State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
Theodore K. Nickel, *Commissioner*

Wisconsin.gov

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Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

BANKERS LIFE AND CASUALTY COMPANY
111 E WACKER DR STE 2100
CHICAGO IL 60601

dated August 10, 2012, and served upon the company on May 30, 2014, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 20th day of June, 2014.

Theodore K. Nickel
Commissioner of Insurance

OFFICE OF THE COMMISSIONER 0F INSURANCE (OCI) STATE OF WISCONSIN

In the Matter of
BANKERS LIFE AND CASUALTY COMPANY,

Respondent.

COMPLIANCE ORDER

FINDINGS OF FACT

WHEREAS, an examination of BANKERS LIFE AND CASUALTY COMPANY, 111 E WACKER DR STE 2100, CHICAGO IL 60601, (the Respondent), was made and a report dated August 10, 2012, has been adopted as the final report by OCI; and

WHEREAS, the report of examination made certain recommendations which are attached to this Order and incorporated by reference; and

WHEREAS, the report of examination has been placed on file as an official public record of OCI.

ORDER

Pursuant to s. 601.41 (4), Wis. Stat., it is ordered that the Respondent shall comply with the recommendations contained in the report of examination and attached to this Order within 90 days from the date of this Order. Compliance with any one or more of the recommendations may be waived in writing by OCI after receiving justifiable written reasons for a waiver.

Dated at Madison, Wisconsin, this 20th day of June, 2014.

Theodore K. Nickel
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

BANKERS LIFE AND CASUALTY COMPANY
CARMEL, INDIANA

JULY 23–AUGUST 10, 2012

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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August 10, 2012

Honorable Theodore K. Nickel
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted July 23–August 10, 2012, of:

BANKERS LIFE AND CASUALTY COMPANY
Carmel, Indiana

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Bankers Life and Casualty Company (the company) started as a mutual assessment company formed in 1932 as a result of the consolidation of Standard Life Insurance Company, Hotel Men's Mutual Benefit Association of the United States and Canada, and Bankers Life and Casualty Company. Standard Life Insurance Company, Chicago, was a stock company, formed in 1942. The oldest predecessor, Hotel Men's Mutual Benefit Association of the United States and Canada, a mutual assessment association, was incorporated on April 6, 1880.

In 1935, John D. MacArthur purchased the company, and he maintained management and financial control through 1978. Upon his death, control of the company was then transferred to The John D. and Catherine T. MacArthur Foundation, an Illinois not-for-profit corporation.

On October 30, 1984, the company was acquired by I.C.H. Corporation, a Louisville, Kentucky, holding company, through a wholly owned subsidiary, Great Southern Life Insurance Company of Texas.

On November 9, 1992, Bankers Life Holding Corporation acquired through a subsidiary, Bankers Life Insurance Company of Illinois, all of the outstanding shares of common stock of the company from I.C.H. Corporation. Bankers Life Holding Corporation was formed by Conseco Capital Partners, L.P., to acquire the company.

Today, the company is a wholly owned subsidiary of Bankers Life Insurance Company of Illinois, an intermediate life insurance holding company, which, in turn, is owned by Conseco, Inc. On January 1, 2000, Certified Life Insurance Company (Certified), a Conseco subsidiary which was operating largely in California, merged into the company and the company assumed all of Certified's in-force business. In December 2002, Conseco, Inc., commenced a re-organization under Chapter 11 and emerged on September 10, 2003.

On November 20, 2007, Bankers Life Insurance Company of Illinois merged into Conseco, Inc., and the company assumed all of the in-force business of Bankers Life Insurance Company of Illinois. Conseco, Inc., changed its name to CNO Financial Group, Inc., on May 11, 2010.

Bankers Life and Casualty Company, based in Carmel, Indiana, and domiciled in Indiana, markets and distributes Medicare supplement insurance, interest-sensitive insurance, traditional life insurance, fixed annuities, and long-term care (LTC) insurance products to the middle-income senior market through career agents and sales managers, supported by a network of community-based branch offices.

The company is licensed in the District of Columbia and all states except New York. In 2010 and 2011, the company reported written premium in the District of Columbia and all states except New York. The table below summarizes the total direct national premium written in 2010 and 2011 as compared it to the total direct premium written in Wisconsin.

National Direct Business to Wisconsin Direct Business Summary

	Life Insurance Premiums	Annuity Considerations	A&H Insurance Premiums	Deposit Type Funds	Other Considerations
2011					
Wisconsin	$ 9,878,985	$ 9,205,855	$ 38,473,021	$ 120,000	$0
National	324,625,211	964,862,195	1,158,087,562	11,013,444	0
2010					
Wisconsin	$ 9,557,107	$ 22,490,802	$ 41,095,783	$ 1,531,792	$0
National	296,208,195	985,708,797	1,269,176,543	762,918,198	0

The majority of the premium written by the company in 2010 and 2011 in Wisconsin and on a national level was Accident and Health premiums. In Wisconsin in 2010, Annuity Considerations followed then Life Insurance Premiums and Deposit Type Funds. In 2011 in Wisconsin, Life Insurance Premiums came in second followed by Annuity Considerations, then Deposit Type Funds. On a national level, in 2010 and in 2011, Annuity Considerations came in second followed by Life Insurance Premiums, then Deposit Type Funds.

The tables below summarize the company's Wisconsin life insurance and annuity premium written and benefits paid in 2010 and 2011, broken down by line of business.

Wisconsin Life Insurance Business

2011	Ordinary	Credit Life	Group	Industrial
Direct Premiums and Annuity Considerations				
Life Insurance	$ 9,878,985	$0	$0	$0
Annuity Considerations	9,205,855	0	0	0
Deposit Type Funds	120,000	0	0	0
Other Considerations	0	0	0	0
Direct Claims and Benefits Paid				
Death Benefits	3,903,406	0	0	0
Annuity Benefits	10,259,853	0	0	0
All Others	28,843,088	0	0	0

Wisconsin Life Insurance Business (continued)

2010	Ordinary	Credit Life	Group	Industrial
Direct Premiums and Annuity Considerations				
Life Insurance	$ 9,557,107	$0	$0	$ 0
Annuity Considerations	22,490,802	0	0	0
Deposit Type Funds	0	0	0	0
Other Considerations	0	0	0	0
Direct Claims and Benefits Paid				
Death Benefits	2,986,571	0	0	2,500
Annuity Benefits	11,334,175	0	0	59,076
All Others	20,832,082	0	0	0

The table below summarizes the company's Medicare supplement business for 2010 and 2011.

Wisconsin Medicare Supplement Business

Classification	Premiums Earned	Amount Incurred Claims	% of Premiums Earned - Incurred Claims	Number of Covered Lives
2011				
Individual Policies				
Most Current 3 Years	$ 3,028,719	$ 2,050,751	67.710%	1,301
All Years Prior to Most Current 3 Years	19,377,543	12,172,345	62.817	5,586
Group Policies				
Most Current 3 Years	0	0	0.000	0
All Years Prior to Most Current 3 Years	3,228,343	2,333,534	72.283	1,068
2010				
Individual Policies				
Most Current 3 Years	4,225,619	2,754,812	65.193	1,923
All Years Prior to Most Current 3 Years	20,920,430	14,295,015	68.330	6,218
Group Policies				
Most Current 3 Years	1,212	207	17.037	0
All Years Prior to Most Current 3 Years	3,354,063	2,661,061	79.338	1,227

The table below summarizes the company's long-term care earned premium for 2010 and 2011, broken down by type of business.

Wisconsin Long-Term Care Business

Actual Earned Premiums Type of Business	2011	2010
Individual	$547,074,668	$566,916,607
Group Direct Response	18,592	21,553
Other Group	0	0
Total	$547,093,260	$566,938,160

Actual Incurred Claims Type of Business	2011	2010
Individual	$456,909,620	$460,786,019
Group Direct Response	19,368	123,842
Other Group	0	0
Total	$456,928,988	$460,909,861

In 2010, the company ranked as the 40th largest writer of individual life insurance business and had a 0.5% share of the market, the 42nd largest writer of annuities with a 0.4% share of the market, and the 18th largest writer of individual accident and health business with a 1.0% share of the market in Wisconsin. In 2011, the company ranked as the 43rd largest writer of individual life insurance business and had a 0.5% share of the market, the 64th largest writer of annuities with a 0.2% share of the market, and the 16th largest writer of individual accident and health business with a 0.9% share of the market in Wisconsin.

The Office of the Commissioner of Insurance (OCI) received 141 complaints against the company between January 1, 2010, through March 31, 2012. A complaint is defined as "a written communication received by the OCI that indicates dissatisfaction with an insurance company or agent." The table on the following page categorizes the complaints received against the company by type of coverage and complaint reason. There may be more than one type of coverage and/or reason for each complaint. The percentages may also vary due to rounding.

Complaints Received

Coverage Type	Reason Type				
	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
2012 (Q1)					
Individual Life		2	1	1	
Individual Annuity		1	2	1	
Long-Term Care		1			
Nursing Home					
Medicare Supplement			2	1	
Individual A&H					
All Others					
Total		**4**	**5**	**3**	
2011					
Individual Life		6	3	6	
Individual Annuity		10	1	3	
Long-Term Care	5		8	1	
Nursing Home			3		
Medicare Supplement		2	4	1	
Individual A&H		1			
All Others			1	1	
Total	**5**	**19**	**20**	**12**	
2010					
Individual Life	1	9	7	4	
Individual Annuity		11	1	3	
Long-Term Care	9	7	5	2	
Nursing Home			1		
Medicare Supplement	1	4	3	3	
Individual A&H			1		
All Others			1		
Total	**11**	**31**	**19**	**12**	

Grievances

The company submitted annual grievance experience reports to OCI for 2010 and 2011 as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined as "any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan, or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured."

The grievance report for 2010 indicates the company received 33 Medicare supplement grievances, of which 81.80% were reversed or approved, 3.0% were compromised, and in 15.20% of the cases the denials were upheld. All of the grievances filed with the

company were related to "Plan Administration" (57.6%) or "Other" (42.4%). The grievance report for 2011 indicates the company received 29 grievances, of which 55.2% were reversed or approved and in 44.8% of the cases the denials were upheld. All of the grievances filed with the company were related to the category "Other" or "Plan Providers." The following table summarizes the grievances for the company for 2010 and 2011.

Grievances Received

Category	Number	Number Approved	Percent Approved	Number Compromised	Percent Compromised	Number Denied	Percent Denied
2010							
Access to Care	0						
Continuity of Care	0						
Drug and Drug Formulary	0						
Emergency Service	0						
Experimental Treatment	0						
Prior Authorization	0						
Not Covered Benefit	0						
Not Medically Necessary	0						
Other	14	11	78.6%	1	7.1%	2	14.3%
Plan Administration	19	16	84.2%			3	15.8%
Plan Providers	0						
Request for Referral	0						
Total	33	27	81.8%	1	3.0%	5	15.2%
2011							
Access to Care							
Continuity of Care							
Drug and Drug Formulary							
Emergency Service							
Experimental Treatment							
Prior Authorization							
Not Covered Benefit							
Not Medically Necessary							
Other	9	7	77.8%			2	22.2%
Plan Administration							
Plan Providers	20	9	45.0%			11	55.0%
Request for Referral							
Total	29	16	55.2%			13	44.8%

Independent Review

Independent review organizations (IROs) certified to conduct reviews in Wisconsin are required to submit to OCI annual reports for the prior calendar year's experience, indicating the names of the insurance companies and whether the action on the claims was upheld or reversed. Issues eligible for independent review include adverse and experimental treatment determinations. The IRO reports indicate that for 2010 and 2011 no IRO requests were filed involving the company.

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine compliance with recommendations made in OCI's previous market conduct examination done in August 2006 with the final report adopted as of November 6, 2007, and to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2010, through March 31, 2012. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination covered individual life, individual annuity, long-term care (LTC), and Medicare supplement business in Wisconsin and included, but was not limited to, a review of:

- Grievances and Independent Review (IRO)
- Policyholder Services and Complaints
- Privacy and Confidentiality
- Producer Licensing
- Advertising
- Claims
- New Business and Underwriting

The examiners also checked for compliance with the changes to both s. 628.347, Wis. Stat., regarding annuity suitability sales supervision and training, and to s. 628.348, Wis. Stat., regarding LTC training and record-keeping.

Wisconsin's Suitability in Annuity Transactions statute, s. 628.347, Wis. Stat., was strengthened effective May 1, 2011. The statute requires that the sale of an individual annuity be suitable for the consumer based on the person's financial situation and needs. Section 628.347, Wis. Stat., requires that insurers establish and maintain a system to supervise the annuity recommendations of its agents. The law requires an agent to complete a four-hour general annuity training course and the company's specific product training prior to the company accepting any annuity applications from the agent. The examination was conducted to determine whether the company has established an effective system to supervise the

recommendations of its agents and has a system in place to prevent the processing of annuity applications from agents who have not completed the proper annuity training.

Section 628.348 (2), Wis. Stat., regarding the sale of LTC insurance, prohibits an individual from selling, soliciting, or negotiating any LTC insurance product in Wisconsin unless the individual is a licensed intermediary (agent or broker) for accident and health insurance or life insurance and has completed an approved initial one-time training course by January 1, 2009. Licensed agents will also be required to complete ongoing training every 24 months thereafter. The statute also requires that insurers maintain and make available to OCI, upon request, verification that their appointed agents are in compliance with the agent training requirements. The initial and the ongoing training requirements are clarified in s. Ins 3.46 (26), Wis. Adm. Code.

In addition, due to the company's complaint and grievance patterns and the number of complaints received against the company regarding LTC claim handling and premium rate increases, the examination also focused on the company's claim handling procedures, marketing and sales techniques, as well as its policyholder service procedures.

Based on the pre-examination complaints review, it was determined that the company's customer service area was not adequately explaining what documents were needed when an insured called in to ask questions about his or her long-term care claims or policy. In reviewing phone logs included in various complaints, it appears the company answered only the question asked regarding LTC claims and did not offer additional information or ask additional questions.

Long-term care claim faxes were lost regularly, or not received at all by the company. Providers and insureds needed to send items multiple times. The unit receiving the claim information was not telling the insured or the provider what information was still missing until someone called later to inquire with the company.

There was poor written communication with the insured with the use of template letters in that the letters were poorly written and did not address the specific situation of the claim.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous market conduct examination of the company, as adopted November 6, 2007, contained 38 recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation.

Grievances and Independent Review (IRO)

1. It is recommended that the company revise its form 16290-WI and remove the 60-day time limit imposed on policyholders to file a grievance in compliance with s. Ins 18.03, Wis. Adm. Code.

   Action: Compliance

2. It is recommended that the company revise its form 16290-WI to state that for any grievance the plan is unable to resolve within 30 calendar days, the time period may be extended an additional 30 calendar days if the insurer provides written notification to the insured that the insurer has not resolved the grievance; when resolution of the grievance may be expected and the reason additional time is needed to consider the grievance in order to demonstrate compliance with s. Ins 18.03 (6), Wis. Adm. Code.

   Action: Compliance

3. It is recommended that the company develop detailed and complete written procedures for the handling of grievances to include definitions of complaints and grievances consistent with the definitions in s. Ins 18.01 (2) and (4), Wis. Adm. Code, and s. 632.83, Wis. Stat.

   Action: Noncompliance. Refer to Current Examination Findings.

4. It is recommended that the company develop and implement grievance and complaint procedures for vendors that administer its Medicare select policies to ensure compliance with s. Ins 18.03 (2) (c) 2., Wis. Adm. Code.

   Action: Compliance

5. It is recommended that the company audit OHMS's grievance process and procedures and its process and procedures for recording and filing annual grievance reports with OCI to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.

   Action: Noncompliance. Refer to Current Examination Findings.

6. It is recommended that the company require OHMS to use the definition of complaint and grievance in Wisconsin insurance law in order to accurately record and report grievances and to document compliance with s. Ins 18.01, Wis. Adm. Code.

   Action: Compliance

7. It is recommended that the company develop and implement written procedures for a compliance program for its Medicare select vendor, including provisions to monitor, supervise and audit the performance of the vendor in carrying out the functions to ensure compliance with s. 632.83, Wis. Stat., and ss. Ins 18.03 (1) (c) and 9.42, Wis. Adm. Code.

   Action: Noncompliance. Refer to Current Examination Findings.

8. It is recommended that the company implement paragraph 3WI within 90 days of adoption of the examination report to ensure compliance with s. Ins 18.11 (2), Wis. Adm. Code.

   Action: Compliance

9. It is recommended that the company revise its form 16163-WI and remove the 60-day time limit imposed on policyholders to file a benefit appeal and to provide information in order to comply with s. 632.84, Wis. Stat.

   Action: Compliance

Policyholder Services and Complaints

10. It is recommended that the company review its complaint tracking system and make any changes necessary to ensure that all health insurance complaints are correctly identified and recorded in order to document compliance with ss. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

    Action: Noncompliance. Refer to Current Examination Findings.

11. It is recommended that the company develop and maintain written complaint log tracking procedures to ensure that it has a system to accurately identify, collect, and record complaints involving annuity sales and contracts, as well as develop and maintain written procedures to conduct periodic reviews of the complaint log that are reasonably designed to assist in detecting and preventing violations relating to the suitability of annuity sales to senior consumers as required by s. 628.347 (3), Wis. Stat.

    Action: Compliance

12. It is recommended that the company conduct an audit of its process for identifying, collecting, storing, and reporting complaints and file with OCI a copy of its audit report in order to document compliance with s. 601.42, Wis. Stat.

    Action: Compliance

Privacy and Confidentiality

13. It is recommended that the company implement a formal structure for reporting on privacy issues to the Board of Directors and others within the company that documents its reporting hierarchy and business unit participation in the privacy compliance process in order to document the company's compliance with s. 610.70, Wis. Stat., and ch. Ins 25, Wis. Adm. Code.

    Action: Compliance

14. It is recommended that the company implement all of the unsatisfied recommendations in its 2004 internal privacy audit in order to document the company's compliance with s. 610.70, Wis. Stat., and ch. Ins 25, Wis. Adm. Code.

    Action: Compliance

Producer Licensing

15. It is recommended that the company revise its existing procedures to include an annual audit of its agent data base to better ensure the accuracy of the data to document compliance with the agent appointment provisions under s. Ins 6.57, Wis. Adm. Code.

    Action: Compliance

16. It is recommended that the company revise its agent termination procedures to ensure that termination letters comply with the return of indicia requirements of s. Ins 6.57 (2), Wis. Adm. Code.

    Action: Compliance

17. It is recommended that the company, when drafting and implementing written procedures, create a record of the implementation of the procedure and maintain a record of any revisions to the procedure to better enable OCI's examination of the company and to verify compliance with Wisconsin insurance laws and regulations.

    Action: Compliance

Advertising

18. It is recommended that the company revise its Medicare select policy form to state that grievances will be acknowledged within 5 days of receipt; to state that if the insurer has not resolved the grievance within 30 days of receipt the company may extend the review period for an additional 30 days and notify the policyholder of the extension and explain why an extension is needed and when resolution can be expected; to include a provision for the expedited review of grievances; and to include information on the independent review process as required by ss. Ins 18.03 (4) and (6) and 18.05, Wis. Adm. Code, and s. 632,835, Wis. Stat.

    Action: Noncompliance. Refer to Current Examination Findings.

19. It is recommended that the company comply with Wisconsin insurance law regarding limitations on issue dates of policies, such as the limitations under s. Ins 3.39 (5) (k), Wis. Adm. Code.

Action: Compliance

Claims

20. It is recommended that the company use ANSI codes on the Explanation of Benefit (EOB) form sent to the claimant and the Remittance Advice (RA) form sent to providers for its Medicare supplement and Medicare select business as required by s. Ins 3.651 (5), Wis. Adm. Code.

Action: Compliance

21. It is recommended that the company develop and implement the use of a Remittance Advice (RA) form for its Medicare supplement and Medicare select business that complies with all of the informational and format requirements of s. Ins 3.651 (3) (b) 4. b., d., and l. and (d), Wis. Adm. Code.

Action: Noncompliance. Refer to Current Examination Findings.

22. It is recommended that the company develop and implement the use of an Explanation of Benefits (EOB) form for its Medicare supplement and Medicare select business that complies with all of the informational and format requirements of s. Ins 3.651 (4) (a) 2., 3., 5. c., e., f., g., h., and l., 6., 7., and 8., Wis. Adm. Code.

Action: Compliance

23. It is recommended that the company resubmit information to OCI regarding their long-term care policies for inclusion in OCI's Long-Term Care Insurance Approved Policies in Wisconsin booklet to show compliance with s. 628.34 (1), Wis. Stat.

Action: Compliance

24. It is recommended that the company institute a process including verifying information sent to OCI for inclusion in its consumer guides and assigning oversight of the reporting.

Action: Compliance

New Business and Underwriting

25. It is recommended that the company develop and implement marketing and underwriting processes and procedures requiring that the company have approved outlines of coverage per calendar year prior to marketing or accepting applications for the corresponding Medicare supplement policy form in order to comply with s. Ins 3.39 (4) (b), Wis. Adm. Code.

    Action: Compliance

26. It is recommended that the company develop and implement underwriting processes and procedures requiring completed replacement forms for all replacements to document compliance of s. Ins 3.39 (23) (c) and (d), Wis. Adm. Code.

    Action: Compliance

27. It is recommended that the company provide notice to its agents that internal replacements require notification to the applicant regarding replacement and completion of the company's replacement form.

    Action: Compliance

28. It is recommended that the company develop and implement procedures to better ensure that applications are not taken by agents or accepted by the company more than 90 days before an applicant turns age 65 to comply with s. Ins 3.39 (25) (d), Wis. Adm. Code.

    Action: Compliance

29. It is recommended that the company cease using medical authorization forms for Medicare supplement applicants in an open enrollment period to ensure compliance with s. Ins 3.39 (4m), Wis. Adm. Code.

    Action: Compliance

30. It is recommended that the company cease using the "Fact Finder" questionnaire when agents are soliciting any Medicare beneficiary for Medicare supplement coverage to ensure compliance with the marketing standards of s. Ins 3.39, Wis. Adm. Code, and s. 3.39 (4m), Wis. Adm. Code.

    Action: Noncompliance. Refer to Current Examination Findings.

31. It is recommended that the company review and update as necessary its agent instructions for submitting applications and its new business and underwriting procedures and schedule and document training it deems necessary to ensure that applications for coverage are properly completed in compliance with s. 628.34, Wis. Stat.

    Action: Compliance

32. It is recommended that the company include as a procedure step for its internal audits the review of applications to document that unnecessary application information is not obtained or retained and that applications are timely submitted in order to document compliance with s. Ins 3.39 (4m), Wis. Adm. Code.

Action: Compliance

33. It is recommended that the company update its written guidelines to require that prior to issuing a home health care policy it obtain a copy of a physical exam, or an assessment of functional capacity, or an attending physician statement or copies of medical records in order to comply s. Ins 3.46 (10) (a), Wis. Adm. Code.

Action: Compliance

34. It is recommended that the company update its written guidelines to address the requirement that the company obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a lapse or termination notice or sign a waiver of these rights to ensure compliance with s. Ins 3.46 (15) (a), Wis. Adm. Code.

Action: Compliance

35. It is recommended that the company develop and implement comprehensive written procedures and guidelines for its new business processors to use to determine the suitability of an annuity sale to a senior consumer to ensure compliance with the requirements of s. 628.347, Wis. Stat.

Action: Compliance

36. It is recommended that the company review and amend its Annuity Suitability Questionnaire, form LA-16298, to include additional information concerning the applicant's current and future financial needs, including monthly expenses, and any other information that is reasonably appropriate for determining the suitability of the sale as required by s. 628.347 (2) (b), Wis. Stat.

Action: Compliance

37. It is recommended that the company develop and implement comprehensive written procedures for the internal processing of life and annuity applications that involve the replacement of existing life and annuity coverages to ensure compliance with the Wisconsin-specific requirements of s. Ins 2.07 (5), Wis. Adm. Code.

Action: Compliance

38. It is recommended that the company develop and implement written procedures and materials for training its agents on the specific Wisconsin replacement requirements of s. Ins 2.07, Wis. Adm. Code.

Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

Company Operations and Management

The examiners reviewed the company's response to the Company Operations & Management interrogatory including Board of Director minutes regarding compliance, and contracts the company has for various services. The examiners also interviewed the CNO Financial Group's Chief Compliance Officer (CCO).

Audits

The internal audit department is responsible for conducting internal audits and branch sales office audits. In addition, the company's Market Assurance Program (MAP) team conducts annual on-site audits of agents' sales practices and branch office operations. This process began in 2011.

The examiners reviewed the CNO Financial Group, Inc.'s Internal Audit Charter provided to the examiners. The charter states that the Board of Directors established the Internal Audit Department at CNO Financial Group, Inc., through the Audit and Enterprise Risk Committee's oversight function. The Vice President of Internal Audit (General Auditor) reports functionally to the Audit and Enterprise Risk Committee of the Board of Directors and administratively to the Chief Executive Officer (CEO) of CNO Financial Group, Inc. The company stated that annually an audit plan is to be submitted to the Audit and Enterprise Risk Committee for their review and approval. The company's Internal Audit Department audits by processes and/or departments, not by legal entity. Departments typically process business by product line for several different legal entities.

The examiners asked the company to explain its process for monitoring complaints involving vendor responsibilities and brought to its attention a complaint that was filed with OCI during the period of review regarding one of the company's Medicare supplement vendors (ESI) not covering diabetic supplies as required under Wisconsin's mandate. The complaint issue was being addressed separately from this market conduct examination. The company indicated that

it was in the process of working towards the ability to track complaints by vendors. The company's Legal Operations Compliance and Consumer Relations areas are working towards this goal.

The examiners were also provided information regarding a new Risk Team environment which is a multi-functional vendor risk team that at the time of the interview was working on developing procedures, guidelines, and risk analysis regarding the company's relationships with its third-party administrators (TPAs), outside service providers (OSPs), and other vendors. The team was created to help develop relationship owner responsibilities, audit scheduling, audit documentation, and some aspects of initial contract review. The team utilizes a monitoring checklist in which a questionnaire is sent to vendors to ensure compliance with contracts. Returned checklists are reviewed by the TPA's relationship manager. A vendor-risk roundtable was also being developed at the time of the interview.

Compliance

The compliance areas of the company were reorganized from their former method of being broken down by entity division, i.e., Bankers Life and Casualty, Colonial Penn, etc., since the current CCO's reign at CNO Financial.

In 2007, Bankers Life and Casualty Company's compliance functions were comprised of Compliance and Complaints, Special Investigations Unit (SIU), Privacy and New Laws, and Compliance Resolution. In 2008, the company's compliance functions were comprised of Market Conduct, Field Compliance, Legal Operations Compliance, Privacy, Special Investigations Unit (SIU) and Compliance Resolutions. In 2009, the Market Conduct function was transferred to the Regulatory Affairs team.

In 2010, the Market Assurance Program (MAP) was added to the company's compliance function. In 2012, MAP was transferred to the Regulatory Affairs team under the direct supervision of the Senior Vice President Government and Regulatory Affairs, and Corporate Compliance was a separate function under Bankers Life Compliance. The MAP team

formerly reported to the CCO. The company explained that the change was made to create synergy between the MAP and market conduct teams.

Contracts

The company contracts with various vendors for data management processing (26 contracts), marketing (65 contracts), and operations (7 contracts). In the examiners' review of a sample of the contracts, the following duties were found to be contracted out by the company:

- Intake of customer service calls
- Quality scoring and/or monitoring of policyholder services
- Processing of policyholder service requests
- Claims processing
- Administrative processing such as converting scanned documents to electronic data for claims processing
- Production support including preventive and corrective maintenance as well as coding and unit testing of application development
- Paymaster services to the company's agents
- Customer lead generation (Medicare supplement, final expense life and long-term care)
- Office furniture

This is not a complete list of services and only a sample of the types of services for which the company contracts with outside vendors.

Legislative/Regulatory Changes

Collection, review, tracking, announcement, implementation and follow-up of regulatory and legislative issues to ensure compliance with state and federal requirements is the responsibility of the Product Approval and Compliance (PAC) Department. The announcements relaying updates are called PAC alerts. A PAC alert can be any state or federal rule, statute, regulation, bulletin, bill, chart, letter or directive that advises, informs, requires, amends, prohibits or implements company procedures. Alerts also arise due to market conduct or internal audit reviews.

In order to determine who to disseminate the PAC alerts to, all are initially reviewed to identify their applicability based on product line, distribution system and state. The PAC Department's review of each item will take into consideration the products and procedures in the

Chicago and Carmel location. For those products that are unique to a particular location, they will be distributed to the location(s) in which they pertain. If the topic pertains to one of the company's business lines (LTC, Medicare supplement, etc.), it is assigned to an analyst who specializes in that particular subject matter.

The analyst responsible for a particular alert will announce the requirement to the affected departments on an enterprise-wide level. In this announcement, the analyst will provide some general background information, the effective date, and actions that need to be taken to the affected area. All alerts are sent to affected areas via e-mail.

The PAC Department periodically reviews the details of selected PAC alerts. Each manager will select no less than five but no more than ten alerts each quarter which were created by members of his or her team. The Senior Director of the PAC Department will monitor these audited alerts to make sure managers are properly logging items, developing correct action plans, communicating issues with their team and correcting any mistakes. Agents are made aware of regulatory updates via Field Compliance Alert Bulletins, training materials, compliance manuals and compliance newsletters.

Producer Licensing

The examiners reviewed the company's response to the Producer Licensing interrogatory, agent agreements, the company's procedures and practices related to producer licensing, listings, terminations and training, including verification of annuity and long-term care training, and the company's agent recruiting processes. The examiners also reviewed random samples of 50 agent appointment files and 48 agent termination files.

Agent's Licensing is primarily responsible for management of agent contracts, appointments, and terminations. The company contracts agents as independent producers and all agents are captive. All company managers are also agents. The hierarchy of agent supervision starting at the top is set forth below. All managers report to the next level of management.

- Branch Sales Manager (BSM)
- Unit Sales Manager (USM)
- Unit Supervisor (USV)
- Unit Field Trainer (UFT)
- Agent (AGT)

The company assigns its Wisconsin agents to territories. The four branch offices in Wisconsin include Madison, Milwaukee, Green Bay and Wausau.

The examiners had requested the company provide 50 agent termination files that were selected through a random sample. Of the 50 agent termination files requested, the company was able to provide copies of electronic documentation supporting the termination process for 48 of the files. The remaining 2 agents were contracted as part of a group operation. The company stated it could not produce the electronic documents requested for those files. These 2 agents were terminated in 2004 and 2006; however, OCI was not notified until 2011. Also, a copy of the written notice to the agent requesting a return of all indicia was not included in 10 of the 48 agent termination files reviewed. Section 628.40, Wis. Stat., "Effect of agent's appointment on insurer," states that "every insurer is bound by any act of its agent performed in this state that is within the scope of the agent's apparent authority, while the agency contract remains in force and after that time until the insurer has made reasonable efforts to recover from the agent its policy forms and other indicia of agency. Reasonable efforts shall include a formal demand in writing for return of the indicia and notice to OCI if the agent does not comply with the demand promptly." Section Ins 6.57 (2), Wis. Adm. Code, states that the "Notice of termination of appointment of individual intermediary in accordance with s. 628.11, Stats., shall be filed prior to or within 30 calendar days of the termination date with OCI. Prior to or within 15 days of filing this termination notice, the insurer shall provide the agent written notice that the agent is no longer to be appointed as a representative of the company and that he or she may not act as its representative. This notice shall also include a formal demand for the return of all indicia of agency. 'Termination date' means the date on which the insurer effectively severs the

agency relationship with its intermediary-agent and withdraws the agent's authority to represent the company in any capacity."

1. **Recommendation:** It is recommended that the company modify, document, and implement its Producer Termination record retention procedures regarding action notices, termination notices, license renewals, license certificates, termination letters, agent position code changes, and other updates for all agents, including those agents contracted as part of a group operation, in order to comply with its record retention schedule and in order to demonstrate compliance with s. 628.40, Wis. Stat., and s. Ins 6.57 (2), Wis. Adm. Code.

2. **Recommendation:** It is recommended that the company implement its Producer Termination record retention procedures to ensure that letters of termination are kept and readily available to OCI upon request as required by s. Ins 6.80, Wis. Adm. Code.

The examiners requested that the company populate a database to be used to compare company agent data with OCI agent data in order to check for discrepancies. In the examiners' review, it was found that 45 agents were not listed as representing the company in the company's data; however, they were listed as representing the company in OCI data. The company explained that the logic used to populate the database failed to include these records.

It was also found that two agents were listed as representing the company as of the end of the exam period in the company data, but they were not listed as representing the company in OCI data as of March 31, 2012. The company explained that the two agents continue to represent the company however not in Wisconsin, and that neither agent has submitted Wisconsin business to the company since their termination. They were included in the data call in error.

Claims

The examiners reviewed the company's response to the Claims interrogatory including procedures for life, annuity and Medicare supplement claims processing; its manuals used in training long-term care claim examiners, Medicare supplement explanation of benefits (EOB) and Remittance Advice (RA) forms, and claim adjustment (ANSI) codes.

Medicare Supplement

The examiners reviewed the company's response to the Medicare Supplement interrogatory. The examiners found that Universal Fidelity Life Insurance Company (UFL) processed all of the company's Medicare supplement claims. The company used Express Scripts to process prescription claims. No outside vendor database was used to process claims as the vendors use the company's software. The company stated that 82% of the Medicare supplement claims were processed electronically without manual intervention.

The examiners reviewed a random sample of 50 Medicare supplement claims paid and 50 Medicare supplement claims not paid. The examiners found that the company used different RA formats for claims paid and claims not paid. The RA provided for review by the company was the internal computer template and not the RA received by the provider. The company stated that the record of payment was attached to the bottom portion of the check sent to the provider when there is an assignment of the claim. The examiners found the information on the bottom of the check did not conform to the format and did not include all the information required by s. Ins 3.651 (3) (b), Wis. Adm. Code. The record of payment did not include the following items which are required:

- Telephone number of a section of the insurer designated to handle questions and appeals from health care providers;
- Policy or certificate number;
- All of the following on a single line:
  - The CPT-4, HCPCS or CDT-1 code;
  - The amount charged by the health care provider;
  - The amount allowed by the insurer;
  - The deductible amount;
  - The copayment amount;
  - The coinsurance amount;
  - The amount of the contractual discount;
  - Each claim adjustment reason code, unless the claim is adjusted solely because of a deductible, copayment or coinsurance or a combination of any of them; or
  - The amount of the contractual discount.

Section Ins 3.651 (3) (b), Wis. Adm. Code, provides that the RA include, at a minimum, specific information, including that addressed in the above finding.

3. **Recommendation:** It is again recommended that the company develop and implement the use of a Remittance Advice (RA) form for its Medicare supplement and Medicare select business (including paid claims) that complies with all of the informational and format requirements of s. Ins 3.651 (3), Wis. Adm. Code.

The examiners found that the RA provided by the company with the Medicare supplement not paid claims did meet the format requirements under Wisconsin insurance law.

The examiners reviewed the language on the bottom of the explanation of benefits form the company used for its Medicare supplement claims to determine if the verbiage was sufficient to notify the insured of appeal/grievance/IRO rights. The examiners found the company notified members of their right to file a grievance at policy issue. The examiners found that the EOB language did not notify the insured of their right to grieve the denial, determination or initiation of disenrollment. It did not direct the insured to the policy or certificate section that delineates the procedure for filing a grievance or describe, in detail, the grievance procedure to the insured to show compliance with s. Ins 18.03 (2) (b), Wis. Adm. Code. Section Ins 18.03 (2) (b), Wis. Adm. Code, states that when notifying the insured of their right to grieve the denial, determination, or initiation of disenrollment, an insurer offering a health benefit plan shall either direct the insured to the policy or certificate section that delineates the procedure for filing a grievance or shall describe, in detail, the grievance procedure to the insured. The notification shall also state the specific reason for the denial, determination, or initiation of disenrollment.

4. **Recommendation:** It is recommended that the company add language to the appeals notice on the bottom of its Medicare supplement explanation of benefits (EOB) form to direct the insured to the policy or certificate section that explains the procedure for filing a grievance or describe, in detail, the grievance procedure to the insured to ensure compliance with s. Ins 18.03 (2) (b), Wis. Adm. Code.

The examiners requested copies of any claims audits performed on the company's third-party vendors that had claims processing authority for any lines during the period of review. The vendors included Univita, HDM Corporation, Universal Fidelity Life Insurance Company, Express Scripts, and OHMS. The contracts provided stated that the company had

the right to conduct audits with prior notice. The examiners found that the company only audited Univita during the period of review. The examiners reviewed the audit report for Univita. No areas of noncompliance were noted.

A recommendation was made in the previous market conduct examination report that the company audit OHMS's grievance process and procedures, and its process and procedures for recording and filing annual grievance reports with OCI to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code. The company stated that no audits were performed on OHMS during the period of review. In response to a request to demonstrate compliance with the recommendation in the previous market conduct examination report that the company develop compliant specification standards to monitor, supervise, and audit the performance of the vendor OHMS, the company stated that the process was in revision and not in production.

5. **Recommendation:** It is again recommended that the company develop and implement written procedures for a compliance program for its Medicare select vendor, including provisions to monitor, supervise and audit the performance of the vendor in carrying out the functions to ensure compliance with s. 632.83, Wis. Stat., and ss. Ins 18.03 (1) (c) and 9.42, Wis. Adm. Code.

6. **Recommendation:** It is again recommended that the company audit OHMS's grievance process and procedures, and its process and procedures for recording and filing annual grievance reports with OCI to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.

7. **Recommendation:** It is recommended that the company establish an audit schedule to ensure that audits of the company's long-term care, Medicare supplement and select claims, including pharmacy claims, processed both internally and externally by the company and its third-party vendors are performed. The company must add a claim audit guideline to its and its vendors' Medicare supplement audit guidelines that ensures claims regarding the state of Wisconsin mandates are processed appropriately to ensure compliance with s. 632.895, Wis. Stat.

Long-Term Care

The examiners reviewed the company's response to the Long-Term Care, Home Health Care, and Nursing Home interrogatory. The examiners found that initial long-term care claims were investigated and processed in the company's Chicago, Illinois, office. The company's long-term care vendor, Univita, processed existing claims. Univita claim examiners

followed Bankers Life and Casualty Company's processes and used its system to process ongoing claims. All documentation produced or communicated by Univita was on the company's forms. The company completed on-site visits annually of Univita and reviewed/audited the vendor periodically based on the company's internal audits' TPA checklist.

The examiners found that long-term care claims were processed manually using the claim processing system to document the claim transaction, issue an EOB, and request check processing. No long-term care claims were processed electronically.

The company provided the examiners with a walk-through demonstration of its initial claim processing center in Chicago, which included demonstrations of the jobs done by a claim assistant, decision maker and claim examiner. The claim assistant's responsibilities included sending acknowledgment letters to policyholders, reviewing claim material for completeness and obtaining missing information. The decision maker's responsibilities include reviewing the claim material and analyzing it for completeness. If it was still incomplete, a final attempt was made to obtain the missing information. A decision was then made with the available information, regardless of the completeness. The claim was then sent to the claim examiner for processing.

OCI received 45 complaints from insureds regarding the company's long-term care products during the period of review. Of those, 19 dealt with filed claims. Many of the complaints received by OCI were regarding the poor written communication on the LTC claim requirements. The letters were not clear and did not address the specific situation of the claim. The company stated it was conducting a long-term care claim letter revision project, which had multiple phases. Phase 1 was completed in December 2011, when an explanation of benefits (EOB) form was implemented that replaced multiple system-generated letters that had been utilized as EOBs. Effective December 19, 2011, the company began processing the long-term care claims EOB in the HIPPA mandated ANSI ASC X12 Health Care Claim Payment/Advice (835) format. The forms were mailed to the insured/provider and explained how the claim was processed.

Phase 2 of the letter revision project consisted of modifying the manually developed decision maker letters for claim approvals and denials. The pilot project for this phase was completed and the full roll out and training on new letters was planned to be implemented by August 1, 2012. The company stated that some letters had been deleted altogether, some replaced and some were completely new.

The examiners reviewed a random sample of 47 paid and long-term care claims. The examiners requested that the company provide copies of all of the required documents needed to open a long-term care claim. The documents included: initial claim form; initial invoice; date of service document; authorization for claim processing; power of attorney documents, if applicable; letter from MD or medical records; vendor license; daily notes, if required; initial assessment, if applicable, and an on-site assessment. The examiners requested copies of company-generated documents such as the acknowledgment letter and copies of all correspondence related to the initial claim.

The examiners found that 15 of the 47 sample claims were initial claims and the rest were continuous claims.

The examiners reviewed a random sample of 25 denied long-term care claims. No exceptions were noted.

Life Insurance and Annuity

The examiners reviewed life and annuity claim files of which all claims paid were random samples, while the claims denied were reviews of the entire population provided to the examiners. The amount of claim files in the population provided was under the amounts of claims that constituted a random sample (25) by the examiners. See below for a breakdown of sample sizes:

- 25 Life Claims Paid
- 11 Life Claims Denied
- 25 Annuity Claims Paid
- 2 Annuity Claims Denied

Life and Annuity claims are not processed electronically.

In the examiners review of the life and annuity claims, it was found that many times the company uses a "BenefitNow" account where the proceeds of a life or annuity claim are placed into an interest-bearing account after the company receives the claimant's initial claim reimbursement request. Once a claim is processed for a "BenefitNow" account, a feed is sent to Open Solutions, the company's third-party administrator for the accounts, and a draft book with a "BenefitNow" Account Welcome Kit is mailed the following day. The company sends claimants a letter notifying them of the interest-bearing account and states that a welcome kit will follow. It is then up to the beneficiary to contact the company again to access those funds. This letter states that the "BenefitNow" account is the primary method in which the company pays proceeds when claims are $5,000 or more. This was used on 10 of the 25 claims paid annuities, which were all $5,000 plus claims. However, only 2 of the 7 life claims that were $5,000 plus were processed with the "BenefitNow" accounts.

Marketing, Sales, and Advertising

The examiners reviewed the company's response to the Marketing, Sales and Advertising interrogatory.

The company was asked to describe the process used by its agents when they first solicit a new applicant for a Medicare supplement product. The company stated that one of the steps in the solicitation process was to ask the applicant's permission before completing a "Fact Finder" form on the applicant. The previous market conduct examination report recommended that the company cease using the "Fact Finder" questionnaire when agents are soliciting any Medicare beneficiary for Medicare supplement coverage to ensure compliance with the marketing standards of s. Ins 3.39, Wis. Adm. Code, and s. Ins 3.39 (4m), Wis. Adm. Code. This marketing practice does not meet the requirements of s. Ins 3.39 (4m), Wis. Adm. Code, and is not in compliance with the recommendation in the previous examination report. As the company

is no longer marketing Medicare supplement policies as of June 2010, the examiners did not make a repeat recommendation.

The examiners reviewed a random sample of 50 advertisements used by the company during the period of review (24 life and annuity, 19 Medicare supplement, 7 long-term care). No exceptions were noted.

New Business and Underwriting

Life Insurance and Annuities

The examiners reviewed the company's response to the New Business and Underwriting interrogatory (Individual Life and Individual Annuities), including the Life Underwriting Policies and Procedures and a bibliography of manuals used in the life/annuity underwriting process. The company uses the Swiss Re online database of underwriting guidelines. In addition, the following systems are used by the company in the underwriting process:

- LifeComm – administration system used by New Business area
- LifePro – administration system used by New Business area
- BFO – Bankers Front Office
- AWD – Automated workflow delivery system utilized by the New Business area to distribute work items

The examiners also reviewed a copy of the company's Quality Audit Process for Annuities as well as a description of the annuity and life audit processes.

For the life audits, the company randomly audits 25 of its fully underwritten applications per underwriter per quarter to verify accuracy against a predetermined checklist. Results are reported to management for use in performance evaluations. The auditor also audits 10 simplified issue life products per processor per quarter.

For the annuity audits, the company audits, at minimum, 10% of each annuity underwriter's issued policies. Typically, the Annuity New Business quality assurance (QA) specialist does this on a daily basis. AWD randomly selects the policies from the prior business

day and they are assigned to the QA specialist for auditing. The audit criteria are comprised of these ten error categories that must be reviewed for each policy selected for quality auditing:

- Suitability
- Funds
- Tax Status
- Ownership
- Commission
- Tasks/ANC Codes
- Plancode/System Info
- Replacement Letter
- IGO/NIGO & Pending
- 1035 Exchange

In the examiners' review of the New Business and Underwriting interrogatory, it was found that although agents are not currently allowed to submit business electronically, the ability to do so is planned within 12 to 18 months. The company does not allow consumers to apply for coverage online or to submit applications electronically.

The charts below indicate the amount of new business applied for, issued, declined, and rejected (when applicable) during the period of review by the company, broken down by line of business (life, annuity) as well as new business type.

New Business Type (Life)	Rejected	Accepted Other Than Originally Applied For	Not Issued	Total Applications Received
Variable	0	0	26	26
Universal	141	1,094	0	1,235
Whole Life	306	5,281	338	5,925
Term	61	181	3	245
Total Received	**508**	**6,556**	**367**	**7,431**

New Business Type (Annuity)	Declines	Accepted Other Than Originally Applied For	Total Applications Received
Variable	0	0	0
Indexed (Fixed)	92	128	1,235
Fixed	138	69	879
Total Received	**230**	**197**	**2,114**

As can be seen in the charts, the majority of the company's life business is whole life, followed by universal, then term. The company only markets fixed annuities, many of which are fixed indexed products.

In the examiners' review of the New Business and Underwriting interrogatory, the "Life Underwriting Policies and Procedures" were also reviewed as well as a random sample of 25 New Business Declines (Life) and 25 New Business Declines (Annuities). It was found that the company's procedures do not include Wisconsin among the states requiring a letter that explains the reasons of coverage denial. The system-generated letter that the company does provide to life applicants or proposed insureds does not advise the reasons for the denial. The letter states an applicant or proposed insured may request the information or it is stated a reason will be provided in a separate letter, which the examiners did not find among the files they reviewed. The letters sent for annuity new business declines do include a reason for coverage denial.

Section 631.17 (2), Wis. Stat., states that an insurer that denies coverage under an individual or group life or disability insurance policy or a certificate of group life or disability insurance shall advise the applicant or proposed insured in writing of the reasons for the denial.

8. **Recommendation:** It is recommended that the company modify its procedures to ensure that at every coverage denial the applicant or proposed insured is notified in writing of the reasons for the denial at the time of the denial to comply with s. 631.17 (2), Wis. Stat.

The examiners reviewed a random sample of 25 New Business Life and 25 New Business Annuity Terminations that occurred during the period of review. In 5 of the life termination files, or 20%, the company failed to provide the proper notice to the insured that clearly stated the effect of nonpayment of premium. In 3 of the 5 files, the company provided a late pay offer which stated the grace period had lapsed but that the insured could provide payment within 45 days to keep the policy active without applying for reinstatement.

Section 631.36 (4) (a), Wis. Stat., requires an insurer to give notice to an insured, not more than 75 days nor less than 10 days prior to the due date of the premium, which states clearly the effect of nonpayment of premium by the due date.

9. **Recommendation:** It is recommended that the company develop, document and implement a process and written procedures to ensure that it provides

insureds with a proper notice of not less than 10 days and not more than 75 days from the premium due date that clearly states the effect of nonpayment of premium in order to comply with s. 631.36 (4), Wis. Stat.

Annuity Suitability

The examiners reviewed the company's response to the Suitability of Annuity Sales interrogatory and interviewed the Director of New Business, who is also responsible for the Annuity New Business Team, to discuss the company's annuity suitability new business processes.

The company implemented a new annuity suitability program in March 2009. The process was updated in January 2010. The program involves gathering information from consumers using the annuity suitability questionnaire (LA-16298G-WI), home office review, and an escalation process. The company applies thresholds to the consumer information that is collected with each annuity application to determine whether the application is subject to an escalated review process and to ensure that the agent's recommendation is suitable. Applications that do not meet the established thresholds are forwarded to an Escalation Team for review and are considered "escalated annuities."

The Escalation Team consists of a committee chairperson from the Legal and Field Compliance Department and members from New Business processing, Product Marketing, and Legal and Field Compliance. Each week two new field members are invited to attend the meetings for that week. Escalation meetings are scheduled daily and it is expected that the Escalation Team will review cases daily as necessitated by volume and two times daily if needed on the 15th and 30th of each month to avoid processing delays.

Once the case has been reviewed, the Escalation Team may approve, reject, pend for additional information from the field or suggest a counter proposal. If additional information is needed or a counter proposal is suggested, New Business will communicate such information directly to the Bankers Sales Office (BSO). New Business will document this communication in the Bankers Front Office (BFO) system as a note entry.

Once a final decision is reached by the Escalation Team, the decision will be communicated to New Business. New Business will then communicate the decision to the BSO. New Business will document this communication in the BFO system as a note entry. The resolution is also entered on the Escalation Team's tracking spreadsheet along with any case discussion in the notes section of the spreadsheet.

The examiners asked whether the company produces reports on the number of annuity applications rejected for being unsuitable for the consumer's needs and the number of contracts "not taken" once issued. The company provided the examiners copies of quarterly and end-of-year reports that contained escalated annuity application data, including the number of applications rejected.

The chart below breaks down the total number of suitability cases escalated in 2010, 2011 and Q1 of 2012, broken down by how many of those escalated cases were approved, rejected, and withdrawn. Beginning January 1, 2011, all Wisconsin applications were escalated, which explains the increase in cases reviewed in 2011 compared to 2010.

Year	Approved	Withdrawn	Rejected	All
2010	68	11	13	92
2011	261	23	6	290
Q1 2012	44	4	3	51

To verify that the suitability information received from consumers is accurate, in addition to the annual on-site audits the MAP team conducts of the branch sales offices since 2011, the company sends a copy of the completed annuity suitability questionnaire to applicants with a request that they confirm that the information on the form is correct. The company also conducts telephone interviews of a sample of all purchasers of annuity contracts to verify that the agent submitted correct suitability information and uses LIMRA surveys as a way to audit its annuity new business sales.

The examiners reviewed all the agents who had signed the annuity new business replacement and non-replacement applications to ensure compliance with the suitability training

required by s. 628.347, Wis. Stat. The examiners then reviewed each of the agent's training information from the annuity new business files via SIRCON to determine whether the agents had completed his or her required four-hour general annuity training course. The examiners reviewed information verifying that agents had completed the company's annuity product-specific training prior to the company accepting any annuity applications from the agent. The examiners also reviewed the training certificates that were provided for the agents included in the agent appointments and terminations samples.

The company's mainframe system (PAL) houses the company agent licensing and required training information and is used by the company to verify and track agent training.

Replacements

The examiners reviewed the company's response to the Replacement interrogatory. The company was asked how it monitors the percent of business involving replacement both company-wide and by individual agents. The company stated that it reviews all situations in which a BSO or an agent has a replacement percentage over 33%. Any office with a replacement percentage above 33% has to provide the company with a written report identifying the reasons for the replacement activity and confirming that this replacement business is in the best interest of the company's clients. If a BSO has not exceeded the 33% threshold the company still requests a written report for any agent at the BSO who has written at least ten life/annuity cases in the previous quarter and has a replacement rate over 33%.

The examiners selected a sample of six agents from the list the company provided of agents that had met the thresholds described. Of the six agents, the company was able to provide written reports for five of the agents. A report was not provided for the sixth agent as the company could not locate a copy of her report. The company was also unable to get in touch with the current Branch Sales Manager to obtain a copy of the report. The company also stated that it has not taken any action against agents who exceeded the threshold as it has not

encountered a situation where the explanation of the reason for the replacements was not appropriate.

The examiners reviewed a random sample of 24 New Business Issued Life Replacement files. In 2 of the files, the company did not provide the policy or contract owner notice of the right to return the policy or contract within 30 days for a full premium or consideration refund, as required by s. Ins 2.07 (6) (a) 4., Wis. Adm. Code. An amendment rider, L-3711(20), was included in both policies, form number L-5Z1, changing the right to return to 20 days from the 10 days printed in the policy. The company stated that although it was printed in the policy that there was a 20-day right to return, it is normal and usual practice for the company to void and refund policies for at least 30 days past the date of issue. In the other replacement files reviewed, the examiners noted that a 30-day right to return was provided in each policy.

Section Ins 2.07 (6) (a) 4., Wis. Adm. Code, requires, in part, that the replacing insurer using producers "provide to the policy or contract owner notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it."

10. **Recommendation:** It is recommended that the company develop, document and implement a process and written procedures to ensure that when a replacement occurs as defined by s. Ins 2.07 (3) (i), Wis. Adm. Code, the company provides its policy and/or contract owners notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it as required by s. Ins 2.07 (6) (a) 4., Wis. Adm. Code.

In 6 of the New Business Issued Life Replacement files reviewed, or 25%, the company could not provide documentation demonstrating that the replaced insurers received the proper notice of replacement or the notice was insufficient due to the lack of timeliness.

The examiners also reviewed a random sample of 25 New Business Issued Annuity Replacement files. In 12 of the 25 files reviewed, or 48%, the replaced insurers again did not receive the proper notice of replacement or it was insufficient due to the lack of timeliness.

Section Ins 2.07 (6) (a) 2., Wis. Adm. Code, states that the insurer must notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement, or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five business days of a request from an existing insurer.

11. **Recommendation:** It is recommended that the company develop, document and implement policies and written procedures ensuring that replaced insurers receive notification of the proposed replacement within five days of receipt of the completed application and that the company maintains copies of the notices as required by ss. Ins 2.07 (6) (a) 2. and 6.80 (5), Wis. Adm. Code.

Long-Term Care Insurance

The examiners reviewed the Long-Term Care, Nursing Home and Home Health Care Business interrogatory.

The examiners requested the company describe how it monitors agent compliance with the ongoing training requirements for agents marketing long-term care insurance as required by s. 628.348 (2), Wis. Stat. The company provided a copy of the Field Compliance Alert from November 12, 2008, which provided information regarding long-term care training requirements. The company's document stated Wisconsin Long-Term Care Partnership (LTCP) education consists of eight credit hours plus two hours Wisconsin-specific education, with four hours every 24 months thereafter. These hours may be applied to the overall continuing education requirement for license renewal if the course is approved for Continuing Education. The LTCP renewal does not coincide with the license renewal.

The company's mainframe system (PAL) houses the company agent licensing and required training information. The company's system noted the date the LTCP was initially taken and also indicated the date it ended. The date used was two years from the initial date of the class. It did not use the agent's license renewal cycle date.

OCI published a bulletin on its Web site to all insurers and licensed agents on November 21, 2008, regarding the long-term care agent training requirements. The bulletin stated that agents completing initial training after January 1, 2009, shall complete the required 4-hour ongoing training by the date of their next complete license renewal cycle. An agent's license renewal date is biennial and based on the last day of the agent's birth month as identified on the agent's license. A frequently asked questions (FAQ) document relating to long-term care training on the OCI Web site asks about the training that is required and provides the answer that "Agents selling long-term care insurance are required to complete eight hours of training by January 1, 2009, and four hours of training every two years thereafter concurrent with each individual's continuing education reporting period." Another question asks when do agents have to complete the four-hour continuing training and answers "Residents must complete the initial eight-hour training and then complete the four-hour training concurrent with their next CE reporting period to remain compliant."

The examiners requested that the company explain how its document complied with s. Ins 3.46 (26) b) 2., Wis. Adm. Code, that states that insurance intermediaries who complete initial training by January 1, 2009, are required to complete the required four hours of ongoing training by the first complete license renewal cycle as specified in s. Ins 6.63, Wis. Adm. Code. Insurance intermediaries completing initial training after January 1, 2009, shall complete the required four hours of ongoing training by the date of their next complete license renewal cycle as specified in s. Ins 6.63, Wis. Adm. Code. The company responded that it found no requirement that the LTCP renewal date and license renewal date must coincide. License renewals occur on the last day of the birth month and LTCP renewal occurs randomly throughout the year based on the certificate completion date.

12. **Recommendation:** It is recommended that the company send a corrected agent alert and update its agent training procedures regarding the four hours of ongoing long-term care training to show that the training coincides with the agent's license renewal to ensure compliance with s. Ins 3.46 (26) (b) 2., Wis. Adm. Code.

The examiners requested that the company provide a copy of the filed annual long-term care reports for benefit appeals and rescission and reformation for the period of review. The company indicated that it was unable to retrieve or reprint the submitted reports as copies of the submitted reports were not printed and maintained in its records. The company was able to provide a copy of the data used to complete one of the fillable forms. The examiners were able to verify that the data matched the submitted report in OCI records. Section Ins 3.46 (10) (j), Wis. Adm. Code, states that every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the commissioner in the format contained in Appendix 8. Section Ins 6.80 (5), Wis. Adm. Code, states that records with regard to insurance company operations in the state of Wisconsin for the preceding three years shall be maintained in the form specified under sub. (4) and be available to OCI, or the insurance regulatory agency of the insurer's state of domicile.

13. **Recommendation:** It is recommended that the company maintain records with regard to insurance company operations in the state of Wisconsin for the preceding three years including, but not limited to, long-term care reports for benefit appeals and rescissions, both state and countrywide, except those that the insured voluntarily effectuated as well as copies of those reports that it annually furnishes to OCI in the proper format to ensure compliance with ss. Ins 6.80 (5) and 3.46 (10) (j), Appendix 8, Wis. Adm. Code.

The examiners reviewed a random sample of 50 issued and 50 not issued long-term care policies. The examiners reviewed the agents who had signed the applications to ensure compliance with the long-term care agent training required by s. Ins 3.46 (26), Wis. Adm. Code. The examiners found 33 agents who had not reported the initial 8 credits of agent training to OCI for continuing education credit. The company provided copies of certificates for 28 agents indicating they had completed the required eight-hour class but had not taken it for continuing education credit. The remaining 5 agents had not reported taking the eight credit class to the company or reported it to OCI for continuing education credit. Company procedures provided

that no application would be accepted and processed without the agent providing documentation of taking the required initial training and required ongoing training. Section Ins 3.46 (26) (a), Wis. Adm. Code, states that no insurance intermediary may sell, solicit or negotiate long-term care insurance in this state unless the intermediary is duly licensed and appointed by an insurer and has completed the initial training and ongoing training every 24 months as specified in s. 628.348 (1), Wis. Stat. The insurer must also be able to verify compliance with the training requirements as specified in s. Ins 3.46 (26) (a), Wis. Adm. Code, and s. 628.348 (2), Wis. Stat.

14. **Recommendation:** It is recommended that the company develop, document and implement a process and written procedures to verify that agents selling long-term care insurance have taken the initial eight credits of long-term care training and ongoing training to ensure compliance with s. Ins 3.46 (26) (a), Wis. Adm. Code, and s. 628.348 (2), Wis. Stat.

