State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K Nickel, Commissioner

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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

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 MILWAUKEE AVE
GLENVIEW IL 60025

dated August 20, 2010, and served upon the company on September 14, 2011, 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 1st day of March, 2013.

Theodore K Nickel
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

GUARANTEE TRUST LIFE INSURANCE COMPANY
GLENVIEW, ILLINOIS

AUGUST 2-20, 2010

TABLE OF CONTENTS

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September 29, 2010

Honorable Theodore K Nickel
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted August 02 to August 20, 2010 of:

GUARANTEE TRUST LIFE INSURANCE COMPANY
Glenview, Illinois

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Guarantee Trust Life Insurance Company (the company) is a mutual life and health insurance company domiciled in the state of Illinois. The company is licensed to do business in 49 states, the District of Columbia and Puerto Rico. The company was founded in 1936 by the Holson family, which still runs the company. The company has multiple business units.

The company operates under an agency system by a field force over 15,000 agents. The company is involved in the sale of a wide array of health and life insurance products, including special risk, credit life and accident, standard life and senior market products, including Medicare supplement and long-term care (LTC). The company also sells several specialty market products including small group, individual major medical and blanket insurance for college, students and youth groups. Due to poor performance of the college health

business, the company scaled back operations in this segment with the intent to terminate unprofitable relationships and begin growing by building a more profitable customer base.

The company sold juvenile and senior life products through direct mail solicitations and telemarketing from leads generated through television advertising. Due to market saturation and extreme pricing competition in 2008, the company stopped selling juvenile life products. In 2006, the company sold the final expense business via a reinsurance transaction. The current portfolio being actively marketed is now compromised of mortgage term and critical illness products.

The company's agency accident and health line is directed primarily to senior health market, providing Medicare supplement, long-term care (LTC), hospital indemnity, cancer and other specialty coverage. In 2006, the company introduced a hospital indemnity product designed to cover out-of-pocket expenses not covered by Medicare Advantage plans.

In 2008, the LTC products were exclusively marketed through Platinum Services based in Dubuque, Iowa.

The company utilized third party administrators (TPAs) to perform various administrative policyholder services such as premium billing and collections, claim adjudication and payment. In 2007, there were approximately 19 different TPAs performing these policyholder service functions on behalf of the company. In addition, the company marketed its products through its subsidiaries: Cornerstone Senior Services and VantageAmerica Solutions, Inc., an organization that provides non-insurance services and discount programs to individuals and groups.

The following table summarizes the total direct national premium written in 2009 and 2008, as compared it to the total direct premium written in Wisconsin.

National Direct Business to Wisconsin Direct Business Summary

2009	Life Insurance Premiums	Annuity Considerations	A&H Premiums	Deposit Type Funds	Other Considerations
Wisconsin	598,801	1,552	8,376,615	0	0
National	42,569,405	187,426	234,650,599	-5,027	0
WI as a % of National	1%	1%	4%	0%	0%
2008	**Life Insurance Premiums**	**Annuity Considerations**	**A&H Premiums**	**Deposit Type Funds**	**Other Considerations**
Wisconsin	580,964	1,678	8,014,985	1	0
National	46,713,946	213,283	243,258,416	6,777	0
WI as a % of National	1%	1%	3%	0%	0%

The majority of the premium written by the company in 2008 and 2009 was for accident and health insurance.

The following tables summarize the premium written and incurred losses in Wisconsin for 2009 and 2008 broken down by line of business.

Premium and Loss Ratio Summary

2009			
Line of Business	**Premium Written**	**% of WI Total**	**Benefits Paid**
Group Policies	2,127,929	25.4%	1,942,989
Federal Employees Health Benefits	0	0.0%	0
Credit (Group & Individual)	117,159	1.4%	97325
Collectively Renewable Policies	0	0.0%	0
Other Individual Policies	6,131,527	73.2%	1,842,989
Total	8,376,615		3,883,303
2008			
Line of Business	**Premium Written**	**% of WI Total**	**Benefits Paid**
Group Policies	2,999,489	37.4%	1,910,531
Federal Employees Health Benefits	0	0.0%	0
Credit (Group & Individual)	86,255	1.1%	117,172
Collectively Renewable Policies	0	0.0%	0
Other Individual Policies	4,929,241	61.5%	1,850,213
Total	8,014,985		3,877,916

WISCONSIN LONG TERM CARE BUSINESS

The following table summarizes the company's Wisconsin long term care business in 2008 and 2009.

2008				
	Wisconsin		National	
	Actual Earned Premium	Actual Incurred Claims	Actual Earned Premium	Actual Incurred Claims
Individual	5,365,862	680,563	158,766,002	100,065,771
Group Direct Response	0	0	0	0
Other Group	0	0	0	0
Total	5,365,862	680,563	158,766,002	100,065,771

2009				
	Wisconsin		National	
	Actual Earned Premium	Actual Incurred Claims	Actual Earned Premium	Actual Incurred Claims
Individual	5,765,816	680,788	180,749,257	109,071,542
Group Direct Response	0	0		
Other Group	0	0		
Total	5,765,816	680,788	180,749,257	109,071,542

Complaints

The Office of the Commissioner of Insurance received 24 complaints against the company between January 01, 2008 through May 27, 2010. A complaint is defined as 'a written communication received by the Commissioner's office that indicates dissatisfaction with an insurance company or agent.' The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint. The company ranked second on the 2008 above average complaint summary published by the OCI. It was not listed on the summary for 2009.

2009										
Reason Type	Claim Handling		Policyholder Service		Underwriting		Marketing & Sales		Total	
Coverage Type	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
Ind A&H			1	50%			1	50%	2	33%
LTC										
Med Sup					1	100%			1	17%
Grp A&H	1	100%							1	17%
Misc Health & Life			1	50%			1	50%	2	33%
Total	1	17%	2	33%	1	17%	2	33%	6	100%

2008										
Reason Type	Claim Handling		Policyholder Service		Underwriting		Marketing & Sales		Total	
Coverage Type	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
Ind A&H	2	100%			1	17%			3	23%
LTC					5	83%			5	38%
Med Sup							1	20%	1	8%
Grp A&H										
Misc Health & Life							4	80%	4	31%
Total	2	16%			6	46%	5	38%	13	100%

GRIEVANCES

A grievance is defined as 'any dissatisfaction with the provision of services or claim practice of an insurer offering health benefit plan, or administration of a health benefit plan by insurer that is expressed in writing to the insurer by, or on behalf of, an insured'. The grievance report for 2009 indicated the company received 34 preferred provider plan grievances and zero grievances for health benefit provider plans. Nineteen or 56% of grievance filed were reversed. The majority of the grievances filed with the company in 2009 were related to plan administration issues.

The grievance report for 2008 indicated the company received 55 preferred provider plan and 17 health benefit provider grievances; 26 or 36% were reversed. All of the grievances filed with the company in 2008 were related to benefit denial issues.

The following tables summarize the grievances for the company for the last two years:

Health Benefit Plans

Category	2009	2008
Access to Care	0	0
Prior Authorization	0	1
Continuity of Care	0	0
Drug & Drug Formulary	0	0
Emergency Services	0	0
Experimental Treatment	0	0
Not Covered Benefit	0	13
Not Medically Necessary	0	0
Other	0	3
Plan Administration	0	0
Plan Providers	0	0
Request for Referral	0	0
Total	**0**	**17**

Preferred Provider Plans

Category	2009	2008
Access to Care	0	0
Prior Authorization	1	7
Continuity of Care	0	0
Drug & Drug Formulary	0	1
Emergency Services	0	0
Experimental Treatment	0	0
Not Covered Benefit	14	21
Not Medically Necessary	0	1
Other	3	22
Plan Administration	0	0
Plan Providers	0	3
Request for Referral	18	0
Total	**34**	**55**

Independent Review

Independent review organizations (IROs) certified to do reviews in Wisconsin are required to submit to the 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 company indicated it had not received requests for IRO review during 2008 and 2009.

II. PURPOSE AND SCOPE

A targeted examination was conducted 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, 2008 through June 30, 2010. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to a review of the company's operations and practices in the areas of electronic-commerce; managed care; marketing, sales and advertising; grievances and IRO; policyholder service and complaints; underwriting and rating; policy forms and rates; claims; privacy; producer licensing; and company operations and management. Also, the examiners reviewed the company's compliance with the Wisconsin Stipulation and Order signed July 28, 2008 regarding long-term care policies.

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

III. CURRENT EXAMINATION FINDINGS

Producer Licensing

The examiners reviewed the company's response to the OCI's producer licensing interrogatory, its agency agreements, producer appointment and termination procedures; verification procedures regarding intermediaries' compliance with long-term care training requirements; and the company's procedure for reconciling its agent appointments with the annual billing statement received from the OCI.

The company stated that its life and health sales department was responsible for agents and agencies oversight and supervision. General agents (GAs) were allowed to solicit and to recommend licensed agents to become appointed with the company. The company categorized its agents as either representatives or as solicitors, which were subagents. The representative's agreement was made directly with the company. The solicitor's agreement was made directly between the general agent and the solicitor. The company's contract/appointment application allowed for commissions to be paid directly to its representative but to pay commissions for policies sold by solicitors directly to general agents.

The company provided a description of its procedures for providing terminated agents with written notice of termination and return of indicia as required by s. Ins 6.57 (2), Wis. Adm. Code. The company's response included a copy of its procedures and sample letters used during the period of review. The examiners found that none of the sample letters included a formal demand for the return of all indicia. The company further explained that general agents were responsible for notifying their subagents of termination, as specified in their contract.

The examiners reviewed a random sample of 25 terminated agent files. The examiners found 16 files did not contain copy of the termination letter sent to the agent. The remaining nine files contained a letter that did not include a formal demand for return of indicia. The examiners requested that the company explain what oversight the company had to ensure that agents were notified of termination and return of indicia to show compliance with s. Ins 6.57

(2), Wis. Adm. Code. The company stated that general agents were responsible for sending termination notice and demand for return of indicia. The examiners found that the company did not have a process to verify that the notice of termination sent by its general agents to the agent requested the return of indicia.

1. **Recommendation:** It is recommended that the company develop a process to demand the return of all indicia in the agent's termination notice to ensure compliance with s. Ins 6.57 (2), Wis. Adm. Code.

The examiners reviewed the commission data provided as part of the data call. The examiners reviewed 100 applications and commission statements and found that one agent sold two policies but did not have a Wisconsin license at the time of sale. Also, the examiners found that three agents were not appointed with the company within 15 days after submitting an application.

2. **Recommendation:** It is recommended that the company develop a process to ensure that it does not accept business directly or enter into an agency contract with an intermediary unless that intermediary is a licensed agent appointed with the insurer in order to comply with s. Ins 6.57 (5), Wis. Adm. Code.

The examiners reviewed nine long-term care not issued applications. The examiners found the following: one agent submitted an application before completing the required two hours Wisconsin specific Medicaid training, and six agents were appointed with the company after submitting an application for LTC insurance. The examiners requested that the company explain how it complied with s. Ins 3.46 (26) (a), Wis. Adm. Code., which states that no insurance intermediary may sell, solicit or negotiate long-term care insurance unless the intermediary is duly licensed and appointed by an insurer and has completed the initial training. The company stated that the general agents monitored and verified agent's compliance with the required long-term care training.

The examiners reviewed the Platinum Services LTC Guidebook. The guide included copy of a company memo sent to Platinum Services regarding approval notice for Platinum LTC products. The memo stated that Wisconsin did not have a separate licensing or continuing

education requirement to solicit LTC insurance. The examiners requested that the company explain how it notified its agents of the changes regarding insurance intermediary LTC training requirements to ensure compliance with s. Ins 3.46 (26), Wis. Adm. Code. The company provided a copy of the email dated December, 2008 sent to Platinum Services. The email stated that any agent appointed in Wisconsin must complete the initial LTC training before the company accepted the LTC application. The examiners were not able to verify that the company notified its agents that all insurance intermediaries must complete the long-term care training prior to selling, soliciting or negotiating long-term care insurance products in Wisconsin.

3. **Recommendation:** It is recommended that the company develop a process to ensure that no insurance intermediary sell, solicit or negotiate long-term care products in the state unless the intermediary is duly licensed and appointed by the company and has completed the long-term care training in order to comply with s. Ins 3.46 (26) (a), Wis. Adm. Code.

Electronic Commerce

The examiners reviewed the company's response to the OCI's electronic commerce interrogatory. The examiners reviewed the company's registered domain names; its use of the internet and world wide web in the marketing and selling of its insurance products; online application process; development and maintenance of the website; electronic lead generation; and monitor of agent's advertising on the internet.

The company's life and health and IT departments were responsible of overseeing the company's internet activities. The URL registered and used by the company was www.gtlic.com. The company did not have a webmaster nor did it use electronic commerce to market directly to consumers. The company had an agent portal by which the agent could complete and submit an application electronically. The company did not provide support for any agent sites. However, the company performed Google searches to monitor unauthorized advertising of its products.

No exceptions were noted regarding the electronic commerce review.

Policyholder Service and Complaints

The examiners reviewed the company's response to the OCI's policyholder service and complaint interrogatory; its complaint handling policies and procedures and its complaint log. The policy owner service (POS) and customer service unit (CSU) provided answers to insured's inquiries or requests. The POS unit handled all written inquiries regarding policy status, general policy information, and requests for changes, cancellations or reinstatements. The CSU handled all telephone inquiries regarding policy status, general policy information, and requests for changes, cancellations or reinstatements. It provided claim status and verification for all accident and health plans other than long-term care. Agent complaints were handled in the agency department including suitability of sale regarding long-term care, nursing home or home health care policies.

The company defined complaint as any written communication primarily expressing a grievance. The company stated that complaints may be received directly from the policyholder, the state's department of insurance, or another intermediary, such as the Better Business Bureau. The company designed a web-based Access database to capture the information for written complaints received directly from the consumer. The complaint could be logged by the home office or TPAs through separate authorization codes. Third-party administrators were required to maintain their own complaint logs and notified the company of any state department of insurance (DOI) complaint. Any consumer complaints received from the DOI and other intermediaries were maintained separately by product approval and compliance unit. If a complaint was coded as "claim" as the complaint reason code, a box appeared and checked by the reviewer if the case was to be tracked for state required grievance registers and/or reporting.

The examiners interviewed the Director of Compliance and Customer Service for Platinum Services. The Director indicated that all complaints were handled, reviewed and answered by customer service representatives. The Director stated that Platinum Services did

not have a mechanism to forward consumer complaints to the company. The examiners reviewed the data provided as part of the data call request. The database did not include any non-DOI complaints. The examiners requested that the company explain how it complied with s. Ins 18.02 (2), Wis. Adm. Code and to provide a list of all non-DOI consumer complaints and the company's annual internal complaint report. The company stated that it defined complaint and grievance as written dissatisfaction but it would expand the tracking of complaints to include any form of dissatisfaction received by phone, in-person or email. The company did not have a system to track non-written consumer complaints. The company provided copy of seven written complaints filed by policyholders that were not included in the database.

The examiners reviewed multiple sales and marketing agreements including advertising files for 23 associations. The largest association was Consumer Alliance USA. The company required each association to maintain a complaint log. However, the company defined complaints as any written correspondence from an insured, agent, provider, attorney, beneficiary, which expresses a specific grievance about the manner in which a matter was handled administratively and which solicits a response.

4. **Recommendation:** It is recommended that the company revise and update its definition of complaint to ensure compliance with s. Ins 18.01 (2), Wis. Adm. Code.

5. **Recommendation:** It is recommended that the company develop a process and written procedures to monitor, review and track complaints from all departments, representatives, general agencies, third-party administrators and vendors in order comply with s. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

Grievance and Independent Review

The examiners reviewed the company's response to the OCI's grievance and independent review interrogatory; its grievance procedures, annual grievance experience reports for 2008 and 2009; and its procedures for handling independent review request.

The company's claim department reviewed grievance, appeal and external review requests. The company defined grievance as any written correspondence expressing disagreement, dissatisfaction, or request for reconsideration on the handling of a prior partial or full denial of benefits. The company stated that it included copy of the Wisconsin appeal form #NOT-02-WI with the policy or certificate. Otherwise, the notice to appeal was included in the explanation of benefit and denial letters.

The examiners reviewed the company's written procedure titled, standard claim department grievance or appeal procedures (Rev. 02/25/10). The document indicated that all qualified written grievances or appeals had to be filed with the company within ninety days after receipt of denial notice. The insured's grievance was directed to the claim department; then the adjuster reviewed prior handling of the claim and either made a correction or provided and explanation for the decision made. The final determination was made no later than 30 calendar days after receipt. Upon second notice of the same grievance, the case was referred to a supervisor for review. The supervisor responded to the insured in writing within 30 days or within three days for an expedited request but no later than 30 calendar days. If the insured was not satisfied with the outcome, the grievance was presented to the manager or vice president of claims for review. The review and determination was made in writing within 30 calendar days.

The examiners requested that the company explain its second appeal process as defined in its written procedures and the TPA's agreements. The company stated that when a claim was denied and if the TPA received a written appeal, the supervisor of the adjuster who handled the original claim reviewed the action and responded to the appeal. If the insured or provider disagreed and requested second appeal, management reviewed the appeal and forwarded the response to the vice-president of the claims department for review.

6. **Recommendation:** It is recommended that the company revise its grievance procedures to ensure compliance with s. Ins 18.03, Wis. Adm. Code.

Underwriting and Rating

The examiners reviewed the company's response to the OCI's new business and rating interrogatory; its rejection notification process; rider and rating guidelines; its replacement, cancellation and terminations procedures.

The company's new business department was responsible for entering data elements into the company's administrative system, setting up file folders for applications, issuing and mailing policies and refunding applications not issued or declined. It also coded the applications in the administrative system to verify that the plan was approved in the state; the applicant met the age limits; the premium was correct and the agent was duly licensed.

The examiners reviewed four group health retiree policies that were cancelled for non-payment of premium. The examiners found that three insureds were part of the City of Beloit group administered by Gilsbar. The fourth insured enrolled in the Senior Choice plan offered through Merchant Industry Fund Group Insurance Trust. The examiners found that the company accepted and processed a Monumental Life Insurance Company application for this insured instead of the company's enrollment form.

The examiners requested a list of all long-term care policies issued in Wisconsin with an initial five year rate guarantee. The examiners found that 591 policyholders replaced their policy form #G0200-WI or #G0280-WI with new policy form #G0600-WI or #G0680-WI. The company stated that new applications were completed and agents were instructed to provide and signed the replacement form. The examiners reviewed 20 submitted long-term care applications. The examiners requested that the company explain how it complied with s. Ins 3.46 (14) (c) 3., Wis. Adm. Code, which states that upon determining that a sale will involve replacement, an insurer or its intermediaries shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of long-term care coverage. In addition, the examiners requested that the company explain why these replacements were not included in the annual Wisconsin replacement report as required

under s. Ins 3.46 (21), Wis. Adm. Code. The company stated that it considered these replacements as conversions rather than true replacement activity. The examiners found that these transactions met the definition of replacement under s. Ins 3.29 (4) (a), Wis. Adm. Code; defined as any transaction wherein new accident and sickness insurance is to be purchased, and it is known to the agent or company at the time of application that as part of the transaction, existing accident and sickness insurance has been or is to be lapsed or benefits thereof substantially reduced.

7. **Recommendation:** It is recommended that the company develop a process to ensure that agents furnish the applicant prior to issuance or delivery a notice regarding replacement of long-term care coverage in order to comply with s. Ins 3.46 (14), Wis. Adm. Code.

8. **Recommendation:** It is recommended that the company develop a process and maintain records for each agent on that agent's amount of long-term care insurance replacement sales in order to ensure compliance with s. Ins 3.46 (21), Wis. Adm. Code.

The examiners reviewed the rate filing for the following long-term care policy forms: G9902, G9903, G9984 and G9986. According to the OCI records, the company filed a 20% rate increase effective October 6, 2008 and a 25% rate increase effective February 2, 2010. The examiners requested a spreadsheet to show all Wisconsin policyholders affected by these rate increases. The examiners found four policyholders received the first rate increase in 2009 and the second rate increase in less than 2 year period. The examiners requested that the company explain how it complied with s. Ins 3.455 (9) (b) 1., Wis. Adm. Code, which states that any premium rate increase after the initial three year period is guaranteed for at least two years after its effective date. The company acknowledged the oversight, adjusted the premium increases and issued a refund to these policyholders.

9. **Recommendation:** It is recommended that the company reprocess the rate increases for those individuals effective between August 1, 1996 and December 31, 2001 to ensure compliance with s. Ins 3.455 (9), Wis. Adm. Code.

Claims

The examiners reviewed the company's response to the OCI's claim interrogatory; its claim administration process and procedures, claim adjustment (ANSI) codes, claim methodology, explanation of benefits (EOB) and remittance advice (RA) forms, and its administrative services and vendor agreements.

The examiners reviewed a random sample of 20 Medicare claims paid, 20 Medicare claims denied and 13 Medicare carve-out claims denied. These claims were processed by the company or Gilsbar, a third party administrator. The examiners requested that the company review its explanation of benefit and remittance advice forms and explain how these forms complied with s. Ins 3.651, Wis. Adm. Code regarding the standardized format. The company stated that it did not use remittance advice forms during the period of review. .

The examiners determined that the explanation of benefit form did not meet the requirements of s. Ins 3.651 (3) (b) 4.b, d, f, g and i, Wis. Adm. Code. The form did not contain the CPT4/HCPCS, the amount allowed, the copayment amount, and the coinsurance amount. In addition, the examiners found that the claim adjustment codes (ANSI code) used in the explanation of benefit did not comply with s. Ins 3.651 (5), Wis. Adm. Code., which states an insurer shall use the updated codes provided by the OCI no later than the first day of the 4th month beginning after being notified that an updated list of codes is available. The company stated that its claim systems had limitations in capturing required data and could not implement ANSI codes. The company stated it was currently converting to a new claim system to be completed in 2012. Once the conversion was completed, the company could determine the capabilities of the new claims stem for compliance with ANSI code requirements.

10. **Recommendation:** It is recommended that the company revise and update the explanation of benefit forms to ensure compliance with s. Ins 3.651 (4), Wis. Adm. Code.

11. **Recommendation:** It is recommended that the company develop a process to update the claim adjustment reason codes (ANSI codes) used on its explanation of benefit forms to ensure compliance with s. Ins 3.651 (5), Wis. Adm. Code.

The examiners reviewed form #G0330 – First Diagnosis Cancer Policy. The policy stated that benefits payable toward a covered service were based upon the usual and customary charge for that service. The examiners noted that the cancer policy schedule and surgical procedure schedule were based on fixed payment amount. The cancer policy surgical schedule stated that if the insured had a surgical procedure performed which was not shown in the surgical schedule, the company would paid a benefit amount based on the difficulty of the procedure as compared to the difficulty of the procedure shown. The examiners requested that the company explain how its claim settlement procedure complied with s. Ins 3.60 (4), Wis. Adm. Code. The company stated that claims were processed as either fixed indemnity benefits or payable up to a fix amount; usual and customary adjudication was not used as claim methodology for cancer products. The company indicated that it no longer marketed policy for G0330 – First Diagnosis Cancer Policy.

