



NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
MARKET CONDUCT REPORT ON EXAMINATION
OF THE
STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

CONDITION:

DECEMBER 31, 2017

DATE OF REPORT:

JUNE 15, 2018

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
MARKET CONDUCT REPORT ON EXAMINATION
OF THE
STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
AS OF
DECEMBER 31, 2017

DATE OF REPORT:

JUNE 15, 2018

EXAMINER:

JOCELYNE TURENE

TABLE OF CONTENTS

<u>ITEM</u>	<u>PAGE NO.</u>
1. Executive summary	2
2. Scope of examination	3
3. Description of Company	4
A. History	4
B. Holding company	4
C. Territory and plan of operations	4
4. Market conduct activities	7
A. Advertising and sales activities	7
B. Underwriting and policy forms	8
C. Treatment of policyholders	10
5. Data files	12
6. Prior report summary and conclusions	13
7. Summary and conclusions	15



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Linda T. Lacewell
Superintendent

July 28, 2020

The Honorable Linda T. Lacewell
Superintendent of Financial Services
New York, New York 10004

Madam:

In accordance with instructions contained in Appointment No. 31676, dated October 16, 2017, and annexed hereto, an examination has been made into the condition and affairs of Standard Security Life Insurance Company of New York, hereinafter referred to as “the Company,” at its home office located at 485 Madison Avenue, New York, NY 10022.

Wherever “Department” appears in this report, it refers to the New York State Department of Financial Services.

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

1. EXECUTIVE SUMMARY

The material violations and recommendation contained in this report are summarized below.

- The Company violated Section 3201(b)(1) of the New York Insurance Law by altering previously approved dental policy forms, by not filing the revised policy forms with the Department for approval, and by using policy forms of an affiliate to issue dental policies in New York. A similar violation was made in the prior report on examination. (See item 4B of this report.)
- The Company violated Section 3201(b)(1) of the New York Insurance Law by altering previously approved vision policy forms, by not filing the revised policy forms with the Department for approval, and by using a policy form with the incorrect policy form number. A similar violation was made in the prior report on examination. (See item 4B of this report.)
- The Company violated Sections 3204(a) and 3204(d) of the New York Insurance Law by selecting the APL as the nonforfeiture option without written consent, when the insured or policyowner had selected the reduced paid-up nonforfeiture option. (See item 4B of this report.)
- The Company violated Sections 3224-a(a) and 3224(b) of the New York Insurance Law by failing to pay dental claims within 45 days of receipt of the claim forms; by failing to provide policyholders, covered persons or healthcare providers with written notification within 30 days of the receipt of the claims, stating the specific reasons why it is not obligated to pay such claims; by failing to pay interest on dental claim payments paid after 45 days of receipt of the claims; by failing to pay a vision claim within 30 days of receipt of the electronic claim form. (See item 4C of this report.)
- The Company violated Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) by failing to make available, as requested by the examiner, the data records that support the annual statement exhibits in the format and substance required within a reasonable time frame. This data related matter was raised in the Company's prior two reports on examination. (See item 5 of this report.)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2013, to December 31, 2017. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2017, 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 Regulations 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 result of the examiner's review is contained in item 6 of this report.

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

3. DESCRIPTION OF COMPANY

A. History

The Company was incorporated as a stock life insurance company under the laws of the State of New York on June 28, 1957, under the name American Security Life Insurance Company of New York. It was licensed and commenced business on December 22, 1958. The present name was adopted in 1958. Initial resources of \$500,000, consisting of common capital stock of \$500,000, were provided through the sale of 250,000 shares of common stock (with a par value of \$2.00 each).

B. Holding Company

The Company is a wholly owned subsidiary of Independence Capital Corp. (“ICC”), a Delaware investment company, which in turn is a wholly owned subsidiary of Independence Holding Company (“IHC”), a Delaware publicly held holding company engaged principally in the life and health insurance business. The ultimate parent of the Company is Geneve Holdings, Inc., a Delaware holding company.

