# 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

MUTUAL OF OMAHA / UNITED OF OMAHA
MUTUAL OF OMAHA PLAZA
OMAHA NE 68175

dated AUGUST 26, 2011, and served upon the company on JANUARY 10, 2012, 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 10th day of January, 2013.

Theodore K. Nickel
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

MUTUAL OF OMAHA INSURANCE COMPANY
&
UNITED OF OMAHA LIFE INSURANCE COMPANY

OMAHA, NEBRASKA

AUGUST 8, 2011 TO AUGUST 26, 2011

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# State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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September 10, 2011

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

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conduct August 8, to August 26, 2011 of:

MUTUAL OF OMAHA INSURANCE COMPANY
&
UNITED OF OMAHA LIFE INSURANCE COMPANY
Omaha, Nebraska

and the following report of the examination is respectfully submitted.

## I. INTRODUCTION

Mutual of Omaha Insurance Company (Mutual) was incorporated under the laws of the State of Nebraska on March 5, 1909, and commenced business January 10, 1910, on the mutual assessment plan under the name, "Mutual Benefit Health and Accident Association." In 1962, the company amended its articles of incorporation changing its corporate structure from a mutual assessment association to a mutual legal reserve company with no power to levy assessments. It also changed its name to "Mutual of Omaha Insurance Company."

Mutual is licensed to write life and accident and health (A&H) insurance in all fifty states including the District of Columbia, Puerto Rico, US Virgin Islands and the British Virgin Islands focusing primarily on accident and health business, specifically Medicare supplement, long-term care, and long and short term disability income.

In 2010 Mutual was ranked as the 18th largest writer of Medicare supplement policies in Wisconsin with $8,412,066 earned premium with no new policies issued that year. The total earned premium for the company's Medicare supplement business in 2009 was $9,648,229 while losing 632 of policies that year. Total policyholders at the end of 2009 was 2506 and at the end of 2010 the total policyholders numbered 1874.

In addition, the company ranked as the 23rd largest writer in Wisconsin of long-term care with $1,656,802 earned premium with 76 new policies issued that year. The total earned premium for the company's long-term care business in 2009 was $1,567,813 while gaining 23 of policies that year. The total policyholders at the end of 2009 was 1183 and at the end of 2010 the total policyholders numbered 1206.

United of Omaha Life Insurance Company (United) was incorporated under the laws of the State of Nebraska on August 9, 1926, and commenced business November 26, 1926, under the name, "United Benefit Life Insurance Company". In 1981 the present company title was adopted.

United was licensed to write life and accident and health (A&H) Insurance in all fifty states including the District of Columbia, Puerto Rico, US Virgin Islands and the British Virgin Islands. The company currently markets annuities, whole life, term life and universal life products, long-term care insurance and was the underwriter for Mutual of Omaha's Medicare supplement plans.

In 2010 United was ranked as the 12th largest writer of Medicare supplement policies in Wisconsin with $11,957,609 earned premium with 6720 new policies issued that year. The total earned premium for the company's Medicare supplement business in 2009 was $4,220,083 while gaining 3101 policies that year. Total policyholders at the end of 2009 were 6051 and at the end of 2010 the total policyholders numbered 9152. In addition, the company ranked as the 37th largest writer of long term care with $1,271,717 earned premium with 271 new policies issued that year. The total earned premium for the company's long-term care business in 2009 was $883,692 while gaining 226 policies that year. The total policyholders at the end of 2009 were 663 and at the end of 2010 the total policyholders numbered 889.

In July 2007, both companies withdrew from the group health market.

Mutual and United occupy the same home office building and to a great extent the same services. In this report, the above entities are collectively referred to as "the companies" or where one company was specifically identified "Mutual" or "United".

The Office of the Commissioner of Insurance received five complaints in 2010 and two complaints in 2011 against Mutual and 17 complaints in 2010 and two complaints in 2011 against United. 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 majority of the complaints were with the underwriting of individual health products, primarily Medicare supplement policies.

## Mutual Complaints

**Through March 31, 2011**

| Reason Type | Total | | Underwriting | | Marketing & Sales | | Claims | |
|---|---|---|---|---|---|---|---|---|
| Coverage Type | No. | % Total | No. | % Total | No. | % Total | No. | % Total |
| Individual A&H | 2 | 100% | 1 | 50% | | % | 1 | 50% |
| Group A&H | | % | | % | | % | | % |
| All Others | | % | | % | | % | | % |
| Total | 2 | | 1 | 50% | | | 1 | 50% |

**2010**

| Reason Type | Total | | Underwriting | | Marketing & Sales | | Plcyhldr Service | |
|---|---|---|---|---|---|---|---|---|
| Coverage Type | No. | % Total | No. | % Total | No. | % Total | No. | % Total |
| Individual A&H | 5 | 100% | 2 | 40% | 2 | 40% | 1 | 20% |
| Group A&H | | % | | % | | % | | % |
| All Others | | % | | % | | % | | % |
| Total | 5 | 100% | 2 | 40% | 2 | 40% | 1 | 20% |

## United Complaints

**Through March 31, 2011**

| Reason Type | Total | | Marketing & Sales | | Plcyhldr Service | |
|---|---|---|---|---|---|---|
| Coverage Type | No. | % Total | No. | % Total | No. | % Total |
| Individual A&H | 2 | 100% | 1 | 50% | 1 | 50% |
| Group A&H | | % | | % | | % |
| All Others | | % | | % | | % |
| Total | 2 | 100% | 1 | 50% | 1 | 50% |

