors. Heavy reliance on these vendors leaves the potential for operational issues not being identified as well as inaccurate recording of financial statements. During the course of the examination, certain account balances such as premiums, claims, producer commissions required recurring adjustments. Some adjustments for the year ended 2015 were not completed until 2017.

Management of CareConnect should implement controls over vendors' processes and procedures to mitigate risks, including, but not limited to (1) implementation of a formal monthly reconciliation process of premiums billed and received to enrollment records; (2) formal review of vendors' claims adjudication systems on a timely basis; (3) formal review process whereby a sample of claims are reviewed for proper payment; and (4) ensure that premiums are billed

according to approved rates and that commissions paid to producers are calculated based on the premiums generated by the producers and the commission schedules approved by DFS.

During the examination process, the examiner noted several instances whereby member premiums were overstated, claims payments made for members who were not active, producer commission overpayments, duplication of interest payments made for violations of the Prompt Pay Law.

It is recommended that the Company exercise greater care in processing its financial reporting.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2015, as contained in the Company's 2015 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 reveal differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2015 filed annual statement.

Independent Accountants

The Company was audited annually, for the years 2014 and 2015, by the accounting firm Ernst & Young LLP. CareConnect received an unmodified opinion in each of those years.

Ernst & Young, LLP 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 discrepancies noted in the admitted asset, furniture and equipment, as shown in 2015 balance sheet below.

A. Balance Sheet

	Company	Examination	Surplus Increase/ Decrease
Assets			
Cash and invested assets	$ 62,530,554	$ 62,530,554	0
Uncollected premiums and agents' balances	7,675,096	7,675,096	0
Accrued retrospective premiums	62,836	62,836	0
Amounts recoverable from reinsurers	7,502,291	7,502,291	0
Electronic data processing equipment and software	661,149	661,149	0
Furniture and equipment	1,542,405	0	$ (1,542,405)
Health care and other amounts receivable	1,833,378	1,833,378	0
Deferred compensation plan	25,054	25,054	0
Total assets	$ 81,832,763	$ 80,290,358	$ (1,542,405)
Liabilities			
Unpaid claims	$ 24,442,254	$ 38,128,420	$ 13,686,166
Accrued medical incentive pool and bonus amounts	2,745,633	2,745,633	0
Premiums received in advance	7,891,417	7,891,417	0
General expenses due and accrued	10,621,562	10,621,562	0
Ceded reinsurance payable	1,832,193	1,832,193	0
Amounts due to parent, subsidiaries and affiliates	4,424,646	4,424,646	0
Aggregate write-ins for other liabilities	7,836,608	7,836,608	0
Total liabilities	$ 59,794,313	$ 73,480,479	$ 13,686,166
Capital and Surplus			
Aggregate write-ins for special surplus funds	$ 1,667,400	1,667,400	0
Common stock	200,000	200,000	0
Gross paid in and contributed surplus	94,353,931	94,353,931	0
Unassigned funds (surplus)	(74,182,881)	(89,411,452)	(15,228,571)
Total capital and surplus	22,038,450	6,809,879	(15,228,571)
Total liabilities, capital and surplus	$ 81,832,763	$ 80,290,358	$ (1,542,405)

Note 1. In 2015 the Company erroneously reported furniture & equipment in the amount $1,542,405 as admitted asset. On January 18, 2017, the Company filed an amendment to non-admit the $1,542,405, which changed the total capital and surplus to $20,496,045.

2. The Department actuary had arrived at a shortfall of $13,686,166, including $7,576,389 for a Premium Deficiency Reserve (PDR) which decreases the capital and surplus to $6,809,879 ($20,496,045 less $13,686,166). The claim reserves reported by CareConnect as of December 31, 2015 is $24,442,254.

3. The Internal Revenue Service ("IRS") routinely conducts a Compliance Assurance evaluation of tax returns for Northwell and its affiliates. There were no known IRS findings reported from the Compliance Assurance completed for December 31, 2013, December 31, 2014 or December 31, 2015. The examiners are unaware any potential exposure of issues related to CareConnect for any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Surplus

Surplus decreased by $31,042,981 from July 17, 2013 through December 31, 2015, detailed as follows:

Revenue		
Net premium income	$169,041,557	
Total revenue		$169,041,557
Expenses		
Hospital and medical benefits	155,685,848	
Claims adjustment expenses	10,109,122	
General administrative expenses	$ 74,753,992	
Total expenses		$ 240,548,962
Net income underwriting loss		(71,507,405)
Net investment income earned		104,665
Aggregate write-ins for other income or expenses		(970)
Net income (loss) before income taxes		(71,403,710)
Federal income taxes		(303)
Net income (loss) after income taxes		$ (71,404,013)

Change in capital and surplus

Capital and surplus, as of July 17, 2013			$ 37,852,860
	Gains in Surplus	Losses in Surplus	
Net income		$71,404,013	
Change in non-admitted assets		2,654,870	
Adjustment in claims unpaid		13,686,165	
Paid-in capital	200,000		
Change in unrealized gains	2,067		
Additions to surplus	56,500,000		
Net increase (decrease) in surplus			$(31,042,981)
Capital and surplus per report on examination, as of December 31, 2015			$ 6,809,879

Note: 1. In 2015 the Company erroneously reported furniture & equipment in the amount $1,542,405 as admitted asset. On January 18, 2017, the Company filed an amendment to non-admit the $1,542,405, which changed the total capital and surplus to $20,496,045.

