REPORT ON EXAMINATION

OF

RENAISSANCE HEALTH INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 2010

DATE OF REPORT **JULY 24, 2012**

EXAMINER **TOMMY KONG**

TABLE OF CONTENTS

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

July 24, 2012

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

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30686, dated March 17, 2011, attached hereto, I have made an examination of Renaissance Health Insurance Company of New York, an accident and health insurance company licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2010, and respectfully submit the following report thereon.

The examination was conducted at the main administrative office of Renaissance Health Insurance Company of New York located at 4100 Okemos Road, Okemos, Michigan.

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

Wherever the designation "RHC" appears herein, without qualification, it should be understood to indicate Renaissance Holding Company, RHICNY's immediate parent.

Wherever the designation "RHSC" appears herein, without qualification, it should be understood to indicate Renaissance Health Service Corporation, RHICNY's ultimate parent.

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

It should be noted that the New York State Insurance Department merged with the New York State Banking Department on October 3, 2011 to become the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination of the Company was conducted as of December 31, 2006. This examination of the Company was a combined financial and market conduct examination and covered the four-year period from January 1, 2007 through December 31, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* ("the Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook, and transactions occurring subsequent to December 31, 2010 were reviewed where deemed appropriate by the examiner.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Company's operations and utilizes that evaluation in formulating the nature and extent of the examination. The 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 risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Company.

The 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 Company was audited annually for the years 2007 through 2010, by the accounting firm of Plante & Moran, PLLC ("P&M"). The Company received an unqualified opinion in each of those years. Certain audit work papers of P&M were reviewed and relied upon in conjunction with this examination. A review was also made of Delta Dental Plan of Michigan, Inc.'s internal audit function and enterprise risk management program with respect to the operations of the Company.

A review was also made to ascertain what actions were taken by the Company with regard to comments and recommendations made in the prior report on examination.

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

2. DESCRIPTION OF THE COMPANY

The Company was incorporated on May 21, 1979 as Arista Insurance Company ("Arista"), a property and casualty insurance company licensed under the laws of the State of New York, and commenced business on October 11, 1979. On August 19, 2002, Delta Dental Plan of Indiana acquired all the issued and outstanding shares of Arista. On September 16, 2003, Arista amended its Article of Incorporation and By-laws and acted to change its license in the State of New York from a property and casualty insurance company, to an accident and health insurer subject to Article 42 of the New York Insurance Law. Concurrently, Arista changed its name to Renaissance Health Insurance Company of New York.

The Company is a for-profit corporation authorized to write accident and health insurance and substantially similar kinds of insurance as defined in Section 1113(a)(3)(i) of the New York Insurance Law. Through its license, the Company currently offers only indemnity dental insurance.

In March of 2006, the Company's ultimate parent, Renaissance Health Service Corporation, reorganized its corporate structure. Several transactions among affiliates occurred as a result, including the transfer of RHICNY to Renaissance Holding Company ("RHC"). Delta Dental Plan of Indiana, Inc. contributed its full ownership in RHICNY to RHC in exchange for RHC's stock. As a result of this transaction, RHC became the immediate parent company of RHICNY.

A. Management and Controls

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a Board of Directors comprised of no less than thirteen (13) and no more than twenty-one (21) members.

As of December 31, 2010, the Company's Board of Directors was comprised of the following thirteen (13) members:

Name and Residence	Principal Business Affiliation
Patrick T. Cahill, JD Milford, Michigan	Retired
Michael B. Clark Westerville, Ohio	Senior VP & Chief Marketing Officer, Delta Dental Plans of Michigan, Ohio, and Indiana
Sherry L. Crisp Okemos, Michigan	Senior Vice President, Operations of Delta Dental Plan of Michigan, Inc.
Laura L. Czelada, CPA Okemos, Michigan	Chief Operating Officer, Renaissance Health Service Corporation
Thomas J. Fleszar, DDS Okemos, Michigan	President & CEO, Renaissance Health Service Corporation
Karen M. Green Okemos, Michigan	Vice President, Quality Assurance & Informatics of Delta Dental Plan of Michigan, Inc.
Nancy E. Hostetler Okemos, Michigan	Senior Vice President, Corporate & Public Affairs of Delta Dental Plan of Michigan, Inc.
Jed J. Jacobson, DDS, MS, MPH Okemos, Michigan	Senior VP & Chief Science Officer, Delta Dental Plan of Michigan, Inc.
Matthew F. Majeske New York, New York	Physician & Psychiatrist, Elmhurst Hospital Center
J. Thomas Perry Nashville, Tennessee	Chief Financial Officer, Delta Dental of Tennessee
James R. Sherin Albany, New York	President & CEO, Retail Counsel of New York State
Philip A. Wenk, DDS Nashville, Tennessee	President & CEO, Delta Dental of Tennessee
Edward J. Zobeck, MEd Okemos, Michigan	Chief Administrative Officer, Renaissance Health Service Corporation

