REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

STARR INDEMNITY AND LIABILITY COMPANY

AS OF JUNE 30, 2013

Conducted from March 3, 2014

Through

September 11, 2015

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 75-1670124
NAIC: 38318

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

I, Laura Klanian, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Starr Indemnity and Liability Company as of June 30, 2013, conducted at the Company's office in New York, New York is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2017-00169 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 6th day of December, 2017.

Laura Klanian
Examiner in Charge

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TABLE OF CONTENTS

I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Starr Indemnity and Liability Company (hereinafter referred to as “Starr Indemnity” or “the Company”) was conducted under the authority of various sections of the Code of Virginia (hereinafter referred to as “the Code”) and regulations found in the Virginia Administrative Code (hereinafter referred to as “VAC”) including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1 and 38.2-1809 of the Code, as well as 14 VAC 5-90-170 A.

The period of time covered for the current examination was July 1, 2010, through June 30, 2013. The on-site examination was conducted at Starr Indemnity’s office in New York, New York from March 3, 2014 to March 6, 2014, and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on September 11, 2015. The violations cited and the comments included in this Report are the opinions of the examiners.

The examiners may not have discovered every non-compliant activity in which the company was engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether Starr Indemnity was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;

14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-215-10 et seq.	Rules Governing Independent External Review of Final Adverse Utilization Review Decisions;
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review; and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Cancellations/Non-renewals
- Complaints
- Claim Practices
- Internal Appeal and External Review

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to Starr Indemnity during the course of the examination.

II. COMPANY HISTORY

Starr Indemnity and Liability Company was incorporated in the State of Texas on May 15, 1919, as a stock insurance company. On July 23, 1980 the Company was licensed In the Commonwealth of Virginia as Republic Insurance Company (Republic) a Property & Casualty insurer with a line of authority to issue accident and sickness insurance. Effective August 1, 2000, Republic was acquired by Columbia Insurance Company (Columbia). On October 3, 2007, Starr International USA, Inc., entered into a stock-purchase agreement with Columbia to acquire the Company. The Company was renamed Starr Indemnity & Liability Company. Starr Indemnity then relocated its statutory home office from Texas to New York while Texas remained its state of domicile. Starr Indemnity is a licensed in 50 states as well as the District of Columbia and Puerto Rico.

As of December 31, 2013, Starr Indemnity's annual statement reported direct premiums earned totaling $1,188,288,187; Virginia direct premiums earned totaled $32,236,132.

III. ADVERTISING

A review was conducted of Starr Indemnity's advertisements to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed (14 VAC 5-90-50).

14 VAC 5-90-170 A requires each insurer to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. The review revealed 1 violation of 14 VAC 5-90-170 A. As discussed in Review Sheet AD01, Starr Indemnity failed to indicate the manner and extent of distribution of the advertising files selected for review. Starr Indemnity failed to respond to the examiners' observations.

The entire population of 4 advertisements distributed in Virginia during the examination time frame was selected for review. The review revealed that 1 of the advertisements contained violations. In the aggregate, there were 3 violations which are discussed in the following paragraphs.

14 VAC 5-90-60 B 1 states that an invitation to contract shall disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy. 14 VAC 5-90-70 states that when an invitation to contract refers to a dollar amount, a specific policy benefit, or the loss for which a benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination, and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions. As discussed in Review Sheet AD02, the review revealed 1 violation of each of these sections. Starr Indemnity's on-line invitation to contract for a non-contributory, group accident-only certificate failed to disclose the applicable exceptions, reductions, and limitations and the provisions related to renewability, cancellability and termination. Starr Indemnity failed to respond to the examiners' observations.

14 VAC 5-90-130 A states that the name of the actual insurer, the form number or numbers of the policies advertised, and the form number of any application shall be stated on all invitations to contract. The review revealed 1 violation of this section. As discussed in Review Sheet AD02, Starr Indemnity's online advertisement failed to disclose the name of the insurer, the policy form number, and the form number of the application. Starr Indemnity failed to respond to the examiners' observations.

14 VAC 5-90-20 B states that every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised. As part of the examination, the examiners requested Starr Indemnity's written description of the Company's system of control over the form,

content and method of dissemination of its advertisements. Starr Indemnity provided the examiners with a copy of a system of control entitled, *Compliance Guidelines for Domestic Accident & Health Advertising Material*. While the cover page contained Starr Indemnity's name and its address that was effective through 2008, the entire document referenced another insurer's forms and procedures. The examiners would caution Starr Indemnity that, although no violation was cited, the Company is responsible for establishing and maintaining a system of control over the content, form, and method of dissemination of all advertisements of its policies.

SUMMARY

Starr Indemnity violated 14 VAC 5-90-60 B 1, 14 VAC 5-90-70, 14 VAC 5-90-130 A, and 14 VAC 5-90-170 A placing it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

IV. POLICY AND OTHER FORMS

A review was completed to determine if Starr Indemnity complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms. Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia.

Sections 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code prohibit the use of policies, certificates, and riders and other forms prior to filing the forms with and receiving approval from the Commission.

The examiners reviewed the policy forms included in the sample new business, cancellation and claim files.

ACCIDENT AND SICKNESS INSURANCE POLICIES

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of accident and sickness policies prior to use.

The review revealed 4 violations of each section. As discussed in Review Sheets PF04 and PF08, Starr Indemnity issued 2 student health policies, an accidental death and dismemberment-only policy, and a blanket accident insurance policy that were not filed with and approved by the Commission as required prior to issue. Starr Indemnity failed to respond to the examiners' observations.

Prior to the commencement of this examination, the Bureau notified Starr Indemnity that policy form AH-12001, that was issued to a Virginia university in 2011, was not filed and approved prior to issuance in the Commonwealth. The Bureau's letter dated November 9, 2012 discussed the use of the unapproved policy and the reasons why the policy was not in compliance. On November 20, 2012, Starr Indemnity responded that the policy was "...*only issued once.*" On December 5, 2012, Starr

Indemnity informed the Bureau the policy was cancelled effective July 1, 2012, and stated,

> "*We have confirmed that no other policies were issued in Virginia using this form*."

As discussed in Review Sheet PF14, the review revealed that policy form AH-12001 was issued twice in the Commonwealth during the examination time frame. Each policy failed to include provisions required by the Affordable Care Act (ACA) as essential health benefits (EHBs). Additionally, the policies failed to include provisions required by Virginia statute and contained subrogation provisions not permitted in Virginia. The applicable Code sections and the number of violations are listed in the chart below:

CODE SECTION	Number of Violations
§ 38.2-305 B	2
§ 38.2-3405 A	2
§ 38.2-3405 B	2
§ 38.2-3407.6:1 A	2
§ 38.2-3415	2
§ 38.2-3431 B	2
§ 38.2-3439 A	1
§ 38.2-3440 A	1
§ 38.2-3440 B	1
§ 38.2-3442	1
§ 38.2-3443 C	1
§ 38.2-3444 A	2
§ 38.2-3445	2
§ 38.2-3525 E	1
§ 38.2-3527	2
§ 38.2-3529	2
§ 38.2-3534	2
§ 38.2-3536 B	2
§ 38.2-3537	2

Starr Indemnity failed to respond to the examiners' observations.

CERTIFICATES OF COVERAGE

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of certificates of coverage prior to use.

The review revealed 2 certificates of coverage that were issued in the Commonwealth that were not filed with and approved by the Commission as required. An example is discussed in Review Sheet PF02 where brochures were used as certificates of coverage, but were not filed with and approved by the Commission as required by these sections.

Starr Indemnity responded that,

> *The students in each instance were covered by a blanket insurance policy, which did not require the issuance of individual certificates. The students were, however, provided a brochure or other document which explained the coverage in detail. The brochures were previously provided to the Bureau during the course of this examination.*

Starr Indemnity further stated that,

> *…the brochures accurately depict the coverage under the policy and therefore considers the brochures to be the certificates.*

Starr Indemnity is in violation of each of these sections each and every time the unfiled and unapproved certificate of coverage was used during the examination time frame.

RIDERS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of riders and endorsements prior to use.

The review revealed 13 violations of each of these sections. An example is discussed in Review Sheet PF10 where Administrative Change Rider, AH-20004, was

used in 4 instances prior to being filed with and approved by the Commission. Starr Indemnity agreed with the examiners' observations.

APPLICATION FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application forms prior to use.

As discussed in Review Sheet PF05b, the review revealed 1 violation of each section. Starr Indemnity utilized the form, Special Risk Accident Program, that contained the logo of another insurer, as a master group application for Starr Indemnity's accident-only coverage issued in Virginia, prior to filing the form with the Commission for approval.

Starr Indemnity failed to respond to the examiners' observations.

EXPLANATIONS OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy, file its EOB forms for approval with the Commission.

As discussed in Review Sheets PF06 and PF07, the review revealed that the EOB forms used by 2 third-party administrators that processed claims on Starr Indemnity's behalf, were not filed with and approved by the Commission as required by this section. Starr Indemnity was in violation of this section in each instance that an unfiled EOB form was used during the examination time frame. Starr Indemnity failed to respond to the examiners' observations.

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	INSTANCES USED	REVIEW SHEET
AH-12001	Blanket Insurance Policy also known as Blanket Business Travel Insurance Policy	§ 38.2-316 A	3	PF04
		§ 38.2-316 C 1	3	PF04
AH-20002	Schedule of Benefits	§ 38.2-316 A	1	PF08
		§ 38.2-316 C 1	1	PF08
none	Accident & Sickness Insurance Plan brochure	§ 38.2-316 A	each time brochure was used as a certificate	PF02
		§ 38.2-316 C 1	each time brochure was used as a certificate	PF02
AH-40001-C	Group Accident-0nly Certificate of Insurance	§ 38.2-316 A	each and every time certificate was issued	PF12
		§ 38.2-316 C 1	each and every time certificate was issued	PF12
AH-20004	Administrative Change Rider	§ 38.2-316 B	4	PF10
		§ 38.2-316 C 1	4	PF10
AH-40004	Administrative Change Rider	§ 38.2-316 B	4	PF09
		§ 38.2-316 C 1	4	PF09
AH-12016	Policy Renewal Rider	§ 38.2-316 B	4	PF11
		§ 38.2-316 C 1	4	PF11
AH-400 10-VA	Virginia Endorsement	§ 38.2-316 B	1	PF13
		§ 38.2-316 C 1	1	PF13
none	Special Risk Accident Program	§ 38.2-316 B	1	PF05b
		§ 38.2-316 C 1	1	PF05b

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	INSTANCES USED	REVIEW SHEET
none	Explanation of Benefits	§ 3407.4 A	each time an EOB was issued	PF06
none	Explanation of Benefits	§ 3407.4 A	each time an EOB was issued	PF07

V. AGENTS

The writing agents designated in the 3 new business files and Starr Indemnity's list of 1,195 agents and 137 agencies appointed during the examination time frame were reviewed to determine compliance with various sections of Title 38.2, Chapter 18 of the Code. A total of 1,335 agents and agencies were reviewed. In addition, a separate review involving 203 agents soliciting business on Starr Indemnity's behalf was completed and is discussed in the Other Agent Review section.

LICENSED AGENT REVIEW

Sections 38.2-1822 A of the Code requires that a person be licensed prior to soliciting subscription contracts.

The review revealed 1 violation of this section. As discussed in Review Sheet AG02, Starr Indemnity accepted new business from an agent that was not licensed in Virginia. Starr Indemnity failed to respond to the examiners' observations.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer shall, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed 4 violations of this section. As discussed in Review Sheets AG01, AG03, AG04 and AG05, Starr Indemnity accepted new business from agents and agencies, and failed to appoint them within 30 days of the execution of the first application that was submitted. Starr Indemnity failed to respond to the examiners' observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency that is not appointed and that was not licensed at the time of the transaction.

The review revealed 5 violations of this section. An example is discussed in Review Sheet AG01, where Starr Indemnity paid commission to an agency that was not appointed by the Company. Starr Indemnity failed to respond to the examiners' observations.

AGENT TRAINING MATERIALS

Section 38.2-1318 C of the Code requires that every company or person, from whom information is sought, shall provide examiners with convenient access to records relating to the business and affairs of the company being examined.

As discussed in Review Sheet AG09, the examiners requested Starr Indemnity's agent training materials. Starr Indemnity failed to respond to the examiners' request, in violation of this section.

OTHER AGENT REVIEW

Prior to the commencement of this examination, a separate investigation was opened by the Bureau after receipt of a complaint alleging misrepresentation by an agent. The examiners determined that the agent, employed by Starr Indemnity's managing general agent, Health Insurance Innovations, LLC (HII; aka Health Plan Intermediaries, LLC), sold 133 insurance policies underwritten by Starr Indemnity without being properly appointed by the company. Based upon this discovery, the Bureau requested that Starr Indemnity review its records and provide a list of all agents

that submitted insurance applications to the insurer and were not appointed within 30 days of the date of execution of the first application between November 2009 and November 2011. Starr Indemnity responded and provided the data in 2 lists. According to Starr Indemnity, the first list consisted of those agents and agencies who executed insurance applications and whose appointments were subsequently processed. The second list consisted of those agents and agencies who executed insurance applications, but Starr Indemnity did not subsequently appoint them because their Virginia license was terminated. Violations were discussed in Review Sheets AG06 and AG07 where 202 unlicensed and/or unappointed agents and agencies submitted executed insurance applications to Starr Indemnity, and sold 1,912 insurance policies during the 2-year period for which they received commission, in violation of §§ 38.2-1812 A, 38.2-1822 A and 38.2-1833 A 1 of the Code.