2. The Department actuary had arrived at a shortfall of $13,686,166, including $7,576,389 for a Premium Deficiency Reserve (PDR), which decreases the capital and surplus to $6,809,879 ($20,496,045 less $13,686,166). The claim reserves reported by CareConnect as of December 31, 2015 is $24,442,254.

4. CLAIMS UNPAID

The examination liability of $30,552,031 for the above captioned account is $6,109,777 greater than the $24,442,254 reported by the Company in its filed annual statement as of December 31, 2015.

The examination analysis of the captioned account was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual and quarterly statements, as well as additional information provided by the Company.

The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles which utilized the Company's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2015.

5. PREMIUM DEFICIENCY RESERVE

The Company reported no liability under this caption as of the examination date. This examination has established the captioned liability in the amount of $7,576,389.

It was noted that the Company had incurred an underwriting loss of $31,908,752 as of December 31, 2015. As a result, the above premium deficiency reserve was established in

accordance with the provisions of Paragraph 18 of the Statements of Statutory Accounting Principles No. 54 (SSAP No. 54) of the NAIC Accounting Practices and Procedures Manual, which states:

> "When the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started."

It is recommended that CareConnect comply with the provisions of Paragraph 18 of SSAP No. 54 of the NAIC Accounting Practices and Procedures Manual by establishing the requisite liability.

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. This market conduct examination was general in nature and is not construed to encompass the more precise scope of a targeted market conduct examination.

The general review was directed at practices of the Company in the following major areas:

- Prompt Pay Law
- Explanation of Benefits
- Grievance/Utilization Review
- Agents & brokers
- Claims & Policy Forms

A. Prompt Pay Law

Sections 3224-a(a) and (b) of the New York Insurance Law state:

> "In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to this article and articles forty-two, forty-three and forty-seven of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall adhere to the following standards:
> (a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.
>
> (b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section. "

In 2015, the Company processed 420,422 claims, 15,648 of these claims that were submitted electronically were found to have taken more than 30 days to be processed. A sample of 167 claims was selected for further review, of which, 98 claims were found to be in violation of Sections 3224-a(a) and (b) of the New York Insurance Law.

The following charts illustrate the Company's compliance with the Prompt Pay Law, as determined by this examination:

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

Total population of claims	420,422
Population of claims processed past 30 days	15,648
Sample size	167
Number of claims with violations	98
Calculated violation rate	**58.68%**
Upper violation limit	66.14%
Lower violation limit	51.22%
Calculated claims in violation	**9,182**
Upper limit claims in error	10,350
Lower limit claims in error	8,015

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 the Company comply with Sections 3224-a(a) and (b) of the New York Insurance Law by paying any undisputed portion of a claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim for

services rendered that is transmitted via the internet or electronic mail or forty-five days of receipt for a claim for services rendered that is submitted by other means, such as paper or facsimile, and, where applicable, notify the policyholder, covered person or health care provider in writing within thirty calendar days of 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.

B. Grievance /Utilization Review

Section 210(b) of the New York Insurance Law states:

> "(b) Beginning September first, nineteen hundred ninety-nine and annually thereafter, the superintendent shall include in such guide, and insurers and entities certified pursuant to article forty-four of the public health law shall provide to the superintendent the information required for such guide in a timely fashion, the following information:
> (1) The number of grievances filed pursuant to section forty-four hundred eight-a of the public health law or article forty-eight of this chapter and the number of such grievances in which an adverse determination of the insurer or entity was reversed in whole or in part versus the number of such determinations which were upheld; and
> (2) The number of appeals to utilization review determinations which were filed pursuant to article forty-nine of the public health law or article forty-nine of this chapter and the number of such determinations which were reversed versus the number of such determinations which were upheld."

The Company submitted 290 utilization review appeal cases and 696 grievance cases as of December 31, 2015. However, the Exhibit of Grievances and Utilization Review Appeals – Part Two of its 2015 New York Supplement filing shows that the Company reported 329 utilization review appeal cases closed and 64 grievance cases closed in 2015. This is a difference of 39 utilization review appeal cases and 631 grievance cases.

It is recommended that the Company comply with the requirements of Section 210(b) of the New York Insurance Law by providing the Department an accurate account of utilization review appeals and grievance cases.

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."

The Company did not issue a biennial report to the Superintendent during the years under examination, in violation of Section 4901(a) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 4901(a) of the New York Insurance Law by filing with the Department a utilization review biennial report containing the 13 items listed in Section 4901(b) of the New York Insurance Law describing its utilization plan.

