



STATE OF NEW YORK INSURANCE DEPARTMENT
REPORT ON MARKET CONDUCT EXAMINATION
OF THE
AMERICAN PROGRESSIVE LIFE AND HEALTH INSURANCE COMPANY
OF NEW YORK

CONDITION:

DECEMBER 31, 2006

DATE OF REPORT:

APRIL 29, 2008

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OF THE
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OF NEW YORK
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EXAMINER:

CHONG KIM

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

David A. Paterson
Governor

James J. Wrynn
Acting Superintendent

January 5, 2010

Honorable James J. Wrynn
Acting Superintendent of Insurance
Albany, New York 12257

Sir:

In accordance with instructions contained in Appointment No. 30270, dated November 3, 2008 and annexed hereto, an examination has been made into the market conduct activities of American Progressive Life and Health Insurance Company of New York, hereinafter referred to as "the Company", at its home office located at 6 International Drive, Rye Brook, New York 10573.

Wherever "Department" appears in this report, it refers to the State of New York Insurance Department.

The report indicating the results of this examination is respectfully submitted.

1. EXECUTIVE SUMMARY

The material findings and violations contained in this report are summarized below:

- The Company violated Sections 3234(b)(7) and 3235(b)(6) of the New York Insurance Law by failing to include on its Explanation of Benefits forms (EOBs), for Long Term Care and Medicare Supplement claims, a description of the appeals process for the consumer to challenge a denial or rejection of a claim. (See item 4D of this report)
- The Company violated Sections 3234(b)(3) and 3235(b)(2) of the New York Insurance Law by failing to include in its (“EOBs”), for Long Term Care and Medicare Supplement claims, the identification of services for which the claims were made. (See item 4D of this report)
- The Company violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 and Section 51.6(b)(6) of Department Regulation No. 60 when it failed to maintain copies of required replacement forms in its policyholder files. (See item 4A of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2004 through December 31, 2006. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2006 but prior to the date of this report (i.e., the completion date of the examination).

The examination comprised a review of market conduct activities and utilized the National Association of Insurance Commissioners' Market Conduct Examiners Handbook or such other examination procedures, as deemed appropriate, in such review.

The examiner reviewed the corrective actions taken by the Company with respect to the market conduct violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 5 of this report.

This report on examination is confined to comments on matters which involve departure from laws, regulations or rules, or which require explanation or description.

3. DESCRIPTION OF THE COMPANY

A. History

The Company was incorporated under the laws of the State of New York as a for-profit health insurance company on September 22, 1945 under the name American Progressive Health Insurance Company of New York. It was licensed and commenced business on March 26, 1946. On January 25, 1979, its charter was amended to include the writing of life insurance and annuities. The Company's present name was adopted at that time.

The Company is a wholly owned subsidiary of American Exchange, a life and accident and health insurance company domiciled in Texas, which, in turn, is a wholly owned subsidiary of the Universal American Financial Corporation, a publicly traded corporation located in New York (Nasdaq ticker symbol UHCO).

B. Territory and Plan of Operation

The Company is authorized to write life insurance, annuities and accident and health insurance as defined in paragraphs 1, 2 and 3 of Section 1113(a) of the New York Insurance Law.

The Company is licensed to transact business in 23 states and the District of Columbia. In 2006, 67.4% of life premiums, 60.8% of annuity considerations and 69.3% of accident and health premiums were received from New York and 18.1% of life premiums, 37% of annuity considerations and 16.1% of accident and health premiums were received from Pennsylvania. 94.5% of the total premiums received in 2006 were derived from the sale of accident and health insurance products. Policies are written on a non-participating basis.

The Company primarily markets accident and health products on both an individual and group basis. The targeted population is the senior age group, ages 65 and over. Specifically, the primary health insurance products, (Medicare Supplement, Medicare Advantage and Medicare Part D), are offered to individual seniors who attain eligibility; i.e. when they are enrolled in Medicare Parts A & B.

The Company also sells whole life policies, with face amounts of less than \$35,000, and annuities. The whole life products are offered on a simplified issue basis and are targeted toward the senior market. Nonqualified and qualified annuity products are offered. The Company does not issue new life or annuity products to individuals over age 85.

The Company initially marketed its business to people living in rural areas. However, since the introduction of Today's Options Medicare Advantage Private Fee-for-Service Plan ("Medicare Advantage") in 2004, the Company expanded its marketing coverage to include metropolitan areas. While the Company originally limited its sales focus of Medicare Advantage to residents of New York and Pennsylvania, it has since broadened its target markets to include several other northeastern states, such as Maine, New Hampshire, and Vermont.