Starr Indemnity failed to respond to the examiners' observations in Review Sheet AG06. However, in response to Review Sheet AG07, Starr Indemnity provided copies of 3 producer database appointment confirmations. Of the 3, only 1 agent was a part of this review. The agent included in this review sold a policy with an effective date of April 23, 2011 and was appointed effective June 27, 2011, 65 calendar days after acceptance of the application for insurance. In this instance, the agent sold 7 policies before being appointed. Starr Indemnity indicated,

> *Many of the producers listed in the referenced spreadsheet are sub producers of Health Insurance Innovations ("HII"), an entity with which Starr had a prior contractual relationship. As a result of the contract with HII, HII was paid commissions directly. No commissions were paid to the individual sub producers of HII. It was later determined by Starr that it was necessary to also appoint the sub producers of HII, and a project was undertaken to appoint those sub producers. Those that are listed as unappointed appear to have lost their licenses between the time of policy and the project to appoint the sub producers. However, as no*

commissions were paid to the individual agents, Starr respectfully disagrees with this review sheet.

Based on Starr Indemnity's response, it agreed with the examiners' observations in part. Starr Indemnity agreed that appointments were required and disagreed with the observations related to the payment of commissions. Starr Indemnity indicated that it paid commissions directly to HII and not the individual sub-producers. However, Bureau records indicate that HII was licensed in Virginia on July 18, 2012 and each of these applications were executed prior to that date. Therefore, neither the agency nor the soliciting agent were licensed and appointed in Virginia during the time frame. No further supporting documentation was provided for the examiners to consider.

VI. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of Starr Indemnity's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; and 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was made to determine whether Starr Indemnity's underwriting guidelines were unfairly discriminatory and whether applications were underwritten in accordance with Starr Indemnity's guidelines.

UNDERWRITING REVIEW

A sample of 3 from a population of 5 group accident and sickness policies issued during the examination time frame was selected for review. The sample included 1 new student health policy and 2 renewed policies consisting of a group accidental death and dismemberment (AD&D) policy and an association policy for AD&D and accident-only coverage.

Prior to the commencement of the examination, the examiners requested, in the Coordinator's Handbook, that Starr Indemnity provide a copy of its underwriting procedures, and/or guidelines, and/or manuals used for the acceptance and/or declination of a group or individual applying for insurance. Starr Indemnity failed to respond to the request. As such, the examiners were unable to determine Starr Indemnity's compliance with its underwriting guidelines or whether those guidelines were unfairly discriminatory.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

Prior to the commencement of the examination, the examiners requested Starr Indemnity's procedures for compliance with 14 VAC 5-180-10 et seq. Starr Indemnity responded, stating,

> *Due to the type of insurance products subject to the Exam, this request is not applicable*.

Starr Indemnity failed to provide its underwriting procedures, guidelines, and/or manual, to include documentation of its compliance with underwriting practices related to HIV infection and AIDS. Therefore, the examiners were unable to determine whether Starr Indemnity was in compliance with this section.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The review revealed 2 violations of this section. An example is discussed in Review Sheet UN05, where the form failed to advise that the individual or the individual's authorized representative of the entitlement to receive a copy of the authorization form.

Starr Indemnity's failed to respond to the examiners' observations.

ADMINISTRATIVE LETTER 2010-12

The purpose of this Administrative Letter is to inform life and accident and sickness insurers of the disclaimer required to be attached to policies in order to comply with § 38.2-1715 B of the Code, which states that an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document, *Notice of Protection Provided by the Virginia Life, Accident and Sickness Insurance Guaranty Association*, was approved effective November 1, 2010. In 2014, Administrative Letter 2010-12 was replaced by Administrative Letter 2014-05 which clarified insurer requirements and updated the address of the Virginia Life, Accident and Sickness Insurance Guaranty Association.

Prior to the commencement of the examination, Starr Indemnity inquired as to whether the Notice has to be sent to the group policyholder or to each individual

certificate holder. The Bureau informed Starr Indemnity on September 24, 2013, that the Notice only has to be sent to the group policyholder.

Starr Indemnity informed the examiners on October 16, 2013, that,

> *The documentation described and the Guaranty Association disclosure form do not exist in the Company's records. However, the Company's affected underwriting department was made aware of this requirement immediately. A disclosure form has been prepared and the Company will begin complying with this requirement in the immediate future*.

Therefore, the review revealed that Starr Indemnity was not in compliance with the Commissioner's request.

VII. NOTICE OF PREMIUM INCREASES

Section 38.2-3407.14 A of the Code requires an insurer to provide prior written notice of intent to increase premiums by more than 35 percent. Section 38.2-3407.14 B of the Code requires that the notice be provided in writing at least 60 days prior to the proposed renewal of coverage to the policyholder, or to the designated consultant or other agent of the group policyholder if requested in writing by the policyholder.

Starr Indemnity informed the examiners that there were no renewals with an increase in premiums of more than 35 percent during the examination time frame.

VIII. CANCELLATIONS/NON-RENEWALS

The examination included a review of Starr Indemnity's cancellation/non-renewal practices and procedures to determine compliance with its policy provisions and the requirements of § 38.2-508 of the Code covering unfair discrimination.

A sample of 33 from a total population of 127 group contracts terminated during the examination time frame was selected for review.

The review revealed that Starr Indemnity was in substantial compliance.

IX. COMPLAINTS

Starr Indemnity's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

The total population of 10 complaints received during the examination time frame was reviewed. The review revealed that Starr Indemnity was in compliance with this section.

X. CLAIM PRACTICES

The examination included a review of Starr Indemnity's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code, and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of student health insurance claims and accident-only claims. Starr Indemnity contracted with third party administrators to process its claims. The TPAs discussed in this section include GBG, contracted to process its student health insurance claims, and Managed Care America, Inc., LLC., (MCA Administrators), contracted to process its accident-only claims. Starr Indemnity provided the examiners with copies of claims procedures from GBG and MCA Administrators.

PAID CLAIM REVIEW

In the aggregate, a sample of 56 from a total population of 264 claims paid during the examination time frame was selected for review.

Accident-Only

A sample of 10 was selected from a population of 29 claims paid during the examination time frame.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 4 violations of this section. An example is discussed in Review

Sheet CL01k related to Starr Indemnity's College Insurance Claim Form, SILC –CF (07/10). The examiners observed that a claim payment was made to the provider although the claim form failed to clearly document that benefits were assigned. The claim form contains 2 signature fields both labeled in large font as AUTHORIZATION FOR RELEASE OF INFORMATION. The initial section appeared to be either mislabeled, misrepresented, or obscured as the smaller font underneath indicated it was actually the assignment of benefits. The second section, correctly labeled, was the authorization to release information. Therefore, the misrepresentation contained in the claim form obscures and misrepresents the benefits, conditions or terms of the policy pertinent to the claim. Starr Indemnity failed to respond, to the examiners' observations.

MCA's *Mail Procedures* state,

> *Mail is processed on a daily basis whether it is received by US mail, fax or email. When received in our office, each item is date stamped by the individual processing the mail and distributed to the correct adjuster for processing*.

The exam revealed 4 instances of non-compliance with these procedures. An example is discussed in Review Sheet CL08k where claim documents were not date stamped, as required by MCA's *Mail Procedures*. In each instance, claim documents were received via facsimile where the fax machine automatically dates the document with the transmission or received date. While fax date stamps are sometimes accepted as the received date, MCA's *Mail Procedures* indicates that each item is to be date stamped by the individual processing the mail, regardless of the method used to send the documentation. Starr Indemnity failed to respond to the examiners' observations.

Interest On Accident-Only Claim Proceeds

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of 15 working days from the insurer's receipt of proof of loss to the date of claim payment. The review revealed 2 violations of this section. An example is discussed in Review Sheet CL10k, where Starr Indemnity took 17 days to pay the claim after receipt of complete proof of loss and failed to pay interest. Starr Indemnity agreed with the examiners' observations.

Student Health

A sample of 46 was selected from a population of 235 claims paid during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. Subsection 1 of Section 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 10 violations of § 38.2-514 B, 9 violations of § 38.2-3407.4 B, and 11 violations of § 38.2-502 of the Code. An example of each is discussed in Review Sheet CL12,

where the EOB included the explanation, "*Since the provider is not a network provider we are responsible for the U&C charges in the network. You are responsible for the balance*", but the EOB also displayed a column entitled "Balance" showing amounts inconsistent with the actual member liability. There was no mention or explanation of the use of networks in the unfiled and unapproved policy. As a result, Starr Indemnity failed to accurately disclose the method of benefit calculation, failed to accurately and clearly set forth the benefits payable under the contract, and issued a statement that misrepresents the benefits of the policy. Starr Indemnity disagreed with the examiners' observations, stating in part that:

> *…With regard to your question on the balance, the balance on the EOB is actually a subtotal of billed charges, re-priced charges (UCR or negotiated), allowed amount, co-payments and deductibles balance or subtotal. For the ones noted above, the billed charges were the same as the UCR, therefore they were reimbursed as 100%. Where the balance and the member's responsibility does not match is where all or part of the allowed amount was applied toward the deductible, and the member has the responsibility of paying the provider the amount charged to deductible or the charges were paid in full and the member does not have any responsibility to the provider.*
>
> *In these instances, the use of an out-of-network provider had no relation to what was paid or credited and therefore was not the best choice of notes to include on the EOB. Starr will recommend that GBG improve the formatting of the EOBs and the notes to make them clearer to the members. The note showing that the member is responsible for the balance is not correct. The EOB is current when it shows the member responsibility. It would have been better to refer to member responsibility rather than balance. However, it does not appear that there is a pattern as there was no intention not to reimburse the member the full amount.*
>
> *The schools choose to use a network option which benefits their members and they take responsibility for informing the students of this added benefit through their website and through materials developed by the school. The enrollment website has information regarding the use of the network, as does the claims website. The students are also given the same message at the Student Health Center. The use of the network providers is 100% of a negotiated rate with no balance billing, but the use of non-network providers has the charges reimbursed at the UC&R amounts. The use of*

UCR generally leaves the member with excess charges and based on information received from GBG, appears to be indicated on the websites.

The examiners responded that the explanation on the EOB has the potential to mislead the member to believe they are responsible for the amount listed in the column labelled as "Balance," which is inconsistent with the amounts shown in the "Member Responsibility" and "Deductible" fields. In addition, the explanation in the EOB does not accurately reflect the situation involving the claims in question, as the billed amount and UCR are the same and the use of out-of-network providers in these instances did not result in a balance. Furthermore, any references on Starr Indemnity's EOBs to in-network or out-of-network providers are not supported by the policy and are in non-compliance with the Code of Virginia.

Section 38.2-3405 B of the Code prohibits subrogation of any person's right to recovery for personal injuries from a third person. Coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 4 violations of § 38.2-3405 B of the Code. An example is discussed in Review Sheet CL10. This issue and Starr Indemnity's response are discussed further in the Denied Claim Review section of the Report. Additionally, subrogation is also discussed in the Policy and Other Forms section.

Section 38.2-3444 A of the Code (effective from July 1, 2011, to January 1, 2014) states that a health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual under the age of 19 by imposing a pre-existing condition exclusion on that individual. The review revealed 1 violation of

this section. As discussed in Review Sheet CL95, the initial claim submission for a 16 year old patient was pended until receipt of a completed Provider Prior Treatment Questionnaire. This issue and Starr Indemnity's response to the Review Sheets are discussed further in the Denied Claim review section of the Report. Additionally, this provision is also discussed in the Policy and Other Forms section.

Interest on Accident and Sickness Claim Proceeds

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

The review revealed 42 violations of this section. An example is discussed in Review Sheet CL32, where Starr Indemnity took 36 calendar days to pay a claim and failed to pay the statutory interest due. Starr Indemnity disagreed, claiming that an agreement between the TPA and the provider allowed 45 days for claim payment. The examiners do not concur and responded that an agreement with the provider does not absolve the Company from complying with the requirements of § 38.2-3407.1 of the Code.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took Starr Indemnity, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays or holidays. The study was conducted on the total sample of 56 paid accident and sickness claims.

PAID CLAIMS			
Claim Type	Working Days to Settle	Number of Claims	Percentage
Accident	0 – 15	9	90%
	16 – 20	1	10%
	Over 20	0	0%
Student Health	0 – 15	7	15%
	16 – 20	7	15%
	Over 20	32	70%

Of the 56 reviewed for the time study, 71% of claims were not settled within 15 working days. The examiners recommend that Starr Indemnity revise its procedures to reduce the percentage of claims paid after 15 working days.