**2010**

| Reason Type | Total | | Underwriting | | Claim Handling | | Marketing & Sales | | Plcyhldr Service | |
|---|---|---|---|---|---|---|---|---|---|---|
| Coverage Type | No. | % Total | No. | % Total | No. | % Total | No. | % Total | No. | % Total |
| Individual A&H | 13 | 76% | 7 | 41% | 1 | 5% | 4 | 23% | 1 | 6% |
| Group A&H | 3 | 18% | | | 3 | 18% | | % | | % |
| PPO | | % | | | | % | | % | | % |
| Individual Life | 1 | 6% | | | | | | | 1 | 6% |
| Total | 17 | 100% | 7 | 41% | 4 | 23% | 4 | 23% | 2 | 12% |

The grievance report for 2010 indicates Mutual received one grievance that was not reversed. The one grievance filed with the company involved its Medicare supplement line of business and was identified as category "other."

The grievance report for 2009 indicated Mutual received one grievance, the one grievance was reversed and corrective action was taken. The one grievance filed with the company in 2009 was related to a health benefit plan regarding a non-covered benefit.

The grievance report for 2010 indicates United received one grievance that was not reversed. The one grievance filed with United in 2010 was in the Medicare Supplement line of business and coded as "other." The grievance report for 2009 indicates United received one grievance; the one grievance was not reversed. The one grievance filed with United in 2009 was related to a health benefit plan and coded as "other".

**Mutual Grievance Table**

| | 2010 | | | 2009 | | |
|---|---|---|---|---|---|---|
| **Category** | **No.** | **No. Reversed** | **% Reversed** | **No.** | **No. Reversed** | **% Reversed** |
| Out-of-Network Provider | | | % | | | % |
| Prescription Drug | | | % | | | % |
| Preexisting Condition | | | % | | | % |
| Out-of-Area Emergency | | | % | | | % |
| Emergency Room | | | % | | | % |
| Durable Medical | | | % | | | % |
| No Preauthorization | | | % | | | % |
| Noncovered Benefit | | | % | | | % |
| Not Medically Necessary | | | % | | | % |
| Usual and Customary | | | % | | | % |
| Request for Preauthorization | | | % | | | % |
| Request for Referral | | | % | | | % |
| Maximum Benefit Reached | | | % | | | % |
| Other | 1 | 0 | 0% | | | % |
| **Total** | 1 | 0 | 0% | 0 | | % |

| | 2010 | | | 2009 | | |
|---|---|---|---|---|---|---|
| **Category** | **No.** | **No. Reversed** | **% Reversed** | **No.** | **No. Reversed** | **% Reversed** |
| Access to Care | | | % | | | % |
| Continuity of Care | | | % | | | % |
| Drug & Drug Formulary | | | % | | | % |
| Emergency Services | | | % | | | % |
| Experimental Treatment | | | % | | | % |
| Prior Authorization | | | % | | | % |

| | 2010 | | | 2009 | | |
|---|---|---|---|---|---|---|
| Category | No. | No. Reversed | % Reversed | No. | No. Reversed | % Reversed |
| Not Covered Benefit | | | % | 1 | 1 | 100% |
| Not Medically Necessary | | | % | | | % |
| Other | | | % | | | % |
| Plan Administration | | | % | | | % |
| Plan Providers | | | % | | | % |
| Request for Referral | | | % | | | % |
| Total | 0 | | % | 1 | 1 | 100% |

## United Grievance Table

| | 2010 | | | 2009 | | |
|---|---|---|---|---|---|---|
| Category | No. | No. Reversed | % Reversed | No. | No. Reversed | % Reversed |
| Out-of-Network Provider | | | % | | | % |
| Prescription Drug | | | % | | | % |
| Preexisting Condition | | | % | | | % |
| Out-of-Area Emergency | | | % | | | % |
| Emergency Room | | | % | | | % |
| Durable Medical | | | % | | | % |
| No Preauthorization | | | % | | | % |
| Noncovered Benefit | | | % | | | % |
| Not Medically Necessary | | | % | | | % |
| Usual and Customary | | | % | | | % |
| Request for Preauthorization | | | % | | | % |
| Request for Referral | | | % | | | % |
| Maximum Benefit Reached | | | % | | | % |
| Other | 1 | 0 | 0% | 1 | 0 | % |
| Total | 1 | 0 | 0% | 1 | 0 | 0% |

| | 2010 | | | 2009 | | |
|---|---|---|---|---|---|---|
| Category | No. | No. Reversed | % Reversed | No. | No. Reversed | % Reversed |
| Access to Care | | | % | | | % |
| Continuity of Care | | | % | | | % |
| Drug & Drug Formulary | | | % | | | % |
| Emergency Services | | | % | | | % |
| Experimental Treatment | | | % | | | % |
| Prior Authorization | | | % | | | % |
| Not Covered Benefit | | | % | | | % |
| Not Medically Necessary | | | % | | | % |
| Other | | | % | | | % |
| Plan Administration | 1 | 0 | % | 1 | 0 | % |
| Plan Providers | | | % | | | % |
| Request for Referral | | | % | | | % |
| Total | 1 | 0 | 0% | 1 | 0 | 0% |

## Independent Review Organizations

Independent review organizations (IROs) certified to do reviews in Wisconsin are required to submit to the OCI annual reports for the prior calendar years' experience indicating the names of the insurance companies and whether the action on the claims was upheld or reversed. Issues eligible for independent reviews include adverse and experimental treatment determinations. The IRO reports indicate that for 2009 and 2010 the companies did not receive any IRO requests.

## II. PURPOSE AND SCOPE

A targeted examination was conducted to determine whether the companies' practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2009 through May 31, 2011 for its Medicare supplement and long-term care insurance lines of business. 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 companies' operations in marketing and sales, underwriting, claims, policy forms, complaints, producer licensing and company operations and management. The report is prepared on an exception basis and comments on those areas of the companies' operations where adverse findings were noted.

## III. CURRENT EXAMINATION FINDINGS

### Claims

The examiners reviewed the companies response to the OCI's claims interrogatory, claim procedures, explanation of benefit (EOB) and remittance advice (RA) claim forms, claim adjustment (ANSI) codes, claim payment methodology and timely payment of the Medicare supplement and long-term care claims. The examiners also reviewed and verified that the companies had annually filed the required Medicare supplement and long-term care benefit appeal reports as required by s. 632.84, Wis. Stat.

The companies indicated that they processed long-term care (LTC) insurance claims for policies issued prior to 2006. The companies had a vendor agreement with Univita to process LTC claims for policies written beginning 2006. The companies indicated that they processed all Medicare supplement claims, and that 97% of the claims were processed electronically.

The examiners requested documentation that the payment sent to health care providers and to the members complied with the standardized explanation of benefits (EOB) and remittance advice (RA) format required in s. Ins 3.651, Wis. Adm. Code.

The companies provided a sample of replicas and copies available online of EOB and explanation of payments forms that they issued to providers and insureds. The examiners found that the EOB used by the companies did not contain diagnostic code or ANSI codes as required by s. Ins 3.651 (4) (a) (5) (c), Wis. Adm. Code, and s. Ins 3.651 (4) (a) (7), Wis. Adm. Code. The companies stated that they did not include CPT codes on the Medicare supplement EOB because a description of the service was printed in the column titled "Nature of Service" and Narrative explanations of the adjustments indicated in the column "Less Charges Not Covered" was explained at the bottom of the EOB in the "NOTES".

The examiners found that in the random sample of Medicare supplement denied claims the companies EOBs included the reason code "maximum usual & customary amount

previously paid for claims preventative care" printed on nine claims. The companies stated they denied each of these claims because the maximum preventative care benefit had been paid and acknowledged that that the remark code was used incorrectly. The companies stated they were currently implementing two new remark codes to better fit this type of situation.

> **1. Recommendation:** It is recommended that the companies provide on the explanation of benefits (EOB) form diagnostic codes and claim adjustment reason (ANSI) codes to comply with s. Ins 3.651 (4) (a) (5) (c), Wis. Adm. Code and s. Ins 3.651 (4) (a) (7), Wis. Adm.
>
> **2. Recommendation:** It is recommended that the companies correct their remark code to reflect that the maximum benefit for preventative care services has been paid in order to comply with s. Ins 3.651 (4) (a) (7) Wis. Adm. Code.

The examiners found that the Medicare supplement RA form did not conform to the format specified in Appendix A in that the companies titled the RA an "Explanation of Payment Report." The RA also did not have a reason code column as required by s. Ins. 3.651 (3) (b) (4) (i), Wis. Adm. Code.

> **3. Recommendation:** It is recommended that the companies comply with Medicare supplement remittance advice (RA) format specified in Appendix A titling the RA as an "Explanation of Payment Report"
>
> **4. Recommendation:** It is recommended that the companies include copay, coinsurance, and discount columns, include ANSI codes, and list the companies' address to comply with s. Ins. 3.651 (3), Wis. Adm. Code.

The examiners reviewed a random sample of 39 paid Mutual of Omaha long-term care claims. The claims data pulled was from January 1, 2010 to May 31, 2011. The examiners found that the company did not pay interest on seven claims that were paid in excess of 30 days after proof of loss was received. The company provided a copy of the procedure to calculate interest. The companies claim system contained a pop-up message that alerted the claim examiner that more than 30 calendar days had elapsed since the last information was received. The claim examiner was responsible to verify the time that had elapsed and determine whether the time was greater than the time allowed in the payee's state. Section 628.46, Wis. Stat., requires that payment of a claim shall not be overdue until 30 days after the

insurer receives the proof of loss required under the policy. The company paid the owed interest after the claims were reviewed with the examiners.

The examiners reviewed a random sample of 26 Mutual of Omaha Medicare Supplement claims denied. The examiners found that the company denied two claims in error, and that benefits were paid more than 30 days after receiving the information needed to allow benefits. The company documented that it paid benefits including interest.

**5. Recommendation:** It is recommended that the company (Mutual) develop a written audit process for paying interest owed on its long-term care claims to ensure compliance with s. 628.46, Wis. Stat.

**6. Recommendation:** It is recommended that the company (Mutual) pay claims within 30 days after receiving supported written notice of the fact of a covered loss and of the amount of the loss to comply with s. 628.46, Wis. Stat. and s. Ins 6.11, Wis. Adm. Code.

**New Business & Underwriting**

The examiners reviewed the companies' response to the OCI's new business and underwriting interrogatory, manuals and online documents used during the underwriting process, field underwriting manual and instructional materials for agents, suitability guidelines and replacement procedures. The companies underwriting department was responsible for underwriting their Medicare supplement business. The companies were responsible for underwriting their long-term care business, but used a vendor called Univita (formerly called Long Term Care Group) to handle all other administrative services. Univita had a process for verifying that the producer listed on all applications had a valid license/appointment and notified the companies if an application was received from an unlicensed/appointed agent.

The companies began offering a LTC partnership policy effective January 19, 2009, but did not offer to existing LTC policyholders the option of exchange to a partnership plan.

The examiners reviewed a random sample of 21 replacement forms of the United of Omaha Medicare supplement not issued policies. The examiners found one replacement form

that was not signed by the agent or dated. The company stated that the policy applied for was not issued and that its underwriting area advised that if the applicant would have been eligible for coverage, it would have required all forms be completed. However, the examiners found that the companies underwriting procedure titled "Medicare Supplement Underwriting Guidelines" stated that "all replacements involving a Medicare supplement, Medicare Select or Medicare Advantage plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application." Section Ins. 3.39 (23) (c), Wis. Adm. Code, states that the replacement notice, signed by the applicant and the agent, shall be furnished to the applicant prior to issuance or delivery of the Medicare supplement policy.

7. **Recommendation:** It is recommended that the company (United) follow its underwriting guidelines involving replacement policies to comply with s. Ins. 3.39 (23) (c), Wis. Adm. Code.

**Producer Licensing**

The examiners reviewed the companies' response to the OCI's producer licensing interrogatory, agent agreements and the companies' procedures and practices related to producer licensing, appointments, terminations, training and recruiting. The companies' policyowner services department was responsible for the management of agent contracts, agent appointments, and terminations. The companies had six primary business units within Policyowner Services: Individual Policy Services, Premium Services, Producer Services, Support Services, Production & Operations Management, and Business Data Services. Mutual of Omaha utilized 11 different agent contracts, nine of which were also utilized by United of Omaha. However, the majority of the agent contracts for both companies were either the General Agent Agreement or the Special Agent Agreement. The companies did not actively recruit subagents; however, they hired corporations that employed agents. The companies entered into a contractual relationship with the corporation and only paid compensation to the

corporation and then the corporation paid the agents. The companies utilized two vendors, Sircon and Kaplan, who were responsible for the electronic agent appointment listings.

The examiners requested from the companies a listing of all Wisconsin agents that represented the companies as of the end of the examination period. The examiners compared these records with the agent database maintained by the OCI. Per the data provided by the company in response to the data call for United of Omaha, the examiners review found that five agent license numbers reported in the data call did not match the agent license numbers in OCI records.

OCI conducted a comparison of Mutual of Omaha's Agent data with OCI records. The comparison indicated that 21 agent license number reported in the data call did not match the agent license number in OCI records. The company's response indicated that the information provided to OCI may not have captured all the necessary information. The company noted that there were typographical errors and a revised process had been put in place to have one associate handle all appointments that did not pass validation with the state data to eliminate risk of typographical discrepancies with the license number.

> 8. **Recommendation:** It is recommended that the companies develop a policy and procedure to reconcile producer appointments and license information on their internal systems to state Department of Insurance data using the National Insurance Producer Registry (NIPR) which contains producer and producer firm licenses and appointment information for states. This reconciliation with OCI should be performed on a yearly basis and become more frequent as needed to update their internal systems to comply with s. Ins 6.57, Wis. Adm. Code and s. 628.03 (1), Wis. Stat.

OCI conducted a comparison of Mutual of Omaha's Agent data with OCI records. The comparison indicated that 2 Agents who were appointed with the company in OCI's records, but were not found in the Company's Agent data.

> 9. **Recommendation:** It is recommended that the company (Mutual) develop a policy and procedure to reconcile producer appointments and license information on its internal systems to state Department of Insurance data using the National Insurance Producer Registry (NIPR) which contains producer and producer firm licenses and appointment information for states. This reconciliation with OCI should be performed on a yearly basis and become more frequent as needed to update its

internal systems to comply with s. Ins 6.57 (1), Wis. Adm. Code and s. 628.11, Wis. Stat.

The examiners reviewed a random sample of 40 agent records, provided by the company in response to the data call for Mutual of Omaha. The examiners review indicated that the agent's termination, license, and appointment dates reported in the data call did not match the dates in OCI's records. The company stated if it did not receive notice of the termination from OCI, and the termination was not initiated by the company for lack of production, disciplinary reasons, etc., the agent was not terminated in the company's system. According to s. Ins 6.57 Wis. Adm. Code., and s. 628.11, Wis. Stat., an insurer shall report to the commissioner at such intervals as the commissioner established by rule all appointments, including renewals of appointments, and all terminations of appointments of insurance agents to do business in this state.

The examiners reviewed a random sample of 150 long-term care applications with the companies. The examiners found two United of Omaha agents who submitted applications but were not appointed with the company. Section Ins 6.57(1), Wis. Adm. Code, states that an application for appointment shall be submitted to the OCI within 15 days after the agent contract is executed or the first insurance application is submitted. The effective date is the date on which the appointment is submitted electronically. The validation report is a computer-generated report prepared by the office of the commissioner of insurance. Billing for initial appointment shall be done annually at the same time and at the same rate as renewal appointments.

Effective January 1, 2009, insurance agents marketing LTC insurance are required to meet LTC training requirements. Section Ins 3.46 (26) (a), Wis. Adm. Code, provides that no producer may sell, solicit or negotiate long-term care insurance unless the producer was duly licensed, appointed and had completed the initial training and ongoing training every 24 months. Insurers were to maintain verification that the producers appointed received the appropriate

training. The examiners reviewed a random sample of 150 long-term care applications with the companies. The examiners found three resident and four non-resident producers who wrote and submitted to the companies applications prior to completing the required LTC agent training. One of the non-resident producers had not taken the required two hours of Wisconsin Medicaid training prior to taking the application but took the four hour on-going training instead. One resident producer submitted an application without taking any training. The companies underwriting procedures indicated that agent training was verified prior to an application being accepted for processing. The companies indicated that in most cases training was completed prior to an application being taken and in other cases coverage was not issued if training was not completed. The examiners found that two of the applications submitted were issued by the companies and the remaining six were not issued due to medical history of the applicant or per their request to withdraw the application. The examiners did not find that any of the applications submitted were not processed due to the producer not having the appropriate training.

The examiners reviewed a random sample of 48 terminated long-term care insurance policies. As part of the file review, the examiners verified that the writing agent had taken the long-term care training as required by s. Ins 3.46 (26) (a) 1.a, Wis. Adm. Code. The examiners found one non-resident producer that had solicited, negotiated and sold two applications without having taken the required long-term care training. The companies underwriting procedure indicated that the companies verified completion of the training prior to starting the processing of the application.

The examiners also reviewed 61 LTC riders not issued and issued. The examiners found four agents submitted applications prior to completing the long term care training. The company stated that there was no edit in the system to prevent issuance of the riders. In response, the company stated that "Our Annuity area does not currently have written procedures for LTC Partnership Training before or after January 1, 2011, however, as indicated in the interrogatory response, as of 5/21/11, when an application is received, information from

the application is entered into our policy issue system (CAPSIL), which includes the date the application is signed, and the producer's production number. The company verified producer information system (Field Org) checked to verify if the appropriate LTC training has been completed. If the application signed date was within the training requirement dates, the system allowed the contract to be issued. If the appropriate training has not been completed, the system would not allow the contract to be issued. The system adds a flag, and the underwriter contacts Producer Services to alert them of the issue. The underwriter also contacts the producer to advise them of the missing training documentation, and to inform them that a new application is needed which must be completed and submitted once training has been completed."

The examiners asked the companies to describe how they monitored an agent's compliance with Wisconsin's continuing education requirements. The companies responded that agents were required to submit proof of completion of LTC training prior to selling LTC insurance. When an agent submitted a LTC training certificate, Producer Services recorded the training information in their internal system (Appointment & Licensing database). If a producer did not complete the required initial training and continuing education prior to selling any LTC insurance, the application that was submitted was declined and returned to the agent. The agent had to complete the required LTC training and resubmit a new application that was signed after the training completion date in order for the LTC policy to be issued. The examiners requested for the period of review to provide copies of the applications that were declined and the copies of the applications if the applications were resubmitted. The companies responded that during the majority of the examination period, they did not use a specific reject code for applications denied due to agent requirements. The companies started using a specific reject reason code to differentiate declines due to client health from declines due to agent requirements (training etc.) on 4/27/2011. Based on this, they could not query the data for the majority of the exam time period, but identified three policies (2 applications, as 1 was a dual

spouse application) within the exam time period that were denied due to agent training requirements. The companies stated there could be additional applications during the examination period, but the companies would have to manually review each declined case to determine which ones were declined to the agent not having completed the long term care training.

The examiners asked the companies to describe the procedures to make sure applications were not accepted from agents who were not appointed or had been terminated with the companies. The companies stated that for long term care Univita applications, Producer Services investigated and notified Univita whether or not the application could be processed. If the application could not be processed, Producer Services notified Univita and underwriting. Underwriting then declined the application.

The examiners asked the company to demonstrate compliance with s. Ins. 3.46 (26) Wis. Adm. Code for agent license no. 1068345. The company provided training certification showing a course completion date of July 28, 2009 however, the application for policy number UO1144086 was July 13, 2009.

For the Medicare Supplement line of business, the companies stated, if a licensing/appointment issue was identified, the issue was referred to Producer Services for resolution prior to issuing the coverage. If the issue cannot be resolved, the application was declined. The examiners requested during the period of review a copy of all applications that were originally declined/not processed due to an agent not being appointed or terminated. The companies provided eleven Medicare Supplement applications that were declined due to the agent not being appointed.

10. **Recommendation:** It is recommended that the companies institute a process for monitoring their new producer appointments to demonstrate that they submitted the appointment to the OCI within 15 days of receipt of the producer contract or first application; they received a validation report and were billed annually to verify the appointment and ensure compliance with s. Ins 6.57 (1), Wis. Adm. Code.

11. **Recommendation:** It is recommended that the companies develop an audit process to verify that the producer is licensed, appointed and has taken the required training prior to selling, soliciting or negotiating a long-term care application to ensure compliance with s. Ins 3.46 (26) (a), Wis. Adm. Code.

12. **Recommendation:** It is recommended that the companies develop a policy or procedure to maintain accurate data to ensure that companies report terminated and re-appointed agents to the OCI to comply with s. Ins 6.57, Wis. Adm. Code.

The examiners reviewed the companies process for ensuring that applications for long-term care, nursing home and home health care policies and long-term care riders attached to annuity polices were not underwritten, processed or issued unless the producer prior to application had completed initial and/or ongoing training. The companies provided a document called the Long-term Care QuickGuide. The QuickGuide stated that if a non-resident producer took a Wisconsin refresher course without having the initial training completed, Wisconsin would accept another states 8 hour course, in addition to Wisconsin's refresher course, as satisfying the producer's initial training requirements . Section Ins. 3.46 (26) (a) 7, Wis. Adm. Code, states satisfaction of the training requirements in any state shall be deemed to satisfy the training requirement in this state subject to verification and compliance with the training requirements in subd. 1. except for the initial 2 hours of Wisconsin specific Medicaid and long-term care information training.

13. **Recommendation:** It is recommended that the companies change the Long-term Care QuickGuide to indicate that non-resident producers who take another states approved 8 hour initial course must also take 2 hours of Wisconsin specific training to ensure compliance with s. Ins 3.46 (26) (a) 7, Wis. Adm. Code.

The examiners asked the companies to describe the procedures for providing all terminated Wisconsin agents with written notice of termination and return of indicia as required by s. Ins 6.57 (2), Wis. Adm. Code and s. 628.40, Wis. Stat. The companies provided a sample termination letter which requested the return or destruction of all confidential information. However, the examiners reviewed a random sample of 50 terminated agent files for the companies. Section Ins 6.57 (2), Wis. Adm. Code, required that the termination letter sent to the agent included a formal demand for the return of all indicia of agency and written notice that

the agent was no longer to be appointed as a representative of the companies and that he or she may not act as their representative. The files provided in 18 terminated agents did not include termination letters. The companies provided copies of agent termination letters for 16 of the 18 agents the examiners requested. Also in the sample of 50 terminated agent files, 22 agent files did not include termination letters that included a request for the return of all indicia of agency nor did they state that the agents were no longer listed and could not represent companies. In addition, the letter did not indicate a specific date of termination with the companies. The companies stated that they 'agree these letters do not include the language required by s. Ins 6.57(2) and we are in the process of revising our termination letters to include the required language." The companies stated that since this would require system changes, they were currently reviewing implementation issues to automatically generate the letters and would provide a projected implementation date as soon as it was available.

> **14. Recommendation:** It is recommended that the companies develop, document, and implement a process and written procedure to provide all agents whose appointment to represent the companies has been terminated, including those agents terminated for non-production, a written notice stating that the agent is no longer to be appointed as a representative of the companies, and requesting that the agent return to the companies all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.

**Policyholder Service & Complaints**

The examiners reviewed the companies' response to the OCI's policyholder service & complaints interrogatory, the companies' complaint handling policies and procedures and the companies' complaint log. The companies' policyholder service department was broken into 6 units (support services, premium services, producer services, individual policy services, production and operations management and business data). For long term care, the companies used a vendor called Univita, which was responsible for policy maintenance including agent/applicant requested coverage changes, policy terminations, applying premium payments, issuing premium refunds, and collections for long term care.

The companies recorded all complaints received in an internal database called Regulatory Affairs Investigation Tracking System (RAITS). Non insurance department complaints were handled by the applicable customer service area. Insurance Department complaints were handled by Corporate Compliance & Ethics in Mutual of Omaha's Home Office. Oral and written complaints received by Univita were referred and logged into the Compliance department. The Compliance department then worked with the appropriate operational areas (application entry, policy owner services, policy issue, customer service or claims) in order to research and respond to each complaint.

The companies defined complaints as any written or verbal communication primarily expressing dissatisfaction by or on behalf of a covered individual. The examiners reviewed all six Mutual of Omaha complaints during the period of review and a random sample of twenty eight United of Omaha complaints from the company's log. No exceptions/recommendations were noted.

**Grievances & IROs**

The examiners reviewed the companies response to the OCI grievance and IRO interrogatory, their written grievance procedures and practices, and their written procedures for handling independent review requests from Wisconsin insured's. The companies indicated that they had a two level grievance process. The first level was handled by Individual Claims/Medicare Supplement department. A second level grievance involved handling by individuals in the Medical claim Review, Clinical Services or IFS support departments. Both levels followed Ins 18 in how they were processed.

The examiners reviewed the five grievance files for the period of review. The number did not match the number of grievances reported on the 2009 and 2010 OCI Grievance Experience Reports because the company reported a grievance for 2010 in error. Grievance

file number 2008-03793 indicated the insured called the company upset about her premiums and why she was not eligible for the new premiums advertised on a flyer she received. The examiners asked the company how this met the definition of a grievance under s. Ins 18.01 (4), Wis. Adm. Code, '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) Claims practices. The company stated they do not believe this situation meets the definition of a grievance. Grievance file number 2009-04079 was an incident report regarding an insured who alleged that agent 2441050 and agent 2025039 told them their Medicare supplement policy included Part D prescription drug coverage.

15. **Recommendation:** It is recommended that the companies follow their definition of a grievance "Grievance means any dissatisfaction with our provision of services or our claims practices that is expressed in writing by, or on behalf of, an Insured Person" when handling/recording grievances to comply with s. Ins. 18.01 (4), Wis. Adm. Code.

The examiners reviewed the five grievance files reported on the Grievance Experience Report for 2009 and 2010. The examiners found that the five grievance files did not contain acknowledgement of the grievance. The examiners asked the companies to explain why none of the five files contained an acknowledgement letter as required by s. Ins 18.04, Wis. Adm. Code. Section Ins 18.04, Wis. Adm. Code, provides that an insurer offering a health benefit plan shall, within 5 business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgement to the insured or the insured's authorized representative confirming receipt of the grievance.

16. **Recommendation:** It is recommended that the companies within 5 days of receipt of a grievance send acknowledgement letters as required by s. Ins. 18.03 (4), Wis. Adm. Code.

The examiners reviewed the five grievances provided by the companies. The examiners compared the grievances to the annual grievance report and to the companies' grievance log. Grievance number 2009-03827 was reported on the Mutual of Omaha Insurance Company HBP Grievance Summary Calendar Year 2009 and on the Mutual of Omaha Insurance Company HBP Grievance Summary Calendar Year 2010. The grievance was also reported on the 2009 and 2010 OCI Grievance Experience Report. The company stated this grievance was reported for 2009 in error. The grievance was entered in 2009, but handling was not completed until 2010. The grievance should have only been reported in the report for calendar year 2009 when it was received.

17. **Recommendation:** It is recommended that the company submit a corrected grievance experience report to comply with s. Ins. 18.06 (2) Wis. Adm. Code.

The examiners reviewed the five grievances provided by the companies. In grievance number 2010-13371, the company acknowledged the insured's letter was not recorded as a grievance due to its oversight. The grievance file indicated that the insured sent another letter dated July 14, 2010, again regarding the same issues, which the company did record as a grievance. The examiners requested the company to demonstrate compliance with s. Ins 18.06, Wis. Adm. Code, which states a grievance must be resolved within 30 calendar days or the company must provide written notice extending the resolution. The company stated that it did not respond to the July 10, 2010 letter until August 23, which was more than 30 days. The insured sent a letter on September 15, 2010, asking for a reconsideration which the company did not record as a grievance and the examiners found that this grievance did not appear on the OCI grievance experience report or in OCI's request for all grievance files. The examiners also found that the company had not sent an acknowledgement letter on this grievance.

18. **Recommendation:** It is recommended that the companies record each complaint and grievance submitted record any as a grievance to comply with s. Ins 18.06, Wis. Adm. Code.

19. **Recommendation:** It is recommended that that the companies acknowledge receipt of a grievance within 5 business days in writing s. Ins 18.03 (4), Wis. Adm. Code.

20. **Recommendation:** It is recommended that the companies resolve a grievance within 30 calendar days to comply with s. Ins 18.03 (6), Wis. Adm. Code.

**Policy Forms & Rates**

The examiners reviewed the companies response to the OCI's policy forms and rates interrogatory and their policies, riders, applications, outline of coverage that were used or in effect during the period of review. The Corporate Compliance and Ethics was responsible for LTC and Medicare supplement rate and form filings and the Rerating area was responsible for rate-only submissions.

The examiners reviewed the policy forms filed during the period of review. The examiners found two policy forms filed under the filing code H21 Health-Other that were used by the companies as their grievance procedure in 2008 and 2010. Filing instructions in SERFF provide that a form must be submitted with a specific product code and this coding was to be used for any health product not specifically listed as a product type in the form filing list in the System for Electronic Rate and Form Filing (SERFF). The companies stated that SERFF did not allow for a filing to be sent using two separate product codes. It used the "catch-all" code which they believed was generic for numerous types of insurance. The examiners found that the health benefit plan that would use the grievance procedure form as part of their policy was the Medicare supplement product. Section 631.20 (1) (c) 3, Wis. Stat., provides that a form first used after August 1, 2008 is exempt from paragraph (a) except for a Medicare replacement policy or a Medicare supplement policy.

21. **Recommendation:** It is recommended that the companies re-file their 2010 grievance procedure form under the Medicare supplement product code to ensure compliance with s. 631.20 (1) (c) 3, Wis. Stat., that requires forms used for Medicare supplement products be filed for review.

## Marketing, Sales & Advertising

The examiners reviewed the companies' response to the OCI's marketing, sales and advertising interrogatory, its marketing, sales and advertising activities, and a random sample of 21 advertising files on site. The examiners also reviewed the companies' marketing goals and agent compensation schedules. The examiners reviewed a random sample of 21 advertisements and the companies' response to lead generation. The companies' indicated that they generally use direct mail and the internet to generate leads for distribution to agents and agencies. All Medicare supplement and LTC leads for Wisconsin were generated in house. The examiners reviewed a sample of agent/agency contracts provided by the companies'. The companies delegate the oversight and supervision to the general agent with whom the independent agent were listed. If the independent agent recruited an additional agent who was listed under the independent agent, then the oversight and supervision was delegated to the independent agent for supervision of the new recruit. The examiners reviewed a random sample of 25 Medicare supplement commission transactions and 25 LTC commission transactions. No exceptions were noted.

## Electronic Commerce

The examiners reviewed the companies' response to the OCI's electronic commerce interrogatory and the companies' corporate website www.mutualofomaha.com and registered domains. Individual policyholders could access their account and benefits with a user name and a password. Agents could access information center however, the agent needed to register to sign into the information center. On the webpage, one could also obtain a free quote for a Medicare supplement policy. No exceptions were noted.

**Company Operations/Management**

The examiners reviewed the companies' response to the OCI company operations & management interrogatory, company documents, administration agreements and audits.

The companies did not have a single comprehensive compliance plan since it was the responsibility of the business areas to implement processes that ensured adequate controls within their area of responsibility to make their business functions complaint with laws, regulations and corporate standards. Each business area updated its compliance procedures as needed. No exceptions were noted.

## IV. CONCLUSION

The market conduct examination involved a targeted review of Mutual of Omaha Insurance Company and United of Omaha Life Insurance companies' practices and procedures for the period of January 1, 2009 to May 31, 2011. The examination report contains 21 recommendations as regards to the companies' practices in claims, underwriting, producer licensing, grievances and policy forms.

## V. SUMMARY OF RECOMMENDATIONS

**Claims**

Page 11 **1. Recommendation:** It is recommended that the companies provide on the explanation of benefits (EOB) form diagnostic codes and claim adjustment reason (ANSI) codes to comply with s. Ins 3.651 (4) (a) (5) (c), Wis. Adm. Code and s. Ins 3.651 (4) (a) (7), Wis. Adm.

Page 11 **2. Recommendation:** It is recommended that the companies correct their remark code to reflect that the maximum benefit for preventative care services has been paid in order to comply with s. Ins 3.651 (4) (a) (7) Wis. Adm. Code.

Page 11 **3. Recommendation:** It is recommended that the companies comply with Medicare supplement remittance advice (RA) format specified in Appendix A titling the RA as an "Explanation of Payment Report"

Page 11 **4. Recommendation:** It is recommended that the companies include copay, coinsurance, discount columns, include ANSI codes, and list the companies' address to comply with s. Ins. 3.651 (3), Wis. Adm. Code.

Page 12 **5. Recommendation:** It is recommended that the company (Mutual) develop a written audit process for paying interest owed on its long-term care claims to ensure compliance with s. 628.46, Wis. Stat.

Page 12 **6. Recommendation:** It is recommended that the company (Mutual) pay claims within 30 days after receiving supported written notice of the fact of a covered loss and of the amount of the loss to comply with s. 628.46, Wis. Stat. and s. Ins 6.11, Wis. Adm. Code

Page 13 **7. Recommendation:** It is recommended that the company (United) follow its underwriting guidelines involving replacement policies to comply with s. Ins. 3.39 (23) (c), Wis. Adm. Code.

Page 14 **8. Recommendation:** It is recommended that the companies develop a policy and procedure to reconcile producer appointments and license information on their internal systems to state Department of Insurance data using the National Insurance Producer Registry (NIPR) which contains producer and producer firm licenses and appointment information for states. This reconciliation with OCI should be performed on a yearly basis and become more frequent as needed to update their internal systems to comply with s. Ins 6.57, Wis. Adm. Code and s. 628.03 (1), Wis. Stat.

Page 14 **9. Recommendation:** It is recommended that the company (Mutual) develop a policy and procedure to reconcile producer appointments and license information on its internal systems to state Department of Insurance data using the National Insurance Producer Registry (NIPR) which contains producer and producer firm licenses and appointment information for states. This reconciliation with OCI should be performed on a yearly basis and become more frequent as needed to update its internal systems to comply with s. Ins 6.57 (1), Wis. Adm. Code and s. 628.11, Wis. Stat.

Page 18 **10. Recommendation:** It is recommended that the companies institute a process for monitoring their new producer appointments to demonstrate that they submitted the appointment to the OCI within 15 days of receipt of the producer contract or first application; they received a validation report and were billed annually to verify the appointment and ensure compliance with s. Ins 6.57 (1), Wis. Adm. Code.

Page 18 **11. Recommendation:** It is recommended that the companies develop an audit process to verify that the producer is licensed, appointed and has taken the required training prior to selling, soliciting or negotiating a long-term care application to ensure compliance with s. Ins 3.46 (26) (a), Wis. Adm. Code.

Page 19 **12. Recommendation:** It is recommended that the companies develop a policy or procedure to maintain accurate data to ensure that companies report terminated and re-appointed agents to the OCI to comply with s. Ins 6.57, Wis. Adm. Code.

Page 19 **13. Recommendation:** It is recommended that the companies change the Long-term Care QuickGuide to indicate that non-resident producers who take another states approved 8 hour initial course must also take 2 hours of Wisconsin specific training to ensure compliance with s. Ins 3.46 (26) (a) 7, Wis. Adm. Code.

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## VI. 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.

| Name | Title |
|---|---|
| John Pegelow | Insurance Examiner |
| Linda Low | Insurance Examiner |
| Kevin Zwart | Insurance Examiner |
| Marshall Dixon | Insurance Examiner |

Respectfully submitted,

Lynn Pink, CIE, MCM
Examiner-in-Charge