The examiners reviewed a random sample of 20 hospital indemnity claim paid. The sample included 10 Advantage Plus hospital indemnity plan claims, which are discussed in the GTL AdvantagePlus section of the report. No exceptions were noted regarding the other 10 claims.

Privacy and Confidentiality

The examiners reviewed the company's response to the OCI's privacy and confidentiality interrogatory; its privacy policies and procedures manual; confidentiality agreement for employees, process for notifying insureds of privacy policy, its privacy notice and authorization for disclosure of health information.

The Board of Director designated the company's senior vice president of administration as the chief privacy officer. The company created a task force to implement its privacy policies and procedures under the Health Insurance Portability and Accountability Act (HIPPA). The company used a software program for training new employees and it was the

responsibility of the manager to train new employees in the company's compliance. The examiners reviewed the HIPPA procedure #0100 (issued 4/1/03). The company required that any documentation included an effective date and revision date to reflect when the document was created or when a change was made. The examiners reviewed the following privacy documents: overview and guide to use of HIPPA procedures and protection of confidential data documentation and were not able to find the effective date or revision date of these documents.

In addition, the company required all departments to develop its privacy procedures. Upon receipt of approval from the steering committee, each department needed to implement its privacy procedures through employee training and provide documentation to the committee upon completion. The examiners reviewed the agent guide, the agent appointment application, the general agent agreement and three marketing and administrative service agreements. The examiners found that these agreements did not contain any reference to the company's privacy policies. The examiners requested that the company identify the individual or department responsible to develop, implement and monitor its business associates or licensee and the company's affiliates and service providers regarding their compliance with HIPPA privacy laws.

. The company stated that it contracted with independent agents. As independent contractors, agents were responsible for compliance with state and federal privacy laws. Outside of information the agents collected from insureds at the time of application, the company did not release personal health information to agents unless insureds provided the company with written authorization to release such information.

Policy Forms

The examiners reviewed the company's response to the OCI's policy form and rates interrogatory. The company's product approval and compliance department were responsible for the preparation of new policy forms and amendments to existing forms. The company's

actuarial department was responsible for filing subsequent premium increases. Once the form was approved for use, the product approval department notified all departments.

The Office of the Commissioner of Insurance updated s. 631.20, Wis. Stat. to reflect changes to the filing and approval of policy forms on or after July 1, 2008. The statute exempts certain insurance policy forms for receiving prior approval before their use. Insurers could use certain policy forms if the insurer complied with all of the following: files the form with the Commissioner 30 days prior to its use; files the form in the manner and format prescribed by the Commissioner and certifies that the form complies with chs. 600 to 655, Wis. Stat. The changes to s. 631.20, Wis. Stat. did not apply to Medicare supplement policy forms and long-term care insurance policy forms, including nursing home and home-health care policy forms.

The examiners reviewed five form filings submitted to the OCI on or after July 1, 2008. In addition, the examiners reviewed a random sample of 144 forms used during the period of review. The examiners noted the following exceptions.

Certificate of Insurance [form MCC-2004-WI (11/08)]

1) The certificate did not include Wisconsin mandated benefits, which did not comply with s. 632.895 and 632.835, Wis. Stat.

Enrollment application form SC-GTL-EA090910

1) The enrollment form was not filed with the OCI for approval prior to use.

12. **Recommendation:** It is recommended that the company update and re-file its small group plan to include coverage for Wisconsin mandated benefits in order to comply with s. 632.895, Wis. Stat.

13. **Recommendation:** It is recommended that the company file its Senior Choice plan enrollment application (form SC-GTL-EA090910) with the OCI for approval in order to comply with s. 631.20, Wis. Stat.

Policy form G0553-WI and outline of coverage form #OCG0553

Discussion of the review of these forms is included later in the report under GTL AdvantagePlus Product.

Marketing, Sales and Advertising

The examiners reviewed the company's response to the OCI's marketing, sales and advertising interrogatory; its advertising files; its marketing, sales and agent activities; and the company's short and long range marketing goals.

The company's life and health sales division, also referred to as the agency department was responsible for marketing, sales and advertising. The advertising files were maintained by the compliance department.

The examiners reviewed the Medicare supplement product and service webpage in the company's website and requested copy of the transmittal form to demonstrate compliance with s. Ins 3.39 (15), Wis. Adm. Code regarding Medicare advertisement filing requirements. The company stated that it did not file the advertisement with the OCI prior to use. Also, the website stated that Medicare supplement "policy could provide benefits for prescription drug". The examiners requested an explanation on how the company complied with s. Ins 3.39 (4) (a) (20), Wis. Adm. Code, which states that a policy with benefits for outpatient prescription drug shall not be issued after December 31, 2005. The company stated that the reference to prescription drug should have been deleted when the company removed the prescription drug benefit from its Medicare supplement policies.

14. **Recommendation:** It is recommended that the company file its Medicare supplement advertisement in order to comply with s. Ins 3.39 (15), Wis. Adm. Code.

The examiners reviewed the Medicare pamphlet [form P1-002 (R 21/2008)] and requested that the company explain how it complied with s. Ins 3.39 (11), Wis. Adm. Code, which states that every prospective Medicare eligible receives a copy of the current edition of the Commissioner's pamphlet *Wisconsin Guide to Health Insurance for People with Medicare* in a type size no smaller than 12 point type. The examiners found that the company reproduced the pamphlet itself and did not use the same type size as required under above regulation.

15. **Recommendation:** It is recommended that the company reprint its *Wisconsin Guide to Health Insurance for People with Medicare* to ensure compliance with s. Ins 3.39 (11), Wis. Adm. Code.

The examiners reviewed the cancer welcome letter (form #HAF-00-1) sent to new applicants. The letter referred to cancer insurance as health insurance coverage. The examiners requested that the company explained how referring to cancer insurance as health insurance coverage complied with s. 628.34, Wis. Stat. The company stated that its welcome letter used the words "health insurance" in the broadest sense of term, i.e. as category of insurance versus product specific.

16. **Recommendation:** It is recommended that the company revise its cancer welcome letter to reference that the policy covers only specified diseases in order to comply with s. 628.34, Wis. Stat.

The examiners reviewed a random sample of 72 advertisements in its advertising file. The examiners noted the following exceptions.

Advertisement form ADH05-07 (Rev 7/08 and Rev 3/09)

Discussion of the review of this advertisement form is included later in the report under GTL AdvantagePlus Product.

Cancer advertisement #ADH32-03 (16B589 Rev. 12/08)

a. Two advertisement forms had the same form number, although the content was different. The forms did not comply with s. Ins 3.27 (9) (c), Wis. Adm. Code.

Association advertisements to market accident, death and dismemberment, and accidental medical expense coverage

b. 19 advertising forms misrepresented policy benefit by overstating its benefits. These forms did not comply with s. 628.34, Wis. Stat.

c. Three advertisements did not identify the insurer which issues the coverage.

Advertisement form PSI02-101 [ADH01-07 (Rev. 9/08)]

d. The advertisement stated that Platinum Services had not raise rates on existing cancer, heart attack and stroke policyholder. The form did not comply with s. Ins

3.27 (12), Wis. Adm. Code which states that the identity of an insurer shall be made clear in all of its advertisements.

Critical provider guide and brochure

The examiners reviewed the critical provider field underwriting guide (form ADL5-10), the company product portfolio training (cross-selling GTL supplemental products PowerPoint presentation) and the critical provider brochure (form ADL4-10). The critical provider, a renewable term life insurance plan, provided accelerated benefit for up to 18 critical or terminal illnesses; such as: cancer, heart attack, kidney failure, major organ transplant, coronary artery bypass surgery, stroke, blindness, coma or paralysis. The accelerated benefit plan provided an accelerated or advanced life benefit if the insured was diagnosed by a physician as having terminal illness and not expect to live more than 6-12 months. According to the agent underwriting guide and plan brochure, the company described its critical provider plan as a 10 or 20 year renewable term life insurance with a critical illness accelerated benefit rider which provide cash benefit for 18 critical conditions. However, the company failed to disclose in its brochure that the plan only provided benefits due to advanced or rapidly progressing illness and when the insured had a life expectancy of 12 months or less, as diagnosed and certified by a doctor. The advertisement did not comply with s. 628.34, Wis. Stat. because it contained false or misleading information, including misinformation misleading because of incompleteness.

17. **Recommendation:** It is recommended that the company review its critical provider advertisement as well as its third-party administrator, vendor, and association advertising files to ensure compliance with s. 628.34, Wis. Stat.

18. **Recommendation:** It is recommended that the company revise its cancer advertising files in order to comply with s. Ins 3.27 (9) (c), Wis. Adm. Code.

19. **Recommendation:** It is recommended that the company revise its marketing agencies advertising files to ensure compliance with s. Ins 3.27 (12), Wis. Adm. Code.

GTL's AdvantagePlus Product

In 2006, the company filed policy form G0553-WI with the OCI and began marketing its limited benefit hospital confinement indemnity plan. The policy included multiple riders, such as: skilled nursing care, cancer and durable medical equipment. Until July 2009, the company marketed and sold its hospital indemnity policy to individuals age 64 ½ and older. After July 2009, the company refiled its rates and expanded the coverage to individual's age 40 to 85. Initially, these policies were guarantee issued but later amended to guarantee issue to individuals ages 64 ½ to 65 ½. Prior to July 2009, these plans were known as Medicare AdvantagePlus plan and marketed to fill the gap of Medicare Advantage plans. After July 2009, the company changed its plan name to AdvantagePlus plan.

The examiners reviewed policy form G0553-WI, the outline of coverage (form #OCG0553) and the disclosure notice (form #MEDDUP5). The basic policy offered benefits for hospital confinement indemnity, hospital confinement due to mental or nervous disorder and emergency room visits. Applicants had the option to purchase the following riders: skilled nursing facility benefit rider, lump sum hospital benefit rider, ambulance service benefit rider, durable medical equipment benefit rider or accidental death and dismemberment rider.

The examiners reviewed three new business hospital indemnity applications sold to Medicare beneficiaries and found that these policyholders purchased the skilled nursing facility benefit rider. The examiners also reviewed 10 AdvantagePlus hospital indemnity claims paid, 14 AdvantagePlus claims denied and the hospital indemnity procedure manual. Section 3.39 (9) (c), Wis. Adm. Code states that an individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person: (1) shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46, Wis. Adm. Code. The examiners requested that the company explain how it complied with s. Ins 3.39 (9), Wis. Adm. Code. The examiners were not able to verify how the company complied with s. Ins 3.39 (9), Wis. Adm. Code.

20. Recommendation: It is recommended that the company cease marketing its skilled nursing facility benefit rider to Medicare eligible individuals who purchase the AdvantagePlus plan unless the nursing home coverage meets the standards set forth in s. Ins 3.46, Wis. Adm. Code, to ensure compliance with s. Ins 3.39 (9), Wis. Adm. Code.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted July 15, 2008. MIPPA applies to any disability insurance policy or certificate designed to reduce or eliminate gaps arising from coverage in a Medicare Advantage or Medicare Part D prescription drug plan. Pursuant to s. 104 (c) of MIPPA, policies and certificates that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage plans shall comply with Medicare supplement requirements. Under s. 104 (c), such plans that are marketed to Medicare eligible individuals must comply with Medicare supplement requirements, including standardization.

The examiners reviewed copies of the agent's newsletter distributed during the period of review. The examiners found that from July 2008 through December 2009 and again on April 2010, the company advertised, marketed and encouraged its agent to sell the AdvantagePlus plan as a supplement to their client's primary health plan. "AdvantagePlus, limited benefit policy, fills gaps in coverage caused by copayments, deductibles and more." The examiners requested that the company explain how it complied with s. Ins 3.39 (1), Wis. Adm. Code and MIPPA laws. The company stated that the AdvantagePlus plan was filed as a limited benefit policy, which paid cash indemnity benefits without regards to the type of primary health insurance an insured may be covered under. The company notified its agent on December 2009 that the AdvantagePlus plan was a limited benefit policy not a Medicare supplement and it did not supplement any federal Medicare plan including Medicare Advantage plans. The examiners determined that the company was marketing its AdvantagePlus plan to Medicare eligible individuals as a supplement to their primary health insurance to help fill the gaps in coverage caused by copayments and deductibles. The company indicated it made

revisions to its advertising material in March 2009, and removed all references to the product as filing a gap in coverage caused by copayments and deductibles.

21. **Recommendation:** It is recommended that the company cease the use of any advertisement for its AdvantagePlus plan that states or implies it fills gaps in or supplements Medicare or Medicare Advantage plans in order to comply with s. Ins 3.39, Wis. Adm. Code.

The examiners reviewed form ADH05-07 (Rev 7/08 and Rev 3/09). The examiners found that the advertisements did not clearly describe the type of coverage provide by the policy advertised and that the company made some representations that were misleading in fact or in implication. The company did not refer to the policy as a limited benefit plan and stated that the new AdvantagePlus plan was designed to supplement the individual's current health plan. The examiners requested that the company explain how it complied with s. Ins 3.27 (4), (6) and (9), Wis. Adm. Code. The company stated that the advertisement described the type of coverage and benefits being offered.

22. **Recommendation:** It is recommended that the company review its AdvantagePlus plan advertisement in order to comply with s. Ins 3.27 (4), (6) and (9), Wis. Adm. Code.

The examiners requested that the company provide the manner and extent of its advertising file for AdvantagPlus plan (form ADH05-07 (Rev7/08)) to show compliance with s. Ins 3.27 (28), Wis. Adm. Code. The company stated that its advertising files were maintained as part of a particular product file and contained copies of the standard and state variation. The product file included state filings, all policy or rider forms, applications, outlines and advertising. The examiners were not able to verify that each advertisement contain a notation indicating the manner and extent of distribution and the form number of any policy, amendment, rider or endorsement form advertised.

23. **Recommendation:** It is recommended that the company develop a process and update its product file to include a notation to each advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised in order to comply with s. Ins 3.27 (28), Wis. Adm. Code.

Company Operations and Management

The examiners reviewed the company's response to the OCI's company operations and management interrogatory; its marketing and administrative agreements; and the company's compliance with Wisconsin Stipulation and Order.

The company did not have a centralized compliance unit. The vice-president of compliance reported directly to the general counsel. The department main duties were: draft and file products in all states; monitor compliance with all federal and state laws; respond to insurance department complaints; and review advertising files. The sales and marketing department handled product development and monitor all agreements with associations. The company did not have a compliance manual; every department was responsible to develop its own guidelines.

The company stated that it had numerous processes in place that monitored the activities of entities that perform various functions on its behalf. The company delegated the following functions to its third-party administrators: administrative services, marketing assistance services, underwriting services, premium billing services, managed care and cost containment services. The company required third-party administrator to complete a comprehensive process and control questionnaire and to review prior to the company performing an annual onsite audit. The claim department handled all third-party administrator audits. The examiners requested copy of internal or external audits during the period of review including copy of audits of its agents and agencies licensed in Wisconsin. The examiners could not verify that the company conducted any audits during the period of review.

24. **Recommendation:** It is recommended that the company develop a process to monitor and audit its third-party administrators, vendors, agents and agencies to ensure their compliance with Wisconsin insurance laws.

Wisconsin Stipulation and Order

The examiners reviewed the company's compliance with the Wisconsin Stipulation and Order signed July 28, 2008. The OCI found that the company failed to comply with the

terms of its long-term care policies, failed to provide proper notice of potential rate increases, and failed to provide at least 60 days advance notice to 1485 Wisconsin policyholder. The OCI issued forfeiture and requested that the company provide the Commissioner verification of compliance with the Illinois Stipulation and Consent Order dated May 18, 2007 and to comply with all Wisconsin insurance laws and agreements made in the Stipulation.

The examiners reviewed a random sample of 11 long-term care policies during the onsite examination. The examiners found that company miscalculated three premium refund issued to Wisconsin policyholders. These findings were noted in policies that had spousal rider, return of premium rider or limited pay rider. The examiners requested that the company explain how it complied with Illinois Stipulation and Order which stated that:

(a) GTL shall revert to the original, at issue, premium rates of its LTC policies and riders until the expiration of the initial rate guarantee period.

(b) GTL shall refund to all policyholders any additional premium received as a result of changing the amount of premium prior to the expiration of the initial rate guarantee period.

(c) GTL policyholders, who terminated their LTC subsequent to receiving the premium rate adjustment on the riders, shall be given the opportunity to reinstate their policy and riders at the premium rates in effect before the adjustment.

(d) GTL shall pay to all affected policyholders interest at a rate of 5% on the additional monies paid by the policyholder due to the increase in the riders' rates. Interest shall be paid from the date the additional premium was paid until the date the refund or credit.

The company provided copy of the corrective action taken for Wisconsin policyholders. The company acknowledged it had found some miscalculations of premium refunds issued to Wisconsin policyholders with policies that had the limited pay rider and indicated that these calculations were complex in nature and performed manually by company staff.

25. **Recommendation:** It is recommended that the company conduct an audit of the 60 Wisconsin long-term care policies with limited pay riders to verify that the manual calculation of premium refund was done correctly to ensure compliance with the Wisconsin Stipulation and Order signed July 28, 2008.

IV. CONCLUSION

This market conduct examination involved a targeted review of Guarantee Trust Life Insurance Company's practices and procedures for the period of review January 1, 2008 to June 30, 2010. The examination resulted in 25 recommendations in the areas of claims; producer licensing; grievance; marketing, sales and advertising; underwriting and rating; policy forms and company operations.

The examiners found that the company's written procedures did not have an effective or revision date. Therefore, the examiners were not able to verify that its written procedures were in effect during the examination time frame.

The examination identified multiple areas as needing improvements; such as: agent training and oversight; identification of company; transparency of the company's relationship with third-party administrators and associations; complaints and grievances; and establishing and maintaining compliance program.

V. SUMMARY OF RECOMMENDATIONS

Producer Licensing

Page 9 1. It is recommended that the company develop a process to demand the return of all indicia in the agent's termination notice to ensure compliance with s. Ins 6.57 (2), Wis. Adm. Code.

Page 9 2. It is recommended that the company develop a process to ensure that it does not accept business directly or enter into an agency contract with an intermediary unless that intermediary is a licensed agent appointed with the insurer in order to comply with s. Ins 6.57 (5), Wis. Adm. Code.

Page 10 3. It is recommended that the company develop a process to ensure that no insurance intermediary sell, solicit or negotiate long-term care products in the state unless the intermediary is duly licensed and appointed by the company and has completed the long-term care training in order to comply with s. Ins 3.46 (26) (a), Wis. Adm. Code.

Policyholder Service and Complaints

Page 12 4. It is recommended that the company revise and update its definition of complaint to ensure compliance with s. Ins 18.01 (2), Wis. Adm. Code.

Page 12 5. It is recommended that the company develop a process and written procedures to monitor, review and track complaints from all departments, representatives, general Agencies, third-party administrators and vendors in order comply with s. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

Grievance and Independent Review

Page 13 6. It is recommended that the company revise its grievance procedures to ensure compliance with s. Ins 18.03, Wis. Adm. Code.

Underwriting and Rating

Page 15 7 It is recommended that the company develop a process to ensure that agents furnish the applicant, prior to issuance or delivery a notice regarding replacement of long-term care coverage in order to comply with s. Ins 3.46 (14), Wis. Adm. Code.

Page 15 8. It is recommended that the company develop a process and maintain records for each agent on that agent's amount of long-term care insurance replacement sales in order to ensure compliance with s. Ins 3.46 (21), Wis. Adm. Code.

Page 15 9. It is recommended that the company reprocess the rate increases for those individuals effective between August 1, 1996 and December 31, 2001 to ensure compliance with s. Ins 3.455 (9), Wis. Adm. Code.

Claims

Page 16 10. It is recommended that the company revise and update the explanation of benefit forms to ensure compliance with s. Ins 3.651 (4), Wis. Adm. Code.

Page 16 11. It is recommended that the company develop a process to update the claim adjustment reason codes (ANSI codes) used on its explanation of benefit forms to ensure compliance with s. Ins 3.651 (5), Wis. Adm. Code.

Policy Forms

Page 19 12. It is recommended that the company update and re-file its small group plan to include coverage for Wisconsin mandated benefits in order to comply with s. 632.895, Wis. Stat.

Page 19 13. It is recommended that the company file its Senior Choice plan enrollment application (form SC-GTL-EA090910) with the OCI for approval in order to comply with s. 631.20, Wis. Stat.

Marketing, Sales and Advertising

Page 20 14 It is recommended that the company file its Medicare supplement advertisement in order to comply with s. Ins 3.39 (15), Wis. Adm. Code.

Page 21 15 It is recommended that the company reprint its *Wisconsin Guide to Health Insurance for People with Medicare* to ensure compliance with s. Ins 3.39 (11), Wis. Adm. Code.

Page 21 16. It is recommended that the company revise its cancer welcome letter to reference that the policy covers only specified diseases in order to comply with s. 628.34, Wis. Stat.

Page 22 17. It is recommended that the company review its critical provider advertisement as well as its third-party administrator, vendor, and association advertising files to ensure compliance with s. 628.34, Wis. Stat.

Page 22 18. It is recommended that the company revise its cancer advertising files in order to comply with s. Ins 3.27 (9) (c), Wis. Adm. Code.

Page 22 19. It is recommended that the company revise its marketing agencies advertising files to ensure compliance with s. Ins 3.27 (12), Wis. Adm. Code.

Page 24 20. It is recommended that the company cease marketing its skilled nursing facility benefit rider to Medicare eligible individuals who purchase the AdvantagePlus plan unless the nursing home coverage meets the standards set forth in s. Ins 3.46, Wis. Adm. Code, to ensure compliance with s. Ins 3.39 (9), Wis. Adm. Code.

Page 25 21. It is recommended that the company cease the use of any advertisement for its AdvantagePlus plan that states or implies it fills gaps in or supplements Medicare or Medicare Advantage plans in order to comply with s. Ins 3.39, Wis. Adm. Code.

Page 25 22. It is recommended that the company review its AdvantagePlus plan advertisement in order to comply with s. Ins 3.27 (4), (6) and (9), Wis. Adm. Code.

Page 25 23. It is recommended that the company develop a process and update its product file to include a notation to each advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised in order to comply with s. Ins 3.27 (28), Wis. Adm. Code.

Company Operations and Management

Page 26 24. It is recommended that the company develop a process to monitor and audit its third-party administrators, vendors, agents and agencies to ensure their compliance with Wisconsin insurance laws.

Page 28 25. It is recommended that the company conduct an audit of the 60 Wisconsin long-term care policies with limited pay riders to verify that the manual calculation of premium refund was done correctly to ensure compliance with the Wisconsin Stipulation and Order signed July 28, 2008.

VI. ACKNOWLEDGMENT

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.

Name	Title
Linda Low	Insurance Examiner
Lynn Pink	Insurance Examiner
Kevin Zwart	Insurance Examiner
Moua Yang	Insurance Examiner

Respectfully submitted,

Nitza Pfaff
Examiner-in-Charge