Section 4903(b) of the New York Insurance Law states, in part:

> "(b)(1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify: (i) whether the services are considered in-network or out-of-network; (ii) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services."

The company classified most of its pre-service utilization cases as post-service. As a result, the cases appeared to be less urgent and allowed for more time to process, in violation of Section 4903(b) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 4903(b) of the New York Insurance Law by making utilization review determinations involving health care services, which require pre-authorization and providing notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information.

C. Agents and Brokers

Section 2114(a)(3) of the New York Insurance Law states:

> "(3) No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating or selling in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article."

The examination noted that, as of December 31, 2015, some producers not licensed as accident and health insurance agents were selling the Company's products, in violation of Section 2114(a)(3) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 2114(a)(3) of the New York Insurance Law by paying commissions for services in soliciting, negotiating or

selling in this state any new contract of accident or health insurance only to producers who are properly licensed to sell its products.

Section 2112(a) of the New York Insurance Law states:

> "(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents or, in the case of a title insurance corporation, title insurance agents, to represent such insurer, fraternal benefit society or health maintenance organization."

The examination noted that, in several instances, the Company did not file a certificate of appointment with the Department when appointing its agents, in violation of Section 2112(a) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 2112(a) of the New York Insurance Law by filing a certificate of appointment with the Department when appointing insurance agents to sell its policies.

Section 2112(d) of the New York Insurance Law states:

> "(d) Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent, or title insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight

> delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication."

It was noted that the Company has not filed producer termination notices with the Department, in violation of Section 2112(d) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 2112(d) of the New York Insurance Law by filing with the Department within 30 days of the termination of its producers a statement of the facts relative to the termination.

Section 4235(h)(1) of the New York Insurance Law states:

> "(h)(1) Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state. A group accident and health insurance policy providing disability and family leave benefits pursuant to article nine of the workers' compensation law shall be subject to the requirements of subsection (n) of this section."

During the years under examination, the Company paid commission rates that are not in compliance with the commission schedules that were approved by the Department, in violation of Section 4235(h)(1) of the New York Insurance Law.

It is recommended that the Company comply the requirements of with Section 4235(h)(1) of the New York Insurance Law by paying to its producers commission rates that are based on a commission schedule approved by the Department.

7. SUBSEQUENT EVENTS

Section 4235(h)(1) of the New York Insurance Law states:

> "(h)(1) Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state. A group accident and health insurance policy providing disability and family leave benefits pursuant to article nine of the workers' compensation law shall be subject to the requirements of subsection (n) of this section."

1. The Company initiated an incentive program whereby CareConnect is offering a bonus to brokers who encourage their members who are associated with policies written with an effective date between January 1, 2016 and December 31, 2016 to visit a Primary Care Physician (PCP) for their annual physical before December 31, 2016. While CareConnect did not pay any commissions pursuant to this program, brokers were contacting members regarding the program although it did not have the Department approval, in violation of Section 4235(h)(1) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 4235(h)(1) of the New York Insurance Law by ceasing to pay or offer to pay to brokers commission, compensation or other fees or allowances which were not filed with the Department.

2. As of December 31, 2015, the Company reported a capital and surplus in the amount of $22,038,450. Then, on January 1, 2017, the Company filed an amendment to its 2015 NAIC annual statement to non-admit furniture in the amount of $1,542,405. Consequently, the Company's capital and surplus decreased to $20,496,045. As of September 30, 2016,

the Company reported capital and surplus in the amount of $3,577,066. On December 7, 2016, the Company received a capital contribution of $69,000,000 from the intermediate Parent. As of December 7, 2016, the Company had received a total Paid in Capital & Contribution of $243,453,931.

In August 2017, the parent, Northwell Health, Inc. (”Northwell”) Board of Trustees determined that Northwell could not continue to support the CareConnect’s business and, therefore, requested permission from the Department for CareConnect to withdraw from the market. On September 28, 2017, DFS approved the Company’s withdrawal plans.

3. The Company's Risk-Based Capital (RBC) ratio was 367.84% as of December 31, 2015. However, as of December 31, 2016, the Company was at an RBC "Company Action Level" with a ratio of 185.4%.

By resolution dated January 30, 2018, submitted to and approved by the Department, the Parent has agreed to provide cash and/or other assets in an amount sufficient to keep CareConnect's risk-based capital, at all times, above a company action level event. Parent has also agreed to provide cash and/or other assets sufficient to pay any and all obligations and liabilities of CareConnect through the completion of the liquidation process.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

ITEM **PAGE NO.**

ITEM **PAGE NO.**

Respectfully submitted,

_____
Edouard Medina
Associate Insurance Examiner

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_____2018

APPOINTMENT NO. **31509**

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

North Shore-LIJ CareConnect Insurance Company, 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 20th day of July, 2016

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau