

1 CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION

2 Harry J. LeVine, Bar No. 105972
45 Fremont Street, 21st Floor
3 San Francisco, CA 94105
4 Telephone: (415) 538-4109
Facsimile: (415) 904-5490

5 Attorneys for the California Department of Insurance

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7
8 BEFORE THE INSURANCE COMMISSIONER

9 OF THE STATE OF CALIFORNIA

10
11 In the Matter of the Licenses and Licensing
Rights of

File No: UPA 05048841

OAH Case No. L-2006080642

12
13 CONSECO SENIOR HEALTH
INSURANCE COMPANY,

STIPULATION AND WAIVER

14
15 Respondent.

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18 TO: THE INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA

19 Respondent Conesco Senior Health Insurance Company ("Respondent") hereby enters
20 into this Stipulation and Waiver and stipulates as follows.

21 WHEREAS, the Insurance Commissioner of the State of California ("Commissioner")
22 filed a "First Amended Order to Show Cause and Notice of Hearing, and Notice of Monetary
23 Penalty, First Amended Statement of Charges/Accusation Including Suspension or Revocation of
24 Certificate of Authority" (Accusation); and

25 WHEREAS, the Accusation alleged that the Commissioner received complaints from
26 policyholders of long term care policies, home health policies, skilled nursing home policies and
27 other policies issued by Respondent (collectively, "LTC Policies" and the benefits thereunder,
28 "LTC Policy Benefits") regarding Respondent's handling of claims under LTC Policies; and

1 WHEREAS, policyholders contended that Respondent failed to properly and timely
2 adjust and pay claims, communicate with the policyholders regarding claims in a timely and
3 responsive manner, and otherwise failed to deal with policyholders consistent with California
4 laws and regulations; and

5 WHEREAS, the Accusation stated that the Commissioner conducted a market conduct
6 examination of Respondent's operating procedures and claims handling practices for Policies for
7 the period between July 1, 2005 and March 31, 2007 and that as a result of the examination, the
8 Commissioner issued reports finding that Respondent engaged in a pattern and practice of
9 violating the Insurance Code §§790.03, 10123.13, 10234.8, 10235.9, 10237.5 and 10235.40, the
10 Fair Claims Settlement Practices Regulations, by among other matters, unduly delaying payment
11 of claims, wrongly denying claims, failing to fairly and properly interpret and apply policy
12 provisions, requiring claimants to submit information that was not relevant and material to
13 claims, failing to respond to claimant inquiries in a timely manner, and failing to respond to
14 communications from the California Department of Insurance ("CDI"); and

15 WHEREAS, Respondent filed a Notice of Defense which denied the allegations set forth
16 in the Accusation as a matter of fact and as a matter of law, which set forth defenses, and which
17 sought a hearing of the matter; and

18 WHEREAS, the matter was set for hearing before the Office of Administrative Hearings;
19 and

20 WHEREAS, Respondent denies the allegations in the Accusation but acknowledges that
21 if the allegations were proven to be true, they would constitute grounds for the Commissioner to
22 obtain the relief sought in the Accusation; and

23 WHEREAS, Respondent wishes to resolve the matters set forth in the Accusation without
24 the need for a hearing solely to avoid the substantial costs of administrative proceedings and
25 diversion of its management staff and other resources required for business operations;

26 NOW, THEREFORE, Respondent stipulates as follows:

27 1. Waiver of Hearing. Respondent waives its right to a hearing in this matter and waives
28 any and all other rights that may be accorded pursuant to Chapter 5, Part 1, Division 3, Title 2 of

1 the Government Code.

2 2. No Admission. Respondent denies the allegations contained in the Accusation and
3 nothing contained herein or contained in any order of the Commissioner adopting this Stipulation
4 and Waiver shall be construed as a concession or admission of the truth or validity of any
5 allegation contained in the Accusation. This Stipulation and Waiver shall not constitute or be
6 construed in any administrative or judicial proceeding as an admission that Respondent engaged
7 in acts, omissions, or practices in violation of Insurance Code §790.03 et seq., the Fair Claims
8 Settlement Practices Regulations, and Insurance Code §10123 (a).

9 3. Policy Interpretation. Respondent's Policies shall be interpreted and applied as set
10 forth herein.

11 A. Medicare Coordination - 42 U.S.C. §1395ss. Coordination and nonduplication
12 pursuant to 42 U.S.C. §1395ss of LTC Policy Benefits with benefits provided by Medicare
13 ("Statutory Coordination") shall be interpreted and applied only as follows:

14 i. The LTC Policy must contain express wording that coordination is required.

15 The following example does not permit coordination:

16 The following applies to this Policy only if required by either state or federal law:
17 Benefits otherwise payable under this Policy will be reduced by any amounts paid
18 by Medicare for the same care, services or supplies.

18 ii. Statutory Coordination does not apply to LTC Policies that are not "tax
19 qualified;"

20 iii. Statutory Coordination does not apply to *per diem* benefits provided by an
21 LTC Policy (i.e., Respondent must pay a *per diem* benefit regardless whether Medicare benefits
22 are received by the policyholder);

23 iv. Statutory Coordination is permissible only to the extent of actual Medicare
24 payments for specific LTC Policy Benefits. All other LTC Policy Benefits shall be paid without
25 reduction.

26 B. Medicare Coordination pursuant to Contractual Policy Terms. Coordination and/or
27 nonduplication of LTC Policy Benefits with benefits provided by Medicare pursuant to the terms
28 of a Policy other than as a result of Statutory Coordination ("Contractual Coordination"), shall be

1 interpreted and applied only as follows:

2 i. The LTC Policy must contain express wording that coordination is permitted or
3 required. The example set forth in Paragraph 3(A)(i) does not permit Contractual Coordination.

4 ii. Contractual Coordination does not apply to *per diem* benefits provided by an
5 LTC Policy unless the LTC Policy contains express wording for such coordination. The
6 following example does not permit Contractual Coordination of per diem benefits:

7 To the extent a benefit is available to you under Medicare ... coverage will not be
8 duplicated under this Policy.

9 iii. Contractual Coordination is not permissible as to any LTC Policy that was
10 issued by Respondent (or its assignor) prior to enactment of Medicare laws or regulations
11 providing long term care benefits;

12 iv. Contractual Coordination is permissible only to the extent of actual Medicare
13 payments for specific LTC Policy Benefits. All other LTC Policy Benefits shall be paid without
14 reduction.

15 C. Policy Elimination Period. An LTC Policy elimination period shall be applied
16 without consideration of the existence or duration of payment of long term care benefits by
17 Medicare. The foregoing precludes, but is not limited to, treating Policy LTC Benefits as being
18 not "payable" during any period when Medicare provides long term care Benefits;

19 D. Waiver of Premiums Benefit in Joint Beneficiary Policies. Unless LTC Policy
20 wording expressly provides otherwise, a waiver of premium (WP) benefit in an LTC Policy with
21 joint beneficiaries shall be interpreted such that satisfaction of any WP elimination period by one
22 of the joint beneficiaries shall waive the premium due, as provided for by the Policy terms, as to
23 both beneficiaries.

24 E. Waiver of Premiums Benefit Elimination Period. Unless LTC Policy wording
25 expressly provides otherwise (whether the LTC Policy has joint or single beneficiaries), the
26 elimination period applicable to LTC Policy benefits shall run concurrently with the elimination
27 period applicable to WP benefits. The following example requires the LTC Policy elimination
28 period and the WP elimination period to concurrently:

1 We will waive the payment of each premium coming due after benefits have been
2 payable under this Policy for at least 90 continuous days and while you continue
to receive covered Care or Services.

3 4. Remediation. Respondent shall undertake and complete the following remediation by
4 March 31, 2010.

5 A. Medicare. Respondent shall review all LTC Policies that were in force on or after
6 January 1, 2004 (including policies that are no longer in force) for which either Statutory
7 Coordination or Contractual Coordination was applied. To the extent that LTC Policy benefits
8 were not paid from and after January 1, 2004 as a result of a coordination interpretation that does
9 not comply with Paragraphs 3(A) or 3(B) above, Respondent shall redetermine coordination as
10 provided for in such Paragraphs and shall pay any resulting LTC Policy benefits to the
11 policyholder. To the extent that Respondent's electronic records and systems reasonably allow
12 identification and determination of LTC Policy Benefits that were not paid prior to January 1,
13 2004 because of a coordination interpretation that does not comply with Paragraphs 3(A) or
14 3(B), Respondent shall also redetermine coordination as provided for in such Paragraphs and
15 shall pay any resulting benefits to the policyholder. Respondent shall pay interest on all benefits
16 required by this Paragraph at the rate of 10% from the date the benefits should have been paid
17 through the date of payment

18 B. Waiver of Premium - Joint Beneficiary Policies. Respondent shall review all joint
19 beneficiary LTC Policies that were in force on or after January 1, 2004 (including policies that
20 are no longer in force) which contain a WP benefit and shall determine whether the WP benefit
21 was applied in accordance with Paragraph 3(D.) For any WP benefit that was not applied in
22 accordance with such Paragraph and which resulted in payment of premiums that should have
23 been waived, Respondent shall pay such premiums to the policyholder. To the extent that
24 Respondent's electronic records and systems reasonably allow identification and determination
25 of WP benefits that were not calculated in accordance with Paragraph 3(D) prior to January 1,
26 2004, Respondent shall also pay such premiums to the policyholder. Respondent shall pay
27 interest on all premiums required by this Paragraph at the rate of 10% from the date the benefits
28 should have been paid through the date of payment.

1 C. Waiver of Premium Elimination Period. Respondent shall review all LTC Policies
2 that were in force on or after January 1, 2004 (including policies that are no longer in force)
3 which contain a WP benefit and shall determine whether the WP elimination period was
4 calculated in accordance with Paragraph 3(E.) For any elimination period that was not
5 calculated in accordance with such Paragraph and which resulted in payment of premiums that
6 should have been waived, Respondent shall pay such premiums to the policyholder. To the
7 extent that Respondent's electronic records and systems reasonably allow identification and
8 determination of WP elimination periods that were not calculated in accordance with Paragraph
9 3(E) prior to January 1, 2004, Respondent shall also pay such premiums to the policyholder.
10 Respondent shall pay interest on all premiums required by this Paragraph at the rate of 10% from
11 the date the benefits should have been paid through the date of payment.

12 D. Inflation Benefit Factor. For any LTC Policy that is in force as of the date of this
13 Stipulation and Waiver that does not have a rejection of inflation benefit factors that was signed
14 by the policyholder and which complies with Insurance Code §10237.5, Respondent shall offer
15 the policyholder the right to purchase an inflation benefit factor that complies with the
16 requirements of the Insurance Code. A policyholder may purchase an inflation benefit factor
17 effective as of any date between January 1, 2008 and December 31, 2009 and premiums shall be
18 paid for such inflation benefit factor from such date. The premium for the inflation benefit factor
19 shall be at the rate that was applicable when the LTC Policy was issued.

20 E. Communication Templates. Respondent shall submit templates to the Commissioner
21 for his approval of written communications to be sent to policyholders explaining any
22 remediation calculation undertaken pursuant to this Paragraph (4) as to his or her Policy. No
23 communication is required in the event that the calculation does not result in a remediation
24 payment to the policyholder. The templates shall be submitted to the Commissioner by
25 September 30, 2009.

26 F. Report. On or before April 30, 2010, Respondent shall provide a report to the
27 Commissioner on the remediation undertaken pursuant to Paragraph 4(A) - (D) which shall
28 identify the following as to each category of remediation:

1 Number of policies reviewed

2 Number of policies remediated for matters after January 1, 2004

3 Number of policies remediated for matters prior to January 1, 2004

4 The report shall further provide an Excel spreadsheet containing the following information as to
5 each policy remediated, for each category of remediation:

6 Policyholder name

7 Claimant name

8 Policy number

9 Claim number

10 Principal paid

11 Interest paid

12 Payment date(s)

13 5. Explanation of Benefits Form. From and after September 1, 2009, Respondent's
14 explanation of benefit forms (EOB Form) issued in connection with payment or denial of
15 benefits under an LTC Policy shall comply with the following:

16 A. Payment of Policy Benefits. An EOB Form shall specify the dates of service for
17 which LTC Policy Benefits are paid. For a continuous period where coverage was provided
18 every day, the start and end dates are sufficient (e.g., "1/1/09-1/31/09, 31 days.") For non-
19 continuous periods, each continuous period and each non-continuous date must be specified.
20 The EOB Form must identify the provider and dates of service for each payment made (in whole
21 or in part.)

22 B. Denial of LTC Policy Benefits. An EOB Form shall specify the dates of service and
23 each invoice for which LTC Policy Benefits are denied and must specify the basis for each
24 denial. Language such as "all other claims ineligible and not covered under the policy" is
25 insufficient.

26 C. LTC Policy Elimination Period. An EOB Form shall specify the specific dates
27 included in calculation of the LTC Policy elimination period and shall specify the total number
28 of days counted. Continuous periods may be specified with start and end dates.

1 D. Application of Daily Benefit Rates. An EOB Form shall specify the dates and
2 corresponding daily rates; e.g., "2/1, 2/4-2/6, 4 days at \$100/day." Continuous periods may be
3 specified with start and end dates.

4 E. Description of Benefits Provided. Each benefit for which payment is made must be
5 specified using words. Codes may not be used. For example, "Personal Care benefit, 2/1, 2/4-
6 2/6 at \$xx/day" is acceptable, "Code 50, 2/1, 2/4 - 2/6, at \$xx/day" is not acceptable.

7 F. Medicare Coordination. If coverage was denied on the basis of Medicare
8 coordination, an EOB Form must specify the dates for which coordination was applied, the
9 Policy benefits to which coordination was applied (e.g., skilled nursing coverage), and the
10 amount of Medicare long term care benefits to which the coordination was applied.

11 G. Multiple Providers. If Policy benefits are paid to multiple providers, the EOB Form
12 must separately identify the payments and dates as to each provider.

13 6. Application of Inflation Benefit Factor. Upon each periodic application of an inflation
14 benefit factor, Respondent shall provide the policyholder with a clear written explanation of the
15 adjusted benefit rates and the manner in which such rates were calculated.

16 7. Application of WP Benefits. In each instance when a WP benefit may become
17 available, Respondent shall provide the policyholder with a clear written statement stating the
18 date the WP elimination period commenced and the date when WP benefit will take effect
19 (assuming the policyholder remains eligible for benefits.) When the WP elimination period has
20 been satisfied, Respondent shall provide a clear written statement to the Policyholder specifying
21 how the elimination period was calculated and applied.

22 8. Monetary Penalty. Within 30 days of receipt of an invoice from the CDI, Respondent
23 will pay a penalty to the CDI in the amount of \$500,000. The payment shall be mailed to the
24 California Department of Insurance, Division of Accounting, 300 Capitol Mall, 13th Floor,
25 Sacramento, California 95814.

26 9. Resolution of Matters. This Stipulation and Waiver, upon acceptance by the
27 Commissioner, constitutes a complete resolution of the matters set forth in the Accusation and
28 constitutes a resolution of the matters set forth in the reports of the Market Conduct Examination.

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10. Respondent freely and voluntarily executes this Stipulation and Waiver, with full realization of the legal rights set forth in the Statement to Respondent.

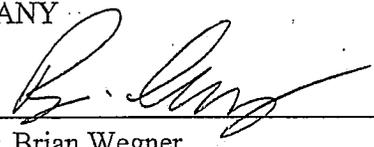
11. This Stipulation and Waiver shall be interpreted and construed in accordance with California law, without regard to choice of law considerations.

12. Respondent acknowledges that this Stipulation and Waiver is a public record under Government Code §11517(d) and that it and any order issued pursuant thereto is accessible to the public pursuant to the California Public Records Act, Government Code §§6250 *et seq.* Pursuant to Insurance Code §12968, this Stipulation and Waiver will be posted on the CDI's internet website.

13. Respondent acknowledges that Insurance Code §12921 requires the Commissioner's approval of the final settlement of this matter. Both the settlement terms and conditions contained herein and the acceptance of those terms and conditions are contingent upon the Commissioner's approval.

Date: July 14, 2009

CONSECO SENIOR HEALTH INSURANCE
COMPANY

By 

Brian Wegner
Executive Vice President and
Chief Operating Officer
(title)