COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT EXAMINATION REPORT

OF

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
NAIC # 76325
Carmel, IN

As of: April 24, 2019
Issued: April 25, 2019

BUREAU OF HEALTH MARKET CONDUCT

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).

Sarah L Bridendall, CFE, CISA, CIE, ALMI, AMCM, ACS, CICSR, AIRC, CCP, MHP, HCAFA, FAHM
Examiner-in-Charge

Sworn to and Subscribed Before me
This 25th Day of April, [2019]

Notary Public

Daniel W Homan
Notary Public - Seal
State of Indiana
Hamilton County
My Commission Expires 03/04/2027
Commission No. NP0718959

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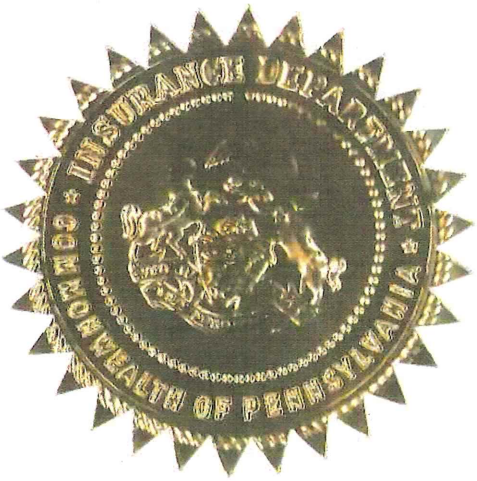
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 28th day of March, 2018, 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.



Jessica K. Altman
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	VIOLATIONS:
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA 550 Congressional Blvd. Ste 200 Carmel, IN 46032	: 40 P.S. § 323.3(a) : 40 P.S. § 323.4(b) : 40 P.S. § 991.1111b : 31 Pa. Code § 146.3 : 31 Pa. Code § 146.6 : 31 Pa. Code § 146.7
Respondent.	Docket No.: MC19-04-020

CONSENT ORDER

And now, this 16th day of May, 2019, 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 into 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 Senior Health Insurance Company of Pennsylvania, and maintains its address at 550 Congressional Blvd. Ste 200, Carmel, IN 46032.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from July 1, 2017 through September 25, 2018.

(c) On April 25, 2019, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent to the Insurance Department on May 10, 2019.

(e) The Examination Report notes violations of the following:

(i) 40 P.S. § 323.3(a) 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 ascertain whether the company has complied with the laws of this Commonwealth;

(ii) 40 P.S. § 323.4(b) requires every company or person from whom information is sought, its officers, directors and agents must provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other

recordings relating to the property, assets, business and affairs of the company being examined;

(iii) 40 P.S. § 991.1111b requires that within 30 business days after receipt of a clean claim, the Company shall pay such claim or send a written notice acknowledging the date of receipt of the claim and either notice that the Company is declining to pay all or part of the claim, and the speicifc reasons for denial, or that additional information is necessary to determine if the claim is payable;

(iv) 31 Pa. Code § 146.3 states that the claim files of the insurer shall be subject to examination by the Commissioner or by 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;

(v) 31 Pa. Code § 146.6 states that if an investigation cannot be completed within thirty (30) days, every forty-five (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;

(vi) 31 Pa. Code § 146.7 requires that within 15 working days after receipt by the insurer of a 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

4. 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. § 991.1111b are punishable under 40 P. S. § 991.1114, which states that 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.

(c) Respondent's violations of 31 Pa. Code §§ 146.3, 146.6, and 146.7 are punishable under 40 P.S. § 1171.9 by an order to cease and desist or license suspension or revocation; under 40 P.S. § 1171.10 by an injunction; and under 40 P.S. § 1171.11 by 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 $5,000 for each violation but not to exceed an aggregate penalty of $50,000 in any six-month period.

(ii) For each method of competition, act or practice which the company did not know or reasonably should have known was in violation of the law, a penalty of not more than $1,000 for each violation but not to exceed an aggregate penalty of $10,000 in any six-month period.

ORDER

5. 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 30 days of the date of this Order.

(c) Respondent shall comply with all recommendations contained in the Examination Report.

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, the Insurance Department 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 Insurance 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 Insurance 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 context 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: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Respondent

President / Vice President

Secretary / Treasurer

COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

This Market Conduct Examination was conducted on Senior Health Insurance Company of Pennsylvania ("SHIP"), hereafter referred to as "Company." The Company's corporate headquarters are located at 550 Congressional Blvd., Suite #200, Carmel, IN 46032. The examination reviews were conducted in the Company's offices and off-site locations during the period September 2018 through December 2018.

Pennsylvania Market Conduct Examination Reports generally note the items that have been reviewed and if a violation of law or regulation exists. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Examination Report may result in imposition of penalties. This Examination Report also includes 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. Summaries issued to the Company throughout the examination process are included in this Examination Report.

It is also noted that certain areas subject to examination are and will continue to be the focus of ongoing compliance emphasis by the Department. Throughout the course of the examination, Company officials were provided status memoranda, which referred to specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations and written summaries were provided to the Company on violations found.

The courtesy and cooperation extended by the Officers and employees of the Company during the conduct of the examination is acknowledged.

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

Constance Arnold, MCM,
Director, Bureau of Market Actions
Pennsylvania Insurance Department

Katie Dzurec, MCM,
Acting Director, Bureau of Health Market Conduct &
Senior Advisor to the Insurance Commissioner
Pennsylvania Insurance Department

Robert Panah, CFE, CISA, MCM, FLMI
President, Assurity Resources, Inc.

Sarah L Bridendall, CFE, CISA, CIE, ALMI, AMCM,
ACS, CICSR, AIRC, CCP, HCAFA, MHP, FAHM
Examiner-in-Charge, Assurity Resources, Inc.

Raymond K. Conover, AIE, ARe, FLMI, MCM
Sr. Market Conduct Examiner, Assurity Resources, Inc.

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 of 1921 and covered the experience period of July 1, 2017 through September 25, 2018 ("Experience Period") unless otherwise noted. The purpose of the examination was to determine compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's policies and procedures in the areas of complaints and claims handling for the Company's sole line of business, long-term care.

Examiners requested that the Company identify the universe of open, paid, and claims closed without payment for the long-term care segment. Files reviewed for examination were selected using random sampling based on the universe identified by the Company.

All reviews conducted throughout the examination included consideration of Company responses to examiner requests pursuant to 40 P.S. §§ 323.3 and 323.4.

III. COMPANY HISTORY AND LICENSING

The Company was originally formed in the Commonwealth of Pennsylvania on July 5, 1887, as a Society for beneficial purposes under the Act of April 29, 1874, as the Home Beneficial Society.

Through Articles of Agreement filed with the Secretary of the Commonwealth of Pennsylvania on December 1, 1964, the Company reincorporated as a stock limited life insurance company under 15 Pa. C.S. § 1911 and was authorized by the Department pursuant to 40 P.S. § 382 for the purposes of making insurance upon the health of individuals and against personal injury and disablement and against death resulting from natural and accidental causes, including endowment insurance in such amounts and upon such condition as is now or hereafter may be provided by law in the case of limited life insurance companies.

The Company was then known as Signal Life Insurance Company, and later as Penn Treaty Life Insurance Company. On June 10, 1976, the Company changed its name to American Travellers Life Insurance Company (ATLIC). In January 1977, the Company was acquired by Great Valley Investors, Inc., a Pennsylvania corporation. In November 1985, Great Valley Investors changed its name to American Travellers Corporation (ATC). On May 12, 1995, ATLIC purchased a subsidiary, the American Accident & Health Insurance Company, from Arista Insurance Company. The name of this subsidiary was subsequently changed to American Travelers Insurance Company of New York and eventually to Conseco Life Insurance Company of New York.

In December 1996, the Company's former direct parent, ATC, was purchased and merged into Conseco, Inc. ("Conseco"). In 1996, the Company was a wholly-owned subsidiary of CIHC, Inc. ("CIHC"), was a wholly-owned subsidiary of Conseco.

In 1997, Conseco reorganized its holding company structure with ATLIC becoming a wholly-owned subsidiary of Jefferson National Life Insurance Company of Texas, a wholly-owned subsidiary of CIHC.

ATLIC acquired Continental Life Insurance Company. Effective May 30, 1997, Transport Life Insurance Company was merged into and with the Company with the Company being the surviving company.

In October 1998, the name of the Company was changed from American Travelers Life Insurance Company to Conseco Senior Health Insurance Company ("CSHI").

As of August 1999, the Company was authorized to transact those classes of insurance as described in 40 P.S. § 382(a)(1) Life and Annuities and (a)(2) Accident and Health. This was a change from a limited life company to (standard) current powers of a life company.

On December 17, 2002, Conseco and CIHC filed voluntary petitions for reorganization under Chapter 11 of the United States Bankruptcy Code. The Company is a separate legal entity and was not included in the petitions. On September 10, 2003, upon consummation of the sixth

amended plan of reorganization, Conseco and CIHC emerged from bankruptcy as CNO Financial Group ("CNO").

The Company ceased sales and went into run-off during 2003.

Effective October 10, 2008, CSHI changed its name to Senior Health Insurance Company of Pennsylvania ("SHIP"). Pursuant to the Separation Agreement effective November 12, 2008, SHIP became a stand-alone company operated by Senior Health Care Oversight Trust ("Oversight Trust"). All the issued and outstanding shares of CSHI that had been held by Conseco were acquired by the Oversight Trust along with aggregate capital contributions of $175,000,000 to SHIP and the Oversight Trust. The purpose of the Oversight Trust is to enable the Company to service policyholders without distraction of a profit motive while the Company runs off its long-term care book of business. The Company's non-long-term care book of business was assigned to Conseco Life Insurance Company ("CLIC") pursuant to an Assignment Agreement and secured by a Trust Agreement, both of which were approved by the Indiana Department of Insurance.

On November 12, 2008, the Department issued an order approving the transfer of the ownership of the Company from the subsidiaries of Conseco to the Oversight Trust. Both the Company and the Oversight Trust operate for the exclusive benefit of the policyholders and with a solvency motive rather than a profit motive. The Oversight Trust is a business trust organized under the laws of the Commonwealth of Pennsylvania and is governed by a Board of Trustees. Concurrent with the transfer of the Company's stock to the Oversight Trust, Conseco and its subsidiaries contributed $164,000,000 of capital to the Company. Of this contribution, $125,000,000 was in the form of a Conseco Senior Note. This note was paid in full on March 30, 2012.

Fuzion Analytics, Inc. ("Fuzion") was formed in 2012 to provide long-term care insurance data mining and analytical services to the Company and other long-term care carriers. Effective July 1, 2012 the Company was a party to three intercompany agreements with Fuzion: Software Subscription Agreement, Consulting and Professional Services Agreement and an Administrative Services Agreement. All three intercompany agreements were approved by the Department and determined to meet the fair and reasonable standards in 40 P.S. § 991.1405(a)(1). The Administrative Services Agreement between the Company and Fuzion was terminated effective March 1, 2014 in connection with the execution of a Management Services Agreement between the Company and Fuzion.

Effective December 31, 2013, the Company transferred its employees and physical assets to Fuzion and executed a Management Services Agreement under which Fuzion provides comprehensive management services to the Company. Effective March 1, 2016, through an amendment to the Company's existing third-party administration agreement with Long Term Care Group ("LTCG"), Fuzion assumed responsibility for the management of the Company's closed block of long-term care insurance business. LTCG remained the TPA.

During 2013, the Company served as a TPA for certain closed blocks of long-term care business controlled by CNO. There were approximately 10,000 policies under administration at December 31, 2013. This TPA arrangement between the Company and CNO was terminated in February of

2014, pursuant to the ceding of this business by CNO to Beechwood Re ("Beechwood"). Simultaneous with the CNO reinsurance transaction, Fuzion assumed management of these closed blocks under a management agreement with Beechwood. This agreement was terminated in 2016.

The Company is currently authorized to transact those classes of insurance described in 40 P.S. § 382(a)(1) Life and Annuities and (a)(2) Accident and Health. The Company has continued to renew business and service existing policyholders as it runs off its long-term care book of business.

The Company is licensed to transact insurance business in the District of Columbia, the U.S. Virgin Islands and all states of the United States except: Connecticut, New York, Rhode Island and Vermont. As reported in the filed 2017 Annual Statement, there were approximately 54,781 individual policies and 1,536 group certificates in force as of December 31, 2017. Premium distribution by state is approximately 13% for Pennsylvania, 9% for Texas, Florida and California, and 6% for Illinois. No other state's premiums comprise 5% or more of total premiums.

IV. COMPANY OPERATIONS AND MANAGEMENT

Examiners requested documentation relating to company operations and management, including third-party agreements and monitoring, and examinations. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review.

A. Third-Party Agreements

Effective March 1, 2016, Fuzion and LTCG are parties to a Master Services Agreement ("Agreement") under which LTCG provides third-party administrator services for premium and claims handling for the Company's closed block of long-term care business. Examiners requested a copy of the Agreement and its Amendments.

In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with contract terms and agreed-upon service levels. The Company has relied upon Service Organization Control reports issued by third parties on the operations of LTCG without conducting its own onsite inspections or internal audits.

B. Contracted-Entity Activity Monitoring

Examiners requested documentation demonstrating the Company adequately monitored the activities of LTCG, the sole entity that contractually assumed a business function or acted on behalf of the Company during the Experience Period.

Between January 2018 and July 2018, the Company experienced an increase in new claims and unprocessed claims. LTCG attributed the increase in unprocessed claims to problems associated with the implementation of system upgrades and training of customer service representatives. The Company responded with more frequent monitoring of inventory levels and implemented a plan with LTCG to reduce the inventory of claims. The inventory of claims returned to normal levels by the end of August 2018. No violations were noted.

C. Examination Request Responses

Examiners requested documentation demonstrating the Company recognized it was required to respond to requests from the examiners in a timely manner. The Company was given latitude on the timeliness of responses and did their best to respond to record requests in a timely manner in compliance with applicable state laws and regulations, including 40 P.S. §§ 323.3 and 323.4. Examiners followed guidelines set forth in Chapter 16, Section A, Standard 9 of the *NAIC Market Regulation Handbook*. The Company provided examiners partial claim files or permitted viewing capability for a limited duration in the presence of Company and LTCG staff, which created

examination delays. The associated violation is noted in the Data Integrity section of this Examination Report.

D. External Examinations

Examiners reviewed all market conduct Examination Reports of the Company that were issued within the preceding five years for fines, penalties and recommendations. No violations were noted.

V. CONSUMER COMPLAINTS

Examiners requested documentation relating to consumer complaints. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to determine compliance with 40 P.S. §§ 991.1101 et seq. and 1171.5, as well as 31 Pa. Code Ch. 146.

A. Complaint Logs

Examiners requested all consumer complaints received during the Experience Period, as well as copies of consumer complaint logs for 2015, 2016, and 2017. The Company identified 71 consumer complaints received during the Experience Period. Of the 71 complaints identified, 25 complaints were forwarded to the Company from the Department. The Company provided 30 sample complaint file documents. The complaint files and the complaint logs were reviewed for compliance with 40 P.S. §1171.5(a)(11). Written complaint files involving claims were also reviewed to ensure compliance with state laws and regulations applicable during the experience period using the guidelines set forth in Chapter 16, Section B, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Complaint Handling Procedures

Examiners requested documentation demonstrating the Company had adequate complaint handling procedures in place and communicated such procedures to policyholders. The Company identified a universe of one process narrative document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with state laws and regulations applicable during the experience period using the guidelines set forth in Chapter 16, Section B, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Complaint Resolution and Disposal

Examiners requested documentation demonstrating the Company took adequate steps to finalize and resolve consumer complaints in accordance with contract language and state laws and regulations applicable during the experience period. The Company identified a universe of 71 consumer complaints. A random sample of 30 complaint files was requested. The documents were reviewed to ensure compliance with state laws and regulations applicable during the experience period using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Complaint Response Time

Examiners requested documentation demonstrating whether the timeframe within which the Company responded to complaints during the experience period was in accordance with applicable state laws and regulations. The Company identified a universe of 71 consumer complaints. A random sample of 30 complaint files was requested. The documents were reviewed to ensure compliance with state laws and regulations applicable during the experience period using the

guidelines set forth in Chapter 16, Section B, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Definition of Complaint

Examiners requested documentation regarding complaint handling policies, including the Company's definition of what constitutes a complaint. The Company provided a universe of one process document which included a definition of a complaint. The Company's definition was consistent with 40 P.S. § 1171.5(a)(11) and in compliance with state laws and regulations applicable during the experience period. No violations were noted.

F. Complaint Summaries

Examiners requested documentation relating to the supervisory review process for consumer complaints and a narrative describing complaint reports and summaries prepared on a recurring basis. The Company identified a universe of one narrative and six periodic reports. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with state laws and regulations applicable during the experience period. No violations were noted.

VI. CLAIMS PROCEDURES

Examiners requested documentation relating to claims procedures. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documentation in this section was reviewed to ensure compliance with 40 P.S. §§ 991.1101 et seq. and 1171.5, as well as 31 Pa. Code Ch. 146.

A. Claimant Initial Contact

Examiners requested documentation demonstrating whether the Company had a policy in place regarding initial contact with the claimant within the required statutory timeframe. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including those listed above and 31 Pa. Code § 146.5, using the guidelines set forth in Chapter 16, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Investigations

Examiners requested documentation demonstrating the Company had policies in place requiring the timely investigation of claims. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including those listed above and 31 Pa. Code § 146.6, using the guidelines set forth in Chapter 16, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Timely Claims Resolution

Examiners requested documentation demonstrating the Company had policies in place requiring the timely resolution of claims. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including those listed above and 31 Pa. Code § 146.7, using the guidelines set forth in Chapter 16, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Claims Handling

Examiners requested a description of how claims were handled during the experience period from the date received through closure, including compliance with timeliness requirements. Examiners also requested policies demonstrating that claims were handled in accordance with policy provisions and state laws and regulations applicable during the experience period. The Company identified a universe of 21 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations

using the guidelines set forth in Chapter 16, Section G, Standard 6 and Chapter 22, Section H, Standard 1 of the *NAIC Market Regulation Handbook.* No violations were noted.

E. Cancelled Benefit Checks

Examiners requested documentation demonstrating the Company had policies in place for handling cancelled benefit checks and drafts. The Company was unable to provide process documents indicating the method of updating the claims system with the status of claims disbursements. Examiners reviewed images of claim disbursement checks for timely issuance, correct amount, correct payee, and proper endorsement. In accordance with the requirements of the examination, the claim disbursement checks were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 10 of the *NAIC Market Regulation Handbook.* No violations were noted.

F. Denied and Closed-without-Payment Claims

Examiners requested documentation demonstrating that claims that were denied or closed-without-payment were done so in accordance with policy provisions and state laws and regulations. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Claims Closing Practices

Examiners requested policies demonstrating that claims handling practices did not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than was due under the policy during the experience period. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to determine compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 11 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Open Claims

Examiners requested a list of claims received that were open and in the process of determining benefit eligibility. The Company identified a population of 18 open claims (18 individual and 0 group claims) as of the close of the experience period, September 25, 2018. A random sample of 10 claims was reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

I. Paid Claims

Examiners requested a list of claims received and paid during the experience period. The Company identified 453 long-term care claims paid (451 individual and two group claims). A random sample of 60 claims was reviewed for compliance with applicable state laws and regulations. The following violations were noted:

5 Violations – 40 P.S. § 991.1111b
Within 30 business days after receipt of a clean claim, the Company shall pay the claim. Review indicated the Company underpaid benefits in five cases.

8 Violations – 31 Pa. Code § 146.3
The claim files of an insurer shall be subject to examination by the Commissioner or her appointed designees. Eight claims were missing pertinent information related to the processing of the respective claims.

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 for the noted claim.

J. Claims Closed without Payment

Examiners requested a list of claims closed without payment during the experience period. The Company identified 146 long-term care claims closed without payment (145 individual and one group claims). A random sample of 30 claims was reviewed to ensure compliance with state laws and regulations applicable during the experience period. The following violations were noted:

1 Violation – 40 P.S. § 991.1111b
Within 30 business days after receipt of a clean claim, the Company shall pay the claim.

AND

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 for the noted claim.

4 Violations – 31 Pa. Code § 146.7
Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days for the noted claims.

VII. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary data call in accordance with National Association of Insurance Commissioners uniformity standards. The purpose of the data call was to provide certain basic examination information, identify preliminary requirements, and to provide specific requirements for requested data elements. Once the Company provided all requested information and data contained within the data call, examiners reviewed and validated the data to ensure accuracy and completeness, and to determine compliance with the Insurance Department Act of 1921, Section 904 (40 P.S. §323). Two data integrity issues were found during the examination. The data integrity issues from each area of review are identified below.

Data Submissions to the PID During the Course of the Examination

Situation: Examiners requested the Master Services Agreement ("Agreement") under which LTCG provides third-party administrator services for premium and claims handling for the Company's closed block of long-term care business.

Finding: The Company was unable to produce a complete copy of the Agreement and omitted certain amendments from the copy provided to examiners.

Situation two: Examiners requested documentation demonstrating the Company recognized it was required to respond to requests from the examiners in a timely manner.

Finding: The Company provided examiners partial claim files or permitted viewing capability for a limited duration in the presence of Company and LTCG staff, which created examination delays.

The following violation was noted:

General Violation – 40 P.S. §§ 323.3(a) and 323.4(b)

Every company or person from whom information is sought must provide the examiners timely, convenient, and free access to all books, records, accounts, papers, documents and any and all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

VIII. RECOMMENDATIONS

The recommendations 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 Examination Report.

1. The Company must review and revise internal control procedures to ensure compliance with claims handling requirements, so that the violations relating to claim acknowledgement, status letters, acceptance or denials, and payments as noted in the Examination Report, do not occur in the future.

2. The Company must provide convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings related to claims handling and processing. Further, the Company must implement procedures to ensure compliance with the requirements of 31 Pa. Code § 146.3 to maintain complete claim files and documentation such that claim files contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

3. The Company must ensure LTCG representatives are trained to fully disclose to first-party claimants the benefits, coverages, alternative plans of care, or other provisions of the insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim.

Additional concerns noted during the examination process are as follows:

1. The Company should maintain a complete copy of the Service Agreement with LTCG in its files.

2. The Company should conduct its own on-site inspections of LTCG's operations over its business at an annual or bi-annual basis.

3. The Company should continue with the current, weekly monitoring of inventory levels and work with LTCG to proactively address changes to service levels as a result of any prospective system or staffing changes. The Company should proactively advise the Insurance Department of significant service level failures.

4. The Company should develop and implement a policy to update the claims system with the status of claims disbursements in a timely manner.

IX. COMPANY RESPONSE

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

May 10, 2019

Via e-mail and Overnight Delivery

Katie Dzurec, Acting Director
Health Market Conduct Bureau
Pennsylvania Department of Insurance
1326 Strawberry Square
Harrisburg, PA 17120

RE: Report on Market Conduct Examination of Senior Health Insurance Company of Pennsylvania
NAIC #76325
Examination Warrant Number: 18-M41-015

Dear Ms. Dzurec:

On behalf of Senior Health Insurance Company of Pennsylvania ("SHIP") and pursuant to 40 P.S. §323.5, we respectfully acknowledge receipt of and hereby submit our response to the Pennsylvania Insurance Department's ("Department's") Report of Examination for the period July 1, 2017 through September 25, 2018 ("Report").

SHIP takes its responsibility to comply with all applicable regulatory and statutory requirements in each state in which it is licensed to do business very seriously. Recognizing that our obligations under the law are continually evolving, we are committed to continued process and procedural improvements to ensure our ongoing regulatory compliance.

We reviewed the Department's findings and recommended corrective measures in the Report regarding claims handling, access to and maintenance of complete claim files and documentation, and staff training for those persons employed by our contracted third-party administrator ("TPA") regarding policy provisions pertinent to a claim. While we are pleased the limited findings in the Report underscore the success of the mechanisms currently in place to promptly and accurately adjudicate claims, we acknowledge the Department's recommendations. We wish to advise the Department that the five claims identified as underpaid due to inadvertent processing errors have already been reprocessed with adjustments.

With respect to certain concerns to SHIP's oversight of its TPA, SHIP has existing processes and procedures in place to facilitate compliance with applicable requirements under the law, including our maintenance onsite of a complete copy of the contract between SHIP and the TPA which was provided to the examiners. As a result of the Department's concerns, we are reviewing, revising, and reinforcing our processes and procedures in response to the concerns noted.

We wish to thank the Department for its insight throughout the course of the examination. Please contact me at (317) 566-7561 or by email at bstaldine@shipltc.com if you have any questions or concerns.

Sincerely,

Barry L. Staldine
President and Chief Executive Officer
Senior Health Insurance Company of Pennsylvania