



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**MARKET CONDUCT
EXAMINATION REPORT**

OF

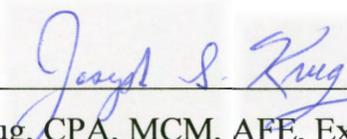
**METROPOLITAN LIFE
INSURANCE COMPANY
NEW YORK, NY**

**As of: February 1, 2016
Issued: March 25, 2016**

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

Verification

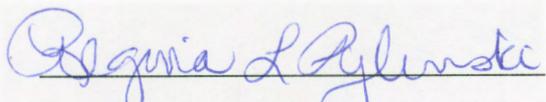
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



Joseph S. Krug, CPA, MCM, AFE, Examiner-In-Charge

Sworn to and Subscribed Before me

This 19th Day of January, 2016



Notary Public

REGINA L. PYLINSKI
Notary Public, State of New York
No. 01PY6301778
Qualified in Chenango County
Commission Expires June 9, 2018

METROPOLITAN LIFE INSURANCE COMPANY
TABLE OF CONTENTS

Order

<u>Section</u>		<u>Page</u>
I.	Introduction	3
II.	Scope of Examination	6
III.	Company History	7
IV.	Company Operations and Management	9
V.	Forms	10
VI.	Producer Licensing	11
VII.	Consumer Complaints	12
VIII.	Policy Inquiries	14
	A. Individual Long Term Care Policy Inquiries	14
	B. Group Long Term Care Policy Inquiries	15
IX.	Underwriting	16
	A. Individual Long Term Care Policies Terminated	16
	B. Group Long Term Care Policies Terminated	16
	C. Underwriting Manuals	17

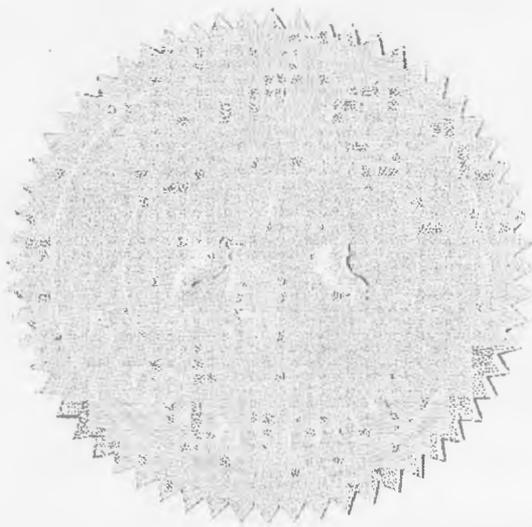
X.	Claims Manuals	18
XI.	Long Term Care Claims	19
A.	Individual Long Term Care Intake Claims Paid	19
B.	Individual Long Term Care Intake Claims Denied	21
C.	Individual Long Term Care Intake Claims Pended	23
D.	Group Long Term Care Intake Claims Paid	25
E.	Group Long Term Care Intake Claims Pended	25
F.	Individual Long Term Care Invoice Claims Paid	26
G.	Individual Long Term Care Invoice Claims Denied	27
H.	Individual Long Term Care Invoice Claims Pended	28
I.	Group Long Term Care Invoice Claims Paid	28
J.	Group Long Term Care Invoice Claims Denied	29
K.	Group Long Term Care Invoice Claims Pended	30
XII.	Marketing & Sales	31
XIII.	Recommendations	32
XIV.	Company Response	33

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 13th 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:
	:	
METROPOLITAN LIFE	:	40 P.S. §§991.1111a
INSURANCE COMPANY	:	991.1111a(5)(3)(i), 991.1111a(b)(2)
200 Park Avenue	:	991.1111a(c), 991.1111b(a)
New York, NY 10166	:	and 991.1111b(a)(2)
	:	
	:	31 Pa. Code §§146.5(b), 146.5(c)
	:	and 146.6
	:	
	:	
Respondent.	:	Docket No. MC16-02-004

CONSENT ORDER

AND NOW, this 25th day of March, 2016, 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 Metropolitan Life Insurance Company, and maintains its address at 200 Park Avenue, New York, NY 10166.
- (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 February 1, 2016, the Insurance Department issued a Market Conduct Examination Report to Respondent.

- (d) A response to the Examination Report was provided by Respondent on March 2, 2016.
- (e) The Examination Report notes violations of the following:
- (i) 40 P.S. §991.1111a, states benefit trigger determinations are subject to the right to an internal appeal and then to the right to an external independent review by an entity certified or approved by the Insurance Department to perform independent reviews of benefit trigger determinations. To comply with Act 51, each insurer is required to:
- For each determination on or after November 6, 2010, that the benefit trigger of an LTCI policy has not been met, provide written notice to the insured and the insured's authorized representative, if applicable. The notice must satisfy the requirements of Section 1111.1(b) of the Act.
 - Follow the internal appeal process specified in Section 1111.1(c), including providing a written description of the insured's right to request an independent review of the benefit determination.
 - If an insured or the insured's authorized representative requests an independent review of the insurer's benefit trigger determination, follow the external review process specified in Section 1111.1(d) of the Act.
 - All notices copied to the Department should be addressed to the Insurance Department, Bureau of Consumer Services, Long Term Care

Benefit Trigger Reviews, 1209 Strawberry Square, Harrisburg, PA
17120.

- (ii) 40 P.S. §991.1111a(5)(3)(i), states that within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization the insured or the insured's authorized representative has chosen from the list of certified approved organizations the insurer has provided to the insured.;
- (iii) 40 P.S. §991.1111a(b)(2), states if an insurer determines the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of the following: (2) The insured's right to internal appeal under subsection (c) and the right to submit new or additional information relating to the benefit trigger denial with the appeal request;
- (iv) 40 P.S. §991.1111a(c), 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), states (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:
- (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(a)(2), states 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: (2) additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary;
- (vii) 31 Pa. Code §146.5(b), states every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within fifteen (15) working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry;

- (viii) 31 Pa. Code §146.5(c), states an appropriate reply shall be made within ten (10) working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected;
- (ix) 31 Pa. Code §146.6, states that if an investigation cannot be completed within thirty (30) days, and 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.

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. §§991.1111a, 991.1111a(5)(3)(i), 991.1111a(b)(2), 991.1111a(c), 991.1111b(a) and 991.1111b(a)(2) 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.

- (c) Respondent's violations of 31 Pa. Code §§146.5(b), 146.5(c) and 146.6 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.

- (d) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 - 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:
 - (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
 - (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

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 Ninety Five Thousand Dollars (\$95,000.00) 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 Commonwealth of Pennsylvania. Payment should be directed to April Phelps, Bureau of Market Actions, 1227 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.

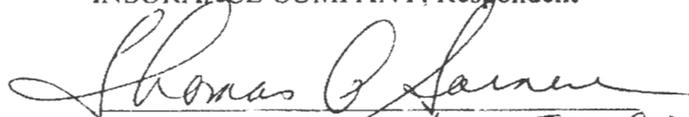
9. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

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.

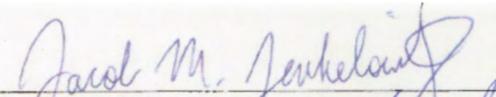
11. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

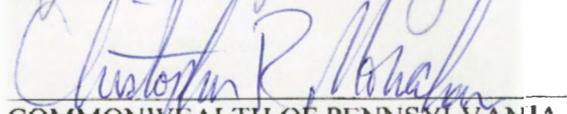
12. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: METROPOLITAN LIFE
INSURANCE COMPANY, Respondent



~~President~~ / Vice President LONG TERM CARE CLAIMS

st 
Secretary / Treasurer


COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Metropolitan Life Insurance Company; hereafter referred to as the “Company,” at the Company’s office located in Tampa, Florida the weeks of September 14, 2015, through September 24, 2015. The remainder of the examination was conducted off-site from September 25, 2015, through December 17, 2015.

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.

Debra L. Sweigard
Pennsylvania Insurance Department
Market Actions Division Chief

Monique Miller
Pennsylvania Insurance Department
Insurance Examiner

Lonnie Suggs, MCM
INS Regulatory Insurance Services
Senior Insurance Examiner

Joseph S. Krug, CPA, MCM, AFE
INS Regulatory Insurance Services
Senior Insurance Examiner
Examiner-in-Charge

Dan Stemcosky, MCM, FLMI, AIRC
INS Regulatory Insurance Services
Supervisory Insurance Examiner

PAGE INTENTIONALLY LEFT BLANK

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 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 market conduct activities for Long Term Care business in Pennsylvania in areas such as: Individual and Group Underwriting, Claims, Forms, Consumer Complaints and Policy Inquiries.

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 category of 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

The National Travelers Insurance Company was originally incorporated on May 4, 1866, in the State of New York. Its name was changed to Metropolitan Life Insurance Company on March 24, 1868.

The Company received its certificate of authority to operate in the Commonwealth of Pennsylvania on January 1, 1867. The Company is authorized to do business in all 50 states, the District of Columbia, Puerto Rico, Guam, Northern Mariana Islands, the U.S. Virgin Islands and Canada.

On January 6, 1915, Metropolitan Life mutualized, changing from a stock life insurance company owned by individuals to a mutual company operated for the benefit of its policyholders.

In 1990, the company changed its corporate signature from Metropolitan Life to the shorter MetLife.

On September 28, 1999, the MetLife Board of Directors adopted a plan for converting the organization from a mutual to a stock company. On November 24, 1999, MetLife announced that it had filed its demutualization plan with the New York State Superintendent of Insurance and on February 18, 2000, the Company's policyholders approved the plan to convert to a stock company.

As of its December 31, 2014, annual statement for Pennsylvania, the Company reported direct premium for accident and health insurance in the amount of \$303,794,788, direct premium for life insurance and annuity considerations in the amount of \$360,496,497, and direct premium for Long Term Care Insurance in the amount of \$27,266,076.

The Company reported that they are no longer selling Long Term Care Insurance. Individual business was closed to new entrants as of April 2011, and group business was closed as of December 31, 2012.

IV. COMPANY OPERATIONS AND MANAGEMENT

The Company was requested to provide information documenting its management and operational procedures in areas for which they conduct business for the Commonwealth of Pennsylvania. The following areas were reviewed:

- General Procedures and Company History
- Internal Audit and Compliance Procedures
- Controls of Computer Information
- Retention of Records
- Information: Collection, Use, & Disclosure (including Privacy of Personal Info)
- Licensed for Lines of Business

These areas were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations. No violations were noted.

V. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with 40 P.S. §477b and 18 Pa. C.S. §4117(k), Fraud notice. No violations were noted.

VI. PRODUCER LICENSING

The Company did not write any new business during the examination period, January 1, 2014, through December 31, 2014, therefore, there was no review of Producer Licensing conducted.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2013 and 2014. The Company identified 12 consumer complaints received during the experience period. All 12 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 complaint files and the 2 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with 31 Pa. Code §146.5(b)(c), 40 P.S. §991.111a et seq. and 40 P.S. §1171.5. The following violations were noted:

1 Violation – 31 Pa. Code §146.5(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. The company response to one Department complaint was untimely.

2 Violations - 40 P.S. §991.111a(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, if applicable, received the insurer's

benefit determination notice. The required one hundred twenty (120) days information regarding the internal appeal process was not provided to 2 claimants.

VIII. POLICY INQUIRIES

The Policy Inquiry review is comprised of individual and group policy inquiries and consists of 2 general segments.

A. Individual Long Term Care Policy Inquiries

B. Group Long Term Care Policy Inquiries

Each segment was reviewed for compliance with 31 Pa. Code, Chapter 89a; 40 P.S. §991.111a et seq. and 40 P.S. §1171.5.

A. Individual Long Term Care Policy Inquiries

The Company was requested to provide a list of all requests for individual long term care policy inquiries during the experience period. The Company identified a universe of 28 requests for individual long term care policy inquiries during the period. All 28 policy inquiry files were requested, received and reviewed. The files were to be reviewed to ensure that the Company was adhering to the provisions of the policy contract and to ensure compliance with 31 Pa. Code, Chapter 89a; 40 P.S. §991.111a et seq. and 40 P.S. §1171.5. The following violations were noted:

2 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 timely status letters in 2 noted claims.

B. Group Long Term Care Policy Inquiries

The Company was requested to provide a list of all group long term care policy inquiries during the experience period. The Company identified a universe of 13 group long term care policy inquiries during the period. All 13 policy inquiry files were requested, received and reviewed. The files were reviewed to ensure that 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 et seq. and 40 P.S. §1171.5. 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 timely status letters in 3 noted claims.

IX. UNDERWRITING

The Underwriting review is comprised of individual and group underwriting areas and consists of 3 general segments.

- A. Individual Long Term Care Policies Terminated**
- B. Group Long Term Care Policies Terminated**
- C. Underwriting Manuals**

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

A. Individual Long Term Care Policies Terminated

The Company was requested to identify all individual long term care insurance policies terminated during the experience period. The Company identified a universe of 279 individual long term care insurance policies terminated. A random sample of 40 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.

B. Group Long Term Care Policies Terminated

The Company was requested to identify all long term care insurance policies terminated during the experience period. The Company identified a universe of 123 group long term care insurance policies terminated. A random sample of 40 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. Underwriting (Manuals) Guidelines

The Company was requested to provide all underwriting manuals utilized during the experience period. The manuals were reviewed to ensure that the guidelines in place were being followed in a uniform and consistent manner and also that there were no underwriting practices or procedures in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. As previously stated, the Company did not write any new business during the experience period. No violations were noted.

The following Underwriting Manuals were provided and reviewed:

1. Non-Voluntary Cancellation – Individual
2. Non-Voluntary Cancellation – Group

X. CLAIM MANUALS

The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided a detailed 539 page claim manual that included claims procedures. 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.

XI. LONG TERM CARE CLAIMS

The review of Long Term Care Claims consisted of 11 general segments.

- A. Individual Long Term Care Intake Claims Paid**
- B. Individual Long Term Care Intake Claims Denied**
- C. Individual Long Term Care Intake Claims Pended**
- D. Group Long Term Care Intake Claims Paid**
- E. Group Long Term Care Intake Claims Pended**
- F. Individual Long Term Care Invoice Claims Paid**
- G. Individual Long Term Care Invoice Claims Denied**
- H. Individual Long Term Care Invoice Claims Pended**
- I. Group Long Term Care Invoice Claims Paid**
- J. Group Long Term Care Invoice Claims Denied**
- K. Group Long Term Care Invoice Claims Pended**

A. Individual Long Term Care Intake 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 78 individual long term care intake claims paid. A random sample of 40 claims paid was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. The following violations were noted:

1 Violation – 31 Pa. Code §146.5(c)

An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggests that a response is expected. The Company failed to reply to communications from one claimant in a timely manner.

25 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 thirty day (30) status letter for 25 noted claims.

16 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 forty five (45) day status letter for 16 noted claims.

2 Violations – 40 P.S. §991.1111a(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, if applicable, received the insurer's benefit determination notice. The correct one hundred twenty (120) days regarding the internal appeal process was not provided to 2 claimants.

1 Violation – 40 P.S. §991.1111b(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. The Company failed to provide a timely written acknowledgement of one noted claim.

B. Individual Long Term Care Intake Claims Denied

The Company was requested to provide a list of all individual long term care intake claims denied during the experience period. The Company identified a universe of 7 individual long term care intake claims denied. All 7 claims denied were requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a 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 Company failed to provide a thirty day (30) status for 7 noted claims.

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 forty five (45) day status letter for 3 noted claims.

1 Violation – 40 P.S. §991.1111a(b)(2)

If an insurer determines the benefit trigger of a long term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of the following: (2) The insured's right to internal appeal under subsection (c) and the right to submit new or additional information relating to the benefit trigger denial with the appeal request. The Company failed to provide the insured the right to an internal appeal in one claim.

5 Violations – 40 P.S. §991.1111a(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 regarding the internal appeal process was not provided to 5 claimants.

1 Violation – 40 P.S. §991.1111a(5)(3)(i)

Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization the insured or the insured's authorized representative has chosen from the list of certified approved organizations the insurer has provided to the insured.

The organizations that the Company provided to the insured were not certified and approved by the Department in one noted file.

C. Individual Long Term Care Intake Claims Pended

The Company was requested to provide a list of all individual long term care intake claims pended during the experience period. The Company identified a universe of 21 individual long term care intake claims pended during the period. A random sample of 10 claims pended was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. The following violations were noted:

2 Violations – 40 P.S. §991.1111a

Benefit trigger determinations are subject to the right to an internal appeal and then to the right to an external independent review by an entity certified or approved by the Insurance Department to perform independent reviews of benefit trigger determinations. To comply with Act 51, each insurer is required to:

- For each determination on or after November 6, 2010, that the benefit trigger of an LTCI policy has not been met, provide written notice to the insured and the insured's authorized representative, if applicable. The notice must satisfy the requirements of section 1111.1(b) of the act.
- Follow the internal appeal process specified in section 1111.1(c), including providing a written description of the insured's right to request an independent review of the benefit determination.
- If an insured or the insured's authorized representative requests an independent review of the insurer's benefit trigger determination, follow the external review process specified in section 1111.1(d) of the act.
- All notices copied to the Department should be addressed to the Insurance Department, Bureau of Consumer Services, Long Term Care Benefit Trigger Reviews, 1209 Strawberry Square, Harrisburg, PA 17120.

A clear, written notice to the insured and the insured's authorized representative was not made available for review in the 2 noted claim files. The claim files did not show proof that the insurer provided the insured with internal appeal and external independent review.

3 Violations – 40 P.S. §991.1111b(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: (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. The Company failed to send a written notice acknowledging the date of receipt of the claim within thirty (30) business days for 3 noted claims.

4 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 4 noted claims.

3 Violations - 40 P.S. §991.1111a(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 one hundred twenty (120) days information regarding the internal appeal process was not provided to the insured in 3 noted claims.

D. Group Long Term Care Intake Claims Paid

The Company was requested to provide a list of all group long term care intake claims paid during the experience period. The Company identified a universe of 15 group long term care intake claims paid during the period. All 15 claims paid were requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. No violations were noted.

E. Group Long Term Care Intake Claims Pended

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 7 group long term care insurance intake claims pended during the period. All 7 claims pended were requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a 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 Company failed to provide a thirty day (30) status letter for 7 noted claims.

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 forty-five (45) day status letter for 3 noted claims.

1 Violation – 40 P.S. §991.1111b(a)(2)

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: (2) additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary. The Company failed to provide a timely written notice of additional information necessary to make a claim determination in one noted claim.

F. Individual Long Term Care Invoice 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 2,113 individual long term care invoice claims paid. A random sample of 50 claims paid was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. No violations were noted.

G. Individual Long Term Care Invoice Claims Denied

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 272 individual long term care insurance invoice claims denied during the period. A random sample of 50 claims denied was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. The following violations were noted:

1 Violation – 40 P.S. §991.1111b(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 insurer is declining to pay all or part of the claim and the specific reason for denial; or Additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary. The Company failed to pay the correct clean claim amount within (30) days in one noted claim.

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 one noted claim.

H. Individual Long Term Care Invoice Claims Pended

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 58 individual long term care insurance invoice claims pended during the period. A random sample of 20 individual long term care insurance invoice claims pended was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. The following violation was noted:

1 Violation – 40 P.S. §991.1111b(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 insurer is declining to pay all or part of the claim and the specific reason for denial; or Additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary. Payment of claim was not made within (30) days after receipt in one noted claim.

I. Group Long Term Care Insurance Invoice 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 867 group long term care insurance invoice claims paid during the period. A random sample of 40 claims paid was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. The following violation was noted:

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 one noted claim.

J. Group Long Term Care Insurance Invoice Claims Denied

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 60 group long term care insurance invoice claims denied during the period. A random sample of 25 claims denied was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. The following violations were noted:

1 Violation – 40 P.S. §991.1111b(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: (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. Payment of claim was not made within (30) days of receipt in one noted file.

1 Violation – 40 P.S. §991.1111b(a)

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 a written notice acknowledging the date of receipt of the claim within (30) days in one noted claim.

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 one noted claim.

K. Group Long Term Care Insurance Invoice Claims Pended

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 29 group long term care insurance invoice claims pended during the period. A random sample of 15 claims pended was requested, received and reviewed. The claim files were reviewed for compliance with 31 Pa. Code, Chapter 146, 40 P.S. §991.1111a and 40 P.S. §991.1111b, Long Term Care Prompt Payment of Claims. No violations were noted.

XII. MARKETING & SALES

The Company did not write any new business during the examination period, January 1, 2014, through December 31, 2014, therefore, there was no review of Marketing and Sales.

XIII. RECOMMENDATIONS

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

1. The Company must review and revise procedures to ensure compliance with 31 Pa. Code §146.5(b) related to the timely complaint response to the Department.
2. The Company must review and revise procedures to ensure compliance with 31 Pa. Code §146.5(c) regarding the timely response to the claimant.
3. The Company must review and revise procedures to ensure compliance with 31 Pa. Code §146.6 regarding the proper use of the 30 and 45 day status letters.
4. The Company must review and revise procedures to ensure compliance with 40 P.S. §991.1111a(c) related to the proper notification of the appeal process.
5. The Company must review and revise procedures to ensure compliance with 40 P.S. §991.1111a(b)(2) regarding the proper notification to the insured concerning the right to appeal.
6. The Company must review and revise procedures to ensure compliance with 40 P.S. §991.1111a(5)(3)(i) related to the certification and approval of an independent review organization.
7. The Company must review and revise procedures to ensure compliance with 40 P.S. §991.1111a regarding the proper written notification to the insured of their rights to an internal appeal and external independent review.
8. The Company must review and revise procedures to ensure compliance with 40 P.S. §991.1111b regarding the requirements for prompt payment of long term care claims.

XIV. COMPANY RESPONSE

Metropolitan Life Insurance Company
1095 Avenue of the Americas
New York, NY 10036
Tel 212-578-9032
ebreen@metlife.com

MetLife[®]

Eileen Breen, MCM, FLMI, AIRC
Director, Market Conduct Examinations
State Regulatory & Government Counsel

Via Electronic Mail and FedEx Overnight Mail

March 2, 2016

Debra L. Sweigard,
Division Chief, Life, Accident and Health Division
Bureau of Market Actions
Pennsylvania Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

RE: Metropolitan Life Insurance Company
Examination Warrant Number: 15-M21-018

Dear Ms. Sweigard:

Metropolitan Life Insurance Company (the "Company") has received your letter dated February 1, 2016 together with the Report of Examination of the Company (the "Report") covering the period January 1, 2014 through December 31, 2014. As you know, the Company participated actively in the examination and has provided additional information and responses to the initial findings. The Company appreciates the opportunity to respond further to the remaining findings and recommendations in the Report.

The Company's responses to specific findings are set forth in the enclosed Response, organized by section in the same order as the Report. The Company takes its obligation to comply with all applicable laws and regulatory authority seriously. The bulk of the violations identified in the Report were based on the Company's failure to provide written status letters and some letters that had incorrect time periods for internal appeal and incorrect or omitted information on the right to an external independent review after the internal appeal. The Company has acknowledged these violations, and has taken corrective action to ensure compliance with the Pennsylvania requirements, in accordance with the Report's recommendations.

With respect to written status letters, the Company previously acknowledged and provided status updates promptly and regularly but did so primarily by phone, documented in the claim file call logs, and not in writing. Prior to the exam, but after the period subject to the exam, the Company implemented corrective action to put in place procedures and training to send written status letters. The Company's claims staff has been trained on the enhanced procedure for sending written status letters within 30 days after receipt of a claim. Subsequent status letters are mailed within 30 calendar days from the date of the previous letter until a decision is made and a decision letter is mailed. The Company enhanced its computer system to provide staff with automatic reminders when the status letters are due based on when the initial claim was received and when previous status letters were mailed.

With respect to the time periods for internal appeal and the right to independent review after appeal, the Company has provided its staff with comprehensive training, reinforcing the right to an independent review by an approved independent review organization in Pennsylvania for an insured whose benefit eligibility is denied. The training included details of the required language to provide in adverse determination letters, as well as the timeframes for appeal by state. The Company also provided its staff with an updated resource document with specific language and timeframes for appeal by state. The Company has also implemented enhanced supervisor review of adverse determination letters to ensure compliance with these requirements, and is checking compliance through its quality assurance program.

While the Company acknowledged these findings and has taken corrective action to ensure compliance with the requirements, the Company strongly disagrees that these findings support alleged violations of the Unfair Insurance Practices Act, 40 P.S. § 1171.5. As discussed more fully in the attached Response, the actions cited in support of these violations do not constitute violations of the subsections relied upon by the Department, or were isolated incidents not constituting a business practice within the meaning of the statute. In particular, the Company disagrees that its detailed phone calls with insureds or their representatives, to acknowledge receipt and discuss status and details of a claim, was detrimental to insureds or amounted to a failure to acknowledge or act promptly with respect to claims. To the contrary, in-person phone calls are beneficial to both the claimants and the Company in explaining and understanding the claim process and the claimant's condition and circumstances.

We appreciate the opportunity to respond to the Report and would be pleased to address any questions you may have or to discuss the examination with the Department at your convenience.

Sincerely,

A handwritten signature in cursive script that reads "Eileen Breen". The signature is written in black ink and is positioned above the printed name.

Eileen Breen

MetLife Response to the Pennsylvania Insurance Department
Report of Examination of Metropolitan Life Insurance Company
Dated February 1, 2016

The following are the Company's responses to the specific findings and recommendations set forth in the Report. The responses are organized by section in the same order as the Report.

VII. CONSUMER COMPLAINTS

1 Violation – 31 Pa. Code § 146.5(b)

The Company response to one Department complaint was untimely.

Company Response:

The Company agrees with this finding.

2 Violations – 40 P.S. § 991.1111a(c)

The required 120 days information regarding the internal appeal process was not provided to 2 claimants.

Company Response:

The Company agrees with these findings and has taken corrective action to provide training and resources to staff to reinforce the state-specific timeframes for appeal.

VIII.A. INDIVIDUAL LONG-TERM CARE POLICY INQUIRIES

2 Violations – 31 Pa. Code § 146.6

The Company failed to provide timely status letters in the noted claims.

Company Response:

The Company agrees with these findings. The Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

VIII.B. GROUP LONG-TERM CARE POLICY INQUIRIES

3 Violations – 31 Pa. Code § 146.6

The Company failed to provide timely status letters in the noted claims.

Company Response:

The Company agrees with these findings. The Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

XI. LONG-TERM CARE CLAIMS

A. Individual Long-Term Care Intake Claims Paid

1 Violation – 31 Pa. Code § 146.5(c)

The Company failed to reply to communications from one claimant in a timely (10 working days) manner.

Company Response:

The Company agrees with this finding. The Company has procedures in place to respond promptly to policyholder communications and in this case the procedure was not followed. The Company has provided additional coaching to the associate involved.

25 Violations – 31 Pa. Code § 146.6

The Company failed to provide a written 30 day status letter for the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

16 Violations – 31 Pa. Code § 146.6

The Company failed to provide a written 45 day status letter for the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

2 Violations – 40 P.S. § 991.1111a(c)

The correct 120 days regarding the internal appeal process was not provided to 2 claimants.

Company Response:

The Company agrees with these findings and has taken corrective action to provide training and resources to staff to reinforce the state-specific timeframes for appeal.

1 Violation – 40 P.S. § 991.1111b(a)

The Company failed to provide a timely (30 days after receipt of claim) written acknowledgement of one noted claim.

Company Response:

The Company agrees with the finding related to the one noted claim.

29 Violations – 40 P.S. § 1171.5(a)(10)(ii)

The Company failed to acknowledge and act promptly upon written or oral communications for the noted claims with such frequency as to indicate a business practice constituting unfair claim settlement or compromise practices.

Company Response:

The Company respectfully disagrees that the findings support any alleged violation of § 40 P.S. 1171.5. As set forth in detail in its response to the Examiners, the Company acted promptly in communicating with insureds, acknowledging all communications and providing frequent verbal status updates, as documented in the claim file call logs. The Company acted promptly once the information required to determine a claim was provided. The Company has acknowledged violations for failure to comply with the technical requirement to provide written 30-day and 45-day status letters, and implemented prior to the exam a corrective procedure to ensure that written acknowledgement and status letters are being sent to insureds. The Company respectfully submits that communicating with insureds by phone rather than in writing, while a violation of the written status letter regulation, does not amount to a violation of 40 P.S. § 1171.5(a)(10)(ii). The Company promptly acknowledged claims and acted promptly on them by contacting insureds by phone to discuss their claim, discuss the claim process, and provide status updates. The Company thus did not “fail to acknowledge or act promptly,” it simply failed to do so in writing. Moreover, as noted, the Company has taken corrective action to implement an enhanced procedure to send written status letters, in addition to continuing to call to speak to insureds to allow for more detailed communications regarding claims.

B. Individual Long-Term Care Intake Claims Denied

7 Violations – 31 Pa. Code § 146.6

The Company failed to provide a written 30 day status letter for the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

3 Violations - 31 Pa. Code § 146.6

The Company failed to provide a written 45 day status letter for the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

1 Violation – 40 P.S. § 991.1111a(b)(2)

The Company failed to provide the insured the right to an internal appeal in one claim.

Company Response:

The Company disagrees with this finding. The Company did in fact provide the insured with the right to an internal appeal (by letter dated 12/5/14, correcting its prior denial letter from a week before, 11/25/14, which inadvertently left out the appeal right language), the insured did file an appeal, and the Company overturned its determination on appeal and found the insured to be eligible for benefits. The Company identified the error and promptly corrected it.

5 Violations – 40 P.S. § 991.1111a(c)

The correct 120 days regarding the internal appeal process was not provided to 5 claimants.

Company Response:

The Company agrees with these findings and has taken corrective action to provide training and resources to staff to reinforce the state-specific timeframes for appeal.

1 Violation – 40 P.S. § 991.1111a(5)(3)(i)

The independent review organizations that the Company provided in its determination letters were not certified and approved by the Department.

Company Response:

The Company agrees with this finding. The associate made an error and provided the wrong list of IROs from the Department's web-site (healthcare IROs rather than LTC). The Company has recently provided comprehensive training to reinforce to its staff the right to independent review in Pennsylvania by an approved Independent Review Organization, including details on the specific information that must be provided in adverse determination letters, and the specific language and timeframes for appeal have been documented in an updated resource document for the staff.

5 Violations – 40 P.S. § 1171.5(a)(10)(i)

The company cannot show proof that accurate appeal and internal review instructions were provided to the insured. This lack of proof constitutes misrepresenting pertinent policy and contract provisions as noted in 5 files and was committed or performed with such frequency as to indicate a business practice constituting unfair claim settlement or compromise practices.

Company Response

The Company respectfully disagrees that the findings support any alleged violation of § 40 P.S. 1171.5. The Company has acknowledged violations for providing the wrong time period in which to appeal and the incorrect IRO list for independent review in the handful of files noted. These were errors by individual claim professionals and were not committed with such frequency as to indicate a business practice or to support such a finding by the Department. The Company has a guideline in place that provides specific information about the appropriate time frame to appeal by state. Unfortunately, that guideline was not followed in these cases due to oversight by the claim professionals. The Company has provided comprehensive training to its staff reinforcing the time periods and right to independent review in Pennsylvania, and the staff has been provided with an updated resource document with specific language and timeframes for appeal. In none of the claims cited in the Report did the Company deny an appeal as untimely

based on the incorrect time period. The Company is also enhancing its review and oversight of denial letters by supervisors to ensure that the appropriate time period to appeal is referenced in adverse determination letters.

7 Violations – 40 P.S. § 1171.5(a)(10)(ii)

The Company failed to acknowledge and act promptly upon written or oral communications for the noted claims with such frequency as to indicate a business practice constituting unfair claim settlement or compromise practices.

Company Response:

The Company respectfully disagrees that the findings support any alleged violation of § 40 P.S. 1171.5. As set forth in detail in its response to the Examiners, the Company acted promptly in communicating with insureds, acknowledging all communications and providing frequent verbal status updates, as documented in the claim file call logs. The Company acted promptly as soon as the information required to determine a claim was received. The Company has acknowledged violations for failure to comply with the technical requirement to provide written 30-day and 45-day status letters, and, in 2015 implemented a corrective procedure to ensure that written acknowledgement and status letters are being sent to insureds. The Company respectfully submits that communicating with insureds by phone rather than in writing, while a violation of the written status letter regulation, does not amount to a violation of 40 P.S. § 1171.5(a)(10)(ii). The Company promptly acknowledged claims and acted promptly on them by contacting insureds by phone to discuss their claim, discuss the claim process, and provide status updates. The Company thus did not “fail to acknowledge or act promptly,” it simply failed to do so in writing. Moreover, as noted, the Company has taken corrective action to implement an enhanced procedure to send written status letters, in addition to continuing to call and speak to insureds to allow for more detailed communications regarding claims.

C. Individual Long-Term Care Intake Claims Pended

2 Violations – 40 P.S. § 991.1111a

The claim files did not show proof that the insurer provided the insured with internal and external independent review rights.

Company Response:

The denial letters on these 2 claims did have internal appeal right language but the company agrees with the violations because the letters failed to include the required reference to the right to independent review by an IRO following an internal appeal. The Company had a guideline in place that was not followed in these 2 letters. Since the exam, the Company has provided comprehensive training to its staff, reinforcing the right to independent review in Pennsylvania by an approved IRO, including details on the specific information that must be provided in adverse determination letters. In addition, the specific language and timeframes for appeal have been distributed to the staff in an updated resource document.

3 Violations – 40 P.S. § 991.1111b(a)

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

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims verbally and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status and acknowledgement letter requirement.

4 Violations – 31 Pa. Code § 146.6

The Company failed to provide a timely status letter in the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

3 Violations – 40 P.S. § 991.1111a(c)

The 120 days information regarding the internal appeal process was not provided to the insured in the noted claims.

Company Response:

The Company agrees with these findings and has taken corrective action to provide training and resources to staff to reinforce the state-specific timeframes for appeal.

E. Group Long-Term Care Intake Claims Pended

7 Violations – 31 Pa. Code § 146.6

The Company failed to provide a written 30 day status letter for the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

3 Violations – 31 Pa. Code § 146.6

The Company failed to provide a written 45 day status letter for the noted claims.

Company Response:

The Company agrees with these findings. As set forth in detail in its response to the Examiners, the Company promptly acknowledged receipt of these claims and provided regular verbal, but not written, status updates. The Company has implemented corrective action to ensure compliance with the written status letter requirement.

1 Violation – 40 P.S. § 991.1111b(a)(2)

The Company failed to provide written notice of additional information necessary to make a claim determination within 30 days after receipt of a claim in one noted claim.

Company Response:

The Company agrees with this finding.

G. Individual Long-Term Care Invoice Claims Denied

1 Violation – 40 P.S. § 991.1111b(a)

The Company failed to pay the correct clean claim amount within 30 days in one noted claim.

Company Response:

The Company agrees with this finding. In connection with the exam, the Company determined that an additional \$8.17 was payable on this claim and payment has been made.

1 Violation – 31 Pa. Code § 146.6

The Company failed to provide a timely 30 day status letter in one noted claim.

Company Response:

The Company agrees with this finding. The claim was processed in 32 days from receipt, and the Company acknowledges that pursuant to its guidelines, a letter requesting the additional information and providing status should have been sent and was not.

H. Individual Long-Term Care Invoice Claims Pended

1 Violation – 40 P.S. § 991.1111b(a)

Payment of claim was not made within 30 days after receipt in one noted claim.

Company Response:

The Company agrees with this finding. The Company did send written notice declining to pay the claim initially, but on re-review in connection with the Exam, the Company determined the claim was payable and the Company issued payment.

I. Group Long-Term Care Invoice Claims Paid

1 Violation – 31 Pa. Code § 146.6

The Company failed to provide a timely status letter in one noted claim.

Company Response:

The Company agrees with this finding. The Company sent an initial letter explaining additional information necessary to make a claim determination but failed to send another status letter until the claim was processed 45 days later. The Company has since implemented corrective action to address this issue and the Company now sends a written follow-up letter within 30 days after the initial letter if information required to make a determination on an invoice is still outstanding.

J. Group Long-Term Care Insurance Invoice Claims Denied

1 Violation – 40 P.S. § 991.1111b(a)

Payment of claim was not made within 30 days of receipt in one noted file.

Company Response:

The Company agrees with this finding. The Company is implementing corrective action by creating a targeted report designed to ensure appropriate payment under these circumstances.

1 Violation – 40 P.S. § 991.1111b(b)

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

Company Response:

The Company agrees with this finding.

1 Violation – 31 Pa. Code § 146.6

The Company failed to provide a timely status letter in one noted claim.

Company Response:

The Company agrees with this finding.

XIII. RECOMMENDATIONS

1. The Company must review and revise procedures to ensure compliance with 31 Pa. Code § 146.5(b) related to timely complaint response to the Department.

Company Response:

The Company has existing procedures to ensure compliance with this provision and the one instance identified in the exam of a late response was the result of a requested extension which was not confirmed. The Company will reinforce its existing procedures.

2. The Company must review and revise procedures to ensure compliance with 31 Pa. Code § 146.5(c) regarding the timely response to the claimant.

Company Response:

The Company has existing procedures to ensure timely responses are provided to claimants and the one instance identified in the exam was the result of a mistake and failure to follow existing procedures by an associate, who has since been coached to ensure compliance with the existing procedure.

3. The Company must review and revise procedures to ensure compliance with 31 Pa. Code § 146.6 regarding the proper use of the 30 and 45 day status letters.

Company Response:

The Company has acknowledged the written status letter findings noted in the Report, and has reviewed and revised its procedures to ensure compliance with Pennsylvania requirements.

4. The Company must review and revise procedures to ensure compliance with 40 P.S. § 991.1111a(c) related to the proper notification of the appeal process.

Company Response:

The Company has acknowledged the appeal rights findings noted in the Report, and is reviewing and revising its procedures and providing training to its staff to ensure compliance with Pennsylvania requirements.

5. The Company must review and revise procedures to ensure compliance with 40 P.S. § 991.1111a(b)(2) regarding the proper notification to the insured concerning the right to appeal.

Company Response:

The Company has acknowledged the appeal rights findings noted in the Report, and is reviewing and revising its procedures and providing training to its staff to ensure compliance with Pennsylvania requirements.

6. The Company must review and revise procedures to ensure compliance with 40 P.S. § 991.1111a(5)(3)(i) related to the certification and approval of an independent review organization.

Company Response:

The Company has acknowledged the independent review organization findings noted in the Report, and is reviewing and revising its procedures and providing training to its staff to ensure compliance with Pennsylvania requirements.

7. The Company must review and revise procedures to ensure compliance with 40 P.S. § 991.1111a regarding the proper written notification to the insured of their rights to an internal appeal and external independent review.

Company Response:

As noted in response to recommendations 4 and 5, the Company has acknowledged the appeal rights findings noted in the Report, and is reviewing and revising its procedures and providing training to its staff to ensure compliance with Pennsylvania requirements.

8. The Company must review and revise procedures to ensure compliance with 40 P.S. § 991.1111b regarding the requirements for prompt payment of long-term care claims.

Company Response:

The Company has existing procedures in place to ensure prompt payment of long-term claims but has acknowledged the findings in the Report where those procedures were not followed, and the Company will review and revise its procedures as needed to ensure compliance with Pennsylvania requirements.

9. The Company must review and revise procedures to ensure compliance with Unfair Insurance Practices and Claim requirements of 40 P.S. § 1171.5(a)(10).

Company Response:

For the reasons set forth above, the Company strongly disagrees with any findings alleging a violation of 40 P.S. § 1171.5. The Company's claim practices are fair, considerate, and responsive to claimants. The acts alleged by the Department to support the alleged violations do not constitute violations of the subsections relied on by the Department, or were isolated instances of noncompliance or mistake. With respect to the underlying acts for failure to send written status letters and providing incorrect appeal language, the Company has acknowledged those findings and has already reviewed and revised its procedures to ensure compliance with the Pennsylvania requirements.