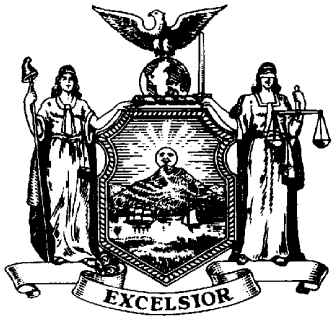

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON MARKET CONDUCT CONDITION EXAMINATION

OF THE

AMERICAN PROGRESSIVE LIFE AND HEALTH INSURANCE COMPANY

OF NEW YORK

CONDITION: DECEMBER 31, 2009

DATE OF REPORT: JUNE 7, 2011

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EXAMINER: PAUL E. ELLIS, CFE

TABLE OF CONTENTS

December 7, 2011

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
New York, New York 10004

Sir:

In accordance with instructions contained in Appointment No. 30538, dated May 27, 2010 and annexed hereto, an examination has been made into the condition and affairs of the 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 New York State Department of Financial Services.

On October 3, 2011, the Insurance Department merged with the Banking Department to create the New York State Department of Financial Services.

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 Section 4226(a)(1) of the New York Insurance Law by using an advertisement that made it appear that an applicant would obtain coverage if an information card is returned within 5 days when in fact an underwriting approval process was required. (See Section 4 A of this report)
- The Company violated Section 219.4(k) of Department Regulation No. 34-A by listing a graded death benefit policy on advertisements that failed to include a statement that benefit payments, during the first three years of the policy, will be less than the policy's face amount. (See Section 4 A of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2007 through December 31, 2009. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2009 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 Regulation 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 COMPANY

A. History

The Company was incorporated as a stock health insurance company under the laws of the State of New York 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.

Initial resources of $151,800, consisting of common capital stock of $101,200 and paid in and contributed surplus of $50,600, were provided through the sale of 1,012 shares of common stock (with a par value of $100 each) for $150 per share. As of December 31, 2009, authorized capital was $2,500,050, consisting of 16,667 shares of common stock with a par value of $150 per share. In 2007, the Company received a surplus contribution of $44,000,000 from its parent, American Exchange Life Insurance Company ("American Exchange"). At December 31, 2009 capital and surplus was $129,460,874.

On December 31, 1998 Universal American Financial Corporation ("UAFC") executed a Share Purchase Agreement with Capital Z Financial Services Fund II (Capital Z) whereby Capital Z invested approximately $81 million and acquired approximately a 59.7% controlling interest in American Exchange. Subsequently on July 30, 1999, American Exchange completed an acquisition of various subsidiaries of the former PennCorp Financial Group, Inc., an insurance holding company by utilizing the proceeds from the Capital Z transaction. The following six insurers, collectively referred to as "PennUnion", were acquired: Pennsylvania Life Insurance Company ("PLIC"), Constitution Life Insurance Company, Union Bankers Insurance Company, Marquette National Life Insurance Company, PennCorp Life Insurance Company (Canada), and Peninsular Life Insurance Company. As of December 31, 2006, Capital Z's interest in UAFC was 34.2%; the remainder was owned by individual shareholders.

In 2007, UAFC acquired MemberHealth, LLC ("MemberHealth") a privately held pharmacy benefit manager and sponsor of Community Care Rx, a national Medicare Part D plan with more than 1.1 million members. MemberHealth offers Medicare prescription drug plans in 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. At the time of acquisition MemberHealth was operating its Medicare Part D business under a waiver from the

Centers for Medicare and Medicaid Services ("CMS") and, as a result, was not licensed in any state. In connection with the acquisition, MemberHealth transferred its New York business to the Company, and business in all other states transferred to PLIC, a subsidiary who also provides Medicare Part D. The Department approved the MemberHealth's transfer of New York business to the Company in September, 2007.

On December 3, 2007 Universal American Financial Corporation changed its name to Universal American Corporation ("Universal American").

Subsequent to the examination date, effective February 26, 2010, ownership of the Company was transferred to UAC Holdings, Inc. an affiliate, and American Exchange was dissolved per approval of the Texas Department of Insurance. Note that the organization chart does not reflect this transaction since UAC Holdings, Inc. was not capitalized and American Exchange was not dissolved until after December 31, 2009.

During the second quarters of 2010 and 2011, the Company paid ordinary dividends to its parent UAC Holdings, Inc. of $12 and $13.3 million, respectively.

On December 31, 2010, it was announced that Universal American and CVS Caremark Corporation had entered into a definitive agreement under which CVS Caremark would acquire 100% of the outstanding stock of Universal American and its Medicare Prescription Drug business ("Medicare Part D") and concurrently distribute to Universal American shareholders 100% of the shares of a newly formed public company which will own all other operations of Universal American, including its Medicare Advantage and traditional insurance business.

On March 2, 2011, it was announced that the U.S. Federal Trade Commission granted antitrust approval for the sale of the Medicare Part D prescription drug business of Universal American Corp to CVS Caremark for approximately $1.25 billion.

On April 29, 2011, this transaction was executed and closed.

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 2009, 68.7% of life premiums, 85.3% of annuity considerations and 68.3% of accident and

health premiums were received from New York and 16.1% of life premiums and 16.8% of accident and health premiums were received from Pennsylvania**.**

C. Direct Operations

The Company's principal lines of business during the examination period were Medicare Advantage and Medicare Part D (reported as other accident and health business), and individual life insurance. Medicare Advantage and Medicare Part D (97.8%) and individual life (1.9%) represented 99.7% of net premium received in 2009. Policies are written on a non participating basis.

The Company's Medicare Advantage products are marketed under Preferred Provider Organization ("PPO") plans and Private Fee For Service ("PFFS") plans. The PPO plans are under contract with CMS and provide basic Medicare covered benefits with reduced member cost sharing as well as additional supplemental benefits, including defined prescription drug benefits. The PPO plans are built around contracted networks of providers. The PFFS plans are also offered under contract with CMS and provide enhanced health care benefits, compared to traditional Medicare, subject to cost sharing and other limitations. The PFFS plans have limited provider network restrictions which allow the members to have more flexibility in the delivery of their health care services than other Medicare Advantage plans with limited provider network restrictions. As a result of the passage of the 2008 Medicare Improvements for Patients and Providers Act, effective January 1, 2011, the Company will continue to offer PFFS products only in areas that have either met approved CMS network access requirements or are in certain designated rural areas.

The Company also markets Medicare supplement insurance plans.

The Company markets small benefit life insurance products to the senior market segment. The life insurance product is simplified issue whole life, low face value. The Company coinsured 100% of the net in-force life and annuity business with First Allmerica Financial Life Insurance Company ("FAFLIC") in April 2009.

The Company distributes Medicare Advantage and Medicare Part D products through a career agency system, independent agents, direct sales and telemarketing. The life insurance products are distributed through career agents and independent agents. The Company

compensates agents using a percentage of premium method for sales of traditional insurance products and on a per application fee basis 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

The examiner reviewed all of the Company's advertising files and the sales activities of the agency force including trade practices, solicitation and the replacement of insurance policies.

Section 4226(a) of the New York Insurance Law states, in part:

> "No insurer authorized to do in this state the business of life, or accident and health insurance, or to make annuity contracts shall:
> (1) issue or circulate, or cause or permit to be issued or circulated on its behalf, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts . . ."

The examiner reviewed the Company's advertising files. The examiner found three advertisements which contained wording inferring that if an applicant completes an information card and returns it to the Company within five days, the applicant would qualify for insurance regardless of the applicant's health condition. However, coverage under the policy was not automatic and the applicant was required to pass an approval process prior to the issuance of a policy.

The Company violated Section 4226(a)(1) of the New York Insurance Law by using an advertisement that made it appear that an applicant would obtain coverage if an information card was returned within five days when in fact an underwriting approval process was required.

Department Regulation No. 34-A states, in part:

> "Section 219.4. Form, content and disclosure requirements of advertisements.
> (k) Any limitations in the policy which would reduce or eliminate the payment of the face or stated amount should be clearly stated, together with the amount of, or formula for, determining any reduced payment. The return of premium, with or without interest, in lieu of the face amount, shall be designated as a limited benefit and be clearly described."

Eight of the advertisements reviewed were for policies with graded death benefits. However, the Company failed to disclose in such advertisements that benefit payments during the first three years of the policy would be less than the face amount of the policy.

The Company violated Section 219.4(k) of Department Regulation No. 34-A by listing a graded death benefit policy on advertisements that failed to include a statement that benefit payments, during the first three years of the policy, will be less than the policy's face amount.

B. 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 samples reviewed, the following findings were noted:

Section 86.4(a) of Department Regulation No. 95 states, in part:

> " . . . all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:
>
> 'Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.' . . .
>
> (e) Notwithstanding the provisions of subdivisions (a) . . . of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval. "

The examiner reviewed the fraud warning statements included on the Company's policy application forms, policy forms and claim forms in use during the examination period. The review found two claim forms that contained fraud warning statements that did not conform with, nor were they essentially similar to, the fraud warning statement language required by Section 86.4(a) of Department Regulation No. 95. The Company did not obtain prior approval from the Department's Frauds Bureau to use the fraud warning statements included on those forms.

The Company violated Section 86.4(a) of Department Regulation No. 95 by using a fraud warning statement which differed from the language prescribed in such Section and by failing to obtain prior approval for such language.

C. 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.

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

5. PRIOR REPORT SUMMARY AND CONCLUSIONS

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

Item	Description
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. The Company trained its New Business and Underwriting Departments that when replacement is indicated on an application all required forms must be present and maintained in the Company's file to ensure compliance with NYID Regulation 60 and NYID Regulation 152.
B	The Company violated Section 52.22(g)(2) of Department Regulation No. 62 by failing to complete the required "Notice to Applicant Regarding Replacement of Coverage of Accident and Health Insurance, HMO Coverage or Employer-Provided Health Benefit Arrangement", in some instances, prior to issuing Medicare Supplement policies. The Company trained its New Business and Underwriting Departments that when replacement is indicated on an application all required forms must be present and maintained in the Company's file to ensure compliance with NYID Regulation 62.
C	The Company violated Sections 3234(b)(3) and 3235(b)(2) of the New York Insurance Law by failing to include on the explanation of benefit forms ("EOBs") issued for Long Term Care and Medicare Supplement claims the identification of service for which the claims were made. The Company mailed letters to all Long Term Care and Medicare Supplement policyholders advising them that if they believed a claim was rejected or denied, in whole or in part, they have the right to appeal any such rejected or denied claim. Since July 1, 2009, the Company includes in its EOBs the identification of service for which claims are made.

Item	Description
D	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. The Company mailed letters to all Long Term Care policyholders advising them that if they believed a claim was rejected or denied, in whole or in part, they have the right to appeal any such rejected or denied claim. Since July 1, 2009, the Company includes in its EOBs, the identification of service for which claims are made and the proper appeal notification.

10. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

Item	Description	Page No(s).
A	The Company violated Section 4226(a) (1) of the New York Insurance Law by using an advertisement that made it appear that an applicant would obtain coverage if the information card is returned within 5 days when in fact an underwriting approval process was required.	8
B	The Company violated Section 219.4(k) of Department Regulation No. 34-A by listing a graded death benefit policy on advertisements that failed to include a statement that benefit payments, during the first three years of the policy, will be less than the policy's face amount.	9
C	The Company violated Section 86.4(a) of Department Regulation No. 95 by using a fraud warning statement which differed from the language prescribed in such Section and by failing to obtain prior approval for such language.	10

Respectfully submitted,

/s/
Paul E. Ellis, CFE
Examiner In-Charge

Noble Consulting Services, Inc.

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

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

/s/
Paul E. Ellis, CFE

Noble Consulting Services, Inc.

Subscribed and sworn to before me

this_____ day of _____

APPOINTMENT NO. 30729

STATE OF NEW YORK

INSURANCE DEPARTMENT

I, JAMES J. WRYNN, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

PAUL ELLIS

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 she 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 16th day of June, 2011

JAMES J. WRYNN
Superintendent of Insurance

Superintendent