The Company was a wholly owned subsidiary of Madison National Life Insurance Company, Inc. (“MNL”), a Wisconsin life insurance company, until September 2011. To simplify the organizational structure within IHC, MNL paid a dividend of 100% of its common stock in the Company to its parent, ICC, effective September 30, 2011. Thus, the Company became a wholly owned subsidiary of ICC.

C. Territory and Plan of Operations

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 all states, the District of Columbia, and the U.S. territories of Puerto Rico and the U.S. Virgin Islands. In 2017, 22.5% of life premiums, 45.03% of annuity considerations, and 29.9% of accident and health premiums were received from New York. Policies are written on a non-participating basis.

The following tables show the percentage of direct premiums received, by state, and by major lines of business for the year 2017:

<u>Life Insurance Premiums</u>		<u>Accident and Health Insurance Premiums</u>	
Pennsylvania	52.3%	New York	29.9%
New York	22.5	Arizona	11.3
Indiana	<u>9.0</u>	California	7.6
		Texas	<u>7.4</u>
Subtotal	83.8%	Subtotal	56.2%
All others	<u>16.2</u>	All others	<u>43.8</u>
Total	<u>100.0%</u>	Total	<u>100.0%</u>

The Company's principle lines of business offered during the examination period were employer medical stop-loss insurance, a short-term statutory benefit product in New York State, commonly known as New York Disability Benefits Law ("DBL"), and specialty health insurance products, which consist of ancillary and supplemental products. The ancillary products included individual and group major medical, short-term major medical, dental, and vision insurance products; the supplemental products included fixed indemnity limited benefit, critical illness, and hospital indemnity. Additionally, the Company had existing in force business in several lines that is in run-off: individual accident and health, individual life, single premium immediate annuities, and miscellaneous insurance products.

The Company placed the major medical insurance business in run-off in 2015, and ceased writing new dental policies in November 2017. On July 31, 2015, the Company and its affiliate MNL, disposed of the in force individual life and annuity business to National Guardian Life Insurance Company through a coinsurance agreement. Also included in the transaction was the sale of the individual life and annuity operations, including all associated information systems and employees. Also, effective March 31, 2016, IHC sold all its membership interest in IHC Risk Solutions, LLC ("Risk Solutions") to Swiss Re Corporate Solutions, a division of Swiss Reinsurance Company Limited. Under the agreement, all the in force stop-loss business produced by the Company through Risk Solutions was coinsured by Swiss Re Corporate Solutions' U.S. carrier, Westport Insurance Corporation, effective January 1, 2016. As a result, the Company's medical stop-loss business is in run-off.

As of December 31, 2017, the Company's entire New York business is in run-off, except for the DBL and Vision business. Effective January 1, 2018, covered New York State employers are required to provide eligible employees with paid family leave ("PFL") coverage. The coverage is added as a rider to all existing DBL policies. As a carrier that writes DBL business, the Company is implementing the PFL coverage to its DBL policies.

The Company's agency operations are conducted on a general agency and brokerage basis.

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 a sample 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 2112(a) of the New York Insurance Law states, in part:

"Every insurer . . . doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents . . . to represent such insurer . . ."

Section 2114(a)(3) of the New York Insurance Law states, in part:

"No insurer . . . doing business in this state . . . shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating or selling in this state any new contract of accident or health insurance . . . except to a licensed accident and health insurance agent of such insurer . . . or to a licensed insurance broker of this state . . ."

The examiner reviewed 24 dental policy files, including the commission statements for the agents of record. The review revealed that IHC Specialty Benefits, Inc. received commission for a policy on July 5, 2013, before being appointed by the Company on September 23, 2014.

The examiner reviewed seven vision policy files, including the commission statements for the agents of record. The review revealed that one agent received commission for a policy on December 3, 2015, before being appointed by the Company on March 5, 2016, and another agent received commission for a policy on October 2, 2014, without being appointed by the Company.