Per the Company's by-laws, the Board of Directors is required to meet once each calendar year, which is designated as the annual meeting of the Board of Directors. The annual meeting is to take place on the second Thursday of May of each year. Special meetings of the Board of Directors may be called by the President, any Vice President or any two (2) directors.

The Board of Directors has a fiduciary responsibility and must evince an ongoing interest in the affairs of the Company. Having one board meeting per year does not fulfill such criteria. It is important that board members meet periodically, preferably at least once each quarter, to set forth their views on relevant matters so that the Board may reach appropriate decisions in a timely manner.

It is recommended that the Board of Directors of RHICNY meet at least quarterly during each calendar year and that RHICNY amend its by-laws to reflect such requirement.

A review of the minutes of the Board of Directors' meetings held during the examination period revealed that the meetings were generally well attended, with all but one board member attending at least one-half of the meetings that they were eligible to attend.

Members of the Board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Company. It is essential that Board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the Board. Board members who fail to attend at least one-half of the Board's regular meetings, unless appropriately excused, do not fulfill such criteria.

It is recommended that members of the Company's Board of Directors attend at least one-half of the Company's Board meetings. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.

The principal officers of the Company as of December 31, 2010 were as follows:

Name	Title
Thomas J. Fleszar, DDS	President & CEO
Nancy E. Hostetler	Secretary
Laura L. Czelada, CPA	Vice President & Treasurer
Stanley S. Mandell	Vice President of Compliance
Madeline Toback	Assistant Vice President of Operations
Goran M. Jurkovic, CPA	Chief Financial Officer

Note**:** On February 14, 2011, subsequent to the examination date, Robert P. Mulligan replaced Thomas J. Fleszar, DDS as President and CEO of the Company.

B. Enterprise Risk Management

As of December 31, 2010 and subsequent thereto, RHSC and the Company had not established a formal Enterprise Risk Management ("ERM") program or any formal evaluation of risks related to the Company.

In conjunction with NAIC initiatives, Department Circular Letter No. 14 (2011) states in part:

> "The Department views ERM as a key component of the risk-focused surveillance process, and expects every insurer to adopt a formal ERM function that identifies, measures, aggregates, and manages risk exposures within predetermined tolerance levels, across all activities of the enterprise of which the insurer is part,…"

It is recommended that the Company, separately or in conjunction with members of its holding company system, adopt a formal ERM function that identifies, measures, aggregates, and manages risk exposures within predetermined tolerance levels, across all activities of the RHSC holding company enterprise.

C. Corporate Governance

The Company does not maintain its own internal audit department. Any internal audit function, to the extent performed for the Company is provided by Delta Dental Plan of Michigan, Inc. (DDPMI) under an administrative services agreement with the Company.

The manager of the internal audit department for DDPMI reports directly to the Chief Administrative Officer. The current organizational structure of the internal audit function may hinder the independence and objectivity required of the position.

Section 1110.A1 of the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing states:

> "The internal audit activity must be free from interference in determining the scope of internal auditing, performing work, and communicating results."

Also, Section 1111 of the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing states:

> "The chief audit executive must communicate and interact directly with the board."

It is recommended that, with regard to the independence of the internal audit function, the Company separately, or in conjunction with members of its holding company system adhere to the standards promulgated under Sections 1100.A1 and 1111 of the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing.

It was noted that during the examination period and subsequent period, a review of the Company's activities was not specifically scoped into Internal Audit's reviews of key functional areas such as claims handling and related areas.

It is recommended that the Company's key activities be scoped into Internal Audit's review of key functional areas as determined necessary by the Company.

A review of the Company's corporate governance revealed that the Board of Directors did not adopt written procedures that would allow the Board to obtain annual certifications from either the manager of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the Board, and from the Company's general counsel, a statement that the Company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable New York State statutes, rules and regulations.