Medicare Supplement Insurance

The company discontinued marketing Medicare supplement products effective June 2010. Company agents market Medicare supplement policies through its sister company, Colonial Penn Life Insurance Company.

Policyholder Service and Complaints

The examiners reviewed the company's response to the Policyholder Service and Complaints interrogatory including the company's complaint handling procedures and a bibliography of reports generated by the Policyholder Service department, as well as a random sample of 50 complaints from the company's complaint log.

The Policyholder Service department is responsible for the in-force administration of the life, health and annuity policies for the company.

Complaint records are stored electronically in the company central repository, which also generates work items through the automated workflow delivery system (AWD). Long-term care complaint records are documented in the Enterprise Complaint System. Each consumer

relations team within the company manages and logs complaints for their specific line of business.

The Long-Term Care Policyholder Service Department is located in Chicago, Illinois. The department handles back-office functions related to long-term care customer service and claim administration including handling written correspondence from customers, addition and removal of waiver of premium and creating long-term care rate quotes for policyholders. The Policyholder Service Department in Carmel, Indiana, services correspondence from long-term care customers and handles most premium-related transactions, as well as basic nonclaim-related servicing.

Customers have access to the company call centers via a toll-free number. The company uses an interactive voice response (IVR) system. Customers can choose from a series of prompts what kind of policy they are calling about (life, health, annuity, long-term care, home health care, or nursing home) and the nature of the inquiry. Based on the prompts selected by the customer, the call is routed to the appropriate call center.

The calls received regarding long-term care, home health care or nursing home policies are routed as follows:

- ACS (Call Center vendor in Jamaica) – Handles Level 1 long-term care customer service calls related to claim status, rate increases, basic benefits, nonclaim-related issues and Policyholder Intake (as backup only).
- Chicago long-term care customer service – Handles agent calls, Policyholder Intake (for policyholders who expect to file a claim within the next 60 days, to review benefits eligibility requirements and go over claim filing process), all Chicago calls and escalations/complex call transfers from ACS/Jamaica.
- In the event the customer selects the wrong policy type (they select Medicare supplement, or life or annuity for example), the call may go to the policyholder service call center in Carmel, Indiana. Typically, unless it is a very basic question, they will then transfer the call to long-term care customer service to ensure appropriate handling.
- For calls received after hours, the caller may enter their policy number and HIPAA validation information (SSN, DOB, etc.) to get to a series of options to receive automated assistance with items such as claim status, policy benefits information (maximums, type of coverage, etc.),

premium information, mailing addresses, local branch office information and forms requests.

The examiners' reviewed a random sample of 50 complaints from the company's complaint log. The sample included annuity policies, life, long-term care, nursing home and Medicare supplement. No exceptions were noted.

Grievance and Independent Review (IRO)

The examiners reviewed the company's response to the Grievance and IRO interrogatory, including its grievance and IRO procedures. Section 632.83, Wis. Stat., provides that every insurer that issues a health benefit plan shall establish and use an internal grievance procedure for the resolution of insureds' grievances with the health benefit plan. The company marketed Medicare supplement and Medicare select insurance policies that meet the definition of health benefit plans.

The examiners found that the company did not have an internal grievance procedure. The company provided the examiners an internal grievance procedure document. However, the examiners found that the document applied to Washington National Insurance Company's specified disease products. The company stated that Medicare supplement grievances have been handled in the same manner as complaints.

The examiners found during the 2006 market conduct examination that the company was not holding any grievance committee meetings. The company established a grievance committee at that time. The examiners found that in early 2008 several operation functions were moved to the administrative office located in Carmel, Indiana. The company stated that after the move to Carmel its grievance procedures failed to meet the requirements of not establishing a grievance committee, not informing insureds of their grievance and IRO rights, and by handing grievances as complaints.

As a result of the examiners' findings on this examination, the company indicated it would use the Ops Risk Roundtable as the grievance committee. The company stated that the

group would handle all required aspects of the grievance process to ensure compliance with ss. Ins 18.03 and 18.05, Wis. Adm. Code, including specifically:

- Having at least one insured other than the grievant serving on the panel
- Handling grievances on an expedited basis
- Notifying the insured of their right to grieve the denial, determination or initiation of disenrollment
- Including a medical consultant
- Sending a notification letter within five days of receipt of the grievance which will include the right to appear in person before the grievance panel and include the release of information notices
- Designating panel members, including a person to sign the panel's decision, which will include a written description of position titles of panel members involved in making the decision
- Re-implementing the process that if the grievance is not resolved within 30 days after the receipt, the time period will be extended an additional 30 days and a letter will be sent to the policyholder indicating that the grievance is not resolved, when it is expected to be resolved and the reason additional time is needed

15. **Recommendation:** It is recommended that the company establish a grievance panel to ensure compliance with ss. Ins 18.03 and 18.05, Wis. Adm. Code.

The examiners found in their review of 50 random complaints from the company's complaint log that the company was not providing grievance rights with Medicare supplement claim denials. The company stated that it defines a complaint as any communication received that primarily expresses a grievance or dissatisfaction with the company, one of its agents or associates. The company stated its definition of grievance was included in the amendment rider 16290A-WI, which was attached to the Medicare supplement policies at issue. The grievance definition in the rider stated that a grievance was "any dissatisfaction with the provision of our services or claims practices that is expressed in writing to Us by, or on behalf of, an insured."

Effective October 1, 2010, changes were made to ch. Ins 18, Wis. Adm. Code, to expand existing independent review rights. The company did file updated riders 16290B-WI and 16290C-WI in 2011 but did not indicate in the filings that the new riders would be provided to existing Medicare supplement insureds. Section Ins 18.01 (4), Wis. Adm. Code, states that a grievance means any dissatisfaction with an insurer offering a health benefit plan or

administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured, including any of the following:

(a) Provision of services
(b) Determination to reform or rescind a policy
(c) Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders
(d) Claim practices

16. **Recommendation:** It is again recommended that the company develop detailed and complete written procedures for the handling of grievances as required by s. 632.83, Wis. Stat., and that includes definitions of complaints and grievances consistent with the definitions in s. Ins 18.01 (2) and (4), Wis. Adm. Code, and s. 632.83, Wis. Stat.

17. **Recommendation:** It is again recommended that the company review its complaint tracking system and make any changes necessary to ensure that all health insurance complaints are correctly identified and recorded in order to document compliance with ss. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

The examiners requested that the company explain how insureds were notified of their right to request an independent review. The company responded that insureds were notified in their original policy documents and not when the insurer made a coverage denial determination as is required by s. 632.835, Wis. Stat., and s. Ins 18.11, Wis. Adm. Code. The company explained that sometime in 2008 after its move of several operations to Carmel, Indiana, the company's independent review procedures no longer complied with the requirements of s. 632.835, Wis. Stat., and s. Ins 18.11, Wis. Adm. Code. Section 632.835 (2) (b), Wis. Stat., states that if a coverage denial determination is made, the insurer involved shall provide notice to the insured of the insured's right to obtain the independent review, how to request the review and the time within which the review must be requested.

18. **Recommendation:** It is recommended that the company implement a process to ensure that the independent review procedure written in its Medicare supplement and select policies are compliant with s. 632.835, Wis. Stat., and s. Ins 18.11, Wis. Adm. Code, and that when a coverage denial determination is made, the company provides a notice to the insured of his or her right to obtain an independent review as required by s. 632.835 (2) (b), Wis. Stat.

The examiners reviewed a random sample of 70 grievance files. The examiners found 51 files did not have acknowledgment letters sent within five business days of receipt of the grievance. Section Ins 18.03 (4), Wis. Adm. Code, states that an insurer offering a health benefit plan shall, within five business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgment to the insured or the insured's authorized representative confirming receipt of the grievance. The company stated that although it had not sent acknowledgment letters since the operations area moved in 2008, effective immediately the Ops Risk Roundtable would be sending the acknowledgment letters to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.

19. **Recommendation:** It is recommended that the company send an acknowledgment letter to the insured within five business days of receipt of a grievance to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.

The examiners' review found that none of the grievance files included documentation that a written notice was sent to the insured of the time and place of the grievance meeting. Section Ins 18.03 (3), Wis. Adm. Code, states that the grievance procedure utilized by an insurer offering a health benefit plan shall include all of the following: (a) A method whereby the insured who filed the grievance, or the insured's authorized representative, has the right to appear in person before the grievance panel to present written or oral information. The insurer shall permit the grievant to submit written questions to the person or persons responsible for making the determination that resulted in the denial, determination, or initiation of disenrollment unless the insurer permits the insured or insured's authorized representative to meet with and question the decision maker or makers. (b) A written notification to the insured of the time and place of the grievance meeting at least seven calendar days before the meeting. The company again referenced its move of early 2008 and how its grievance procedures failed to comply with the requirements of the Wisconsin Administrative Code since sometime after the move.

20. **Recommendation:** it is recommended that the company re-establish procedures to send a written notice to the insured of the time and place of the

grievance meeting at least seven calendar days before the meeting to ensure compliance with s. Ins 18.03 (3), Wis. Adm. Code.

The examiners found five grievance files where the company had not completed its review within 30 days and had not sent an extension letter to the grievant explaining why the grievance was delayed. Section Ins 18.03 (6) (b), Wis. Adm. Code, states that an insurer offering a health benefit plan shall resolve a grievance within 30 calendar days of receiving a grievance. If the insurer offering a health benefit plan is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the insurer provides a written notification to the insured and the insured's authorized representative, if applicable, of all of the following: 1. the insurer has not resolved the grievance; 2. when resolution of the grievance may be expected; and 3. the reason additional time is needed.

21. **Recommendation:** It is recommended that the company re-establish its procedures for sending an extension letter to notify a grievant that the grievance is delayed to ensure compliance with s. Ins 18.03 (6) (b), Wis. Adm. Code.

Benefit Appeals

The examiners reviewed the 45 long-term care benefit appeals that were received during the period of review. No exceptions were noted.