The Company violated Section 2114(a)(3) of the New York Insurance Law by paying commissions to three agents before being appointed to represent the Company.

The Company violated Section 2112(a) of the New York Insurance Law by failing to file a certificate of appointment with the Superintendent to appoint one of its agents to represent the Company.

B. Underwriting and Policy Forms

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

Section 3201(a) of the New York Insurance Law states, in part:

“In this article, ‘policy form’ means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto, affording benefits of the kinds of insurance specified in paragraphs one, two, three or twenty-four of subsection (a) of section one thousand one hundred thirteen of this chapter . . .”

Section 3201(b)(1) of the New York Insurance Law states, in part:

“No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law. A group life, group accident, group health, group accident and health or blanket accident and health insurance certificate evidencing insurance coverage on a resident of this state shall be deemed to have been delivered in this state, regardless of the place of actual delivery . . .”

The examiner reviewed a sample of 24 dental policies issued by the Company during the examination period. The examiner compared the dental policy forms used by the Company to the dental policy forms approved by the Department, policy forms “SSL ADEN-MBR APP 0905 NY.a” and “SSL GDEN-EEAPP 0505 NY.a.” In 22 of the 24 issued policies (92%), the examiner noted that the application forms used by the Company had been altered by either having text inserted into or omitted from the application forms approved by the Department. Additionally, the Company used policy form “MNL AGDEN-MBR APP 0905 NY.a” to issue policy number DENDBII99001732 and policy form “MNL GDEN-SCH2 NY.a” to issue policy number MWD14821, both which are policy forms of MNL, an affiliate of the Company that is not licensed in New York. Any time changes are made to a previously approved form, the revised form is considered a new form and should be submitted to the Department for approval.

The Company violated Section 3201(b)(1) of the New York Insurance Law by altering previously approved dental policy forms, by not filing the revised policy forms with the Department for approval, and by using policy forms of an affiliate to issue dental policies in New York. A similar violation was made in the prior report on examination.

The examiner reviewed 19 vision policies issued by the Company during the examination period. The examiner compared the vision application forms used by the Company to the application forms approved by the Department, policy forms “SSL V06APP-EM” and “SSL GVIS-GRPAPP 1005 NY.a.” The examiner noted that the application forms used by the Company had been altered by either having text inserted into or omitted from the application forms approved by the Department. Additionally, the form number on policy form “SSL GVIS-GRPAPP 1005 NY.A” was incorrect. The Company did not submit the revised application forms to the Department for approval. A similar violation was made in the prior report on examination.

The Company violated Section 3201(b)(1) of the New York Insurance Law by altering previously approved vision policy forms, by not filing the revised policy forms with the Department for approval, and by using a policy form with the incorrect policy form number. A similar violation was made in the prior report on examination.

Section 3204(a) of the New York Insurance Law states, in part:

“(1) Every policy of life, accident or health insurance, or contract of annuity, delivered or issued for delivery in this state, shall contain the entire contract between the parties, and nothing shall be incorporated therein by reference to any writing, unless a copy thereof is endorsed upon or attached to the policy or contract when issued. . . .

(3) Such policy or contract cannot be modified, nor can any rights or requirements be waived, except in writing signed by a person specified by the insurer in such policy or contract.”

Section 3204(d) of the New York Insurance Law states, in part:

(d) No insertion in or other alteration of any written application for any such policy or contract shall be made by any person other than the applicant without his written consent . . .”

The examiner reviewed a sample of eleven policies with the automatic premium loan (“APL”) nonforfeiture option. The review revealed that in 7 of the 11 selected policies (64%), the application forms did not have the APL option box checked to indicate the insured’s or policyowner’s selection of this nonforfeiture option. The Company stated that when these policies were acquired, they were converted into its administrative system with the APL as the nonforfeiture option. The review of the policy files also revealed that the APL option for the seven policies should have been the reduced paid-up nonforfeiture option, the option selected by the applicant. Additionally, the Company could not provide any documentation to show if the insured

or policyowner changed the policy's nonforfeiture option before being converted in the Company's administrative system.

The Company violated Sections 3204(a) and 3204(d) of the New York Insurance Law by selecting the APL as the nonforfeiture option without written consent, when the insured or policyowner had selected the reduced paid-up nonforfeiture option.

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.

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

“. . . (a) Except in a case where the obligation of an insurer . . . to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer . . . shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt or bill for services rendered that is submitted by other means such as paper or facsimile.

(b) In a case where the obligation of an insurer . . . to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer . . . shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

- (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
- (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. . . .

(c)(1) . . . [E]ach claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer . . . that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or

health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes . . . or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, [the] insurer . . . shall not be required to pay interest on such claim. . . .”

The examiner reviewed a sample of 65 dental claims and noted that the Company did not pay 7 of the claims (11%) within 45 days of receipt of the claim forms. In 5 of the claims (8%), the Company did not provide policyholders with written notification within 30 days of receipt of the claims, stating the specific reasons why it is not liable for such claims. Also, in 3 of the claims (5%) the Company did not pay within 45 days of receipt of the claim forms and did not pay interest on the amount of such claim payments, where the interest amount owed was more than two dollars.

The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay dental claims within 45 days of receipt of the claim forms.

The Company violated Section 3224-a(b) of the New York Insurance Law by failing to provide policyholders, covered person or healthcare provider with written notification within 30 days of the receipt of the claims, stating the specific reasons why it is not obligated to pay such claims.

The Company violated Section 3224-a(c) of the New York Insurance Law by failing to pay interest on dental claim payments paid after 45 days of receipt of the claims.

The examiner reviewed a sample of 24 vision claims and noted that the Company did not pay 1 of the claims (4.2%) within 30 days of receipt of the electronic claim form.

The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay a vision claim within 30 days of receipt of the electronic claim form.

5. DATA FILES

Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) states, in part:

“The records shall be readily available and easily accessible to the superintendent in accordance with Insurance Law, Section 310. The records shall be in a readable form. . . . Upon request of the superintendent, the insurer shall provide a hard copy of the record, or, if the record is maintained in a medium which is used by the superintendent, the insurer may provide the record in that medium. Failure to produce and provide a record within a reasonable time frame shall be deemed a violation of Insurance Law, Section 308 unless the insurer can demonstrate that there is a reasonable justification for that delay.”

On July 21, 2017, approximately three months before the start of the market conduct on-site examination, the examination’s coordinator provided the Company with a pre-examination letter requesting various data files. Among the data files requested were the in-force policy and certificate listings, claims listings, and the reconciliations of these data files to the respective lines or exhibits of the annual statements. The letter requested that the data files include certain fields such as the resident state and the contract state to help the examiner choose from policies underwritten in New York. In addition, the claims listings were to include the dates the Company was notified of the claim, the date the claim was received, and the date the claim was paid.

The Company was unable to provide the resident state and the contract state for its policy and certificate level data. The Company also took over eight months to provide the reconciliation of its claims data to the appropriate exhibits of the annual statements.

The Company violated Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) by failing to make available, as requested by the examiner, the data records that support the annual statement exhibits in the format and substance required within a reasonable time frame. This data related matter was raised in the Company’s prior two reports on examination.

6. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the market conduct 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 215.17(a) of 11 NYCRR 215 (Insurance Regulation 34) by failing to maintain an advertising file with a notation indicating the manner and extent of distribution.</p> <p>The Company's advertising tracking system contains a notation indicating the manner and extent of distribution for each advertisement.</p>
B	<p>The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy application forms that were not filed with and approved by the Superintendent.</p> <p>The Company failed to take corrective action on this prior report violation. (See item 4B of this report.)</p>
C	<p>The examiner recommended that the Company submit all altered application forms to the Department for review and approval.</p> <p>The Company failed to take corrective action on this prior report recommendation. (See item 4B of this report.)</p>
D	<p>The examiner recommended that the Company include complete form numbers, on all policy forms used by the Company.</p> <p>The Company failed to take corrective action on this prior report recommendation. (See item 4B of this report.)</p>
E	<p>The examiner recommended that the Company ensure that its stop loss applications are properly completed, signed and dated by both applicant and agent, and indicate the city and state where the applications are completed.</p> <p>The Company has ensured that its stop loss applications are properly completed, are signed and dated by applicable parties, and are included with the city and state where the applicants were completed. As of January 1, 2016, the Company's stop loss business is in run-off.</p>

<u>Item</u>	<u>Description</u>
F	<p>The examiner recommended that the Company maintain its data files in a manner that includes the various fields requested by the examiner along with reconciliations to the Annual Statement Exhibits to better facilitate future examinations. A similar recommendation was made in the prior report on examination.</p> <p>The files provided in response to the pre-examination letter did not include all the various fields requested by the examiner or all the reconciliations of the data files to the annual statement exhibits. The Company failed to take corrective action in response to this prior report recommendation. (See item 5 of this report.)</p>

7. SUMMARY AND CONCLUSIONS

Following are the violations contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The Company violated Section 2114(a)(3) of the New York Insurance Law by paying commissions to three agents before those agents were appointed to represent the Company.	7
B	The Company violated Section 2112(a) of the New York Insurance Law by failing to file a certificate of appointment with the Superintendent to appoint one of its agents to represent the Company.	7
C	The Company violated Section 3201(b)(1) of the New York Insurance Law by altering previously approved dental policy forms, by not filing the revised policy forms with the Department for approval, and by using policy forms of an affiliate to issue dental policies in New York. A similar violation was made in the prior report on examination.	8
D	The Company violated Section 3201(b)(1) of the New York Insurance Law by altering previously approved vision policy forms, by not filing the revised policy forms with the Department for approval, and by using a policy form with the incorrect policy form number. A similar violation was made in the prior report on examination.	9
E	The Company violated Sections 3204(a) and 3204(d) of the New York Insurance Law by selecting the APL as the nonforfeiture option without written consent, when the insured or policyowner had selected the reduced paid-up nonforfeiture option.	10
F	The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay dental claims within 45 days of receipt of the claim forms.	11
G	The Company violated Section 3224-a(b) of the New York Insurance Law by failing to provide policyholders, covered person or healthcare provider with written notification within 30 days of the receipt of the claims, stating the specific reasons why it is not obligated to pay such claims.	11
H	The Company violated Section 3224-a(c) of the New York Insurance Law by failing to pay interest on dental claim payments paid after 45 days of receipt of the claims.	11

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
I	The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay a vision claim within 30 days of receipt of the electronic claim form.	11
J	The Company violated Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) by failing to make available, as requested by the examiner, the data records that support the annual statement exhibits in the format and substance required within a reasonable time frame. This data related matter was raised in the Company's prior two reports on examination.	12

Respectfully submitted,

_____/s/
Jocelyne Turene
Senior Insurance Examiner

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

Jocelyne Turene, being duly sworn, deposes and says that the foregoing report, subscribed by her,
is true to the best of her knowledge and belief.

_____/s/
Jocelyne Turene

Subscribed and sworn to before me
this _____ day of _____

APPOINTMENT NO. 31676

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

*I, **MARIA T. VULLO**, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

JOCELYNE TURENE

as a proper person to examine the affairs of the

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

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

COMPANY

with such other information as she shall deem requisite.

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

this 16th day of October, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: *Mark McLeod*

MARK MCLEOD
DEPUTY CHIEF - LIFE BUREAU

