

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

**PENN TREATY NETWORK AMERICA
INSURANCE COMPANY**
Allentown, Pennsylvania

**AS OF
May 5, 2008**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION**

Issued: June 26, 2008

PENN TREATY NETWORK AMERICA INSURANCE COMPANY

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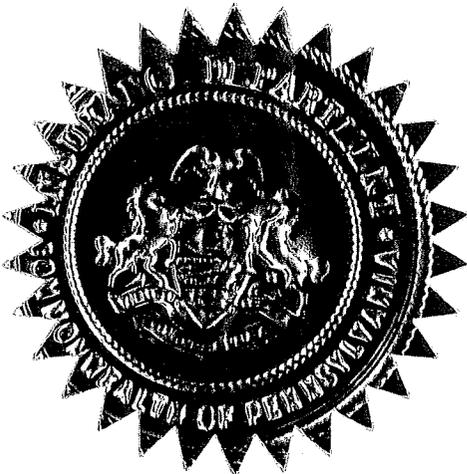
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 6th day of July, 2007, 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 Randolph L. Rohrbaugh, 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.





Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
PENN TREATY NETWORK	:	Section 903 of the Insurance
AMERICA INSURANCE COMPANY	:	Department Act, Act of May 17, 1921,
3440 Lehigh Street	:	P.L. 789, No. 285 (40 P.S. § 323.3)
Allentown, PA 18103	:	
	:	Section 671-A of Act 147 of 2002
	:	(40 P.S. § 310.71)
	:	
	:	Section 3(A) of the Health and Accident
	:	Reform Act, No. 159 (40 P.S. § 3803)
	:	
	:	Section 411B of the Insurance Company
	:	Law, Act of May 17, 1921, P.L. 682,
	:	No. 284 (40 P.S. §511b)
	:	
	:	Section 5(a)(10) of the Unfair Insurance
	:	Practices Act, Act of July 22, 1974,
	:	P.L. 589, No. 205 (40 P.S. §§ 1171.5)
	:	
	:	Title 31, Pennsylvania Code, Sections
	:	51.5, 89a.105, 89a.113, 89a.121, 89a.127,
	:	146.3, 146.5, 146.6, 146a.21 and 146.7
	:	
	:	Title 18, Pennsylvania Consolidated
	:	Statutes, Section 4117(k)
	:	
Respondent.	:	Docket No. MC08-06-013

CONSENT ORDER

AND NOW, this *26th* day of *JUNE*, 2008, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra. or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

- (a) Respondent is Penn Treaty Network America Insurance Company, and maintains its address at 3440 Lehigh Street, Allentown, Pennsylvania.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from July 1, 2005 through June 30, 2006.
- (c) On May 5, 2008, the Insurance Department issued a Market Conduct Examination Report to Respondent.

- (d) A response to the Examination Report was provided by Respondent on June 4, 2008.
- (e) After consideration of the June 4, 2008 response, the Insurance Department has modified the Examination Report as attached.
- (f) The Examination Report notes violations of the following:
 - (i) Section 903(a) of the Insurance Department Act (40 P.S. § 323.3), which requires every company subject to examination to keep all books, records, accounts, papers, documents and any computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require in order that its representatives may readily verify the financial condition of the company, and ascertain whether the company has complied with the laws of this Commonwealth;
 - (ii) Section 671-A of Act 147 of 2002 (40 P.S. § 310.71), which prohibits producers from transacting business within this Commonwealth without written appointment as required by the Act;
 - (iii) Section 3(a) of Act 159 (40 P.S. § 3803(a)), which requires each insurer and HMO to file with the Department any form which it proposes to issue in this Commonwealth;

- (iv) Section 411B of Insurance Company Law, No. 284 (40 P.S. §511b), which states life insurance death benefits not paid within 30 days after satisfactory proof of death shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date the benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than 180 days after the death of the insured and the death benefits are not paid within 30 days after satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid;
- (v) Section 5(a)(10) of the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.5), which prohibits unfair claims settlement or compromise practices committed or performed with such frequency as to indicate a business practice;
- (vi) Title 31, Pennsylvania Code, Section 51.5, which states a company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth;

- (vii) Title 31, Pennsylvania Code, Section 89a.105, which prohibits a policy from being delivered or issued for delivery as long term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except in the case of a qualified long-term care contract, expenses for services or items to the extent that the expenses are reimbursable under Medicare or would be reimbursable, but for the deductible or coinsurance amount;
- (viii) Title 31, Pennsylvania Code, Section 89a.113, which requires application forms to include the questions listed in this section of the regulation designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 1103, the questions listed in this section of the regulation may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate-holder has been notified of the replacement;

(ix) Title 31, Pennsylvania Code, Section 89a.121, which requires:

(a) Every insurer, nonprofit hospital plan and professional health services plan corporation or other entity marketing long-term care insurance (the issuer) shall meet the following conditions:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(2) Train its producers in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

(b) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the items in paragraph (1) into consideration.

(1) The producer and issuer shall take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(ii) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(iii) The values, benefits and costs of the applicant's existing insurance when compared to the values, benefits and costs of the recommended purchase or replacement.

(2) The issuer, and when a producer is involved, the producer shall make reasonable efforts to obtain the information in paragraph (1). The efforts shall include presentation to the applicant, at or prior to application of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B (relating to long-term care insurance personal worksheet), in at least 12 point type. The issuer may request the applicant to provide additional information to comply with its

suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.

- (3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
 - (4) The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.
- (c) The issuer shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.
 - (d) Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.
 - (e) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C (relating to things you should know before you buy long-term care insurance), in at least 12 point type.
 - (f) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the one presented in Appendix D (relating to long-term care insurance suitability letter). If the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.
 - (g) The issuer shall report annually to the Commissioner the total number of applications received from residents of this Commonwealth, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards and the number of those who chose to confirm after receiving a suitability letter.

(x) Title 31, Pennsylvania Code, Section 89a.127, which states a long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of producer solicitations, a producer shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with an application or enrollment form;

(xi) Title 31, Pennsylvania Code, Section 146.3, which requires the claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed;

(xii) Title 31, Pennsylvania Code, Section 146.5, which requires every insurer, upon receiving notification of a claim, shall within 10 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;

(xiii) Title 31, Pennsylvania Code, Section 146.6, which states that if an 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;

(xiv) Title 31, Pennsylvania Code, Section 146a.21, which sets forth conditions for disclosure: except as otherwise authorized in this chapter, a licensee may not, directly or through an affiliate, disclose nonpublic personal financial information about a consumer to a nonaffiliated third party unless all of the following conditions are met:

(1) The licensee has provided to the consumer an initial notice as required under §146a.11 (relating to initial privacy notice to consumers required).

(2) The licensee has provided to the consumer an opt out notice as required in §146a.14 (relating to form of opt out notice to consumers and opt out methods).

(3) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure.

(4) The consumer does not opt out.

(xv) Title 31, Pennsylvania Code, Section 146.7, which requires within 15 working days after receipt by the insurer of properly executed proofs of loss,

the insurer shall advise the first-party claimant of the acceptance or denial of the claim; and

- (xvi) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires all applications for insurance and all claim forms shall contain or have attached thereto the following notice: “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties”.

CONCLUSIONS OF LAW

4. In accordance with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent’s violations of Section 671-A of Act 147 of 2002 are punishable by the following, under Section 691-A of Act 147 of 2002 (40 P.S. § 310.91):

- (i) suspension, revocation or refusal to issue the certificate of qualification or license;
 - (ii) imposition of a civil penalty not to exceed five thousand dollars (\$5,000.00) for every violation of the Act;
 - (iii) an order to cease and desist; and
 - (iv) any other conditions as the Commissioner deems appropriate.
- (c) Respondent's violations of Section 3 of the Health and Accident Reform Act, Act, No. 159 (40 P.S. § 3803) are punishable under Section 13 of the Act:
- (i) suspension or revocation of the license of the offending insurer or HMO;
 - (ii) refusal, for a period not to exceed one year, to issue a new license to the offending insurer or HMO;
 - (iii) a fine of not more than \$5,000 for each violation of this Act;
 - (iv) a fine of not more than \$10,000 for each willful violation of this Act;
 - (v) a fine of not more than \$25,000 for each willful violation of Section 6.
- (d) Respondent's violations of Section 411B of the Insurance Company Law, No. 284 (40 P.S. §511b) are punishable by the following, under 40 P.S. § 625-10: Upon determination by hearing that this act has been violated, the commissioner may issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than \$5,000 per violation.

(e) Respondent's violations of the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.5) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. §1171.9):

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

(f) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
- (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

(g) Respondent's violations of Title 31, Pennsylvania Code, Sections 89a.105, 89a.113, 89a.121 and 89a.127 are punishable under Section 354 of the Insurance Company Law (40 P.S. § 477b) by suspension or revocation of the license(s) of Respondent; refusal, for a period not to exceed one year thereafter,

to issue a new license to Respondent; or imposition of a fine of not more than one \$1,000.00 for each act in violation of the Act.

- (h) Respondent's violations of Title 31, Pennsylvania Code, Sections 51.5, 146.3, 146.5, 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10, 1171.11), as captioned above.

ORDER

5. In accordance with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) 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.
- (c) Respondent shall comply with all Recommendations contained in the Attached Report.

- (d) Claims Processing Review. Respondent shall review all denied claims for the period of 7-1-05 through 6-30-08 in accordance with the Recommendations in the Attached Report in a manner and timeframe acceptable to the Department.
- (e) Respondent shall provide to the Department quarterly reports (“Quarterly Reports”). Each Quarterly Report shall be due and delivered to the Department in a form acceptable to the Department within 30 calendar days of the end of the calendar quarter, with the first report covering the third quarter of calendar year 2008. Each Quarterly Report shall address, resolve and monitor Respondent's compliance with the Recommendations in the Attached Report.
- (f) If the Department determines that the Quarterly Reports show, or if the Department otherwise has information, that Respondent is not fully and timely complying with the terms of this Consent Order or the terms of the Recommendations contained in the Attached Report, the Department may request, and Respondent shall consent to, access to the Board of Directors of Respondent. In its sole discretion, the Department may agree to a meeting with a proxy for the Board of Directors or the Audit Committee in lieu of meeting with those entities.
- (g) The Department will conduct a re-examination of the issues addressed by the Examination on or after July 1, 2009 for the period as of July 1, 2008 through June 30, 2009, and make all reasonable efforts to complete such re-examinations within six months of the date of commencement (“Re-Examination”). Nothing

in this section shall abrogate the Department's ability to utilize the Examiners to the fullest extent under applicable examination laws to perform all functions necessary and authorized under the examination laws to ensure timely and competent monitoring for compliance with this Consent Order and the Recommendations in the Attached Report.

