REPORT ON EXAMINATION

OF

HORIZON HEALTHCARE INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 2005

DATE OF REPORT **OCTOBER 26, 2007**

EXAMINER **KAIWEN K. GUO**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Elliot Spitzer
Governor

Eric R. Dinallo
Superintendent

October 26, 2007

Honorable Eric R. Dinallo
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 22474, dated March 10, 2006, attached hereto, I have made an examination into the condition and affairs of Horizon Healthcare Insurance Company of New York, a for-profit accident and health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2005. The following report thereon is respectfully submitted.

The examination was conducted at the Company's statutory home office located at 1180 Avenue of the Americas, New York, New York 10036.

Wherever the terms "Company" or "HHICNY", appear herein, without qualification, they should be understood to refer to Horizon Healthcare Insurance Company of New York.

1. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2003, through December 31, 2005. A previous examination was conducted as of June 30, 2002. Where deemed appropriate, transactions occurring subsequent to December 31, 2005 were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2005, in accordance with Statutory Accounting Principles ("SAP"), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Company's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners (NAIC):

History of the Company
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of Company
Business in force
Reinsurance
Loss experience
Accounts and records
Financial statements
Treatment of policyholders and claimants

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 COMPANY

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

According to the Articles of Incorporation, the number of shares issued and outstanding shall be one hundred (100), having a par value of two thousand dollars ($2,000) each for a total common capital stock of two hundred thousand dollars ($200,000). Ownership of the Company is divided between Horizon Healthcare Holding Corp. ("HHHC"), formerly known as Medigroup Holding Company, Inc. and Horizon Healthcare of New York, Inc. ("HHNY"), a domestic health maintenance organization ("HMO"); each of which owns fifty (50) shares of common stock purchased at one hundred fifty thousand dollars ($150,000) for an initial total capital of three hundred thousand dollars ($300,000 - $200,000 capital and $100,000 paid in and contributed surplus). Both entities are in turn owned by the ultimate parent, Horizon Blue Cross Blue Shield of New Jersey ("BCBSNJ").

Due to excessive underwriting losses, BCBSNJ made a business decision to discontinue offering HMO business through HHNY, and these corporations went through a reorganization process to withdraw and liquidate HHNY. On March 31, 2005, as part of the restructuring

plan, the New York Insurance and Health Departments approved a proposal by Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey to (1) consolidate the ownership of the two intermediate holding companies within the holding company system and (2) restructure the ownership interests of the Company.

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

Subsequent to the examination date, effective August 7, 2006, the Company entered into agreements to sell the renewal rights of the Company's insured medical enrollment to a major New York health insurer and its uninsured enrollment to a large third party administrator (TPA). The Company withdrew its health insurance products in New York over a transition period of 180 days, ending on February 28, 2007. It will continue to offer dental business. This matter is discussed further in Section 7 of this report ("Subsequent Event").

A. Management and Controls

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in and exercised by its Board of Directors and the number of directors shall be no less than thirteen, nor more than nineteen, of which no less than three shall be New York residents.

As of December 31, 2005, the Company's Board of Directors consisted of the following thirteen members:

Name and Residence	Principal Business Affiliation
William J. Marino Morris Plain, NJ	President and Chief Executive Officer, Horizon Blue Cross Blue Shield of New Jersey
Christy W. Bell Chester, NJ	Senior Vice-President, Horizon Blue Cross Blue Shield of New Jersey
John G. Hansbury Titusville, NJ	Life Insurance and Financial Planner, Hansbury Associates
Charles R. Dees Jr. PhD Seaside, NJ	Vice President for University Advancement, New Jersey Institute of Technology
Lawrence B. Altman New York, NY	Vice President, Horizon Blue Cross Blue Shield of New Jersey
Kenneth A. Brause New York, NY	Vice President, Horizon Blue Cross Blue Shield of New Jersey
Christopher M. Lepre Neschanic, NJ	Vice President, Horizon Blue Cross Blue Shield of New Jersey
Robert A. Marino West Caldwell, NJ	Senior Vice President, Horizon Blue Cross Blue Shield of New Jersey
Michael R.McGarvey, MD New York, NY	Retired

Name and Residence	Principal Business Affiliation
Robert J. Pures River Vale, NJ	Senior Vice-President, Horizon Blue Cross Blue Shield of New Jersey
Jerrold Shenkman, Esq. Scarsdale, NY	Assistant General Counsel, Horizon Blue Cross Blue Shield of New Jersey
James A. Skidmore, Jr. Berkeley Heights, NJ	Chairman, President and Chief Executive Officer, Science Management Corp.
Peter G. Stewart, Esq. Caldwell, NJ	Partner, Carella, Byrne, Bain, Gilfillan, Cecchi, Stewart & Olstein

The principal officers of the Company as of December 31, 2005 were as follows:

Name	Title
Minalkumar Ashokkumar Patel	President and Chief Operating Officer
Robert A. Marino	Chief Executive Officer
Christopher Michael Lepre	Vice-President
John Wellington Campbell	Secretary
Raymond Matthew Bascio	Vice-President

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

Section 2.07 of the Company's by-laws states:

> *"The Board of Directors shall, approximately one month prior to the annual meeting of the shareholders, appoint a Nominating Committee of no fewer than three (3) Directors which shall file in writing with the Secretary of the Corporation a list of nominees for election by the shareholders as Directors of the Corporation to fill expiring terms."*

During the period under examination, various individuals were elected to the Board; however, a Nominating Committee was never formed, as is required by the abovementioned citation of the Company's by-laws. Rather, the election of the Board members was made by the parent companies, Horizon Healthcare Holding Company, LLC and Horizon Healthcare of New York, Inc.

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

It is recommended that the Company comply with Section 2.07 of the Company's by-laws and have the Board of Directors appoint a Nominating Committee, of no fewer than three Directors, prior to the annual shareholders' meeting. Further, the Nominating Committee shall file, in writing with the Secretary of the Company, a list of nominees for election to the Board of Directors of the Corporation.

Subsequent to the date of examination, and consistent with the Company's stated intentions following its receipt of the previous report on examination, for the 2006 Annual Meeting, the Company's board of directors appointed a Nominating Committee, and this Committee filed in writing, with the Secretary, a list of nominees for election to the board.