Policy Forms and Rates

The examiners reviewed the company's response to the Policy Forms and Rates interrogatory. The examiners reviewed the policy forms filed with OCI during the period of review for life and annuity, long-term care, and Medicare supplement. The company ceased marketing Medicare supplement in 2010. It had not filed long-term care forms except for a rate increase in 2010.

The examiners found that the company's Product Approval and Compliance department was responsible for form filings and for initial rate filings. The department filed all forms, new product rates and advertising for all company product lines. The company's Actuarial department was responsible for rate filings for in-force health products. Automated

programming ensured the most current version of forms were produced and requested by company systems.

The examiners asked the company to demonstrate compliance with a recommendation in the previous market conduct examination report that the company revise its Medicare select policy form to state that grievances will be acknowledged within 5 days of receipt; to state that if the insurer has not resolved the grievance within 30 days of receipt, the company may extend the review period for an additional 30 days and notify the policyholder of the extension and explain why an extension is needed and when resolution can be expected; to include a provision for the expedited review of grievances; and to include information on the independent review process as required by ss. Ins 18.03 (4) and (6) and 18.05, Wis. Adm. Code, and s. 632.835, Wis. Stat. The company was unable to demonstrate that it had revised its Medicare select policy form. It re-emphasized its short- and long-term plans to re-establish compliance with Wisconsin's grievance procedure by amending its Medicare select policy form to state that grievances will be acknowledged within 5 days of receipt, and that if the insurer has not resolved the grievance within 30 days of receipt, the company may extend the review period for an additional 30 days by notifying the policyholder of the extension and explaining why an extension is needed and when resolution can be expected. The policy would be amended to include a provision for the expedited review of grievances and to include information on the independent review process as required by ss. Ins 18.03 (4) and (6) and 18.05, Wis. Adm. Code, and s. 632.835, Wis. Stat.

22. **Recommendation:** It is again recommended that the company revise its Medicare select policy form to state that grievances will be acknowledged within 5 days of receipt; to state that if the insurer has not resolved the grievance within 30 days of receipt the company may extend the review period for an additional 30 days and notify the policyholder of the extension and explain why an extension is needed and when resolution can be expected; to include a provision for the expedited review of grievances; and to include information on the independent review process as required by ss. Ins 18.03 (4) and (6) and 18.05, Wis. Adm. Code, and s. 632.835, Wis. Stat.

V. CONCLUSION

The examination findings resulted in 16 new recommendations and the repeat of 6 previous examination recommendations, most of which were related to the company's lack of a grievance panel and process. The company explained that, as a result of the findings in the 2005 Wisconsin Market Conduct examination that the company was not holding grievance committee meetings, a grievance committee was established. However, in early 2008, several operation functions were moved to the administrative office located in Carmel, Indiana. Sometime after this transition, the company's grievance procedures failed to comply with the requirements of Wisconsin law.

The examiners also found that the company had failed to file Medicare supplement and long-term care advertisements with OCI. There were other new business issues regarding the company's failure to provide reasons for coverage denials on life new business, and failure to provide insureds notice of the effects of nonpayment of premium on life policies. There were also areas of noncompliance regarding the lack of timeliness in sending notices concerning possible replacement of life insurance to the replaced insurance companies and not providing the required 30-day free look on replaced life and annuity policies.

Other issues included the lack of oversight of the company's third-party vendors and administrators, including the company's failure to maintain a sufficient audit schedule.

VI. SUMMARY OF RECOMMENDATIONS

Producer Licensing

Page 23 1. It is recommended that the company modify, document, and implement its Producer Termination record retention procedures regarding action notices, termination notices, license renewals, license certificates, termination letters, agent position code changes, and other updates for all agents, including those agents contracted as part of a group operation, in order to comply with its record retention schedule and in order to demonstrate compliance with s. 628.40, Wis. Stat., and s. Ins 6.57 (2), Wis. Adm. Code.

Page 23 2. It is recommended that the company implement its Producer Termination record retention procedures to ensure that letters of termination are kept and readily available to OCI upon request as required by s. Ins 6.80, Wis. Adm. Code.

Claims

Page 25 3. It is again recommended that the company develop and implement the use of a Remittance Advice (RA) form for its Medicare supplement and Medicare select business (including paid claims) that complies with all of the informational and format requirements of s. Ins 3.651 (3), Wis. Adm. Code.

Page 25 4. It is recommended that the company add language to the appeals notice on the bottom of its Medicare supplement explanation of benefits (EOB) form to direct the insured to the policy or certificate section that explains the procedure for filing a grievance or describe, in detail, the grievance procedure to the insured to ensure compliance with s. Ins 18.03 (2) (b), Wis. Adm. Code.

Page 26 5. It is again recommended that the company develop and implement written procedures for a compliance program for its Medicare select vendor, including provisions to monitor, supervise and audit the performance of the vendor in carrying out the functions to ensure compliance with s. 632.83, Wis. Stat., and ss. Ins 18.03 (1) (c) and 9.42, Wis. Adm. Code.

Page 26 6. It is again recommended that the company audit OHMS's grievance process and procedures, and its process and procedures for recording and filing annual grievance reports with OCI to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.

Page 26 7. It is recommended that the company establish an audit schedule to ensure that audits of the company's long-term care, Medicare supplement and select claims, including pharmacy claims, processed both internally and externally by the company and its third-party vendors are performed. The company must add a claim audit guideline to its and its vendors' Medicare supplement audit guidelines that ensures claims regarding the state of Wisconsin mandates are processed appropriately to ensure compliance with s. 632.895, Wis. Stat.

New Business and Underwriting

Page 32 8. It is recommended that the company modify its procedures to ensure that at every coverage denial the applicant or proposed insured is notified in writing of the reasons for the denial at the time of the denial to comply with s. 631.17 (2), Wis. Stat.

Page 32 9. It is recommended that the company develop, document and implement a process and written procedures to ensure that it provides insureds with a proper notice of not less than 10 days and not more than 75 days from the premium due date that clearly states the effect of nonpayment of premium in order to comply with s. 631.36 (4), Wis. Stat.

Page 36 10. It is recommended that the company develop, document and implement a process and written procedures to ensure that when a replacement occurs as defined by s. Ins 2.07 (3) (i), Wis. Adm. Code, the company provides its policy and/or contract owners notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it as required by s. Ins 2.07 (6) (a) 4., Wis. Adm. Code.

Page 37 11. It is recommended that the company develop, document and implement policies and written procedures ensuring that replaced insurers receive notification of the proposed replacement within five days of receipt of the completed application and that the company maintains copies of the notices as required by ss. Ins 2.07 (6) (a) 2. and 6.80 (5), Wis. Adm. Code.

Page 38 12. It is recommended that the company send a corrected agent alert and update its agent training procedures regarding the four hours of ongoing long-term care training to show that the training coincides with the agent's license renewal to ensure compliance with s. Ins 3.46 (26) (b) 2., Wis. Adm. Code.

Page 39 13. It is recommended that the company maintain records with regard to insurance company operations in the state of Wisconsin for the preceding three years including, but not limited to, long-term care reports for benefit appeals and rescissions, both state and countrywide, except those that the insured voluntarily effectuated as well as copies of those reports that it annually furnishes to OCI in the proper format to ensure compliance with ss. Ins 6.80 (5) and 3.46 (10) (j), Appendix 8, Wis. Adm. Code.

Page 40 14. It is recommended that the company develop, document and implement a process and written procedures to verify that agents selling long-term care insurance have taken the initial eight credits of long-term care training and ongoing training to ensure compliance with s. Ins 3.46 (26) (a), Wis. Adm. Code, and s. 628.348 (2), Wis. Stat.

Policyholder Service and Complaints

Page 43 15. It is recommended that the company establish a grievance panel to ensure compliance with ss. Ins 18.03 and 18.05, Wis. Adm. Code.

Page 44 16. It is again recommended that the company develop detailed and complete written procedures for the handling of grievances as required by s. 632.83, Wis. Stat., and that includes definitions of complaints and grievances consistent with the definitions in s. Ins 18.01 (2) and (4), Wis. Adm. Code.

Page 44 17. It is again recommended that the company review its complaint tracking system and make any changes necessary to ensure that all health insurance complaints are correctly identified and recorded in order to document compliance with ss. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

Page 44 18. It is recommended that the company implement a process to ensure that the independent review procedure written in its Medicare supplement and select policies are compliant with s. 632.835, Wis. Stat., and s. Ins 18.11, Wis. Adm. Code, and that when a coverage denial determination is made, the company provides a notice to the insured of his or her right to obtain an independent review as required by s. 632.835 (2) (b), Wis. Stat.

Page 45 19. It is recommended that the company send an acknowledgment letter to the insured within five business days of receipt of a grievance to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.

Page 45 20. It is recommended that the company re-establish its procedures to send a written notice to the insured of the time and place of the grievance meeting at least seven calendar days before the meeting to ensure compliance with s. Ins 18.03 (3), Wis. Adm. Code.

Page 46 21. It is recommended that the company re-establish its procedures for sending an extension letter to notify a grievant that the grievance is delayed to ensure compliance with s. Ins 18.03 (6) (b), Wis. Adm. Code.

Policy Forms and Rates

Page 47 22. It is again recommended that the company revise its Medicare select policy form to state that grievances will be acknowledged within 5 days of receipt; to state that if the insurer has not resolved the grievance within 30 days of receipt the company may extend the review period for an additional 30 days and notify the policyholder of the extension and explain why an extension is needed and when resolution can be expected; to include a provision for the expedited review of grievances; and to include information on the independent review process as required by ss. Ins 18.03 (4) and (6) and 18.05, Wis. Adm. Code, and s. 632.835, Wis. Stat.

VII. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination.

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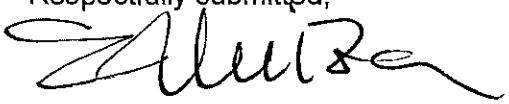
Renee Fabry	Insurance Examiner - Senior
Mary Richardson	Insurance Examiner
Bill Strelow	Insurance Examiner
Nate Gasser	Insurance Examiner

Respectfully submitted,



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