- (h) This Consent Order only resolves violations related to matters identified in the Attached Report and which occurred prior to the date of execution of this Consent Order. This Consent Order is not intended to, nor may it be construed to, limit the authority of the Department from investigating and taking appropriate action against Respondent, its producers or other representatives, or third parties, as provided by law or regulation, with regard to a valid consumer, provider or third-party complaint.

- (i) Respondent shall be assessed One Hundred and Fifty Thousand Dollars (\$150,000.00) in penalty payable to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report. Seventy Five Thousand Dollars (\$75,000.00) shall be payable no later than thirty (30) days after the date of this Order. The remainder of the penalty amount will be suspended, pending the results of the Re-examination and the Department's Determination, if any, that Respondent has not fully and timely satisfied the Recommendations in the Attached Report and the terms of this Consent Order.

- (j) In the event that the Department finds, after reasonable investigation, that Respondent has willfully and materially breached the terms of this Consent Order, then any penalty or fine imposed as a result of such finding shall not be limited by the assessment or other limiting provisions of this Consent Order.

- (k) Respondent shall continue to fund any operational enhancements necessary to timely and fully implement and accomplish the Recommendations in the Attached Report.

- (l) Nothing herein shall confer any rights upon any persons or entities other than the Department and Respondent.

- (m) Payment of the penalty assessed herein shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Ginny Marquart, Administrative Assistant, Bureau of Enforcement, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this

Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

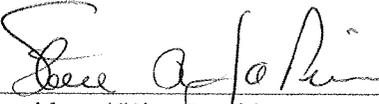
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

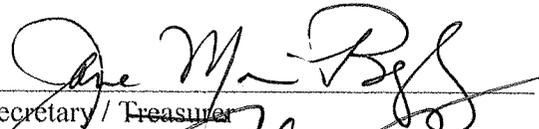
11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained

herein, and this Consent Order is not effective until executed by the Insurance
Commissioner or a duly authorized delegee.

BY: PENN TREATY NETWORK AMERICA
INSURANCE COMPANY, Respondent



President / Vice President



Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA
By: Randolph L. Rohrbaugh
Deputy Insurance Commissioner

I. INTRODUCTION

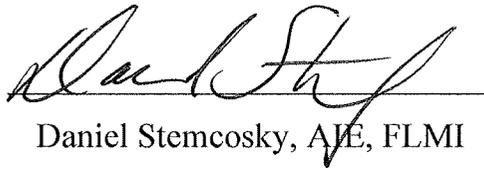
The Market Conduct Examination was conducted on The Penn Treaty Network America Insurance Company, hereafter referred to as “Company,” at the Company’s offices located in Allentown, Pennsylvania, January 29, 2007 through July 13, 2007. Subsequent review and follow-up was conducted in the office of the 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 are not 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.

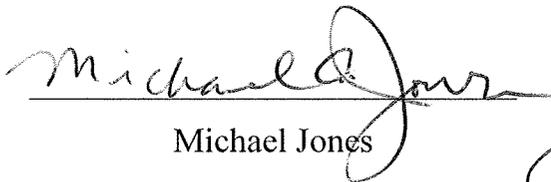
Throughout the course of the examination, Company officials were provided status memoranda which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials 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.

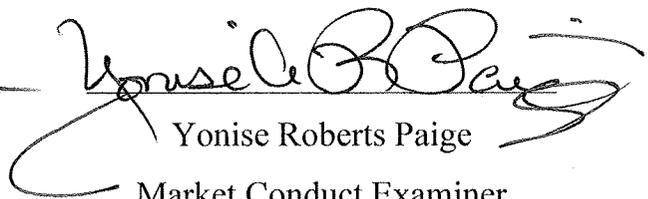
The undersigned participated in the Examination and in the preparation of this Report.



Daniel Stemcosky, AJE, FLMI
Market Conduct Division Chief



Michael Jones
Market Conduct Examiner



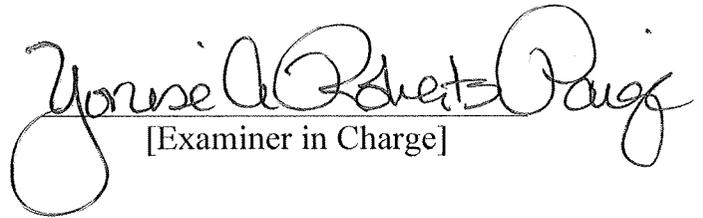
Yonise Roberts Paige
Market Conduct Examiner



Frank Kyazze
Market Conduct Examiner

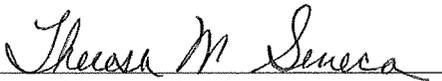
Verification

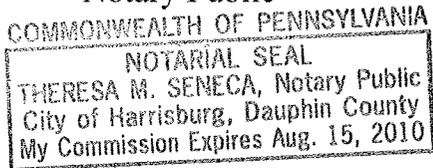
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).


[Examiner in Charge]

Sworn to and Subscribed Before me

This / Day of *May*, 2008


Notary Public



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 July 1, 2005, through June 30, 2006, unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in the following areas: Consumer Complaints, Forms, Producer Licensing, Underwriting Practices and Procedures, and Claim Handling Practices and Procedures.

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 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, are included and grouped within the respective general categories of this Report.

III. COMPANY HISTORY AND LICENSING

Penn Treaty Americansm Corporation ("PTAC"), a Pennsylvania insurance holding company, through its insurance company subsidiaries, is a provider of long term care insurance ("LTCi") in the United States. Its policies cover all levels of nursing care and home health care. It markets insurance policies through its insurance company subsidiaries, Penn Treaty Network America Insurance Company, Penn Treaty Network Insurance Company, Penn Treaty Network Insurance Company in California, American Network Insurance Company and American Independent Insurance Company of New York.

The Penn Treaty Network America Insurance Company ("PTNA" or "Company") was incorporated in the Commonwealth of Pennsylvania on February 26, 1954, and commenced business on March 23, 1954. PTNA is a mutual life insurance company and is licensed in all states and the District of Columbia.

PTNA distributes its products nationally, through 21,000 producers. Currently, over 96% of the business is long term care insurance. In 2006, the Company had approximately 160,000 policyholders nationwide including 17,334 policyholders residing in Pennsylvania.

As of its December 31, 2006, annual statement for Pennsylvania, the Company reported direct premium for accident and health insurance in the amount of \$32,655,833, and direct premium for life insurance and annuity considerations in the amount of \$298,442.

IV. ADVERTISING

Title 31, Pennsylvania Code, Section 51.2(c) provides that “Any advertisements, whether or not actually filed or required to be filed with the Department under the provisions of this Regulation may be reviewed at any time at the discretion of the Department.” The Department, in exercising its discretionary authority for reviewing advertising, requested the Company’s latest Annual Statement with the Advertising Certificate of Compliance as required by Title 31, Pennsylvania Code Section 51.5.

1 Violation - Title 31, Pennsylvania Code, Section 51.5 - Certificate of compliance:

A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth.

The Company did not provide the Advertising Certificate of Compliance.

V. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy contracts, riders, endorsements and applications used in order to determine compliance with requirements of Insurance Company Law, Chapter 2, Section 354 (40 P.S. §477b), as well as provisions for various mandated benefits. Applications and claim forms were also reviewed to determine compliance with Title 18, Pa. C.S., Section 4117(k). The following violations were noted:

11 Violations – Title 18, Pennsylvania Consolidated Statutes, Section 4117(k) – Insurance Fraud:

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

The individual enrollment form and application form noted did not contain the required fraud statement. The forms frequency of use is listed in the table below.

Form Description	Form #	Section	Sample	Usage
Individual Enrollment Form	PTL88AH-GROUP	Group Long Term Care Certificates Issued (1)	12	9
Long Term Care Application	G-PTA-APP-E	Group Long Term Care Conversions (2)	2	2

39 Violations –Accident and Health Reform Filing Act 159, Section 3(a)

(40 P.S. §3803(a)) – Form Filings:

(a) Form Filings – Each insurer and HMO shall file with the department any form which it proposes to issue in this Commonwealth.

The noted documents were used for purposes of issuing long term care policies without showing evidence of having been filed with and approved by the Department. The form type, number, the section of the exam where the violation was noted and frequency of use is listed in the table below.

Form Description	Form #	Section	Sample	Usage
Group Long Term Care Application	G-PTA-APP-E	Group Long Term Care Conversions (2)	2	2
Individual Long Term Care Application	Missing	Individual Long Term Care Policies Issued (3)	100	1
Individual Long Term Care Policy Schedule Form	SR400(PA)REV2-N	Individual Long Term Care Policies Issued (3)	100	36

16 Violations - Title 31, Pennsylvania Code, Section 89a.105 - Policy practices and provisions:

(b) Limitations and exclusions.

(1) A policy may not be delivered or issued for delivery in this Commonwealth as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

...

(vii) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (Medicare) (42 U.S.C.A. §§ 1395—1395ggg) or would be so reimbursable but for the application of a deductible or coinsurance amount.

The Company currently pays as an exclusion, Medicare deductible and/or coinsurance amounts which are non-permissible for tax qualified long-term care insurance contracts. The following forms listed in the table below did not contain the required Medicare limitations and exclusions.

Form Description	Form #
Long Term Care	ALP2-TQ-P(PA)
Long Term Care	IL5-TQ-P(PA)
Franchise LTC	FIL5-TQ-P(PA)
Simple LTC Solution	SS-TQ-P(PA)
Franchise Simple LTC Solution	FSS-TQ-P(PA)
Comprehensive LTC	PF2600-2-TQ(PA)
Franchise Comprehensive LTC	FPF2600-2-TQ(PA)
TQ Nursing Facility	SR400(PA)-N
Comprehensive Group LTC	G-PF2-TQ-P(PA)
Comprehensive Group LTC	G-PF2-TQ-P(PA)(Rev)
Comprehensive LTC Certificate	G-PF2600-2-TQ-P-CERT(PA)
Comprehensive LTC Certificate	G-PF2600-2-TQ-P-CERT(PA)(Rev)
Comprehensive Long Term Care Policy	PF3-TQ-P (PA)
Franchise Comprehensive LTC Policy	FPF3-TQ-P (PA)
Tax Qualified Long Term Care	ALP-TQ-P(PA)
Tax Qualified Long Term Care	LTCTP-6500(PA)-N

VI. PRODUCER LICENSING

The Company was requested to provide a list of all producers active and terminated during the experience period. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits producers from doing business on behalf of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1-A (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all agent terminations to the Department.