Department Circular Letter No. 9 (1999) states in part:

> "…the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations."

> "Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations."

It is recommended that the Board of Directors adopt written procedures that require the Board to obtain annual certifications from either the manager of internal audit or independent CPA that the responsible officers have implemented procedures adopted by the Board, and from the Company's general counsel, a statement that the Company's current claims adjudication procedures, including those set forth in current claims manual, are in accordance with applicable New York State statutes, rules and regulations, as required by Department Circular Letter No. 9 (1999).

Circular Letter No. 9 (1999) also states in part:

> "The board is reminded that their responsibility to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself."

It is also recommended that the Company's Board of Directors obtain annual certifications from its third-party claims administrators that claims are being processed in accordance with the Company's current claims manual and applicable New York State statutes, rules and regulations, as required by Department Circular Letter No. 9 (1999).

D. Territory and Plan of Operation

The Company was licensed on September 16, 2003 to transact accident and health insurance business as defined in Section 1113(a)(3)(i) of the New York Insurance Law. The

Company currently writes dental indemnity insurance in the State of New York. The majority of the Company's premiums were written in the following counties in the State of New York: Erie, Niagara, Monroe and Onondaga.

As of December 31, 2010, the Company wrote $987,443 in total net premiums.

The following chart depicts the Company's membership at each year-end:

	2007	2008	2009	2010
Enrollment	163	153	3,078	2,667

The increase in membership during 2009 was the result of a Fortune 500 company's bankruptcy restructuring process which led to the elimination of group dental coverage for its retirees. The retirees who reside in New York were offered the option to purchase individual dental coverage underwritten by the Company.

In December 2009, pursuant to the bankruptcy restructuring process, the Fortune 500 company was mandated to offer COBRA coverage to its retirees. Such mandate allowed retirees, who previously maintained individual coverage with the Company to purchase individual dental coverage from Delta Dental Plan of Michigan, Inc., an affiliate of the Company. As a result, some retirees switched their dental insurance coverage from the dental plan underwritten by the Company to one administered by Delta Dental Plan of Michigan, Inc., which led to a decrease in the Company's membership in 2010.

E. Reinsurance

During the examination period, the Company did not assume any reinsurance business. The Company maintained three ceded reinsurance treaties.

On October 1, 2008, the Company entered into a quota share reinsurance agreement with HM Life Insurance Company of New York ("HM"), an authorized reinsurer, to cede 20% of the premiums and liabilities of its limited benefit group dental indemnity insurance coverage sold with HM's medical products.

