

SOUTH DAKOTA DIVISION OF INSURANCE
MARKET CONDUCT EXAMINATION REPORT
OF
ABILITY INSURANCE COMPANY

NAIC Code 71471
1515 South 75th Street
Omaha, NE 68124

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SALUTATION

May 31, 2013

Honorable Merle Scheiber
Insurance Director
State of South Dakota
445 E. Capitol Avenue
Pierre, South Dakota 57501

Dear Director Scheiber:

In compliance with the instructions contained in the Order for Examination, dated December 21, 2010 and pursuant to statutory provisions including SDCL Ch. 58-3, a Market Conduct Examination has been conducted of the affairs and practices of:

Ability Insurance Company.

Ability Insurance Company, hereinafter referred to as the "Company," or as "Ability," is incorporated under the laws of the State of Nebraska. This examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

1515 South 75th Street, Omaha, Nebraska 68124

The off-site examination phase was performed at the offices of the South Dakota Division of Insurance, hereinafter referred to as the "Division" or "SDDOI," and other appropriate locations.

The report of examination thereon is respectfully submitted.

FOREWORD

This examination reflects Ability Insurance Company's insurance activities in the State of South Dakota. This Market Conduct Examination Report is, in general, a report by test. Some of the information reviewed by the examiners, however, may not be referenced in this written report regarding practices, procedures, or files that did not result in any errors or irregularities. Failure to comment on specific products, procedures or files does not constitute approval thereof by the South Dakota Division of Insurance.

In performing this examination the SDDOI selected a portion of the Company's operations for review. This report does not fully reflect a review of all of the practices and activities of the Company.

Where used in the report:

“Company” or “Ability” refers to Ability Insurance Company

“SDCL” refers to the Statutes of South Dakota

“ARSD” refers to South Dakota Administrative Rules

“SDDOI” refers to the South Dakota Division of Insurance

“NAIC” refers to the National Association of Insurance Commissioners

“NAIC MRH” refers to the NAIC's *Market Regulation Handbook*

SCOPE OF EXAMINATION

The South Dakota Division of Insurance has authority to perform this examination pursuant to, but not limited to, SDCL Ch. 58-3. This examination of Ability began March 4, 2011 and covered the period of January 1, 2006 through June 30, 2010, unless otherwise noted. This examination focused on a review of the Company's Complaint Handling, Rates, Forms, and Claims.

This examination was performed in accordance with Market Regulation standards established by the Division and examination procedures established by the NAIC. While the examiner's report on the errors found in individual files, the examination also reviewed general business practices of the Company.

EXECUTIVE SUMMARY

This Market Conduct Examination focused on the business practices of Ability for its closed block of Long Term Care line of business which it insures and administers.

The Company has approximately 60,000 long-term care policies with about \$100 million in annual premiums, and cedes 74.9% of the retained Long Term Care business on a quota share basis to Ability Re Bermuda.

The Company is a Nebraska domiciled Stock Life and Health Insurance Company, and is licensed to write life and health insurance business in all states and the District of Columbia, except Connecticut, Maine, New Hampshire, New Jersey, New York, Rhode Island and Vermont. As of the 2009 annual statement for the State of South Dakota, the Company reported premium considerations in the amount of \$22,898,732 of which \$1,481,525 represented the State of South Dakota.

The examiners noted deficiencies in the areas of the Company's Complaints, Denied Claims, Policy Forms and Withdrawn Claims. The details of these findings are provided in the respective sections of the report. In summary, the examiners noted the following:

- **Complaint Handling** – The examiners noted 7 files that were missing pertinent information. The Company failed to respond to the SDDOI in violation of SDCL § 58-33-66. The Company failed to recognize the certification of home health care in 1 complaint file. The same file lacked a copy of the doctor's certification, and there was no response to correspondence from the doctor. The complaints/appeals were resolved inappropriately. The Company's resolution of a complaint/appeal was incorrect.
- **Rates and Forms** - Ability Long Term Care (LTC) policy forms MP-LT 698 and MP-LT 694. After review of the language in various sections of the Ability LTC policy forms the examiners find that the Company's Form Numbers MP-LT698 and MP-LT694, failed to comply with applicable South Dakota long term care insurance statutes and rules.
- **Denied Claims** – The examiners noted that 33 claims were denied inappropriately. One denied claim was missing a response to the doctor's appeal letter. The Company failed to provide a reasonable explanation for the denial of a claim or offer a compromise settlement. The Company failed to acknowledge and act within 30 days after receipt of all requested information of claims in 4 instances. The Company denied claims where there was evidence that the insured may have qualified for benefits under the "Medical Necessity" trigger, but no Attending Physician Statement was requested by the Company.
- **Withdrawn Claims** – The Company encouraged claimants and/or their representatives to withdraw claims after coaching by Case Managers. The Case Managers provided inaccurate, incorrect or incomplete information relating to the provisions of the insureds' policy or the requirements relating to Long Term Care insurance under South Dakota statutes and/or administrative rules.

Recommendations have been made to address the cited exceptions in the report.

The Company has agreed to comply with the recommendations and in the case of the Denied Claims and Withdrawn Claims, the Company reports it has already taken corrective action by implementing changes to its policies and claim adjudication process.

EXPLANATION OF THE EXAMINATION PROCESS

COMPANY OPERATIONS

The examiners determine whether the Company facilitates the examination process by providing complete, accurate and timely records and data.

COMPLAINTS

The examiners review the complaints the Company receives directly from consumers, the complaints submitted by the Division to the Company and the complaints received by the Division directly from consumers. The purpose of the review is to determine the accuracy of handling and the resolution of the complaint along with the timeliness of the response.

RATES AND FORMS

The examiners review the Company's policy forms, to ensure the contract language is not ambiguous, and that the provisions of the policies adequately protect insureds. In addition, the examiners review rates used, rate histories and supporting documentation to verify compliance with South Dakota rate filing and usage requirements.

CLAIMS

The examiners review the claim practices of the Company in order to determine efficiency of handling, accuracy of payment, adherence to contract provisions and compliance with South Dakota law.

The types of practices considered to be an error include, but are not limited to, an unreasonable delay in the acknowledgment, investigation or payment/denial of a claim; the failure of the company to correctly calculate claim benefits; or the failure of the Company to comply with South Dakota law regarding claim settlement practices.

SAMPLING OF FILES

The examiners conduct a census review of the total population of files where practical. In instances where the total population of a specific set of files is prohibitive to conducting the review in an expedient manner, the examiners use a sampling of the universe of files. Samples may be selected by one of the following methods:

Systematic - a sample obtained by taking every n th unit from a list containing the total population. The size of the sample, n , is calculated by dividing the desired sample size into N , the population size.

Random - selecting a sample for study from a population so that each unit is chosen entirely by chance; every member of the population has an equal probability of being included. No items or units have been "preselected" out of the field. Random selections may be attained through use of a random numbers table or a random numbers generator in computer software.

BACKGROUND INFORMATION

COMPANY OVERVIEW

A. HISTORY

Prior to September 2007, Medico Insurance Company wholly owned its subsidiary, Medico Life Insurance Company. In September 2007, Ability Resources, Inc. purchased Medico Life Insurance Company, along with the closed block of Long Term Care business held by both Medico and Medico Life. Subsequently, Ability changed the name of Medico Life Insurance Company to Ability Insurance Company.

For a few years after the September 2007 transaction, Medico continued to administer the Long Term Care business through a formal Services Agreement. Over time, Ability gradually migrated the administrative services for the Long Term Care business to itself. The majority of Ability's client services and claims staff are comprised of Medico employees who moved to Ability because of their Long Term Care claims expertise.

Ability Resources specializes in buying and administering closed blocks of LTC insurance.

B. PROFILE

The Ability Resources Family of reinsurance and insurance services was formed in 2007 to purchase closed blocks of business. Ability's initial activities are largely with portfolios of LTC insurers seeking to divest their individual and group business segments. Most of Ability's clients and prospects have ceased marketing new business.

The following is an excerpt from the AM Best Report of Ability Insurance Company:

BUSINESS REVIEW

Ability Insurance Co. (formerly known as Medico Life Insurance Company (MLIC) until March 2009) and Ability Reinsurance (Bermuda) Ltd (Ability Re Bermuda) are wholly-owned subsidiaries of the ultimate parent, Ability Reinsurance Holdings Ltd (Ability Re Holdco). Ability Reinsurance (Bermuda) Ltd is a Bermuda registered company that reinsures a portion of Medico's risk. Ability Resources, Inc. (Ability Re US) is a Delaware registered intermediate holding company that employs senior management and owns AIC.

Ability Re US was capitalized in September 2007 with the purchase of the former MLIC from Medico Insurance Company. Ability Insurance now has approximately 60,000 long-term care policies with about \$100 million in annual

premiums, and cedes 74.9% of the retained Long Term Care business on a quota share basis to Ability Re Bermuda. The new owners initially invested \$85 million in Ability Re Holdco, of which \$50 million was allocated to Ability Re Bermuda and \$35 million to Ability Re US. Besides the \$19 million in book reserves, AIC was capitalized with \$12 million from its new owners and \$13 million of deferred tax asset.

In March 2009, the company diversified its risk profile by taking a majority quota share in a funeral/pre-need block of business. The ceding commission paid to the originator was financed with excess capital on hand, and the originator will continue to administer the business. The former MLIC was the first operating company acquired by Ability Re US. MLIC had previously written accident and health coverage in 43 states and the District of Columbia. For many years, the company's core product line was individual senior life insurance, with emphasis on the sale of final expense policies sold in conjunction with the organization's long-term care and Medicare supplement business. In addition to its core products, the company also issued cancer, hospital indemnity, disability income, and accidental death and dismemberment policies. MLIC stopped writing new business in September 2007.

Ability Insurance Company is a Nebraska domiciled Stock Life and Health Insurance Company and as such is controlled by its shareholder. The Company is licensed to write life and health insurance business in all states and the District of Columbia except for, Connecticut, Maine, New Hampshire, New Jersey, New York, Rhode Island and Vermont.

As of the 2009 annual statement for the State of South Dakota, Ability Insurance Company reported premium considerations in the amount of \$22,898,732 of which \$1,481,525 represented the State of South Dakota.

EXAMINATION FINDINGS

I. COMPANY OPERATIONS

This examination focused on the Company's claims practices; therefore an in-depth review of the Company's Operations and Management was not conducted during this examination. The examiners reviewed the Company's practices and procedures for providing complete, accurate and timely data throughout the course of the examination.

Finding 1: The Company failed to provide timely responses to the examiners' criticisms or accurate records and data during the examination by providing inaccurate and incomplete data. The Company has failed to facilitate and aid the examination pursuant to SDCL § 58-3-7. It should be noted that except for the non-timely responses, the Company's staff cooperated with the examiners throughout the course of the examination.

Examples of delays in the examination include:

None of the 15 examiners' criticisms (Crits) relating to complaints, denied claims and withdrawn claims were responded to in a timely manner. Responses to written criticisms are required to be returned to the examiners by the third working day following presentation of the document to the Examination Coordinator. However it is noted that health issues on the part of the exam coordinator may have contributed to delays in replying.

The Company is required to provide complete, accurate and responsive information to all requests by the examiners, pursuant to SDCL § 58-3-7.

SDCL § 58-3-7 Information to be available--Cooperation of persons being examined

Every person being examined, its officers, employees, insurance producers, and representatives shall produce and make freely available to the director or the director's examiners the accounts, records, documents, files, information, assets, and matters in the director's possession or control relating to the subject of the examination; and shall otherwise facilitate and aid the examination as far as reasonably possible.

Recommendation 1: It is recommended that the Company ensure compliance with policies and procedures that provide complete and timely records and data to the examiners pursuant to SDCL § 58-3-7. The Company has agreed to comply with Recommendation No. 1. Moreover, Ability Re US has recently hired a new general counsel and enhanced its legal team, which it believes will facilitate timely responses to future requests.

II. COMPLAINT HANDLING

After review of the Long Term Care Complaint files, the examiners find that the Company failed to comply with South Dakota Statutes and/or Administrative Rules in the handling of a number of customer complaints.

The Company provided a list of all complaints filed during the examination period. The list included complaints received from the South Dakota Division of Insurance as well as complaints made directly to the Company on behalf of South Dakota consumers. The Company provided a list of 31 complaints. Of the 31 complaints, 23 were received from the South Dakota Division of Insurance and 8 were received directly from the consumers or their representatives. All 31 complaint files were requested, received and reviewed. The files were reviewed for compliance with the State of South Dakota Statutes, Rules and Regulations. The following exceptions were noted:

Complaints

Field Size:	31
Sample Size:	31
Sample Type:	Census
Number of Files with Errors:	11

Finding 2: The Company failed to retain copies of pertinent documents in 7 of the complaint files. Information missing from the 7 complaint files include 2 complaint resolution letters, 2 letters of communication referenced in the files, 4 referenced copies of checks, 1 doctor's certification, 1 denied appeal instructions, 4 explanations of benefits, 2 company response letters and 1 reversal of denied claim letter. The failure to retain records pertained to files that were created by Medico Insurance Company prior to Ability Insurance Company's assumption of this business.

SDCL § 58-1-26 Retention of records

Any insurer, nonprofit, surgical, dental or hospital plan, a health maintenance organization, or any other person required to be licensed or registered under this title shall retain all books and records that are subject to examination pursuant to chapter 58-3 for a period of not less than five years.

Recommendation 2: It is recommended that the Company retain all books and records that are subject to examination and comply with SDCL § 58-1-26. Since acquiring Medico, the Company asserts it has instituted procedures to assure that such books and records are maintained.

Finding 3: The Company failed to respond to a Division letter dated 12/15/06. The letter referenced is a communication from the Division to the Company involving the active review of a Division complaint under SDCL § 58-33-66. It is noted that the failure to timely reply to this complaint took place prior to the Company's assumption of this business.

SDCL § 58-33-66 Unfair or deceptive insurance practices

Unfair or deceptive acts or practices in the business of insurance include the following:

- (1) Failing to respond to an inquiry from or failing to supply documents requested by the Division of Insurance within twenty days of receipt of such inquiry or request;
- (2) Knowingly supplying the Division of Insurance with false, misleading, or incomplete information.

Recommendation 3: It is recommended that the Company ensure compliance with policies and procedures which require responses in a timely fashion in compliance with SDCL § 58-33-66. The Company reports it has taken steps to ensure compliance since its assumption of the business from Medico. Moreover, as previously noted, Ability Re US has recently hired a new general counsel and enhanced its legal team, which it believes will facilitate timely responses to future requests.

Finding 4: The Company failed to recognize the documentation of a physician's certification of a patient's need for home health care. There was no response to correspondence from the doctor.

While there were other instances as part of the claim review, there was 1 instance in the complaint review that is part of the pattern of not accepting physician certifications which would constitute failure to comply with ARSD 20:06:21:08.

ARSD 20:06:21:08 "Medically necessary" defined

When "medically necessary" is used as a condition to qualify for benefits it may not be defined more restrictively than as requiring the certification of the insured's physician.

If a policy does not have a prior hospitalization requirement, then the following definition of medical necessity may be used: Treatment that is appropriate and consistent with the diagnosed condition.

This is treatment that, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition. This definition of medical necessity may not be used for policies which condition benefits on inability to perform ADLs or functional incapacity.

Recommendation 4: It is recommended that the Company ensure compliance with policies and procedures that recognize facility and doctor certifications and comply with ARSD 20:06:21:08.

The Company reports that since the examination period, it now fully complies with South Dakota regulations concerning "medical necessity". Under South Dakota regulation 20:06:21:08 for non-tax qualified policies, only the "certification" of the insured's physician is necessary to qualify for benefits under the Medical Necessity trigger. The Company further reports that since the examination period, it has instituted substantive changes with respect to the manner in which it determines benefit eligibility on its most widely held long term care policies. In particular, Case Managers no longer make benefit qualification determinations. With the adoption of the physician-based model, the insured's physician determines benefit qualifier(s) (one, two or three benefit qualifiers, depending upon the construct of each policy).

Finding 5: The complaints/appeals in 4 complaint files were resolved inappropriately. The Attending Physician Statement and/or doctor's notes located in these files indicate that the physician certified the required care as being necessary. The complaint/appeal resolution did not recognize that "Medical Necessity" is an independent "Trigger" for benefits and that under South Dakota Administrative Rule, a physician's certification of the need for such care is sufficient to satisfy the Benefit Qualifier.

ARSD 20:06:21:08 "Medically necessary" defined

When "medically necessary " is used as a condition to qualify for benefits it may not be defined more restrictively than as requiring the certification of the insured's physician.

If a policy does not have a prior hospitalization requirement, then the following definition of medical necessity may be used: Treatment that is appropriate and consistent with the diagnosed condition.

This is treatment that, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition. This definition of medical necessity may not be used for policies which condition benefits on inability to perform ADLs or functional incapacity.

Recommendation 5: It is recommended that when "medically necessary" is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the insured's physician in compliance with ARSD 20:06:21:08.

The Company reports that since the examination period, it now fully complies with South Dakota regulations concerning "medical necessity". Under South Dakota regulation 20:06:21:08 for non-tax qualified policies, only the "certification" of the insured's physician is necessary to qualify for benefits under the Medical Necessity trigger. The Company further reports that since the examination period, it has instituted substantive changes with respect to the manner in which it determines benefit eligibility on its most widely held long term care policies. In particular, Case Managers no longer make benefit qualification determinations. With the adoption of the physician-based model, the insured's physician determines benefit qualifier(s) (one, two or three benefit qualifiers, depending upon the construct of each policy).

III. FORMS

The examiners reviewed the Company's policy forms to determine compliance with filing requirements, to ensure the contract language is not ambiguous, and that the provisions otherwise is in compliance with applicable law. In addition, the examiners reviewed the rate history documentation and procedures to determine the Company's compliance with the rate filing and usage requirements.

After review of the Ability Long Term Care policy forms, the examiners found that the Company's Form Numbers MP-LT698 and MP-LT694, Long Term Care Policies, failed to comply with applicable South Dakota long term care insurance statutes and rules.

Finding 6: LTC policy form MP-LT698, approved 6/28/1999, contains language in PART C-Exceptions (3) relating to Mental and Nervous disorders that exceeded the permissible exclusions from coverage found in SDCL § 58-17B-6 and ARSD 20:06:21:04. The policy language is in violation of SDCL § 58-17B-6.

SDCL § 58-17B-6 Defining "preexisting conditions"--Requirements--Exclusions for loss or confinement--Extending limitation periods

No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in subdivision 58-17B-2(4)(a):

...

(2) May exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

Additionally, the MP-LT698 states that the policy covers Mental and Nervous Disorders first diagnosed after the effective date of the policy. This language would exclude coverage for such ailments in perpetuity. This policy form also included the following:

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

The first diagnosed provision and the above-referenced pre-existing condition provision conflict.

LTC policy forms MP-LT698 and MP-LT694, approved 7/26/1996, contain language in PART C –Exceptions (4) relating to Alcoholism that exceeds the permissible exclusions from coverage found in ARSD 20:06:21:04. MP-LT698 policy will not pay benefits for alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a physician. The regulation permits exclusion only for charges related to the actual treatment for alcoholism or drug abuse.

ARSD 20:06:21:04 Permissible exclusions from coverage

A long-term care insurance policy may exclude or limit coverage for the following:

...

(3) Alcoholism or drug abuse. This subdivision does not permit an exclusion or limitation for long-term care services due to the insured's alcoholism or drug abuse, other than for the treatment of alcoholism or drug abuse;

...

(9) Mental or nervous disorders. This subdivision does not permit exclusion or limitation of benefits because of Alzheimer's disease;

...

Policy form MP-LT694 and MP-LT698 were filed and approved prior to the effective date of the modification to ARSD 20:06:21:04 which clarified permissible exclusions relating to alcohol and drug abuse.

Recommendation 6: It is recommended that the Company communicate in writing to each policyholder as to how the above-referenced finding will be addressed for purposes of claim adjudication and submit the communication to the Division for approval. It is further recommended that the Company be bound by the claims adjudication communication contained in this recommendation. The Company agrees to inform its policyholders of this change in South Dakota law as it applies to its policies and is adjudicating claims accordingly.

Finding 7: LTC policy forms MP-LT698 and MP-LT694 contains language in PART H (1) Benefit Qualifiers, relating to Medical Necessity that is more restrictive than ARSD 20:06:21:08. The policy's definition of medical necessity includes the phrase "Treatment that is appropriate and consistent and could not have been omitted..." However, because there is an ADL trigger in the MP-LT698 and MP-LT694 policies, the definition should only include the certification of physician language found in ARSD 20:06:21:08.

ARSD 20:06:21:08 "Medically necessary" defined

When "medically necessary" is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the insured's physician.

If a policy does not have a prior hospitalization requirement, then the following definition of medical necessity may be used: Treatment that is appropriate and consistent with the diagnosed condition. This is treatment that, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition. This definition of medical necessity may not be used for policies which condition benefits on inability to perform ADLs or functional incapacity.

Recommendation 7: It is recommended that the Company comply with the provisions of ARSD 20:06:21:08. As a remedial measure, it is recommended that the Company, for any claims processed during the examination period or any subsequent claim adjudications that notwithstanding any noncompliant language in the medical necessity benefit qualification definition in the MP-LT694 and MP-LT698 policies, the Company will not require anything more than a physician's certification that covered care is medically necessary.

The Company reports that since the examination period, it now fully complies with South Dakota regulations concerning "medical necessity". Under South Dakota regulation 20:06:21:08 for non-tax qualified policies, only the "certification" of the insured's physician is necessary to qualify for benefits under the Medical Necessity trigger. The Company further reports that since the examination period, it has instituted substantive changes with respect to the manner in which it determines benefit eligibility on its most widely held long term care policies. In particular,

Case Managers no longer make benefit qualification determinations. With the adoption of the physician-based model, the insured's physician determines benefit qualifier(s) (one, two or three benefit qualifiers, depending upon the construct of each policy).

Finding 8: LTC policy forms MP-LT698 and MP-LT694 contain language in PART F – Definitions, relating to Cognitive Impairment. The policy definition describes “deterioration or loss of your intellectual capacity due to organic brain disease or disorder”. This definition is more restrictive than ARSD 20:06:21:01(6) as that rule does not permit a requirement that the cognitive impairment be the result of organic brain disease.

LTC policy forms MP-LT698 and MP-LT694 contains language in PART H (3) – Benefit Qualifier, relating to Cognitive Impairment that is more restrictive than that seen in ARSD 20:06:21:01(6). The cognitive deficit trigger in the MP-LT698 and MP-LT694 policies state that the claimant must require “supervision and direction”. Whereas, ARSD 20:06:21:55(4) requires “supervision or verbal cueing by another person”.

ARSD 20:06:21:01 Definitions

Terms used in this chapter mean:

...

(6) "Cognitive impairment," a deficiency in a person's short- or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to awareness of safety;

...

Recommendation 8: It is recommended that the Company communicate in writing to each policyholder as to how the above-referenced finding will be addressed for purposes of claim adjudication and submit the communication to the Division for approval. It is further recommended that the Company be bound by the claims adjudication communication contained in this recommendation. The Company agrees to inform its policyholders of this change in South Dakota law as it applies to its policies and is adjudicating claims accordingly.

Finding 9: LTC policy form MP-LT698 contains language in the PART F - Definitions which requires care that is prescribed in “your Plan of Care”. This language is more restrictive than provided for by ARSD 20:06:21:55 and ARSD 20:06:21:08.

LTC policy form MP-LT698 contains language in PART F - Definitions, relating to Plan of Care that requires that the plan must be prepared by “your care coordinator”. This language is more restrictive than that seen in the triggers for benefits found in ARSD 20:06:21:55 and ARSD 20:06:21:08.

ARSD 20:06:21:55 Standards for benefit triggers

Long-term care policies must comply with the following standards for benefit triggers:

(1) A long-term care policy may require a recommendation by a physician that the services are necessary because of illness, injury, or infirmity, but may not condition benefits on medical necessity. If a long-term care policy provides for medical necessity as an additional mechanism to qualify for benefits, the policy may condition benefits for that additional benefit trigger based on medical necessity;

(2) Long-term care insurance policies must condition the payment of benefits on an assessment of the insured's ability to perform activities of daily living or on cognitive impairment. Activities of daily living included in a policy must include at least the six activities of daily living listed in subdivision 20:06:21:01(1) and as defined in § 20:06:21:01. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subdivision 20:06:21:01(1) if they are consistent with or no more restrictive than those contained in subdivision (1) of this section and this subdivision. A determination of impairment may not be more restrictive than requiring either a deficiency in the ability to perform three of the activities of daily living or the presence of cognitive impairment;

(3) An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however, the provisions may not restrict and may not be in lieu of the requirements contained in subdivisions (1) and (2) of this section;

...

Recommendation 9: It is recommended that, notwithstanding the noncompliant policy provisions regarding a plan of care, the Company implement as part of its claim processing procedures that a plan of care may be prepared by a claimant's physician. The Company reports that it currently interprets the care coordination provisions of the policy to permit Plans of Care to be prepared by the policyholder's physician.

Finding 10: Ability LTC policy form MP-LT698 contains language in PART L – Additional Benefits, relating to Bed Reservation Benefit that conditions eligibility on prior hospitalization. The condition states:

(1) You must be hospitalized temporarily during the course of your covered stay in a Nursing Facility or Assisted Living Care Facility.

The condition requiring prior hospitalization is not permitted by SDCL § 58-17B-7(1).

SDCL § 58-17B-7 Requirements for long-term care insurance policies--Post-confinement, post-acute care, or recuperative benefits

No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement;

...

Recommendation 10: It is recommended that the Company communicate in writing to each policyholder as to how the above-referenced finding will be addressed for purposes of claim adjudication and submit the communication to the Division for approval. It is further recommended that the Company be bound by the claims adjudication communication contained in this recommendation. The Company reports that it has not conditioned the bed reservation benefit on prior hospitalization. Nevertheless the Company will comply with the Recommendation providing notice to policyholders and adjudicate claims accordingly.

Finding 11: LTC policy form MP-LT698 contains language in PART R – Policy Provisions (2) and LTC policy form MP-LT694 contains language in PART Q – Policy Provisions (2), relating to Time Limit on Certain Defenses. The policy states (emphasis added):

After two years from the policy date, no misstatement, except knowing and intentional misstatements relating to the insured's health, can be used to void the policy. If the policy is reinstated on the basis of a health application, the contestable period will be two years from the reinstatement date.

The provision extending the contestability period in the event of reinstatement is more restrictive than ARSD 20:06:21:49.

ARSD 20:06:21:49 Incontestability period

The following incontestability periods must be complied with for long-term care policies:

- (1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage;
- (2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought;
- (3) After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; the policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health;

...

Recommendation 11: It is recommended that the Company take steps to ensure that no policy is contested in a manner that is not compliant with ARSD 20:06:21:49. It is recommended that the Company ensure compliance with policies and procedures that ensure that any reinstatements pursuant to SDCL § 58-17-19 will be done without underwriting. The Company reports that it has not used health application in circumstances where policies are reinstated. Nevertheless, the Company will comply with the Recommendation providing notice to policyholders and adjudicate claims accordingly.

Finding 12: LTC policy form MP-LT694 contains language in PART Q – Policy Provisions (9), relating to Intoxicants and Narcotics that states the Company will not be liable for loss sustained because of the insured’s being under the influence of a narcotic. SDCL § 58-17-30.8 prohibits exclusion of benefits for injuries sustained while under the influence of alcohol or drugs. Additionally, ARSD 20:06:21:04 permits exclusions from coverage only for the treatment of alcohol or drug abuse. Policy form MP-LT694 was approved on 7/26/1996, which was prior to the effective date of SDCL § 58-17-30.8 and the modification to ARSD 20:06:21:04.

SDCL § 58-17-30.8 Exclusion of benefits for injury while under the influence of alcohol or drugs prohibited--Exception for sickness or injury caused in commission of felony.

A policy or certificate of health insurance for an individual that is delivered, issued for delivery, or renewed in this state may not exclude the payment of benefits for injuries sustained by an insured person because the insured was under the influence of alcohol or drugs, as defined by § 32-23-1.

Nothing in this section precludes a health insurer from excluding coverage for an insured for any sickness or injury caused in the commission of a felony.

ARSD 20:06:21:04 Permissible exclusions from coverage

A long-term care insurance policy may exclude or limit coverage for the following:

...

(3) Alcoholism or drug abuse. This subdivision does not permit an exclusion or limitation for long-term care services due to the insured's alcoholism or drug abuse, other than for the treatment of alcoholism or drug abuse;

...

While an insured’s alcohol or drug use may not be used as a basis for denial of a claim, nothing in SDCL § 58-17-30.8 or ARSD 20:06:21:04 requires an insurer to cover the treatment of alcoholism or drug abuse.

Recommendation 12: It is recommended that the Company communicate in writing to each policyholder as to how the above-referenced finding will be addressed for purposes of claim adjudication and submit the communication to the Division for approval. It is further recommended that the Company be bound by the claims adjudication communication contained in this recommendation. The Company will comply with the Recommendation providing notice to policyholders and is adjudicating claims accordingly.

IV. RATES REVIEW

As part of the South Dakota Market Conduct Examination of Ability Insurance Company, an analysis of Long Term Care rate increases was conducted for Policy Forms: 3358, LT691, LT692, LT694, LT695, LT696, LT698, AC597 & LT201.

During the examination time period, Ability Insurance Company filed for and received approval for two long term care rate increases. The approved rate increases were 20% (approved April 3, 2006; 20% was an average rate revision) and 29.2% (approved June 23, 2010; 29.2% was an average rate revision). The Actuary sought to determine if the past rate increases were actuarially justified (with particular emphasis on the last two rate increases) and whether or not the current rates were adequate.

In order to make these determinations, the exam team's Actuary performed independent projections of historical South Dakota experience and historical nationwide experience. Projections were done for each policy form and for all forms aggregated on both South Dakota and nationwide experience. These projections were done to test compliance with South Dakota Administrative Rules ARSD 20:06:21:05 (lifetime loss ratio of 60%) and ARSD 20:06:21:64 (inequality test of incurred claims and earned premiums). All of the examiners' projections indicated that the past rate increases were actuarially justified under either ARSD 20:06:21:05 or ARSD 20:06:21:64. Actuarial projections also indicated that Ability will qualify for future actuarially justified rate increases and therefore it appears that the current rates may not be adequate to fund future liabilities. All of the above assumes that future experience emerges in a manner similar to or worse than the projected experience in the examiners' projections. In this regard the Actuary also reviewed Ability's projection from the 2006 rate filing and noted that the actual loss ratios from 2006 through 2011 were greater than the future projected loss ratios for 2006 through 2011. In other words Ability's experience from 2006 through 2011 was worse than the projected experience used to justify the 2006 rate increase.

V. DENIED CLAIMS

The Company was requested to provide a list of all South Dakota claims denied during the examination period. The Company identified a universe of 71 denied claims. All 71 claim files were requested, received and reviewed. The files were reviewed for compliance with the State of South Dakota Statutes and Regulations.

Denied Claims

Field Size:	71
Sample Size:	71
Sample Type:	Census
Number of Files with Errors:	33

Finding 13: The Company denied 22 claims inappropriately. In these claims the Attending Physician Statement and/or doctor's notes indicate that the physician certified the required care as being necessary because of illness, injury or cognitive impairment, or that without such alternative care the condition would require nursing facility care.

ARSD 20:06:21:08 "Medically necessary" defined

When "medically necessary" is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the insured's physician.

If a policy does not have a prior hospitalization requirement, then the following definition of medical necessity may be used: Treatment that is appropriate and consistent with the diagnosed condition. This is treatment that, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition. This definition of medical necessity may not be used for policies which condition benefits on inability to perform ADLs or functional incapacity.

Recommendation 13: It is recommended that the Company adjudicate claims appropriately and in accordance with ARSD 20:06:21:08. It is recommended that when the Company conditions benefits based on medical necessity, that it not be more restrictive than requiring the certification of the insured's physician.

The Company reports that since the examination period, it now fully complies with South Dakota regulations concerning "medical necessity". Under South Dakota regulation 20:06:21:08 for non-tax qualified policies, only the "certification" of the insured's physician is necessary to qualify for benefits under the Medical Necessity trigger. The Company further reports that since the examination period, it has instituted substantive changes with respect to the manner in which it determines benefit eligibility on its most widely held long term care policies. In particular, Case Managers no longer make benefit qualification determinations. With the adoption of the physician-based model, the insured's physician determines benefit qualifier(s) (one, two or three benefit qualifiers, depending upon the construct of each policy).

Finding 14: One denied claim was missing a response to the Doctor's letter of appeal dated 10/20/09 in violation of ARSD 20:06:21:72. With respect to the claim in question, since the exam benefits were paid in the amount of \$102,695.62

ARSD 20:06:21:72 Disclosure to applicant for a claim denial

If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

- (1) Provide a written explanation of the reasons for the denial; and
- (2) Make available all information directly related to the denial.

Recommendation 14: It is recommended that the Company shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof: (1) Provide a written explanation of the reasons for the denial; and (2) Make available all information directly related to the denial and comply with ARSD 20:06:21:72. The Company reports it is complying with the Recommendation.

Finding 15: In 4 denied claim files, the Company failed to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim. Claim denials were not maintained in Ability's claim files and were only produced via Medico Insurance Company upon being requested. The Company also failed to maintain claim files as required by SDCL § 58-3-7.4. It is noted that the claim files in question originated with and were adjudicated by Medico Insurance Company prior to the date the Company assumed the business.

SDCL § 58-3-7.4 Insurer's claim files subject to examination--File maintenance requirements

Each insurer's claim files for policies or certificates are subject to examination pursuant to chapter 58-3 by the director of insurance. To aid in the examination:

- ...
- (2) Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim

...

Recommendation 15: While the Company does have current procedures to address this finding, it is recommended that the Company ensure that claim files contain detailed documentation in order to permit reconstruction of the insurer's activities relative to each claim pursuant to SDCL § 58-3-7.4. It is further recommended that the Company provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement. The Company reports it is complying with the Recommendation.

Finding 16: The Company failed to deny 2 claims within 30 days after receipt of all requested information (proof of loss). It is noted that the failure to deny 2 claims within 30 days of receipt of all requested information took place when Medico Insurance Company was administering the book of business prior to the Company assuming this business.

SDCL § 58-33-67 Unfair or deceptive practices in dealing with insured

In dealing with the insured or representative of the insured, unfair or deceptive acts or practices in the business of insurance include, but are not limited to, the following:

- (1) Failing to acknowledge and act within thirty days upon communications with respect to claims arising under insurance policies and to adopt and adhere to reasonable standards for the prompt investigation of such claims;

...

Recommendation 16: It is recommended that the Company acknowledge and act within 30 days upon communications with respect to claims arising under insurance policies and to adopt and adhere to reasonable standards for the prompt investigation of such claims and comply with SDCL § 58-33-67. The Company will comply with the Recommendation.

Finding 17: The Company denied 4 claims on the basis that the benefit qualifier was not met. However, there was evidence that the insureds may have qualified for benefits under the “Medical Necessity” trigger in their policies but no Attending Physician Statement was requested by the Company.

The claims in the 4 files were denied. However, there was evidence that the insured may have qualified for benefits under the “Medical Necessity” trigger in their policies but no Attending Physician Statement was requested by the Company.

The examiners found that the Ability policy language and ARSD 20:06:21:08 require that the Company seek a physician’s certification of need for care before an informed claim decision can be made. The 4 claims were improperly denied as the Company failed to adopt reasonable standards for the investigation of claims.

ARSD 20:06:21:08 "Medically necessary" defined

When “medically necessary” is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the insured’s physician.

If a policy does not have a prior hospitalization requirement, then the following definition of medical necessity may be used: Treatment that is appropriate and consistent with the diagnosed condition.

This is treatment that, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient’s condition. This definition of medical necessity may not be used for policies which condition benefits on inability to perform ADLs or functional incapacity.

Recommendation 17: It is recommended that the Company acknowledge and act within 30 days upon communications with respect to claims arising under insurance policies and to adopt and adhere to reasonable standards for the prompt investigation of such claims including investigating whether a claimant qualifies for benefits under the medical necessity standard when there is evidence indicating the claimant may qualify. It is also recommended that when “medically necessary” is used as a condition to qualify for benefits, it may not be defined more

restrictively than as requiring the certification of the insured’s physician. The Company should comply with ARSD 20:06:21:08.

The Company reports that since the examination period, it now fully complies with South Dakota regulations concerning “medical necessity”. Under South Dakota regulation 20:06:21:08 for non-tax qualified policies, only the “certification” of the insured’s physician is necessary to qualify for benefits under the Medical Necessity trigger. The Company further reports that since the examination period, it has instituted substantive changes with respect to the manner in which it determines benefit eligibility on its most widely held long term care policies. In particular, Case Managers no longer make benefit qualification determinations. With the adoption of the physician-based model, the insured’s physician determines benefit qualifier(s) (one, two or three benefit qualifiers, depending upon the construct of each policy).

VI. WITHDRAWN CLAIMS

The Company was requested to provide a list of all withdrawn claims during the examination period. The Company identified a universe of 28 withdrawn claims. All 28 withdrawn claims were requested, received and reviewed. The files were reviewed for compliance with the State of South Dakota Statutes and Regulations.

In the review of denied claims, the examiners encountered the Company’s practice of encouraging policyholders or their representatives to withdraw claims that had been filed on Long Term Care policies. This alternative method of claim settlement was identified by the Company as “Closed at Request of Insured”.

In most withdrawn claim files, there was a letter from the Company that stated “This claim is closed and benefit eligibility will not be investigated”.

Withdrawn Claims

Field Size:	28
Sample Size:	28
Sample Type:	Census
Number of Files with Errors:	18

Finding 18: There were 18 claims that were not paid or denied but were disposed of as “withdrawn claims” after repeated and insistent coaching by Ability Case Managers (CM). Additionally, the CM provided inaccurate, incorrect or incomplete information relating to the provisions of the insureds’ policy or the requirements relating to Long Term Care insurance under South Dakota statutes and/or administrative rules. After review of the population of Long Term Care withdrawn claim files and voice recordings, the examiners found that the Company failed to adjudicate claims per the contract language and as required under SDCL § 58-12-1.

It was Ability's previous practice to encourage claimants and/or representatives to withdraw claims. The withdrawal of claims is found in the Case Managers' instructions in the Company's claim manual.

SDCL § 58-12-1 Forms for proof of loss—Furnishing by insurer on request.

An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

Recommendation 18: It is recommended that the Company adjudicate claims per the contract and as required under SDCL § 58-12-1. It is further recommended that the Company not urge, persuade or otherwise coach claimants to withdraw claims and that the Company only withdraw claims upon the independent express written request of the claimant. To avoid any confusion among policyholders, the Company reports it has adopted a policy that no longer allows policyholders to withdraw claims.

Finding 19: After review of the population of Long Term Care withdrawn claim files and voice recordings, the examiners found that the Company failed to adjudicate 7 claims per the terms of the insureds' contracts and as required under ARSD 20:06:21:08. In these claims, the Company misled claimants/representatives and provided inaccurate and incomplete information relating to the provisions of the Ability LTC policies involved and/or the requirements relating to Long Term Care insurance under South Dakota statutes and/or administrative rules, including ARSD 20:06:21:08.

ARSD § 20:06:21:08 "Medically necessary" defined

When "medically necessary" is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the insured's physician.

If a policy does not have a prior hospitalization requirement, then the following definition of medical necessity may be used: Treatment that is appropriate and consistent with the diagnosed condition. This is treatment that, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition. This definition of medical necessity may not be used for policies which condition benefits on inability to perform ADLs or functional incapacity.

Recommendation 19: It is recommended that the Company adjudicate claims per the contract and as required under ARSD 20:06:21:08 and that the Company ensure compliance with policies and procedures that ensure that no misleading claims information is provided to claimants.

The Company reports that since the examination period, it now fully complies with South Dakota regulations concerning "medical necessity". Under South Dakota regulation 20:06:21:08

for non-tax qualified policies, only the “certification” of the insured’s physician is necessary to qualify for benefits under the Medical Necessity trigger. The Company further reports that since the examination period, it has instituted substantive changes with respect to the manner in which it determines benefit eligibility on its most widely held long term care policies. In particular, Case Managers no longer make benefit qualification determinations. With the adoption of the physician-based model, the insured’s physician determines benefit qualifier(s) (one, two or three benefit qualifiers, depending upon the construct of each policy).

To avoid any confusion among policyholders, the Company reports it has adopted a policy that no longer allows policyholders to withdraw claims.

Finding 20: The Ability CM misrepresented the benefit qualification in the MP-LT694 policy in the referenced claim. ARSD 20:06:21:04 does not permit an exclusion or limitation for long term care services due to the insured’s alcoholism other than the treatment for alcoholism. The decision to withdraw was based on inaccurate and deceptive information from the Company.

While an insured’s alcohol or drug use may not be used as a basis for denial of a claim, nothing in SDCL § 58-17-30.8 or ARSD 20:06:21:04 requires an insurer to cover the treatment of alcoholism or drug abuse.

ARSD 20:06:21:04 Permissible exclusions from coverage

A long-term care insurance policy may exclude or limit coverage for the following:

...

(3) Alcoholism or drug abuse. This subdivision does not permit an exclusion or limitation for long-term care services due to the insured's alcoholism or drug abuse, other than for the treatment of alcoholism or drug abuse;

...

Recommendation 20: It is recommended that the Company adjudicate the claim per the contract as required under ARSD 20:06:21:04 and that the Company provide accurate information about benefit qualifications to claimants. To avoid any confusion among policyholders, the Company reports it has adopted a policy that no longer allows policyholders to withdraw claims.

CONCLUSION

The examination was conducted by Examiners Roger Fournier, Frank Kyazze and Gwendolyn J. Douglas and Actuary Arthur Lucker.
It is respectfully submitted to the SDDOI.



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