REPORT OF TARGETED MARKET CONDUCT EXAMINATION

OF

NEW YORK LIFE INSURANCE COMPANY

NAIC# 66915

AS OF

DECEMBER 31, 2007

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

NEW YORK LIFE INSURANCE COMPANY
NAIC # 66915

The above examination was conducted by Sandra Lewis, CIE, MCM, Market Conduct Examiner-in-Charge, and James R. Dargavel, CIE, MCM, Examinations Data Specialist.

The examination covered the period of January 1, 2007, through December 31, 2007.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of James R. Dargavel, CIE, MCM, Examinations Data Specialist, the examination of New York Life Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis

Sandra Lewis, CIE, MCM
Market Conduct Examiner-in-Charge

Subscribed and sworn to before me this 27th day of July, 2009.

Notary Public

My Commission Expires 2/14/2012

OFFICIAL SEAL
NICK STAMAS
NOTARY PUBLIC - State of Arizona
MARICOPA COUNTY
My Comm. Expires Feb. 14, 2012

FOREWORD

This targeted market conduct examination of New York Life Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent market conduct examiners contracting with the Department. A targeted market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following components of the Company's major medical insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims; and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from January 1, 2007, through December 31, 2007 for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to

determine compliance with the standard. The standards applied during the examination are stated in this Report at page 10.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners utilized both examination by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed as to those populations without the need to utilize computer software.

Denied claim file sampling was based on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using ACL (formerly "Audit Command Language") software and computer data files provided by the Company's Representative, Randi Bader, Associate General Counsel. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was generally less than 5%, the standard was considered as "met." A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

COMPANY BACKGROUND

The Company processes Arizona claims using five claims processing systems: WEBTPA, GISLBAR, MARSH, Harrington, and Affinity Insurance Services ("AIS"). The Examiners selected samples from each of the five claims processing systems. The Examination Report has been broken down to show the findings by examination standard for each of the claim processing offices.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 10, and the examination findings are reported beginning on page 6.

1. The Company failed Standard No. 1, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to conduct a timely and reasonable investigation of claims before denying claims. The Examiners found that:
    a. For claims processed by the MARSH claim system, the Company failed to investigate two (6%) of 31 denied claims reviewed;
    b. For claims processed by the Harrington claim system, the Company failed to investigate four (16%) of 25 claims denied as "not covered;"
    c. For claims processed by the Harrington claim system, the Company failed to investigate 16 (59%) of 27 claims denied using a letter of explanation; and
    d. For claims processed under the AIS claim system, the Company failed to investigate 12 (44%) of 27 files denied due to "medical necessity."
2. The Company failed Standard No. 2 (forms review), in apparent violation of A.R.S. §§ 20-461(A)(1) and (A)(15) and 20-2533(D). The Examiners found that:
    a. For claims processed by the WEBTPA, MARSH, Harrington, and AIS claim systems, the Company used Explanation of Benefits ("EOB") forms that failed to inform the insured of the right to appeal the denial, but instead referred the insured to the Department in the event of a disagreement about the denial. The forms also supplied a phone number for the Department that has not been in use for more than three years.
    b. For claims processed by the GILSBAR claim system, the Company used an EOB form that misstated the time period during which an appeal may be filed.
3. The Company passed Standard No. 3.

PROCEDURES PERFORMED

The Examiners reviewed the Company's appeal policies and procedures, claims manuals, training manuals, and responses to interrogatories in preparation for the file reviews to be conducted. The Examiners conducted a review of the claim forms associated with the denial of

claims during the examination period, as well as policies and procedures for calculating and paying interest on reprocessed claims.

The Company reported that it had no appeals from denied claims during the examination period. Therefore the Examiners did not review any appeals for the purpose of determining denial trends.

WEBTPA

The Company provided a population of 12 Arizona claims denied by the WEBTPA system during the examination period. Due to the small number of denials, the Examiners selected all 12 (100%) of these files for review. One file was eliminated from the sample because the benefits were applied to the insured's deductible, and therefore this claim was not within the scope of the examination. The remaining 11 files were reviewed, as illustrated by the table on page 5 below.

GILSBAR

The Company provided a population of 20 Arizona claims denied by the GILSBAR system during the examination period. Due to the small number of denials, the Examiners selected all 20 (100%) of these files for review. Five files were eliminated from the sample as paid claims, and therefore these claims were not within the scope of the examination. The remaining 15 files were reviewed, as illustrated by the table on page 5 below.

MARSH

The Company provided a population of 107 Arizona claims denied by the MARSH system during the examination period. The Examination Data Specialist used ACL software to analyze this information to determine the most frequently denied procedure codes and/or most frequently used reasons for denial. This analysis was used to extract a subpopulation of 31 denied claims based on the reasons given for the denial. The Examiners selected one sample of 31 (100%) from these files based on the categories of denial code reasons identified during the claims analysis. All 31 files met the examination criteria and were reviewed by the Examiners, as illustrated by the table on page 5 below.

HARRINGTON

The Company provided a population of 2,154 Arizona claims denied by the Harrington system during the examination period. The Examination Data Specialist used ACL software to

analyze this information to determine the most frequently denied CPT-4 codes, procedure codes and/or the most frequently used reasons for denial. This analysis was used to extract a subpopulation of 626 denied claims in three categories based on the reasons given for denial. The Examiners selected three random samples totaling 57 files based on the categories of denial code reasons identified during the claims analysis. Two files were eliminated from the sample because the benefits were paid and/or applied to the insured's deductible, and therefore these claims were not within the scope of the examination. The remaining 55 files were reviewed as illustrated by the table below.