DENIED CLAIM REVIEW

Accident-Only

A sample of 15 was selected from a population of 40 claims denied during the examination time frame.

Subsection 1 of 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation

and the actual amount which has been or will be paid to the provider of services. The review revealed 3 violations of § 38.2-502 and 2 violations of § 38.2-514 B of the Code. An example is discussed in Review Sheet CL16k where a claim was denied as a duplicate of a previously paid claim, and the EOB indicated that the insured was financially responsible for all billed charges. The EOB incorrectly indicated amounts in the Patient Responsibility section, and did not clearly and accurately disclose the method of benefit calculation. Starr Indemnity disagreed stating,

> *The charges were originally paid on 7/7/11 to the insured (received 6/22/11). Another copy of the bill was received and denied as previously paid to the insured. The charge amounts are listed under patient responsibility because ultimately, it is the patient's responsibility to settle with the provider if there is an outstanding balance*.

The examiners do not concur. The Patient Responsibility field, the Amount Not Covered field, and the Not Covered column on the EOB misrepresent pertinent facts and are misleading, and do not indicate the method by which those amounts were derived or calculated. The EOB has the capacity and tendency to mislead by indicating that the insured is financially responsible for these duplicate charges, as neither Starr Indemnity nor MCA has knowledge of or access to the status of the insured's account with the provider. Therefore, the Company failed to comply with §§ 38.2-502 and 38.2-514 B of the Code.

MCA's *Mail Procedures* state,

> *Mail is processed on a daily basis whether it is received by US mail, fax or email. When received in our office, each item is date stamped by the individual processing the mail and distributed to the correct adjuster for processing*.

The exam revealed 4 instances of non-compliance with these procedures. An example is discussed in Review Sheet CL15k where claim documents were not date stamped, as

required by MCA's *Mail Procedures*. Starr Indemnity disagreed with other observations in each of the review sheets, but did not address this issue. In each instance, claim documents were received via facsimile where the fax machine automatically date-stamped the document with the transmission or received date. Although fax date stamps are sometimes accepted as the received date, MCA's *Mail Procedures* indicated that each item is to be date stamped by the individual processing the mail regardless of the method used to send the documentation.

Student Health

A sample of 65 was selected from a population of 421 claims denied during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 10 violations of § 38.2-514 B and 13 violations of § 38.2-502 of the Code. An example of each is discussed in Review Sheet CL72, where a duplicate submission was denied indicating that the member was responsible for the full billed amount despite the fact that benefits were approved for the original claim with a deductible shown as the only member liability. As a result, Starr Indemnity failed to accurately disclose the method of

benefit calculation and issued a statement that misrepresents the benefits of the policy. Starr Indemnity disagreed, stating in part that,

> … *GBG's system does not show any deductible or any other line items on claims that are pended for additional information, closed, duplicates or that request additional information. For these types of requests will reflect the total amount billed, which until GBG is able to ensure it is a valid claim and adjudicate it, it is the member's potential responsibility. The system is not programed to allow a deductible to be displayed until the claim is adjudicated. It is not a misrepresentation or inaccurate display of benefits or coverage – it is an initial summary of the bill amount received. Once the claim is adjudicated, the correct information is shown across the top of the EOB, it shows repricing that may have been applied, copayments and/or deductibles and the actual benefit payable by Starr Indemnity. The member responsibility box is a summary of the total responsibility and does not indicate who is responsible for paying. We do not believe there is any misrepresentation in the manner the benefits are displayed*…

The examiners responded that the potential to mislead exists when the member receives two separate EOBs for the same services displaying conflicting amounts in the "MEMBER RESPONSIBILITY" field and that, as the deductible information would be available in the Company's system when the original claim has already been processed, the member's correct liability from the original claim approval for the services performed should continue to be displayed on the EOB for any subsequent duplicate denial.

Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 5 violations of § 38.2-3407.4 B of the Code. An example is discussed in Review Sheet CL83, where the EOB for the reprocessing of a denied claim with benefits approved displayed allowable amounts that exceeded the re-priced amounts and re-priced amounts that exceeded the billed amounts, and the amounts shown for the deductible, member responsibility, and amount payable contradicted one another. As a

result, Starr Indemnity failed to accurately and clearly set forth the benefits payable under the contract. Starr Indemnity disagreed, stating in part that

> *…The discrepancy is the amount allowed and repriced and the claim amounts have to do with currency exchange. The original amount paid was in Canadian dollars and the amount paid on the EOB is in USD or vice versa. The numbers were manually generated to get the right amount reimbursable to the member…*

The examiners responded that while the member may have been reimbursed the correct amount, the manual generation of figures to populate certain fields on the EOB without logical calculation does not clearly and accurately set forth the benefits payable under the contract.

Section 38.2-3405 B of the Code prohibits subrogation of any person's right to recovery for personal injuries from a third person. Coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 8 violations of § 38.2-3405 B of the Code. An example is discussed in Review Sheet CL03, where Starr Indemnity denied the claim pending receipt of a completed Medical Accident Questionnaire. This questionnaire included the following question:

> C. OTHER COVERAGE
> Is there another insurance plan with potential financial liability for this injury? (Workman's Compensation, Automobile or Property Insurance)
> __ Yes __ No **if YES, please attach details (Policy Name, Policy Number and Contact Number) of other insurance information**

Starr Indemnity disagreed with the examiners' observations, stating in part that,

> *…GBG sends out the medical questionnaire to determine the cause of the accident. It is true that the request asks for liability for automobile carrier,*

but it also to determine how the accident occurred. There are exclusions in this policy regarding accidents as follows:

10 – "Sickness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate club sports and professional sports".
#12 – "Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planning, bungee jumping, racing or speed contests, scuba diving, paintballing, or parachuting."
#35 – "Accidents occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation except …"
#46 - "Any accident where the covered person is the operator of a motor vehicle and does not possess a current and valid driver's license except while Driver's Education Program."

In addition to this language there is also Excess Language in the Policy that limits our Liability in Auto Accident to $5000.00.
Page 34
Excess Provision – "No benefit under this Policy is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance. However, Injury due to a motor vehicle accident is limited to $5000 per accident.

I believe that this shows the necessity to use this questionnaire…

The examiners responded that, while Starr Indemnity's need to determine the cause of an accident based on certain policy limitations is acknowledged, the denial of a claim to request information in any capacity regarding the potential liability of automobile or property insurance is in non-compliance with the Code of Virginia. As Starr Indemnity was also previously informed by letters from the Bureau dated April 18, 2011, and November 9, 2012, the Excess Provision, in addition to other language in the policy related to subrogation and the exclusion of benefits paid by automobile insurance, is in non-compliance with § 38.2-3405 of the Code; therefore, Starr Indemnity is in non-compliance for each instance in which a claim is pended, denied, or paid at a reduced benefit amount based on these policy provisions.

Section 38.2-3442 A 2 (effective July 1, 2011) of the Code states that a health carrier shall provide coverage for and not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Section 38.2-3442 A 3 (effective July 1, 2011) of the Code states that a health carrier shall provide coverage for and not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to evidence-informed preventive care and screenings with respect to infants, children, and adolescents provided for in comprehensive guidelines supported by the Health Resources and Services Administration. These recommendations and guidelines, as listed on the website www.healthcare.gov, specify that coverage is required for the influenza virus vaccine from birth to age 18 and medical history for all children ages 1 to 4 years. The review revealed 2 violations of § 38.2-3442 A 2 of the Code and 9 violations of § 38.2-3442 A 3 of the Code. An example of each is discussed in Review Sheet CL120, where Starr Indemnity denied a claim for a one-year-old child as not covered that included procedures for each of these services. As a result, Starr Indemnity failed to provide the required coverage for immunizations and preventive services. Starr Indemnity disagreed, stating in part that,

> *…The claim identified was correctly denied. The Patient Protection Affordable Care Act identified 26 preventative services for children that were to be offered beginning on or after September 23, 2010. These rules were applicable to new health insurance plans or insurance policies. The Starr Indemnity policy was not issued as a comprehensive health plan, but as a limited benefit plan to which these new rules were not applicable. The preventive benefits referred to here were not covered benefits in the limited benefit plan. Limited benefit plans are exempt from the guidelines supported by the Health Resources and Services Administration*.

The examiners responded that as the policy in question appears to be that of student health including coverage for medical expenses that is renewable and for a term of 365 days, it is the position of the Bureau that the policy is subject to the requirements of the Affordable Care Act, specifically §§ 38.2-3442 A 2 and 38.2-3442 A 3 of the Code.

Section 38.2-3444 A of the Code (effective from July 1, 2011 to January 1, 2014) states that a health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual under the age of 19 by imposing a pre-existing condition exclusion on that individual. The review revealed 1 violation of this section. As discussed in Review Sheet CL94, a claim for a 17 year old patient was denied pending receipt of a completed questionnaire requesting information from the provider regarding possible prior treatment received for a specific diagnosis, in violation of § 38.2-3444 A of the Code. Starr Indemnity disagreed, stating in part that:

> …*The policy under which the sickness and accident medical benefits are offered is a limited benefit, short term travel form to which the waiver of pre-existing conditions does not apply. PPACA does not apply to these forms or products*.

The examiners responded that Starr Indemnity's product appears to be a student health policy, and it is the position of the Bureau that the Affordable Care Act and this Code Section apply.

Starr Indemnity's policy indicates that doctor office visits are reimbursable at "*100% of Usual & Customary Charges*" after the deductible is met. The review revealed that Starr Indemnity was in non-compliance with its policy in 2 instances. An example is discussed in Review Sheet CL06, where a claim for this service was denied with the explanation "*…this claim is denied due to the injury was not reported with in the 30 days from the date of the Injury occured….*" As no language is included in the policy

regarding this reporting time frame, the denial of a claim based on this requirement is in non-compliance with the policy.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 56 paid claims and 80 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

The review was conducted using the date the letter or check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-30 – In 7 instances, the insurer's claim files failed to contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. An example is discussed in Review Sheet CL66, where the file for a claim involving multiple submissions and processed under different claim numbers failed to include documentation of receipt date, process date, and EOB information for 2 out of the 3 processings involved.

14 VAC 5-400-40 A - In 29 instances, Starr Indemnity misrepresented insurance policy provisions related to the coverage at issue. An example is discussed in Review Sheet CL74, where Starr Indemnity sent an EOB to the member indicating that the services billed were processed previously. Starr Indemnity had paid these services previously; however, the EOB indicated that the member was responsible for the charges.

14 VAC 5-400-50 A - In 70 instances, claims were not acknowledged within 10 working days of receipt of notification of the claim. An example is discussed in Review

Sheet CL15, where Starr Indemnity took 30 working days to acknowledge receipt of a claim. Starr Indemnity agreed with the examiners' observations.

14 VAC 5-400-60 A - In 56 instances, Starr Indemnity failed to notify the first party claimant of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss. An example is discussed in Review Sheet CL17, where Starr Indemnity took 26 working days to affirm the claim after receipt of proof of loss. Starr Indemnity agreed with the examiners' observations.

14 VAC 5-400-60 B - In 35 instances, a claim investigation was not completed within 45 days from the date of notification of the claim, and Starr Indemnity failed to send the claimant a letter setting forth the reason additional time was needed for investigation. An example is discussed in Review Sheet CL45, where no correspondence was sent to the claimant until the EOB that was issued 51 days after the notification date. Starr Indemnity agreed with the examiners' observations.

14 VAC 5-400-70 B - In 36 instances, Starr Indemnity failed to include a reasonable explanation of the basis for denial in the written denial. An example is discussed in Review Sheet CL70, where a claim was denied requesting office notes despite the fact that they were included with the original claim submission. Starr Indemnity disagreed, explaining that the denial was actually "…based on the non-receipt of the Medical Accident Questionnaire" requested on a previous claim. The examiners responded that the explanation for the denial provided on the EOB does not correctly identify the information needed to process the claim and, therefore, does not accurately reflect the reason for claim denial.

14 VAC 5-400-70 D - In 15 instances, Starr Indemnity failed to offer a claimant an amount which is fair and reasonable in accordance with policy provisions. An example

is discussed in Review Sheet CL06, where claim payment was denied based on a requirement to report an injury within 30 days that was not included in the policy.

The violations of 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D, occurred with such frequency as to indicate a general business practice, placing Starr Indemnity in violation of each section.

THREATENED LITIGATION

Starr Indemnity informed the examiners that there were no claim files that involved threatened litigation during the examination time frame.

XI. INTERNAL APPEAL AND EXTERNAL REVIEW

Chapter 59 of Title 38.2 of the Code requires certain actions to be taken by the Bureau of Insurance on any appeal of a final adverse decision made by a utilization review entity. 14 VAC 5-215-10 et seq., which was repealed and replaced by 14 VAC 5-216-10 et seq. effective July 1, 2011, provides a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions and procedures for expedited consideration of appeals in cases of emergency health care.

Prior to the commencement of the examination, Starr Indemnity informed the examiners that,

> *Due the type of insurance products subject to the Exam, this request is not applicable*.

The examiners disagree. The Code of Virginia and the Virginia Administrative Code do not provide for exceptions based on the type of accident and sickness product. Therefore, the accident and sickness insurance that Starr Indemnity provides is subject to Chapter 59 and 14 VAC 5-215-10 et seq., as well as 14 VAC 5-216-10 et seq., regardless of whether the policy is a student health insurance policy or other type of accident and sickness policy. However, based on the examiners' review of complaints, it appears there were no requests for an independent external review of final adverse decisions during the examination time frame.

14 VAC 5-216-30 B requires that as part of each health carrier's health benefit plan and any adverse benefit determination, each health carrier shall provide notice of its available internal appeals procedures (including urgent care appeals) including timeframes for submission of an appeal, the health carrier's review and response. Such

notice shall also include the name, address, and telephone number of the person or organizational unit designated to coordinate the review of the appeal for the health carrier, and contact information for the Bureau of Insurance.

The review revealed 1 violation of this section where Starr Indemnity failed to provide notice of its available complaint procedures, in violation of 14 VAC 5-216-30 B and in non-compliance with its complaint and appeal procedures. As discussed in Review Sheet CP09, in 1 instance, GBG's procedure called *Virginia Complaints, Grievances and Appeals*, was not provided to individual insureds as certificates were not issued. Starr Indemnity disagreed stating,

> …*the right to appeal for an adverse benefit determination for this particular complainant was included as part of the explanation of benefits as demonstrated by the attached example*.

Starr Indemnity's response included a sample EOB for the insured in question which stated that,

> *GBG Administrative Services acts as an administrator for Starr Indemnity & Liability Company, the underwriter of this coverage. Your plan offers you the right to appeal a claim if you are dissatisfied with the outcome. Additional information about the appeals process may be found in the Brochure*.

The examiners reviewed the EOB statement. The unfiled and unapproved EOB contains a statement, 3 sentences long, indicating the insured has the right to appeal and directs the insured to the "Brochure." The brochure describes the process in one paragraph, while the procedures, *Virginia Complaints, Grievances And Appeals*, is 4 pages long. The procedure described in the brochure fails to provide all required elements such as timeframes for submission of an appeal; the name, address, and telephone number of the person or organizational unit designated to coordinate the review of the appeal; and contact information for the Bureau of Insurance. It appears

that the procedure is directed toward the insured, and was not provided to the insured as required. Therefore, Starr Indemnity failed to provide notice of its available complaint procedures, in violation of 14 VAC 5-216-30 B.

XII. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, Starr Indemnity shall:

1. Revise and strengthen its procedures for maintaining a complete advertising file that comply with the requirements of 14 VAC 5-90-170 A;
2. Review and revise its procedures to ensure that its advertisements comply with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
3. Establish and maintain a system of control over the content, form, and dissemination of all advertisements of its policies, as required by 14 VAC 5-90-20 B;
4. Review and revise its procedures to ensure that all of its policies, certificates of coverage, master group applications, policy riders and endorsements are filed with and approved by the Commission prior to use in the Commonwealth, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code;
5. Review and revise its procedures to ensure that all Explanation of Benefit (EOB) forms used by Starr Indemnity are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code;
6. File with the Commission for approval all accident and sickness policy forms currently in use or contemplated for use, remove all references to subrogation, excess provision and other inappropriate exclusions; and discontinue use of any forms that have not been approved in their final form, as required by 14 VAC 5-100-50 2 and 14 VAC 5-100-50 3, as well as §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code;

7. Review and revise its procedures to ensure that all agents representing Starr Indemnity directly, or indirectly through managing general agents, are licensed and appointed prior to accepting new business and the Company's payment of commissions are in compliance with § 38.2-1822 A, § 38.2-1812 A and § 38.2-1833 A 1 of the Code;

8. Establish and implement procedures to ensure compliance with Administrative Letter 2010-12;

9. Review all claims paid under student health plans in effect between 2011 and 2013 and all accident claims paid between 2014, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid;

10. Review all claims processed under student health plans that were in effect between 2011 and 2013 that resulted in a Medical Accident Questionnaire being sent to the claimant or resulted in subrogation; determine which claims were not paid due to accident information not being received, were incorrectly denied, or the claim payment was reduced, in violation of § 38.2-3405 B of the Code; reopen and reprocess all affected claims so that they are paid without subrogation or, if needed, appropriate questionnaires are sent to determine eligibility for benefits. Send checks for any payments along with

letters of explanation stating specifically, “As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission’s Bureau of Insurance, it was revealed that Starr Indemnity failed to adjudicate this claim correctly. Please accept the enclosed payment.” After which, furnish the examiners with documentation of the reprocessed claims and payments;

11. Immediately discontinue use of any questionnaires that are in violation of § 38.2-3405 B of the Code;

12. Review and revise mail-processing procedures for Starr Indemnity and all of its third-party administrators to ensure that received dates are accurately captured using the first date of receipt as the received date;

13. Review and reopen all student health claims for preventive services that were not processed in accordance with §§ 38.2-3442 A 2 and 38.2-3442 A 3 of the Code between 2011 and 2013 and reprocess those claims in accordance with these sections. Send a letter of explanation along with each payment stating, “As a result of a Target Market Conduct Examination conducted by the State Corporation Commission’s Bureau of Insurance, this claim was not processed in accordance with §§ 38.2-3442 A 2 and 38.2-3442 A 3 of the Code. Please accept this payment amount.” Documentation of the review and adjusted amounts paid should be provided to the examiners within 180 days of this Report being finalized;

14. Review and reopen all claims for individuals under age 19 that were denied under student health plans that were in effect between 2011 and 2013 by imposing a pre-existing condition exclusion in error and reprocess those

claims in accordance with § 38.2-3444 of the Code where necessary. Send a letter of explanation along with each payment stating, "As a result of a Target Market Conduct Examination conducted by the State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with § 38.2-3444. Please accept this payment amount." Documentation of the review and adjusted amounts paid should be provided to the examiners within 180 days of this Report being finalized;

15. Establish and maintain procedures to ensure that claims are processed in accordance with policy provisions;
16. Establish and maintain procedures to ensure that all explanation of benefits forms clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider, as required by §§ 38.2-514 B and 38.2-3407.4 B;
17. Establish and maintain procedures to ensure that claim files contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed, as required by 14 VAC 5-400-30;
18. Establish and maintain procedures to ensure that benefits, coverages or other provisions of an insurance policy or contract are not obscured or concealed from claimants, either directly or by omission, as required by § 38.2-502 of the Code and 14 VAC 5-400-40 A;
19. Review and revise all claim forms to ensure that sections related to the authorization to release information and the assignment of benefits are properly labeled;

20. Establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;

21. Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;

22. Review and strengthen its established procedures to ensure that notification of a claim under investigation is sent every 45 days from the date of notification of the claim and every 45 days thereafter, as required by 14 VAC 5-400-60 B;

23. Establish and maintain procedures to ensure that it includes a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B;

24. Establish and maintain procedures to ensure that a claimant is offered an amount that is fair and reasonable, as required by 14 VAC 5-400-70 D;

25. Review and revise its procedures to ensure that it provides, to all insureds, notice of its available internal appeals procedures to include all provisions required by 14 VAC 5-216-30 B, and;

26. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XIII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by Starr Indemnity's officers and employees during the course of this examination is gratefully acknowledged.

Brant Lyons, MCM, and Laura Klanian, MCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health Division

XIV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

ADVERTISING
14 VAC 5-90-170 A, 1 violation, AD01
14 VAC 5-90-60 B 1, 1 violation, AD02
14 VAC 5-90-70, 1 violation, AD02
14 VAC 5-90-130 A, 1 violation, AD02
POLICY FORMS
§ 38.2-305 B, 2 violations, PF14 (2)
§ 38.2-316 A, 4 violations, PF04 (3), PF02 (each and every time an unapproved brochure was used and issued as a certificate during the examination time fame), PF08, PF12 (each and every time the unapproved certificate was issued during the examination time frame)
§ 38.2-316 B, 14 violations, PF05b, PF09 (4), PF10 (4), PF11 (4), PF13
§ 38.2-316 C 1, 18 violations, PF04 (3), PF02 (each and every time an unapproved brochure was used and issued as a certificate during the examination time fame), PF05b, PF08, PF09 (4), PF10 (4), PF11 (4), PF12 (each and every time the unapproved certificate was issued during the examination time frame), PF13
§ 38.2-3405 A, 2 violations, PF14 (2)
§ 38.2-3405 B, 2 violations, PF14 (2)
§ 38.2-3407.4 A, violation in each instance issued, PF06, PF07
§ 38.2-3407.6:1 A, 2 violations, PF14 (2)
§ 38.2-3415, 2 violations, PF14 (2)
§ 38.2-3431 B, 2 violations, PF14 (2)
§ 38.2-3439 A, 1 violation, PF14
§ 38.2-3440 A, 1 violation, PF14

§ 38.2-3440 B, 1 violation, PF14
§ 38.2-3442, 1 violation, PF14
§ 38.2-3443 C, 1 violation, PF14
§ 38.2-3444 A, 2 violations, PF14 (2)
§ 38.2-3445, 2 violations, PF14 (2)
§ 38.2-3525 E, 1 violation, PF14
§ 38.2-3527, 2 violations, PF14 (2)
§ 38.2-3529, 2 violations, PF14 (2)
§ 38.2-3534, 2 violations, PF14 (2)
§ 38.2-3536 B, 2 violations, PF14 (2)
§ 38.2-3537, 2 violations, PF14 (2)
AGENTS
§ 38.2-1812 A, 207 violations, AG01, AG02, AG03, AG04, AG05, AG06 (17), AG07 (185)
§ 38.2-1822 A, 18 violations, AG01, AG06 (17)
§ 38.2-1833 A 1, 1,637 violations, AG01, AG03, AG04, AG05, AG07 (1,633)
§ 38.2-1318 C, 1 violation, AG09
UNDERWRITING
§ 38.2-606, 2 violations, UN05, UN06
CLAIMS PRACTICES
§ 38.2-502, 31 violations, CL01k, CL04k, CL05k, CL06, CL06k, CL07, CL07k, CL12 (9), CL13 (4), CL15k, CL16k, CL46, CL72, CL73, CL74, CL75, CL83, CL84, CL86, CL97
§ 38.2-514 B, 22 violations, CL12 (9), CL13 (4), CL16k, CL17k, CL72, CL73, CL74, CL75, CL83, CL86, CL97

§ 38.2-3405 B, 12 violations, CL01 (2), CL02, CL03, CL04, CL05, CL06, CL07, CL08, CL09, CL10, CL11
§ 38.2-3407.1 B, 44 violations, CL03, CL04, CL08, CL08k, CL09, CL10, CL10k, CL16, CL19, CL20, CL21, CL23, CL24, CL25, CL29, CL30, CL31, CL32, CL36, CL37, CL38, CL39, CL40, CL41, CL42, CL43, CL45, CL47, CL48, CL51, CL52, CL53, CL66, CL68, CL73, CL76, CL77, CL80, CL81, CL82, CL83, CL90, CL91, CL93
§ 38.2-3407.4 B, 14 violations, CL12 (9), CL13 (4), CL83
§ 38.2-3442 A 2, 2 violations, CL112, CL120
§ 38.2-3442 A 3, 9 violations, CL111, CL113, CL114, CL115, CL116, CL117, CL118, CL119, CL120
§ 38.2-3444 A, 2 violations, CL94, CL95
14 VAC 5-400-30, 7 instances, CL07K, CL12k, CL15k, CL66, CL67, CL68, CL86
14 VAC 5-400-40 A, 29 violations, CL01k, CL02, CL04k, CL05k, CL06, CL06k, CL07, CL07K, CL12 (9), CL13 (4), CL72, CL73, CL74, CL75, CL83, CL86, CL97
14 VAC 5-400-50 A, 70 violations, CL03k, CL04, CL06, CL07k, CL08, CL08k, CL09, CL10k, CL11, CL11k, CL14, CL15, CL16, CL16k, CL17, CL17k, CL18, CL19, CL20, CL21, CL22, CL23, CL24, CL25, CL26, CL27, CL28, CL29, CL30, CL31, CL33, CL35, CL36, CL37, CL39, CL40, CL41, CL43, CL44, CL45, CL47, CL49, CL50, CL51, CL52, CL54, CL55, CL56, CL57, CL58, CL59, CL61, CL62, CL63, CL64, CL66, CL68, CL70, CL71, CL73, CL78, CL79, CL81, CL83, CL85, CL88, CL92, CL96, CL98, CL99
14 VAC 5-400-60 A, 56 violations, CL03, CL04, CL08, CL09, CL09k, CL10, CL10k, CL11k, CL15, CL16, CL17, CL18, CL19, CL20, CL21, CL23, CL25, CL26, CL27, CL28, CL29, CL30, CL31, CL33, CL35, CL37, CL39, CL40, CL41, CL43, CL45, CL47, CL49, CL50, CL51, CL52, CL53, CL54, CL55, CL56, CL57, CL61, CL64, CL71, CL73, CL74, CL79, CL81, CL82, CL85, CL86, CL87, CL88, CL96, CL98
14 VAC 5-400-60 B, 35 violations, CL08, CL09, CL09k, CL10k, CL16, CL18, CL19, CL20, CL21, CL23, CL25, CL26, CL27, CL29, CL30, CL31, , CL33, CL34, CL35, CL36,

