



**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

**MARKET CONDUCT  
EXAMINATION REPORT**

**OF**

**GUARDIAN LIFE  
INSURANCE COMPANY  
NEW YORK, NY**

**As of: JANUARY 29, 2013  
Issued: FEBRUARY 28, 2013**

**BUREAU OF MARKET ACTIONS  
LIFE AND HEALTH DIVISION**

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27<sup>th</sup> day of April, 2011, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



  
Michael F. Consedine  
Insurance Commissioner

Guardian Life Insurance Company  
Market Conduct Examination as of the  
close of business on January 29, 2013

Docket No.  
MC13-01-022

### ORDER

A market conduct examination of Guardian Life Insurance Company (referred to herein as "Respondent") was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. §323.1, *et seq.*, for the period January 1, 2010, through December 31, 2010. The Market Conduct Examination Report disclosed exceptions relative to the company's claims and trade practices at a rate below the NAIC benchmark error rate of 7 percent established for auditing claim practices and 10 percent for other trade practices. Furthermore, based upon Respondent's response to the Examination Report, the Department is satisfied that Respondent has taken corrective measures pursuant to the recommendations of the Examination Report.

It is hereby ordered as follows:

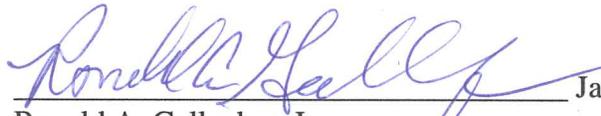
1. The attached Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.
2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with all recommendations contained in the attached Report.

4. Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. §323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: The Pennsylvania Insurance Department

  
\_\_\_\_\_  
Ronald A. Gallagher, Jr.  
Deputy Insurance Commissioner

January 28, 2013

**GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**  
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## **I. INTRODUCTION**

The Market Conduct Examination was conducted on Guardian Life Insurance Company of America; hereafter referred to as “Company,” at the Company’s office located in New York City, New York from November 28, 2011, through July 18, 2012. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Yonise A. Roberts Paige  
Market Conduct Division Chief

Lonnie L. Suggs  
Market Conduct Examiner

Gary L. Boose  
Market Conduct Examiner

## Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



Lonnie L. Suggs, MCM

[Examiner in Charge]

Sworn to and Subscribed Before me

This 3<sup>rd</sup> Day of December, 2012



Notary Public

**My commission expires May 10, 2016**

## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2009, through December 31, 2010, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the market conduct activities in areas such as: your Company's activities relating to Company operations/management, claims practices and procedures, policy forms and filings and producer licensing.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

### **III. COMPANY HISTORY AND LICENSING**

The Guardian Life Insurance Company of America was incorporated as a stock life insurance company under the laws of the State of New York on April 10, 1860 and commenced business on July 16, 1860 as The Germania Life Insurance Company. In 1918, the name was changed to its present name, The Guardian Life Insurance Company of America. In 1924, the company adopted a plan to convert to a mutual company. In 1945, Guardian acquired all of the outstanding stock of the Company. Effective January 1, 1946, the company adopted and amended its charter and by-laws and became a mutual company. Guardian is licensed in all 50 states.

Guardian is one of the largest mutual life insurance companies in the United States. Guardian and its subsidiaries offer individuals, small business owners and their employee's life, disability, health, long-term care, dental and vision insurance products.

#### **The following is a list of Guardian subsidiaries and affiliates:**

Berkshire Life Insurance Company of America (BLICOA)

First Commonwealth, Inc.

Guardian Baillie Gifford Limited

The Guardian Insurance & Annuity Company, Inc. (GIAC)

Guardian Investor Services LLC (GIS)

RS Investment Management Co. LLC

Innovative Underwriters, Inc.

Managed Dental Care (California)

Managed DentalGuard, Inc. (New Jersey)

Managed DentalGuard, Inc. (Texas)  
Park Avenue Life Insurance Company  
Park Avenue Securities LLC  
American Financial Systems, Inc.  
eMoney Advisor Holdings, LLC  
Family Service Life Insurance Company  
Sentinel American Life Insurance Company

As of the Annual Statement for the year ending 2009 for Pennsylvania, The Guardian Life Insurance of Company America reported direct premium and annuity considerations in the amount of \$153,823,139.00; and direct premium earned for accident and health in the amount of \$119,596,827.00.

## **IV. CLAIMS AND CLAIMS MANUALS**

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following claim manuals:

### **Individual Disability Income Insurance Claims Handling Manual (Berkshire Life Insurance Company of America).**

1. Manual Introduction.
2. Statement of Principles.
3. Privacy Statement.
4. Fair Claim Practice Reference Guide.
5. State Claims Regulations.
6. Red Flags (Fraud Identifiers)

### **Major Medical Policies.**

1. Workflow for Opening a New Major Medical File.
2. Processing Hints.
3. Workflow for Processing a Major Medical Claim.
  - a. Policy forms NC046 GC049 AH050.
  - b. Tracking Deductibles.
  - c. Coverage of Benefits (COB).
  - d. Processing Overpayments

### **Workflow for Opening a New Medicare Supplement Claim File.**

1. Open a New Claim.
2. General Guidelines.
3. Guidelines for 048-13 Plans.
4. Guidelines for 065-00 Plans.
5. Guidelines for 079-13 Plans.
6. Entering Deductibles

### **Workflow for Processing a Medicare Supplemental Claim.**

1. Processing Guidelines.
2. Nursing Charge Sheets

### **Health Claim Administrative System (HCA) “Your Health Claim Training Manual”**

1. Introducing HCA (Claims System CICS).
2. Getting Your Work Ready for HCA.
3. Entering Your Transactions.
4. Reports.
5. On-Line.
6. Daily Batch Output.
7. Weekly Output.
8. Month-End.
9. Quarterly.
10. Annual.
11. Checking Controls Before Report Distribution.
12. Reference Exhibits

**Berkshire Life Insurance Company of America (BLICOA) Claims Management Procedures provided by the Company to the Examiner's on 6/27/2012 (updated 3/18/2011 (kw), 2/21/2012 (lem))**

1. Adverse Determinations.
2. Appeal Procedures.
3. Complaint Procedures.
4. Outstanding Check Procedure.
5. Medical Record Review Request Form.
6. Claims Guide To Social Security Disability Insurance Benefits.
7. The 5-Step Sequential Evaluation.
8. Waiver of Premium Procedures.

**Berkshire Life Insurance Company of America (BLICOA) Administrative Claims Procedures provided by the Company to the Examiner's on 6/27/2012**

1. Set-Up Procedures (updated 4-12-2012 (mmv)).
2. Claims Initial Payments on Disability Insurance Claims (updated 6/23/2010 (kb)).
3. Claims Closing File Procedures (revised 6-13-2011 (kb)).
4. Expense Payment Procedures (1/29/2009 (lem) updated 8-16-2010).
5. DI Claims Production Support Inbox – Notes (no dates).
6. Duplicate Policy Request (5/18/2011 pmw).
7. EFT ACH Return/Change Procedures (08/01/2009 (dfb) Updated 8/17/2011).
8. E-Mailed Field Service/Investigative Reports (6/23/2010 (kb)).

**Berkshire Life Insurance Company of America (BLICOA) Administrative  
Claims Procedures provided by the Company to the Examiner's on 07/05/2012**

1. Incoming Mail – Opening and Prep. 12/16/05 (cl) Updated 06/22/10 (kb)
2. Mailed Field Service /Investigative Reports updated 01/03/2008 (kb)
3. Ordering Guardian Claim Files. Updated 09/29/2009 (kb)
4. Instructions for setting up Unemployment Waiver claims. Undated
5. Retention for Incoming mail 10/12/09 (lem) Revised 10/07/11 (dfb)
6. Subpoenas. 08/23/05 (cl) rev. 10/24/07 (lm)
7. Guardian Life Insurance Company (GLIC). Life Waiver of Premium.  
12/08/2010 (kw)
8. Incoming Faxes. Updated 08/12/09 (lem)
9. Incoming mail – Checks / Returned Benefit Checks from USPS 03/16/2011  
(mmv)
10. Indexing Documents. Revised 07/20/05 (kk) updated 06/22/10 (kb)
11. Mailing Letters. Updated 06/23/11 (mmv)
12. Ordering App Files. 10/05/2009 (kb)
13. Duplicate Policies – Ordering. 02/13/2008 (lm)
14. Provider Specific Authorizations. 03/30/11 (mmv)
15. Rainbow Help Research. Revised 07/08/08 (lem) updated 07/20/2011 (dfb)
16. Re-Mailing Returned Checks/Mail. 09/15/05 (lp) updated 07/20/2011 (dfb)
17. Returned mail from Postal Service. Revised 05/19/11 (mmv)
18. Saving Electronic Documents. 10/06/2009 (kb)
19. Saving Media. Updated 06/23/2011 (mmv)
20. Scanning to Cypress. Updated 05/19/2011 (mmv)
21. Social Security DEQY Requests. Updated 06//07/2011 ( mmv)
22. Transcription Instructions. updated 06/23/2011 (mmv)
23. Waiver Status Updates. 05/29/09 (lem) updates 06/01/10 (kb)

24. Waiver of Premium on Berkshire and BLICOA. Policies Administrated  
CLOAS updated 01/07/08 (lm) revised 09/20/05 (dl) (Handled by Premium  
Payment Dept)
25. Adding a Newly Issued FIO Policy to a Cypress File. (07/09/10 (dll)
26. Assembling Policy Pages. Updated 04/16/2010 (kb)
27. Cypress & Mainframe Change of Address. 03/18/2011 (kw)
28. Change of SSN (Social Security Number). Updated 07/02/08 (lem) updated  
07/01/10 (kb)
29. Disbursing Checks. Updated 08/13/2010 (kb)
30. Check Registers. 11/11/2010 (kb)
31. Multiple Expense Payments. 08/16/10 (lem)

**Berkshire Life Insurance Company of America (BLICOA) Administrative  
Claims Procedures provided by the Company to the Examiner's on 6/27/2012**

1. Set-Up Procedures (updated 4-12-2012 (mmv).
2. Claims Initial Payments on Disability Insurance Claims (updated 6/23/2010  
(kb).
3. Claims Closing File Procedures (revised 6-13-2011 (kb).
4. Expense Payment Procedures (1/29/2009 (lem) updated 8-16-2010).

**Berkshire Life Insurance Company of America (BLICOA) Administrative  
Claims Procedures provided by the Company to the Examiner's on 07/05/2012**

1. Incoming Mail – Opening and Prep. 12/16/05 (cl) Updated 06/22/10 (kb)
2. Guardian Life Insurance Company (GLIC). Life Waiver of Premium.  
12/08/2010 (kw)
3. Incoming Faxes. Updated 08/12/09 (lem)

4. Incoming mail – Checks / Returned Benefit Checks from USPS 03/16/2011 (mmv)
5. Mailing Letters. Updated 06/23/11 (mmv)
6. Provider Specific Authorizations. 03/30/11 (mmv)
7. Re-Mailing Returned Checks/Mail. 09/15/05 (lp) updated 07/20/2011 (dfb)
8. Saving Electronic Documents.10/06/2009 (kb)
9. Scanning to Cypress. Updated 05/19/2011 (mmv)
10. Waiver Status Updates.05/29/09 (lem) updates 06/01/10 (kb)
11. Waiver of Premium on Berkshire and BLICOA. Policies Administrated CLOAS updated 01/07/08 (lm) revised 09/20/05 (dl) (Handled by Premium Payment Dept)
12. Disbursing Checks. Updated 08/13/2010 (kb)
13. Multiple Expense Payments. 08/16/10 (lem)

The claim documents were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. The following violations were noted:

**17 Violations - Insurance Department Act, Section 903 (a)(40 P.S. § 323.3)**

(a) Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The claims handling documents provided by Berkshire Life Insurance Company of America (BLICOA) did not adhere to the examination period of January 1, 2009 through December 31, 2010, as their claims handling procedures

documents were changed during the period without retaining prior records. The company indicated to the department that when new claim procedures or manuals are updated, the prior editions are not retained.

