



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

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In the Matter of

AMERICAN MEDICAL AND LIFE  
INSURANCE COMPANY,

**STIPULATION**  
No. 2009-0256-S

Respondent.

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WHEREAS, American Medical and Life Insurance Company ("Respondent") is a domestic insurance company authorized to transact life, annuities and accident and health insurance business in this state pursuant to the provisions of the New York Insurance Law ("Insurance Law"); and

WHEREAS, after an investigation of Respondent's limited medical benefit group insurance programs, the New York State Insurance Department ("Department") has determined that Respondent violated certain provisions of the Insurance Law and/or Department Regulations; and

WHEREAS, Respondent has been advised and is aware of its right to notice and a hearing on said violations; and

WHEREAS, Respondent wishes to resolve the investigation and said violations by entering into a stipulation with the Department on the terms and conditions hereinafter set forth in lieu of proceeding with a formal hearing in this matter; NOW THEREFORE,

IT IS HEREBY STIPULATED AND AGREED, by and between Respondent and the Department, subject to the approval of the Superintendent of Insurance, as follows:

1. Respondent waives its right to further notice and a hearing in this matter and admits, for purposes of this proceeding, that in connection with the solicitation and sale of its group limited medical benefit policies in the State of New York, Respondent violated the Insurance Law and Department Regulations as follows:

- (a) Section 4235(c)(1)(K)(i) of the Insurance Law establishes minimum standards for associations that may be issued a group health insurance policy. Among other things, the association must be "organized and maintained in good faith for purposes principally

other than that of obtaining insurance.” In October, 2006, Respondent issued a master group health insurance policy to an association known as The National Congress of Employees (“NCE”) without conducting an adequate inquiry into whether NCE satisfied the criteria of Section 4235(c)(1)(K)(i). In fact, at the time the policy was issued, NCE did not meet the requirements of Section 4235(c)(1)(K)(i). From approximately October, 2006 to January, 2009, several thousand individuals were issued certificates under the NCE policy, in violation of Section 4235(c)(1)(K)(i).

(b) Pursuant to Section 3201(b)(1) of the Insurance Law, no health insurance policy form may be issued in this state unless it has been filed with and approved by the Superintendent. For its limited medical benefit group policies, Respondent obtained Department approval of a written application form that contained important disclosures about the limited coverage provided under the policy, which was to be completed by each individual who applied for coverage under the group policy. However, during the approximate period August, 2006 to January, 2009, Respondent enrolled thousands of individuals in the NCE and other limited benefit group policies through the internet and telephone without using the approved written application form, in violation of Section 3201(b)(1).

(c) Pursuant to Section 2102(a)(1) of the Insurance Law, no person may act as an insurance agent in this state without having authority to do so by virtue of a license issued and in force pursuant to the Insurance Law. In addition, pursuant to Section 2114(a)(3) of the Insurance Law, an insurer may not pay any commission or other compensation to any person for services in soliciting, negotiating or selling a health insurance contract in this state unless the person is a licensed accident and health insurance agent of the insurer. However, during the approximate period August, 2006 to January, 2009, Respondent permitted unlicensed individuals to solicit and sell insurance coverage under the NCE and other limited benefit group policies, and permitted such individuals to receive commissions for their services, in violation of Sections 2102(a)(1) and 2114(a)(3).

(d) Department Regulation No. 34 [11 NYCRR Part 215] establishes minimum standards for insurer advertising of accident and health insurance products in order to assure truthful and adequate disclosure of all material and relevant information to the insurance buying public. During the approximate period August, 2008 to present, Respondent, through its agent, Cinergy Health, Inc. (“Cinergy”), placed television advertisements of its limited medical benefit plans which the Department has found to be

misleading in several respects and violative of the following provisions of Department Regulation No. 34:

(i) Pursuant to Sections 215.6(a)(1) and 215.6(a)(2) of Department Regulation No. 34 [11 NYCRR §§ 215.6(a)(1) and 215.6(a)(2)], no advertisement shall use deceptive words or phrases that have the capacity, tendency or effect of misleading or deceiving purchasers as to the nature or extent of any policy benefit payable, or exaggerate any benefit beyond the terms of the policy. However, the television advertisement aired by Cinergy on behalf of Respondent stated that Respondent's insurance covers "doctors, hospitals, accidents, pregnancy, labs, diagnosis, emergencies and surgery" and that there are "no annual limits or deductibles for surgery," when in fact there were limitations on the coverage such as a limit of \$100 per visit for five doctor visits per year. By not indicating the significant limitations in the coverage, the advertisement created the misleading impression that Respondent's limited medical benefit plan actually offered major medical or comprehensive coverage, which it did not.

(ii) Pursuant to Section 215.6(a)(3) of Department Regulation No. 34 [11 NYCRR § 215.6(a)(3)], all words and phrases used in an advertisement to describe policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered. However, the television advertisement aired by Cinergy on behalf of Respondent stated that "Most Pre-Existing Conditions Are Accepted," without defining or describing "pre-existing condition," and without disclosing that the policy actually had a six-month waiting period for pre-existing conditions.

(iii) Pursuant to Section 215.5(c) of Department Regulation No. 34 [11 NYCRR § 215.5(c)] an advertisement should contain in a prominent place and style the expected benefit ratio for the policy. However, the television advertisement aired by Cinergy on behalf of the Respondent did not contain the expected benefit ratio.

(iv) Pursuant to Section 215.13(a) of Department Regulation No. 34 [11 NYCRR § 215.13(a)] an advertisement should clearly identify the insurer and not use a symbol or other device which without disclosing the name of the actual insurer would have the tendency to mislead or deceive the true identity of the insurer. The television advertisement aired by Cinergy on behalf of the Respondent prominently displayed the "Cinergy Health" logo and name throughout the duration of the advertisement, while the name of

Respondent is shown inconspicuously for only a few seconds.

(v) Pursuant to Sections 215.2(b) and 215.17(a) of Department Regulation No. 34 [11 NYCRR §§ 215.2(b) and 215.17(a)], an insurer is responsible for all advertisements and shall establish and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. However, Respondent failed to establish and maintain a system of control over the content of television advertisements aired by Cinergy on behalf of Respondent.

2. In consequence of the foregoing, Respondent consents to the imposition of a civil penalty in the sum of Seven Hundred Thousand Dollars (\$700,000.00), receipt of which is hereby acknowledged.

3. Respondent shall terminate all of its limited medical benefit policies issued and delivered in New York (other than dental) effective December 31, 2009. Respondent shall offer conversion to individual coverage to all affected New York resident certificate holders under the terminated group policies. Respondent shall also offer individual conversion to all affected non-resident certificated holders for whom similar and continuous coverage is not available. Respondent shall file and obtain all necessary regulatory approvals for the conversion policies within ninety (90) days from the date of approval of this Stipulation.

4. Respondent consents to the withdrawal, pursuant to Sections 3110 and 3202 of the Insurance Law, of all of its limited medical benefit insurance policy forms previously approved for use in this state (other than dental). Such withdrawal shall be effective ninety (90) days from the date of approval of this Stipulation. Respondent further agrees to withdraw all pending applications filed with the Department for approval of policy forms pertaining to limited medical benefit insurance (other than dental). This paragraph shall not apply to the policy forms for individual conversion policies referenced in the preceding paragraph 3.

5. Respondent shall immediately direct its marketing agencies to terminate all of its current television commercial advertising of its limited medical benefit insurance plans. Respondent shall take all further steps necessary to ensure that such advertising is completely terminated, both in and outside of the State of New York, within twenty (20) days from the date of approval of this Stipulation.

6. Respondent agrees to fully cooperate with the Department in resolving all consumer complaints received by the Department regarding Respondent's limited medical benefit insurance programs.

7. Respondent shall, within thirty (30) days from the date of approval of this Stipulation, retain independent outside counsel to conduct a comprehensive investigation and review of Respondent's compliance processes, procedures and internal controls. Such counsel shall prepare a written report of its findings, with specific recommendations regarding how Respondent can enhance its compliance processes,

procedures and internal controls, in order to improve oversight over Respondent's agents and third party administrators, and to prevent future violations of New York law in connection with the solicitation, sale and marketing of Respondent's insurance products. Such report shall be prepared within seventy-five (75) days from the date of approval of this Stipulation, and shall be presented to Respondent's Board of Directors ("Board") and to the Superintendent.

8. Respondent shall, within one hundred twenty (120) days from the date of approval of this Stipulation, prepare a Compliance Monitoring Plan ("Compliance Plan") establishing controls and procedures to ensure compliance with all applicable regulatory requirements. Respondent's Board shall monitor Respondent's implementation of and adherence to the Compliance Plan, and shall receive reports from Respondent's senior management no less than quarterly on the functioning of the Compliance Plan. Such quarterly reports shall be filed with the Superintendent and shall continue until the Board advises the Superintendent in writing that it is satisfied that Respondent's compliance function has achieved a satisfactory level.

9. Respondent acknowledges that this Stipulation, and any admission contained herein, may be used against it by the Department in this proceeding and any future proceeding by the Department if there is reason to believe the terms of the Stipulation have been violated by Respondent, or if the Department institutes disciplinary action against Respondent for any reason other than the acts considered in this investigation. Nothing in this Stipulation affects Respondent's right to take factual or legal positions in litigation or other legal proceedings in which the Department is not a party.

Dated: New York, New York  
7/20/2009

NEW YORK STATE INSURANCE DEPARTMENT

By: \_\_\_\_\_  
Jon G. Rothblatt  
Assistant Deputy Superintendent and Counsel

AMERICAN MEDICAL AND LIFE INSURANCE  
COMPANY

By: \_\_\_\_\_  
Name: MICHAEL A. JAMES  
Title: EXECUTIVE VICE PRESIDENT  
AND GENERAL COUNSEL