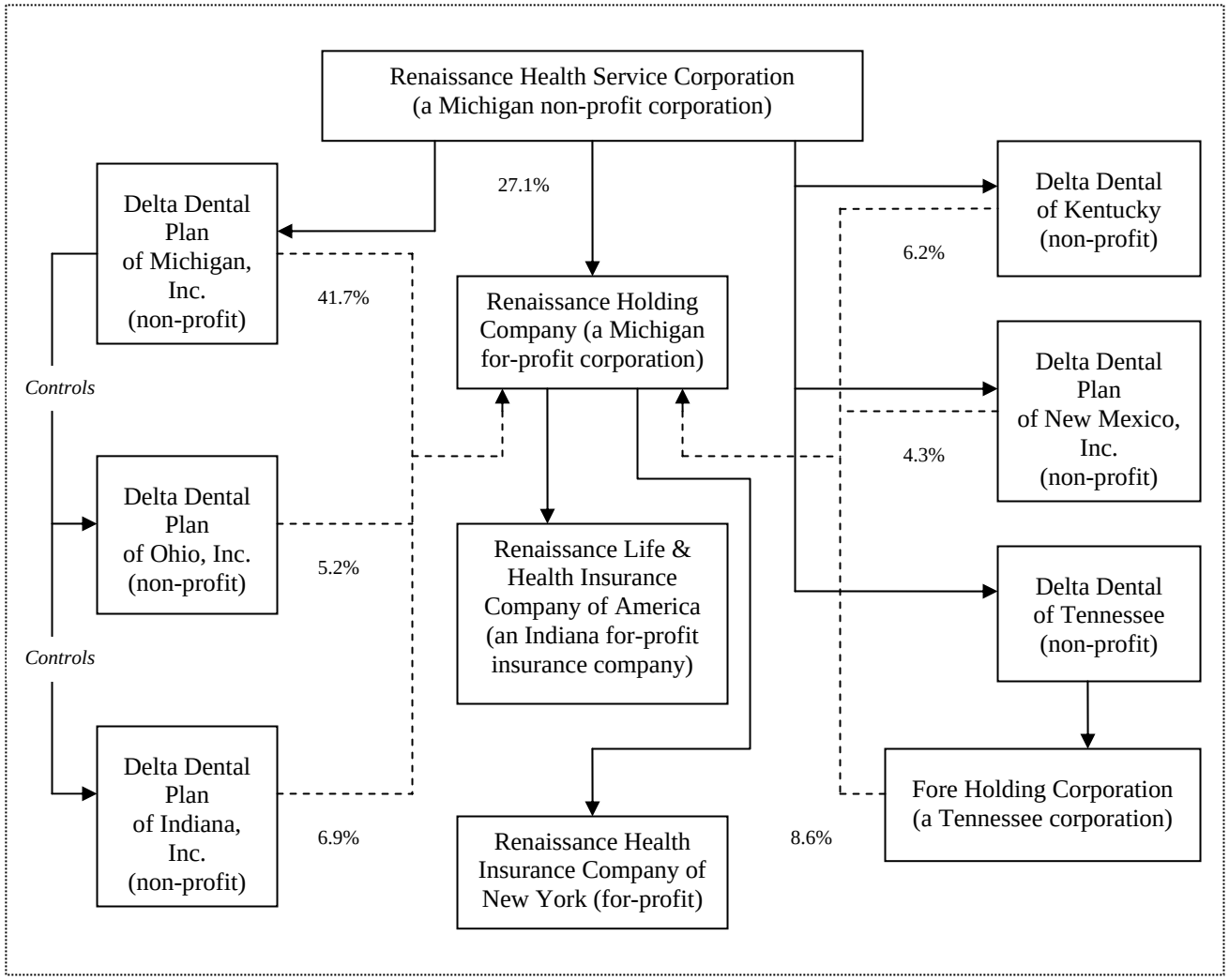
On January 1, 2010, the reinsurance agreement with HM was amended whereby a minimum of 1,000 lives must first be covered before the reinsurance takes effect. As of December 31, 2010 and subsequent thereto, the Company did not meet the aforementioned minimum lives requirement pertaining to this agreement and no reinsurance was ceded during 2010 under this agreement.

On January 1, 2009, the Company entered into a quota share reinsurance agreement with Northeast Delta Dental, a non-affiliated and unauthorized reinsurer, providing for the quota share cession of approximately 1% of the premiums and liabilities associated with the individual dental indemnity insurance sold to the individual retiree population.

On July 1, 2009, the Company entered into another quota share reinsurance agreement with Delta Dental of Kansas, a non-affiliated and unauthorized reinsurer. It provided for an additional quota share cession of approximately 1% of the premiums and liabilities associated with the individual dental indemnity insurance sold to the individual retiree population.

F. Holding Company System

The structure of the Company's holding company system as of December 31, 2010 was as follows:



The Company's immediate parent is Renaissance Holding Company ("RHC"), a Michigan for-profit corporation, and its ultimate parent is Renaissance Health Service Corporation ("RHSC"), a Michigan non-profit corporation. RHC was established as a holding company for Renaissance Life & Health Insurance Company of America and RHICNY, whereas RHSC was established as a holding company for the Delta Dental Plans of Michigan and New Mexico and the Delta Dentals of Kentucky and Tennessee.

In March of 2006, RHSC underwent a corporate restructuring. This resulted in Delta Dental Plan of Indiana, Inc. transferring full ownership of the Company to RHC in exchange for a partial ownership of RHC. As a result of this transaction, Delta Dental Plan of Indiana, Inc. obtained a 6.9% ownership of RHC.

Since August 15, 2003, the Company has maintained a general administrative services agreement with Delta Dental Plan of Michigan, Inc. ("DDPMI"), which was approved by the Department. This agreement was later amended on December 31, 2007. Such amendment has been reviewed by the Department and filed. This agreement remains in effect until terminated by DDPMI or the Company. This agreement provides for DDPMI to render administrative and related services to the Company.