The Company has a policy in place for all directors, officers, and employees that requires them to complete a conflict of interest questionnaire, and annually disclose all interests or activities which are, or might be, in conflict with their duties at the Company. The following states in part the aforementioned policy known as the "Officer and Employee Code of Business Conduct and Conflict of Interest Questionnaire":

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

In response to the Department's Examination Planning Questionnaire, the Company stated that:

> *"Yes, as required by the Code, each officer, director and employee is required to execute a statement annually that they have read and understand the provision of the Code. The statement also requires the individual to state that they are in full compliance with the Code. Attached is a copy of the current Questionnaire in use by the Company."*

The examination revealed that three directors, two directors and five directors, in 2005, 2004 and 2003, respectively, did not submit the required conflict of interest statements.

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

B. Adoption of Procedure Manuals – Circular Letter No. 9 (1999)

Circular Letter No. 9 (1999) – "Adoption of Procedure Manuals", dated May 25, 1999, was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and insurers licensed to write health insurance in New York State. The Circular Letter applies to HHICNY as an insurer licensed to write health insurance in New York.

Circular Letter No. 9 (1999) – "Adoption of Procedure Manuals" states:

> "It is recommended that 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 regulation."

The examination revealed that the aforementioned annual certifications were never obtained.

It is recommended that the Company's Board comply with the requirements of Circular Letter No. 9 (1999) by obtaining the required certifications.

C. Territory, Plan of Operation and Enrollment

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

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

	Hospital & Medical	Dental	Total
2003	$147,792,212	$2,381,328	$150,173,540
2004	168,008,343	4,662,501	172,670,844
2005	194,191,549	5,964,695	200,156,244

During the period January 1, 2003 through December 31, 2005, the Company experienced a net increase in policyholders of 22,037. An analysis of this increase in enrollment is set forth below:

	2003	2004	2005
Enrollment, January 1	54,932	59,312	72,320
Net Gain/(Loss)	4,380	13,008	4,649
Enrollment at December 31	59,312	72,320	76,969

D. Reinsurance

As of December 31, 2005, the Company had an excess of loss reinsurance contract in effect with an authorized reinsurer, Alianz Life Insurance Company of New York. The contract's effective date was January 1, 2005 and it expired on December 31, 2005.

The reinsurance coverage in effect in 2005 was as follows:

Line of Business: Fully Insured Medical

Excess of Loss Retention: $400,000 per covered person per contract year.

Maximum Reimbursement: $1,600,000 per covered person per contract year.

Policy Limit: Fully insured group medical insurance policies with a policy limit of $2,000,000.

A new reinsurance agreement, effective January 1, 2006, was executed between the Company and its ultimate parent, Horizon Blue Cross Blue Shield of New Jersey. This reinsurance agreement was approved by the Insurance Department under Article 15 of the New York Insurance Law.

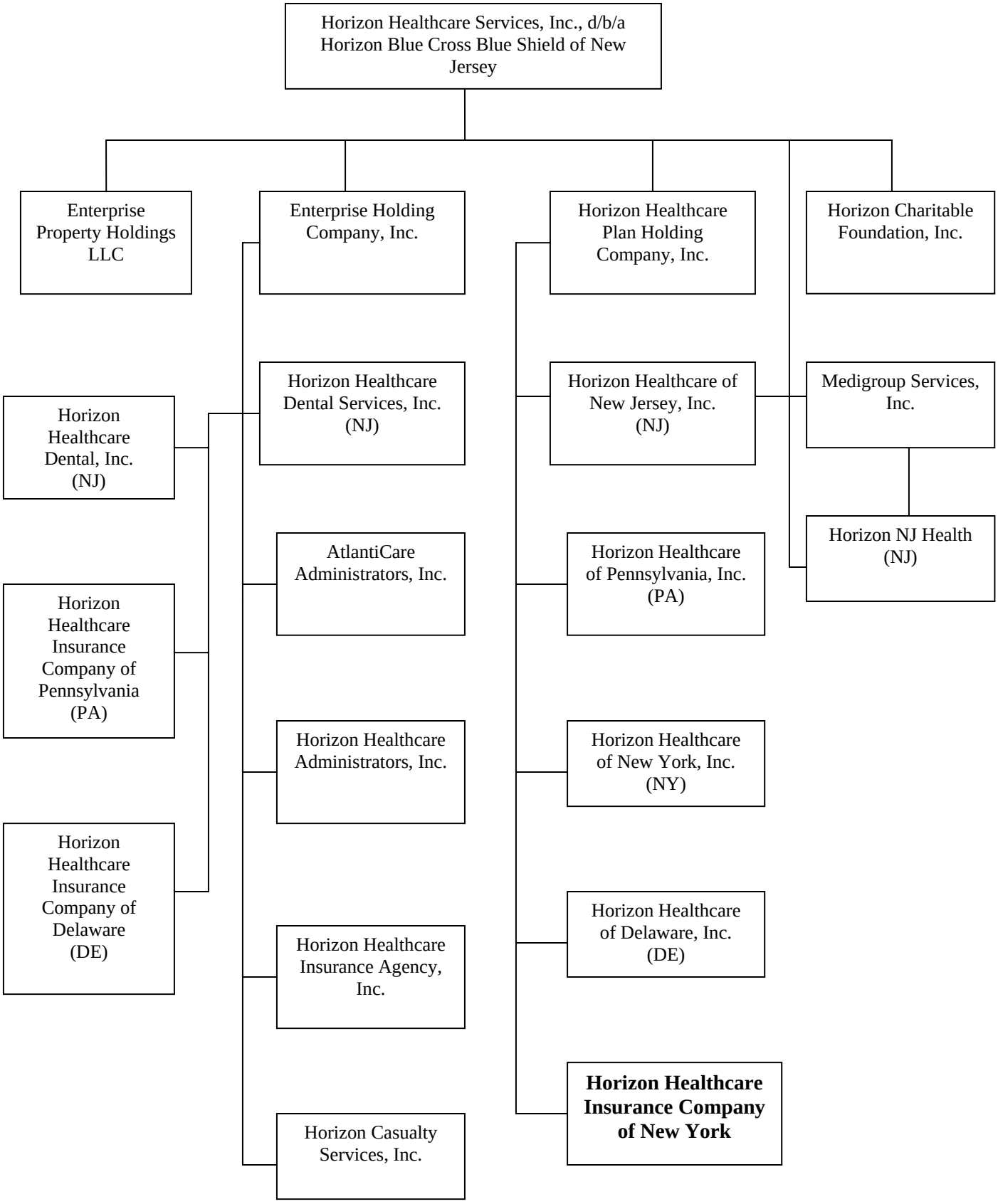
The reinsurance agreements contained all of the standard clauses required by the Insurance Department, including insolvency protection mandated by Section 1308(a) of the New York Insurance Law.

E. Holding Company System

Horizon Healthcare Insurance Company of New York was incorporated on January 6, 1998 under the name of Medigroup Insurance Company (NY). It commenced doing business on February 22, 1999. The Company is 100% owned by Horizon Healthcare Plan Holding Company, Inc. which is 100% owned by their ultimate parent, Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey.

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

The following represents the Holding Company System as reported in Schedule Y of the Company's filed December 31, 2005 annual statement:


Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey
Enterprise Property Holdings LLC
Enterprise Holding Company, Inc.
Horizon Healthcare Plan Holding Company, Inc.
Horizon Charitable Foundation, Inc.
Horizon Healthcare Dental, Inc. (NJ)
Horizon Healthcare Dental Services, Inc. (NJ)
Horizon Healthcare of New Jersey, Inc. (NJ)
Medigroup Services, Inc.
Horizon Healthcare Insurance Company of Pennsylvania (PA)
AtlantiCare Administrators, Inc.
Horizon Healthcare of Pennsylvania, Inc. (PA)
Horizon NJ Health (NJ)
Horizon Healthcare Insurance Company of Delaware (DE)
Horizon Healthcare Administrators, Inc.
Horizon Healthcare of New York, Inc. (NY)
Horizon Healthcare Insurance Agency, Inc.
Horizon Healthcare of Delaware, Inc. (DE)
Horizon Casualty Services, Inc.
Horizon Healthcare Insurance Company of New York

i. Horizon Healthcare of New Jersey, Inc.

The Company has various service agreements with members of its holding company system, specifically Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), Horizon Healthcare of New York, Inc. (HHNY), AtlantiCare Administrators, Inc. (AtlantiCare) and Horizon Healthcare Dental Services, Inc. (HHDS). These agreements were approved by the Department pursuant to Article 15 of the New York Insurance Law.

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

The service agreement with HHNY provides that the Company will perform services such as recommending candidates to provide general managerial and administrative support to HHNY, recruit hospitals and physicians and to expand the existing provider network, and aid in the development of subscriber and provider support services, as well as miscellaneous administrative functions.

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

The AtlantiCare agreement calls for the Company to have general responsibility to perform sales and marketing services, account management, provider relations, out-of-area network provider arrangements and new case installation for its administrative services only ("ASO") business. AtlantiCare is also responsible for such ASO business related functions as claims processing, claims adjudication, enrollment, billing and banking, client support services, and reporting.

In 2005, a substantial amount of transactions occurred between Horizon Healthcare of New Jersey, Inc. (HHNJ), a New Jersey HMO, and the Company. Most of these transactions were shown as "Attributable/chargeback" and "Misc". There were expenses charged to the Company based on different allocation formulas. Services related to these expenses included: customer service, utilization review management, strategic/planning, and financial/auditing. There was no service agreement between the Company and HHNJ.

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

> "(c) The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credits, or investments, involving five percent or more of the insurer's admitted assets at last year-end."

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

> "(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 such shorter period as he may permit, and he has not disapproved it within such period:
>
> (3) rendering of services on a regular or systematic basis; or…"

The Company booked an aggregate amount of $22,000,448 for transactions between the Company and HHNJ, during 2005. This amount exceeded five percent (5%) of the Company's admitted assets ($74,551,711) reported at last year-end. However, as was noted above, a formal written agreement was not submitted for approval to the Insurance Department pursuant to the requirements of either Sections 1505(c) or 1505(d)(3) of the New York Insurance Law.

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

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

Due to the Company's discontinuance of its healthcare operations, as detailed in Item 7 herein, Horizon Healthcare of New Jersey ceased providing services to the Company on June 14, 2007, therefore, this comment is no longer applicable. However, the Company agrees to abide by Article 15 of the Insurance Law in regard to all future applicable transactions.

Section 1505(a)(1), (2) and (3) of the New York Insurance Law state in part:

> "(a) Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:
>
> (1) the terms shall be fair and equitable;
> (2) charges or fees for services performed shall be reasonable; and
> (3) expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied."

Section 1505(b) of the New York Insurance Law which pertains to transactions within a holding company system affecting controlled insurers further states:

> "(b) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties."

In the absence of a formal written agreement, the examiner was unable to determine whether the transactions between the Company and HHNJ complied with the requirements of the aforementioned statutes. Further, the accounting information was not maintained in a format whereby the abovementioned transactions could be specifically identified or accounted for.

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

Due to the Company's discontinuance of its healthcare operations, as detailed in Item 7 herein, Horizon Healthcare of New Jersey ceased providing services to the Company on June 14, 2007, therefore, this comment is no longer applicable. However, the Company agrees to abide by Article 15 of the Insurance Law in regard to all future applicable transactions.

ii. Cash Accounts

The examiner's review of the settlement of certain financial accounts such as uncollected premiums, advanced premiums and claims liabilities revealed that there is no evidence that premiums were deposited in the Company's bank account(s) and that claims were paid out of the Company's bank account. The examination indicated that all premiums were deposited in a New Jersey checking account titled solely in the name of the ultimate parent company, Horizon Blue Cross Blue Shield of New Jersey. Premiums are allocated to the Company on a monthly basis solely in the form of a journal entry. For claims payments, all checks are issued by BCBSNJ, but the checks do not identify the company that is actually making the payment. The checks contain the name "Horizon Healthcare", but not the name of the Company (HHICNY).

iii. Custodian Agreement

The Company's investment accounts are maintained in two trust accounts. The bonds account ($61,287,184) is maintained with JP Morgan Chase and short-term investments ($3,929,922) are maintained by SEI Investment (d/b/a TreasuryPoint.com). The Company provided the examiners with copies of two custodian agreements. The JP Morgan Chase agreement has no effective date, but it was executed on May 19, 1994. The agreement will remain in force until expressly revoked in writing by either party. The SEI Investment agreement was executed on May 8, 2002. Both agreements were executed between the ultimate parent company, Horizon Blue Cross Blue Shield of New Jersey, Inc. and the aforementioned

institutions. Without an effective agreement under HHICNY's name, the Company does not appear to have an effective control over its assets maintained by these institutions.

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

It was also noted that the Company responded "No" to question number 21.1 contained in the general interrogatories of its 2005 filed annual statement:

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

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

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

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

F. Record Retention Policy

The Company has a Record Retention Policy in conjunction with its ultimate parent company, Horizon Blue Cross and Blue Shield of New Jersey.

Section (a) of Department Regulation 152 (11 NYCRR 243) states in part:

> "(a) In addition to any other requirement contained in Insurance Law Section 325, any other section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part."

The Regulation further requires that insurance company's books, records, files, securities, data compilations and other documents be maintained for six calendar years, or until after the filing of the report on examination in which the record was subject to review, whichever is longer.

A review of the Record Retention Policy indicated that the policy does not comply with requirement of Regulation 152, in that no specific retention period is mentioned in the policy.

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

Subsequent to the examination date, December 2006, the Company, in conjunction with members of its holding company, revised its record retention policy, and it is now in compliance with Department Regulation 152.

G. Disaster Response Filing

During the examination, the Company provided the examiner its Horizon Business Resumption Plan and Horizon Disaster Recovery Plan. It should be noted that both are policies maintained in conjunction with the ultimate parent company, Horizon Blue Cross Blue Shield of New Jersey.

Insurance Department Circular Letter No. 23 (2005) requires that annually, on each June 1st, all accident and health insurers shall file with the Department the Disaster Response Plan, the Disaster Response Questionnaire, and the Business Continuity Plan and Questionnaire. The Department had no record of such filing, nor could the Company verify that it filed these required documents.

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

H. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles as adopted by Department Regulation 172 or annual statement instructions. A description of such items is as follows:

1. Magellan is a service provider for the Company's mental health claims. Administrative fees in the amount of $582,563 were paid to Magellan in 2005, in accordance with the terms of a Managed Care Service Agreement. The examination disclosed that the Company classified Magellan's administrative expenses as a "Capitation payment", and as such the expenses were allocated to claims expenses.

It is recommended that the Company properly classify its expenses.

2. The examination also disclosed that the Company made payments under the Health Care Reform Act ("HCRA") for required surcharges in 2005. The payment was allocated to the "General Expenses Due and Accrued" account. The proper allocation should have been to the paid claims account.

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

3. The Company had a credit balance shown for its federal and foreign income tax recoverable account in its 2005 annual statement. The credit was the result of the Company's operating loss in 2005. As of December 31, 2005, the balance of the account was $4,389,801.

Insurance Department Circular Letter No. 33 (1979) states in part:

> "1. Every domestic insurer which is a party to a consolidated federal income tax filing must have a definitive written agreement, approved by its Board of Directors, governing its participation therein."

The Circular Letter further states in part:

> "5. All settlements under this agreement shall be made within 30 days of the filing of the applicable estimated or actual consolidated federal corporate income tax return with the Internal Revenue Service, except where a refund is due the parent…"

The Company has a tax allocation agreement with the ultimate parent company, Horizon Blue Cross Blue of New Jersey. The agreement was executed in 1998 and it has a provision that settlement of tax credits be made within 30 days of the filing of the tax return. The examination revealed that a consolidated tax return was filed on September 15, 2006, however, the settlement wasn't made until November 10, 2006.

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

I. Significant Operating Ratios

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

	Amounts	Ratio
Claims incurred	$497,130,488	95%
Claims adjustment expenses incurred	30,754,756	6%
General administrative expenses incurred	73,736,629	14%
Net underwriting loss	(78,621,245)	(15)%
Premiums earned	$523,000,628	100%

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as determined by this examination and as reported by the Company in its filed December 31, 2005 annual statement:

Assets	Examination	Company	Surplus Increase (Decrease)
Bonds	$61,287,184	$61,287,184	
Cash and short-term Investments	3,929,922	3,929,922	
Investment income due & accrued	415,151	415,151	
Uncollected premiums	5,510,212	5,510,212	
Amounts receivable relating to uninsured plans	245,765	245,765	
Current federal & foreign income tax receivable	4,389,801	4,389,801	
Net deferred tax asset	811,654	811,654	
Total Assets	$76,589,689	$76,589,689	
Liabilities	**Examination**	**Company**	
Claims unpaid	$33,476,152	$33,476,152	
Unpaid claims adjustment expenses	1,318,000	1,318,000	
Aggregate health policy reserves	8,435,480	1,135,480	(7,300,000)
Premiums received in advance	2,611,617	2,611,617	
General expenses due or accrued	3,201,339	3,201,339	
Amounts withheld or retained for the account of others	8,222	8,222	
Amounts due to parent, subsidiaries, and affiliates	6,022,513	6,022,513	$ 0
Total Liabilities	$55,073,323	47,773,323	(7,300,000)
Capital and surplus			
Common capital stock	$200,000	$200,000	
Gross paid in and contributed surplus	155,100,000	155,100,000	
Unassigned funds (surplus)	(133,783,634)	(126,483,634)	(7,300,000)
Total capital and surplus	21,516,366	28,816,366	(7,300,000)
Total liabilities, capital and surplus	$76,589,689	$76,589,689	($7,300,000)

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2005. 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. Underwriting and Investment Exhibit

Capital and surplus decreased by $6,350,541 during the examination period, June 30, 2002 through December 31, 2005, detailed as follows:

Revenue		
Net premium income	$522,847,993	
Change in unearned premium reserves	152,635	
Total revenue		$523,000,628
Hospital and Medical Expenses		
Hospital/Medical benefits	$353,693,658	
Other professional services	69,677,855	
Prescription drugs	74,427,252	
Net reinsurance recoveries	(668,277)	
Total medical and hospital expenses		$497,130,488
Administrative Expenses		
Claims adjustment expenses	$30,754,756	
General administrative expenses	73,736,629	
Total underwriting expenses		$601,621,873
Net underwriting loss		(78,621,245)
Net investment gains		7,654,685
Net income before federal income taxes		
Federal and foreign income taxes incurred		14,080,864
Net loss		$(56,885,696)

Change in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus per report on examination as of June 30, 2002			$27,866,906
Net loss		$56,885,696	
Change in non-admitted assets		1,332,473	
Change in net deferred income tax	$ 316,174		
Gross paid in and contributed surplus	50,000,000		
Change in unassigned funds	8,851,455		
Change in aggregate health policy reserves		7,300,000	
Net decrease in capital and surplus			(6,350,540)
Capital and surplus per report on examination as of December 31, 2005			$21,516,366

4. AGGREGATE HEALTH POLICY RESERVES

The examination established the captioned liability of $7,300,000 as of the examination date. This liability was based on the Health Bureau Actuarial Unit's analysis of the Company's underwriting results, which concluded that the Company maintains a "Premium Deficiency Reserve" of $7.3M; all of which applies to its Large Group line of business. The Reserves determined by the Department employed various actuarial methodologies that utilized statistical data relevant to claims experience for medical care benefits accumulated over an extended period of time as provided by the Company.

This reserve was established in accordance with the provisions of Paragraph 18 of the Statements of Statutory Accounting Principles (SSAP) No. 54, 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 the Company comply with the provisions of Paragraph 18 of the Statements of Statutory Accounting Principles No. 54 by establishing the requisite liability for each line of business where a premium deficiency exists.

5. CLAIMS UNPAID

The examination liability of $33,476,152 is the same as that reported by the Company in its filed annual statement as of December 31, 2005. The examination analysis of the unpaid claims liability 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.

6. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct investigation. The review was directed at the practices of the Company in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Explanation of benefits statements
D. Advertising
E. Sales
F. Complaints
G. Grievances
H. Utilization review and appeals
I. Fraud prevention and detection
J. Appointment of agents

A. Claims Processing

The examination included a review of the Company's claims settlement practices and oversight of the claims adjudication process by the Company's management. The Company receives its claims through both electronic submissions and the US Post Office. The Company utilizes various intermediaries as its electronic claims clearing house. Approximately 25% of all claims were electronically submitted in 2005. For electronically submitted claims the Company erroneously recorded the date the claims were received from its electronic clearing house as the claims receipt date; not the date the claims were received by the clearing house, as is proper. This matter is further addressed in the Prompt Pay Law section of this report. All claims

received are assigned a 14 digit identification number. The last digit is "0" for claims received for the first time; if the last digit is other than zero, this represents an adjusted claim.

A review of the Company's claims practices and procedures was performed by using a statistical sampling methodology covering claims processed during the period of January 1, 2005 through December 31, 2005, in order to evaluate the overall accuracy and compliance environment of its claims processing environment., the examiner selected a sample of 167 Institution (hospital) claims and a separate sample of 167 Professional (medical) claims for review.

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

The term "claim" can be defined in a myriad of ways. For the purpose of this report, a "claim" is defined by the Company as a grouping of all line items (e.g. procedures/services or service dates) on any one claim form. It was possible, through the computer system used for this examination, to match or "roll-up" all procedures into one item, which is the basis of the Department's statistical sample of claims, or the sample unit. To ensure the completeness of the claims population being tested, the total dollars paid were totaled and reconciled to the paid

claims data reported by the Company for the period January 1, 2005 through December 31, 2005, and included in its annual statement filed with the Department for calendar year 2005.

The examination revealed that the overall claims processing financial accuracy level was 83.23% for Hospital claims and 92.22% for Medical claims. The overall claims processing procedural accuracy level is 82.04% for Hospital claims and 91.62% for Medical claims. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times claim transactions were processed in accordance with the Company's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such it is counted both as a financial error and a procedural error. In summary, of the 167 Medical claims reviewed, 13 contained financial errors and 14 contained procedural errors; of the 167 Hospital claims reviewed, 28 contained financial errors and 30 contained procedural errors.

The following tables summarize the claims processing errors:

Summary of Financial Claims Accuracy

	Medical	Hospital
Claims Population	715,118	56,463
Sample Size	167	167
Claims with errors	13	28
Calculated Error Rate	**7.78%**	**16.77%**
Calculated Accuracy Rate	**92.22%**	**83.23%**
Upper Error Limit	11.85%	22.43%
Lower Error Limit	3.72%	11.10%
Calculated claims in error	**55,636**	**9,469**
Upper limit claims in error	84,741	12,665
Lower limit claims in error	26,602	6,267

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

Summary of Procedural Claims Accuracy

	Medical	Hospital
Claims Population	715,118	56,463
Sample Size	167	167
Claims with errors	14	30
Calculated Error Rate	**8.38%**	**17.96%**
Calculated Accuracy Rate	**91.62%**	**82.04%**
Upper Error Limit	12.59%	23.79%
Lower Error Limit	4.18%	12.14%
Calculated claims in error	**59,927**	**10,141**
Upper limit claims in error	90,033	13,433
Lower limit claims in errors	29,892	6,855

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

During the process of reviewing the claims transactions within the various claim adjudication samples noted above, the following was noted:

- Claims were incorrectly denied using an edit code "B240" ("verify par status and then pay accordingly") while the processing was still incomplete.
- Claims were processed using the incorrect rate because there was no central location for hospital fees, and no uniform practice for claim processors to access applicable rates.
- The claims processors were unable to reconstruct the historical rate used by third party administrators (e.g. Multiplan, PHCS and Magellan) because HHICNY did not maintain the fee schedule for these vendors. It also appears that the Company did not provide adequate oversight of these vendors since no formal audits of vendors were completed during the examination period.
- In instances where bulk adjustments of rates were made, the Company did not properly account for and pay "Prompt Pay" interest.

It is recommended that the Company take steps to identify and correct errors that may be occurring on an ongoing basis and consider providing training to individual who process claims.

It is also recommended that the Company require its vendors to maintain documentation that demonstrates compliance with its claims processing guidelines and statutory requirements.

As noted above, the claims processors were unable to reconstruct the historical rate used by third party administrators because HHICNY did not maintain the fee schedule for these vendors.

Part 243.2(b)(4) of Department Regulation 152 (11 NYCRR 243.2) states:

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

Further, Part 216.11 of Department Regulation 64 (11 NYCRR 216.11) states in part:

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

It is recommended that the Company provide proper oversight for its third party administrators to ensure that they comply with Part 243.2(b)(4) of Department Regulation 152 and retain historical claims information, such as rates, that is necessary to verify proper adjudication of its claims.

It is also recommended that the Company provide proper oversight for its third party administrators to ensure that they comply with Part 216.11 of Department Regulation 64, by maintaining all data within its claim files so that the Insurance Department examiners can reconstruct the claim.

B. Prompt Pay Law

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within forty-five days of receipt.

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

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

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

> "In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment…"

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

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

In order to test the Company's compliance with the abovementioned Prompt Pay Law, two statistical samples were drawn from the populations of Hospital and Medical claims that were not paid within 45 days of receipt, from a population of claims adjudicated during the period January 1, 2005 through December 31, 2005. Both samples were comprised 167 claims.

The review disclosed compliance problems relative to Sections 3224-a(a), 3224-a(b), and 3224-a(c) of the New York Insurance Law, as summarized in the following tables:

Summary of Violations of Section 3224-a(a) of the NYIL

	Medical	**Hospital**
Population of claims adjudicated past 45 days of receipt	14,662	3,773
Sample size	167	167
Number of claims with violations	101	106
Calculated Violation Rate	**60.48%**	**63.47%**
Calculated Accuracy Rate	**39.52%**	**36.53%**
Upper Violation Limit	67.89%	70.78%
Lower Violation Limit	53.06%	56.17%
Calculated claims in violations	**8,868**	**2,395**
Upper limit claims in violation	9,954	2,671
Lower limit claims in violation	7,780	2,140

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

Summary of Violations Section 3224-a(b) of the NYIL

	Hospital	**Medical**
Population of claims adjudicated past 45 days of receipt	14,662	3,773
Sample Size	167	167
Number of claims with violations	67	60
Calculated Violation Rate	**39.52%**	**35.93%**
Calculated Accuracy Rate	**60.48%**	**64.07%**
Upper Violation Limit	46.94%	43.21%
Lower Violation Limit	32.11%	28.65%
Calculated claims in violations	**5,794**	**1,356**
Upper limit claims in violation	6,882	1,630
Lower limit claims in violation	4,708	1,081

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

Summary of Violations of Section 3224-a(c) of the NYIL*

	Medical	Hospital
Population of claims adjudicated past 45 days of receipt	14,662	3,773
Sample Size	167	167
Number of claims with violations	9	66
Calculated Violation Rate	**5.39%**	**39.52%**
Calculated Accuracy Rate	**94.61%**	**60.48%**
Upper Violation Limit	8.81%	46.94%
Lower Violation Limit	1.96%	32.11%
Calculated claims in violation	**790**	**1,491**
Upper limit claims in violation	1,292	1,771
Lower limit claims in violation	287	1,212

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

*The violation of Section 3224-a(c) noted above directly relate to and should be considered a subset of the Section 3224-a(a) violations.

The total number of Hospital and Medical claims adjudicated in 2005 were 56,463 and 715,118, respectively. The population of Hospital and Medical claims that were adjudicated past 45 days after receipt in 2005 was 3,773 and 14,662, respectively.

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

It is recommended that the Company implement the necessary procedures to ensure compliance with Section 3224-a(b) of the New York Insurance Law and send out requisite notification within 30 days where applicable.

It is also recommended that the Company create procedures to ensure that outstanding claims in its claims system are paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law.

It is further recommended that the Company comply with Section 3224-a(c) of the New York Insurance Law and pay the correct amount of interest when interest is due.

As mentioned previously in Section 6A of this report, the Company considered the claims receipt date for electronically submitted claims to be the date the Company received the claims from the clearing house, rather than the date the claim was received by the electronic clearing house. Thus, the determination of the Company's Prompt Pay Law violations was probably lower than the actual determined amount.

It is recommended that the Company revise this process to allow the claims adjudication system to recognize the claims receipt date as the date the electronic clearing house receives the claims.

C. Complaints

Department Circular Letter No. 11 (1978) provides that all licensed insurance companies establish an internal department specifically designated to investigate and resolve complaints filed by its subscribers, with the Insurance Department' Consumer Services Bureau and that these

insurance companies take action, as necessitated as a result of the complaint investigation findings.

Circular Letter No. 11 (1978) provides guidelines for the Complaint Departments of all licensed insurance companies. Additionally, the Circular Letter requires that all insurers maintain an ongoing central log to register and monitor all complaint activity. The Circular Letter states in part:

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

The examination revealed that among the listing of the above eleven (11) required items, the Company's complaint log did not contain the items 5, 6 and 7.

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

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

The examiners were provided with a complaint listing by the Department's Consumer Services Bureau that indicated 194 complaints filed in 2005. A review of the Company's complaint log revealed that 264 complaints were received. According to the Company, the complaint log contained not only complaints for HHICNY, but it also contained complaints for Horizon Healthcare of New York, Inc., an affiliated HMO whose business was discontinued in 2005. The examination review revealed that the complaint log did not identify which entity was the subject of the complaint.

It is recommended that the Company clearly identify the entity that is the subject of the complaint in the complaint log and maintain complaint files in a separate complaint log for each entity.

Whenever a complaint is in regard to a Prompt Pay issue, the Department's Consumer Services Bureau requires that the insurer fill out a bar-coded form which contains detailed information about the claim. The form is to be filled out by the insurer and returned to the Consumer Services Bureau with related correspondence.

A review of a sample of the complaint files revealed that the Company did not fill out the form and return it to the Consumer Services Bureau as required.

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

D. Utilization Review and Appeals

The Company relies on its own "in-house" utilization review ("UR") management to conduct utilization reviews. The examiner obtained a sample of 40 utilization review files from the listing of UR cases completed in 2005. In addition, the examiner also obtained and reviewed the Company's various policies that pertain to the function of UR management and appeals; some of these policies included related entities of HHICNY.

Section 4904(b) of the New York Insurance Law states in part:

> "…Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal."

The examiner's review of the Company's UR Program ("Utilization Management Program Description") indicated that the statement in the "Expedited Appeals" section appeared to be in violation of the aforementioned statute. The following is an excerpt from the UR Program:

> *"Expedited Appeals Process:*
>
> …expedited appeals are completed within seventy-two hours or as required by the medical exigencies of the case."

Similar appeals statements were found in the Company's "Medical Appeal Process brochure" and the "Medical Appeal Process Description"; both are distributed to its members when adverse determination letters are sent.

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

As detailed in Item 7 herein, the Company discontinued its healthcare operations, resulting in all such enrollment being terminated as of February 28, 2007. Thus, the Company's utilization management program was discontinued at that time, as it does not service the Company's remaining dental insurance business, nor does it offers utilization management to third parties. Therefore, this comment is no longer applicable.

During the examination review of the Company's compliance with applicable statutes in regard to UR, nine of the requested files were not provided to the examiners. According to the Company, it does not keep the appeal files if an appeal is overturned, in these cases the determination letters were sent to the providers with a "cc", indicating the same were also sent to the member; however, the actual copy of the letters were not kept in the file.

Part 243.2(b)(8) of Department Regulation 152 (11 NYCRR 243.2) states in part:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:

> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

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

As noted in Item 2F herein, the Company revised its record retention policy subsequent to the examination date.

The Company's "Exhibit of Grievances and Utilization Review Appeals" in its filed New York Supplement at December 31, 2005, erroneously showed a total number of 222 appeal cases. The examiners obtained a listing of all appeals from the Company, which showed 735 appeals cases for 2005.

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

E. Notices of Policy Terminations

In the fourth quarter of 2005, the Company decided to discontinue certain policies and replaced them with new policies effective April 1, 2006. In doing so, the Company provided notices to group policyholders informing them of the termination of policies, but no such notices were provided to the individual policyholders.

Section 3221(p)(3)(A)(i) of the New York Insurance Law states in part:

> "(p)(3)(A) In any case in which an insurer decides to discontinue offering a particular class of group or blanket policy of hospital, surgical or medical expense insurance offered in the small or large group market, the policy of such class may be discontinued by the insurer in accordance with this chapter in such market only if:
>
> (i) the insurer provides written notice to each policyholder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety days prior to the date of discontinuance of such coverage; …"

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

F. Appointment of Agents

The examiner reviewed a sample of agent appointment files selected from a listing of agents utilized during the examination period. The new process (appointment form (AGI-1 form) is no longer used) requires that insurers make the agent appointment "on-line" via the internet. When the process is complete, a confirmation is generated that indicates the date of appointment, as well as a confirmation number. When the examiner requested copies of such confirmation, the Company was unable to produce such documentation.

Part 243.2(b)(5) of Department Regulation 152 (11 NYCRR 243.2) states in part:

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

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

7. SUBSEQUENT EVENT

Effective August 7, 2006, the Company entered into an agreement to sell the renewal rights of the Company's insured medical enrollment to Empire HealthChoice Assurance, Inc. ("Empire"). This agreement calls for the conveyance and assignment of the rights to renew any hospital and medical insurance policy subscribed to with the Company. The agreement consists of an immediate down payment by Empire, and further payments based on the number of insureds migrating to Empire. Empire agreed to provide the "Renewed Members" with the opportunity to subscribe to any Empire plan that is generally available to customers of similar size, however, the renewed member maintains their right to choose any other plan.

The hospital and medical business was fully transferred to Empire by the end of February 2007; since the completion of this transaction, the Company offers and retains only dental business.

8. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The previous report on examination as of June 30, 2002 contained forty nine (49) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
	Management	
1.	It is recommended that the board of directors appoint a nominating committee prior to the annual shareholder's meeting in compliance with Article 2, Section 2.07 of the Company's by law. The Company has not complied with this recommendation. A similar recommendation was made in this report.	6
2.	It is recommended that the Company's board of directors' underwriting and surplus discussions be documented. The Company has complied with this recommendation.	6
3.	It is recommended that all agreements within the holding company system be approved by the Board of Directors prior to implementation. The Company has complied with this recommendation.	7
4.	It is recommended that the Company's investment be approved by its board of directors or a committee thereof in compliance with Section 1411(a) of the New York Insurance Law. The Company has complied with this recommendation.	7
5.	It is also recommended that HHICNY's board of directors create and implement company specific policies and procedures that will enable it to approve the sales and purchases of its investments. The Company has complied with this recommendation.	7
	Holding Company System	
6.	It is recommended that the Company and BCBSNJ follow the terms of the contract approved by the Department. The Company has complied with this recommendation.	12

ITEM NO.		PAGE NO.
7.	It is recommended that HHICNY and BCBSNJ maintain appropriate written agreement to formalize the services to be provided along with terms, conditions and the duties, of each company, and submit them to the Department pursuant to Section 1505(d). The Company has complied with this recommendation.	13
8.	It is recommended that the Company settle its Federal income tax recoverable account in cash or securities eligible as investment as required by the Tax Allocation Agreement and Circular Letter 33 (1979). The Company has complied with this recommendation.	15
9.	It is also recommended that the Company follow the terms of the Tax Allocation Agreement and settle the Federal income tax recoverable within 30 days term specified in the agreement. The Company has not complied with this recommendation. A similar recommendation is made in this report.	15
10.	It is recommended that the Company submit to the Department, for approval, all holding company service agreements prior to entering to transactions as required by Section 1505(d)(3) of the New York Insurance Law. The Company has not complied with this recommendation. A similar recommendation is made in this report.	17
11.	It is recommended that the Company provide more detail in the management service agreement for portfolio management including investment guidelines. The Company has complied with this recommendation.	17
12.	It is recommended that HHICNY create service agreements with HHNJ and with HHH that formalizes any services provided between the companies. The Company has not complied with this recommendation. A similar recommendation is made in this report.	19

ITEM NO.		PAGE NO.
13.	It is recommended that such service agreements be submitted to the New York Insurance Department for approval as required by Section 1503(d)(3) of the New York Insurance Law. The Company has not complied with this recommendation. A similar recommendation is made in this report.	19
14.	It is recommended that the Company take steps to strengthen and improve adherence to accounting procedures and controls concerning the issuance of wire transfer. The Company has complied with this recommendation.	20
15.	It is recommended the Company maintain a wire transfer log or other adequate documentation that will provide an audit trial allowing examiners to trace the flow of all wire transfers. The Company has complied with this recommendation.	20
16.	It is recommended that the Company create a basis for the apportionment of those expenses requiring allocation in greater compliance with SSAP No. 70, paragraph 7 and 8. The Company has complied with this recommendation.	22
17.	It is recommended that the Company comply with the requirement of Section 1217 of the New York Insurance Law. The Company has complied with this recommendation.	23
18.	It is recommended that the Company record the proper amounts to its advertising expense. The Company has complied with this recommendation.	23
19.	It is recommended that the Company report expenses that it (as opposed to its parent) has incurred. The Company has complied with this recommendation.	23
20.	It is recommended that the Company comply with Sections 1505(b) and 1712 of the New York Insurance Law by taking steps to more clearly define the New York entity and by improving its compliance with Section 1505(b) and 1712. The Company disagreed with this finding.	24

ITEM NO. **PAGE NO.**

ITEM NO.		PAGE NO.
34.	It is recommended that the Company disclose the name of the New York licensed insurer placing the advertisement as required by Part 215.13(a) of Department Regulation 34. The Company has complied with this recommendation.	43
35.	It is recommended that the Company keep updated contracts that it holds with its advertising agencies. The Company has complied with this recommendation.	44
36.	It is further recommended that the Company obtain an amended agreement to include itself with the agencies under contract. This situation is no longer applicable during this examination, however, the Company fully acknowledged that it will comply with this recommendation if similar situation arise in the future.	44
37.	It is again recommended that the Company comply with Section 1712 of the New York Insurance Law to assure that the Company has a separate legal and operating identity. The Company has complied with this recommendation.	45
38.	It is recommended that the Company comply with Part 215.7(a) of Department Regulation No. 34 and maintain a complete file containing every printed, published or prepared advertisement for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of the time. The Company has complied with this recommendation.	45
	Sales	
39.	It is recommended that the Company comply with Section 2102(a)(l). The Company has complied with this recommendation.	47

ITEM NO.		PAGE NO.
40.	It is recommended that HHICNY be in compliance with Section 2103(e)(2) and 2112(a) of the New York Insurance Law and submit Form AGT-1 to the Department. Form AGT-1 is no longer in used. The Department now requires insurer submit appointment electronically through the internet. The Company still has record keeping deficiencies in this area, particularly it did not keep the confirmation record generated after the appointment was made. A similar recommendation was made in this report.	48
41.	It is recommended that HHICNY comply with Section 2112(d) of the New York Insurance Law. The Company has complied with this recommendation.	48
	Complaint	
42.	It is recommended that all fields mentioned in the guidelines of Circular Letter 11 (1978) be included in the company's electronic complaint Log maintained within its IT systems or otherwise. The Company has not complied with this recommendation. A similar recommendation was made in this report.	50
43.	It is recommended that HHICNY keep a log of all complaints, including direct complaints to the Company. The Company has complied with this recommendation.	51
44.	It is also recommended that the Company comply with Part 243.2(b)(6) of Department Regulation 152. The Company has complied with this recommendation.	51
45.	It is recommended that the Company adopt procedures to reply in a timely manner to the Department's inquiries. The Company has complied with this recommendation.	51

ITEM NO. **PAGE NO.**

Grievances

Fraud Detection and Prevention

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	**Management and Controls**	
i.	It is recommended that the Company comply with Section 2.07 of the Company's by-laws and have the Board of Directors appoint a Nominating Committee, of no fewer than three Directors, prior to the annual shareholders' meeting in compliance with Section 2.07 of the Company's by-laws. Further, the Nominating Committee shall file, in writing with the Secretary of the Company, a list of nominees for election to the Board of Directors of the Corporation. Subsequent to the date of examination, and consistent with the Company's stated intentions following its receipt of the previous report on examination, for the 2006 Annual Meeting, the Company's board of directors appointed a Nominating Committee, and this Committee filed in writing, with the Secretary, a list of nominees for election to the board.	7
ii.	It is recommended that all directors and officers comply with the Corporate Code of Business Conduct and Ethics and that conflict of interest questionnaires be completed on an annual basis.	8
B.	**Adoption of Procedure Manual – Circular Letter No. 9 (1999)**	
	It is recommended that the Company's Board comply with the requirements of Circular Letter No. 9 (1999) by obtaining the required certifications.	9
C.	**Holding Company System**	
i.	It is recommended that the Company comply with Section 1505(c) of the New York Insurance Law by executing a formal written agreement with Horizon Healthcare of New Jersey, Inc. It is further recommended that the Company comply with Section 1505(d)(3) of the New York Insurance Law and submit this agreement to the Superintendent of Insurance for his non-disapproval. Due to the Company's discontinuance of its healthcare operations, as detailed in Item 7 herein, Horizon Healthcare of New Jersey ceased providing services to the Company on June 14, 2007, therefore, this comment is no longer applicable. However, the Company agrees to abide by Article 15 of the Insurance Law in regard to all future applicable transactions.	16

ITEM **PAGE NO.**

Appointment No. 22474

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***Howard Mills***, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Kaiwen Guo

as a proper person to examine into the affairs of the

Horizon Healthcare Insurance Company of New York

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

Company

with such information as he shall deem requisite.

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

this 10th day of March 2006

Howard Mills
Superintendent of Insurance