The Company provided a list of 100 active producers of which 5 records were duplicates, and 25 terminated producers of which 1 was a duplicate. The remaining 95 active producers and 24 terminated producers were compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made to the producers identified as producers on applications reviewed in the various policy issued sections of the exam. The following violations were noted:

10 Violations – Insurance Department Act of 1921, as amended, Act 147 of 2002, Section 671-A (40 P.S. §310.71) – Appointments:

(a) Representative of the insurer. – An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed.

- (b) Representative of the consumer. – An insurance producer acting on behalf of or representing an insurance consumer shall execute a written agreement with the insurance consumer prior to representing or acting on their behalf that:*
- (1) delineates the services to be provided; and*
 - (2) provides full and complete disclosure of the fee to be paid to the insurance producer by the insurance consumer.*
- (c) Notification to department. – An insurer that appoints an insurance producer shall file with the department a notice of appointment. The notice shall state for which companies within the insurer’s holding company system or group the appointment is made....*
- (d) Termination of appointment. – Once appointed, an insurance producer shall remain appointed by an insurer until such time as the insurer terminates the appointment in writing to the insurance producer or until the insurance producer’s license is suspended, revoked or otherwise terminated.*
- (e) Appointment fee. – An appointment fee of \$12.50 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation....*
- (f) Reporting. – An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer.*

The Company failed to file a notice of appointment and submit appointment fees to the Insurance Department for the following 7 individuals identified as producers on 10 applications in the Long Term Care Policies Issued section of the exam.

Producer Last Name	Producer First Name	Number of Applications
Nyce	Kelly	1
John	Anthony	1
Koren	Ilan	3
Butterworth	Michael	2
Wolfe	Mark	1
Cohen	Alan	1
McMullin Jr	Francis	1

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2001, 2002, 2003, and 2004. The Company identified 77 consumer complaints received during the experience period. A random sample of 25 consumer complaints files were requested, received and reviewed. Of the 25 complaints identified, 2 complaint files were non-Pennsylvania jurisdiction (FL and CA) and 14 complaint files had been forwarded by the Department. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, Act 205 of 1974 (40 P.S. §1171.1). Section 5 (a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years: "This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints 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 violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

- (a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than*

writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

- (b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.*
- (c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.*
- (d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).*

Any delay in acknowledging a claim and providing necessary forms serves to delay the processing of a claim and payment to a claimant, causing harm to the claimant. There was no evidence in the noted complaint claim files that the Company provided the claimants with instructions and reasonable assistance so the claimants could comply with the insurer's requirements to process the claims.

7 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

Every insurer shall complete investigation of a claim within 30 days after notification of 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.

This provision requires the Company to provide the claimant a status of his or her claim in writing. This serves to provide the claimant notification of any outstanding requirements to process the claim and to provide a reasonable explanation for the delay in processing. When the Company does not send a status letter or sends the letter late, it can potentially delay the processing and payment of the claim to the claimant, causing harm to the claimant. The Company failed to provide timely status letters for the seven noted claim files.

3,317 Violations - Title 31, Pennsylvania Code, Section 146a.21(a) - Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties:

(a) Conditions for disclosure. Except as otherwise authorized in this chapter, a licensee may not, directly or through an affiliate, disclose nonpublic personal financial information about a consumer to a nonaffiliated third party unless all of the following conditions are met:

(1) The licensee has provided to the consumer an initial notice as required under §146a.11 (relating to initial privacy notice to consumers required).

(2) The licensee has provided to the consumer an opt out notice as required in §146a.14 (relating to form of opt out notice to consumers and opt out methods).

(3) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure.

(4) The consumer does not opt out.

The Company disclosed nonpublic personal financial information on the mailing envelopes of the Company's Annual Privacy Notice to 3,317 consumers without providing the consumer an opportunity to opt out.

4 Violations - Title 31, Pennsylvania Code, Section 146.7 - Standards for prompt, fair and equitable settlements applicable to insurers:

(a) Acceptance or denial of a claim shall comply with the following:

(1) 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(d) Insurers may not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Insurers may not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the rights of the claimant may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the rights of the claimant. The notice shall be given to first-party claimants 30 days, and to third-party claimants 60 days, before the date on which the time limit may expire.

(f) An insurer may not make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

The Company is required to provide the claimant acceptance or denial of his or her claim within 15 days business days of receipt of a properly executed proof of claim. This means that the claimant has complied with all of the claims documents that the Company has advised are necessary to make a claim decision. This step, of course, cannot occur until the Company complies with, among other regulations, Section 146.5, requiring the Company to provide the claimant acknowledgement and claims documents, and Section 146.6, requiring the Company to provide the claimant a status of outstanding documentation necessary for the Company to make a claim determination. Failure of a company to comply with all three of these regulations can delay claim payment or claim denial, and can delay resolution of any appeal of the Company's claim denial, causing harm to the claimant. The Company failed to provide notice of acceptance or denial within 15 working days in the four noted complaint claim files.

12 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

(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:

...

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

...

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

...

(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

...

(xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company failed to disclose the policy coverage or policy provision in which payment or reduction of payment was made. The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the 12 noted complaint claim files. Two of these claim violations were for inappropriate denial.

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in 5 general segments.

- A. Underwriting Guidelines
- B. Group Long Term Care Certificates Issued
- C. Group Long Term Care Conversions
- D. Individual Long Term Care Policies Issued
- E. Individual Home Health Care Policies Issued

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or producer licensing appear in those respective sections of the Report and are not duplicated in this Underwriting portion of the Report.

A. Underwriting Guidelines

The Company was requested to provide copies of all established written underwriting guidelines in use during the experience period. Underwriting guidelines were reviewed to ensure guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place which could possibly be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following guide was provided and reviewed:

	Underwriting Guide
	TABLE OF CONTENTS
	1. General Information Introduction Underwriting Consideration Suitability Guidelines Underwriting Tools/Protocol Underwriting Classes (defined)
	2. Underwriting Guidelines Build tables (height/weight charts) Medical Conditions
	3. Medications Unacceptable Medications Common Medications and why typically prescribed
	4. Procedural Information Replacements Counter Offers Spousal Discounts Reissues Increasing/ Decreasing Benefits Reinstatements Effective Dates Saving Age

B. Group Long Term Care Certificates Issued

The Company was requested to provide a list of all group long term care certificates for persons enrolled during the experience period. The Company provided a list of 12 certificates. All 12 certificate files were requested, received and reviewed. The files were reviewed to ensure compliance with issuance statutes and regulations and as well as Title 18, Pennsylvania Consolidated Statutes, Section 4117(k). No violations were noted.

C. Group Long Term Care Conversions

The Company was requested to provide a list of all group long term care conversions issued during the experience period. The Company identified a universe of 2 conversions issued. Both files were requested, received and reviewed. The files were reviewed to determine compliance with Insurance Company Law Section 621.2(d) (40 P.S. § 756.2), and Title 31, Pennsylvania Code, Section 89a.105(d), Group Provisions for Conversions. The following violations were noted.

1 Violation - Insurance Department Act, Section 903 (40 P.S. § 323.3) – Authority, scope and scheduling of examinations:

(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 ... ascertain whether the company or person has complied with the laws of this Commonwealth.

The noted file was missing the insured's application date, which is essential to determining compliance with 40 P.S. §756.2 and 31 Pa. Code §89a.105(d).

D. Individual Long Term Care Policies Issued

The Company identified a universe of 752 individual long term care policies issued during the experience period. A random sampling of 100 policy files was requested. All 100 policy files were requested, received and reviewed. An initial

review found 18 files to be declined by the company and 15 were determined as declined by the insured. The policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted.

18 Violations - Title 31, Pennsylvania Code, Section 89a.113 – 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 has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 1103 of the act (40 P.S. §991.1103), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate-holder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid? If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.

(4) *Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?*

(b) *Producers shall list health insurance policies they have sold to the applicant.*

(1) *List policies sold that are still in force.*

(2) *List policies sold in the past 5 years that are no longer in force.*

(c) *Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and health or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner: [see regulation]*

(d) *Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner: [see regulation]*

(e) *Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, the name of the insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.*

(f) *The insurer shall maintain records demonstrating delivery date of policies so that this date can be used to determine the commencement of the 30-day policy examination period. Delivery date shall be deemed the date the policy is received by the policyholder.*

The replacement question in two of the noted files was not answered, in one noted file the replacement question was altered without consent and 15 of the noted files did not contain evidence of policy delivery. One reason the insurer must maintain records demonstrating the delivery date of policies is so that this date can be used to determine the commencement of the 30-day policy examination period. During the policy examination period, the insured has a “free look” provision which allows them to return the policy to the Company, as required by 40 P.S. §991.1110. When the Company receives the returned policy during this time, they must refund the premium to the insured.

6 Violations - Title 31, Pennsylvania Code, Section 89a.121 – Suitability:

(a) Every insurer, nonprofit hospital plan and professional health services plan corporation or other entity marketing long-term care insurance (the issuer) shall meet the following conditions:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(2) Train its producers in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

(b) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the items in paragraph (1) into consideration.

(1) The producer and issuer shall take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(ii) The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(iii) *The values, benefits and costs of the applicant's existing insurance when compared to the values, benefits and costs of the recommended purchase or replacement.*

(2) *The issuer, and when a producer is involved, the producer shall make reasonable efforts to obtain the information in paragraph (1). The efforts shall include presentation to the applicant, at or prior to application of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B (relating to long-term care insurance personal worksheet), in at least 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.*

(3) *A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.*

(4) *The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.*

(c) *The issuer shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.*

(d) *Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.*

(e) *At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in*

Appendix C (relating to things you should know before you buy long-term care insurance), in at least 12 point type.

(f) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the one presented in Appendix D (relating to long-term care insurance suitability letter). If the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(g) The issuer shall report annually to the Commissioner the total number of applications received from residents of this Commonwealth, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards and the number of those who chose to confirm after receiving a suitability letter.

Suitability standards are utilized to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant. They will take into consideration the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage and the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs. Evidence of using suitability standards was missing in the six noted files.

1 Violation - Title 31, Pennsylvania Code, Section 89a.127 – Requirement to deliver shopper's guide:

A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or

approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of producer solicitations, a producer shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with an application or enrollment form.

Evidence that The Shopper's Guide was delivered to the applicant was missing in one noted file.

E. Individual Home Health Care Policies Issued

The Company was requested to provide a list of all individual home health care policies issued during the experience period. The Company identified a list of 95 home health care policies issued. A random sample of 25 policy files was requested, received and reviewed. An initial review found 10 files to be declined by the Company and 5 were determined as declined by the insured. All of the policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. No violations were noted.

IX. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files.

CLAIMS MANUAL

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 direct access to an on-line data base titled "PA MARKET CONDUCT". The following represents the specific items referenced and reviewed within the data base:

- **Archived Topics**
 1. Claims Processing Protocol
 2. Interest
 3. Opening and Closing Claims
 4. Additional info Request Procedures
 5. Pending Claims Process
 6. EOB Fields and Codes Guidelines
 7. Notepad and Claims Comment Screens
 8. Facility Stay Procedure – Ongoing Claim Payment

- **Manual Topics**
 1. TQ vs. NON TQ
 2. Master File & Underwriting File
 3. What is LTC
 4. Late Claim Filing
 5. Facility Claim Procedure Checklist
 6. Appeals Process
 7. Claims Denial

- **Privacy Manual**

- **Company Procedure for Claims Processing of Tax Qualified Long Term Care Policies**

The claim manuals and procedures were reviewed for any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or otherwise warranting further review. No violations were noted.

CLAIM FILES

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, Act 205 of 1974 (40 P.S. §§1171.1 et seq.). The claims were also reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices. The life claims were additionally reviewed for compliance with the Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b).

The Claim file review consisted of 13 areas:

- A. Cancer Claims
- B. Disability Claims
- C. Home Health Care Claims
- D. Home Health Care Claims (Additional)
- E. Home Health Care Claims Denied
- F. Home Health Care Claims Denied (Other)
- G. Hospital Indemnity Claims
- H. Individual Life Claims
- I. Long Term Care Claims
- J. Long Term Claims (Additional)
- K. Long Term Claims Denied
- L. Long Term Claims Denied (Other)
- M. Miscellaneous Claims

Claims identified as “Unique” are the result of an analysis of the universe of claims provided by the Company that identify the claims submitted by and attributable to an individual policyholder. These “Unique” claims were submitted by the same individual for different dates of service or procedures.

Although the Company could not define an “Other than Denied” claim, after review an “Other than Denied” claim appeared to be a claim that was primarily denied for lack of information or documentation.

The following Regulations and Statutes were found to be violated in one or more areas of the claims files reviewed:

Title 31, Pennsylvania Code, Section 146.3 – file and record documentation:

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

Title 31, Pennsylvania Code, Section 146.5 - Failure to acknowledge pertinent communications:

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

Any delay in acknowledging a claim and providing necessary forms serves to delay the processing of the claim and payment to a claimant, causing harm to the claimant.

Title 31, Pennsylvania Code, Section 146.6 - Standards for prompt investigation of claims.

Every insurer shall complete investigation of a claim within 30 days after notification of 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 is required to provide the claimant a status of their claim in writing. This serves to provide the claimant notification of any outstanding requirements to process the claim or to provide a reasonable explanation for the delay in processing. When the Company does not send a status letter or sends the letter late, it can potentially delay the processing and payment of the claim to the claimant, causing harm to the claimant.

Title 31, Pennsylvania Code, Section 146.7 - Standards for prompt, fair and equitable settlements applicable to insurers.

(a) Acceptance or denial of a claim shall comply with the following:

(1) 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is

needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(d) Insurers may not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Insurers may not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the rights of the claimant may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the rights of the claimant. The notice shall be given to first-party claimants 30 days, and to third-party claimants 60 days, before the date on which the time limit may expire.

(f) An insurer may not make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

The Company is required to provide the claimant acceptance or denial of his or her claim within 15 days business days of a properly executed proof of claim. This means that the claimant has complied with all of the claims documents that the Company has advised are necessary to make a claim decision. This step, of course, cannot occur until the Company complies with, among other regulations, Section 146.5, requiring the Company to provide the claimant acknowledgement and claims documents, and Section 146.6, requiring the Company to provide the claimant a status of outstanding documentation necessary for the Company to make a claim determination. Failure of a company to comply with these all three of these Regulations can delay claim payment or claim denial, and can delay resolution of any appeal of the Company's claim denial, causing harm to the claimant.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

(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.

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

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

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(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.

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

...

(xii) Delaying the investigation or payment of claims by requiring the insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. 511b) – Payment of Benefits:

(a) Except as set forth in subsection (b), life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date the benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured and the death benefits are not paid within thirty days after satisfactory proof of death was submitted to the insurer, interest shall accrue

from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

(b) Notwithstanding section 6 of the act of May 11, 1949 (P.L. 1210, No. 367), referred to as the Group Life Insurance Policy Law, this section shall apply to all life insurance policies except variable insurance policies.

(c) The term "left on deposit" shall mean a specific settlement option provided within the life insurance policy under which the death benefit proceeds are retained by the insurer for the beneficiary and are credited with a specific rate of interest.

A. Cancer Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 55 cancer claims. Additional analysis determined that the 55 claims were submitted by and attributable to 21 unique individuals, since several claims were submitted by the same individual for different dates of service. All 21 of the unique cancer claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLS.	146.5 VIOLS.	146.7 VIOLS.
1	CB-50	1 POLICY	2	0	1
2	CB-50-78F	2 POLICIES	19	1	1
3	CB-50-78I	12 POLICIES	1, 14, 15, 16	3	2
4	CB200	1 POLICY	11	1	1
5	0095	5 POLICIES	6, 7, 18	3	1
	TOTAL	21 POLICIES		8	6

8 Violations - Title 31, Pennsylvania Code, Section 146.5 - Failure to acknowledge pertinent communications:

The Company failed to acknowledge the eight noted claim files within 10 working days.

6 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days in the five noted claim files.

B. Disability Claims

The Company was requested to provide a list of unique disability claims received during the experience period. The Company identified a universe of 76 disability claims. Additional analysis determined that the 76 claims were submitted by and attributable to 19 unique individuals since several claims were submitted by the same individual for different dates of service or procedures. All 19 of the unique disability claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLS.	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.
1	0058	1 POLICY	0	0	0	0
2	1000	2 POLICIES	9	0	0	1
3	0088-1005-75	7 POLICIES	4, 10, 13, 15, 18	4	1	1
4	0225-1005-285	2 POLICIES	0	0	0	0
5	ADI - 81	1 POLICY	0	0	0	0
6	DI92PA-P	1 POLICY	0	0	0	0
7	PTL-101	1 POLICY	17	0	0	1
8	PTL-117	1 POLICY	6	0	1	1
	PTL-201-F	3 POLICIES	8	1	1	0
	TOTAL	19 POLICIES		5	3	4

5 Violations - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to provide the claimant an Employer Statement, a necessary claim form so that the claimant could comply with the processing of the five noted claim files.

3 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the three noted claim files.

4 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days in the four noted claim files.

C. Home Health Care Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 618 home health care claims. Additional analysis determined that the universe of 618 claims were submitted by and attributable to 156 unique individuals since several claims were submitted by the same individual for different dates of service. A random sample of 25 of the unique home health claim files was requested, received, and reviewed. The 25 claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLS.	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	HHC	3 POLICIES	13, 22	0	2	0	2
2	HHC92RPA	2 POLICIES	0	0	0	0	0
3	IL2FPA	7 POLICIES	4, 12	0	2	0	2
4	IL94RBPA	12 POLICIES	6, 15, 17, 23, 24, 25	1	6	1	6
5	LTCTP6700	1 POLICY	0	0	0	0	0
	TOTAL	25 POLICIES		1	10	1	10

1 Violation - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to acknowledge the one noted claim within 10 working days.

10 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the ten noted claim files.

1 Violation - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the one noted claim file.

10 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices for the ten noted claim files.

D. Home Health Care Claims (Additional)

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 618 home health care claims. Additional analysis determined that the universe of 618 claims were submitted by and attributable to 156 individuals since several claims were submitted by the same individual for different dates of service. A random sample of 25 unique home health care claim files was requested, received and reviewed in section 10 and an additional 50 files was requested, received and reviewed for this section. The 50 claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	HHC	3 POLICIES	31	1	0	1
2	HHC92-PA	1 POLICY	34	1	0	1
3	HHC92-PA-P	6 POLICIES	21	1	0	1
4	HHC92-RPA-P	2 POLICIES	30	1	0	1
5	IL2FPA	15 POLICIES	11, 12, 16, 24, 41, 47, 48	6	1	6
6	IL4	1 POLICY	0	0	0	0
7	IL5	1 POLICY	10	1	0	1
8	IL94BPA-P	3 POLICIES	44	1	0	1
9	IL94RBPA-P	17 POLICIES	6, 17, 18, 29, 45, 50	6	0	6
10	IL94RPA-P	1 POLICY	0	0	0	0
	TOTAL	50 POLICIES		18	1	18

18 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the eighteen noted claim files.

1 Violation - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the one noted claim file.

18 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the eighteen noted claim files.

E. Home Health Care Claims Denied

The Company was requested to provide a list of all claims denied during the experience period. The Company identified 145 denied claims. Of the 145 denied claims, 63 were home health care denied claims and 82 were long term care denied claims. The long term care denied claims review is addressed in Sections K and L below. Of the 63 home health care claims denied, 17 claims were later identified by the Company as actual denials and 46 claims were identified as “other than denied.” A claim identified as “other than denied” was a claim that did not meet the National Association of Insurance Commissioners (NAIC) definition of a true denial but may have been denied for lack of information or documentation. All 17 actual denied claims were requested, received and reviewed. A sample of 21 of the 46 home health care claims identified as “other than denied” were requested and received and their review is addressed in Section F below. Of the 17 denied claims, 6 were determined to be home health care claims and 11 were determined to be eligibility requests for home health services or pre-certification for services.

The following table is a synopsis of the denial reason and claim files reviewed:

# of Files	DENIAL CODE	DENIAL CODE REASON	PERCENTAGE
1	33	Loss Incurred after Policy Lapsed	5.5
4	35	NTQ Forms Only – Did Not Meet Triggers	24
1	37	Qualified Forms – Did Not Meet 2 ADL or Cognitive Impairment Status	5.5
1	52	Elimination Period Not Satisfied	5.5
3	54	Type of Service Not Covered by Policy	18
4	56	Maximum Benefits Previously Paid Under Policy	24
2	64	Miscellaneous (Not Otherwise Listed Above)	12
1	68	FM/PCG Information Not Returned	5.5
17			100

The claim files were reviewed to ensure compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and Title 31, Pennsylvania Code, Chapter 146 and to ensure the Company’s claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	6700/NFR	1 POLICY	0	0	0	0
2	FPF2600PA	1 POLICY	0	0	0	0
3	HHC	2 POLICIES	3	1	0	0
4	HHC92R-P	2 POLICIES	0	0	0	0
5	IL2FPA	1 POLICY	1	1	1	0
6	IL94	4 POLICIES	7	0	0	1
7	IL94RBPA-P	2 POLICIES	2, 4	0	0	2
8	LTC2400 W/5500 RIDER	1 POLICY	6	0	0	1
9	LTC6700 W/INFLATION RIDER	1 POLICY	5	0	0	1
10	LTC91B	1 POLICY	0	0	0	0
11	PF2600	1 POLICY	0	0	0	0
	TOTAL	17 POLICIES		2	1	5

2 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the two noted claim files.

1 Violation - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the one noted claim file.

3 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices for the five noted claim files. Two of these claim violations were for claim denials resulting from inefficiencies in claim handling.

F. Home Health Care Claims Denied (Other)

The Company was requested to provide a list of all claims denied during the experience period. The Company identified 145 denied claims. Of the 145 denied claims, 63 were home health care denied claims and 82 were long term care denied claims. The long term care denied claims review is addressed in Sections K and L below. Of the 63 home health care claims denied, 17 claims were later identified by the Company as actual denials and 46 claims were identified as “other than denied.” A claim identified as “other than denied” was a claim that did not meet the National Association of Insurance Commissioners (NAIC) definition of a true denial but may have been denied for lack of information or documentation. All 17 actual denied claims were requested and their review is addressed in Section E above. A sample of 21 of the 46 home health care claims identified as “other than denied” were requested and reviewed. Of the 21 “other than denied” claims, 2 were determined to be outside the experience period and 1 was determined to be a paid claim (never denied).

The following table is a synopsis of the denial reason and claim files reviewed:

# of Files	DENIAL CODE	DENIAL CODE REASON	PERCENTAGE
2	35	NTQ Forms Only – Did Not Meet Triggers	9.5
16	58	Did Not Receive Requested Information	76.1
1	64	Miscellaneous (Not Otherwise Listed Above)	4.8
1	68	FM/PCG Information Not Returned	4.8
1	69	FM/PCG Information Incomplete	4.8
21			100

The remaining 18 claims were reviewed to ensure compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and Title 31, Pennsylvania Code, Chapter 146 and to ensure the Company’s claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	IL2(PA)-N	10 POLICIES	1, 2, 4, 6, 7, 8, 15	0	3	2	7
2	IL4-PREVPA	1 POLICY	19	0	1	0	1
3	LTCTP6500(PA)-N	1 POLICY	21	1	1	0	1
4	LTCTP6700	2 POLICIES	13, 14	0	2	0	2
5	P2400/P5501	1 POLICY	3	0	1	0	1
	PF2600(PA)-P	6 POLICIES	9, 10, 12, 20	0	2	0	4
	TOTAL	21 POLICIES		1	10	2	16

1 Violation - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to acknowledge one noted claim files within 10 working days.

10 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the ten noted claim files.

2 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the two noted claim files.

16 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the sixteen noted files.

G. Hospital Indemnity Claims

The Company was requested to provide a list of hospital indemnity claims received during the experience period. The Company identified a universe of 109 hospital indemnity claims. Additional analysis determined that the 109 claims were submitted by and attributable to 54 unique individuals since several claims were submitted by the same individual for different dates of service or procedures. A random sample of 25 of the unique hospital indemnity claim files was requested, received and reviewed. The review of the sample showed four additional claims that shared the same date of service with the requested items resulting in a total of 29 claim files. The 29 claims files were reviewed for compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS
1	0228	8 POLICIES	20	1	1	1	1
2	HCI	1 POLICY	10	1	1	1	1
3	HCP	5 POLICIES	1, 3, 14, 21, 22	5	5	5	5
4	WHI	3 POLICIES	0	0	0	0	0
5	WHI/MED SUP	11 POLICIES	0	0	0	0	0
6	WHI-60	1 POLICY	0	0	0	0	0
	TOTAL	29 POLICIES		7	7	7	7

7 Violations - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to acknowledge the seven noted claim files within 10 working days.

7 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the seven noted claim files.

7 Violations - Title 31, Pennsylvania Code, Section 146.7 - Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the seven noted claim files.

7 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the seven noted files.

H. Individual Life Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 44 individual life claims. Additional analysis determined that 35 of the 44 life claims were not duplicates. All 35 of the unique individual life claims were requested, received and reviewed. The review of the sample showed six additional claims as a result of multiple beneficiaries that totaled 41 claim files. The 41 claim files were reviewed for compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)), the Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.3 VIOLS.	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.	411B	ACT 205 VIOLS
1	3005	8 POLICIES	11, 17A, 17B, 17C, 21, 27	1	6	4	2	0	6
2	CH	1 POLICY	16	0	1	0	1	0	1
3	FE92	23 POLICIES	4, 5, 18, 20, 22, 29, 30, 34, 35	0	7	3	4	1	9
4	WL	2 POLICIES	8, 12		2	1	1	0	2
5	WLIP-79-3104	1 POLICY	0	0	0	0	0	0	0
	TOTAL	35 POLICIES		1	16	8	8	1	18

1 Violation – Title 31, Pennsylvania Code, Section 146.3 – File and record documentation:

In the noted claim file, evidence of premium refund was missing.

16 Violations - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to acknowledge the one noted claim file within 10 working days and failed to provide any acknowledgment in seventeen of the noted claim files.

8 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide a status letter for eight of the noted claim files.

8 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the eight noted claim files.

1 Violation - Insurance Company Law, Section 411B (40 P.S. §511b) - Payment of Benefits:

Interest was not paid on the late payment in the one noted claim file.

18 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the eighteen noted files.

I. Long Term Care Claims

The Company was requested to provide a list of long term care claims received during the experience period. The Company identified a universe of 2,183 long term care claims. Additional analysis determined that the 2,183 claims were submitted by and attributable to 402 unique individuals since several claims were submitted by the same individual for different dates of service. A random sample of 50 unique long term care claim files was requested, received and reviewed. The

50 claim files were reviewed for compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.3 VIOLS.	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS
1	0203	2 POLICIES	0	0	0	0	0	0
2	ALP	2 POLICIES	4, 33	1	0	2	0	2
3	LTC-1	6 POLICIES	1, 46	0	1	0	1	1
4	LTC-91	12 POLICIES	47, 48, 52	0	1	2	0	2
5	LTCTP-6500	1 POLICY	0	0	0	0	0	0
6	N2400	3 POLICIES	19, 42	0	0	1	1	2
7	NHP	5 POLICIES	9, 27, 34	0	0	3	0	3
8	NHPGR	1 POLICY	0	0	0	0	0	0
9	P2400	8 POLICIES	17, 20, 26, 35, 40	0	0	2	4	4
10	P2400 W/5501	3 POLICIES	14	0	0	2	1	2
11	PF2	2 POLICIES	16	0	1	0	0	0
12	PF2600	5 POLICIES	29, 39	0	1	2	0	2
	TOTAL	50 POLICIES		1	4	14	7	18

1 Violation – Title 31, Pennsylvania Code, Section 146.3 – File and record documentation:

In the noted file, evidence was missing of an explanation of benefits that demonstrated application of elimination period.

4 Violations - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to acknowledge four noted claim files within 10 working days.

14 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters in fourteen noted claim files.

7 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days in the seven noted claim files.

18 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the eighteen noted claim files.

J. Long Term Claims (Additional)

The Company was requested to provide a list of long term care claims received during the experience period. The Company identified a universe of 2,183 long term care claims. Additional analysis determined that the 2,183 claims were submitted by and attributable to 402 unique individuals since several claims were submitted by the same individual for different dates of service. A random sample of 50 unique long term claim files was requested, received and reviewed in section 13 and an additional 50 files was requested, received and reviewed for this section. The 50 claim files were reviewed for compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLATIONS	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	ALP	1 POLICY	0	0	0	0
2	LTC-1	6 POLICIES	7, 12, 15, 25, 26	2	4	5
3	LTC-91	5 POLICIES	0	0	0	0
4	LTC-93	1 POLICY	0	0	0	0
5	LTCTP-6000	1 POLICY	17	1	1	1
6	LTCTP-6500	1 POLICY	50	1	0	1
7	N2400	3 POLICIES	1	1	0	1
8	NHP	2 POLICIES	8	1	0	1
9	NHP-A	4 POLICIES	37	1	0	1
10	NHP-GR	3 POLICIES	9	1	1	1
11	NHP-HER	1 POLICY	0	0	0	0
12	P2400	3 POLICIES	20, 39, 40	3	2	3
13	P2400 W/5501	1 POLICY	0	0	0	0
14	PF2600	10 POLICIES	3, 4, 5, 43	2	1	4
15	SR400	2 POLICIES	14, 19	1	1	2
	TOTAL	50 POLICIES		14	10	20

14 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to acknowledge fourteen noted claim files within 10 working days.

10 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the ten noted claim files.

20 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the twenty noted claim files.

K. Long Term Claims Denied

The Company was requested to provide a list of all claims denied during the experience period. The Company identified 145 denied claims. Of the 145 denied claims, 63 were home health care denied claims and 82 were long term care denied claims. The home health care denied claims review is addressed in summary Sections E and F. Of the 82 long term care claims denied, 31 claims were later identified by the Company as actual denials and 51 claims were identified as “other than denied.” All 31 actual denied claims were requested and reviewed. A sample of 15 of the 51 long term care claims identified as “other than denied” were requested and their review is addressed in summary Section L. The 31 denied claim files were reviewed to ensure compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and 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:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLS.	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	0232	1 POLICY	6	3	0	1
2	ALP	2 POLICIES	17, 31	0	0	2
3	ALPPA-TQ	2 POLICIES	10, 16	2	0	2
4	CCB5	1 POLICY	0	0	0	0
5	IL94	2 POLICIES	12	1	1	1
6	LTC-1	3 POLICIES	18	2	1	1
7	LTC-91	1 POLICY	0	0	0	0
8	LTC94RPA	1 POLICY	23	0	0	1
9	LTCTP-6000	3 POLICIES	9, 19	4	1	1
10	LTCTP-6500	2 POLICIES	28	0	0	2
11	NHP	2 POLICIES	29	1	1	1
12	P2400	5 POLICIES	7	1	1	1
13	P2600	1 POLICY	0	0	0	0
14	PF2600	2 POLICIES	8	0	0	1
15	PF2TQPA-100	1 POLICY	0	0	0	0
16	SR400	2 POLICIES	25, 26	0	2	2
	TOTAL	31 POLICIES		14	7	16

14 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for fourteen noted claim files.

7 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days for the seven noted claim files.

16 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the sixteen noted files. Four of these claim violations were for claim denials resulting from inefficiencies in claim handling.

K. Long Term Claims Denied (Other)

The Company was requested to provide a list of all claims denied during the experience period. The Company identified 145 denied claims. Of the 145 denied claims, 63 were home health care denied claims and 82 were long term care denied claims. The home health care denied claims review is addressed in summary Sections E and F. Of the 82 long term care claims denied, 31 claims were later identified by the Company as actual denials and 51 claims were identified as “other than denied.” All 31 actual denied claims were requested and their review is addressed in summary Section K. A sample of 15 of the 51 long term care claims identified as “other than denied” were requested and reviewed.

Of the 15 denied claims, 2 were determined not to be long term care claims and 4 were determined to be paid claims (never denied).

Below is a list of Denial Codes with the Denial Reasons presented by the Company for the reviewed files:

# of Files	DENIAL CODE	DENIAL CODE REASON	PERCENTAGE
1	35	NTQ Forms Only – Did Not Meet Triggers	6.6
1	39	Loss Due to Mental/Nervous Condition	6.6
1	52	Elimination Period Not Satisfied	6.6
1	53	Prior Hospital Requirement Not Satisfied	6.6
1	54	Type of Service Not Covered by Policy	6.6
4	58	Did Not Receive Requested Information	27
6	Blank	None	40
15			100%

The remaining 9 long term care denied claim files were reviewed to ensure compliance with the Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)) and 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:

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLS.	146.6 VIOLS.	146.7 VIOLS.	ACT 205 VIOLS.
1	0201	1 POLICY	0	0	0	0
2	ALP	1 POLICY	13	0	0	1
3	FLTC91	1 POLICY	0	0	0	0
4	IL2FPA	1 POLICY	9	0	0	1
5	LTC-1	1 POLICY	1	1	0	1
6	LTC91	2 POLICIES	0	0	0	0
7	LTCTP-6000	1 POLICY	0	0	0	0
8	N2400	1 POLICY	0	0	0	0
9	NHPGR	4 POLICIES	6, 7, 10	3	0	3
10	P2400	1 POLICY	0	0	0	0
11	PF2600	1 POLICY	0	0	0	0
	TOTAL	15 POLICIES		1	0	6

1 Violation - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide timely status letters for the noted claim file.

6 Violations – Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the six noted files. Two of these claim violations were for claim denials resulting from inefficiencies in claim handling.

L. Miscellaneous Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 39 miscellaneous claims. The results of a unique sampling showed that there was a total of only 12 individuals within the total universe since several claims were submitted by the same individual for different dates of service. All 12 claim files were requested, received and reviewed. The 12 claim files reviewed were all paid directly to the insured. The claim files were reviewed for compliance Title 31, Pennsylvania Code, Chapter 146.

	POLICY FORM NUMBER	NUMBER OF POLICIES	SAMPLE RECORD NUMBERS WITH VIOLS.	146.5 VIOLS.	146.6 VIOLS.	146.7 VIOLS.
1	0002	1 POLICY	0	0	0	0
2	0212	1 POLICY	0	0	0	1
3	0217	2 POLICIES	0	0	1	0
4	CC-2	1 POLICY	6	1	1	1
5	HCR	1 POLICY	0	0	0	0
6	HW-1	6 POLICIES	2	1	0	0
	TOTAL	12 POLICIES		2	2	2

The following chart is a synopsis of the company's miscellaneous claim type and the violations noted are listed below:

NUMBER OF CLAIMS	CLAIM TYPE	PERCENT
6	Medical-Surgical	50
1	Long Term Care	8
4	Prescription	34
1	Unknown	8
12	TOTAL	100

2 Violations - Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications:

The Company failed to acknowledge the two noted claim files within 10 working days.

2 Violations - Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims:

The Company failed to provide a status letter for the two noted claim files.

2 Violations - Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers:

The Company failed to provide notice of acceptance or denial within 15 working days in the two noted claim files.

LONG TERM CARE ANNUAL REPORTING

The Company's Long Term Care Annual Reporting for the experience period July 1, 2005 to June 30, 2006 was reviewed to ensure compliance with Title 31, Pennsylvania Code, Chapter 89a. No violations were noted.

XI. 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 internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act, Act 205 of 1974 (40 P.S. §1171.5).
2. 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.
3. The Company must review all claims that were denied during the period of July 1, 2005, through June 30, 2008. The Company shall provide to the Department a report of the results upon completion of the review and verification of claim payment on the claims noted in the review that required payment or additional payment.
4. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146a, Privacy of Consumer Financial Information.
5. The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, as amended, Act 147 of 2002, Section 671-A (40 P.S. §310.71)
6. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 89a, Long-Term Care Insurance. This includes, but is not limited to, 89a.105 Policy practices and provisions, b. limitations and exclusions; Section 89a.113, replacement and policy delivery for “free look provision”; Section 89a.12, Suitability; and Section 89a.127, shoppers guide delivery.
7. The Company must review and revise all internal control procedures to ensure compliance with form filing requirements of Accident and Health Filing Reform Act, Act 159 of 1996 (40 P.S. §3803)

8. The Company must review and revise internal control procedures to ensure compliance with the interest payment requirements of Section 411B of the Insurance Company Law of 1921 (40 P.S. §511b).
9. 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), (40 P.S. §323.3) of the Insurance Department Act.
10. The Company must implement procedures to ensure compliance with the fraud statement notice requirements of Title 18 Pa. C. S. §4117(k).

XII. COMPANY RESPONSE



Penn Treaty Network America Insurance Company

(PTNA Life Insurance Company in CA)

June 25, 2008

**Sent Via E-Mail @ dstemcosky@state.pa.us
& UPS Ground Delivery**

Daniel A. Stemcosky, AIE, FLMI
Market Conduct Division Chief
Pennsylvania Department of Insurance
1321 Strawberry Square
Harrisburg, PA 17120

RE: Penn Treaty Network America Insurance Company/NAIC #63282
Examination Warrant Number: 06-M25-015

Dear Mr. Stemcosky:

Please allow this letter and the attached response to serve as Penn Treaty's response to the Department's modified Examination Report ("Report") dated June 23, 2008. In accordance with the Department's procedures, Penn Treaty requests that this letter and the attached response be included (i) as part of the Report; and (ii) in any public dissemination of the Report.

Penn Treaty sincerely thanks the Department for the consideration and cooperation exhibited by the Department representatives during this thorough examination and review process.

As the Department is aware, this examination occurred during 2007 and the period of review of this examination was July 1, 2005 through June 30, 2006. As discussed with the Department during the examination and during the Exit Summary conference, prior to the Department's examination, the Company has proactively reviewed, enhanced and modified, as appropriate, its claim processes, systems and protocols to ensure consistency of approach, regulatory compliance and (most importantly) policyholder service. This effort led to the addition of an Executive Vice President of Insurance Operations, who was hired in 2005 to specifically lead the claims and policyholder service areas, which has resulted in the implementation of numerous enhancements to procedures and automation designed to improve claim processing efficiency,

policyholder service and process metrics. These enhancements are discussed in more detail in our response to the Examination Report.

We would like to assure the Department of our continuing commitment to full compliance with all regulatory requirements. I am available to discuss any further questions you may have at your convenience.

Respectfully,

A handwritten signature in black ink, appearing to read "Jane M. Bagley". The signature is fluid and cursive, with a large initial "J" and a long, sweeping tail.

Jane M. Bagley
Senior Vice President and Corporate Counsel
Penn Treaty Network America Insurance Company

JMB/bb

Enclosures



Penn Treaty Network America Insurance Company

(PTNA Life Insurance Company in CA)

June 25, 2008

Daniel A. Stemcosky, AIE, FLMI
Market Conduct Division Chief
Pennsylvania Department of Insurance
1321 Strawberry Square
Harrisburg, PA 17120

RE: Penn Treaty Network America Insurance Company/NAIC #63282
Examination Warrant Number: 06-M25-015

Dear Mr. Stemcosky:

Thank you for providing us with a copy of the modified Report of Examination of Penn Treaty Network America Insurance Company covering the period of July 1, 2005, through June 30, 2006. We appreciate the Department's time and efforts in conducting its Examination and would like to take this opportunity to respond to the Department's comments and recommendations as set forth in the modified Report.

IV. Advertising

Title 31, Pennsylvania Code, Section 51.5 – Certificate of Compliance:

As stated in earlier responses to the Department, the Company agrees that an Advertising Certificate of Compliance was not filed with the 2005 Annual statement because of the confusion (as described below) surrounding whether such a filing was required. Following the Department's notice that an Advertising Certificate of Compliance was in fact required, the Company promptly complied with this requirement and will continue to do so in the future.

While we regret the omission of the Advertising Certificate of Compliance with the 2005 Annual statement, we respectfully request that this violation be excused for the following reasons:

Penn Treaty acted in good faith and consulted the Department's Licensed Life, Accident and Health Insurers – Required Filings Checklist publications ("Publications") that clearly indicated that a "Certificate of Complicate" was not required by a domestic insurer. These Publications, year-after-year, indicated that a Certificate of Compliance did not need to be filed by domestic insurers. Therefore, it

was reasonably interpreted that the Advertising Certificate of Compliance was not required to be filed in the 2005 Annual statement;

Penn Treaty has reviewed the Department's response wherein the Department advised that the Publications we cited in our response regarding the "Certificate of Compliance" meant a "Financial Certificate of Compliance" and not an "Advertising Certificate of Compliance." The Company was unable to locate any statutory references to a Financial Certificate of Compliance. Adding to the confusion, the 2008 Publication now specifically references Title 31, Pennsylvania Code, Section 51.5, the Advertising Certificate of Compliance, when listing the requirement to file a "Certificate of Compliance"; and

We understand from discussions with the Department that the "Certificate of Compliance," as presented in the Publications, has led to confusion among numerous insurers.