CL37, CL39, CL40, CL43, CL45, CL47, CL49, CL50, CL51, CL52, CL73, CL81, CL82, CL85, CL86
14 VAC 5-400-70 B, 36 violations, CL01, CL02, CL05, CL06, CL07, CL42, CL43, CL44, CL45, CL46, CL48, CL66, CL67, CL68, CL70, CL76, CL77, CL79, CL80, CL83, CL84, CL89, CL91, CL93, CL94, CL95, CL111, CL112, CL113, CL114, CL115, CL116, CL117, CL118, CL119, CL120
14 VAC 5-400-70 D, 15 violations, CL01, CL02, CL06, CL07, CL94, CL111, CL112, CL113, CL114, CL115, CL116, CL117, CL118, CL119, CL120
INTERNAL APPEAL AND EXTERNAL REVIEW
14 VAC 5-216-30 B, 1 violation, CP09

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

July 12, 2016

CERTIFIED MAIL 7015 1520 0003 0918 9564
RETURN RECEIPT REQUESTED

Francesca Lulgjuraj
Assistance Counsel and Compliance Director
Starr Insurance Holdings, Inc.
399 Park Avenue, 8th Floor
New York, NY 10022

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Gardner:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Starr Indemnity & Liability Company (Starr Indemnity) for the period of July 1, 2010, through June 30, 2013. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of Starr Indemnity, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. Starr Indemnity's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R Fairbanks

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

STARR
COMPANIES
GLOBAL INSURANCE & INVESTMENTS

Jeffrey Herman
Vice President and Head
Global Accident & Health
Starr Insurance Holdings, Inc.
399 Park Avenue
9th Floor
New York, NY 10022

December 21, 2016

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Division
Virginia Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

RE: Market Conduct Examination Report Exposure Draft

Dear Ms. Fairbanks:

This letter is in response to your letter addressed to Mark Gardner, former Vice President and Compliance Officer for Starr Indemnity & Liability Company ("Starr Indemnity") regarding the Market Conduct Examination of Starr Indemnity for the period of July 1, 2010, through June 30, 2013.

As you are aware, the examination conducted of Starr Indemnity took place over the course of several months, extensive documentation was prepared and collected and significant resources were dedicated to respond to the various requests for information prior to, during and subsequent to the on-site review with the examination team.

We have included the issues raised in your examination report by topic in bold below, and have followed each of those items with Starr Indemnity's response for your consideration. As indicated by the responses set forth below, Starr Indemnity has already addressed many of these items or has indicated the areas for which we respectfully disagree. In addition, for the items with which we disagree, we would like the opportunity to provide supporting documentation for your consideration:

1. **Managed Care Health Insurance Plans.**

Starr Indemnity is able to confirm the following facts, which may assist in the examination team's understanding of the nature of the benefit provided to claimants. Starr Indemnity, through its former Third Party Administrator, did utilize the services of a network. However, the network was not utilized for purposes of the services or seeking to prefer one provider over another. Rather, the network was a re-pricing network, which allowed claimants to go to any provider. The network was then responsible for attempting to reprice the cost, regardless of the provider. It appears therefore that the explanation field of the Explanation of Benefits may have caused some confusion for the examination team.

Further, with regard to the written agreement between Starr Indemnity and its Third Party Administrator, while the language in the agreement does include a reference to "Cost of Preferred Provider Organization fees," it also continues that "or other similar cost containment programs." It is Starr Indemnity's position that the repricing network is not the type of network that falls within the definition of MCHIP as set by the Virginia Administrative Code ("Code").

In addition, Starr Indemnity would like to note it does not currently offer sickness policies in Virginia, and instead focuses on accident policies.

Lastly, it should be noted Starr Indemnity has recently contacted and discussed this matter with the Department by phone to confirm its understanding that this type of arrangement would not fall under the definition of MCHIP, and received a verbal confirmation. Starr Indemnity therefore respectfully requests that this item be removed from the examination report.

2. Advertising.

Starr Indemnity did not engage in advertising directly in Virginia. Starr Indemnity contracted with producers and/or Managing General Agents to underwrite insurance products. These agreements required the producers or Managing General Agents to submit any potential advertising or marketing materials to Starr Indemnity for review. Starr Indemnity did not appear to have any further documents other than those provided to the examination team during the review process.

Pursuant to 14 VAC 5-90-60 B 1, "an invitation to contract shall disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy." Pursuant to 14 VAC 5-90-30, "invitation to contract" "means an advertisement that includes in any manner an application for insurance. It is not an invitation to inquire nor an institutional advertisement."

Starr Indemnity would like to clarify that the accident insurance provided did not require an application.

Because there was no application for the accident insurance, the advertising on the National Rifle Association's website does not qualify as an invitation to contract. As a result, the requirements imposed by 14 VAC 5-90-60 B 1 do not apply to this advertisement.

In addition, because the insurance provided coverage for all accidents and not specified accidents only, the requirements imposed by 14 VAC 5-90-60 B 6 do not apply to this advertisement.

Starr Indemnity has undertaken to enhance its procedures with regard to advertising and marketing by revising its guidelines for marketing, which require that any and all advertising, whether it be from a Managing General Agent or otherwise, be reviewed by the legal department to ensure compliance with state regulations.

Further, Starr Indemnity has implemented a records retention policy and retention schedule. These requirements are emphasized in the revised guidelines.

Starr Indemnity therefore respectfully requests that this item be removed from the examination report.

3. Policy and other forms.

a. Group Insurance Policies

According to the Starr Indemnity's records, form AH-12001 was filed for and received approval on August 12, 2009.

In addition, Starr Indemnity questions whether the student policies in question would fall under the definition of "Group Health Plan," within the meaning of this section.

Further, Starr Indemnity notes that the examination covered the time period July 1, 2010 through June 30, 2013. However, the examination cites the following Code provisions that were not in effect during the examination period:

1. § 38.2-3407.18 was effective July 1, 2014 and therefore after the examination time frame.
2. § 38.2-3425E appears to have expired as far back as 2010 and therefore was not in effect at the time policies relevant to the examination were issued.
3. §38.2-3439 was not in effect with regard to grandfathered group health plans and was therefore not subject to this Code section during the examination time frame.
4. §38.2-3440A was made effective January 1, 2014 and therefore after the examination time frame.
5. §38.2-3440B was made effective January 1, 2014 and therefore after the examination time frame.
6. §38.2-3442 was not in effect with regard to grandfathered group health plans and was therefore not subject to this Code section during the examination time frame.
7. §38.2-3443C was not in effect with regard to grandfathered group health plans and was therefore not subject to this Code section during the examination time frame.

In addition, with regard to §38.2-3431B, Starr Indemnity respectfully notes that it does not believe it is in violation of this Code provision as it defines terms. Starr Indemnity is willing to provide further documentation and respectfully requests the examination team consider the above and remove the items that do not appear to be applicable.

However, Starr Indemnity has implemented an underwriting audit function, which is responsible for ensuring policies are issued utilizing filed forms and rates.

b. Certificates of Coverage

While Starr Indemnity agrees it did not file the brochures on the student accident and sickness policies, Starr Indemnity is able to confirm it ceased writing these specific policies subsequent to the examination period. Further, Starr Indemnity is able to confirm it ceased writing accident and sickness policies subsequent to the examination period and is currently offering accident only policies.

c. Riders

As noted, Starr Indemnity agreed with the examiner findings.

d. Application Forms

The particular policy in question was inherited from another insurer and thereafter Starr Indemnity ceased writing this policy. As it was inherited from another insurer, the application form bore the logo of the prior carrier. It is Starr Indemnity's position that the other carrier would have been responsible for filing the application for approval. Starr Indemnity therefore respectfully requests that this item be removed from the examination report.

e. Explanations of Benefits

Starr Indemnity ceased writing these specific policies subsequent to the examination period.

Further, Starr Indemnity ceased writing accident and sickness policies subsequent to the examination period and is currently offering accident only policies.

In addition, Starr Indemnity has terminated its relationship with the Third Party Administrators previously handling claims on its behalf.

4. Agents.

a. Licensed Agent Review

Starr Indemnity implemented a robust set of protocols to effectively manage the producer appointment process. As of 2012, Starr Indemnity began utilizing software that maintains and supports the updating and adding or removing of producers to more efficiently manage compliance with producer licensing requirements.

The software receives a data feed from the National Insurance Producer Registry ("NIPR"), a public-private partnership that facilitates the producer-licensing process. Therefore, Starr Indemnity can ensure that the information maintained in the software is accurate and up-to-date.

The process begins with a submission received from a common relationship manager software ("CRM") licensed by Starr Indemnity, which maintains internal records for all producers. When the submission is received, the Starr Underwriting Services Technician searches the CRM by the producer name, producer number or other identifier to determine whether the producer can be found in the software.

Assuming the producer is in Starr Indemnity's producer-licensing database, the producer's license is checked against the risk state by using the feed from the software. If the producer holds a valid license for that state, the clearance process proceeds. If the producer does not hold a valid license, the CRM automatically blocks the submission from continuing and additional steps are needed.

Because Starr Indemnity is required to pay annual appointment fees to state insurance authorities for each producer appointed to represent the company in a given state, the procedure addresses this requirement as well. The Starr Underwriting Services Department processes all state producer appointments and terminations through the software except those for:

- The Commonwealth of Massachusetts, which prohibits the use of NIPR partners and requires all such actions to be processed through their state website; and
- Florida appointments or terminations for producers who are Florida residents, which must be processed through Florida's state system. Non-resident Florida appointments may be processed through Starr Indemnity's producer-licensing software.

The Starr Underwriting Services Division reviews invoices for producer appointment fees against producer information in Starr Indemnity's producer-licensing software and CRM in order to:

- Ensure that the producer-licensing software records are consistent with producer records from all 50 states; and
- Terminate inactive producers and eliminate state appointment fees associated with inactive producers.

Starr Indemnity believes this automated process combined with reliable and accurate data received from NIPR, is an effective control to ensure we are appointing licensed producers in all states. The effectiveness of the Producer Management Procedures and Controls are reviewed and updated periodically on an as needed basis.

b. Appointed Agent Review

Starr Indemnity is able to confirm the set of protocols summarized in the above section allow Starr Indemnity to effectively ensure appointments are made on a timely basis.

c. Commissions

Starr Indemnity is able to confirm the set of protocols summarized in the above section allow Starr Indemnity to effectively ensure no commissions are paid to agents or agencies that are not appointed.

d. Agent Training Materials

Starr Indemnity previously relied on its Managing General Agents to provide relevant agent training to the agents employed by them. In addition, Starr Indemnity did require that employees complete mandatory compliance training during the examination period.

In addition, Starr Indemnity has instituted a third party agent training program subsequent to the examination period.

e. Other Agent Review

Starr Indemnity has implemented an auditing program for third-party Managing General Agents ("MGAs") that the Company uses for various products. Starr selects which MGAs it will audit based on a variety of factors, including past performance and volume of business. The audits are designed to determine whether the MGAs are adhering to Starr procedures, underwriting policies and guidelines. The frequency of these audits is determined on a case-by-case basis.

In addition, Starr Indemnity began performing financial and operational audits of our MGAs in 2010. The procedures for these audits were thereafter revised to include a mechanism for auditing the procedures and controls in place by the MGAs in order to ensure that all sub-producers used by the MGA are properly licensed and appointed.

Further, as mentioned above, the robust automated processes apply to MGAs. Starr includes a requirement in its standard agreements with MGAs that the MGA is responsible for maintaining its licenses in the states where it writes business on Starr's behalf. In addition, Starr requests and is provided with documentation from its MGAs evidencing that MGAs must have contracts with any sub-producers the MGA uses to produce business for Starr. Moreover, Starr Indemnity mandates that contracts between an MGA and its sub-producers must include license requirements similar to the licensing requirements that Starr Indemnity imposes on its MGAs. Starr requires all MGAs that write Accident & Health policies provide a list of all sub-producers it will use for Starr business. Lastly, the MGA provides a monthly bordereaux to Starr in order to ensure that the sub-producers used are duly licensed and appointed where required.

5. Underwriting Review.

Starr Indemnity has overarching underwriting guidelines for the underwriters it employs and every profit center is audited on the underwriting guidelines on an annual basis. In addition, each profit center is required to peer review a minimum of four underwriting files per underwriter per quarter. These underwriting compliance audits are performed by a dedicated team of auditors that report directly to Starr Indemnity's senior management.

Starr Indemnity requests the opportunity to provide the underwriting guidelines to the examiners at this time.

6. Insurance Information and Privacy Protection Act.

Starr Indemnity benefits from a multi-faceted compliance program that includes (i) wide-ranging policies and procedures covering the code of business ethics and conduct, anti-bribery and anti-corruption, anti-money laundering, data privacy and security, insider trading, social media, records retention and other topics; (ii) required on-line compliance training classes offered on a quarterly basis providing employees with practical examples of the various compliance policies and procedures at work and offering employees an opportunity to review the policies and keep current with any new developments as a result of changes in applicable law and/or regulation; and (iii) the Starr Hotline Program, which is a dual, telephone and on-line reporting mechanism enabling employees to anonymously report suspected violations of law or internal company policies and procedures.