The Company's agency operations are conducted on a general agency basis, utilizing the services of both General and Independent Agents. The Company compensates the agents by using a percent of premium method, which includes commissions and overrides, on sales of traditional insurance products; and a per application fee for sales of its Medicare Advantage plans.

4. MARKET CONDUCT ACTIVITIES

The examiner reviewed various elements of the Company's market conduct activities affecting policyholders, claimants, and beneficiaries to determine compliance with applicable statutes and regulations and the operating rules of the Company.

A. Advertising and Sales Activities

1. Life Replacements

Department Regulation No. 60 states, in part:

“Section 51.6 Duties of Insurer

(b) Where a replacement has occurred or likely to occur, the insurer replacing the life insurance policy or annuity contract shall:...

(6) Where the required forms are received with the application and found to be in compliance with this Part, maintain copies of: any proposal, including the sales material used in the sale of the proposed life insurance policy or annuity contract; proof of receipt by the applicant of the "*IMPORTANT* Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts;" the signed and completed "Disclosure Statement;" and the notification of replacement to the insurer whose life insurance policy or annuity contract is to be replaced indexed by agent and broker, for six calendar years or until after the filing of the report on examination in which the transaction was subject to review by the appropriate insurance official of its state of domicile, whichever is later;

Section 243.2(b) of Department Regulation No. 152 states, in part:

“Except as otherwise required by law or regulation, an insurer shall maintain:

(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer... A policy record shall include...(iv) other information necessary for reconstructing the solicitation, rating, and underwriting of the contract.”

The examiner reviewed a sample of 25 New York incoming life replacement policies from a total population of 47 replacements processed during the examination period. The review revealed discrepancies with 14 policies. In some instances, the examiner found more than one discrepancy with a replacement. Specifically, the examiner noted the following:

- In 6 instances, the Company did not maintain either the Important Notice or the completed Disclosure Statement in the policy file.
- In 13 instances, the Company did not maintain:
 - A. The Authorization form, which is a form signed by the applicant, authorizing the replacing insurer to obtain information from the replaced insurer.
 - B. Replacement Notice Letter, which is a letter sent to the existing insurer requesting the release of pertinent information on the existing coverage.
 - C. Documentation from the replaced insurer to support the replaced contract values used in Parts B and C of the Disclosure Statement.

The Company violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 and Section 51.6(b)(6) of Department Regulation No. 60 by failing to maintain copies of the required replacement forms in its files.

The examiner recommends that the Company implement procedures requiring its agents to submit copies of all the information received from the replaced company in order for the Company to ascertain that the information in the Disclosure Statement is accurate and meets the requirements of Department Regulation No. 60 and Regulation No. 152.

B. Medicare Supplement Replacements

Where the sale of a Medicare Supplement insurance policy involves the replacement of an existing accident and health insurance policy, Section 52.22(g)(2) of Department Regulation No. 62 requires that the Company or its agents furnish an applicant with a “Notice to Applicant Regarding Replacement of Coverage of Accident and Health Insurance, HMO Coverage or Employer-Provided Health Benefit Arrangement” (“Notice”). Such Notice is to be signed by the applicant prior to issuance or delivery of the Medicare Supplement policy.

The examiner reviewed a sample of 60 Medicare Supplement replacement policies that were issued during the examination period. The examination review revealed that in 5 instances the agents did not complete the required Notice prior to issuing the policy.

The examiner recommends that the Company implement procedures to ensure that the required Notice, in compliance with Section 52.22(g)(2) of Department Regulation No. 62, is furnished to the applicant prior to the issuance of the policy.

C. Underwriting and Policy Forms

The examiner reviewed a sample of new underwriting files, both issued and declined, and the applicable policy forms.

Based upon the sample reviewed, no significant findings were noted.

D. Treatment of Policyholders

The examiner reviewed a sample of various types of claims, surrenders, changes and lapses. The examiner also reviewed the various controls involved, checked the accuracy of the computations and traced the accounting data to the books of account.

The examiner reviewed explanation of benefit forms (“EOBs”) used by the Company in the processing of its health claims. An EOB is an important link between the subscriber, provider and insurance company. It should clearly communicate to the subscriber and/or provider that the Company has processed a claim and how that claim was processed. It should correctly describe the service provided, charges submitted, the date the claim was received, the amount allowed for the specific services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers.

Sections 3234 and 3235 of the New York Insurance Law set forth minimum EOB requirements for claims arising under certain accident and health insurance policies, and claims arising under Medicare Supplement policies, respectively. Pursuant to Sections 3234 and 3235 of the New York Insurance Law, every insurer is required to provide the insured or subscriber with an EOB in response to the filing of any claim under a policy or certificate.

Section 3234(b) of the New York Insurance Law states, in part:

“The explanation of benefits form must include at least the following:

(3) an identification of the service for which the claim is made; and...

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.”

Section 3235(b) of the New York Insurance Law stipulates that an EOB must include at least the following:

“(2) a statement that the name and address of the provider of service, an identification of the service, the amount charged for the service, and the medicare approved amount are specified on the medicare explanation of benefits form to which the claim corresponds; and...

(6) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.”

The examiner reviewed a sample of 67 EOBs, 17 of which were issued for Long Term Care claims and 50 for Medicare Supplement claims. The review revealed that the EOBs:

- failed to provide an identification of the service for which the claim is made. Rather than identifying the specific service(s) for which the claim was submitted, it identifies the general category of care. This type of disclosure is inadequate as it denies the insured or subscriber information needed in order to establish whether an appeal or complaint is warranted or whether a fraudulent bill was submitted.
- failed to specify the consumer's right to file an appeal of a denial of benefits or rejection of a claim.

The Company violated Sections 3234(b)(3) and 3235(b)(2) of the New York Insurance Law by failing to include on the EOBs the identification of services for which the claim was made.

The Company violated Sections 3234(b)(7) and 3235(b)(6) of the New York Insurance Law by failing to include on the EOBs a description of the appeals process for the consumer to challenge a denial or rejection of a claim.

The examiner recommends that the Company provide notice and a description of the appeals process for all subscribers affected, and inform them that they can submit appeals and if appropriate, have the claims re-adjudicated.

5. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in the prior report on examination and the subsequent actions taken by the Company in response to each citation:

<u>Item</u>	<u>Description</u>
A	<p>The Company violated Section 51.6(b) of Department Regulation No. 60 by failing to maintain copies of sales proposals, and by failing to maintain proof of receipt by the applicant of the Important Notice Regarding Replacement.</p> <p>The Company implemented new procedures to assure that proper annuity sales and replacement documents are completed by the applicant and the agent on each annuity sales. The replacement documents are to be reviewed by the Company's Annuity Services department, with the agent and/or applicant where required, and that the documentation is properly retained in the policy files.</p>
B	<p>The Company violated Section 51.7(a)(1) of Department Regulation No. 60 by providing inaccurate, incomplete and misleading Disclosure Statements to prospective contractholders.</p> <p>The Company implemented new procedures to assure that proper annuity sales and replacement documents are completed by the applicant and the agent on each annuity sales. The replacement documents are to be reviewed by the Company's Annuity Services department, with the agent and/or applicant where required, and that the documentation is properly retained in the policy files.</p>
C	<p>The Company violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 by failing to maintain records necessary for reconstructing the solicitation, rating, and underwriting of replacement contracts, as well as other records.</p> <p>The Company implemented new procedures to assure that proper annuity sales and replacement documents are completed by the applicant and the agent on each annuity sales. The replacement documents are to be reviewed by the Company's Annuity Services department, with the agent and/or applicant where required, and that the documentation is properly retained in the policy files. However the examiner's review shows that the Company does not maintain all of the required replacement documents for Life sales – (See item 4A of this report).</p>
D	<p>The Company violated Section 3201(b)(1) by changing two policy and application forms, which had been approved by the Superintendent, without refileing the changed forms for approval.</p> <p>The Company ceased using the aforementioned application forms. Instead, the Company is using the original application forms while the amended forms are being reviewed by the Department.</p>

<u>Item</u>	<u>Description</u>
E	<p>The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to maintain a log of all consumer complaints.</p> <p>The Company has maintained a log of all consumer complaints.</p>
F	<p>The Company violated Section 52.22(h)(4)(i)(1) of Department Regulation No. 62 by failing to adequately implement procedures to assure that excessive Medicare Supplement insurance was not sold or issued, and by failing to establish auditable procedures for verifying compliance with the Regulation.</p> <p>As for the inter-company duplication, the Company has added a second reminder to policyholders whose applications indicate a replacement. The second notice is sent about 30 days after the replacement policy is issued. As for the intra-company duplication, the Company has revised its computer programs to check for any duplicate policies by using social security numbers, name, and date of birth.</p>
G	<p>The examiner recommends that the Company refund all premiums collected from policyholders who were sold duplicative Medicare Supplement coverage.</p> <p>As part of a remediation plan, the Company refunded the premiums for the duplicate coverage.</p>
H	<p>The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish and maintain a system of control over the content, form and method of dissemination of advertisements for its Medicare Supplement policies.</p> <p>The Company instituted new controls to ensure that its Compliance Department reviews and approves all Medicare Supplement advertising, and reminds all agents and agencies that only Company approved lead cards can be used in soliciting on behalf of the Company.</p>
I	<p>The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain a complete advertising file for its Medicare Supplement business.</p> <p>The Company revised its procedures to ensure that the advertising file contains all information required by Section 215.17(a) of Department Regulation No. 34.</p>

<u>ITEM</u>	<u>Description</u>
J	<p>The Company violated Section 52.22(b)(9) of Department Regulation No. 62 by failing to provide, prior to their use, copies of Medicare Supplement advertisements to the Superintendent for review.</p> <p>The Company revised its procedures to ensure that all Medicare Supplement advertising is submitted for the Superintendent's approval.</p>
K	<p>The Company violated Section 52.22(h)(4)(i)(2)(iii) of Regulation No. 62 by failing to disclose in cold lead advertisements in a conspicuous manner that the purpose of the method of marketing was the solicitation of Medicare Supplement insurance and that contact would be made by an insurance agent or insurance company.</p> <p>The Company informed all agents and agencies that only Company approved lead cards can be used in soliciting on behalf of the Company. In addition, the Company prohibits all agents from using cold lead advertisements.</p>
L	<p>The Company violated Section 52.22(g)(3) of Department Regulation No. 62 by failing to provide policyholders with the required Medicare Supplement replacement notice within 30 days of the date of the first premium due notice.</p> <p>The Company instituted a procedure to send policyholders the requisite replacement notice within 30 days after an issuance of a replacement policy in accordance with Section 52.22(g)(3) of Department Regulation No. 62.</p>
M	<p>The Company violated Section 4224 of the New York Insurance Law by making or permitting unfair discrimination between individuals of the same class, and giving an inducement to certain Medicare Supplement applicants by failing to collect or charge the applicable application fee in all instances.</p> <p>The Company revised its marketing procedures to be in compliance with Section 4224 of the New York Insurance.</p>

6. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The Company violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 and Section 51.6(b)(6) of Department Regulation No. 60 by failing to maintain copies of required replacement forms.	7
B	The examiner recommends that the Company implement procedures to require its agents to submit copies of all the information received from the replaced company in order for the Company to ascertain that the information in the Disclosure Statement is accurate and meet the requirement of Department Regulation No. 152.	7
C	The examiner recommends that the Company implement procedures to ensure that the required Notice, in compliance with Section 52.22(g)(2) of Department Regulation No. 62, is furnished to the applicant prior to the issuance of the policy.	7
D	The Company violated Section 3234(b)(3) and 3235(b)(2) of the New York Insurance Law by failing to include on the EOBs issued for Long Term Care and Medicare Supplement claims, the identification of service for which the claims were made.	9
E	The Company violated Sections 3234(b)(7) and 3235(b)(6) of the New York Insurance Law by failing to include on the EOBs issued for Long Term Care and Medicare Supplement claims a description of the appeals process for the consumer to challenge a denial or rejection of a claim	9
F	The examiner recommends that the Company provide notice and a description of the appeals process for all subscribers affected, and inform them that they can submit appeals and if appropriate, have the claims re-adjudicated	9

Respectfully submitted,

_____/s/_____
Chong Kim
Senior Insurance Examiner

STATE OF NEW YORK)
)SS:
COUNTY OF NEW YORK)

Chong Kim, being duly sworn, deposes and says that the foregoing report, subscribed by him, is true to the best of his knowledge and belief.

_____/s/_____
Chong Kim

Subscribed and sworn to before me
this _____ day of _____

APPOINTMENT NO. 30270

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ERIC R. DINALLO, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

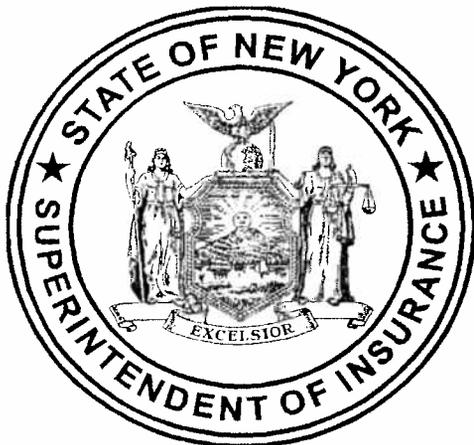
CHONG KIM

as a proper person to examine into the affairs of the
AMERICAN PROGRESSIVE LIFE & HEALTH INSURANCE COMPANY OF NEW YORK
and to make a report to me in writing of the condition of the said
COMPANY

with such other information as he shall deem requisite.

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

this 3rd day of November, 2008



ERIC R. DINALLO
Superintendent of Insurance

Eric Dinallo
Superintendent