AIS

The Company provided a population of 327 Arizona claims denied by the AIS system during the examination period. The Examination Data Specialist used ACL software to analyze this information to determine the most frequently denied CPT-4 codes, procedure codes and/or the most frequently used reasons for denial. This analysis was used to extract a subpopulation of 158 denied claims in three categories based on the reasons given for denial. The Examiners selected three random samples totaling 59 files based on the categories of denial code reasons identified during the claims analysis. All 59 files met the examination criteria and were reviewed by the Examiners, as illustrated by the table below.

Summary of Claim Sampling by Claim Processing System

The following table summarizes the samples selected and reviewed by the Examiners:

ADOI Prefix	Description	Sub-Population	Selected Sample	Reviewed Sample
NY-WEB	WEBTPA (all)	**12**	**12**	**11**
NY-GIL	GILSBAR (all)	**20**	**20**	**15**
NY-MAR	MARSH (7 reason codes)	**31**	**31**	**31**
NY-HA-CO	Harrington – consultant denials	3	3	3
NY-HA-NC	Harrington – not covered	127	27	25
NY-HA-LT	Harrington – letter/free text	496	27	27
	Harrington Subtotal =	**626**	**57**	**55**
NY-AIS-MN	AIS – medical necessity	78	27	27
NY-AIS-NC	AIS – not covered	75	27	27
NY-AIS-PX	AIS – preexisting condition	5	5	5
	AIS Subtotal =	**158**	**59**	**59**
	Totals =	**847**	**179**	**171**

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's denied claims, policy forms, EOB forms, and appeal forms, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F)

The Examiners reviewed one claim sample from WEBTPA, one claim sample from GILSBAR, one claim sample from MARSH, three claim samples from Harrington, and three claim samples from AIS and found apparent violations of Standard 1 as described below:

MARSH (NY-MAR)

The Examiners reviewed one sample of 31 denied claims processed by MARSH and found that the Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to perform an adequate investigation before denying two (6%) of the claims reviewed. Reference PF # 003.

Harrington (NY-HA-NC)

The Examiners reviewed a sample of 25 denied claims processed by Harrington that were denied using an EOB code that indicated the service was not covered and found that the Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to perform an adequate investigation before denying four (16%) of the claims reviewed. Reference PF # 007.

Harrington (NY-HA-LT)

The Examiners reviewed a sample of 27 denied claims processed by Harrington that were denied using an EOB code that indicated the reason would be provided by letter and found that the Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to perform an adequate investigation before denying 16 (59%) of the claims reviewed. Reference PF # 010.

AIS (NY-AIS-MN)

The Examiners reviewed a sample of 27 denied claims processed by AIS that were denied using an EOB code that indicated the service was not medically necessary and found that the Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to perform an adequate investigation before denying 12 (44%) of the claims reviewed. Reference PF # 012.

Summary of Findings – Standard 1 File Review

ADOI Prefix	Sub-Population	Sample Reviewed	Exceptions	Error Ratio	PF #
NY-WEB	12	11	0	0%	
NY-GIL	20	15	0	0%	
NY-MAR	31	31	2	6%	003
NY-HA-CO	3	3	0	0.0	
NY-HA-NC	127	25	4	16%	007
NY-HA-LT	496	27	16	59%	010
NY-AIS-MN	78	27	12	44%	012
NY-AIS-NC	75	27	0	0%	
NY-AIS-PX	5	5	0	0%	
Totals =		**171**	**34**	**20%**	

A 20% error ratio does not meet the standard; therefore recommendations are warranted.

Recommendation 1

Within 90 days of the filed date of this Report, the Company should provide documentation that procedures and controls are in place to ensure that the Company conducts timely investigation of claims and does not deny claims without conducting a reasonable investigation to comply with A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's denied claims, policy forms, EOB forms, appeal forms and claim denial letters, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision.	A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a)

The Examiners reviewed one claim sample from WEBTPA, one claim sample from GILSBAR, one claim sample from MARSH, three claim samples from the Harrington, and three claim samples from AIS and found apparent violations of Standard 1 as described below:

FORMS REVIEW

As a result of the review of the EOB forms and denial letters issued by the Company during the examination period the Examiners identified apparent violations of Standard 2. A standard in the areas of procedures, forms, and policy forms use was not met if any exception was identified, and therefore recommendations are warranted.

The Examiners found that the Company used EOB forms during the examination period that failed to provide a summary of the right to appeal as required by A.R.S. § 20-2533(D). In each of the following cases, the EOB form erroneously advised the insured to contact the Arizona Department of Insurance in the case of a disagreement about the denial. The forms used by WEBTPA, MARSH, and Harrington provided a phone number that has not been active for more than three years.

Claim System	Form Number	PF #
WEBTPA	None available	001
MARSH	None available	004
Harrington	None available	006, 008, 011
AIS	None available	013, 014, 015

In their review of the claims denied by the GILSBAR system, the Examiners found that the Company used an EOB form during the examination period that failed to provide correct information regarding the right to appeal as required by A.R.S. § 20-2533(D). The EOB form

erroneously advised the insured that a denial must be appealed within 180 days of the denial; however, Arizona law permits an insured to appeal a denied claim within two years of the denial.

Recommendations 2 and 3

Within 90 days of the filed date of this Report, the Company should:

2. Provide documentation that all EOB messages and claim denial letters have been modified to notify the member of the right to appeal to comply with A.R.S. § 20-2533(D); and
3. Provide documentation that all EOB messages and claim denial letters have been modified to provide the correct information regarding the time for filing an appeal and/or levels of available appeal, to comply with A.R.S. §§ 20-2533(D), 20-2535(A) and/or 20-2536(A).

SUMMARY OF STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).		X
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.		X
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).	X	