



**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

**MARKET CONDUCT  
EXAMINATION REPORT**

**OF**

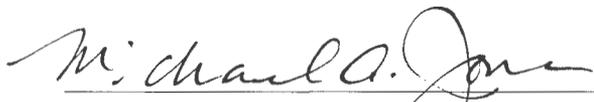
**CONTINENTAL  
CASUALTY COMPANY**  
Chicago, IL

**As of: November 5, 2015  
Issued: December 29, 2015**

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

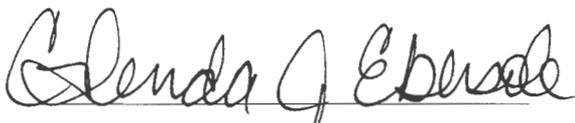
## Verification

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).

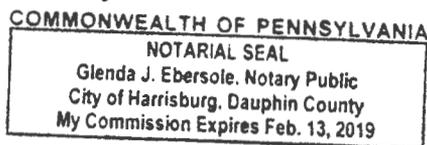
  
Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 22<sup>nd</sup> Day of October, 2015



Notary Public



# **CONTINENTAL CASUALTY COMPANY**

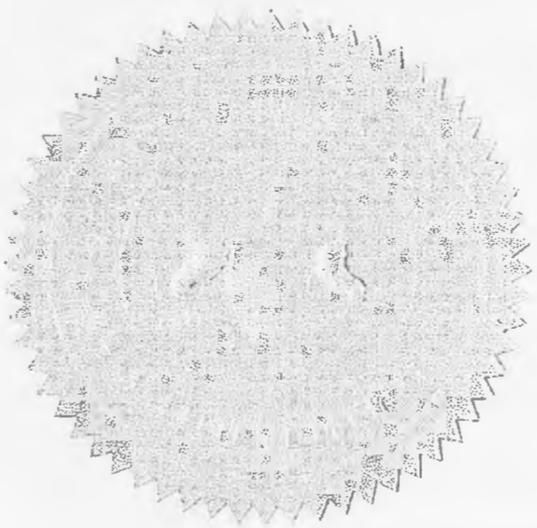
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BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

**ORDER**

AND NOW, this 13<sup>th</sup> day of November, 2015, 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 Christopher R. Monahan, 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.



Teresa D. Miller  
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
CONTINENTAL CASUALTY	:	40 P.S. §§310.41a(a) and 310.71(a)
COMPANY	:	
333 S. Wabash Avenue	:	40 P.S. §§991.1111(a)(b)(c)(d)
Chicago, IL 60604	:	991.1111a(c), 991.1111b(a)
	:	and 991.1111b(b)
	:	
	:	31 Pa. Code §§146.3, 146.5, 146.6
	:	and 146.7
	:	
	:	
	:	
	:	
	:	
	:	
Respondent.	:	Docket No. MC15-11-011

CONSENT ORDER

AND NOW, this 29<sup>th</sup> day of December 2015, 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.

3. Respondent neither admits nor denies the Findings of Fact or Conclusions of Law contained herein. No acts by Respondent that are alleged to be violations of Pennsylvania law in the referenced provisions were the result of any conscious policy to evade the requirements of Pennsylvania law.

#### FINDINGS OF FACT

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

- (a) Respondent is Continental Casualty Company, and maintains its address at 333 South Wabash Avenue, Chicago, IL 60604.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2014 to December 31, 2014.

- (c) On November 5, 2015, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on December 7, 2015.
- (e) The Examination Report notes violations of the following:
  - (i) 40 P.S. §310.41a(a), which prohibits any entity or the appointed agent of any entity from transacting the business of insurance through anyone acting without an insurance producer license;
  - (ii) 40 P.S. §310.71(a), which states that 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;
  - (iii) 40 P.S. §991.1111(a)(b)(c)(d), which states:
    - (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

- (b) The department shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.
  - (c) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.
  - (d) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form;
- (iv) 40 P.S. §991.1111a(c), which states the insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within one hundred twenty (120) calendar days after the insured and the insured's authorized representative, in applicable, received the insurer's benefit determination notice;
- (v) 40 P.S. §991.1111b(a), which states (a) Within thirty (30) after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and one of the following:
1. The insurer is declining to pay all or part of the claim and the specific reason for denial; or

2. Additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary;
- (vi) 40 P.S. §991.1111b(b), which requires within thirty (30) business days after receipt of a requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice the insurer is declining to pay all or part of a claim and the specific reason or reasons for denial;
- (vii) 31 Pa. Code §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;
- (viii) 31 Pa. Code §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;

- (ix) 31 Pa. Code §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;
- (x) 31 Pa. Code §146.7, which requires within 15 working days after receipt by the insurer of properly executed proof of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer;

#### CONCLUSIONS OF LAW

5. In accord 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 40 P.S. §§310.41a(a) and 310.71(a) are punishable by the following, under (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 31 Pa. Code §§991.1111(a)(b)(c)(d), 991.1111a(c), 991.1111b(a) and 991.1111b(b) are punishable under 40 P. S. §991.1114 which states an insurer or producer found to have violated the requirements relating to the regulations of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty of up to three times the amount of any commissions paid for each policy involved in the violation or \$10,000, whichever is greater.
  
- (d) Respondent's violations of 31 Pa. Code §§146.3, 146.5, 146.6 and 146.7 are punishable under Sections 1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 1171.5 and 1171.9):
  - (i) cease and desist from engaging in the prohibited activity;
  - (ii) suspension or revocation of the license(s) of Respondent.

ORDER

6. In accord 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) Respondent shall pay Thirty-Five Thousand Dollars (\$35,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.
- (e) Payment of this matter shall be made by check payable to the Pennsylvania Insurance Department. Payment should be directed to April Phelps,

Bureau of Market Actions, 1311 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

7. 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.

8. 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.

9. 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.

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

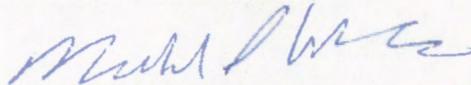
11. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

12. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegate 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 delegate.

BY: CONTINENTAL CASUALTY COMPANY,  
Respondent



President / Vice President



~~Secretary / Treasurer~~ SVP + Deputy General Counsel



COMMONWEALTH OF PENNSYLVANIA  
Christopher R. Monahan  
Deputy Insurance Commissioner

## I. INTRODUCTION

The Market Conduct Examination was conducted on Continental Casualty Company; hereafter referred to as “Company,” at the Company’s office located in Chicago, IL, from June 2, 2015 through June 12, 2015. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

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

Deborah Lee  
Market Conduct Division, Acting Chief

Michael A. Jones  
Market Conduct Examiner in Charge

Monique Miller  
Market Conduct Examiner

Josephine Sitter  
Market Conduct Examiner, MCM

Lonnie Suggs  
Market Conduct Examiner, MCM

## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2014, through December 31, 2014, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Long Term Care, Advertising, Producer Licensing, Forms, Underwriting Practices and Procedures as well as Consumer Complaints.

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

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

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

Continental Casualty Company (CCC) was originally chartered on November 29, 1897, as Continental Assurance Company of North America, as an Indiana corporation. On November 1, 1900, the name was changed to “Continental Casualty Company”. The Company continued as an Indiana corporation until June 30, 1948 at which time it merged with its subsidiary, the Concasco Casualty Insurance Company of Illinois, which was incorporated February 17, 1948 under the provisions of the Illinois and Indiana laws, the Concasco Casualty Insurance Company of Illinois became the surviving company. Simultaneously, the name of the survivor was changed to Continental Casualty Company on June 30, 1948.

The Financial control is held indirectly by Loews Corporation (Loews), a publicly traded corporation. Loews acquired control late in 1974. As of December 31, 2003, CNA Financial Corporation, a publicly traded corporation, contributed all of the outstanding shares of CCC to The Continental Corporation, a holding corporation domiciled in the State of New York.

The company was licensed in Illinois on February 17, 1948 and is licensed to do business in the District of Columbia, Puerto Rico, U.S. Virgin Islands and all 50 states. It is also licensed in all Canadian provinces and territories and is an Authorized/Registered Foreign Reinsurer in Bolivia, Colombia, Ecuador, Mexico, Panama, Paraguay, Philippines, and Venezuela.

As of the Annual Statement for the year 2014, for Pennsylvania, the Continental Casualty Company reported direct premium earned for guaranteed renewable accident and health in the amount of \$1,244,773 and 2014 direct premium earned for group accident and health in the amount of (\$144,434).

#### **IV. ADVERTISING**

The Department, in exercising its discretionary authority requested, received and reviewed the Company's Advertising Certificate of Compliance. The certification was reviewed to ensure compliance with 31, Pa. Code §51.5. Subsection 51.5 provides that "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." No violations were noted.