V. Forms

Title 18, Pennsylvania Consolidated Statutes, Section 4117(k) – Fraud statement - individual enrollment form and application form.

Please note that the application forms in question were related to group coverage for a group that was no longer in force and the form was, and is, no longer in use. A memorandum has been sent to the appropriate areas to further ensure that distribution or acceptance of this application form for underwriting has been stopped.

Accident and Health Reform Filing Act 159, Section 3(a) (40 P.S. §3803(a) – Form Filings:

This question revolves around a previously filed product that was being re-marketed with an increased daily benefit. As a result, this product was not re-filed and the form number remained the same.

Title 31, Pennsylvania Code, Section 89a.105 – Policy Practices and provisions: Policy exclusion language - Medicare deductible and/or coinsurance amounts.

Prior to the examination, the Company had already been working with the Department's Form Filing Division to amend the pertinent sentence in the exclusionary language in the listed products. An Amendatory Rider has been approved by the Department and is currently being mailed to all Pennsylvania policyholders with a Tax-Qualified policy.

The Company filed for, and received Departmental approval for, amended policy language so that benefits would not be reimbursable for services covered by Medicare, in compliance with the standards set forth by HIPAA. While the Company believes that the prior policy language was more favorable to the Company's policyholders, the Company acknowledges that the policy language was required to be amended in accordance with HIPAA.

VI. Producer Licensing

Insurance Department Act of 1921, as amended, Act 147 of 2002, Section 671-A (40 P.S. §310.71) – Appointments: Notice of appointment and appointment fee submission to the Insurance Department

The Company has taken appropriate measures to ensure that all agents are appointed prior to acting on the Company's behalf. The Company has distributed reminder notifications to its agency force that agents must be appointed prior to marketing any products. The Company's Underwriting Department has changed its procedures to help ensure that applications can not be processed unless an agent has been appointed prior to the date of application.

VII. Consumer Complaints

Title 31, Pennsylvania Code, Section 146.5 – Acknowledgement of pertinent communications: Instructions and reasonable assistance to claimants regarding the requirements to process claims.

The Company's procedures have been enhanced so that upon notification of a claim a letter is immediately sent to the policyholder with the appropriate claim forms and instructions for filing a claim.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Status letters.

The Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146a.21(a) –Disclosure of nonpublic personal financial information to nonaffiliated third parties: Disclosure of nonpublic personal information on the mailing envelopes of the Company's Annual Privacy Notice

The Company has specific guidelines for processing all Privacy Notices, which state that "labels should never include a policy number". This information has previously been provided to and discussed with the Department. The mailing in question was a one-time error/ mailing in 2006 that was done outside of the Company's established guidelines. This one-time mailing included policy numbers on address labels. This mailing was done at the direction of an employee who is no longer employed by the Company.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days

The Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve claim turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a) (10) (40 P.S. §1171.5(a) (10): Disclosure of policy coverage/policy provision related to payment or reduction of payment.

The company acknowledges that there were instances where the Explanation of Benefits failed to provide an explanation for the difference between the amount billed by the provider and the amount paid by the Company. These instances were outside of our established procedures, which require that the examiner must enter a "Remarks Code" to explain why the paid amount differs from the billed amount. These instances were all due to examiner error, and the Company's claims management team has reinforced the importance of complying with this established procedure.

VIII. Underwriting

A. Underwriting Guidelines:

No Violations were noted.

B. Group Long-Term Care Certificates Issued:

No Violations were noted.

C. Group Long-Term Care Conversions

Insurance Department Act, Section 903 (40 P.S. § 323.3) – Authority, scope and scheduling of examinations: Insured's application date required under 40 P.S. §756.2 and 31 Pa. Code §89a. 105(d).

The Company notes that there was one cited violation which pertained to a conversion policy that was guaranteed issue and, therefore, no underwriting was required because the application from the issuance of the original group policy was used. The Company's Underwriting Department has been made aware that any future conversions to individual long-term care policies require completion of the Pennsylvania approved application for the product being purchased.

D. Individual Long-Term care Policies Issued

Title 31, Pennsylvania Code, Section 89a.113 – Requirements for application forms and replacement coverage: Replacement question and evidence of policy delivery.

The Company acknowledges three files in which the replacement section of the application was left blank. The Company has taken appropriate action within its Underwriting Department to ensure future compliance.

In January 2007, the Company initiated a new procedure related to policy delivery receipts to help ensure that policies are delivered in compliance with Title 31, Pennsylvania Code, Section 89a.113 (f). This procedure requires that the Company receive from the agent a Delivery Receipt signed by the insured prior to agent commissions being processed. This procedure only impacts the payment of commissions and does not have any effect on the issuance or renewal of the policy. The Company believes that this new procedure has effectively addressed the issue related to unreturned Delivery Receipts.

Title 31, Pennsylvania Code, Section 89a121- Suitability: Evidence of using suitability standards.

The Company acknowledges that there were six files cited for improper evidence of suitability at or before the date of application. The Company would like to stress that upon initial receipt of four of these forms, the Company identified that the forms were not correctly completed and the forms were immediately returned to the agent for completion. These four applications were subsequently withdrawn by the applicants and, therefore, the agents did not return the suitability information. The applicants of the other two files in question waived the suitability disclosure but failed to check one of the boxes on the form.

Title 31, Pennsylvania Code, Section 89a.127 – Requirement to deliver shopper’s guide:

Evidence of Shopper’s Guide delivery to the applicant.

The Company acknowledges that there was one file where evidence of delivery of the Shopper’s Guide to the applicant was missing. (The applicant signed the application indicating that the Shopper’s Guide was received, however the applicant failed to check one additional box on the application form.) The Company’s Underwriting Department has been notified to ensure that every application contains all of the necessary evidence of delivery of the Shopper’s Guide to the applicant.

E. Individual Home Health care Policies Issued

No violations were noted.

IX. Claims

Claims Manual - No violations were noted.

Claim Files:

A. Cancer Claims

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement of claim files within 10 working days.

As previously described in this Response, the Company’s claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 workings days.

As described above, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national

basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

B. Disability Claims

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Employer Statement claim form.

The Company has updated its Disability Claim Form to include an Employer Statement. A copy of the Employer Statement form is attached for the Department's information and review.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letters.

As previously described, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Acceptance or denial within 15 working days.

As previously described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

C. Home Health Care Claims

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement within 10 working days.

The Company acknowledges that there was one claim file that was not acknowledged within 10 working days. The Company would like to add that as previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and

to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letters.

As previously discussed with the Department, the Company believes that the practice of sending one letter which serves as both an acknowledgment and a status of a claim satisfies the requirements of Section 146.5 and Section 146.6. The Company appreciates the Department's position that two separate letters should be sent to policyholders. In the spirit of cooperation and as a indication of the Company's good faith efforts to comply with the Department's requirements, the Company has updated its claims procedural manual to require two separate letters: (i) an acknowledgment letter within 10 days of receipt of a new claim; and (ii) a timely status letter within 30 days of receipt of a claim.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

As described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above related to Sections 146.5, 146.6 and 146.7. In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders.

In summary, the Company would like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements. It is the Company's strong belief that any errors committed, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

D. Home Health Care Claims (Additional)

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letters.

As previously discussed with the Department, the Company believes that the practice of sending one letter which serves as both an acknowledgment and a status of a claim satisfies the requirements of Section 146.5 and Section 146.6. The Company appreciates the Department's position that two separate letters should be sent to policyholders. In the spirit of cooperation and as a indication of the Company's good faith efforts to comply with the Department's requirements, the Company has updated its claims procedural manual to require two separate letters: (i) an acknowledgment letter within 10 days of receipt of a new claim; and (ii) a timely status letter within 30 days of receipt of a claim.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

The Company disagrees with this one violation and believes that the claim file documentation indicates that this claim was paid within 15 working days. Additionally, as described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above to violations of Sections 146.5, 146.6 and 146.7. In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders.

In summary, the Company would like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements. It is the Company's strong belief that any errors committed, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

E. Home Health Care Claims Denied

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letters.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

As previously described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail, and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above to violations of Sections 146.5, 146.6 and 146.7. In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders.

The Company notes that two claims were cited for claim processing inefficiencies. The Company agreed with one violation and re-opened the claim. As to the second claim, the Company disagrees because this claim was not denied. The claim was closed due to non-receipt of information that was needed in order to determine provider eligibility. The policyholder was advised that the claim would be re-opened upon the Company's receipt of this additional information. This information was never received.

In summary, the Company would like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements. It is the Company's strong belief that any errors committed, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

F. Home Health Care Claims Denied (Other)

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement of claim within 10 working days.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letters.

As previously discussed with the Department, the Company believes that the practice of sending one letter which serves as both an acknowledgment and a status of a claim satisfies the requirements of Section 146.5 and Section 146.6. The Company appreciates the Department's position that two separate letters should be sent to policyholders. In the spirit of cooperation and as a indication of the Company's good faith efforts to comply with the Department's requirements, the Company has updated its claims procedural manual to require two separate letters: (i) an acknowledgment letter within 10 days of receipt of a new claim; and (ii) a timely status letter within 30 days of receipt of a claim.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

As described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above to violations of Sections 146.5, 146.6 and 146.7. In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders.

G. Hospital Indemnity Claims

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement of claims within 10 working days.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letters.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

As described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above to violations of Sections 146.5, 146.6 and 146.7.

In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders. The Company would also like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance

with all state regulatory requirements. It is the Company's strong belief that any errors committed, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

H. Individual Life Claims

Title 31, Pennsylvania Code, Section 146.3 – File and record documentation: Evidence of premium refund.

The Company acknowledges that there was one noted life insurance claim file with a premium refund of 17 days that was not issued. The Company has issued the refund with interest.

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement of claim within 10 working days.

The Company notes that it no longer has any life policies in force. The Company's block of individual life business was sold to another party in 2006 and transferred in 2007.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letter.

The Company notes that it no longer has any life policies in force. The Company's block of individual life business was sold to another party in 2006 and transferred in 2007.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

The Company notes that it no longer has any life policies in force. The Company's block of individual life business was sold to another party in 2006 and transferred in 2007.

Insurance Company Law, Section 411B (40 P.S. §511b) – Payment of Benefits: Interest for late payment.

The Company notes that this was the only violation of all files reviewed and this instance was the result of examiner error. The interest was paid based on the date of receipt of the required information to the date of payment of the interest.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company continues to believe that because of the limited number of violations and because of the explanations for these matters, citations pursuant to ACT 205 violations are not warranted. Additionally, upon review of the Department's table regarding the number of days it took the Company to issue payment, the Company would like to point out that the payments (with the exception of one) were all made within 28 days. The one exception was a result of examiner error and was not an intentional delay, and the benefit was re-issued with interest.

In summary, the Company would like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements. It is the Company's strong belief that the errors committed, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

I. Long-Term Care Claims

Title 31, Pennsylvania Code, Section 146.3 – File and record documentation: Evidence of explanation of benefits that demonstrates application of elimination period.

The Company acknowledges that there was one claim file related to examiner error in entering an incorrect description code. This error has been corrected.

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement of claim within 10 working days.

The Company respectfully continues to disagree with two of the four cited violations based on the language of the policies that clearly state that written proof of loss is required. Upon receipt of the written proof of loss, payment was issued on these two policies within 10 days; therefore, the Company does not believe that an acknowledgement letter was required. During the Exit Conference, the Department agreed to re-review section 146.5 and 146.6 in connection with the policy language.

With regard to the remaining two files, as previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letter.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

As described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national

basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above to violations of Sections 146.5, 146.6 and 146.7. In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders.

In summary, the Company would like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements. It is the Company's strong belief that the errors committed, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

J. Long-Term Care Claims (Additional)

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Acknowledgement of claim within 10 working days.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

The Company continues to disagree with two violations based on the date of receipt of all required information in order for the Company to make payment. In one instance, an incomplete claim form (one of two pages) was received and upon receipt of the second page, the claim was paid within 15 days. In the second instance, the Company issued payment within 15 days of receipt of the results of an assessment, which is required to verify and validate the policyholder's current functionality and care needs based on the 90-day Chronically Ill Provision of the policy.

As described in this Response, the Company has implemented numerous enhancements and updates to its processing systems both since the period of this examination (2005-2006). These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company respectfully disagrees with the application of violations of the Unfair Insurance Practices Act. The Company refers the Department to the responses above to violations of Sections 146.5, 146.6 and 146.7. In addition, as previously noted, over the past several years the Company has implemented numerous enhancements and systems to improve our adjudication of claims. The Company is committed to ongoing reviews and development of systems that will assist us to provide the best service to our policyholders.

K. Long-Term Care Claims Denied

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Acknowledgement of claim within 10 working days.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

The Company continues to disagree with two of these violations for the reasons previously stated.

As described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company notes that some of the cited violations of Act 205 include incorrect dates that were manually entered into the Company's computer system. The Company understands the importance of correct data and had reinforced this matter with its claims examiners. However, it is important to note that incorrect dates in the system do not affect the processing of the claim because claims are adjudicated based on the actual dates recorded within our imaging system. It is the Company's strong belief that these examiner errors of entering incorrect dates, in and of themselves, do not rise to the level of frequency and magnitude so as to constitute a finding of being a "general business practice".

In addition, the Department noted certain violations because the Company had listed claims for which no payment was made where the charges were applied to the Elimination Period of the policy. These files were incorrectly categorized by the Company as "denied" claims instead of "closed" claims.

As previously discussed with the Department, the Company changed its procedures prior to completion of this Examination so that all services applied to the Elimination Period are now processed on an Explanation of Benefits and correctly identified as a "closed" claim, not a "denied" claim.

The Company notes that the Department cites four violations related to claim denials. The Company notes that three of these files were the result of examiner error. All four files have been re-reviewed and adjustments were processed prior to this Report.

In summary of this section, the Company would like the Department to know that Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements.

The Company also refers the Department to the responses herein related to Sections 146.5, 146.6 and 146.7 for corrective actions already put into place.

L. Long-Term Care Claims Denied (Other)

Title 31, Pennsylvania Code, Section 146.6 - Standards for prompt investigation of claims: Timely status letter.

The Company acknowledged this one violation and would like to add that, as previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Unfair Insurance Practices Act, Act 205 of 1974, Section 5(a)(10) (40 P.S. §1171.5(a)(10)):

The Company acknowledges that both files noted by the Department for claim inefficiencies were the result of examiner error. Both claims have been re-reviewed and appropriate adjustments have been processed.

As previously stated in this Response, Penn Treaty claim adjudication practices have been, and continue to be, executed with the intent of being prompt, fair and accurate, and in accordance with each policyholder's contractual provisions, as well as in compliance with all state regulatory requirements.

M. Miscellaneous Claims

Title 31, Pennsylvania Code, Section 146.5 – Failure to acknowledge pertinent communications: Acknowledgement of claim within 10 working days.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.6 – Standards for prompt investigation of claims: Timely status letter.

As previously described in this Response, the Company's claims system has been enhanced to automatically alert claim examiners and their supervisors to timelines required for sending and receiving policyholder claim correspondence for each claim file, and to better track and manage the timelines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

Title 31, Pennsylvania Code, Section 146.7 – Standards for prompt, fair and equitable settlements applicable to insurers: Notice of acceptance or denial within 15 working days.

As previously described in this Response, the Company has implemented numerous enhancements and updates to its processing systems since 2005. These enhancements have served to further automate claims processing and have resulted in more expedient claim adjudication processing. In fact, on a national basis, as of May 28, 2008, 93% of our claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. Examples of such enhancements include a new work queue that now automatically alerts examiners to newly received mail and reports that alert claim examiners to open claims with no payments. The Company continuously reviews, updates and enhances its work processes to improve our turn-around time.

X. Long-Term care Annual Reporting

No Violations noted.

XI. Recommendations

1-2. As described in the Company's Response, beginning in March 2006 (one-year prior to the commencement of this Examination) the Company implemented a series of claim programming enhancements to its claims system. These enhancements include, among other items:

(i) an "Additional Information Screen" which alerts claim examiners to the time-lines required for sending and receiving policyholder claim correspondence. This screen prompts examiners to send out correspondence at required intervals and to follow-up with policyholders on correspondence that has already been sent out, but for which no response has been received. The Additional Information Screen functionality also provides a report for use by Supervisors to monitor claim examiner compliance with correspondence requirements;

(ii) a front end imaging program which serves as an electronic workflow for the Company's claim operation. This workflow program alerts claim examiners immediately to correspondence that has been received from policyholders on both new and established claims. This facilitates a faster turn-around for eligibility decisions and claim payment processing; and

(iii) additional reporting enhancements for use by supervisors and examiners to better track and manage claim file time-lines related to collecting necessary documentation on newly submitted claims, as well as the sending and receiving of all other claim related correspondence.

These, as well as other enhancements, serve to further automate claims processing and have resulted in more expedient claim adjudication. In fact, on a national basis, as of May 28, 2008, 93% of the Company's claims are processed within 15 days and 97% are processed within 30 days of receipt of all requisite claim information. The Company continuously reviews, updates and enhances its work processes to improve claim turn-around time as we strive to uphold our excellent record of providing financial protection for America's seniors, and paying claims on a timely, reliable basis, and providing service that results in high policyholder satisfaction marks.

3. As previously discussed with the Department, the Company has offered to review all claims that were denied between the period of July 1, 2005 through June 30, 2008 and provide a report to the Department with the results of the review upon completion. The Company will provide verification of claim payment on any claims noted in the review that required payment.

4. The Company has specific guidelines for processing all Privacy Notices, which state that "labels should never include a policy number". This information has previously been provided to and discussed with the Department. The Company acknowledges that there was one instance in 2006 that resulted in labels that included policy numbers on address labels. This mailing was done at the direction of an employee who is no longer employed by the Company. The Company recognizes the importance of protecting policyholder privacy and the Company has implemented controls to ensure all consumers' personal information is protected. In furtherance of the Company's efforts to protect the privacy of our customers, the Company is enhancing the automation of the process of sending privacy notices. The Company believes that this will serve to further ensure continued compliance with Chapter 146a, Privacy of Consumer Financial Information.

5. The Company has taken measures to ensure that appointment paperwork for agents is processed prior to such agents acting on the Company's behalf. The Company has distributed notifications to its agency force that agents must be appointed prior to marketing any products. The Company's Underwriting Department has changed its procedures to help ensure that applications cannot be processed unless an agent has been appointed prior to the date of application.

6. In January 2007, the Company initiated a new procedure related to policy delivery receipts to help ensure that policies are delivered in compliance with Title 31, Pennsylvania Code, Section 89a.113 (f). This procedure requires that the Company receive from the agent a Delivery Receipt signed by the insured prior to agent commissions being processed. This procedure only impacts the payment of commissions and does not have any effect on the issuance or renewal of the policy. The Company believes that this new procedure has effectively addressed the issue related to unreturned Delivery Receipts. The Company has also reviewed procedures related to suitability requirements. The Company has instituted new procedures to help ensure that all areas of suitability information are received for all applications.

With regard to the one matter relating to evidence of delivery of the shoppers guide to an applicant, the Company has updated internal procedures to help ensure that all pertinent sections on the Company's insurance applications are reviewed carefully.

7. The Company believes that all forms have been properly filed in compliance with the filing requirements of Accident and Health Reform Act, Act 159 of 1996.

8. As stated previously, of all claim files reviewed by the Department, there was only one violation for failure to pay interest. The Company has reviewed all internal controls relative to the payment of interest as required by Section 411B. Penn Treaty has enhanced the automation of interest calculations within its claim computer system. This new functionality will reduce human error and assist in identifying when a claim invoice is subject to the addition of interest.

9. The Company notes that there was one violation related to a group policy converted to an individual policy. Because the policy was guaranteed issue with no underwriting required, the original application was used. The Company has updated Underwriting procedures to require a new application for the conversion policy. The Company had previously updated our procedures to review all information received relative to an application for a long-term care policy to ensure all forms are completed as required.

10. The Company has updated all forms to include the required "fraud statement" to ensure compliance with the requirements of Title 18 Pa. C. S. §4117(k).

We would like to assure the Department of our continuing commitment to full compliance with all regulatory requirements, and thank the Department again for the cooperation and courtesies extended during the Examination process.

Respectfully,



Jane M. Bagley

Senior Vice President and Corporate Counsel
Penn Treaty Network America Insurance Company