These services may include: accounting and reporting, underwriting, data processing, billing and collection of premiums, claims processing and payment services, reinsurance, marketing, provider relations, investments, internal audit and record keeping. The reimbursement of these services are allocated based on actual costs incurred in connection with the services provided, but are not to exceed the Company's estimated cost of providing such services to itself.

On August 1, 2007, the Company executed an administrative services agreement with Renaissance Life & Health Insurance Company of America ("RLHICA"), which was approved by the Department. This agreement was later amended, effective on January 1, 2010. Such amendment to this agreement was approved by this Department on November 16, 2009.

This agreement remains in effect until terminated by RLHICA or the Company. Either party may terminate the agreement by giving the other party written notice of termination at least sixty (60) days prior to termination or, if terminated immediately, upon mutual consent. This agreement includes some of the same administrative services provided in the general administrative services agreement the Company has with DDPMI.

These services include: accounting and reporting, actuarial, underwriting, eligibility maintenance, data processing, billing and collection of premiums, claims processing and payment services, marketing, agent related services, provider relations, customer service, and record keeping. The reimbursements of these services are allocated based on the following: actual costs incurred in connection with the services provided, reasonable and customary allocable costs associated with actual costs and/or the services provided. Expenses incurred and payments received are to be allocated on an equitable basis in conformity with customary insurance accounting practices consistently applied.

On December 10, 2009, the Company entered into a consolidated tax allocation agreement with its immediate parent, RHC, and the following affiliates: RLHICA, Renaissance Health Networks, LLC, TML, LLC, Renaissance Dental Network, LLC and Dental Wellness Network, LLC. This agreement requires RHC to prepare and file, on behalf of the members that are party to the agreement, a consolidated federal income tax return, for each taxable year, beginning with the 2009 tax year. This agreement was approved by the Department on November 18, 2009.

G. Significant Operating Ratios

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

	Amounts	Ratios
Claims (net of reinsurance recoverable)	1,282,316	79.38 %
Claim adjustment expenses	91,483	5.66 %
General administrative expenses	451,440	27.94 %
Net underwriting loss	(209,697)	(12.98)%
Net premium income	$1,615,542	100.00 %

As of the examination date, the following ratio was considered outside of the NAIC's benchmarks:

Description	Result	Unfavorable Benchmark
Investment yield ratio	1.54%	Less than 3% and greater than or equal to 6%

The investment yield ratio's unfavorable benchmark result was the result of a declining net investment income for each year during the examination period. This decline was primarily due to a decline in interest rates.

As of December 31, 2010, the Company's total adjusted capital was $948,618. This amount was well over the Company's authorized control level risk-based capital of $39,377.

H. New York Insurance Law Section 325(a) Plan

As of December 31, 2010, the Company did not maintain its books and records within the State of New York in accordance with Section 325(a) of the New York Insurance Law

Section 325(a) of the New York Insurance Law states in part:

> "Every domestic insurer …shall …keep and maintain at its principal office in this state its charter and by-laws…and its books of account, and if a domestic stock corporation a record containing the names and addresses of its shareholders, the number and class of shares held by each and the dates when they respectively became the owners of record thereof, and if a domestic corporation the minutes of any meetings of its shareholders, policyholders, board of directors and committees thereof."

Subsequent to the examination date, the Company's Section 325(a) plan was approved by the Department on December 12, 2011.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus as determined by this examination as of December 31, 2010. This statement is the same as the balance sheet filed by the Company in its filed December 31, 2010 annual statement:

Assets	Examination	Company
Bonds	$ 300,495	$ 300,495
Common stocks	39,896	39,896
Cash and short-term investments	688,796	688,796
Investment income due and accrued	40	40
Uncollected premiums in course of collection	40,575	40,575
Amounts recoverable from reinsurers	3,784	3,784
Other amounts receivable under reinsurance contracts	675	675
Net deferred tax asset	80,598	80,598
Receivables from parent, subsidiaries and affiliates	74,380	74,380
Total assets	$1,229,239	$1,229,239

Liabilities	Examination	Company
Claims unpaid	$ 39,049	$ 39,049
Unpaid claims adjustment expenses	1,449	1,449
Aggregate health policy reserves	38,941	38,941
Premiums received in advance	168,659	168,659
General expenses due or accrued	22,154	22,154
Ceded reinsurance premiums payable	4,737	4,737
Amounts due to parent, subsidiaries and affiliates	5,632	5,632
Total liabilities	$ 280,621	$ 280,621
Capital and Surplus		
Common capital stock	$ 200,000	$ 200,000
Gross paid in and contributed surplus	889,806	889,806
Unassigned funds	(141,188)	(141,188)
Total capital and surplus	$ 948,618	$ 948,618
Total liabilities, capital and surplus	$1,229,239	$1,229,239

Note: The Internal Revenue Service has not conducted any audits of the consolidated federal income tax returns filed on behalf of the Company through tax year 2010. 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 $281,444 during the four-year examination period, January 1, 2007 through December 31, 2010, detailed as follows:

Revenue		
Premium	$1,615,542	
Total revenue		$1,615,542
Expenses		
Claims (net of reinsurance recoverable)	$1,282,316	
Claims adjustment expenses	91,483	
General administrative expenses	451,440	
Total expenses		$1,825,239
Net underwriting loss		(209,697)
Net investment income		77,155
Aggregate write-ins for other expenses		(1,327)
Net loss		$(133,869)

Change in Capital and Surplus

Capital and surplus, per report on examination as of December 31, 2006			$667,174
	Gains in Surplus	Losses in Surplus	
Net loss		$133,869	
Change in net deferred income tax	$ 74,157		
Change in non-admitted assets		8,844	
Paid in surplus	350,000		
			$281,444
Capital and surplus, per report on examination as of December 31, 2010			$948,618

4. CLAIMS UNPAID

The examination liability of $39,049 is the same as the amount reported by the Company as of December 31, 2010.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements as verified during the examination.

The examination reserve was based upon actual payments made through a period 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, 2010.

5. 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 subscribers 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 practices of the Company in the following major areas:

A. Sales and advertising
B. Fraud prevention plan
C. Claim forms
D. Explanation of benefits statements
E. Prompt Pay Law

A. Sales and Advertising

A review of the Company's advertising materials found that the Company did not clearly identify the source of statistics used in its advertisements. Specifically, two advertisements were identified in which the Company failed to provide the source for support to its claim of: *"99.5% accuracy on all claims"* and *"90% of all claims processed within 14 days"*, respectively.

Section 215.9(c) of Department Regulation No. 34 (11 NYCRR 215.9) states in part:

> "The source of any statistics used in an advertisement shall be identified in such advertisement…"

It is recommended that the Company comply with Section 215.9(c) of Department Regulation No. 34 by identifying the source of the statistics used within its advertisements.

B. Fraud Prevention Plan

In 2009, the Company, although meeting the total policies requirement of Section 409(a) of the New York Insurance Law, failed to file with the Department a fraud prevention plan.

Section 409(a) of the New York Insurance Law states in part as follows:

> "Every insurer writing…individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, except for insurers that write less than three thousand of such policies shall… file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state."

It is recommended that the Company comply with the requirements of Section 409(a) of the New York Insurance Law by filing a fraud prevention plan with the Department.

C. Claim Forms

The Company's claim forms used during the examination period contained a fraud warning that was not in compliance with the requirements prescribed by Section 86.4(a) of Department Regulation No. 95 (11 NYCRR 86.4).

Section 86.4(a) of Department Regulation No. 95 (11 NYCRR 86.4) requires the following frauds statement be included on issued claim forms:

> "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

It is recommended that the Company revise the fraud statement included within its claim forms to comply with the wording prescribed by Section 86.4(a) of Department Regulation No. 95.

D. Explanation of Benefits Statements

A review of the Company's Explanation of Benefits Statements found that the form failed to contain the mandatory disclosure language required by Section 3234(b)(7) of the New York Insurance Law.

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

> "(b) The explanation of benefits form must include at least the following:
>
> (7) …a notification that failure to comply with such requirements may lead to forfeiture of a consumer right to challenge a denial or rejection, even when a request for clarification has been made."

It is recommended that the Company comply with the requirements of Section 3234(b)(7) of the New York Insurance Law by including the mandatory disclosure language on its Explanation of Benefits forms.

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

E. Prompt Pay Law

A review of the Company's Prompt Pay Law compliance was performed by using a statistical sampling methodology, using the computer software program ACL.

For the purpose of this report, a "claim" is the total number of items submitted by a single provider on a single claim form, as reviewed and entered into the claims processing system. This claim may consist of various lines, procedures or service dates. It was possible, through the use of ACL, to match or "roll-up" all the procedures from a single claim into one item, which was the basis of the Department's statistical sample of claims or the sample unit.

New York Insurance Law Section 3224-a, "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 thirty days when received via the Internet or electronic mail or forty-five days when received by mail or facsimile.

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

> "…insurer …shall pay the claim to a policyholder …or make a payment to a …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 of a claim …for services rendered that is submitted by other means, such as paper or facsimile."

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

> "In a case where the obligation of an insurer …to pay a claim …is not reasonably clear …an insurer …shall …notify the policyholder, covered person or …provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim …stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim…"

§ 3224-a(c) of the New York Insurance Law states in part that:

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

The examination performed testing to determine the Company's compliance with the Prompt Pay Law. In order to accomplish this, a population consisting of all claims submitted between January 1, 2010 and December 31, 2010 that were not paid within the time frame(s) prescribed by Section 3224-a(a) of the New York Insurance Law were identified. The result of this process revealed that from the total population of 8,117 claims adjudicated in 2010, there were 136 electronic claims that took longer than 30 days to pay and 167 paper claims that took longer than 45 days to pay. The 136 electronic and 167 paper claims were selected to establish whether they were adjudicated in violation of the time frames prescribed by Section 3224-a(a) of the New York Insurance Law.

Of the 136 electronic claims adjudicated after 30 days of receipt, 62 of those claims were confirmed violations. Of the 167 paper claims adjudicated after 45 days of receipt, 62 of those claims were also confirmed violations.

It should be noted that the Section 3224-a(a) violations resulted mainly from the Company manually adjudicating claims from the previously mentioned Fortune 500 company's retirees with two dental policies and both were primary with no coordination of benefits. Given this unusual circumstance, the Company felt that it was acting in good faith by manually adjudicating these claims, which led to a delay in payments, and thus the Company did not pay any interest relative to such claims.

It is recommended that the Company take steps to ensure compliance with Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of its claims.

It is also recommended that the Company review all claims not paid within the time frames prescribed by Section 3224-a(a) of the New York Insurance Law to determine whether any applicable interest is due and pay such interest, as required by Section 3224-a(c) of the New York Insurance Law.

Violations of Section 3224-a(b) of the New York Insurance Law were established through the isolation of all claims that took more than 30 days to deny or in cases where additional information was requested. The result of the examiner's analysis revealed a population of 217 possible violations. A sample of 167 claims was extracted from the population and reviewed. Of this sample, there were 42 confirmed violations.

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

Total claim population	8,117
Population of claims adjudicated after 30 days of receipt	217
Sample size	167
Number of claims with violations	42
Calculated violation rate	25.15%
Calculated claims in violation	55

It is recommended that the Company take steps to ensure compliance with Section 3224-a(b) of the New York Insurance Law regarding the denial of its claims.

A general claims adjudication review was also done. Using ACL, a sample of 50 claims was extracted from the total population of 8,117 claims adjudicated in 2010. There were no problem areas noted during the review.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2006, contained the following five (5) comments and recommendations (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
1.	It is recommended that the Company ensure that conflict of interest statements for directors and officers are completed and maintained on file. *The Company has complied with this recommendation.*	6
2.	It is recommended that the Company comply with New York Insurance Department Regulation 62 (11 NYCRR 52.40(e)) and discontinue the unapproved discounting and deviation of its filed rates with the Department. *The Company has complied with this recommendation.*	18
3.	It is recommended that the Company comply with Section 3231(d) of the New York Insurance Law and file for approval the premium rates and policy forms used for individual insurance coverage issued to subscribers in 2007. *The Company has complied with this recommendation.*	18
4.	It is recommended that the Company issue EOBs that include all of the requisite information required by Section 3234(b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights. *The Company has not fully complied with this recommendation as of the examination date. A similar recommendation is included within this report on examination.*	21
5.	It is recommended that the Company submit to the Insurance Department a utilization review program as required by Section 4901(a) of the New York State Insurance Law. *The Company has complied with this recommendation.*	21

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. **30686**

STATE OF NEW YORK
INSURANCE DEPARTMENT

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

Tommy Kong

as a proper person to examine into the affairs of the

Renaissance Health Insurance Company of New York

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

Company

with such other information as he shall deem requisite.

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

This 17th day of March, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR