REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

TIME INSURANCE COMPANY

AS OF JUNE 30, 2013

Conducted from February 3, 2014

through

June 30, 2014

By

Market Conduct Section

Life and Health Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 39-0658730
NAIC: 69477

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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

I, Melissa Gerachis, Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Time Insurance Company as of June 30, 2013, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2014-00222 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this the Bureau at the City of Richmond, Virginia, this 15th day of December, 2014.

Melissa Gerachis

Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of Time Insurance Company (hereinafter referred to as "Time"), was conducted under the authority of various sections of the Code of Virginia (hereinafter referred to as "the Code") and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC"), including but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1,38.2-1809, 38.2-3407.15 C, and 38.2-5808 B of the Code, as well as 14 VAC 5-90-170 A.

The period of time covered for the current examination, generally, was July 1, 2012, through June 30, 2013. The examination was conducted at the office of the State Corporation Commission's Bureau of Insurance (hereinafter referred to as the "Bureau") from February 3, 2014, through June 30, 2014. The violations cited and the comments included in this Report are the opinion of the examiners. The examiners may not have discovered every unacceptable or non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether Time was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;

14 VAC 5-130-10 et seq.	Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms;
14 VAC 5-140-10 et seq.	Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review; and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIP)
- Ethics and Fairness in Carrier Business Practices
- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium Notices/Reinstatements/Policy Loans and Loan Interest
- Cancellations/Nonrenewals
- Complaints
- Claim Practices

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to Time during the course of the examination.

II. COMPANY HISTORY

Time Insurance Company first organized in LaCrosse, Wisconsin in 1892 as the LaCrosse Mutual Aid Association. The company then moved to Milwaukee in 1900 and by 1905 took the name Time Indemnity. On February 11, 1910, the company incorporated and changed its name to Time Insurance Company. Time Insurance Company commenced business on March 6, 1910.

In April 1969, Time Holdings, Inc. was formed to become the parent company of Time Insurance Company. During January 1978, control of Time Holdings, Inc. was acquired by N.V. AMEV, a Dutch financial services company located in Utrecht, The Netherlands. During 1994, N.V. AMEV became Fortis AMEV. Effective April 1, 1998, Time Insurance Company changed its name to Fortis Insurance Company. Fortis Insurance Company's direct parent is Interfinancial, Inc., which, in turn, is controlled by Fortis, Inc., in New York, New York. The ultimate controlling entities are Fortis AG, located in Belgium, and Fortis AMEV. Effective January 1, 1999, Fortis AG was renamed Fortis (B), and Fortis AMEV was renamed Fortis (NL) N.V. On September 27, 2001, Fortis (B) was replaced by Fortis SA/NV, a Belgian company, and Fortis (NL) N.V. was replaced by Fortis N.V., a Netherlands company. The U.S. operations were known as Fortis, Inc., which was renamed Assurant, Inc. when it became a publicly traded company on the New York Stock Exchange through an Initial Public Offering on February 5, 2004. Effective September 6, 2005, Fortis Insurance Company changed its name back to Time Insurance Company (Time).

Time is licensed in 48 states and the District of Columbia. Time's primary business is the issuance of accident and health insurance, and its business segment

focus is individual and small employer group health insurance. Time's individual health products are primarily for annually renewable major medical coverages. Most of Time's individual health products are Preferred Provider Organization (PPO) plans, which enable the insured to elect any health care provider and provide for higher benefit payments when health care is rendered by a participating network provider.

Time markets through a regional sales distribution system using independent agents throughout its territory. Individual medical products are also marketed through national accounts relationships and through direct distribution channels.

Effective March 1, 2000, Time established a reinsurance agreement with John Hancock Life Insurance Company (John Hancock) whereby Time transferred to John Hancock all of Time's liability for long-term care insurance policies. The agreement, which is structured as a sale of the business line, provides for Time's cession of risks to John Hancock on a 100% coinsurance basis. John Hancock is the administrator of the business.

Effective April 1, 2001, Time entered into a reinsurance agreement with Hartford Life and Annuity Insurance Company (Hartford) for the transfer to Hartford of business comprised of certain individual life insurance policies and annuity business written by Time. The agreement, which is structured as a sale of the business line, provides for Time's cession of risks to Hartford on a 100% coinsurance basis. Hartford is the administrator of the business.

Net admitted assets as of December 31, 2013, totaled $691,510,276. As of December 31, 2013, total direct life insurance premiums and annuity considerations in Virginia were $1,150,345, and direct accident and health insurance premiums were $21,987,943.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIP)

Section 38.2-5801 of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.

4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

The review revealed that Time was in substantial compliance with this section.

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and

the State Health Commissioner. The examiners reviewed a sample of 30 out of a total population of 390 complaints/appeals received during the examination time frame.

As discussed in the following paragraph, the review revealed 7 instances in which Time failed to maintain its established complaint system, in violation of § 38.2-5804 A of the Code.

TIMELINESS

Under *Key Definitions*, Time's complaint and appeal procedures indicate that "a complaint pertaining to a covered person's request that the health plan reconsiders a denial for, or reimbursement or [sic], a service is considered an appeal," and the definition includes complaints brought by enrollees or by providers acting on behalf of an enrollee. The *Internal Appeal Process* section of the filed and approved complaint system further specifies that, for an internal appeal, the company's decision must be communicated no later than thirty (30) days after receipt of the appeal, and this requirement is confirmed in Time's *Grievance Requirements Grid*, a chart that was provided with the company's complaints procedures. The grid indicates that responses to Virginia appeals are to be completed within 30 calendar days. As discussed in Review Sheet MC04, the review revealed that Time did not communicate its decision until 41 calendar days after the appeal was received. Time disagreed with the examiners' observations, advising that a "second version" of the company's Virginia Grievance process, implemented January 25, 2012, and provided to the examiners, "reflects a 60 calendar day completion time." The examiners do not concur. Although the revised procedures do indicate a 60 calendar day completion time, the revised completion time refers only to "grievances," which are not defined. The procedure

revisions effective January 25, 2012, do not address “appeals,” and no changes were made to the company’s filed and approved complaint system regarding appeals. The definition remained unchanged, and the complaint system continued to indicate a response completion time of 30 calendar days for appeals.

PROVIDER CONTRACTS

Section 38.2-5805 B of the Code requires that every contract with a provider enabling an MCHIP to provide health care services shall be in writing. Section 38.2-5802 C of the Code states that the health carrier shall maintain a complete file of all contracts made with health care providers, which shall be subject to examination by the Commission.

The examiners selected a sample of 20 from a total population of 61,592 provider contracts in force during the examination time frame. The review revealed that Time was in substantial compliance with these sections.

IV. ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services. Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section.

PROVIDER CONTRACTS

The examiners reviewed a sample of 16 professional and 4 facility contracts from a total population of 60,738 professional and 854 facility provider contracts in force during the examination time frame. The provider contracts were reviewed to determine if they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed that 4 sample provider contracts failed to contain 10 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	4	EF01
§ 38.2-3407.15 B 2	4	EF11
§ 38.2-3407.15 B 3	4	EF12
§ 38.2-3407.15 B 4	4	EF13
§ 38.2-3407.15 B 5	4	EF01
§ 38.2-3407.15 B 6	4	EF11
§ 38.2-3407.15 B 7	4	EF12
§ 38.2-3407.15 B 9	4	EF11
§ 38.2-3407.15 B 10	4	EF12
§ 38.2-3407.15 B 11	4	EF13

Time agreed with the examiners' observations.

SUMMARY

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 B of the Code. Time's failure to amend its provider contracts to comply with § 38.2-3407.15 B of the Code occurred with such frequency as to indicate a general business practice, placing Time in violation of § 38.2-510 A 15 of the Code.

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits as a general business practice the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain provisions requiring the carrier to adhere to and comply with sections 1 through 11 of these subsections in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The total population of 6 claims processed under the sample provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims. The review revealed that Time was in substantial compliance with these sections.

V. ADVERTISING

A review was conducted of Time's advertisements to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-90-50)

14 VAC 5-90-170 A requires each insurer to maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement with a notation attached indicating the manner and extent of distribution and the form number of any policy advertised. The review revealed that Time was in substantial compliance.

A sample of 25 was selected from a population of 182 advertisements distributed in Virginia during the examination time frame. The examiners would note that 5 of the sample advertisements listed in the advertisement file were not provided since Time changed vendors in November 2012, and the text for the advertisements was not available. Therefore, 20 advertisements were reviewed.

The review revealed that 4 of the advertisements contained violations. In the aggregate, there were 6 violations, which are discussed in the following paragraphs.

14 VAC 5-90-40 sets forth the requirement that all information shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading. Review Sheets AD01, AD02, AD03 and AD04 discuss 4 violations of this section. The advertisements contained footnotes throughout that pertained to the products being offered that had been minimized to the point that they were difficult to read. Time disagreed with the examiners' findings, stating that the electronic copies delivered to the examiners were the cause of the footnotes being difficult to read and an original copy was furnished by mail. The examiners responded that this does not change the fact that the footnotes pertinent to the products being offered had been minimized.

14 VAC 5-90-50 B states that advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. Review Sheet AD01 discusses 1 violation of this section. The advertisement contained the statement that "A big reason people visit the doctor is wellness or preventive care" which is potentially misleading. Time disagreed, stating that their actuarial staff reported that wellness was 6% of claim counts and that if pharmacy claims were excluded the figure rose to 11%. Time also stated that the assertion in question is no longer used in current product advertisements. The examiners maintain that 6% or even 11% does not substantiate the statement in the advertisement.

14 VAC 5-90-60 B 6 requires advertisements for policies providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously state in boldface type and all capital letters the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following:

"**THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."**

Review Sheet AD01 discusses 1 violation of this section. Time offered supplemental coverage in addition to a major medical insurance plan for individuals and families that included critical illness coverage. The plan paid cash directly to the policyholder for such illnesses as cancer and heart attack/stroke; however, the advertisement failed to include the required specified illness disclosure. Time disagreed with the examiners, stating that the supplemental products availability varied by state and were not available for issue in Virginia and that Time found no conflict with Virginia's regulations. The examiners responded that the Collateral Tracking Sheet that Time used to determine the manner and extent of distribution clearly stated that the advertisement was disseminated in Virginia.

SUMMARY

Time violated 14 VAC 5-90-40, 14 VAC 5-90-50 B, and 14 VAC 5-90-60 B 6, placing it in violation of subsection 1 of §38.2-502 and § 38.2-503 of the Code.

VI. POLICY AND OTHER FORMS

A review was conducted to determine if Time complied with various statutory, regulatory and administrative requirements governing the filing and approval of forms. Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia. 14 VAC 5-200-77 and 14 VAC 5-200-153 set forth the applicable filing and approval requirements for long-term care policies.

POLICIES/CERTIFICATES

Sections 38.2-316 A and 38.2-316 C of the Code set forth the requirements for the filing and approval of policy forms prior to use.

The examiners reviewed a sample of 30 from the total population of 1,229 accident and sickness policies issued during the examination time frame.

The review revealed that the policies and the attached amendments/riders issued were filed with and approved by the Commission.

APPLICATIONS/ENDORSEMENTS

Sections 38.2-316 B and 38.2-316 C of the Code set forth the requirements for the filing and approval of application forms prior to use.

The review revealed that the application forms used by Time were filed with and approved by the Commission.

ACCIDENT AND SICKNESS RATE FILING

Sections 38.2-316 A and 38.2-316 C of the Code set forth the requirements for the filing of rates and rate changes. 14 VAC 5-200-77 and 14 VAC 5-200-153 set forth the filing of rate and rate changes for long-term care insurance policies.

The review revealed that Time was in substantial compliance.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval by the Commission.

The examiners' review of 40 sample major medical claims processed by Time and 30 sample long-term claims processed by John Hancock revealed that the EOB forms issued had not been filed with and approved by the Commission. These violations are discussed in Review Sheets CL04-JH, CL12, and CL19. Time's use of an EOB that had not been filed with and approved by the Commission placed Time in violation of § 38.2-3407.4 A of the Code in 66 instances. Time agreed with the examiners' observations and subsequently filed the major medical EOB form referred to in Review Sheets CL12 and CL19.

VII. AGENTS

The purpose of this review was to determine compliance with various Sections of Title 38.2, Chapter 18 of the Code.

A sample of 14 from a population of 4,840 agent and agency appointments in effect during the examination time frame was selected for review. In addition, the writing agents or agencies designated in the 30 new business files were also reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A of the Code prohibit a person from acting as an agent prior to obtaining a license to transact the business of insurance in the Commonwealth. The review revealed that Time was in substantial compliance with this section.

APPOINTED AGENT REVIEW

Section 38.2-1833 A of the Code requires that an insurer, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent. The review revealed that Time was in substantial compliance with this section.

Administrative Letters

Administrative Letter 2002-2 was sent to all insurers conducting business in Virginia with the request that insurers insert a separate document in each new agent's packet directing the new agent to be aware of certain administrative letters specifically applicable to licensed agents in Virginia, and advising that a complete listing of these administrative letters is available on the Bureau of Insurance website.

Administrative Letter 2002-9 was sent to all insurers conducting business in Virginia with the request that insurers instruct each newly appointed Virginia agent to review this Administrative Letter at the Bureau of Insurance website.

The review revealed that Time did not comply with the Commissioner's request. Time indicated that they do not direct agents to the specific Administrative Letters on the Bureau's web site; however, the company further indicated that it has initiated a revision to its procedures to notify and refer agents accordingly.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency that was not appointed or licensed at the time of the transaction. The review revealed that Time was in substantial compliance with this section.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment.

A sample of 6 from a population of 655 agent and agency terminations processed during the examination time frame was selected for review. The review revealed that Time was in substantial compliance with this section.

VIII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of Time's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; 14 VAC 5-140-10 et seq., Rules Governing the Implementation of Individual Accident and Sickness Insurance Minimum Standards Act and 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was made to determine whether Time's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with Time's guidelines, and whether correct premiums were being charged.

UNDERWRITING REVIEW

A sample of 30 from a population of 1,229 individual policies underwritten and issued during the examination time frame was selected for review. The review revealed that Time was in substantial compliance with its underwriting guidelines and no unfair discrimination was found.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that Time was in substantial compliance with this section.

MECHANICAL RATING REVIEW

The review revealed that Time had calculated its premiums in accordance with its filed rates.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group insurance that are individually underwritten.

The review revealed that the NIP forms provided to applicants for coverage complied with the requirements of this section.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The examiners reviewed the disclosure authorization forms used during the underwriting process and found them to be in substantial compliance with this section.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 A of the Code requires that in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission.

Administrative Letter 1981-15 provides life and health insurers with a prototype AUD notice. An AUD notice containing wording substantially similar to the wording in the prototype notice is deemed to be approved for use in Virginia.

The examiners reviewed a sample of 30 from a population of 160 applications that were declined during the examination time frame.

Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that in the event of an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

As discussed in Review Sheet UN01, the review revealed 30 violations of each of these sections. Time agreed with the examiners' observations.

IX. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST

Time's practices for the billing and collection of premiums and reinstatements were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM NOTICES

Upon application for insurance, the applicant generally has four options related to premium notice or billing. Such options include direct bill, list bill, credit card billing (CRD) or electronic fund transfer (COM) from the insured's checking or savings account. The billing frequency for direct bill may be quarterly, semiannually or annually. The billing frequency for list bill, CRD and COM may be monthly, quarterly, semiannually or annually. For CRD and COM, policy owners may choose a draft date of the 1st to the 28th or the deduction will be determined by the policy effective date. Policy owners may make changes to the billing method by phone. The review revealed that Time was in substantial compliance with its procedures.

Section 38.2-3407.14 A of the Code requires an insurer to provide prior written notice of intent to increase premiums by more than 35 percent. Section 38.2-3407.14 B of the Code requires that the notice be provided in writing at least 60 days prior to the proposed renewal of coverage. Time advised the examiners that there were no groups or individuals covered under policies/contracts issued in Virginia whose premium increased by more than 35 percent at the proposed renewal of coverage during the examination time frame. In addition, Time affirmed that when changing rates, written

notification is provided to affected policyholders not less than 60 days prior to the effective date of the new premium rate.

REINSTATEMENTS

LIFE INSURANCE

A policy will be considered for reinstatement if the policy has been lapsed for less than the time period set forth in the contract. Typically, this is a 3 or 5-year period for life policies. The completed reinstatement application can be mailed, faxed, or emailed for processing. Once the application is received, Policy Change evaluates the application. If necessary, Policy Change sends the application to Underwriting. The company will not accept money with the application or before the reinstatement is approved. If money accompanies the application, the money is returned to the policyholder. At the time the reinstatement is approved, the policyholder will be advised of the amount required to reinstate the policy.

The examiners reviewed the total population of 4 reinstatement requests received by Hartford during the examination time frame. The review revealed that reinstatements were processed in accordance with established procedures and policy provisions.

ACCIDENT & SICKNESS INSURANCE

For most policies, a reinstatement will be considered if the reinstatement form is received within 180 days from the lapse date. Reinstatement applications for long-term care policies must be received within 5 months of the lapse date. The reinstatement period for accident medical expense policies is 60 days. All reinstatement requests, with the exception of dental policy reinstatements, are sent to underwriting for review.

If reinstatement is denied, a declination letter is sent. If the reinstatement is approved, a letter requesting the premium due is sent to the policy owner.

The examiners reviewed a sample of 5 from a total population of 13 reinstatements processed by Time and the total population of 2 reinstatements processed by John Hancock. In total, a sample of 7 from a population of 15 policies where reinstatement was requested during the examination time frame was reviewed. The review revealed that the reinstatements were processed in accordance with established procedures and policy provisions.

POLICY LOANS AND LOAN INTEREST

Time's procedures state that once a loan request is received and the amount requested is valid, it will be processed within 3 business days. Loan interest is payable on the unpaid balance at the end of each policy year. As of the policy anniversary, loan interest, if not paid, is capitalized and added to the existing loan balance to bear interest at the same rate.

The examiners reviewed a sample of 30 from a population of 304 policy loan transactions processed by Hartford that took place during the examination time frame. The review revealed that policy loans and loan interest were calculated and processed in accordance with established procedures and policy provisions.

CASH WITHDRAWALS

The examiners reviewed the total population of 4 life insurance policies with cash withdrawal transactions processed by Hartford. The review revealed that cash withdrawals were calculated in accordance with established procedures and the policy provisions.

X. CANCELLATIONS/NONRENEWALS

The examination included a review of Time's cancellation/non-renewal practices and procedures to determine compliance with its contract provisions and the requirements of § 38.2-508 of the Code covering unfair discrimination; and the requirements of 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

LIFE INSURANCE

Cash Surrenders

The examiners reviewed a sample of 17 from a total population of 55 policies surrendered for cash transactions processed by Hartford that took place during the examination time frame. The examiners reviewed the policy values and calculations for each cash surrender.

The review revealed that the cash surrender amounts were calculated in accordance with the policy provisions.

Reduced Paid-Up and Extended Term Insurance

The examiners reviewed the total population of 1 policy converted to reduced paid-up insurance along with a sample of 4 from a total population of 7 policies that converted to extended term insurance processed by Hartford during the examination time frame.

The review revealed that the conversions were handled in accordance with established procedures and the policy provisions.

Cancellations

The examiners reviewed the total population of 1 individual annuity cancellation and a sample of 17 from a population of 50 individual life cancellations processed by Hartford. The review revealed that cancellations were processed in substantial compliance with established procedures and policy provisions.

ACCIDENT AND SICKNESS

The examiners reviewed a sample of 25 from a total population of 286 accident and sickness policy cancellation transactions processed by Time and a sample of 12 from a population of 42 long-term care cancellation transactions processed by John Hancock. In total, a sample of 37 from a population of 328 policies that were cancelled during the examination time frame was reviewed. The review revealed that cancellations were processed in accordance with established procedures and policy provisions.

XI. COMPLAINTS

Time's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 30 from a total population of 390 written complaints received during the examination time frame was reviewed. The review revealed that Time was in substantial compliance with this section.

XII. CLAIM PRACTICES

The examination included a review of Time's claim practices for compliance with §§ 38.2-510, 38.2-3115 and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of individual major medical, dental, long-term care, individual life, and individual annuity claims. All major medical and dental claims were processed by Time. All long-term care claims were processed by John Hancock. Individual life and annuity claims were processed by Hartford. The examiners were provided with copies of all claims manuals.

PAID CLAIM REVIEW

Life and Annuity

A sample of 27 was selected from a total population of 44 life and annuity claims paid during the examination time frame. While the review revealed that the claims were processed in accordance with established procedures and policy provisions, unfair claim settlement practices are discussed in a subsequent section.

Accident and Sickness

A sample of 69 was selected from a total population of 687 major medical, dental, and long-term care claims paid during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide an explanation of benefits that does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider

of services. Section 38.2-3407.4 B of the Code states that an explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL02-JH, the review revealed 1 violation of these sections. In this instance, the April 2013 Nursing Facility Benefit should have been paid at a daily benefit of $228 rather than the $222 daily benefit that was paid. Time agreed with the examiners' observations and stated, in part that:

> The policy's maximum daily benefit from April 1, 2012 through March 31, 2013 was $222.00 per day. On April 1, 2013, the maximum daily benefit was increased by $6.00 through the Form 2022 - Lifetime 5% Annual Automatic Benefit Increase Rider to $228.00 per day. This is why the benefit reimbursement increased per day from $222.00 to $228.00 starting on April 1, 2013.
> Generally, invoices are processed in the month in which the care is provided. The April invoice was received on March 27, 2013 and was not processed correctly because it was processed prior to the anniversary update. The daily benefit of $222.00 was paid for this month; however, $228.00 per day should have been paid from April 1, 2013 – April 30, 2013. We regret the error and have sent an additional payment of $180.00 that was owed, and an interest check in the amount of $10.30.

Interest – Life & Annuity

Section 38.2-3115 B of the Code states that interest upon the principal sum shall be paid at an annual rate of 2.5% or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater.

The review revealed that Time was in substantial compliance.

Interest – Accident & Sickness

Section 38.2-3407.1 B of the Code states that interest upon accident and sickness claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

The review revealed that Time was in substantial compliance.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took Time, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays, or holidays. The study was conducted on the total sample of 96 paid claims.

PAID CLAIMS		
Working Days To Settle	Number of Claims	Percentage
0 – 15	81	84.38%
16 – 20	4	4.17%
Over 20	11	11.45%

Of the 96 claims reviewed for the time study, 15 claims (15.63%) were not settled within 15 working days. The examiners recommend that Time review its procedures to reduce the percentage of claims paid after 15 working days.

DENIED CLAIM REVIEW

Life and Annuity

The examiners were informed by Time that there were no life and annuity claims denied during the examination time frame.

Accident and Sickness

A sample of 61 from a total population of 443 major medical, dental and long-term care claims denied during the examination time frame was reviewed. The review revealed that the claims were processed in accordance with established procedures and policy provisions.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

A total sample of 157 paid and denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-60 A states that within 15 working days after receipt of a properly executed proof of loss, a first party claimant shall be advised of the acceptance or denial of a claim by the insurer.

14 VAC 5-400-70 D requires that, in any case where there is no dispute as to coverage or liability, every insurer must offer to a first party claimant, or to a first party claimant's authorized representative, an amount which is fair and reasonable as shown by the investigation of the claim, provided the amount so offered is within policy limits and in accordance with policy provisions.

The review was conducted using the date the letter or check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-50 A - In 1 instance, a claim was not acknowledged within 10 working days. This instance is discussed in Review Sheet CL16.

14 VAC 5-400-60 A - In 15 instances, claimants were not advised of acceptance or denial of a claim within 15 working days after proof of loss was received. An example is discussed in Review Sheet CL01-HL, where Time took 27 working days to advise the claimant of acceptance of the claim. Time agreed with the examiners' observations.

14 VAC 5-400-70 D - In 1 instance, Time failed to offer a claimant an amount that is fair and reasonable in accordance with policy provisions. This instance is discussed in Review Sheet CL02-JH.

The violations of 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice placing Time in violation of § 38.2-510 A 5 of the Code.

THREATENED LITIGATION

The examiners were informed by Time that it received no claims involving threatened litigation during the examination time frame.

XIII. CORRECTIVE ACTION PLAN

Based on the findings in this Report, Time shall:

1. Strengthen and maintain its procedures to ensure that the approved complaint system is followed in the processing of written complaints, as required by § 38.2-5804 A of the Code;
2. Strengthen its procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;
3. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40, 14 VAC 5-90-50 B and 14 VAC 5-90-60 B 6, as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
4. Immediately file its long-term care EOB form as required by §38.2-3407.4 A of the Code;
5. Strengthen and maintain procedures to ensure that its Explanation of Benefits forms are filed with and approved by the Commission, as required by §38.2-3407.4 A of the Code;
6. Establish and implement procedures to ensure compliance with Administrative Letters 2002-2 and 2002-9;
7. Establish and maintain procedures to ensure that the AUD notice required by §§ 38.2-610 A 1 and 38.2-610 A 2 of the Code is provided to declined applicants in accordance with the guidelines established by Administrative Letters 1981-15 and 2003-6;
8. Strengthen its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured or claimant clearly and accurately

discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code;

9. Review its established procedures to acknowledge receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;

10. Revise its established procedures to ensure that claimants are notified of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss or why additional time is needed to make that determination, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code;

11. Review its established procedures to ensure that it offers an amount which is fair and reasonable as shown by the investigation of the claim, as required by 14 VAC 5-400-70 D; and

12. Within 90 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XIV. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by Time's officers and employees during the course of this examination is gratefully acknowledged.

Laura Wilson, MCM, Bill Benson, FLMI, AIE, ACS, MCM, AIRC, and Melissa Gerachis, FLMI, AIRC, MCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Supervisor, Market Conduct Section
Life and Health Division
Bureau of Insurance

XV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED HEALTH CARE INSURANCE PLANS (MCHIPS)
§ 38.2-5804 A, **7** violations, MC01, MC02, MC03, MC04, MC05, MC07, MC08
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
§ 38.2-3407,15 B 1, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 2, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 3, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 4, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 5, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 6, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 7, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407,15 B 9, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407.15 B 10, **4** violations, EF01, EF11, EF12, EF13
§ 38.2-3407.15 B 11, **4** violations, EF01, EF11, EF12, EF13
ADVERTISING/MARKETING COMMUNICATIONS
14 VAC 5-90-40, **4** violations, AD01, AD02, AD03, AD04
14 VAC 5-90-50 B, **1** violation, AD01
14 VAC 5-90-60 B 6, **1** violation, AD01
POLICY AND OTHER FORMS
§ 38.2-3407.4 A, **66** violations, CL12 (**20**), CL19 (**20**), CL04-JH (**26**)
UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-610 A 1, **30** violations, UN01
§ 38.2-610 A 2, **30** violations, UN01
CLAIM PRACTICES
§ 38.2-514 B, **1** violation, CL02-JH
§ 38.2-3407.4 B, **1** violation, CL02-JH
14 VAC 5-400-50 A, **1** violation, CL16
14 VAC 5-400-60 A and §§ 38.2-510 A 3 and 38.2-510 A 5 of the Code, **15** violations, CL02, CL15, CL16, CL01-HL, CL02-HL, CL03-HL, CL04-HL, CL05-HL, CL06-HL,

CL07-HL, CL08-HL, CL09-HL, CL10-HL, CL11-HL, CL12-HL
14 VAC 5-400-70 D, **1** violation, CL02-JH

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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August 22, 2014

CERTIFIED MAIL 7013 2630 0001 8681 0693
RETURN RECEIPT REQUESTED

Ms. Amy Jo Jones
Director Compliance
Time Insurance Company
501 W. Michigan
Milwaukee, WI 53201

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Jones:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Time Insurance Company for the period of July 1, 2012, through June 30, 2013. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of Time Insurance Company, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. Time Insurance Company's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

501 West Michigan
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Milwaukee, WI 53201-3050
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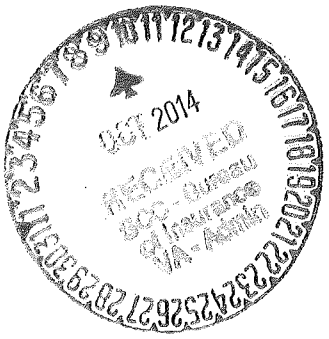

October 3, 2014

Julie Fairbanks
Principal Insurance Market Examiner
Virginia Bureau of Insurance – Life and Health Division
P.O. Box 1157
Richmond, VA 23218

VIA EMAIL & U.S. Mail

Re: Market Conduct Examination Report
Time Insurance Company

Dear Ms. Fairbanks:

We are writing in response to your letter of August 22, 2014. Thank for the opportunity to review the Draft of the Market Conduct Examination Report of Time Insurance Company and provide our comments. We will say at the outset that we do not have any recommended changes to the Report. We will confine our remarks to those sections of the Report that identify items found to be in non-compliance with Virginia Insurance Laws and Regulations. The Report reflects that our Company was found to be in substantial compliance for the majority of the items tested.

In Section III "Manage Care Health Insurance Plans (MCHIP)," the Report describes seven instances in which complaint response timeframes did not comport with the complaint system filed with the Bureau pursuant to Section 38.2-5804 A of the Code. The issue we identified was that our filed complaint system did not completely explicate the different timeframes for appeals of "adverse determinations" (as defined in Section 38.2-3556 of the Code) and all other appeals (e.g., contract exclusions). The appeal timeframe for "adverse determinations" is governed by the requirements we must meet in order to retain our certification from the Utilization Review Accreditation Commission. In contrast, appeals for issues not related to "adverse determinations"

were amended January 25, 2012 to be handled in compliance with the response timeframes permitted in 14 VAC 5-216-40(E)(2). After several consultations with Bureau staff, an amended complaint system addressing these issues was filed with the Bureau (as well as the Virginia Department of Health) on August 25, 2014.

In Section IV "Ethics and Fairness in Carrier Business Practices," the Report notes that four of twenty provider contracts reviewed failed to contain ten of the eleven provisions required by Section 38.2-3407.15 B of the Code. Our Company contracts with providers indirectly, through intermediary Preferred Provider Organizations (PPO), to obtain access to fee-for-service discounts negotiated by the PPO's. The four provider contracts cited in the Report were negotiated by a particular PPO (one of four reviewed) that declined to respond to the examiner's criticisms. As a result, our Company notified the PPO in question on July 1, 2014 that we were terminating our Provider Services Agreement effective October 1, 2014. Our contract required 90 days notice to terminate the agreement.

In Section V "Advertising," four of twenty advertisements were cited for an aggregate six violations of Rules Governing Advertising of Accident and Sickness Insurance (14 VAC 5-90-10 et seq.):

- All four advertising pieces were found to contain footnotes that were "minimized, rendered obscure or presented in an ambiguous fashion." In each case, the footnotes in question were printed in grey type. We are in the process of changing all advertising used in Virginia to ensure that footnotes are in black type.
- One advertisement was cited for including a potentially misleading statement regarding preventative care. The advertisement in question is no longer in use and we have reviewed all current advertisements to ensure that none include that statement.
- One advertisement was cited for failure to include a statement in boldface type and all capital letters identifying that the benefits offered are for a limited benefit policy. The advertisement in question is no longer in use and its replacement does not include references to the availability of other, limited benefit plans. In

addition, all advertisements for such limited benefit plans currently in use in Virginia have been reviewed for compliance with this requirement.

In Section VI "Policy and Other Forms," one area of concern was noted. Explanation of Benefits (EOB) forms in use by Time Insurance Company were not filed and approved by the Bureau, as required by Section 38.2-3407 A of the Code. The Company's EOB's were filed with the Bureau beginning on November 27, 2013. We have responded to a number of objections to our filings and anticipate refiling within a week of the date of this letter. We would note that filing issues relate to the required appeal language that is contingent upon the approval of the complaint system amendments discussed above.

In addition, the Report notes that John Hancock Life Insurance Company ("Hancock"), the administrator of Long Term Care coverage ceded by Time under a 100% reinsurance agreement, was also cited for failure to file and obtain approval of EOB forms. We have attached their response to the Draft report as Attachment 1. Hancock's response addresses this item in discussing Item #4 from Section XIII. "Corrective Action Plan" of the Report.

In Section VII, "Agents," the Report notes that our Company had not complied with the Commissioner's request in Administrative Letter 2002-9 to advise agents to review relevant Administrative Letters at the Bureau of Insurance website. The requested notice was implemented for distribution to existing and new agents appointed in Virginia on June 13, 2014.

In Section VII "Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection", in the subsection regarding "Adverse Underwriting Decisions (AUD)", the Report describes the findings that the Company's procedures for providing notice of Adverse Underwriting Determinations (AUD) did not comply with Section 38.2-610 A of the Code. The problems identified were twofold:

1. The AUD notice in use did not contain all of the elements contained in the prototype AUD Notice provided with Administrative Letter 1981-15; and,

2. No AUD notice was provided to applicants whose applications were deemed "incomplete". Administrative Letter 2003-6 specified that such applications are deemed to be "adverse underwriting determinations".

We corrected these issues on April 11, 2014.

In Section XII "Claim Practices", in the subsection "Paid Claim Review", one violation is discussed relating to a Long Term Care claim processed under the 100% reinsurance agreement with John Hancock Life Insurance Company. We have attached their response to the Draft report as Attachment 1. Hancock's response addresses this item in discussing Item #8 from Section XIII. "Corrective Action Plan" of the Report.

In Section XII "Claim Practices", in the subsection "Unfair Claim Settlement Practices Review", three sections of 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices are discussed:

1. 14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time. One Time Insurance Company Accident and Sickness claim was found to be in non-compliance with this requirement. In this instance, the consumer was issued a policy in Virginia in 1983 and moved to another state in 1993. Our Company applied the claim response requirements of that state when processing the claim. We have amended claim procedures to apply the requirements of the state of issue for processing claims.

2. 14 VAC 5-400-60 A states that within 15 working days after receipt of a properly executed proof of loss, a first party claimant shall be advised of the acceptance or denial of a claim by the insurer.

   Three of the 15 instances cited involved Time Insurance Company Accident and Sickness claims:

One instance, discussed in Review Sheet CL-16, resulted from applying out-of-state requirements as discussed in 1., above. We have amended procedures to apply the requirements of the state in which the policy is issued.

The second instance (Review Sheet CL-15) resulted from a system outage by the vendor our Company has retained to issue Explanation of Benefit (EOB) statements and remittance notices. The EOB's did not print on the date they were to be mailed. We have obtained a statement of corrective action from the vendor detailing increased monitoring protocols to prevent and/or respond to any such occurrence in the future.

The third instance (Review Sheet CL-02) involved an EOB issued to the first party claimant on the 16th working day after receipt. This was the result of different mail date protocols for Remittance Advice release and the EOB release to the first-party claimant. The Remittance Advice in this instance was sent on the 12th working day following receipt of the claim. We have amended procedures to ensure that EOB's are sent to the first party claimant on the same date that the Remittance Advice is released.

The remaining 12 claims cited involved Life claims, administered under a 100% reinsurance agreement with Hartford Life Insurance Company ("Hartford"). We have obtained a statement from Hartford addressing actions taken to address this issue, which is enclosed as Attachment 2.

3. 14 VAC 5-400-70 D requires that, in any case where there is no dispute as to coverage or liability, every insurer must offer to a first party claimant, or to a first party claimant's authorized representative, an amount which is fair and reasonable as shown by the investigation of the claim, provided the amount so offered is within policy limits and in accordance with policy provisions. One Long Term Care claim processed by processed under the 100% reinsurance agreement with John Hancock Life Insurance Company. We have attached their response to the Draft report as Attachment 1. Hancock's response addresses this item in discussing Item #11 from Section XIII. "Corrective Action Plan" of the Report.

We would like to take this opportunity to express our appreciation for the professionalism and courtesy demonstrated by the Bureau's staff in the conduct of this examination. Our Company is committed to compliance with all laws and regulations of the Commonwealth of Virginia and we look forward to bringing the examination to a successful conclusion.

Sincerely,

Steven E. Johnson, FLMI, AIRC, ACS
Senior Market Conduct Analyst
Assurant Health Regulatory Compliance

Encl.

ATTACHMENT 1

John Hancock Life Insurance Company (U.S.A.)
US Insurance Compliance
197 Clarendon Street
Boston, Massachusetts 02116
Tel: (617) – 572-1997
Fax: (617) – 572-0399
E-mail: rfamiglietti@jhancock.com

Richard Famiglietti
Sr. Compliance Consultant

September 19, 2014

To: **Virginia Market Conduct Examiners**

Re: **Market Conduct Examination of Long Term Claims Closed Block of Time Insurance Company {Draft Report Response}**

We appreciate the opportunity afforded by the Bureau of Insurance Division of the Virginia State Corporation Commission ("BOI") to respond to the Draft Report provided on September 5, 2014 regarding the review of processes and procedures for the administration of Long-term Care policies by John Hancock Life Insurance Company (U.S.A.), NAIC #: 65838, for Time Insurance Company, NAIC #69477.

Additional clarifications, commentary and responses to section "XII. Corrective Action Plan" of the Draft Report is provided below. We have responded to issues in the same order as they appear in the Draft Report.

Within the section of the Report titled "XII. Corrective Action Plan", item #4 states:

"4. Immediately file its long-term care EOB form as required by §38.2-3407.4 A of the Code;"

JH Response:

It is not clear to John Hancock ("the Company") that Section 38.2-3407.4 A of the Code is applicable to long-term care insurance. As noted in the draft report, Section 38.2-3407.4A of the Code requires that "each insurer issuing an accident and sickness insurance policy….shall file for approval explanation of benefit forms."

Accident and sickness insurance is defined and governed by Chapters 34 and 35 of the Code, whereas long-term care insurance has been regulated since 1987 in a separate and distinct chapter of the Code under Chapter 52 (VA Code Ann. 38.25200 et seq.). Prior to that time, long-term care insurance had been regulated pursuant to the requirements that apply to accident and sickness insurance under Chapters 34 and 35.

The definition of "Accident and Sickness" insurance found in Section 38.2-109 of the Code does not specifically include or exclude long-term care insurance. Also, the filing checklist for long-term care insurance found on the BOI's website does not include a line-item for filing explanation of benefit forms. In addition, the checklist for filing explanation of benefit forms does not specifically reference long-term care insurance. Thus, the BOI's filing guidance does

not indicate that it expects insurers to file explanation of benefit forms for long-term care insurance.

To date, the Company has not been required to file its explanation of benefit forms in any state for long-term care insurance since its history of doing business in 1987. We are not aware of any other carrier that is filing its explanation of benefit forms for long-term care insurance in any other state.

As such, the Company respectfully requests the BOI's reconsideration of this matter.

Within the section of the Report titled "XII. Corrective Action Plan", item #8 states:

"8. Strengthen its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured or claimant clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code; "

JH Response:

John Hancock has been working to strengthen the information on the Explanation of Benefits (EOB) to more clearly and accurately disclose the method of benefit calculation, the actual amount which has been paid and the benefits payable under the contract. John Hancock began work on a long term project in 2010 to replace the claim administration system with an enhanced system to include improved EOBs.

Beginning in February 2011, all new claims opened for Time Insurance were administered on the new claims system. The EOBs from the new claim system clearly and accurately disclose the method of benefit calculation, the actual amount which has been paid and the benefits payable under the contract.

John Hancock had planned to convert the claims on the old system to the new system, but it was determined that the conversion posed too high a risk to active claim data integrity. Since new claims have been added to our new system in 2011, the system from which this finding is made is being sunset.

Within the section of the Report titled "XII. Corrective Action Plan", item #11 states:

"11. Review its established procedures to ensure that it offers an amount which is fair and reasonable as shown by the investigation of the claim, as required by 14 VAC 5-400-70 D;"

JH Response:

The systems and procedures established to ensure correct payments were reviewed. In our review, we confirmed advanced facility payments processed prior to the inflation anniversary date are processed at the lower daily benefit. The Company has updated its process to generate a review past payment task in the claims system. This system flag will be created when an advanced facility payment is being processed on a claim where inflation is being applied. This system flag will alert the payment processor that inflation is being applied. The payment processor will then ensure the correct amount owed based on the applied inflation is processed.

We appreciate your considerations with our commentary and thank you for your attention to this matter.

Regards,

Richard Famiglietti
Sr. Compliance Consultant

ATTACHMENT 2

VIA EMAIL

Confidential Treatment Requested

September 17, 2014

Shane D. McCann, Assistant
Vice President
Talcott Resolution Compliance
The Hartford
Direct Dial: (860) 843-3317
Fax: (860) 392-3436

Mr. Steven E. Johnson, FLMI, AIRC, ACS
Senior Market Conduct Analyst, Regulatory Compliance
Assurant Health
501 W. Michigan Street
Milwaukee, WI 53201

Re: Virginia Market Conduct Examination
Time Insurance Company
Draft Report – The Hartford's Comments

Dear Mr. Johnson:

The Company acknowledges the finding. In January of 2013, Prudential Insurance Company of America ("Prudential") became the third party administrator for The Hartford's individual life insurance business. In order to improve service levels, staff additions and cross training have been implemented. In addition, Prudential monitors daily reports which track adherence to claim service standards for the timely payment of claims. Prudential's claims handling area has also implemented a revised claim acknowledgement letter and corresponding procedure (please see attachments). The letters will be customized as necessary to communicate to the beneficiary what claim requirements are outstanding. Both the revised letter and corresponding procedure were implemented on March 31, 2014.

Please contact me if you have any questions or concerns regarding these materials.

Very truly yours,

Shane D. McCann

****

The enclosed materials contain confidential and proprietary commercial information concerning the Company. Accordingly, the Company hereby requests that the enclosed documents and this cover letter be afforded confidential treatment pursuant to Virginia's Freedom of Information Act, §2.2-3700 et seq. If these documents become the subject of an inquiry, please contact me at (860) 843-3317, and we will provide further information in support of the Companies' request for confidential treatment.

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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October 16, 2014

CERTIFIED MAIL 7002 0860 0001 3221 4062
RETURN RECEIPT REQUESTED

Steven E. Johnson, FLMI, AIRC, ACS
Senior Market Conduct Analyst
Time Insurance Company
501 West Michigan
Milwaukee, WI 53201

Dear Mr. Johnson:

The Bureau of Insurance (hereinafter referred to as "the Bureau") has completed its review of your October 3, 2014, response to the Target Market Conduct Examination Report of Time Insurance Company (hereinafter referred to as "Time" or "the Company") sent with my letter of August 22, 2014.

Your response indicates that Time has concerns regarding the writing of the Report. This letter addresses those concerns in the same order as presented in your October 3rd response. Since Time's response will be attached to the final Report, this response does not address those issues where the Company indicated agreement.

The Bureau acknowledges the corrective actions that Time has already taken as the result of this examination. As noted in Corrective Action Plan (CAP) Item 12, within 90 days of finalization of the Report, Time will be required to document compliance with all of the corrective action items included in the Final Report. Upon receipt, the examiners will review the documentation provided and communicate with you and your staff if they have any questions or require additional documentation or further action.

Policy and Other Forms

Explanation of Benefits (EOB)

The examiners acknowledge John Hancock Life Insurance Company's ("Hancock") objection to filing its long-term care EOB form as required by § 38.2-3407.4 A of the Code of Virginia ("Code"). The Bureau disagrees with Hancock's analysis and finds its claim that accident and sickness insurance and long-term care insurance are wholly distinct to be contrary to the way in which accident and sickness

insurance and long-term care insurance have long been regulated in the Commonwealth of Virginia ("Commonwealth").

Article 2 of Chapter 100 of Title 38.2 of the Code defines and lists the varying classes of insurance that are regulated by the Commonwealth. Long-term care insurance is not listed as a separate class of insurance in Article 2. Thus, it follows that long-term care insurance must fall within another class of insurance that is defined in Article 2 of Chapter 100 – namely, within accident and sickness insurance, as defined in § 38.2-109 of the Code.

Long-term care insurance has long been viewed as a subset of accident and sickness insurance. As an illustration, Chapter 140 of Title 14 of the Virginia Administrative Code, which sets forth the minimum standards for individual accident and sickness policies, provides that, "This chapter (14VAC5-140) shall apply to *all individual accident and sickness insurance* policies delivered or issued for delivery in this Commonwealth *except it shall not apply to* Medicare supplement, *long-term care,* and specified disease policies" (emphasis added). If long-term care insurance did not fall under the umbrella of accident and sickness insurance, there would be no need to except these policies out of the scope of Chapter 140.

Hancock argues that the fact that long-term care insurance and accident and sickness insurance are governed by separate chapters of the Code and separate regulations means that they are distinct categories of insurance. However, this conclusion is not warranted. The existence of differing statutory and regulatory requirements does not necessarily mean that there is no overlap between accident and sickness insurance and long-term care insurance or that requirements that apply to accident and sickness insurance do not also apply to long-term care insurance. In fact, several other specific types of accident and sickness insurance, including specified disease policies and Medicare supplement, also fall under the umbrella of accident and sickness insurance despite the fact that they are governed by separate chapters of the Virginia Administrative Code.

It is also important to note that in the Commonwealth, carriers that are licensed to issue accident and sickness insurance are permitted to issue long-term care insurance to the extent that they are otherwise authorized to issue life insurance or accident and sickness insurance. *See, e.g.,* § 38.2-5200 of the Code. There is no license that is specific to the issuance of long-term care insurance; it falls under the accident and sickness license. This further supports the view that long-term care insurance is a type of accident and sickness insurance rather than a wholly distinct category of insurance.

With regard to the applicability of § 38.2-3407 A of the Code to long-term care insurance policies, § 38.2-5201 of the Code states that all long-term care policies and certificates, "shall comply with all the provisions of this title related to insurance policies and certificates generally, except Article 2 (§ 38.2-3408 *et seq.*) of Chapter 34 and Chapter 36 of this title. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling." Section 38.2-5201 of the Code clearly sweeps in the provisions of Chapter 34 of Title

38.2 of the Code, with the exception of Article 2, pertaining to mandated benefits. Thus, since there is no direct conflict between § 38.2-3407 A of the Code and the provisions of Chapter 52, § 38.2-3407 A of the Code would apply to long-term care policies and certificates.

Hancock states that the filing checklist for long-term care insurance found on the Bureau's website does not include a line item for filing an EOB form and that the checklist for filing EOB forms does not specifically reference long-term care insurance. The examiners have reviewed the checklists and note that the checklist for filing long-term care insurance, or any other type of accident and sickness insurance, provides guidance for filing the policy form. In addition, the EOB checklist does not reference any policy type rather it is the checklist for accident and sickness insurance as defined in Article 1 of Chapter 34 of Title 38.2

Finally, Hancock argues that it has not been required to file its EOB forms in any state for long-term care insurance and it is not aware of any other carrier that is filing EOB forms for long-term care insurance in any other state. The Bureau has consistently required that all insurers issuing long-term care insurance in the Commonwealth file their EOB form as required by § 38.2-3407 A of the Code.

The report appears correct as written.

Corrective Action Plan

CAP 4: Based on the reasons discussed above, CAP Item 4 will remain in the Report.

We do not plan to make any revisions before the Report becomes final.

On the basis of our review of the entire file, it appears that Time has violated the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and §§ 38.2-503, 38.2-510 A 5, 38.2-510 A 15, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-610 A 1, 38.2-610 A 2, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40, 14 VAC 5-90-50 B and 14 VAC 5-90-60 B, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-50 A, 14 VAC 5-400-60 A and 14 VAC 5-400-70 D, Rules Governing Unfair Claims Settlement Practices.

Violations of the above sections of the Code and Virginia Administrative Code can subject Time to monetary penalties of up to $5,000 for each violation and the suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter.

Very truly yours,

Julie R. Fairbanks, AIE, FLMI, AIRC
Supervisor
Market Conduct Section
Life and Health Division
Telephone (804) 371-9385

cc: Bob Grissom

Steven E. Johnson, FLMI, AIRC, ACS
Senior Market Conduct Analyst
Time Insurance Company
501 West Michigan
Milwaukee, WI 53201

Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS
Deputy Commissioner
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218

530109

RE: **Alleged violations of the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and §§ 38.2-503, 38.2-510 A 5, 38.2-510 A 15, and 38.2-514 B of the Code of Virginia as well as violations of §§ 38.2-610 A 1, 38.2-610 A 2, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40, 14 VAC 5-90-50 B and 14 VAC 5-90-60 B 6, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-50 A, 14 VAC -400-60 A and 14 VAC 5-400-70 D, Rules Governing Unfair Claims Settlement Practices.**

Dear Ms. Battle:

This will acknowledge receipt of your letter dated October 22, 2014, concerning the above-captioned matter.

Time wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $19,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing, and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of June 30, 2013.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,

Company Representative

11/20/14
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA 141210188

STATE CORPORATION COMMISSION

AT RICHMOND, DECEMBER 8, 2014

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2014-00222

TIME INSURANCE COMPANY,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Time Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Commonwealth"), in certain instances, violated §§ 38.2-502 (1) and 38.2-503 of the Code of Virginia ("Code"), as well as 14 VAC 5-90-40, 14 VAC 5-90-50 B and 14 VAC 5-90-60 B (6) of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertising requirements; violated §§ 38.2-510 A (5) and 38.2-510 A (15) of the Code, as well as 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, and 14 VAC 5-400-70 D of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to properly handle claims with such frequency as to indicate a general business practice; violated § 38.2-514 B of the Code by failing to make proper disclosures; violated §§ 38.2-610 A (1) and 38.2-610 A (2) of the Code by failing to accurately provide the required adverse underwriting decision and reasons to insureds; violated §§ 38.2-3407.4 A and 38.2-3407.4 B of the Code by failing to comply with explanation of benefits practices; violated §§ 38.2-3407.15 B (1),

38.2-3407.15 B (2), 38.2-3407.15 B (3), 38.2-3407.15 B (4), 38.2-3407.15 B (5), 38.2-3407.15 B (6), 38.2-3407.15 B (7), 38.2-3407.15 B (9), 38.2-3407.15 B (10), and 38.2-3407.15 B (11) of the Code by failing to comply with ethics and fairness requirements for business practices; and violated § 38.2-5804 A of the Code by failing to comply with procedures to establish and maintain a complaint system for each of its Managed Care Health Insurance Plans (MCHIPS).

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to the Commonwealth the sum of Nineteen Thousand Dollars ($19,000), waived its right to a hearing, and agreed to comply with the corrective action plan contained in the Target Market Conduct Examination Report as of June 30, 2013.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Steven E. Johnson, Senior Market Conduct Analyst, Time Insurance Company, 501 West Michigan, Milwaukee, Wisconsin 53201; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission