

**SOUTH DAKOTA DIVISION OF INSURANCE**  
**MARKET CONDUCT EXAMINATION REPORT**

ON

**WASHINGTON NATIONAL INSURANCE COMPANY**  
**FORMERLY DBA CONSECO HEALTH INSURANCE**  
**COMPANY**

NAIC # 78174  
11825 N. Pennsylvania Street  
Carmel, IN 46032

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## SALUTATION

June 21, 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 23, 2009 and pursuant to statutory provisions including SDCL Ch. 58-3, a Market Conduct Examination has been conducted of the affairs and practices of:

Washington National Insurance Company formerly DBA Conseco Health Insurance Company.

Conseco Health Insurance Company is incorporated under the laws of the State of Arizona. 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:

11825 N. Pennsylvania Street, Carmel, IN 46032.

The off-site phase was performed at the offices of the South Dakota Division of Insurance and other appropriate locations.

The report of examination thereon is respectfully submitted.

## **FOREWORD**

This examination reflects Conseco Health 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 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 South Dakota Division of Insurance 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” refers to Conseco Health Insurance Company now known as Washington National Insurance Company

“SDCL” refers to the Statutes of South Dakota

“ARSD” refers to South Dakota's Administrative Rules

“SDDOI” or “Division” refers to the South Dakota Division of Insurance

“NAIC” refers to the National Association of Insurance Commissioners

## **SCOPE OF EXAMINATION**

The South Dakota Division of Insurance has authority to perform this examination pursuant to, but not limited to, SDCL § 58-3. This examination of the Company began March 1, 2010 and covered the period of January 1, 2005 through December 31, 2009, unless otherwise noted. This examination focused on a review of the Company's Complaint Handling practices, Policyholder Services, Marketing & Sales practices, Producer Licensing, Underwriting & Rating practices and Claims Handling for supplemental health insurance products.

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

## **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.

### **COMPLAINT HANDLING**

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.

### **MARKETING AND SALES**

The examiners review the Company's advertising for all products sold applicable to the examination scope to ensure they are marketed correctly. The examiners also review the development and approval process for both Company and producer generated advertisements. In addition, producer training materials used during the examination period are reviewed.

### **PRODUCER LICENSING**

The examiners compare the Company and SDDOI producer appointment and termination listings to ensure they are in compliance with the licensing and appointment laws of South Dakota. The examiners review procedures and practices for compliance with South Dakota statutes and regulations to test for compliance.

### **UNDERWRITING AND RATING**

The examiners review the Company's underwriting and rating practices, which includes the use of policy forms, adherence to underwriting guidelines and company manuals, assessment of premium and termination procedures to determine if the Company is in compliance with South Dakota's statutes and regulations. The examiners also determine if the Company's procedures assist it in meeting compliance obligations, contractual obligations and business effectiveness. The examiners also look at the oversight utilized by the Company to ensure its procedures are being followed and performing as intended.

The examiners review the Company's policy forms and underwriting guidelines to determine compliance with filing requirements, to ensure the contract language is not ambiguous and that the provisions of the policies adequately protect insureds. In addition, the examiners review active and terminated policy files to determine if the Company is adhering to its own underwriting guidelines and procedures.

## CLAIMS

The examiners review the claims 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 examiners also look at the oversight utilized by the Company to ensure its procedures are being followed and performing as intended.

The types of practices considered to be in error include, but are not limited to, an unreasonable delay in the acknowledgment of a claim, 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.

## POLICYHOLDER SERVICE

The examiners reviewed the policyholder services practices of the Company in order to determine compliance with the statutes and/or regulations pertaining to billing notices, policy issuance, insured requested cancelations, delays or no response to correspondence, responsiveness/accuracy of responses to correspondence, premium refunds and coverage questions. The findings related to policyholder services are addressed in other sections to avoid duplication.

## 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.

## EXECUTIVE SUMMARY

This Market Conduct Examination focused on the business practices of Washington National Insurance Company, formerly DBA Conseco Health Insurance Company's sale of supplemental health insurance.

These products provide limited benefits for Accidental Injury, Cancer Treatment, Heart/Stroke, Intensive Care and Medicare Supplement. These policies offer benefits associated with injuries and illness including certain costs that may not be covered under a traditional health policy and to assist in the payment of co-payments, deductibles and other expenses.

The SDDOI also requested a review of the Company's operations through file reviews and inquiries into Marketing and Sales practices and Producer Licensing practices, Complaint Handling, Claims, Policyholder Service, and Company Operations. The examiners reviewed three items of concern to the Division. First, the examiners reviewed the use of a Return of Premium benefit and the conversion of policies being used as an opportunity for further interaction with policyholders, including additional sales. Second, the examiners reviewed the Company's licensing oversight and controls, in particular the licensing record of a top producer. Finally, the examiners reviewed the Company's handling of Medicare Supplement policies and claims. The Company no longer sells Medicare Supplement policies.

The examiners noted deficiencies in the Company's procedures and practices in the following areas:

1. Company Operations – the Company failed to provide accurate and complete documentation and information throughout the examination; responses to requests for documents and information were often delayed and/or lacking in detail which prolonged the length of the examination; insufficient documentation in almost every complaint, claim and policy file; the Company failed to maintain agent statements from investigations. Also, the Company does not have suitability guidelines; the Company does not adhere to reasonable standards for the prompt investigation of claims; the Company has engaged in misrepresentation and deceptive sales practices. The Company does not maintain proof of delivery, nor does it accurately record the date of receipt on all documents.
2. Marketing and Sales - information about the free-look provision is not included in the sales presentations of producers; outlines of coverage were not provided to applicants nor were signed acknowledgements of receipts obtained; sales practices are misleading and deceptive, and result in unsuitable sales; weak oversight of producers; the Company's controls over its sales practices for conversions are inadequate<sup>1</sup>. Also, some marketing materials do not accurately reflect benefits and limitations. The Company has substantially revised their sales materials since the examination period.

3. Producer Licensing - the Company allowed insurance contracts to be issued through and payment of commissions to be made to an unlicensed producer; the Company has inadequate controls and audit procedures.
4. Complaint Handling – the Company’s procedures for cancellation requests allow for processing to exceed 20 days; issues uncovered in complaints are not addressed company-wide; failure to respond in a timely manner; failure to properly or thoroughly investigate complaints.
5. Underwriting and Rating - the Company: failed to issue and mail unearned premium within 20 days of a request for cancellation; failed to provide the reason for cancellation; failed to provide and/or failed to maintain documentation of notice of cancellation. Also, the Company failed to include required disclosures, and statements in Medicare Supplement forms. The Company duplicated Medicare Supplement coverage.
6. Claims – the Company uses a “business” day rule rather than a “calendar” day rule for claims processing. The Company: failed to issue Explanation of Benefits on denied claims; failed to include the claim number on correspondence; failed to maintain copies of denial letters from December 6, 2005 to December 15, 2005; improperly denied claims; failed to deny claims in a timely manner; included improper denial reasons in denial letters; and failed to maintain acknowledgement letters.
7. Policyholder Service - The examiners review the policyholder services practices of the Company in order to determine compliance with the statutes and/or regulations pertaining to billing notices, policy issuance, insured requested cancellations, delays or no response to correspondence, responsiveness/accuracy to correspondence, premium refunds and coverage questions. These practices were reviewed during this examination, however, since the findings are intertwined with other areas that were reviewed, such as Complaints and Claims Handling practices, the findings for this review are reported in those sections of the report.

<sup>1</sup> The Company’s definition of the term “conversion” is not converting from a group policy to an individual policy, but rather from one individual product to another individual product. The Company defines a conversion as, “changing the coverage from one product family to a new one. This includes Capital American policies that have been changed or converted to a Conseco product.” Since this involves the issuance of a new policy that replaces the previous policy, the Division considers this a replacement.

## **BACKGROUND INFORMATION**

### **COMPANY OVERVIEW**

#### **A. HISTORY**

The Company was originally organized and incorporated as Capitol American Life Insurance Company (Capitol American) in 1970 under the laws of the State of Arizona. The holding company has a number of acquisitions and mergers including a bankruptcy in its history. Capitol American was acquired through a holding company acquisition in 1997 by Conseco, Inc. and changed its name in 1998 to Conseco Health Insurance Company.

Since the period of the examination, the holding company for the group of affiliated companies changed its name from Conseco, Inc. to CNO Financial Group, Inc. In 2010, Conseco Health Insurance Company also merged into an affiliated company within the CNO Group, Washington National Insurance Company, and is now known by that name.

#### **B. PROFILE**

The Company is a Fortune 500 company, with approximately \$4 billion in annual revenues. The Company sells supplemental health products, including Medicare supplemental insurance, cancer insurance, heart/stroke insurance, intensive care insurance and accidental injury insurance.

The Company's Medicare Supplement insurance coverage is designed to assist in the payment of expenses not covered under Medicare Plan Part A and Part B. The Company's cancer, heart/stroke and hospitalization policies offer benefit payments to policyholders and offers cash benefits designed to assist in the payment of co-payments, deductibles and other expenses.

## **EXAMINATION FINDINGS**

### **I. COMPANY OPERATIONS**

#### **RETURN OF PREMIUM**

There are two policy riders that interplay in the sale of the Company's supplemental health products, the Return of Premium (ROP) and Cash Value (CV). The CV structure of benefits generally includes ROP beginning after five years, regardless of claims paid, but is based on a percentage of time that the policy has been in force.

The ROP benefit provision returns 100% of the premiums paid minus any claims at the end of the policy term or at maturity provided that all applicable provisions have been met and provided the policy has not lapsed or been replaced. This time period is usually twenty years from the inception of the policy. There are also variations in the ROP maturity date based on the age of the insured. The following description was provided by the Company:

Here is an example of what happens to the return of premium when a policy is converted. The original policy in this example was issued in 1999, so the original return

of premium maturity date is in 2019. However, you can see that in 2005 there was a conversion and the new level of benefits go into effect after the waiting period of thirty days. Upon conversion, the premiums paid in to this point freeze and are held until the original maturity date (2019) when they are released on the policy anniversary date to the policyholder, if the policy is still in force. For example, let's say that they had \$3,000 paid into this policy in premiums upon the effective date of the conversion in 2005. That \$3,000 would be frozen and then released on the policy anniversary date of the original policy in 2019. The same process for cash value is used but instead the maturity date for the cash value benefit is 25 years rather than 20.

On or about 1999 there was a fundamental shift in the Company's marketing and selling from ROP riders to CV riders on newer policies. While the Company may replace one ROP policy with another, the Company generally sells the CV rider when it changes policyholders from older policies that contained the ROP benefit to new policies. The Company refers to this change of policies as a "conversion" and not a replacement.

The Company stated that they do not have any replacements, whether internal or external. All traditional replacements are considered "conversions" by the Company.

***Finding 1:*** The Company acquired Capitol American Life Insurance Company effective March 4, 1997. Of the specified disease policies received in the acquisition, there remain 6,893 policies in force in South Dakota as of March 31, 2013. A total of 4,878 of these policies have been converted which represents a conversion rate of 70.77%. Since acquisition, there remain 10,047 policies in force in South Dakota that the Company has issued directly as of March 31, 2013. This number comprises 1,043 policies with a return of premium (ROP) rider, 8,895 policies with a cash value (CV) rider and 316 policies which have neither rider. A total of 298 of these policies have converted which represents a conversion rate of 2.97%. Overall, this represents a conversion rate of current in force policies of 30.19%. The vast majority of conversions occurred with inherited Capitol American ROP policies and the vast majority of issued policies since acquisition have been CV policies. CV policies provide enhanced benefits and premiums are returned regardless of claims. The ROP to CV conversion process, including any possible disadvantage to the insured as a result of conversion, has not been adequately disclosed in the PMA Playbook. The Company failed to comply with ARSD 20:06:10:05, ARSD 20:06:10:06 and ARSD 20:06:10:08.

***Recommendation 1:*** The Company revise its solicitation and training materials so as to ensure that applicants who are presented with CV policies are provided with information as to its limitations in receiving a CV benefit.

***Finding 2:*** Performance Matters Associates, Inc., (PMA) is an Independent Marketing Organization (IMO) that handles the cancer policy sales for the Company. PMA's Playbook describes the Company's products as follows:

*Do not confuse conversions with upgrade. A conversion is changing the coverage from one product family to a new one. An upgrade is defined as increasing the benefits within the current plan. On conversions, a new policy number is issued. On upgrades, the*

*current policy number will be retained. Conversions to the CI96 product can be made from any previous Conseco health product that has overall benefits that are less than the coverage the customer is converting to. The main insured on the original plan must remain the main insured on the converted plan. You cannot change the main insured to the spouse at the time of conversions. A full modal premium payment, monthly or annual, must be submitted with the conversion application. Just like new business, there is a 30-day waiting period on the conversion policy for the converted portion of the cancer benefits.*

*Conversion Amendments are provided to the insured when a policy is converted and the Company issues a new policy form to the insured and a new policy number is assigned. If the converted policy includes ROP or CV, a new ROP or CV rider and maturity date will be issued.*

PMA training its agents in this way evidences a decision by the Company to encourage its agents to make misleading, deceptive, and unsuitable sales in violation of SDCL § 58-33A-10, ARSD 20:06:10:04, and 20:06:10:02.01.

**Recommendation 2:** It is recommended that the Company institute internal controls and procedures to ensure that the ROP/CV products are represented in a manner that complies with the statutes and does not misrepresent the benefits offered. Additionally, the Company must institute internal controls and procedures to ensure that the sale of ROP/CV riders are suitable. The internal controls and procedures established must adequately address replacements and how replacements are described to consumers.

**Finding 3:** The examiners found no specific sales materials/documents that explain the effect of a conversion on the policy benefits. In relation to the effect a conversion has on the ROP rider - premiums paid from the original policy effective date until the date of conversion are “frozen” until the original policy’s maturity date, usually 20 years from the effective date. For the new converted policy, a CV period begins with the effective date of the converted policy. A Conversion Amendment is used to effect this change. This scenario is the same for policies converted with a CV Rider as well, however, the original maturity date is 25 years instead of 20 years. Benefits on the new converted policy are held for a waiting period of 30 days until they are eligible to be used. During this “waiting period” claims are paid/processed using the original policy benefits. Note: Appendix A contains a description of the Company’s internal guidelines/explanations related to the conversion process, ROP and CV riders.

The incorporation by reference of the prior maturity date, persons excluded, benefit levels, and premiums paid on the prior policy fails to comply with SDCL § 58-11-39.

**Recommendation 3:** It is recommended that the Company institute internal controls and procedures to ensure that the ROP/CV products are represented in a manner that complies with the statutes and does not misrepresent the benefits offered. Additionally, the Company must institute internal controls and procedures to ensure that the sales of ROP/CV riders are suitable. The internal controls and procedures established must adequately address replacements and how replacements are described to consumers. It is recommended that the Company revise its policy

forms so as to comply with SDCL § 58-11-39. It is recommended that the Company file all marketing materials with the Division for its review and approval pursuant to ARSD 20:06:10:20, 20:06: 10:02.01, and SDCL § 58-33A-12.

***Finding 4:*** The ROP monies go directly to the insured either by check or through a Company Benefits Now Account (BNA). Any ROP over \$2,000 is automatically established as a BNA. The BNA can be used in the same manner as a checking account although no other monies can be deposited. Also, these accounts do not have FDIC protection. The BNA and its limitations are not disclosed to the consumer. This is a violation of SDCL § 58-33A-10 and ARSD 20:06:10:04.

***Recommendation 4:*** It is recommended that the Company provide the claimant, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options. It is recommended that the Company obtain a signed disclosure from the insured stating that they have been informed of the limitations of the BNA and still choose to accept this method of payment. It is recommended that the Company inform the claimant that the BNA is a retained asset account and is not guaranteed by the Federal Deposit Insurance Corporation (FDIC).

***Finding 5:*** According to the Company, the ROP funds are delivered by the agent in a sealed package or sent to the consumer by mail. The examiners found no instances of delivery to the policyholder by mail. When an agent is involved in the delivery of the ROP they are instructed to use the delivery as an opportunity for interaction with the policyholder, including the opportunity for additional sales. There is an emphasis within the agent materials (*e.g.*, the PMA Playbook) for sales during this ROP process. The Company does not have adequate controls in place to ensure all sales are suitable and that excessive insurance is not sold in violation of ARSD 20:06: 10:02.01 (2) and 20:06:13:43:01.

***Recommendation 5:*** It is recommended that the Company cease using the payment of a policy benefit as a sales opportunity. It is recommended that the Company instruct all of its agents and IMOs to cease using the payment of a policy benefit as a sales opportunity. It is recommended that the Company have adequate controls in place to enforce this prohibition among its sales force. It is recommended that the Company have adequate controls in place to ensure all sales are suitable and that excessive insurance is not sold, pursuant to ARSD 20:06: 10:02.01 (2) and 20:06:13:43:01.

***Finding 6:*** The account includes a booklet of checks that can be used in increments of \$250 or more.

***Recommendation 6:*** It is recommended that the Company provide an option to access the entire ROP amount in one transaction.

#### OTHER COMPANY OPERATIONS

***Finding 7:*** The Company failed to provide accurate and complete records and data throughout the examination. The Company's responses to requests for documents and information were often delayed and/or lacking in detail which prolonged the length of the examination. By providing inaccurate and incomplete data, the Company failed to facilitate and aid the

examination as required. The Company was slow to respond to requests from the examiners and often provided information in a piecemeal fashion. Examples of these failures and delays are provided throughout this report in the respective areas. Examples of the additional inquiries and information that were required that resulted in lengthening the time of the examination beyond the anticipated time are listed below:

1. During the review of the 50 Denied Medicare Supplement claims a request was made for the Company to provide all documentation even though the files had been previously delivered pursuant to an earlier request. After this production and subsequent review, a memorandum was issued to the Company for the lack of documentation. The Company then furnished additional documentation that required yet another review and additional time that subsequently changed the proposed findings from failure to maintain documentation to failure to maintain denial letters in 2 files. The findings for failure to facilitate the examination and failure to retain all pertinent documents still remain.
2. A sample of 50 files of Denied claims in Specified Heart Disease, Heart Attack and Stroke policies was examined. In a number of these files, the examiners requested the reason(s) for the denial. The examiners also met with the Company and requested an explanation of the documentation in the file. In response to the inquiry, the Company simply referred the examiners back to the file. This required additional time for the examiners to re-examine the files and to send additional requests for information and documentation.
3. A sample of 100 files was furnished and reviewed for Cancellations (Other) in the Underwriting and Rating review. Due to a lack of documentation, a memorandum was issued that cited a failure in documentation for almost all of the originally produced files. In response to this memorandum the Company submitted a large amount of additional documentation. Additional time for review was necessitated by the second production of documents. The findings for failure to facilitate the examination and failure to retain all pertinent documents still remain.
4. The complaint files were examined early during the examination and were poorly organized and contained comments, notes, indications of previous activity, telephone logs, and non-designated claim information. Multiple date stamps were found on various documents in the files and no date stamps were found on others. The examiners made numerous requests in order to complete the file review, both general in nature and directed to specific files. The Company was eventually requested to reconstruct some of the files for examination by providing a timeline of file activity.
5. In the Underwriting and Rating review the examiners reviewed 50 Conversion files. Issues in the initial production of documents primarily revolved around copies of policies not being in the files. Specimen policies were provided rather than copies of the original policies, including policies issued under the name of a predecessor company, Capitol American, which no longer exists. Providing the records in this manner required the examiners to issue additional requests which delayed the exam.
6. The Company initially stated that it had no Medicare Supplement replacements. Upon conclusion of the fieldwork for this examination the Company then reported that they

indeed had 7 internal replacements and 518 external replacements. A request was made for the Company to provide a sample of these files and again, there was a significant delay by the Company in providing the files for review.

7. The examiners sent several inquiries to the Company regarding missing complaint files. It was not until after the examiners informed the Company that if the missing files were not provided that they would be considered violations that the Company then provided the files. The Company responded to the examiners' requests for the remaining files 2 weeks after receipt of the request. The response time used for this examination was 3-5 business days.

This constitutes a failure to facilitate an examination in violation of SDCL §§ 58-6-47(5) and 58-3-7, and a failure to maintain records in accordance with SDCL § 58-1-26.

**Recommendation 7:** It is recommended that the Company provide timely, complete and accurate records, information, and data during an examination, pursuant to SDCL §§ 58-3-7 and 58-1-26. It is recommended that the Company ensure that it facilitates and aids the examination as far as reasonably possible.

**Finding 8:** The Company stated they have no suitability requirements for any products/lines of business reviewed in this examination. It is a concern that the Company is converting or replacing policies with longer maturity dates with no regard for the age of the policyholder or if the provisions are appropriate for the policyholder at that given time. This is in violation of ARSD 20:06: 10:02.01.

**Recommendation 8:** It is recommended that the Company institute suitability guidelines for all of its products and lines.

**Finding 9:** For all lines of business, the Company assigns a new claim number for claims reopened after being closed or abandoned. When additional information is received on the exact same matter, the new information is assigned a new claim number; however, this new number is not cross-referenced to the original claim. Upon submission of the new information, the adjuster must determine if any previous claims were submitted and retrieve that information. This is a cumbersome and ineffective system that results in errors in claim handling. It should be noted that the Company indicates that management has instituted a program that addresses this issue.

**Recommendation 9:** It is recommended that the Company maintain the original claim number for claims that are reopened after being closed or abandoned in order to prevent claim handling errors and subsequent complaints. It is recommended that the Company improve its claims handling systems and processes to reduce the number of mistakes in the handling of claims. It is recommended that the Company adopt and adhere to reasonable standards for the prompt investigation of claims as required by SDCL §§ 58-3-7 and 58-3-7.4.

**Finding 10:** The Company failed to maintain a certificate of mailing or delivery receipt for specified disease policies. Evidence of this issue was found in several consumer complaints that related to the insured having never received a copy of their policy.

**Recommendation 10:** It is recommended that the Company retain proof of delivery as required by SDCL §§ 58-17-11.1 and 58-1-26.

**Finding 11:** The Company failed to maintain a certificate of mailing or delivery receipt for Medicare Supplement policies when those policies were mailed to the policyholder. Evidence of this issue was found in several consumer complaints that related to the insured having never received a copy of their policy.

**Recommendation 11:** It is recommended that the Company retain proof of delivery as required by SDCL §§ 58-17A-8.1 and 58-1-26.

**Finding 12:** The claims and complaints arrive in the mailroom where they are stamped with the date of receipt. The documents that are received late in the day are stamped the next morning. This practice is a violation of SDCL §§ 58-3-7.4(3), 58-17-11, 58-33-38, 58-17A-8, and 58-33-66(2).

**Recommendation 12:** It is recommended that the Company accurately record the date of receipt on all documents.

**Finding 13:** The received material is scanned into an imaging system and the claims adjusters generally work with the material electronically. The scanner will image the front and back of pages. It will sometimes scan blank pages because of dirt or other markings on the original document. A processor in the mailroom will view each scan and delete the blank pages. Once scanned, the hard copies of documents are shredded. The examiners and Division staff observed pages with light writing or other markings that were discarded as blank pages.

**Recommendation 13:** It is recommended that the Company modify its mail handling procedures and scanning practices to ensure no document is destroyed until the Company has confirmed that a complete and accurate image of the document has been created. It is recommended that the Company not allow mailroom processors to delete any scanned pages; the entire claim/complaint material should be provided to the handler for review prior to the deletion of any blank pages.

## **II. MARKETING AND SALES**

### **PMA OVERVIEW**

The Company stated that various Independent Marketing Organizations (IMOs) are engaged in selling its products throughout the country. The sales occur through licensed agents working within these organizations. The Company refers to PMA as an IMO, however, it is a wholly owned subsidiary of the CNO group of companies. PMA was originally three companies that have since merged into one involving both worksite and individual products. PMA is based in Dallas, Texas.

**Finding 14:** The Company’s producers are trained not to discuss the free-look period and this information is not included in any agent sales material, in violation of SDCL § 58-33-5 and ARSD 20:06:10:04.

**Recommendation 14:** It is recommended that the Company provide training to its agents to require disclosure of the free-look period to prospective applicants and incorporate the free-look provision into its sales literature and presentations for all of its products, as required by SDCL § 58-17-11. It is recommended that all marketing documents equally explain the exclusions and limitations, as well as the benefits, of the policy pursuant to ARSD 20:06: 10:02.01 (2).

**Finding 15:** The Company’s agents did not leave outlines of coverage nor obtain acknowledgement of receipt of outlines of coverage in violation of SDCL § 58-33A-5.

**Recommendation 15:** It is recommended that the Company comply with the outline of coverage requirements of SDCL § 58-33A-5

## PMA SALES PRACTICES

The examiners reviewed the PMA Consumer Marketing Division agent “Playbook” that provides detailed instructions on how to sell supplemental health policies to consumers. The Playbook is essentially a “how to” guide for agents to reference and to use in sales presentations. Some of the topics included are: techniques and tips on selling, fundamental day to day expectations, “keys to success,” the use of referrals and testimonials, sales strategies for door to door interactions, typical weekly work schedule actions and environments, compliance and compensation details.

**Finding 16:** Sales training material for producers (the PMA Playbook, Chapter 7, page 13) provides specific techniques for acquiring testimonials for ROP or the payment of claims. Although compliance is mentioned, the instruction to the producer provides specific phrases for use and specifically instructs the producer to “guide their [the consumer’s] thinking.” This directive improperly promotes testimonials that are not genuine or do not represent the current opinion of the author. In regard to obtaining testimonials from insureds who have received a ROP or had claims processed, the following instructions state:

*“Pull out the testimonial form, lay it in front of them. It is not uncommon that the policyholder doesn’t know what to write, so help guide their thinking. If the testimonial is about a claim paid by Consec Health, focus on phrases like:*

- *we needed the benefits when it counted*
- *we never thought it would happen to us*
- *the benefits paid came in handy*
- *the company paid just like it said it would in the policy*
- *paid in addition to the other insurance we have*
- *the benefits paid directly to us*
- *we didn’t realize the out-of-pocket expenses would be so much*
- *we recommend this coverage to everyone*

*If the testimonial is for a Return of Premium – some ideas:*

- *we forgot we had that rider, we bought the policy for the coverage, but it sure was nice to get that call.*
- *we just got our premium back and we expect to get it back again in XX years – even if we have a claim.*
- *sure is nice to have a company give your money back*

*Please ensure that you are following the compliance procedures for testimonials. These guidelines are meant to protect the individual’s right to privacy and also protect you.”*

*But what should happen every single time you deliver a return of premium settlement - certain things have to happen. First and foremost, you have to get a testimonial that we delivered on what we promised that we would do, that after a period of time they get their money back.”*

*Every time you get a return of premium settlement - if you’ve given someone a check for \$8,000 or \$10,000, you should be able to leverage that into referrals.*

This practice violates ARSD 20:06:10:09 and SDCL § 58-33A-10.

**Recommendation 16:** It is recommended that the Company correct the PMA Playbook in particular and all sales material in general to ensure that the material is accurate, complies with all statutory and rule requirements, and does not violate ARSD 20:06:10:09 or SDCL § 58-33A-10. It is recommended that the Company eliminate instructions that encourage agents to “guide” insureds in writing testimonials.

**Finding 17:** Agent complaints by policyholders are normally received by the Company or the SDDOI which then results in an inquiry made to PMA by the Company. If requested by the Company, PMA will obtain an agent statement with a response deadline given to the agent of four or five days. The Company decides whether or not to take action against the agent, however, PMA will provide input.

The examiners found the agent statements to be so incomplete as to be of no use. There were instances where no statement was obtained, the statement was obtained from the agent but not retained by the Company, and in many instances the statement simply contained an inadequate reiteration of the basic events alleged in the complaint. In several files, no agent investigation was performed yet was obviously warranted based upon the allegations in the complaint. In one complaint the Company noted of the agent, “his volume of sales mitigates the complaint ratio.” Since the agent statement is either missing or incomplete, it is a violation of SDCL §§ 58-33-66 and 58-1-26.

**Recommendation 17:** It is recommended that the Company initiate corrective action to ensure that all agent-related complaints are thoroughly and properly investigated and documented. It is recommended that the Company ensure that its responses to the SDDOI are complete and accurate. It is recommended that the Company ensure its investigations comply with the

Company's own written procedures. It is recommended that the Company obtain agent statements that provide a detailed account of the agent's activity throughout the handling of the file in question.

***Finding 18:*** The PMA Playbook directs agents to focus on generating additional sales when delivering BNA account checkbooks instead of focusing on the suitability of a sale as required by ARSD 20:06: 10:02.01.

The agent is given a list of consumers who were already sold Company products. The Playbook also encourages pressure tactics - the agent is told to use phrases such as, "did you know Mr. Jones just bought a policy from me," "focus on the over 65 - they have the time, they have the money, they have the need, ... it gets us into town." The consumer is portrayed as another sales opportunity. The PMA Playbook states:

*Our ability to leverage Medicare Supplement sales. What our top representatives are able to do is that they go into a home and they're able to, from a med supp sale, save a prospect \$200 to \$500. A good sales representative will effectively leverage that into another sales opportunity, whether it's a cancer, a heart, an accident or a life, again improving your closing percentage.*

***Recommendation 18:*** It is recommended that the Company sell its policies on their own merit and the consumer's actual needs. It is recommended that the Company establish suitability guidelines that take into account possible overinsurance through the sale of health insurance to persons who have Medicare Supplement coverage.

***Finding 19:*** The examiners inquired as to whether the monies from the ROP benefit were being directed to pay for conversions to other policies. Interviews at PMA revealed that agents are encouraged, via the Playbook, to use the opportunity in returning the premium as an opportunity for interaction with the policyholder, including a "foot in the door" for additional sales.

***Recommendation 19:*** It is recommended that the Company change its sales materials to ensure its sales practices and oversight procedures comply with SDCL § 58-33-5 and ARSD 20:06: 10:02.01.

***Finding 20:*** The following notations of interest are based on a review of the PMA Playbook. Additional concerns within the Playbook include an emphasis on selling to the elderly, use of out of date statistics, privacy concerns, cross-selling of products, field underwriting, formulation of testimonials, inadequate disclosures and strong sales tactics. Several of the practices violate South Dakota's rules and laws, specifically ARSD 20:06:10:02.01 (2) which prohibits high pressure sales tactics. The following items in their totality could lead to instances of misrepresentation and high pressure sales tactics. Specific areas of concern include:

Chapter 1

Pages 3, 4 - Out of date statistics (ARSD 20:06:10:10) used relate to Cancer, Heart Disease costs and lack of dates for income statistics

## Chapter 2

- Page 8 - Dated statistics (ARSD 20:06:10:10) related to ICU cost and average stay
- Page 14 - Out of date statistics (ARSD 20:06:10:10)
- Page 24 - Out of date statistics (ARSD 20:06:10:10)
- Page 35 - Transition to selling whole life product

## Chapter 4

- Pages 8, 11 - Unsuitable sales techniques for Medicare Supplement (ARSD 20:06:14:03, 20:06:13:43, 20:06:13:43.01, and 20:06:13:43.02)

## Chapter 5

- Page 3 - Sales pressure tactics related to telling prospect only in town for a short time (ARSD 20:06:10:16)

## Chapter 7

- Page 13 - Creation of testimonials (ARSD 20:06:10:09 and SDCL § 58-33A-10)

**Recommendation 20:** It is recommended that the Company revise the Playbook to comply with the above South Dakota statues and regulations.

## GENERAL MARKETING AND SALES

**Finding 21:** A sales script for a Cancer Policy labeled CancerAid 1½ Unit was reviewed. There are three types of policies - CancerAid 1½ Unit, 1 Unit policy (basic) and a ½ Unit policy. The script indicates under the Return of Premium section (page 4) that 100% of premiums will be returned even if claims are paid under three separate scenarios; no claims, small claims (< \$2,000) and large claims (\$40,000 - \$100,000). These scenarios and sales statements are in direct conflict with all other sales and marketing material reviewed for the Cancer policies where it is stated that the ROP will be paid *less* claims paid. Additionally, none of the copies of the Cancer policies provided to the examiners match this type of ROP benefit, including the riders. Misrepresentation is a violation of SDCL § 58-33-5.

**Recommendation 21:** It is recommended that the Company ensure all marketing material accurately reflects the benefit provisions and limitations/exclusions of the policy being advertised or solicited, pursuant to SDCL § 58-33-5.

**Finding 22:** The Company allows individuals to own multiple policies for the same coverages yet with a “cap” on benefits; this is applicable to all policy types. This limitation, however, is not disclosed in the advertising/marketing materials.

**Recommendation 22:** It is recommended that the Company clearly state in its marketing materials and sales training materials that while an individual may own multiple policies that provide coverage for the same benefit, there is a cap on the benefit amount that will be paid, pursuant to SDCL §§ 58-17-14 and 58-11-39.

***Finding 23:*** ROP/CV complaint files are spread over a number of issues such as cancellation near maturity of ROP, failure to issue/send policies, the insured questioning the use of the BNA, the agent not timely delivering the ROP check, failure to issue benefits and the ROP being tied to a new sale. These complaints indicate that the product has not been adequately explained to the consumer. There are also instances of improper sales tactics by the agents alleged in the complaints.

***Recommendation 23:*** It is recommended that the Company ensure all marketing material accurately reflects the benefit provisions and limitations/exclusions of the policy being advertised or solicited, pursuant to SDCL § 58-33-5.

***Finding 24:*** The examiners also reviewed documents related to the following other areas: Commission Schedule Procedure, Development and Production of Advertised Material Procedure, Producer Award and Incentive Description, Producer Generated Advertising Procedures, Producer Notification of Statutes, New Regulations or Products and Sales Reports.

No errors were noted in Finding 24.

### **III. PRODUCER LICENSING**

This review is divided into two parts, a review of Agent 58668 and a review of Producer Licensing in general. The purpose of the review of Agent 58668 is to determine the circumstances surrounding the failure of the Company to properly license and appoint this agent.

#### **BACKGROUND INFORMATION ON AGENT 58668**

Agent 58668 sold Conseco health insurance from 2001-2009 while licensed as a producer to sell only limited lines credit insurance in South Dakota. Agent 58668 was not licensed in South Dakota at the time he submitted his application to the Company in 2001. The Company sponsored Agent 58668 and submitted his licensing paperwork. The Company failed to recognize that “credit health only” was checked on his licensing application.

Information obtained during this examination shows that Agent 58668 provided an altered or forged license to the Company in 2004 showing his authority to sell health policies. Agent 58668 continued to represent the Company until his lack of proper authority was brought to the Company’s attention in 2009 by regulators.

Agent 58668 had regulatory issues in North Dakota and Iowa. He received commissions during this time and was a top producer for the Company, earning commissions from 2001 to 2009 in the amount of \$1,454,877.14. In addition to being an agent, Agent 58668 also managed other agents as a regional and district manager.

The Company terminated Agent 58668’s appointment in 2009 after receiving notice of his licensure status.

**Finding 25:** The Company issued policies through and paid commissions to a person who was not licensed as an agent in South Dakota in violation of SDCL §§ 58-30-92 and 58-30-171.

**Recommendation 25:** It is recommended that the Company adopt procedures to ensure that policies are not issued and commissions are not paid to persons who are not licensed and that the procedures comply with SDCL §§ 58-30-92 and 58-30-171, including the cross checking with state information on licensing and appointments.

**Finding 26:** The examiners reviewed the Company's audit procedures and oversight/controls for Producer Licensing. The Company was asked to provide the following audit information:

6. Audits:

- a. Provide copies of all agent and agency audits conducted during the scope of this examination.
- b. Explain why Agent 58668's lack of authority was not discovered during these audits.

The Company responded as follows:

- With regards to question 6.a., the Company does not perform agent and agency audits on the PMA branches; however, the Company did perform an audit of the Commission's area, which includes verifying agent licensing.
- With regards to question 6.b., the Company only tests a sample during these audits, and Agent 58668 was not included in the sample.

The Company stated that it is their practice to audit half of their business each year. However, the audits performed by the Company were commission audits, not licensing audits. During the scope of this examination the Company did not conduct any agent or agency licensing audits. The failure to identify that Agent 58668 was not licensed spanned 10 consecutive years beginning in 2001. The Company does not have sufficient producer licensing controls in place to prevent a recurrence of the events as described above. These deficiencies are in violation of SDCL §§ 58-30-92 and 58-30-171.

**Recommendation 26:** It is recommended that the Company's Audit Procedures improve upon the frequency and extent of its producer, TPA/MGA/IMO audits. It is recommended that the Company implement a written Internal Audit Procedure, focusing on an enhanced review and audit process for all claims and complaints. It is recommended that the procedures ensure that all agents are monitored for licensure at least once per year.

## GENERAL PRODUCER LICENSING

**Finding 27:** The examiners compared the list of currently appointed producers to the SDDOI's website. The examiners also reviewed a random sample of 25 producers to determine if they were properly licensed at the time of sale. All producers were properly licensed.

No errors were noted in Finding 27.

**Finding 28:** The examiners reviewed the list of producers who received commission during the policy period. This information was compared to the currently appointed list; any noted discrepancies were explained by the Company as overrides, renewals for policies sold while actively licensed but no longer appointed and commissions paid during appointments that have now been terminated. In regard to overrides, the Company provided a screenshot of the SDDOI website that shows the payments were allowable.

No errors were noted in Finding 28.

**Finding 29:** The examiners reviewed the list of New Business written during the examination period. A random sample of 10 producers writing business was reviewed against the SDDOI website. This review showed they were properly licensed and appointed for the time period.

No errors were noted in Finding 29.

**Finding 30:** The examiners reviewed the list of agents terminated during the examination period. Except for 1 agent listed as terminated for cause, the reasons stated for the termination of agents were for lack of production or at IMO's request. When a producer is terminated, the Company advises that a letter is sent to the agent notifying him/her that their contract and appointment with the Company will be terminated. If the termination is not for cause, the Company provides a 30 day notice as required by the contract. At the end of the 30 days, the Company electronically processes the termination through an electronic vendor. The spreadsheets of commissions paid by the Company shows that the Company pays former agents after termination. A random sample of 10 terminated producers compared to the SDDOI database produced no exceptions.

No errors were noted in Finding 30.

#### **IV. COMPLAINT HANDLING**

The examiners reviewed 124 Consumer complaints and 114 SDDOI complaints, for a total of 238 files. All 238 complaint files were requested for review. Initially the Company did not provide 36 of the 238 files for review. The examiners sent several inquiries to the Company regarding the missing files. It was not until the examiners informed the Company that if the missing files were not provided, the complaints would be considered violations that the Company provided the files. It still took the Company another 2 weeks to respond to this request.

**Finding 31:** Many of the complaints that were reviewed relate to the Company making duplicative or unnecessary requests, lost documents and mistakes in payments. The majority of the payment errors were a function of file handling mistakes and inefficient automated claims systems.

The complaint files had an overall lack of general file organization by the Company, missing documentation, a confusing Company practice pertaining to conversions, ROP/CV benefits, and the Company's medical expense claims. In a majority of the complaint files the

examiners sent multiple requests for information to the Company in order to determine the handling and resolution of the complaints. It took approximately four written requests for information/documentation per complaint before the examiner could determine how each complaint was handled.

Multiple date stamps or no date stamps were found on various documents in the files. Six complaint files were identified where the Company response to the SDDOI complaint references a wrong date for the actual receipt date of the complaint in violation of SDCL § 58-33-66.

In several of the files the underlying cause of the problem was inaccurate processing of claims, cancellation requests and ROP benefits. These errors are attributed to a myriad of factors, including staffing, training issues, and general non-compliance with processes and procedures. The Company's failure to maintain complete files, failure to maintain files in a manner that allows for examination of the records and failure to maintain claim files in a manner that can be reconstructed constitute violations of SDCL §§ 58-1-26, 58-3-7, and 58-3-7.4(2).

**Recommendation 31:** It is recommended that the Company change its complaint handling procedures so as to ensure that all complaint files are complete, accurate, organized, readily accessible and able to be reconstructed. It is recommended that problems identified in complaints be addressed company-wide.

#### CLAIMS RELATED COMPLAINTS

**Finding 32:** No exceptions were noted.

#### CANCELLATION COMPLAINTS

**Finding 33:** The Company's process for cancellations within 30 days is not in compliance with the time frame of 20 days, pursuant to ARSD 20:06:29:03. Ten complainants stated they submitted forms to the Company to cancel their coverage yet the Company claims they never received the forms. Further, the policy was never canceled nor was the automatic premium withdrawal from the consumer's checking account ever canceled. There were also instances of a consumer submitting their cancellation requests to their agent or to PMA yet the consumer never received an acknowledgement of their request and/or had to make numerous requests to obtain the cancellation. It should be noted that the Company has improved cancellation processing timeliness, and currently averages 5 days to process a cancellation.

**Recommendation 33:** It is recommended that the Company process all cancellation requests within 20 days as required by ARSD 20:06:29:03. In addition, given the difficulty the Company had with providing accurate data during the examination, the Company must conduct an audit of all cancellations for the lines of business subject to this examination made during the scope of this examination and determine whether or not the consumer was paid a correct and timely refund. The Company will report their findings to the SDDOI within 90 days of the adoption of the examination report.

***Finding 34:*** Complaint file 73030 - this file references the Company's practice of not providing refunds on cancellations for a Medicare Supplement policy.

***Recommendation 34:*** It is recommended that the Company adopt procedures to ensure that credits, refunds and coverage overlap are properly paid pursuant to ARSD 20:06:13:43. It is also recommended that the Company revise its refund procedures to explicitly allow refunds during free-look periods and when converting from a Medicare Supplement policy to Medicare Advantage or Medicare Cost policy pursuant to ARSD 20:06:13:45 and ARSD 20:06:13:43.03.

## GENERAL COMPLAINT HANDLING

***Finding 35:*** Nineteen complaint files resulted in payment only after a complaint was filed with the SDDOI. Many of the concerns raised in the complaints center around opportunities missed by the Company to correct an issue before it escalated into a major problem needing the SDDOI's involvement in order to resolve the issue(s). These files also show a failure by the Company to adopt and adhere to reasonable standards for the prompt investigation of claims in violation of SDCL § 58-33-67. The Company has a systemic problem evaluating files for claim payment given the number of files where the Company issued payment after the SDDOI's involvement.

***Recommendation 35:*** It is recommended that the Company implement a process in which complaints are reviewed not just to address the immediate concern of the consumer, but are also reviewed to determine procedurally where an error may have taken place and then to determine what corrective actions need to be implemented.

***Finding 36:*** The Company failed to respond to the SDDOI in a timely manner in 10 complaint files. The Company references a request it made to the SDDOI for an extension to respond, however, the files contain no affirmative evidence of extensions being granted by the SDDOI.

***Recommendation 36:*** It is recommended that the Company respond within 20 days to SDDOI complaints, pursuant to SDCL § 58-33-66. It is recommended that the Company first request an extension of time to respond to complaints and then once it receives an affirmative response from the SDDOI for an extension, that the response be documented in the file.

***Finding 37:*** Six SDDOI complaint files pertain to the Company's failure to properly or thoroughly investigate a claim and/or complaint and poor policyholder service.

Complaint files 60384 and 122238 - Policy number 611156 is insured by the Company under a Cancer policy and has received a Waiver of Premium (WOP) due to disability. Pursuant to the policy's provisions the insured is periodically required to file a WOP Claim Form that includes a certification of disability by his physician. Over an extended period of time the Company has lost documents, erroneously sent notices that seem to terminate his coverage, and requested the same forms multiple times.

This indicates a systemic problem in record keeping and claims file retention in violation of SDCL §§ 58-1-26 and 58-3-7.4.