## V. 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 or as a representative 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 producer terminations to the Department.

The Company provided a list of 12 active producers and 7 terminated producers. All 19 producers were compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the individuals identified as producers on applications reviewed in the policy issued sections of the exam. The following violations were noted:

### **1 Violation – 40 P.S. §310.71**

- 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 producer. The Company listed the producer as active; however, the Department records did not indicate the appointment.

Last Name	First Name
Hale	Keith

**4 Violations – 40 P.S. §310.71**

- (a) Termination. - An insurer which terminates an appointment pursuant to section 671-A(d) shall notify the department in writing on a form approved by the department, or through an electronic process approved by the department, within 30 days following the effective date of the termination.
- (b) Reason for termination. – If the reason for the termination was a violation of this act or if the insurer had knowledge that the licensee was found to have engaged in any activity prohibited by this act, the insurer shall inform the department in the notification.

The following 4 producer/agencies were listed as terminated by the Company but the Department record listed them as being active or the termination was not reported in a timely manner.

Producer Last/Agency	Producer First	Termination Date
Special Risk Insurance Services Inc.		20100701
Allen	Stephan	20140201
Aon Consulting Inc.		20091001
Loesel Schaaf Insurance Agency Inc.		20140201

**2 Violations - 40 P.S. §310.41a**

(a) Any insurance entity or licensee accepting applications or orders for insurance or securing any insurance business that was sold, solicited or negotiated by any person acting without an insurance producer license shall be subject to civil penalty of no more than \$5000 per violation in accordance with this act. This section shall not prohibit an insurer from accepting an insurance application directly from a consumer or prohibit the payment or receipt of referral fees in accordance with this act.

(b) A person that violates this section commits a misdemeanor of the third degree.

The files indicated group contracts were “House Account” which no broker sold directly for CNA. The active licensing information could not be establishment in the 2 noted files.

## **VI. FORMS**

The Company was requested to provide a list of company filed policy forms, endorsements and applications used during the experience period. The Company provided a list of 210 forms. Stamp approved forms were provided for 10 filed forms. The 10 forms provided and additional forms were reviewed in various underwriting sections of the examination to ensure compliance with 40 P.S. §477b.1 and 18 Pa. Code §4117(k), Fraud notice. No violations were noted.

## **VII. CONSUMER COMPLAINTS**

The Company was requested to identify all consumer complaints received during the experience period January 1, 2014 to December 31, 2014 and provide copies of consumer complaint logs for 2010, 2011, 2012, and 2013. The Company provided 14 regulatory and 11 non-regulatory consumer complaints that were received during the experience period. All 25 complaint files were requested, received, and reviewed. The company also provided complaint logs as requested. 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 purpose of the review was to determine compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.5). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with 31 Pa. Code, §146.5(b)(c). The following violations were noted:

### **1 Violation – 31 Pa. Code §146.3**

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. The denial letter was missing from the noted file.

### **6 Violations – 31 Pa. Code §146.5**

(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 communication from a claimant who reasonably suggests 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). Verification the company (a) acknowledged receipt of claims within 10 working days; (c) provided an appropriate reply within 10 working days and (d) 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 policy conditions and reasonable requirements of the insurer.

The complaint notice requirements could not be established in the 6 noted files.

### **1 Violation - 31 Pa. Code §146.6**

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

**1 Violation - 31 Pa. Code §146.7**

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

## **VIII. UNDERWRITING**

The Underwriting review consisted of 6 general segments.

- A. Underwriting Guidelines
- B. Individual LTC Policies Terminated (Comprehensive)
- C. Individual LTC Policies Terminated (Facility)
- D. Group Long-Term Care Policies Issued
- E. Group Long-Term Care Policies Declines
- F. Group Long-Term Care Policies Terminated

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

### **A. Underwriting Guidelines**

The Company was requested to provide all long-term care underwriting guidelines, manuals and controls utilized during the experience period. The Company uses Univita a third-party administrator located in Eden Prairie, MN and their long term care insurance manual to conduct underwriting and determine risk selection. In addition, the Company supplements the Univita long-term care insurance manual with CNA Group Criteria Guidelines which includes additional underwriting requirements. The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation.

The following Manual and Guidelines were reviewed:

1. Univita Long-Term Care Insurance Underwriting Manual, version 8.0, dated January 2012, vol. I
2. CNA Group Criteria (eff. 4/1/14)
3. Quality Assurance for Underwriter (eff. 5/1/14)
4. Control and Audits
  - a. CNA Clinical QA Program (eff. 10/2012)
  - b. CNA Financial QA Program (eff. 10/2012)
  - c. Univita All Client Audit form – LTC Claims Audit form
  - d. Univita Claim Exam QA Program – Quality Assurance for Claim Exam

#### **B. Individual Long Term Care Policies Terminated (Comprehensive)**

The Company was requested to identify all individual long-term care insurance policies terminated during the experience period. The Company identified 521 long-term care comprehensive insurance policies terminated. A random sample of 35 terminated files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations and proper return of any unearned premium. No violations were noted.

#### **C. Individual Long Term Care Insurance Policies Terminated (Facility)**

The Company was requested to identify all individual long-term care insurance policies terminated during the experience period. The Company identified 155 long-term care facility insurance policies terminated during the period. A random sample of 20 terminated files was requested, received and reviewed. The files were reviewed to ensure

compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

#### **D. Group Long Term Care Insurance Policies Issued**

The Company was requested to provide a list of all group long-term care insurance policies issued during the experience period. The Company identified 61 group long-term care insurance policies issued during the period. A random sample of 5 group policy files was requested, received and reviewed. The policy files were reviewed to determine compliance to issuance statutes and regulations. No violations were noted.

#### **E. Group Long Term Care Insurance Policies Declined**

The Company was requested to provide a list of all group long-term care group certificates declined during the experience period. The Company identified 44 group long-term care insurance policies declined coverage during the period. A random sample of 10 files was requested, received and reviewed. All 10 group long-term care certificates files reviewed were declined for not meeting company standards of insurability for coverage. The policy files were reviewed to determine compliance to issuance statutes and regulations and to ensure declinations were not the result of any discriminatory underwriting practice. No violations were noted.

#### **F. Group Long Term Care Insurance Terminated (Comprehensive)**

The Company was requested to identify all group long-term care insurance certificates terminated during the experience period. The Company identified 90 group long-term care comprehensive insurance certificates terminated. A random sample of 20 files was

requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations and proper return of any unearned premium. The following violations were noted:

**16 Violations – 40 P.S. §991.1111**

- (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.
- (b) The department shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.
- (c) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.
- (d) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

Evidence that the required outline of coverage was provided could not be established in the 16 noted files.

**11 Violations – 31 Pa. Code §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 required shopper’s guide was provided to the prospective applicant could not be established in the 11 noted files.

## IX. CLAIMS & CLAIMS MANUALS

The Claims review consisted of 6 general segments.

- A. Claims Manual-LTC Individual & Group
- B. Individual Long Term Care Claims Paid
- C. Individual Long Term Care Claims Denied
- D. Group Long Term Care Claims Paid
- E. Group Long Term Care Claims Denied
- F. Request for Services Denied

### **A. Claim Manuals – Long Term Care**

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 claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Company provided the following Claim Manuals:

- **Claims Control Manuals:**
  - CNA Clinical QA Program
  - CNA Financial QA Program
  - Univita All Clients Audit Form
  - Univita Claims Exam QA Program
- **Individual:**
  - CNA Guidelines – ILTC Series, *pdf*
  - ILTC Claims Guidelines, *word*
  - Claims Paths – Various
  - Guideline & training Information – Various
  - Recertification – Various, *PowerPoint*
  - Intake Information
  - Various Misc. Items

- **Group:**
  - GLTC Group Various, *word*
  - GLTC Group Claims Guidelines – Various, *pdf*
  - Group Training – Various, *PowerPoint*
    - Intake
    - Recertification

## **B. Individual Long Term Care Insurance Claims Paid**

The Company was requested to provide a list of all long-term care insurance policy claims during the experience period. The Company identified a universe of 13,380 individual long-term care insurance claims paid during the period. A random sample of 100 claims paid was requested, received and reviewed. The claim paid files were reviewed for compliance with 31 Pa. Code, Chapter 146 and 40 P.S. §991.1111b, Long-Term Care Prompt Payment of Claims. The following violations were noted:

### **3 Violations - 31 Pa. Code §146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide a timely status letter in the 3 noted claims.

### **3 Violations – 40 P.S. §991.1111b(a)**

(a) Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and one of the following:

The Company failed to send a written notice acknowledging the date of receipt of the claim within 30 days for the 3 noted claim files.

### **C. Individual Long-Term Care Insurance Claims Denied**

The Company was requested to provide a list of all long-term care insurance claims denied during the experience period. The Company identified a universe of 2,583 individual long-term care insurance claims denied during the period. A random sample of 100 individual long-term care insurance claims denied was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and to ensure compliance with 31 Pa. Code, Chapter 146 and 40 P.S. §991.1111b, Long term Care Prompt Payment of Claims. The following violations were noted.

#### **7 Violations - 31 Pa. Code §146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The timely status letter(s) was not made available for review in the 7 noted claim files.

#### **3 Violations – 40 P.S. § 991.1111b(a)**

(a) Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and one of the following:

The written notice acknowledging the date of receipt of the claim within (30) days was not made available for review in the 3 noted files.

### **3 Violations - 40 P.S. §991.1111b(b)**

(b) Within thirty (30) business days after receipt of the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice the insurer is declining to pay all or part of a claim and the specific reason or reasons for denial.

The Company failed to send notice to insured within 30 days declining payment and specify reason for denial for the 3 noted claim files.

### **D. Group Long-Term Care Insurance Claims Paid**

The Company was requested to provide a list of all long-term care insurance policy claims during the experience period. The Company identified a universe of 651 group long-term care insurance claims paid during the period. A random sample of 50 group long-term care insurance claims paid was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146 and 40 P.S. §991.1111b, Long-Term Care Prompt Payment of Claims. The following violations were noted:

### **3 Violations - 31 Pa. Code §146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide a timely status letter in the 3 noted claim files.

### **1 Violation – 40 P.S. §991.1111b(a)**

(a) Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim

or send a written notice acknowledging the date of receipt of the claim and one of the following:

The Company failed to send a written notice acknowledging the date of receipt of the claim within (30) days in the noted file.

### **E. Group Long-Term Care Insurance Claims Denied**

The Company was requested to provide a list of all long-term care insurance claims denied during the experience period. The Company identified a universe of 89 group long-term care insurance claims denied during the period. A random sample of 50 claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and to ensure compliance with 31 Pa. Code, Chapter 146 and 40 P.S. §991.1111b, Long-Term Care Prompt Payment of Claims. The following violations were noted.

#### **6 Violations - 31 Pa. Code §146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide a timely status letter in the 6 noted claims files.

#### **5 Violations – 40 P.S. § 991.1111b(a)**

(a) Within thirty (30) after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or

send a written notice acknowledging the date of receipt of the claim and one of the following:

The written notice acknowledging the date of receipt of the claim within (30) days was not made available for review in the 5 noted files.

**5 Violations – 40 P.S. § 991.1111b(b)**

(b) Within thirty (30) business days after receipt of the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice the insurer is declining to pay all or part of a claim and the specific reason or reasons for denial.

The Company failed to send notice to insured within 30 days declining payment and specify reason for denial for the 5 noted claim files.

**F. Request for Long-Term Care Insurance Services Denied (Policy Inquires)**

The Company was requested to provide a list of all requests for long-term care insurance services denied during the experience period. The Company identified a universe of 41 requests for long-term care insurance services denied during the period. All 41 files were requested and received. A total of 22 files were reviewed to ensure the Company was adhering to the provisions of the policy contract and to ensure compliance with 31 Pa. Code, Chapter 89a; 40 P.S. §991.1111a, Long Term Care and 40 P.S. §1171.5 The Unfair Insurance Practices Act. The following violations were noted.

**6 Violations - 40 P.S. §991.1111a(c)**

(c) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within one hundred twenty (120) calendar days after the insured and the insured's authorized representative, in applicable, received

the insurer's benefit determination notice. The correct one hundred twenty (120) days information regarding the internal appeal process was not provided to the insured in 5 of the 6 noted files. The remaining file did not include any language.

**Department Note:** The violations for not meeting the standards for a benefit trigger (31 Pa. Code §89a.124) were removed for the policies issued prior to March 16, 2002. However, the Department agrees with the Company in that the claim files must be reopened and further investigated for possible benefit eligibility related to having met the standards for a benefit trigger. The Company likewise agreed to contact the Department with the final disposition of these claim reviews, any amounts found eligible and paid, including any interest due.

## **X. 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 internal control procedures to ensure compliance with 31 Pa Code, Chapter 89a., Long Term Care Insurance Model Regulation.
2. The Company must review and revise internal control procedures to ensure compliance with 31 Pa Code, Chapter 146, Unfair Claims Settlement Practices.
3. The Company must review and revise Licensing procedures to ensure compliance with Sections 641.1-A and 671-A of the Insurance Department Act of 1921 (40 P.S. §§310.41a and 310.71).
4. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §991.1111, Long-Term Care.

## **XI. COMPANY RESPONSE**



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December 7, 2015

Ms. Constance Arnold  
Director, Bureau of Market Actions  
Pennsylvania Insurance Department  
1321 Strawberry Square  
Harrisburg, PA 17120

**RE: Market Conduct Examination of Continental Casualty  
Company (NAIC # 20443)**

Dear Ms. Arnold:

Continental Casualty Company (Company) is in receipt of your letter of November 5, 2015, and the Pennsylvania Insurance Department's Report of Examination (Report) for Warrant Number 15-M21-005 covering the Company's long term care insurance business for the period January 1, 2014, through December 31, 2014. We appreciate the opportunity to respond to the Report and its findings and recommendations.

The Company is committed to being in compliance with all applicable laws and regulations relating to operations in Pennsylvania. The Company is also fully committed to its long term care business and its contractual obligations to its policyholders. As such, we are encouraged that the Report noted no violations in connection with the Company's obligations relating to advertising, policy forms, underwriting guidelines, individual policy terminations, group policy declinations, and claim manuals.

The Company acknowledges that the Report and recommendations identified areas for improvement, such as the timeliness of certain aspects of claim processing, including required status letters. To that end, the Company has worked diligently over the past couple of years to improve timeliness and customer service through the modification and enhancement of various procedures, as well as increasing staff and resources. Through these continuing efforts, we have seen significant improvement in various claim-related timeliness metrics from the beginning of the period examined to the present. For example, from January 2014 through October 2015, metrics maintained by the Company reflect that the average turnaround time from the initial notice of claim to claim decision has improved by more than 40%, while the average turnaround time for the recertification of claims has improved by almost 90%. Further, as noted in the report, the Company also acknowledges that it is

reviewing five claim files for possible benefit eligibility and will provide information regarding this review under separate cover.

In addition, the Company acknowledges that the Report identified what we believe to be certain isolated instances of noncompliance, such as untimely producer terminations and incorrect appeal language. Along those lines, the Company also acknowledges and appreciates that the Report did not find that any instances of noncompliance rose to the level of a "business practice". Regardless, the Company remains committed and focused on ensuring that appropriate actions are taken to confirm compliance with the issues identified in the Report.

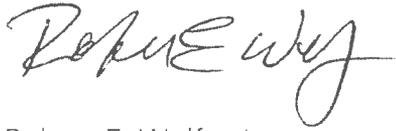
The Company does wish to note, however, that more than 30% of the violations found in the Report pertain to an alleged lack of documentation evidencing that the Company sent the NAIC Shoppers Guide and Outline of Coverage, as required by 31 Pa. Code Section 89a.127 and 40 P.S. Section 991.1111, respectively. As discussed during the examination, the Company respectfully disagrees that it failed to provide these required documents to its policyholders at the time of application or enrollment. Although these particular policy files do not include documentary evidence of delivery, the Company had well-established processes in place during the exam period regarding the creation and mailing of "enrollment kits" to prospective insureds, which ensured that the Shopper's Guide and Outline of Coverage were delivered.

According to our process, an enrollment kit was created for each employer group account sold and the entire kit was mailed upon the request of each potential applicant. The enrollment kit for every group included the application, Shoppers Guide, the Outline of Coverage and policy brochures, as well as any other required forms, disclosures and worksheets. Thus, while these individual policy files may lack proof of mailing of the Shoppers Guide and Outline of Coverage to that individual applicant, the Company's process was designed such that an insured could not have received an application other than as part of his or her receipt of an entire enrollment kit – which included such documents. As a result, we are confident that all insureds enrolled in our group plans received a Shoppers Guide and Outline of Coverage. Additionally, it is worth noting that new enrollment into group accounts will be closing in early 2016, at which time there will no longer be a need to send such documents.

In closing, the Company appreciates the opportunity to respond to the Report and would like to thank the Department's staff for its assistance and cooperation throughout the examination. In determining the appropriate resolution of the examination, we would respectfully request that the Department take into account the significant improvements in claim processing timeliness and customer service since the beginning of the exam period, the lack of "business practice" findings in the Report and the Company's position that insureds suffered no harm with respect to the Shopper's Guide and Outline of Coverage issues.

Should the Department have any questions or needs any additional information, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert E. Wolfe, Jr." in a cursive style.

Robert E. Wolfe, Jr.