**The claim file review included the following 10 areas:**

- A.** Health Insurance Paid Claims
- B.** Health Insurance Denied Claims
- C.** Individual Disability Income Denied Claims
- D.** Individual Disability Overhead Expenses Denied Claims
- E.** Individual Disability Reducing Term Income Denied Claims
- F.** Individual Disability Income Paid Claims
- G.** Individual Disability Overhead Expenses Paid Claims
- H.** Individual Disability Buy-Out Income Paid Claims
- I.** Individual Disability Income Pended Claims
- J.** Individual Disability Buy-Out Income Pended Claims

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

**A. Health Insurance Paid Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 314 health insurance claims paid during the period. A random sample of 25 health insurance paid claim files were requested, received and reviewed. The provider submitted health insurance paid claim

files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. **The following violations were noted:**

**7 Violations - Title 31, Pennsylvania Code, Section 146.5**

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the noted claims within 10 working days in the 7 claims noted.

**1 Violation - Title 31, Pennsylvania Code, Section 146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letter in the noted file in the noted claim.

**4 Violations - Title 31, Pennsylvania Code, Section 146.7**

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days for the 4 claims noted.

**7 Violations – Pennsylvania Insurance Law, Unfair Insurance Practices Act, No. 205, Section 5 (40 P.S. §1171.5)** (a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

The noted violations were committed or performed with such frequency to indicate a business practice. A total of 3 members accounted for the 9 occurrences identified.

### **B. Health Insurance Denied Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 107 health insurance claims denied during the period. A random sample of 25 health insurance denied claims were requested, received and reviewed. The provider submitted health insurance denied claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code,

Chapter 146 and to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

**6 Violations - Title 31, Pennsylvania Code, Section 146.5**

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. **The Company failed to acknowledge the noted claims within 10 working days for the 6 claims noted.**

**1 Violation - Title 31, Pennsylvania Code, Section 146.7**

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days in the noted claim.

**6 Violations – Pennsylvania Insurance Law, Unfair Insurance Practices Act, No. 205, Section 5 (40 P.S. §1171.5)**

(a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

- (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

The noted violations were committed or performed with such frequency to indicate a business practice in the 6 claims noted.

### **C. Individual Disability Income Denied Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 143 individual disability income claims denied during the period. A random sample of 25 claims denied were requested, received and reviewed. Of the 25 claim files reviewed, 6 claims were denied due to the lack of providing proof of loss by the insured. The remaining 17 claims were paid. Of these 17 claims paid, 2 were paid under Reservation of Rights (ROR) after approval by management and 1 claim was paid after a legal agreement. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. No violations were noted.

**DEPARTMENT CONCERN:** The Company should implement guidelines and standards to avoid any potential discriminatory action in the processing and handling of claims relevant to reservation of rights and advance payment.

### **D. Individual Disability Overhead Expenses Denied Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 11 claims denied during the period. An Overhead Disability policy provides funding for the ongoing monthly business expenses (such as employee salaries, utilities charges, rent and equipment payments) necessary to maintain continuing operations in the event an owner or key person becomes disabled. All 11 claims denied were requested, received and

reviewed. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. No violations noted.

### **E. Individual Disability Reducing Term Denied Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 3 claims. A Reducing Term Disability policy makes payments on monthly (usually business) loan obligations. The reducing term refers to monthly benefit is payable only for the remaining term of indebtedness or obligation. All 3 claims denied files were requested, received and reviewed. The 3 files reviewed were for the same claimant, two (2) claims were paid and the third claim file was a duplicate. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. No violations were noted.

## **F. Individual Disability Income Paid Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 78 individual disability income claims paid during the period. A random sample of 25 individual disability income paid claim files were requested, received and reviewed. The submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

### **1 Violation – Title 31, Pennsylvania Code, Section 146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters in the noted claim.

## **G. Individual Disability Overhead Expenses Paid Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 4 claim paid during the period. An Overhead Disability policy provides funding for the ongoing monthly business expenses (such as employee salaries, utilities charges, rent and equipment payments) necessary to maintain continuing operations in the event an owner or key person becomes disabled. All 4 claim files paid were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

## **H. Individual Income Disability Buy-Out Paid Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 4 claims paid during the period. A Disability Buy-Out policy provides the funding for the purchase of a disabled owner's interest in the event of a long-term disability. All 4 claim files were requested, received and reviewed. The 4 claims paid were for the same claimant. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

## **I. Individual Disability Income Pended Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 18 claims pended during the period. All 18 claim pended files were requested, received and reviewed. Of the 18 claims pended, 1 claim was later paid under Reservation of Rights (ROR) and 1 claim was later paid under Advanced Payment after approval by management. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

**DEPARTMENT CONCERN:** The Company should implement guidelines and standards to avoid any potential discriminatory action in the processing and handling of claims relevant to reservation of rights and advance payment.

## **J. Individual Disability Buy-Out Pended Claims**

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 1 claim pended during the period. A Disability Buy-Out policy provides the funding for the purchase of a disabled owner's interest in the event of a long-term disability. The 1 claim pended file was requested, received and reviewed. The claim file was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

## **V. PRODUCER LICENSING**

The Company was requested to provide a list of all active and terminated producers during the experience period. The Company provided a list of 663 active producers, and 112 terminated producers during the period. A random sample of 25 active producers and 25 terminated producer files were compared to departmental records verify appointments, terminations and licensing. In addition, a comparison was made of producers identified on applications reviewed in the policy issued sections of the exam. No violations were noted.

## **VI. CONSUMER COMPLAINTS**

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2006, 2007, 2008, and 2009. The Company identified 34 consumer complaints received during the experience period. All 34 complaint files were requested, received, and reviewed. The company also provided 154 complaint logs for the 4 prior years. Written consumer complaints that were forwarded to the Company by the Pennsylvania Insurance Department during the experience period were compared to the Company's 4 year complaint logs and were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5 (a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, PA Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices. The following violation was noted:

### **1 Violation - Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 PS § 991.2166), Prompt Payment of Provider Claims (A)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 157 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The following provider submitted claim was paid after the required 45 days in the noted file.

## **VII. RECOMMENDATIONS**

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a) of the Insurance Department Act of 1921 (40 P.S. §323.3)
2. The Company must review and revise procedures to ensure the timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings related to the property, assets, business and affairs of the Company to ensure compliance with Section 904(b) of the Insurance Department Act of 1921 (40 P.S. §323.4).
3. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

4. The Company must review and revise internal control procedures to ensure clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim as required by Section 2166 (A) of the Insurance Company Law of 1921 (40 P.S. §991.2166), Prompt Payment of Provider Claims .
  
5. The Company must implement procedures to ensure compliance with the requirements of Insurance Department Act of 1921 “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance – Act 205, Section 5 (40 P.S. §1171.5).
  
6. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

**VIII. COMPANY RESPONSE**



December 28, 2012

**Carol B. Crosson**  
*Senior Project Manager*  
*Market Conduct & Compliance*

Yonise Roberts Paige  
Chief, Life and Health Division  
Pennsylvania Insurance Department  
Market Action Bureau  
1321 Strawberry Square  
Harrisburg, PA 17120

RE: Response to Draft Report on Examination  
Examination Warrant Number: 11-M24-001  
The Guardian Life Insurance Company of America, NAIC # 64246

Dear Ms. Paige:

The Guardian Life Insurance Company of America (Guardian) hereby responds to the Pennsylvania Insurance Department's DRAFT Report of Examination dated December 3, 2012.

Please note that this response does not reference sections of the report where 'no violations' were noted. However, a Company response for review and consideration is provided for each Department finding, concern and recommendation.

We thank you and your staff for the courtesy and cooperation extended to us during this examination.

If you have any questions, do not hesitate to contact me. Thank you.

Sincerely,

Carol B. Crosson

# Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

## RESPONSE TO EXAMINATION REPORT

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# Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

## **IV. Claims and Claims Manuals**

*(Examination Report page 8 – 14)*

### **Company Note:**

The examination report lists claim manuals provided by the Company for review on pages 8 – 13. The Company notes that the list contains 17 duplicate items.

The Company respectfully requests that the Department remove the following items listed on pages 12 and 13 in the examination report as these items are duplicative of those listed on pages 10 and 11:

- Berkshire Life Insurance Company of America (BLICOA) Administrative procedures provided by the Company to the Examiners on June 27, 2012 listing items 1 – 4, and
- Berkshire Life Insurance Company of America (BLICOA) Administrative procedures provided by the Company to the Examiner's on July 5, 2012 listing items 1 – 13.

### **Finding:**

#### **17 Violations – Insurance Department Act, Section 903 (a)(40 P.S. § 323.3)**

- (a) Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The claims handling documents provided by Berkshire Life Insurance Company of America (BLICOA) did not adhere to the examination period of January 1, 2009 through December 31, 2010, as their claims handling procedure documents were changed during the period without retaining prior records. The company indicated to the department that when new claim procedures or manuals are updated, the prior editions are not retained.

### **Company Response:**

The Company agrees that prior editions of 17 claims administrative documents were not retained.

The Company respectfully requests that references to “claims handling documents” be changed to “claims administrative documents” in order to distinguish these types of materials provided. Also, the Company notes that there were no issues raised regarding the Company’s ability to retrieve prior versions of the actual claims manual.

### **Corrective Action:**

Effective November 2012, the Company instituted corrective measures to ensure that versions of claims administrative documents are appropriately maintained going forward.

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

### **IV. Claims and Claims Manuals** **A. Health Insurance Paid Claims** *(Examination Report page 14 - 16)*

#### **Finding:**

##### **7 Violations – Title 31, Pennsylvania Code, Section 146.5**

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the noted claims within 10 working days for the 7 claims noted.

#### **Company Response:**

The Company agrees that it took longer than 10 working days to acknowledge the 7 claims noted.

The Company notes that the referenced policies are highly unique, with numerous form variants (differing deductibles and policy provisions). The manual adjudication of these claims involves considerably more time and is more prone to error than is automated adjudication of standard claims.

#### **Corrective Action:**

As of this writing, the Company has exited the medical market nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultantly low claim volume, the Company is better situated to promptly acknowledge claims it receives.

#### **Finding:**

##### **1 Violation – Title 31, Pennsylvania Code, Section 146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letter in the noted file in the noted claim.

#### **Company Response:**

The Company respectfully disagrees that it failed to provide the claimant a timely status letter regarding the noted claim.

The Company completed the initial claim investigation within 30 days of receiving the claim. The same day, 7/6/2009, the Company sent the claimant a written Explanation of Benefits explaining that the claim amount would be applied to the policy deductible, and not paid out. On 7/20/2009, the Company received information regarding additional claim activity which it also applied to the claim deductible. This additional claim activity made the claim originally

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

processed on 7/6/2009 eligible for payment to the claimant. The Company promptly reprocessed the claim and issued payment on 7/26/2009.

### **Finding:**

#### **4 Violations – Title 31, Pennsylvania Code, Section 146.7**

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days for the 4 claims noted.

#### **Company Response:**

The Company agrees that it took longer than 15 working days to provide notice of acceptance or denial, for the four claims noted.

The Company notes that the referenced policies are highly unique, with numerous form variants (differing deductibles and policy provisions). The manual adjudication of these claims involves considerably more time, and is more prone to error than is the automated adjudication of standard claims.

#### **Corrective Action:**

As of this writing, the Company has exited the medical market nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultantly low claim volume, the Company is better situated to provide any remaining claimants prompt notice of a claim's acceptance or denial.

### **Finding:**

#### **7 Violations – Pennsylvania Insurance Law, Unfair Insurance Practices Act, No. 205, Section 5 (40 §1171.5)**

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices in the business of insurance means:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

The noted violations were committed or performed with such frequency to indicate a business practice. A total of 3 members accounted for the 9 occurrences identified.

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

### **Company Response:**

The Company respectfully disagrees that it engages in unfair claims practices, and maintains that claims are adjudicated according to state requirements.

While the Company makes every effort to process claims in accordance with state requirements, these are highly unique policies, with numerous form variants (different deductibles and policy provisions) which require considerably more time to process than do standard claims with system adjudication.

### **Corrective Action:**

As of this writing, the Company has exited the medical market, nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultant low claim volume, the Company is better situated to promptly process claims it receives.

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

### **IV. Claims and Claims Manuals** **B. Health Insurance Denied Claims** *(Examination Report page 16 – 17)*

#### **Finding:**

#### **6 Violations – Title 31, Pennsylvania Code, Section 146.5**

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the noted claims within 10 working days for the 6 claims noted.

#### **Company Response**

The Company agrees that it took longer than 10 working days to acknowledge the 6 claims noted.

The Company notes that the referenced policies are highly unique, with numerous form variants (differing deductibles and policy provisions). The manual adjudication of these claims involves considerably more time and is more prone to error than is automated adjudication of standard claims.

#### **Corrective Action:**

As of this writing, the Company has exited the medical market nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultantly low claim volume, the Company is better situated to promptly acknowledge claims it receives.

#### **Finding:**

#### **1 Violation – Title 31, Pennsylvania Code, Section 146.7**

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days in the noted claim.

#### **Company Response:**

The Company agrees that it took 18 working days to deny the noted claim.

The Company notes that the referenced policies are highly unique with numerous form variants (differing deductibles and policy provisions). The manual adjudication of these claims involves considerably more time and is more prone to error than is the automated adjudication of standard claims.

#### **Finding:**

#### **6 Violations – Pennsylvania Insurance Law, Unfair Insurance Practices Act, No. 205, Section 5 (40 §1171.5)**

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

(a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices in the business of insurance means:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

The noted violations were committed or performed with such frequency to indicate a business practice in the 6 claims noted.

### **Company Response:**

The Company respectfully disagrees that it engages in unfair claims practices, and maintains that claims are adjudicated according to state requirements.

While the Company makes every effort to process claims in accordance with state requirements, these are highly unique policies, with numerous form variants (different deductibles and policy provisions) which require considerably more time to process than do standard claims with system adjudication.

### **Corrective Action:**

As of this writing, the Company has exited the medical market, nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultant low claim volume, the Company is better situated to promptly process claims it receives.

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

### **IV. Claims and Claims Manuals**

#### **C. Individual Disability Income Denied Claims**

*(Examination Report page 18)*

##### **Department Concern:**

The Company should implement guidelines and standards to avoid any potential discriminatory action in the processing and handling of claims relevant to reservation of rights and advance payment.

##### **Company Response:**

The Company acknowledges the noted Department concern. In December 2012, the Company provided the Department with copies of guidelines regarding advance payment of claims and payment under reservation of rights. These written guidelines were circulated to the Claims handling staff in November 2012. As of November 29, 2012, they were included in the claims handling procedures (Claims Reference Guide) and will be noted with a date for historical version purposes.

# Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

## **IV. Claims and Claims Manuals**

### **F. Individual Disability Income Paid Claims**

*(Examination Report page 20)*

#### **Finding:**

##### **1 Violation – Title 31, Pennsylvania Code, Section 146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters in the noted claim.

#### **Company Response:**

The Company partially agrees and partially disagrees with the Department's identification of this item.

The Company communicated with the insured during the evaluation period of the claim and subsequently made full payment of the claim as prescribed by PA Code. However, the Company agrees that there was no written communication to the insured between the closure and payment period.

The Company maintains that this is an isolated instance and does not represent a systemic weakness in the Individual Disability claims process.

# Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

## **IV. Claims and Claims Manuals**

### **I. Individual Disability Income Pending Claims**

*(Examination Report page 21)*

#### **Department Concern:**

The Company should implement guidelines and standards to avoid any potential discriminatory action in the processing and handling of claims relevant to reservation of rights and advance payment.

#### **Company Response:**

The Company acknowledges the noted Department concern. In December 2012, the Company provided the Department with copies of guidelines regarding advance payment of claims and payment under reservation of rights. These written guidelines were circulated to the Claims handling staff in November 2012. As of November 29, 2012, they were included in the claims handling procedures (Claims Reference Guide) and will be noted with a date for historical version purposes.

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

### **VI. Consumer Complaints** *(Examination Report page 24)*

#### **Finding:**

#### **1 Violation – Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 PS §991.2166), Prompt Payment of Provider Claims (A)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 157 sampled clean claims paid over 45 days revealed to validate the accuracy of the claim report provided by the Company. The following provider submitted claim was paid after the required 45 days in the noted file.

#### **Company Response:**

The Company agrees that the noted claim was paid after 45 days.

This isolated instance of non compliance was the result of a coding error. When the coding error was detected and corrected the payment of \$1959.79 was issued to the dentist, which included all applicable interest.

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

### **VII. Recommendations**

*(Examination Report pages 25-26)*

1. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings related to the property, assets, business and affairs of the Company are maintained in such a manner and for such period of time to ensure compliance with Section 903(a) of the Insurance Department Act of 1921 (40 P.S. §323.3)

**Company Response:**

Effective November 2012, the Company revised procedures so that it will retain prior versions of individual disability claims management and administrative procedures for seven years.

2. The Company must review and revise procedures to ensure the timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings related to the property, assets, business and affairs of the Company to ensure compliance with Section 904(b) of the Insurance Department Act of 1921 (40 P.S. §323.4)

**Company Response:**

Effective November 2012, the Company revised procedures so that it will retain prior versions of individual disability claims management and administrative procedures for seven years.

3. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

**Company Response:**

As of this writing, The Company has exited the group medical market nationwide and, as such, has no in-force group medical policies under which providers submit claims for reimbursement. Separately, the Company recently completed a large scale project to automate prompt payment requirements within its dental claim adjudication systems.

4. The Company must review and revise internal control procedures to ensure clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim as required by Section 2166 (A) of the Insurance Company of 1921 (40 P.S. §991.2166), Prompt Payment of Provider Claims.

**Company Response:**

## Pennsylvania Market Conduct Examination

The Guardian Life Insurance Company of America (NAIC#64246)

As of this writing, The Company has exited the group medical market nationwide and, as such, has no in-force group medical policies under which providers submit claims for reimbursement. Separately, the Company recently completed a large scale project to automate prompt payment requirements within its dental claim adjudication systems.

5. The Company must implement procedures to ensure compliance with the requirements of Insurance Department Act of 1921 “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance – Act 205, Section 5 (40 P.S. §1171.5).

### **Company Response**

The Company maintains that it does not engage in unfair claim practices and that it adjudicates claims according to state requirements. The policies under review are highly unique with numerous form variants (different deductibles and policy provisions) which require considerably more time to process than do standard, auto-adjudicated claims.

Please note that as of this writing, the Company has exited the medical market, nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultantly low claim volume, the Company is better situated to promptly process claims it receives.

6. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

### **Company Response**

The Company maintains that it does not engage in unfair claim practices and that it adjudicates claims according to state requirements. The policies under review are highly unique with numerous form variants (different deductibles and policy provisions) which require considerably more time to process than do standard, auto-adjudicated claims.

Please note that as of this writing, the Company has exited the medical market, nationwide, and has only 4 medical lives remaining in Pennsylvania. Given the resultantly low claim volume, the Company is better situated to promptly process claims it receives.