

## **EXECUTIVE SUMMARY**

The KID performed a market conduct examination of GTL. The period of examination was January 1, 2004 through December 31, 2008. Lines of business reviewed include accident and health, life insurance, and long-term care (LTC) insurance. The examiners reviewed the Companies' operations/management policies, marketing and sales, complaint files and claim files at the Company's administrative office in Glenview, IL.

The reason the market conduct exam was conducted was due to an issue uncovered through complaints where the company had incorrectly increased premiums on LTC policies. To summarize, in 2004 GTL began selling LTC policies with a rate guarantee for a five-year term to Kansas consumers. There were two riders that were sold as part of the policy (Return of Premium (ROP) and Spousal Enhancement (SE)). The rate actually charged was not on file with KID. In 2005 GTL informed Kansas consumers who had purchased said policies that an increase in premium was assessed as a result of a computer miscalculation on the riders. They gave customers the option at that time to remove the riders and receive a full refund. As of December 2005, if they chose to keep the riders, GTL would correct the rates and the premiums would increase.

The Illinois Department of Insurance had issued a consent order against GTL that the "Company shall revert to the original, at issue, premium rates of its long term care policies and riders...until the expiration of the initial rate guarantee period...and shall refund...any additional premium moneys received as a result of the changing the amount of premiums prior to the expiration of the initial rate guarantee period. For all policies that remain in force, any required refund or premium credit shall be made no later than the expiration of the initial rate guarantee period." KID also entered into an agreement with GTL where they would not charge the new rate as of 2005 and then refund the overcharged amount at the end of the five year guaranteed period. Another option the Company was giving policyholders was to convert to a new LTC policy (while returning all premiums paid for the ROP and Compound Inflation Protection (CIP) riders as well as the amount overpaid for the SE rider).

There were a number of complaints in which the Company did not calculate the premium returns properly and regarding agents using high pressure sales practices to convert existing LTC policies to the newer LTC policy offered by GTL. The market conduct exam was conducted to determine compliance with the terms the agreement between the Company and KID, the IL DOI consent order, as well as to determine if refund calculations were made correctly.

## **LIST OF RECOMMENDATIONS**

### **Marketing and Sales Recommendations**

#### **A. General**

There were twenty-seven (27) total complaints closed at KID against the Company in 2008. Of those complaints, fourteen (14) had reasons related to marketing and sales. The following is a breakdown of the specific reasons for the marketing and sales complaints:

<u>No.</u>	<u>Reason</u>
9	High Pressure Sales Tactics
2	Agent Handling
2	Misleading Advertising
1	Misrepresentation

- GTL needs to take a more proactive approach to training and monitoring their agents. Within 60 days the Company should provide KID with an oversight plan for more stringent controls over the entities (TPA's, GA's and marketing groups) that market and sell their products.

## **B. Critical Provider Program**

GTL's Critical Provider Product Brochure does not clearly define the type of policy being advertised; this is in violation of the life advertising regulation, K.A.R. 40-9-118 Section 5, (5). The cover page of the brochure has to clearly and prominently describe the type of policy advertised.

The Company markets a 10 and 20 year term life policy under the banner of their "Critical Provider Program". Included in this program is a Critical and Terminal Illness Benefit Rider. Their Critical Provider Product Brochure is in violation of the Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b). The brochure did not have the phrase, "accelerated benefit" or words of similar import in its title. The Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b) requires an accelerated benefit form approved in Kansas to include the phrase, "accelerated benefit" or words of similar import in its title.

Examiner Note: The Company has since revised the brochure for this product.

The cover letter sent to a new customer with the policy appears misleading and is a violation of K.S.A. 40-2404 (1)(a)&(e). The first point made in the letter talks about lump sum cash benefits being paid out for critical or terminal illness or being confined to a nursing home and using the money for paying health insurance deductibles or medical expenses etc. This gives the impression that it is a health policy. It isn't until the third paragraph that the letter indicates that they are actually buying a life insurance policy. The letter does not indicate to the consumer that they are actually buying a term life insurance policy with a rider that provides some accelerated benefits.

Examiner Note: The Company has already revised this cover letter.

The application for the Critical Provider Product is in violation of K.A.R. 40-2-20(b) as well as K.S.A. 40-2404 (1) (a)&(e). It does not clearly indicate it is a term life policy with "accelerated benefit". It includes the term "Full Critical Illness Coverage," which appears to be misleading and suggestive of health coverage.

- Within 30 days the Company shall provide KID a revised application for this product.

The Company was accepting applications for their critical provider program that were not filed with KID. This is a violation of K.S.A. 40-442 and K.S.A. 40-443.

- The Company should implement procedures to better monitor applications being submitted for coverage to ensure the applications being used are adequate.

### **C. Cancer Policy Outline of Coverage**

- GTL needs to revise their outline of coverage cancer form to come into compliance with K.A.R. 40-4-23(b)(3)(A)(E)&(F). The following areas need addressed:
  1. The outline of coverage needs to include a designation for the date, name and signature of the insurance agent or the name of the employee of the insurer, if no agent is involved, who assumes responsibility for the outline.
  2. The outline of coverage form needs to disclose policy provisions relating to the cancellation of coverage.
  3. The outline of coverage form needs to disclose policy premiums

Examiner Note: The Company has already re-filed this form.

### **D. Individual Products - Advertising forms for Student Blanket Coverage**

- There are several advertising forms for student blanket coverage that need updated to be in compliance with provisions within K.A.R. 40-9-100. Within 30 days, the Company needs to provide evidence that the following documents have been revised:
  1. Six student blanket coverage advertising forms need to be revised and have a form number to identify the brochure per K.A.R. 40-9-100 Guideline 2-B.
  2. Two brochures are in violation of K.A.R. 40-9-100 Guideline Section 11 and need to be revised removing any disparaging comparisons and statements of non-comparable policies.
  3. One brochure needs to be revised to indicate the source of the statistics quoted in the material per K.A.R. 40-9-100 Guideline 9-B.

### **E. Association Business**

1. In five different situations a particular Association's marketer incorrectly used enrollment forms which reflected a carrier other than GTL. Kansas does not require filings for out-of-state based association business and the individual certificates issued to Kansas members for those associations are not subject to

Kansas statutes and regulations. The agreement to provide 24-hour accident insurance to members of the Association is between Guarantee Trust Life and the Association itself. It is the master application between these parties and not the Association enrollment form which forms the basis of the insurance contract.

- The Company needs to implement more stringent monitoring procedures on marketers for this product or require more documentation when policies are written.
2. In reviewing the association membership form there was only one dollar amount shown. The application for the blanket sickness and accident insurance must be separate from the association membership application. The insurance premium must be clearly visible to the insured, not co-mingled with the association dues per K.S.A. 40-2215(a).
- Within 30 days, the Company should provide confirmation that the membership form as been revised to separate insurance premium form the association dues.

### **Claims Recommendations**

1. Both the Company and their TPA, First Agency, need to review their procedures to insure if a claim cannot be processed within 30 days as clean claim because of lack of documentation, they must send notification and include what additional information is necessary in order to consider the claim for payment per K.S.A. 40-2442 (a).

Company Response: First Agency has been advised to revise its procedure when it receives notice of claim without the medical bills. Going forward, it will include (within the receipt of claim notification) a sentence requesting the medical bills to be sent so that the claim may be considered for payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.
2. The Company and their TPA, First Agency, need to revise their procedures to notify the claimants when the full amount of the claim was paid per K.A.R. 40-1-34, Section 8(a).

Company Response: The Company's home office claim management staff is in the process of working with First Agency to revise its current procedures so that in all situations a claimant will be notified on the status of claim payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

3. The EOB's use a number code with a few words to explain the reason for the denial. The specific policy provision, condition or exclusion usually is not referenced by policy page number, section or paragraph. Many of the denials on the EOB's sent to the claimant were vague. This is a violation of K.A.R. 40-1-34, Section 8(a).

Company Response: The Company provided an electronic communication sent from GTL's Claim Department manager to Claim Department supervisors addressing the use of EOB remark codes and to use more specific description for a claim denial.

The Company plans to convert to a new Claims Processing system in the very near future. At that time, EOB remark codes will be re-evaluated to ensure compliance with states' laws so that the insured and/or provider have appropriate and sufficient information forming the basis for any denial. However, in the meantime, supervisors have been instructed that certain EOB remark codes can no longer be used.

- Within 30 days, the Company should provide a status update of their new claim system and enhanced EOB denial explanation program.