Complaint file 79189 - The husband and wife had a Family Cancer policy. The husband died and the wife downgraded to an individual policy. After her 70th birthday, the wife seeks ROP based on her age as the insured. The Company refuses and bases the ROP on the husband's age as the main insured. The SDDOI questioned this interpretation but the Company maintained its position. The Company states in its file comments (page 20) that "This is an old ROP rider that is not as clearer [sic]... ." The comments further state that the Company reviewers agreed in January 2007 that ROP should be paid. The insured was also told by the Company that it would pay the matured ROP. A check was processed and issued in the amount of \$6,474.18 but the Company issued a stop payment. No payment has been made to date. This constitutes a violation of SDCL § 58-33-36.

Complaint file 70112 - The insured states that an application and check in the amount of \$100.68 was sent to the Company in June 2005 for a guaranteed issue Cancer policy for their daughter when she reached 21 years of age. The Company has no record of the application, only the check that was cashed by the Company in July 2005. The insured states they called several times. Company records show that a copy of the application and the original check cashed by the Company was again sent to the Company in January 2006. The Company records show a call from the insured in February 2006 and another copy of the application in March 2006 by fax from the agent. A SDDOI complaint was received on March 17, 2006. The policy was issued on March 20, 2010. Additional issues appear to continue with SDDOI inquiries regarding premium billing and the insured not receiving the policy until May 2010. This untimely delay constitutes a violation of SDCL § 58-11-33.

Complaint file 95918 - An application and check in the amount of \$100.68 was sent to the Company in August 2007 for a guaranteed issue Cancer policy for their daughter when she reached 21 years of age. The insured also states that they received a refund of \$100.68 with no explanation in September 2007. The Company records indicate this was sent in error. A SDDOI complaint was received by the Company on October 17, 2007. The policy was issued on November 16, 2007. The insured states that the policy was not received until January 11, 2008. The timeline prepared by the Company notes that the policy was mailed to the insured on November 21, 2007 but the insured called on December 18, 2007, December 28, 2007 and January 9, 2008 advising that she had not received the policy. This untimely delay constitutes a violation of SDCL § 58-17-11.1 and 58-11-33.

Complaint file 68960 - the Company sent letters in December 2005 and January 2006 advising the insured of overpayment under a Cancer policy for hospice care in the amount of \$4,400.00 and the Company requested a refund. The Company received the SDDOI complaint on February 20, 2006. The Company subsequently determined that the letters had been sent in error. The lack of a reasonable claim investigation is in violation of SDCL § 58-33-67.

**Recommendation 37:** It is recommended that the Company improve its complaint handling and complaint investigation procedures. It is recommended that the Company review these

complaints and determine whether it should take any remedial actions. The Company shall report its findings to the SDDOI within 90 days of adoption of the examination report.

## **V. UNDERWRITING AND RATING**

Throughout the review of all of the underwriting files, either inadequate documentation was provided or the information that was provided was inaccurate. The missing documentation in a number of the files made it difficult for the examiners to complete the review. The lack of documentation was an ongoing issue throughout this examination.

### Canceled/Terminated Review

Field Size:	312
Sample Size:	50
Sample Type:	Systematic
Violations:	0

***Finding 38:*** No errors were noted.

### Cancellations - Others

Field Size:	3,368
Sample:	100
Sample Type:	Systematic
Violations:	13

***Finding 39:*** During the exam, the reason for cancellation in 13 files could not be determined based upon the documents in the file in violation of SDCL § 58-3-7.

***Recommendation 39:*** It is recommended that the Company improve its record retention practices to ensure that all cancellation related requests/correspondence are maintained, as required by SDCL § 58-3-7.

### Cancellations for Non-Payment of Premium

Field Size:	2,280
Sample Size:	100
Sample Type:	Systematic
Violations:	92

***Finding 40:*** The Company failed to provide a notice of cancellation for non-payment of premium and/or the file failed to contain any cancellation correspondence/documentation for 92 files.

**Recommendation 40:** It is recommended that the Company ensure its cancellation procedures allow it to send the insured a notice of non-payment of premium prior to canceling the coverage, as required by the policy's provisions and SDCL § 58-33-60. It is recommended that the Company improve its record retention practices to ensure that all cancellation related requests/correspondence are maintained, as required by SDCL § 58-1-26.

#### New Business Review

For purposes of this review, a sample of 50 files was made from the Company's Conversion listing and a sample of 50 files was made from the Company's Upgrade/Downgrade listing, for a total of 100 files to be reviewed.

Throughout the review of all of the underwriting files, there was either inadequate documentation or the information that was provided proved to be inaccurate. The missing documentation in a number of the files made it difficult for the examiners to complete the review. The lack of documentation has been an ongoing issue throughout this examination.

#### Heart/Stroke Rescissions

Field Size:	9
Sample Size:	9
Sample Type:	Census
Violations:	0

**Finding 41:** The examiners reviewed all 9 rescission files for Heart/Stroke policies.

No errors were noted in Finding 41.

#### Cancer Rescissions

Field Size:	3
Sample Size:	3
Sample Type:	Census
Violations:	0

**Finding 42:** The examiners reviewed all three rescission files for cancer policies.

No errors were noted in Finding 42.

#### Medicare Supplement Policy Files

**Finding 43:** The Company initially informed the examiners that it had no Medicare Supplement replacements. Upon conclusion of the field work for this examination, the Company then reported that they did have replacements: there were 7 internal replacements and 518 external replacements. The SDDOI directed the examiners to pull a sample and review these files.

Prior to conducting this review, the examiners had to explain to the Company what comprises a complete policy file, and what type of information the Company was required to maintain. Given that the Company did not readily know this requirement, the examiners question the validity of the Company's data and record retention practices/controls. A list of the information the examiners provided to the Company is attached as Appendix B.

In general, the Company was not able to provide complete files, and of the files that were provided, the necessary information was not retained in the file. The Company initially asked for an extension until June 15<sup>th</sup> to provide a response to the examiners' inquiries; a second request for an extension was also made with a new due date of materials of June 22<sup>nd</sup>. Subsequent requests were made for additional time to provide more information. These delays constitute a violation of SDCL § 58-3-7.

**Recommendation 43:** It is recommended that the Company provide timely, complete and accurate records, information, and data during an examination pursuant to SDCL §§ 58-3-7 and 58-1-26. It is recommended that the Company ensure that it facilitates and aids the examination as far as reasonably possible.

**Finding 44:** The Outline of Medicare Supplement Coverage, Form #OC-A-1950-SD, was used by the Company from approximately May 2000 to December 2005. This form does not comply with the requirements of ARSD 20:03:13:36 and Appendix D because it does not include the following required language:

*We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State.*

**Recommendation 44:** It is recommended that the Company review its Medicare Supplement outline of coverage form to ensure compliance with ARSD 20:03:13:36 and Appendix D and make any appropriate changes.

**Finding 45:** The Application for Medicare Supplement Policy, Form HA-1949, found in five policy files contained substantial variances from the language required by ARSD 20:06:13:32. The variances include:

1. The application language differs from part 4 of the Statements section.
2. The application does not include the introductory statement of the Questions section.
3. The application does not include part 1(a) of the Questions section.
5. Bullet point (4) on the Company's application, under the "Statements to Proposed Insured," varies from the required language under "Statements" in the Administrative Rule.

**Recommendation 45:** It is recommended that the Company correct its Medicare Supplement application by including the required language contained in ARSD 20:06:13:32. It is recommended that the Company re-file the corrected form with the SDDOI.

**Finding 46:** The Company's application form HA-19492, used in 36 of the 50 policy files, does not comply with the requirements of ARSD 20:06:13:32, and fails to establish procedures consistent with ARSD 20:06:13:57. The Company's application omits the language required under the Administrative Rule section of "Questions" in paragraph 4(d) that requires the "paid-to or expiration date" for the existing Medicare Supplement policy. The application also omits the initial paragraph in that regulatory section.

The Company's supplemental form HA1949-SUP2 also fails to contain question 4(d) as required by ARSD 20:06:13:32. This rule requests that the "paid-to or expiration date" be provided for the existing Medicare Supplement policy.

Thirty-nine of the 50 policy files did not contain both application form HA-19492 and the complete supplemental form HA1949-SUP2.

The Company's application HA-19492 does not comply with the requirements of ARSD 20:06:13:32. There are variances with the "Questions" found in the rule by not placing as the first paragraph within the Company's application the sentence beginning with, "If you lost or are losing..." and the omission of question 4(d), which requests the "paid-to or expiration date" of the existing Medicare Supplement Policy.

**Recommendation 46:** It is recommended that the Company correct its Medicare Supplement application and supplemental form by including the required language contained in ARSD 20:06:13:32. It is recommended that the Company re-file the corrected forms with the SDDOI.

**Finding 47:** The Company's Replacement Form found in 50 of the files reviewed does not comply with ARSD 20:06:13:57, 20:06:13:35, and Appendix C as it does not include paragraphs 1 and 2 as required by the rule.

**Recommendation 47:** It is recommended that the Company correct its Medicare Supplement replacement form to comply with ARSD 20:06:13:35 and ARSD 20:06:13:57. It is recommended that the Company re-file the corrected form with the SDDOI.

**Finding 48:** In file #1-304162625, the Company failed to issue a refund within 20 days in violation of ARSD 20:06:29:03. The cancellation request was received by the Company on March 26, 2005 and a refund was not generated until June 9, 2005.

**Recommendation 48:** It is recommended that the Company ensure all refunds are made within 20 days as required by ARSD 20:06:29:03.

**Finding 49:** In file 3-304162776, the Company initially processed the cancellation in error with no refund, according to its understanding that South Dakota is a "no-refund" state, contrary to SDCL § 58-17-11. However, the cancellation was within the free-look period so the "no-refund" rule did not apply. The Company subsequently corrected this error and sent the insured a refund, however, it was not within the 20 day refund requirement of ARSD 20:06:29:03. The cancellation request was received on May 2, 2005, it was incorrectly processed with no refund

on May 18, 2005, and then the Company corrected the error by issuing a refund on June 17, 2005.

**Recommendation 49:** It is recommended that the Company review its cancellation procedures to ensure that all refunds are made within 20 days as required by ARSD 20:06:29:03 and SDCL § 58-17-11.

**Finding 50:** In File 6-304163137, the Company cancelled the policy rather than adjust the premium where there was an overlap of coverage with another company. In addition, while the company did eventually refund the premium, it failed to do so within twenty days. Also the company did not include on its application the following question: “If so, what is the paid-to or expiration date of your policy?” The company failed to comply with ARSD20:06:13:43, ARSD 20:06:13:32, ARSD 20:06:29:03, and SDCL 58-17A-15. The Company no longer markets Medicare Supplement insurance.

**Recommendation 50:** The Company review its files to determine if any insureds had duplication of coverage and adjust the coverage dates and refund unearned premiums accordingly.

**Finding 51:** The Company has no written procedures in place to ensure compliance with ARSD 20:06:13:43.01, 20:06:13:43.02, and 20:06:13:57. The Company failed to adhere to the suitability requirements of ARSD 20:06:13:43.01, 20:06:13:43.02, and 20:06:13:57. The Company stated that the administrative rules only apply to agents. The Company also stated that its application form satisfies any of the suitability requirements in conjunction with efforts by its agents.

**Recommendation 51:** It is recommended that the Company create policies and procedures to ensure that it is complying with the suitability requirements of ARSD 20:06:13:43.01, 20:06:13:43.02 and 20:06:13:57. It is recommended that the Company’s suitability procedures be auditable. It is recommended that the Company develop its own suitability standards and require all Company personnel to adhere to them and not rely solely upon its agents to make suitability determinations. It is recommended that the Company file its policies and procedures relative to ARSD 20:06:13:43.01, 20:06:13:43.02 and 20:06:13:57 with the Division within 90 days of the adoption of the examination report.

**Finding 52:** The Company sold policies to six individuals resulting in a duplication of coverage. This results in overinsurance in violation of SDCL § 58-17A-15 and ARSD 20:06:13:43.

**Recommendation 52:** It is recommended that the Company have procedures in place that will allow it to review all policies prior to issuance to ensure it does not issue coverage that will result in a duplication of coverage, as per the requirements of SDCL § 58-17A-15, ARSD 20:06:13:43.03, and 20:06:13:57(2). It is recommended that the Company refund any premiums for duplicate coverage.

## VI. CLAIMS

The examiners reviewed the heart/stroke, cancer, accident and Medicare Supplement claims. These are the only product lines that had claims filed during the scope of the examination.

The examination time exceeded the original time estimate because the Company did not provide accurate responses to inquiries. In a number of files, the examiner requested the reason(s) for denial for each billed amount. In response, the Company simply referred the examiner back to the file which did not contain sufficient information in the first place. This required the examiner to send several additional requests for information.

Throughout the claims review there were 196 examples where files were found to be insufficiently documented. These examples include:

- a. 17 files where most of the file documentation is missing
- b. 20 files with insufficient documentation to determine if refunds were timely made
- c. 12 files where there was no letter from the insured requesting cancellation
- d. 20 files where there was no calculation worksheet for refund of unearned premium
- e. 95 files where there is no explanatory letter to the insured regarding any action by the Company
- f. 32 Medicare Supplement files where the lack of documentation required additional requests for documents.

***Finding 53:*** The Company stated that they have adopted a “business” day rule rather than a “calendar” day. The Company has a general business practice of taking up to 45 business days to process claims, thus exceeding the 45 calendar day requirement. In SDDOI Complaint file 61186 the Company’s processor(s) even referred to needing 30-45 business days for claims processing as a normal business practice. This business rule violates SDCL §§ 58-33-67 and 58-17-25.

***Recommendation 53:*** It is recommended that the Company’s claim processing procedures be revised to ensure all claims are timely processed. It is recommended that the Company alter its procedures so as to comply with SDCL § 2-14-2.

### PAID CLAIMS

#### Paid Claims - Accident Policies

Field Size:	1,864
Sample Size:	50
Sample Type:	Systematic
Violations:	0

No errors were noted in these files.

#### Paid Claims - Cancer Policies

Field Size:	4,430
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Sample Size: 50  
Sample Type: Systematic  
Violations: 0

No errors were noted in these files.

Paid Claims - Heart/Stroke Policies

Field Size: 322  
Sample Size: 50  
Sample Type: Systematic  
Violations: 0

No errors were noted in these files.

Paid Claims - ICU Policies

Field Size: 8  
Sample Size: 8  
Sample Type: Census  
Violations: 0

No errors were noted in these files.

Paid Claims - Medicare Supplement

Field Size: 27,016  
Sample Size: 100  
Sample Type: Systematic  
Violations: 0

No errors were noted in these files.

**DENIED CLAIMS**

***Finding 54:*** In regard to claim documentation for all denied claim files, the Company stated that no Explanation of Benefits (EOBs) are issued on denials and most files do not contain a claim form since those forms remain with the initially submitted bills in another Company file. Most files were found to only contain a screenshot of internal Company actions (*i.e.*, BCPTS screen), the letters sent from the Company, submitted bills and at times, medical reports. This violates SDCL § 58-33-67.

***Recommendation 54:*** It is recommended that the Company issue an Explanation of Benefits or a comparable notice to the insured/claimant on denials to ensure the claimant knows the reason for the Company's action, that the Company acknowledges receipt of a claim that was submitted and that the Company provides, in writing, the reason(s) for a claim denial as required by SDCL § 58-33-67.

**Finding 55:** All Denied claim letters failed to contain a claim number on the correspondence. This lack of detail is problematic for insureds when attempting to associate multiple claims with the payments made and is in violation of SDCL § 58-33-67.

**Recommendation 55:** It is recommended that the Company provide the claim number and policy number on all correspondence sent to a consumer as required by SDCL § 58-33-67.

**Finding 56:** The Company failed to maintain documents, in particular sent denial letters, from December 6, 2005 - December 15, 2005. The Company also systematically purged certain documents every 18 months until 2006. These practices constitute a violation of SDCL § 58-1-26. Since this is a pattern error, the violation occurred with every claim denial during this time period.

**Recommendation 56:** It is recommended that the Company review its internal operations to ensure no documents are systematically purged. It is recommended that the Company ensure all files are maintained in accordance with SDCL § 58-1-26.

#### Denied Claims - Specified Heart Disease, Heart Attack and Stroke Policies

Field Size:	658
Sample Size:	50
Sample Type:	Systematic
Violations:	10

**Finding 57:** Three claims were improperly denied in violation of SDCL § 58-33-67.

**Recommendation 57:** It is recommended that the Company ensure its claims handling practices and procedures comply with the requirements of SDCL § 58-33-67.

**Finding 58:** Three claims were not denied timely in violation of SDCL § 58-33-67. In one response, the Company stated that the cause of the delay was due to a high claims inventory count.

**Recommendation 58:** It is recommended that the Company ensure its claims handling practices and procedures allow it to issue a claim denial in a timely manner, pursuant to SDCL § 58-33-67.

**Finding 59:** Three claim files contained denial letters with improper reasons for the denial in violation of SDCL § 58-33-67. The denial letter was not in the file that was closed due to insufficient information and the file did not contain a denial letter with the appropriate denial reason.

**Recommendation 59:** It is recommended that the Company ensure its claims handling practices and procedures allow it to retain the denial reason and documentation in the claim file. It is recommended that when additional claim information is required that the Company clearly state in its correspondence what specific information is needed.

Denied Claims - Cancer Policies

Field Size: 3,880  
Sample Size: 50  
Sample Type: Systematic  
Violations: 3

**Finding 60:** One claim was denied in error, violating SDCL § 58-33-67. The Company provided the following statement: “The adjustor who processed claim 309990 failed to recognize that this policy pays benefits for side effects of cancer or cancer treatment.” The denied benefit was later paid.

**Recommendation 60:** It is recommended that the Company revise its claim handling procedures to comply with SDCL § 58-33-67.

**Finding 61:** Two claim denial files were cited for failure to maintain an acknowledgment letter. The Company stated that, “The acknowledgment letter was stored in our records for 18 months then purged. This record keeping procedure was changed in 2006 so that all letters are permanently stored.” The Company also indicated during a June 16, 2010 meeting with the examiners that claim documentation could not be replicated from December of 2005 because of management’s decision to “turn off system processes that archived documentation.” This system was turned off on December 6, 2005 and turned back on December 15, 2005. These practices violate SDCL § 58-1-26.

**Recommendation 61:** It is recommended that the Company review its internal operations to ensure no documents are systematically purged to comply with SDCL § 58-1-26.

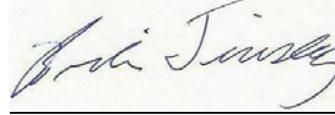
Denied Claims - Medicare Supplement Policies

Field Size: 1,256  
Sample: 50  
Sample Type: Systematic  
Violations: 32

No errors were noted in these files.

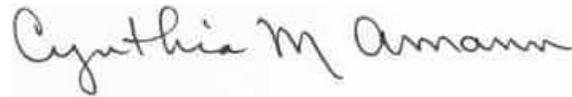
## CONCLUSION

The examination was conducted by Brian Tinsley, J. Joseph Cohen and Sean Connolly. It is respectfully submitted to the SDDOI.



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Brian Tinsley, EIC, MCM  
Market Conduct Examiner-in-Charge  
INS Regulatory Insurance Services, Inc



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Cynthia M Amann, MCM  
Market Conduct Supervising Examiner  
INS Regulatory Insurance Services, Inc

## APPENDIX A

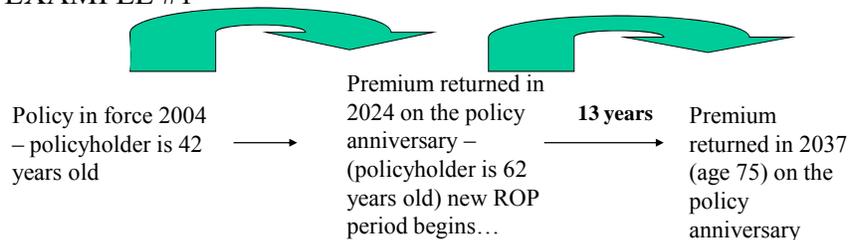
The examiners were provided a number of internal guidelines for the conversion process. Sales scripts and training documentation instructs agents how to describe the conversion process to prospective insureds. For example, within the producer training documents, the Company provided an illustration of the Return of Premium/Cash Value Process that includes the following examples.

### **Return of Premium Rider Example and explanation**

- *If the policyholder is 64 or younger at the beginning of a ROP period, all premiums paid are returned every 20 years or on the policy anniversary date following the age of 75 if that comes sooner*
- *If the return of premium period begins after the age of 65, all premiums paid are returned every 10 years*
- *Regardless of any claims against the policy*
- *The policy must be kept in force per the terms of the contract*

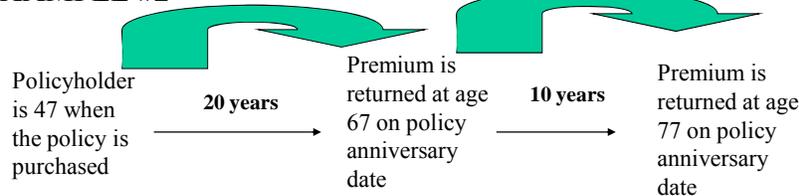
### **Example of ROP Rider**

#### EXAMPLE #1



Each and every 20 years or on the policy anniversary date after age 75 if that comes sooner

#### EXAMPLE #2



The premium return period began AFTER the age of 65, therefore the return is every 10 years.

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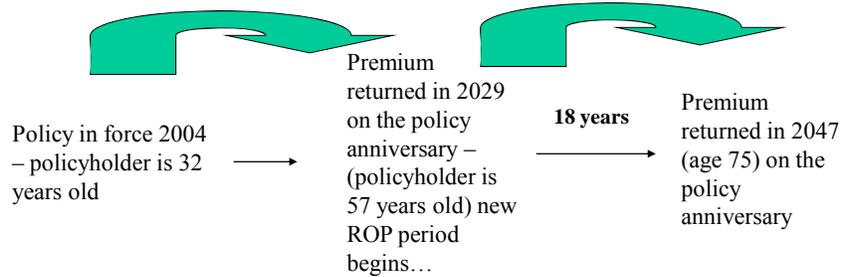
**Example of Cash Value Rider and explanation**

(Note: The internal documentation sometimes uses ROP and CV interchangeably in slides.)

- *If the policyholder is 64 or younger at the beginning of a CV period, all premiums paid are returned every 25 years or on the policy anniversary date following the age of 75 if that comes sooner*
- *If the cash value period begins after the age of 65, the premiums paid are returned every 10 years*
- *Regardless of any claims against the policy*
- *The policy must be kept in force*
- *Once the CV rider has remained in force for 6 years, a percentage of the premiums paid regardless of claims incurred, can be returned to the policyholder*
- *Only if the policyholder terminates the policy*
- *The percentages of that return vary by state*
- *The policyholder would not be eligible to reinstate the policy once the CV has been paid*
- *If the rider is terminated but the policy kept in force, no money is returned*

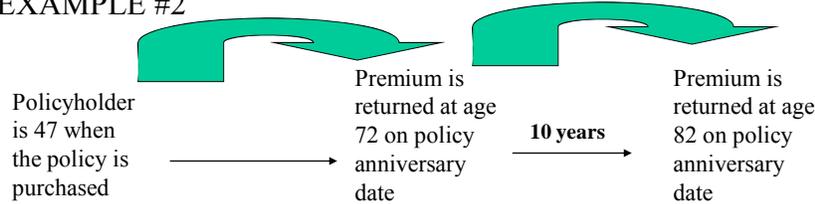
**Example of CV Rider**

**EXAMPLE #1**



Each and every 25 years or at age 75 whichever comes first

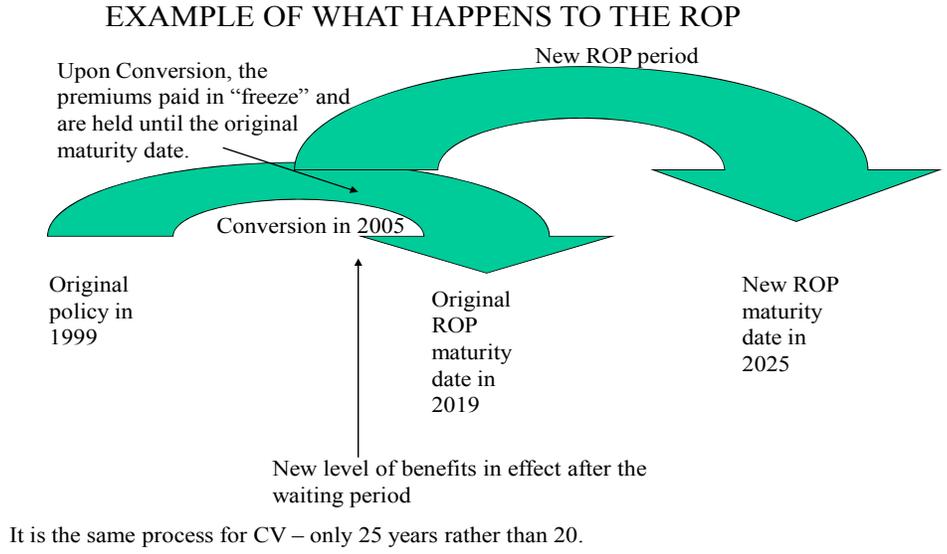
**EXAMPLE #2**



The premium return period began AFTER the age of 65, therefore the return is every 10 years.

For agent information only. Not for public use.

The Company also provided the following information slide pertaining to the effect of a conversion on Return of Premium:



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## APPENDIX B

Policy Records to be Maintained. The following records shall be maintained:

(A) A policy record file shall be maintained for each policy issued. Policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage.

Policy records shall include the following:

1. The actual, completed application for each contract.

A. The application shall bear the signature of the applicant.

B. The application shall bear a clearly legible means by which an examiner can identify any insurance producer involved in the transaction. The examiners shall be provided with any information needed to determine the identity of said insurance producer;

2. Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, and any written or electronic correspondence to or from the insured pertaining to the coverage.

3. Any binder with terms and conditions that differ from the terms and conditions of the policy subsequently issued; and

4. Any guidelines, manuals or other information necessary for the reconstruction of the rating and underwriting of the policy.

### MDCR SUPP - Specific

Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare Supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare Supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing such questions and statements may be used.