The compliance program is managed by its Compliance Director who works in and is physically located within the Office of the General Counsel. Certain employees have been identified to assume compliance responsibilities for the various offices, and these employees ultimately report to the Compliance Director. The compliance program establishes and maintains a culture of compliance which transcends all business operations and processes. To meet this objective, required practices and obligations are clearly communicated to all employees, including senior management. Senior management plays an active role, in tandem with the compliance function, of ensuring that employees, directly and indirect reporting to senior managers, complete their job functions in accordance with Starr Indemnity's compliance standards. All new employees are provided with and are required to acknowledge the code of business ethics and conduct, which references and includes the other compliance policies and all existing employees are required to re-acknowledge the code of business ethics and conduct and other compliance policies annually.

One of the cornerstones of the Starr Indemnity's compliance and ethics program is its on-line compliance training program. Every employee in every office—including international locations—is required to take an on-line compliance training course quarterly. These courses, offered by a premier vendor, take up to 45 minutes to complete and include multiple choice examinations.

The on-line training program is supplemented by the Starr Hotline Program. This dual, telephone and on-line, reporting mechanism enables employees to anonymously report suspected violations of law or internal policies. In addition, if an employee encounters a situation in which he/she believes the internal principles of compliance and integrity are being compromised, all employees are encouraged to discuss those concerns with his/her supervisor, the head of the department or a Human Resources representative.

Both the Starr Hotline Program and the on-line compliance training program are in addition to the Starr Indemnity's formal compliance policies. The Starr Indemnity has distributed to all employees and posted on its intranet compliance policies on the following topics:

1. Information Systems Security Policy
2. Privacy Guide
3. Bring Your Own Device Policy
4. Records Retention Policy
5. Policy on Prevention of Insider Trading
6. Anti-Corruption Policy
7. OFAC Policy
8. Anti-Money Laundering Policy

9. Social Media Policy

In addition, the Third Party Agent training referenced in the above section contains guidance regarding the handling of information. Lastly, the agency agreements for MGAs and TPAs Third Party Agents have been updated to include robust privacy and information security protections to provide further guidance on our requirements for the handling of personal, privileged information or other sensitive information.

7. Cancellations/Non-renewals.

Starr Indemnity questions whether the student policies in question would fall under the definition of "Group Health Plan," within the meaning of this section.

8. Claim Practices.

Starr Indemnity agrees that the Third Party Administrator ("TPA") appears to have not followed their procedures. However, Starr Indemnity would like to note the purpose for which the date stamp is required is to record its receipt, which is achieved when received by facsimile. In addition, Starr Indemnity would like to note that this TPA does not currently have any active claims in Virginia on Starr Indemnity insurance policies.

Further, Starr Indemnity has implemented an auditing program for TPAs the Company uses for claims. Starr selects which TPAs it will audit based on a variety of factors, including past performance and volume of claims. The audits are designed to determine whether the TPAs are appropriately handling claims. The frequency of these audits is determined on a case-by-case basis.

In addition, Starr Indemnity began performing financial and operational audits of TPAs in 2010. Starr Indemnity periodically reviews its procedures for auditing its TPAs and makes changes as necessary. The procedures for these audits will be reviewed to determine whether we should incorporate whether they are adhering to their stated procedures.

It is unclear as to why a response on review sheets CL32 and CL95 was not provided. However, Starr Indemnity would like the opportunity to provide the documentation at this time.

In addition, Starr Indemnity no longer offers sickness coverage in Virginia, which would appear to exempt Starr Indemnity from the requirement of issuing Explanation of Benefit forms.

Lastly, Starr Indemnity would like to note it has terminated its relationship with its former TPA, GBG, subsequent to the examination period.

9. Internal Appeal and External Review

Starr Indemnity respectfully disagrees with this item. While all of the information was not included on the Explanation of Benefits, it was incorporated by reference in materials provided to the insured. Starr Indemnity respectfully requests that the examination team reconsider.

In conclusion, Starr Indemnity believes that its internal controls framework supports the nature, scope and complexity of our operations at this time. We strive to ensure that Starr Indemnity continues to grow successfully and continues to provide best-in-class service to our customers. As Starr Indemnity continues to grow, we will continue to reevaluate, strengthen and improve our compliance framework and controls.

The responses set forth above demonstrate Starr Indemnity's commitment to ensuring the items noted in the examination findings have been remediated or are in the process of being remediated and addressed. Starr

Indemnity will review the feasibility of the corrective actions recommended in the examination report for the items for which we have not already addressed. We hope this assists in your understanding that Starr Indemnity's approach with respect to its operating and control framework is measured and reasonable and we look forward to discussing in further detail if given the opportunity.

If at any time you have any questions or would like to see any additional documentation, we would be happy to provide it to you.

Thank you very much for your time and consideration.

Sincerely,

Jeffrey Herman
Vice President and Head, Global Accident & Health
Starr Insurance Holdings, Inc.

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

July 18, 2017

CERTIFIED MAIL 7015 1520 0003 0918 9991
RETURN RECEIPT REQUESTED

Jeffrey Herman
Vice President and Head, Global Accident & Health
Starr Insurance Holdings, Inc.
399 Park Avenue, 8th Floor
New York, NY 10022

RE: Target Market Conduct Examination Report of Starr Indemnity & Liability Company

Dear Mr. Herman:

The Bureau of Insurance (hereinafter referred to as "the Bureau") has completed its review of your December 21, 2016, response to the Target Market Conduct Examination Report of Starr Indemnity & Liability Company (hereinafter referred to as "Starr Indemnity") sent with my letter of July 12, 2016.

Starr Indemnity expressed concerns regarding the writing of the Report and asked for the opportunity to provide additional supporting documentation for consideration. The examiners offered Starr Indemnity several weeks to provide additional documentation, and the documentation provided was reviewed and considered prior to drafting this response.

This letter addresses Starr Indemnity's concerns in the same order as presented in your December 21st response. Since Starr Indemnity's response will be attached to the final Report, this response does not address those issues where the Company indicated agreement.

The Bureau acknowledges any corrective actions that Starr Indemnity has already taken as the result of this examination. As noted in Corrective Action Plan (CAP) Item # 26 (formerly Item 28), within 120 days of finalization of the Report, Starr Indemnity will be required to document compliance with all of the corrective action items

included in the Final Report. Upon receipt, the examiners will review the documentation provided and communicate with you and your staff if they have any questions or require additional documentation or further action.

1. Managed Care Health Insurance Plans

The Bureau reviewed the additional documentation that was provided and considered it along with your response. After further discussion with the Financial Regulation Division and Office of General Counsel, the decision was made to remove this violation from the report as it does not appear that Starr Indemnity was operating as an MCHIP without the proper license during the examination time frame. The Report has been revised accordingly. While Starr Indemnity is not currently selling health insurance coverage in Virginia, should Starr Indemnity decide to return to Virginia's health insurance market, the Bureau would strongly encourage the Company to contact the Company Licensing Section before proceeding. Starr Indemnity may also want to review Administrative Letter 2016-09, which is available on the Bureau's website at http://scc.virginia.gov.

2. Advertising

While Starr Indemnity may not have engaged in advertising directly in Virginia, Starr Indemnity did contract with third parties to advertise the Company's products on its behalf. Whether advertising pieces are developed by Starr Indemnity, its producers, or Managing General Agents (MGAs), it is Starr Indemnity's responsibility to properly maintain its advertising file to include the manner and extent of distribution, as required by 14 VAC 5-90-170 A.

With respect to 14 VAC 5-90-60 B 1, Starr Indemnity asserted that "the accident insurance provided did not require an application"; therefore, it is not an invitation to inquire, an invitation to contract, or an institutional advertisement. However, the advertisement specifically states "to apply for the $25,000 in accidental death insurance and $2,500 in coverage for members seriously injured in the line of duty, please supply the required information below." Therefore it would appear that an "application" is required and a direct link to the application is included in the advertisement. As such, this would be an invitation to contract. The violation will remain in the Report.

Your response asserts that the insurance being advertised provides coverage for all accidents rather than specified accidents, and that 14 VAC 5-90-60 B 6 is not applicable. The Report will be revised to remove this violation.

While the Bureau acknowledges Starr Indemnity's efforts to strengthen its procedures to ensure future compliance with Virginia's Rules Governing Advertisement of Accident and Sickness Insurance, the report reflects the violations that occurred during the examination time frame, therefore, no changes to the Report are necessary. Starr Indemnity will be required to provide copies of its revised procedures documenting compliance with the Corrective Action Plan within 120 days of the finalization of the Report.

3. Policy and Other Forms

a. Group Insurance Policies

Policy form number AH-12001(5-09) was approved on August 12, 2009 under PLIS-126187155. However, policy form number AH-12001 was issued and delivered to 2 schools in Virginia during the examination time frame, and was not filed with and approved by the Commission as required. The language in policy form number AH-12001 varies significantly from policy form number AH-12001(5-09), and the differences noted were not addressed in the statement of variability. Starr Indemnity confirmed in a letter dated November 20, 2012, to the Bureau that policy form number AH-12001 was not filed and approved.

The subtitle, Group Insurance Policies, will be renamed Accident and Sickness Insurance Policies. The title change will not affect the violations discussed in that section.

The examiners reviewed the effective date and content of the Code sections that Starr Indemnity asserts were not in effect during the examination time frame. Below are the results of that review.

- § 38.2-3407.18 of the Code was originally effective 07/01/2012 and was revised effective 07/01/2014. Since policy AH-12001 terminated for the 2 schools on or before 07/01/2012, the violation will be removed and the Report will be revised to reflect this change.

- § 38.2-3425 E of the Code expired in 1995. Due to a typographical error, the Report should have read § 38.2-3525 E of the Code. Section 38.2-3525 E of the Code was effective 07/01/2011. Since only 1 school renewed with policy AH-12001 and the renewal was effective 07/01/2011, the violations will be reduced from 2 to 1 for this Code section. The Report will be revised to reflect this change.

- §§ 38.2-3439, 38.2-3440 A, 38.2-3440 B, and 38.2-3442 of the Code were effective 07/01/2011 and were revised effective 01/01/2014. Since only 1 school renewed with policy AH-12001 and the renewal was effective 07/01/2011, the violations will be reduced from 2 to 1 for each of these Code sections. The Report will be revised to reflect these changes.

- § 38.2-3443 C of the Code was enacted effective 07/01/2011. Since only 1 school renewed with policy AH-12001 and the renewal was effective 07/01/2011, the violations will be reduced from 2 to 1 for this Code section. The Report will be revised to reflect this change.

In regards to § 38.2-3431 B of the Code, the Bureau determined that Starr Indemnity's description in Section 8 of policy AH-12001, did not fully describe creditable coverage as set forth in this Code section, and is therefore, not in compliance. Starr Indemnity indicated it is willing to provide further documentation. Until that documentation is provided for the Bureau's consideration, the violation will remain in the Report.

The Bureau acknowledges Starr Indemnity's efforts to implement an underwriting audit function to ensure that forms and rates have been filed prior to issue. The Bureau would note that any change to a filed and approved form that is generally outside of any variability identified, and any change to a form number or logo, requires that the form be filed and approved prior to use.

d. Application Forms

Starr Indemnity asserts that the form in question was inherited from another insurer and that the master group application contained the logo of the prior insurer. Sections 38.2-316 B and C of the Code prohibit any application form from being used with a policy or contract, unless the form of such application has been filed with and approved by the Commission. Since Starr Indemnity accepted the risk associated with this group, the Company was also responsible for ensuring that all forms issued to this group be filed with and approved by the Commission prior to issue. The master group application form was signed June 1, 2012, and the policy was issued August 1, 2012. Starr Indemnity failed to file the application form with the Commission as required. The violation will remain in the Report.

In response to the examiners' findings, Francesca Lulgjuraj provided the examiners with various documents for review. The document titled, *Underwriting Directives 9-4-14*, indicates in the first bullet-point that Starr Indemnity prefers to use its own application form, but would accept any other application as long as it contained the same or similar information. While this directive is dated after the examination time frame, it appears,

based on practice, that it was part of Starr Indemnity's procedures during the examination time frame. The Bureau encourages Starr Indemnity to revisit and revise that directive.

4. Agents

e. Other Agent Review

With regard to the automated processes that apply to MGAs, Starr Indemnity indicated that its standard agreement with the MGAs hold the MGA responsible for maintaining licenses. Starr Indemnity is responsible for complying with Virginia's statutes and regulation, even if the insurer delegates certain functions to third parties.

5. Underwriting Review

Starr Indemnity may provide additional documentation for consideration prior to finalization of the Report. However, Ms. Lulgjuraj previously provided various underwriting documents that appear to be effective after the examination time frame. Unless Starr Indemnity can provide procedures that were in effect during the examination time frame, the Report appears correct as written. Starr Indemnity will have 120 days from the date of finalization of this Report to provide evidence of corrective actions taken to bring its operations into compliance with Virginia law.

7. Cancellations/Non-Renewals

Upon further review, the violations of § 38.2-3532.3 G 1 of the Code have been removed from the Report.

8. Claim Practices

Your letter indicates that Starr Indemnity is unclear as to why responses to CL32 and CL95 were not provided and asked for an opportunity to provide documentation. As a point of clarification, Starr Indemnity did respond to both review sheets during the course of the exam, but the Company did not provide any additional documentation to support its position. Subsequent to receipt of your December 21st letter, Ms. Lulgjuraj provided additional documentation related to CL32. The additional documentation has been reviewed and the violations of 14 VAC 5-400-50 A, 14 VAC 5-400-60 A and 14 VAC 5-400-60 B associated with Review Sheet CL32 have been removed from the Report. However, the examiners' review revealed that interest was still due and not paid as required; therefore, the violation of §38.2-3407.1 of the Code associated with Review Sheet CL32 will remain in the Report.

The additional information that Starr Indemnity provided in response to CL95 appears to pertain to the claim discussed in CL44. The additional documentation has been reviewed and the violation of 14 VAC 5-400-70 D and the 1 instance of non-compliance with the policy discussed in Review Sheet CL44 have been removed from the Report. The violation of 14 VAC 5-400-50 A will remain as Starr Indemnity failed to acknowledge receipt of notification of the claim within 10 working days. The violation of 14 VAC 5-400-70 B will also remain as the claim was denied pending receipt of a Prior Treatment Questionnaire, which was not a reasonable denial in that this individual was 18 and Starr Indemnity was prohibited by §38.2-3444 A of the Code from denying this claim had a pre-existing condition been identified. A revised copy of the Report is attached for your review.

9. Internal Appeal and External Review

Starr Indemnity asserts that the Company is in compliance with 14 VAC5-216-30 B in that the Explanation of Benefits directs the insured to the Brochure for additional information about the appeals process. 14 VAC5-216-30 B requires that as part of any adverse benefit determination, each health carrier shall provide notice of its available internal appeals procedures, including time frames for submission of an appeal, the health carrier's review and response, contact information for the person or organizational unit designated to coordinate the review of the appeal for the health carrier, and contact information for the Bureau of Insurance. In this instance, the Explanation of Benefits is the adverse benefit determination, and Starr Indemnity failed to include the information required by this section. While the Brochure referenced in the Explanation of Benefits provides some additional information regarding the appeals process, it fails to include all of the information required by this section. As such, the violation will remain in the Report.

A copy of the revised Report is attached, and incorporates the only substantive revisions the examiners plan to make before it becomes final. Starr Indemnity will be required to complete the Corrective Action Plan within 120 days of this Report being finalized.

On the basis of our review of the entire file, it appears that Starr Indemnity has violated the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and §§ 38.2-503 and 514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-305 B, 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-606, 38.2-1318 C, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3405 A, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B,

38.2-3407.6:1 A, 38.2-3415, 38.2-3431 B, 38.2-3439, 38.2-3440 A, 38.2-3440 B, 38.2-3442, 38.2-3442 A 2, 38.2-3442 A 3, , 38.2-3443 C, 38.2-3444 A, 38.2-3445, 38.2-3525 E, 38.2-3527, 38.2-3529, 38.2-3534, 38.2-3536 B, and 38.2-3537 of the Code; as well as 14 VAC 5-90-60 B 1, 14 VAC 5-90-70, 14 VAC 5-90-130 A, and 14 VAC 5-90-170 A, Rules Governing Advertisement of Accident and Sickness Insurance; 14 VAC 5-216-30 B, Rules Governing Internal Appeal and External Review; and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D, Rules Governing Unfair Claims Settlement Practices.

Violations of the above sections of the Code can subject Starr Indemnity to monetary penalties of up to $5,000 for each violation and the suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter.

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health
804-371-9385

cc: Bob Grissom

STARR
COMPANIES
GLOBAL INSURANCE & INVESTMENTS

Francesca Lulgjuraj
Assistant General Counsel and
Compliance Director
Starr Insurance Holdings, Inc.
399 Park Avenue
8th Floor
New York, NY 10022

August 30, 2017

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Division
Virginia Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

RE: Market Conduct Examination Report Draft and Correspondence

Dear Ms. Fairbanks:

This letter is in response to your letter and draft examination report addressed to Jeffrey Herman, former Vice President and Head of Global Accident & Health for Starr Indemnity & Liability Company ("Starr Indemnity") regarding the Market Conduct Examination of Starr Indemnity for the period of July 1, 2010, through June 30, 2013.

We have reviewed the draft report and compared it with the prior version of the examination report to which we provided prior comments. We appreciate the adjustments that have been made to the report.

We have included certain areas of the report for which we disagree, and have followed each of those items with Starr Indemnity's response for your consideration. In addition, with regard to the suggested corrective action, Starr Indemnity would like to limit the scope of the corrective action and has provided information below and as attached for your consideration of these requests:

1. § 38.2-3439

The Department asserts that § 38.2-3439 was violated on one occasion and this violation will be reflected in the exam report. In the revised report, the DOI states: "Additionally, the policies failed to include provisions required by Virginia statute and contained subrogation provisions not permitted in Virginia. The applicable Code sections and the number of violations are listed in the chart below." The chart contains, among other provisions, § 38.2-3439. Neither the letter nor the revised report specify which subsection of § 38.2-3439 was allegedly violated.

The title of § 38.2-3439 is: "Dependent coverage for individuals to age 26," and subsection A reads: "Notwithstanding any provision of § 38.2-3500 or 38.2-3525, or any other section of this title to the contrary, a health carrier that makes available dependent coverage for a child shall make that coverage available for a child until such child attains the age of 26."

Based on these statutory provisions, it is Starr Indemnity's position that § 38.2-3439 does not apply to the student health plans that Starr Indemnity wrote in Virginia because this statutory provision applies to dependent children. The student health plans were issued to educational institutions with students as the certificate holders. The students therefore were not covered because they qualified dependent children of covered individuals. Rather, the students themselves were the covered individuals because of the nature of the insurance.

Because § 38.2-3439 is not relevant to these student health plans, we respectfully request that this alleged violation be removed.

2. Underwriting Review

Attached please find the underwriting guidelines that were in effect during the examination time frame for Starr Indemnity. Starr Indemnity respectfully requests the Department reconsider its position regarding the unfair or discriminatory practices section.

3. Insurance Information and Privacy Protection Act.

While Starr Indemnity agrees the form does not disclose of the individual or the individual's representative of his/her rights to review the authorization, Starr believes it has a robust set of procedures for protecting sensitive and personal information.

As noted in our prior correspondence to the Department, Starr Indemnity benefits from a multi-faceted compliance program that includes (i) wide-ranging policies and procedures covering the code of business ethics and conduct, anti-bribery and anti-corruption, anti-money laundering, data privacy and security, insider trading, social media, records retention and other topics; (ii) required on-line compliance training classes offered on a quarterly basis providing employees with practical examples of the various compliance policies and procedures at work and offering employees an opportunity to review the policies and keep current with any new developments as a result of changes in applicable law and/or regulation; and (iii) the Starr Hotline Program, which is a dual, telephone and on-line reporting mechanism enabling employees to anonymously report suspected violations of law or internal company policies and procedures.

The compliance program is managed by its Compliance Director who works in and is physically located within the Office of the General Counsel. Certain employees have been identified to assume compliance responsibilities for the various offices, and these employees ultimately report to the Compliance Director. The compliance program establishes and maintains a culture of compliance which transcends all business operations and processes. To meet this objective, required practices and obligations are clearly communicated to all employees, including senior management. Senior management plays an active role, in tandem with the compliance function, of ensuring that employees, directly and indirect reporting to senior managers, complete their job functions in accordance with Starr Indemnity's compliance standards. All new employees are provided with and are required to acknowledge the code of business ethics and conduct, which references and includes the other compliance policies and all existing employees are required to re-acknowledge the code of business ethics and conduct and other compliance policies annually.

One of the cornerstones of the Starr Indemnity's compliance and ethics program is its on-line compliance training program. Every employee in every office—including international locations—is required to take an on-line compliance training course quarterly. These courses, offered by a premier vendor, take up to 45 minutes to complete and include multiple choice examinations.

The on-line training program is supplemented by the Starr Hotline Program. This dual, telephone and on-line, reporting mechanism enables employees to anonymously report suspected violations of law or internal policies. In addition, if an employee encounters a situation in which he/she believes the internal principles of compliance and integrity are being compromised, all employees are encouraged to discuss those concerns with his/her supervisor, the head of the department or a Human Resources representative.

Both the Starr Hotline Program and the on-line compliance training program are in addition to the Starr Indemnity's formal compliance policies. The Starr Indemnity has distributed to all employees and posted on its intranet compliance policies on the following topics:

1. Information Systems Security Policy
2. Privacy Guide
3. Bring Your Own Device Policy
4. Records Retention Policy
5. Policy on Prevention of Insider Trading
6. Anti-Corruption Policy
7. OFAC Policy
8. Anti-Money Laundering Policy
9. Social Media Policy

In addition, the Third Party Agent training referenced in the above section contains guidance regarding the handling of information. Lastly, the agency agreements for MGAs and TPAs Third Party Agents have been updated to include robust privacy and information security protections to provide further guidance on our requirements for the handling of personal, privileged information or other sensitive information.

4. Corrective Action.

a. Advertising

As previously noted, Starr Indemnity has undertaken to enhance its procedures with regard to advertising and marketing by revising its guidelines for marketing, which require that any and all advertising, whether it be from a Managing General Agent or otherwise, be reviewed by the legal department to ensure compliance with state regulations.

Further, Starr Indemnity has implemented a records retention policy and retention schedule. These requirements are emphasized in the revised guidelines.

Attached please find the relevant documentation demonstrating the above have been addressed. Starr Indemnity therefore requests that this corrective action be noted as already completed or be removed from the examination report.

b. Filed and approved forms

As previously noted, Starr Indemnity has implemented an underwriting audit function, which is responsible for ensuring policies are issued utilizing filed forms and rates. In addition, as previously noted, Starr Indemniy does not currently offer sickness policies in Virginia, and instead focuses on accident policies. Starr Indemnity

therefore requests that this corrective action be noted as already completed or be removed from the examination report.

c. Agent appointments

As previously noted in our prior correspondence, Starr Indemnity implemented a robust set of protocols to effectively manage the producer appointment process. As of 2012, Starr Indemnity began utilizing software that maintains and supports the updating and adding or removing of producers to more efficiently manage compliance with producer licensing requirements.

The software receives a data feed from the National Insurance Producer Registry ("NIPR"), a public-private partnership that facilitates the producer-licensing process. Therefore, Starr Indemnity can ensure that the information maintained in the software is accurate and up-to-date.

The process begins with a submission received from a common relationship manager software ("CRM") licensed by Starr Indemnity, which maintains internal records for all producers. When the submission is received, the Starr Underwriting Services Technician searches the CRM by the producer name, producer number or other identifier to determine whether the producer can be found in the software.

Assuming the producer is in Starr Indemnity's producer-licensing database, the producer's license is checked against the risk state by using the feed from the software. If the producer holds a valid license for that state, the clearance process proceeds. If the producer does not hold a valid license, the CRM automatically blocks the submission from continuing and additional steps are needed.

Because Starr Indemnity is required to pay annual appointment fees to state insurance authorities for each producer appointed to represent the company in a given state, the procedure addresses this requirement as well. The Starr Underwriting Services Department processes all state producer appointments and terminations through the software except those for:

- The Commonwealth of Massachusetts, which prohibits the use of NIPR partners and requires all such actions to be processed through their state website; and
- Florida appointments or terminations for producers who are Florida residents, which must be processed through Florida's state system. Non-resident Florida appointments may be processed through Starr Indemnity's producer-licensing software.

The Starr Underwriting Services Division reviews invoices for producer appointment fees against producer information in Starr Indemnity's producer-licensing software and CRM in order to:

- Ensure that the producer-licensing software records are consistent with producer records from all 50 states; and
- Terminate inactive producers and eliminate state appointment fees associated with inactive producers.

Starr Indemnity believes this automated process combined with reliable and accurate data received from NIPR, is an effective control to ensure we are appointing licensed producers in all states. The effectiveness of the Producer Management Procedures and Controls are reviewed and updated periodically on an as needed basis.

Starr Indemnity is able to confirm the set of protocols summarized in the above section allow Starr Indemnity to effectively ensure appointments are made on a timely basis.

Starr Indemnity is able to confirm the set of protocols summarized in the above section allow Starr Indemnity to effectively ensure no commissions are paid to agents or agencies that are not appointed.

d. Claim Files Review

As previously noted, Starr Indemnity does not currently offer sickness policies in Virginia, and instead focuses on accident policies.

In addition and as previously noted, Starr Indemnity has terminated its relationship with its former TPAs, GBG and MCA, subsequent to the examination period.

The suggested corrective action appears to be quite broad in scope. Even assuming the corrective action is limited to accident and health claims, Starr Indemnity would need to review and re-evaluate hundreds of claims, which would take considerable time and effort. Because Starr Indemnity has terminated its relationship with its former TPAs, it not likely these entities would be fully cooperative with such a request from Starr.

As indicated by our prior responses and information provided, Starr Indemnity has already remediated and addressed the various items raised by the examination review. Also, because Starr Indemnity does not offer sickness policies in Virginia, there is no ongoing concern.

Lastly, as the examination period covered 2010-2013, should Starr Indemnity ultimately agree to such a review, Starr Indemnity would request the review be limited to that period and that it would be permitted an extended period to review these claims and make appropriate determinations.

e. Explanation of Benefits

Starr Indemnity no longer offers sickness coverage in Virginia, which would appear to exempt Starr Indemnity from the requirement of issuing Explanation of Benefit forms.

Lastly, Starr Indemnity would like to note it has terminated its relationship with its former TPA, GBG, subsequent to the examination period.

Starr Indemnity therefore respectfully requests that the corrective action raised in the examination be waived in whole or in part.

If at any time you have any questions or would like to see any additional documentation, we would be happy to provide it to you.

Thank you very much for your time and consideration.

Sincerely,

Francesca Lulgjuraj
Assistant General Counsel and Compliance Director
Starr Insurance Holdings, Inc.

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

October 3, 2017

CERTIFIED MAIL 7015 1520 0003 0919 0096
RETURN RECEIPT REQUESTED

Francesca Lulgjuraj
Assistant General Counsel and Compliance Director
Starr Insurance Holdings, Inc.
399 Park Avenue, 8th Floor
New York, NY 10022

RE: Target Market Conduct Examination Report of Starr Indemnity & Liability Company

Dear Ms. Lulgjuraj:

The Bureau of Insurance (hereinafter referred to as "the Bureau") has completed its review of your August 30, 2017, response to the Target Market Conduct Examination Report of Starr Indemnity & Liability Company (hereinafter referred to as "Starr Indemnity"). Starr Indemnity expressed additional concerns regarding the writing of the Report and provided supporting documentation for consideration. The documentation provided was reviewed prior to drafting this response.

This letter addresses Starr Indemnity's concerns in the same order as presented in the August 30th response. Since Starr Indemnity's response will be attached to the final Report, this response does not address those issues where the Company indicated agreement.

1. § 38.2-3439

Starr Indemnity argues that §38.2-3439 of the Code does not apply to the student health plan that was issued in Virginia during the exam timeframe because the students themselves were the covered individuals. However, the student health plan that was issued in Virginia during the exam timeframe that was cited in the Report extended coverage to an eligible spouse and eligible dependent children of "any Class 1 Covered Person". The examiners reviewed several claims for dependent children of the Covered

Person during the course of the exam. Section 38.2-3439 of the Code requires a health carrier that makes available dependent coverage for a child to make such coverage available for a child until such child attains the age of 26. As such, it appears that § 38.2-3439 of the Code does apply to the student health policies that were issued in Virginia during the exam timeframe, and the violation will remain.

The examiners agree that the violation cited in the Report should specify that Starr Indemnity is in violation of § 38.2-3439 A of the Code and the Report has been revised accordingly.

2. Underwriting Review

The examiners acknowledge that Starr Indemnity has now provided the underwriting guidelines that were in effect during the exam timeframe. Since the underwriting guidelines were not made available during the examination process, the examiners were not able to perform a complete underwriting review and the Report will reflect such. However, the violation of § 38.2-1318 C of the Code cited in Review Sheet UN02 has been removed from the Report.

3. Insurance Information and Privacy Protection Act

Based on Starr Indemnity's response, it appears that the company agrees that its disclosure authorization form failed to advise the individual or the individual's authorized representative of the right to receive a copy of the authorization form, in violation of § 38.2-606 of the Code. Starr Indemnity's response, which includes a detailed explanation of its compliance program, will be included in the final Report. No changes to the Report are necessary.

4. Corrective Action

a. Advertising

The examiners reviewed the documentation provided and acknowledge that Starr Indemnity has satisfactorily completed items 1-3 of the Corrective Action Plan. Starr Indemnity's August 30th letter and this response will be made a part of the final Report; therefore, changes to the Report are not necessary.

b. Filed and approved forms

The examiners reviewed the documentation provided and acknowledge that Starr Indemnity has satisfactorily completed item 4 of the Corrective Action Plan. Starr

Indemnity's August 30th letter and this response will be made a part of the final Report; therefore, changes to the Report are not necessary.

c. Agent appointments

The examiners acknowledge the procedures that have been put into place subsequent to the examination timeframe to ensure that all agents selling Starr Indemnity's products in Virginia are properly licensed and appointed.

d. Claims Files Review

While the examiners understand that Starr Indemnity does not currently have any student health policies in force in Virginia, and is not currently offering student health coverage in Virginia, the examination revealed a number of instances where claims were processed incorrectly and monies may be owed to Starr Indemnity's insureds under the terms of their coverage. Therefore, the corrective action items pertaining to claims will remain in the Report. However, upon further consideration, the Report has been revised to limit corrective action plan items 10, 13 and 14 to claims processed under student health plans issued in Virginia that were in effect between 2011 and 2013. Interest violations were observed during the examiners' review of both accident claims and student health claims; therefore, the corrective action will remain. However, it has been revised to require review of student health claims paid under policies in effect between 2011 and 2013 and accident claims paid in 2014, 2015, 2016 and the current year.

e. Explanation of Benefits

Section 38.2-3407.4 of the Code applies to all accident and sickness insurance policies issued in the Commonwealth, and the examiners understand that Starr Indemnity continues to offer accident policies in Virginia. If Starr Indemnity sends a form to insureds that falls within the definition of an explanation of benefits set forth in § 38.2-3407.4 D of the Code, then that form would have to be filed with and approved by the Commission. No changes to the Report are necessary.

The termination of Starr Indemnity's relationship with its third party administrator does not relieve the Company of its contractual obligations. The exam revealed numerous violations of Virginia's statutes and regulations and corrective action is required. The Report has been revised to allow 180 days for Starr Indemnity to document compliance with the Corrective Action Plan

A copy of the revised Report is attached, and incorporates the only substantive revisions the examiners plan to make before it becomes final.

On the basis of our review of the entire file, it appears that Starr Indemnity has violated the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and §§ 38.2-503 and 514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-305 B, 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-606, 38.2-1318 C, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3405 A, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.6:1 A, 38.2-3415, 38.2-3431 B, 38.2-3439, 38.2-3440 A, 38.2-3440 B, 38.2-3442, 38.2-3442 A 2, 38.2-3442 A 3, 38.2-3443 C, 38.2-3444 A, 38.2-3445, 38.2-3525 E, 38.2-3527, 38.2-3529, 38.2-3534, 38.2-3536 B, and 38.2-3537 of the Code; as well as 14 VAC 5-90-60 B 1, 14 VAC 5-90-70, 14 VAC 5-90-130 A, and 14 VAC 5-90-170 A, Rules Governing Advertisement of Accident and Sickness Insurance; 14 VAC 5-216-30 B, Rules Governing Internal Appeal and External Review; and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D, Rules Governing Unfair Claims Settlement Practices.

In that no changes are necessary to the settlement offer, the Bureau requests that Starr Indemnity respond to Deputy Commissioner Blauvelt's July 20th letter within 20 days of the date of this letter.

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health
804-371-9385

cc: Bob Grissom

Francesca Lulgjuraj
Assistant General Counsel and Compliance Director, CCEP, CIPP/US, CIPP/E
Starr Indemnity and Liability Company
399 Park Avenue, 8th Floor
New York, NY 10022

Julie Blauvelt
Deputy Commissioner
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218

RE: Alleged violations of the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, §§ 38.2-503 and 38.2-514 B of the Code as well as §§ 38.2-305 B, 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-606, 38.2-1318 C, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3405 A, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.6:1 A, 38.2-3415, 38.2-3431 B, 38.2-3439 A, 38.2-3440 A, 38.2-3440 B, 38.2-3442, 38.2-3442 A 2, 38.2-3442 A 3, 38.2-3443 C, 38.2-3444 A, 38.2-3445, 38.2-3525 E, 38.2-3527, 38.2-3529, 38.2-3534, 38.2-3536 B, and 38.2-3537 of the Code; as well as 14 VAC 5-90-60 B 1, 14 VAC 5-90-70, 14 VAC 5-90-130 A, and 14 VAC 5-90-170 A, Rules Governing Advertisement of Accident and Sickness Insurance; 14 VAC 5-216-30 B, Rules Governing Internal Appeal and External Review; and 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D, Rules Governing Unfair Claims Settlement Practices.

Dear Ms. Blauvelt:

This will acknowledge receipt of your letter dated July 20, 2017, concerning the above-captioned matter.

Starr Indemnity wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $53,000, payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing and agrees to cease and desist from future violations of §§ 38.2-316 A, 38.2-316 B, 38.2 316 C 1, 38.2-1812 A, 38.2-1822 A, and 38.2-1833 A 1, and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2013.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,

Francesca Lulgjuraj
Company Representative

11/17/17
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, DECEMBER 4, 2017

171210025

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DOCUMENT CONTROL CENTER

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COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2017-00169

STARR INDEMNITY AND LIABILITY COMPANY,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Starr Indemnity and Liability Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), violated: § 38.2-305 B of the Code of Virginia ("Code") by failing to include the required notice in policy forms; §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C (1) of the Code by failing to comply with policy form filing requirements; § 38.2-502 (1) of the Code by misrepresenting the terms of the policy; § 38.2-503 of the Code by engaging in deceptive and misleading advertising practices; § 38.2-514 B of the Code by failing to make proper disclosure in the explanation of benefits; § 38.2-606 of the Code by utilizing a disclosure authorization form without the proper disclosures; § 38.2-1318 C of the Code by failing to provide convenient access to company records; § 38.2-1812 A of the Code by paying commissions to agents that are not properly licensed and appointed; § 38.2-1822 A of the Code by knowingly permitting a person to act as an agent without first obtaining a license in the manner and form prescribed by the Commission; § 38.2-1833 A (1) of the Code by failing to comply with agent appointment requirements; §§ 38.2-3405 A and 38.2-3405 B of the Code by including subrogation provisions in policy forms and by improperly allowing the subrogation of

a claims payment; § 38.2-3407.1 B of the Code by failing to comply with the requirement for the payment of interest on claim proceeds; § 38.2-3407.4 A of the Code by failing to file for approval its explanation of benefits forms prior to use; § 38.2-3407.4 B of the Code by failing to accurately and clearly set forth the benefits payable under the contract in the explanation of benefits; § 38.2-3407.6:1 A of the Code by failing to include the required notice of denial of benefits for certain prescription drugs prohibited in policy forms; § 38.2-3415 of the Code by issuing policy forms that include prohibited exclusions or reductions in benefits; § 38.2-3431 B of the Code by failing to include individual health insurance in the definition of creditable coverage in policy forms; § 38.2-3439 A of the Code by failing to make dependent coverage available for a child until such child attains the age of 26; §§ 38.2-3440 A and 38.2-3440 B of the Code by failing to comply with lifetime and annual limits requirements in policy forms; § 38.2-3442 of the Code by failing to include coverage for preventive services in policy forms; §§ 38.2-3442 A (2) and 38.2-3442 A (3) of the Code by failing to provide the required coverage for immunizations and preventive services; § 38.2-3443 C of the Code by failing to provide notice to a covered person of the terms and conditions of the plan related to the designation of a participating health care professional in policy forms; § 38.2-3444 A of the Code by failing to comply with preexisting condition exclusions requirements; § 38.2-3445 of the Code by failing to provide required coverage for emergency services in policy forms; § 38.2-3525 E of the Code by failing to include the eligibility requirement in policy forms; § 38.2-3527 of the Code by failing to include the grace period provision required in policy forms; § 38.2-3529 of the Code by failing to include the required entire contract provision in policy forms; § 38.2-3534 of the Code by failing to provide notice of claim provisions in policy forms; § 38.2-3536 B of the Code by failing to provide proof of loss provisions in policy forms; § 38.2-3537 of the Code by failing

to provide timing of payment of claims after receipt of proof of loss provisions in policy forms; 14 VAC 5-90-60 B (1), 14 VAC 5-90-70, 14 VAC 5-90-130 A, and 14 VAC 5-90-170 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertisement requirements; 14 VAC 5-216-30 B of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.*, by failing to comply with internal appeal and external review procedures approved by the Commission; and 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to properly handle claims with such frequency as to indicate a general business practice.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to Virginia the sum of Fifty-Three Thousand Dollars ($53,000) and waived its right to a hearing, agreed to the entry by the Commission of a cease and desist order, and agreed to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2013.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) The Defendant shall cease and desist from future violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C (1), 38.2-1812 A, 38.2-1822 A, and 38.2-1833 A (1) of the Code.

(3) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Francesca Lulgjuraj, Assistant General Counsel and Compliance Director, Starr Indemnity and Liability Company, 399 Park Ave, 8th Floor, New York, New York 10022; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie S. Blauvelt.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission