MARKET CONDUCT EXAMINATION REPORT

ON

CONSECO SENIOR HEALTH INSURANCE COMPANY

NAIC Company Code 76325
Carmel, Indiana

AS OF
April 30, 2007

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EXECUTIVE SUMMARY

A multistate examination was conducted on Bankers Life and Casualty Insurance Company and Conseco Senior Health Insurance Company, hereinafter referred to as "Company." Both Companies are subsidiaries of Conseco Inc. Holding Company System. The examination was called to address the concerns and public issues brought forth through the media and individual state insurance departments concerning the Company's business practices especially in the long term care insurance market. In order to address those concerns and issues on a national level, a collaborative effort or multistate examination was determined to be the most efficient and cost effective approach. The multistate examination was coordinated with the National Association of Insurance Commissioners' (NAIC) Market Analysis Working Group and was conducted on behalf of initially 39 participating states under the leadership of Pennsylvania, Florida, Illinois, Indiana and Texas. The onsite examination of Bankers Life and Casualty Insurance Company was conducted in Chicago, Illinois simultaneously with the onsite examination of Conseco Senior Health Insurance Company in Carmel, Indiana. For clarity of reporting, separate Reports will be issued on each company.

The purpose of the multistate examination was to determine if both companies were maintaining appropriate business practices, especially in the long term care insurance lines.

The examination of both companies focused on areas of Complaint Handling, and Long Term Care and Home Health Care Claim Handling. Since Conseco Senior Health Insurance Company no longer writes new business, the focus on marketing and sales activities was restricted to Bankers Life and Casualty Insurance Company and included all product lines. The examination included a review of the Company's activities in all states, with the Lead States of Pennsylvania, Florida, Illinois, Indiana, and Texas overseeing the daily examination activities.

The Company self-reported a number of issues that had been identified prior to the initiation of this examination through the media, internal audits and other state market conduct examinations. The predominant issue of Conseco Senior Health Insurance Company was the appropriateness of the processing of long term care claims. The Company has continually expressed its interest in entering into a Corrective Action Plan with participating states to address the specific claim processing issues, self-identified issues and any additional issues identified and verified as a result of the examination.

Based on the Company's self-reporting, prior market conduct examination reports and the large population of data files identified, a random sampling of selected files based on certain criteria was utilized to select the files reviewed for this examination.

In order to provide for a complete, efficient and expeditious review of the sampled files from all jurisdictions, the Lead States and the Company agreed the review was to be conducted based on the Company's compliance with NAIC standards. Where compliance determination required more specific state timelines (days), the examiners would apply the timelines applicable to Pennsylvania insurance regulations.

A number of issues were noted during the course of the examination. The issues related to the Company's complaint and claims handling practices. The deficiencies in the Company's complaint and claims handling practices are summarized as follows:

Complaints

- Complaints are not recorded in the required format on a Company complaint register.
- The Company does not have adequate complaint handling procedures in place to properly adequately respond to and process complaints and does not readily communicate such complaint procedures to policyholders.
- The time frame within which the Company responds to, investigates and resolves complaints is not in accordance with applicable statutes, rules, and regulations.
- The Company does not maintain adequate complaint files.

Claims

- The initial contact by the Company with the claimant is not within the required time frame.
- Investigations of pending claims are not conducted in a timely manner.
- Claims are not handled, settled and paid in a timely manner as required by statutes, rules and regulations.
- Claim files are not adequately documented or maintained.
- Claim files are not handled in accordance with policy provisions and state law.

For each of the cited exceptions in the report, recommendations have been made to address the issues and concerns noted by the examiners. Accordingly, the results of operational improvements implemented by the Company, which occurred after the examination period (i.e., after April 30, 2007), are not reflected in the data contained in this Report. Details of the corrective actions taken by the Company to address the findings of this review are listed in the Company Response section of this Report.

INTRODUCTION

An examination was conducted on Conseco Senior Health Insurance Company, at the Company's offices located in Carmel, Indiana, from July 9, 2007 through October 19, 2007. Preliminary work for the examination and subsequent review and follow-up was conducted at the examination offices of Insurance Regulatory Insurance Services, Inc.

The examination included an assessment of the Company's activities in all states. This multistate examination represents 39 states with the Lead States of Pennsylvania, Florida, Illinois, Indiana, and Texas overseeing the daily examination activities. The examination firm of Insurance Regulatory Insurance Services, Inc., Philadelphia, Pennsylvania, was selected to conduct the examination of this Company on behalf of all of the participating states.

Throughout the course of the examination, Company officials were provided memoranda or inquiries, which referenced specific policy numbers with citation to each section of law at issue. Additional information was requested from the Company to clarify potential violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and to review the written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

SCOPE OF EXAMINATION

The examination was conducted pursuant to the authority granted by the participating states. A complete list of participating states and the applicable statutory authority for each state may be found in Appendix A. The experience period or scope covered in this report is January 1, 2005, through April 30, 2007, unless otherwise noted. The purpose of this examination is to determine compliance by the Company with the insurance laws and regulations of the participating states.

The examination relied on the standards included in the NAIC's *Market Conduct Examiners' Handbook* and focused on the Company's Complaint and Claim Handling practices and procedures. The Company was requested to identify the universe of files for each segment of the review. Based on the Company's self-reporting, prior market conduct examination reports and the large population of data files identified, a random sampling of selected files based on certain criteria was utilized to select the files reviewed for this examination.

COMPANY HISTORY AND LICENSING

Company Formation

Conseco Senior Health Insurance Company is a stock life and health insurance company domiciled in the Commonwealth of Pennsylvania. The Company was originally formed in Pennsylvania on July 5, 1887, as a society for beneficial purposes named the Home Beneficial Society. Through Articles of Agreement filed with the Secretary of the Commonwealth of Pennsylvania on December 1, 1964, the Company was reincorporated as a stock limited life insurance Company and the name was changed to Signal Life Insurance Company.

The Company changed its name in 1968 to Penn Treaty Life Insurance Company. Penn Treaty was suspended in January of 1970 and all of its business was reinsured by Pilgrim Life Insurance Company. The Company was subsequently sold and the suspension lifted. On June 10, 1976, the Company changed its name to American Travellers Life Insurance Company. In January 1977, Great Valley Investors, Inc. purchased all of the issued and outstanding shares of common stock of the Company. In November 1985, Great Valley Investors, Inc. changed its name to American Travelers Corporation.

On December 17, 1996, Conseco, Inc. acquired American Travellers Insurance Company when it purchased American Travellers Corporation. Centralization of the common service functions moved to Carmel, Indiana in September 1997 with claims processing being performed in Chicago, Illinois until 2004. In 2004, claims processing also moved to Carmel, Indiana.

In 1997, Conseco reorganized its holding company structure with American Travellers Insurance Company becoming a wholly-owned subsidiary of Jefferson National Life Insurance Company of Texas. In addition, Continental Life Insurance Company was acquired. On November 10, 1997, American Travellers Insurance Company became the surviving entity in a merger with another Company, Transport Life Insurance Company. On November 2, 1998 the name of the Company was changed to Conseco Senior Health Insurance Company. Effective September 30, 1999, United General Life Insurance Company was merged with the Company. Continental Life Insurance Company was merged with the Company on October 1, 2000.

On December 17, 2002 Conseco, Inc. filed for permission to reorganize under Chapter 11 bankruptcy protection. Conseco, Inc. completed its reorganization and emerged from Chapter 11 bankruptcy on September 10, 2003. In April of 2003, the Company ceased writing any new business.

Licensure

A list of the participating states and the date the Company was authorized to conduct business in each state is included in Appendix A. The Company is authorized to do business in 46 states, the District of Columbia and the U.S. and British Virgin Islands.

Product Offerings

As previously stated, the Company ceased writing new business in 2003. The inforce business is composed primarily of Long Term Care policies. Additional inforce products include specified disease policies, ordinary life insurance and individual annuities.

In its December 31, 2006 annual statement filed with the NAIC, the Company reported nationwide premiums and annuity considerations for life insurance in the amount of $4,707,594, annuities in the amount of $11,310, and accident and health contracts in the amount of $334,169,054. There were 185,830 life insurance contracts, 264,317 individual accident and health policies, 5,881 group accident and health policies and 415 deferred annuities inforce as of December 31, 2006. According to the Company's marketing materials, its primary focus is on reducing operating expenses and improving the efficiency of operations across all business functions. In December 2006, the Company announced the plan for reorganizing its back office operations with the intent of further decreasing operating expenses. Since the Company does not currently market new products and given that its predominant inforce business, Long Term Care has experienced significant losses, the Company has an impact on the ratings its affiliates receive from nationally recognized rating organizations. As of October 2, 2006, A.M. Best affirmed the financial strength rating of "B (Fair)".

Previous Market Conduct Examinations

Prior to the initiation of this multistate examination, the Company had been the subject of 12 Market Conduct Examinations conducted by a number of states from 2005 through 2007.

METHODOLOGY

There are three general categories of sampling techniques used during examinations: generic, random sample and electronic. A "generic" review is conducted through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner. A "random sample" review is conducted through direct review of a random sample of files using sampling methodology described in the NAIC's *Market Conduct Examiners Handbook.* An "electronic" review is conducted through the use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically evaluates 100% of the records of a particular type. The sampling techniques used are based on a ninety-five percent (95%) confidence level. This means that there is a ninety-five percent (95%) confidence level that the error percentages shown in the various standards tested are representative of the entire set of records from which it was drawn.

After utilizing a selection criteria representative of the percentage of claims paid/denied from each state, the sampling technique used in this examination was the random sample method.

The focus of this multistate examination was on the Complaint Handling and Claims Handling (Paid and Denied) practices for Long Term Care Insurance. From a universe of 6,083 complaints representing all jurisdictions, the examiners randomly selected and reviewed 150 Complaints. From a universe of 423,337 Paid/Denied Claims, representing all jurisdictions, a selection criteria was utilized to select files from all jurisdictions based on the percentage of the actual number of claims paid/denied from each jurisdiction. As a result of the selection criteria utilized, a total of 1200 claim files were randomly selected for review.

Examination Standards from the NAIC's *Market Conduct Examiners Handbook* were applied to each of the areas tested. Observations, and recommendations where indicated are presented for each of the standards tested. Where compliance determination required more specific state timelines (days), the examiners applied the timelines applicable to Pennsylvania Regulations.

COMPANY OPERATIONS/MANAGEMENT

Standard: Records are adequate, accessible, consistent, orderly and comply with record retention requirements.

The examiners found the records were not adequate, accessible, consistent, orderly or compliant with record retention requirements. These observations apply to both the Complaint Handling review and the Claims Handling review portions of the examination. The examiners encountered some difficulty conducting file reviews due to missing or incomplete information in the complaint and claim files. Specific details regarding the complaint files and claim files are discussed in the appropriate sections that follow.

Standard: The Company cooperates on a timely basis with examiners performing the examinations.

The Company was provided five business days to respond to individual complaint files and individual claim file requests. Time extensions were granted for the Company to respond to many of the examiner requests.

COMPLAINT HANDLING

The examination included two phases of Complaint Handling review. Phase I included the analysis of electronic complaint data. Phase II included a review of a random sample of 150 complaint files. For the purposes of this examination, the examiners relied on the following NAIC definition of a complaint: "A complaint is a written communication primarily expressing a grievance."

Phase I – Analysis of Electronic Complaint Data

2005-2006

The examiners analyzed a file of complaint data received from Conseco Senior Health Insurance Company for the period January 1, 2005 through December 31, 2006. The file contained 4,926 complaints received during the period under review. The examiners found that the Company failed to maintain complete and accurate complaint data as required for the 2005-2006 period.

The Company was given specifications for submitting complaint data in the document entitled Multistate Examination Plan dated May 10, 2007. Appendix A, Section D of that document listed 19 data fields required for each complaint along with a description of what the data in each of those fields should represent. The examiners found that the Company did not submit the data as specified in the data call. The Company utilized the data field "CmpRes" to track the "Functional Area" involved in the complaint rather than the reason for the complaint and added the field "CmpRes2" to track the reason within the Functional Area identified in field "CmpRes". The Company defined the data field, "CmpTmTp" as the "Complaint Inquiry Type" rather than for the manner in which the complaint was transmitted to the Company as outlined in the data call.

The data was also found to be incomplete. The files did not have the Complaint Source (CmpSrc) data or Agent Code information.

Data analysis indicates that Claims (48.7%) and Policyholder Information (30.0%) have the largest share of complaints by Functional Area followed by Policy Change Request (9.1%) and Premium/Billing (9.0%).

Long-Term Care (71.1%) comprised the largest share of complaints by coverage type followed by Home Health Care (24.2%) and Nursing Home (4.7%).

Twenty-five states had 50 or more of the 4,926 reported complaints. This finding indicates that the Company's complaints are not limited to certain geographic or demographic populations.

Analysis of the files reveals that the average number of complaints per month dropped significantly from 2005 to 2006 and the total number of complaints in 2006 dropped by more than 50%.

The examiners note that each complaint record in the file corresponded to a unique Inquiry ID number. Review of the 4,926 total complaint records for 2005-2006 found that 1,216 (24.7%) complaints involved policy numbers associated with multiple Inquiry ID's. Analysis revealed the following: 456 policy numbers had 2 Inquiry ID's, 68 policy numbers had 3 Inquiry ID's, 17 policy numbers had 4 Inquiry ID's, 5 policy numbers had 5 Inquiry ID's and 1 policy number had 7 Inquiry ID's.

"Claims" was listed as the "Functional Area" involved in 764 (62.8%) of these 1,216 records. Claims procedures, delays, denials and unsatisfactory settlements were listed as the reason for the complaint in 623 (81.5%) of the 764 complaints listed under the Claims function. Policyholder Information was identified as the "Functional Area" in 279 inquiries (22.9%) and Premium/Billing was identified as the "Functional Area" in 99 (8.1%) of the 1216 records reviewed.

State Departments of Insurance (DOI) were identified as the "Inquiry Type" in 511 (42%) of the 1,216 records associated with multiple Inquiry ID's and Attorneys were identified as the "Inquiry Type" in 263 (21.6%) of the 1,216 records in this separate multiple Inquiry ID study.

The Company does not capture complaints by the manner in which the complaints were received. The data field, "CmpTmTp", was defined by the Company as the "Complaint Inquiry Type." DOI Complaints were identified as the "Inquiry Type" in 33.7% of the 4,926 complaints, Consumer Complaints were identified as the "Inquiry Type" in 20.5% and some manner of Attorney involvement was identified as the "Inquiry Type" in 38.5% of the total complaints reported.

The examiners conclude that such a high percentage of DOI and Attorney transmitted complaints are an indication that initial complaints are not timely and adequately resolved thereby resulting in a second complaint. This is borne out by the large number of policies (547) with more than one Inquiry ID.

The Company's Resolution data inadequately describes the complaint disposition (*i.e.* "Developed Action Plan", "No Recommendation", "Reported to DOI", and "Responded to Complaint"). Three records show a Resolution of "Pending" for a specified reason but all three have corresponding resolution dates. The examiners found that 35.8% of the complaints were resolved in favor of the Complainant. A high percentage of reversed decisions is an indication that the Company's procedures may be inadequate.

2007

The examiners also analyzed a file of complaint data received from Conseco Senior Health Insurance Company for the period January 1, 2007 through April 30, 2007. The file contained 1,157 complaints received during the period.

Analysis of the submitted complaint data indicates that the Company's claims handing practices and policyholder service procedures showed no marked improvement over the 2005-2006 period.

As with the 2005-2006 period, the Company failed to maintain complete and accurate information.

Data analysis indicates that Claims (45.6%) and Policyholder Information (25%) have the largest share of complaints by Functional Area followed by Policy Admin Request (10.1%) and Premium/Billing (9.4%).

Long-Term Care (75.6%) comprised the largest share of complaints by coverage type followed by Home Health Care (19.6%) and Nursing Home (4.8%).

Seventeen states had 20 or more of the 1,157 reported complaints. This indicates that the Company's complaints are not limited to certain geographic or demographic populations.

The average number of complaints per month for 2007 shows a significant increase compared with 2005 and 2006. During the first four months of 2007, the Company averaged 289 complaints compared with 208 per month in 2006 and 228 per month in 2005 for the same period.

The examiners note that each complaint record in the file corresponds to a unique Inquiry ID number. Review of the 1,157 total complaint records for 2007 found that 193 (16.7%) complaints involved policy numbers associated with multiple Inquiry ID's. Analysis revealed the following: 79 policy numbers had 2 Inquiry ID's, 9 policy numbers had 3 Inquiry ID's and 2 policy numbers had 4 Inquiry ID's.

"Claims" was listed as the "Functional Area" involved in 101 (52.3%) of these 193 records. Claims procedures, delays, denials and unsatisfactory settlements were listed as the reason for the complaint in 79 (78.2%) of the 101 complaints listed under the Claims function. Policyholder Information was identified as the "Functional Area" in 45 inquiries (23.3%) and Premium/Billing was identified as the "Functional Area" in 23 (11.9%) of the 193 records reviewed.

"Consumer Complaint" was identified as the "Inquiry Type" in 69 (35.2%) of 193 records associated with multiple Inquiry ID's. State DOI's were identified as the "Inquiry Type" in 57 (29.5%) of the 193 records and Attorneys were identified as the "Inquiry Type" in 42 (21.8%) of the 193 records in this separate multiple Inquiry ID study.

The data field, "CmpTmTp", was defined by the Company as the "Complaint Inquiry Type". DOI Complaints were identified as the "Inquiry Type" in 24.5% of the 1157 total complaints, Consumer Complaints were identified as the "Inquiry Type" in 42.5% and some manner of Attorney involvement was identified as the "Inquiry Type" in 25.6% of the total complaints reported at the time of the examination in 2007.

The examiners conclude that a continued high percentage of DOI and Attorney transmitted complaints are an indication that the Company did not measurably improve its complaint handling procedures. Initial complaints were not timely and adequately resolved resulting in a

substantial number of policies (90) that already have more than one Inquiry ID in the first four months of 2007.

The Company's Resolution data inadequately described the complaint disposition (*i.e.* "Developed Action Plan", "No Recommendation", "Reported to DOI", and "Responded to Complaint").

There was no appreciable improvement noted in the Company's complaint tracking procedures based on comparisons between the data submitted for the 2005-2006 periods and the data for the first four months of 2007.

Phase II – Complaint File Sampling Review

From the population of 6,083 complaints, a random sample of 150 complaint files was selected for review. During the examiners' review of the complaint files, each file was evaluated to determine if the file met criteria in accordance with standards in the *NAIC's Market Conduct Examiners' Handbook.* Where compliance determination required more specific state timelines (days), the examiners applied the timelines applicable to Pennsylvania Regulations. The specific standards and findings are summarized below.

The examiners measured the completeness of the complaint files using an approach that a "complete" complaint file should provide empirical evidence to support the handling and outcome of the complaint. The evidence should, at a minimum, include the original copy of the insured's complaint, the Company's response and relevant documentation to support the handling of the complaint. Relevant documentation should provide the reader a clear and complete understanding of the insured's complaint and the steps the Company undertook to resolve the complaint.

The Company provided the examiners 150 complaint files to review. Upon completing the initial review, the examiners determined that the majority of the files were incomplete and several requests for additional information were required in order for the examiners to ascertain the handling of the complaint. The Company stated that multiple systems and departments needed to be accessed or information has to be requested from them in order to provide all relevant documentation associated with each complaint. All documentation relevant to each complaint is not maintained in one file in any area of the Company.

Upon review it was determined that 34 of the complaints were not complaints, but in fact were inquiries. When asked for an explanation, the Company responded that all correspondence is logged as a complaint and they have no means of differentiating an inquiry from a complaint. Additional complaint files were pulled to replace the files determined to be inquiries.

Standard: All complaints are recorded in the required format on the company complaint register.

An insurer is required to maintain a complete record of all the complaints received. The record must indicate the total number of complaints since the last examination, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.

According to the Company and examination team observations, all complaints are logged into the Inquiry Database system known as the "IDB." However, the Company does not maintain and update a formal complaint register. Additional documentation related to complaints is located in several other systems not directly connected by complaint number.

Standard: The company has adequate complaint handling procedures in place and communicates such procedures to policyholders.

The examination team did not find evidence that the Company provides information regarding its complaint handling procedures to policyholders.

Standard: The company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules, regulations and contract language.

The Company did not provide adequate documentation to demonstrate proper disposition of the complaint in 16 of the files reviewed.

Standard: The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules, and regulations.

Pursuant to 31 Pa. Code §146.5(a), the Company has ten working days to initially respond to complaints. Sixty-six of the files sampled contained response times greater than that allowed by regulation.

In addition, the examination team noticed a trend in which the Company's "Date Received" stamp, which is marked by the department that receives the document, does not coincide with the actual date the document was received at the Company as recorded by the mailroom. This occurrence was noted in 30 of the complaints sampled.

CLAIM HANDLING

From a universe of 423,337 Paid/Denied Claims, representing all jurisdictions, selection criteria for the claim sampling was developed to select files from all jurisdictions based on the percentage of actual number of claims paid/denied from each jurisdiction. A total of 1,200 claim files were randomly selected for review. During the course of the examination and after reviewing 75 paid claim files and 250 denied claim files, it became apparent that any further review and findings of the remaining sampled claim files would be redundant. The Lead States and the Company agreed that the findings in the reviewed files, along with the Company's self-reported findings would be sufficient to verify the Company's claims compliance issues.

During the examiners' review of the claim files, each file was evaluated to determine if the file met criteria in accordance with standards in the NAIC's *Market Conduct Examiners' Handbook.* Where compliance determination required more specific state timelines (days), the examiners applied the timelines applicable to Pennsylvania Regulations. The specific standards and findings are summarized below.

Standard: The initial contact by the company with the claimant is within the required time frame.

The Company created a system in August 2005 that automatically generates an acknowledgment letter upon the receipt of a claim. This acknowledgment letter is a form letter and does not include the assigned claim number. Therefore, when a claimant submits more than one claim to the Company, it has no way of identifying to which claim the acknowledgement letter pertains. Many of the claim files produced in 2005 do not have acknowledgement letters. Automatically generated acknowledgement letters were often not included in the files provided to the examiners.

The examiners found that the Company did not acknowledge receipt of a claim within the required time frame of ten days in 37% of the Paid Claims files and 21% of the Denied Claims files reviewed for the entire examination period.

The Company's compliance with the required time frame for acknowledging claims has improved from 2005 to 2007.

Standard: Investigations are conducted in a timely manner.

Based on the examiners review of the Paid Claim files, the Company did not always complete a claims investigation within 30 days. In many instances the Company bundled claims together and paid them under a single claim. This process resulted in delays in payment. The Company also assigns 'holds' to claim payments that cause numerous delays in claim handling.

In instances where a claim was not resolved in 30 days, and the Company continued its investigation, the examiners did not find evidence of correspondence or status letters from the Company to the claimant or provider informing them that additional time is needed to resolve the claim.

Standard: Claims are settled and paid in a timely manner as required by statutes, rules and regulations.

The examination team determined that deficiencies in the Company's claim handling processes and procedures contribute to delays in adjudicating claim files. These deficiencies include:

- Conflicting Date Received information (the Company records the date received as the date the claim is scanned into the Company's system and not by the actual date it is received by the Company).
- Multiple claim numbers opened and closed per event.
- Claims are bundled together and paid under one claim.
- Claims are opened in error and left open for an unspecified period of time.
- Duplicate claim payments.
- The Company rejecting claims that do not include Daily Progress Notes, itemized bills and the provider's license.
- Inappropriate use of 'pended' or 'hold' claim status in the BICPS system resulting in delays in the claim handling process.
- The Company's inability to pay and deny a claim on the same claim number, therefore, requiring the adjuster to open another claim number to settle the claim.

The examiners found that the Company did not pay or deny claims within the required time frame of 15 working days in 47% of the Paid Claims files and 44% of the Denied Claims files reviewed for the entire examination period.

Standard: The company responds to claim correspondence in a timely manner.

The initial claim review noted several files containing claimant correspondence with the Company in addition to the proof of loss. In most instances, the only acknowledgment of the communication by the Company was the acknowledgement letter, claim payment or denial letter.

The Company records the Date Received as the date the claim is scanned into its own database and not the actual day the claim is received by the Company. This practice allows for many inconsistencies in the reporting of the date a claim is received. This process also contributes to numerous delays in claim handling.

The examiners found that the Company did not date stamp pertinent information in 62% of the Paid Claims files and 41% of the Denied Claims files reviewed for the entire examination period.

The Company's accuracy in reporting the actual Date Received for Paid Claim files has increased from 2005 (28%) to 2007 (77%).

The Company's accuracy in reporting the actual Date Received for Denied Claim files has increased from 2005 (57%) to 2007 (59%).

The Company records "Holds" on its BICPS screens, the Company's tool for tracking the progress and closing of claims. When a Hold is placed on a claim, the adjuster is supposed to provide an explanation for the Hold in the comments area of the screen. However, after the claim is closed these comments are deleted, thus preventing the examiners from learning why the Hold was originally placed on a claim. The Hold directly affects the release of claim payments and the claim adjudication process.

Standard: Claim files are adequately documented.

Based upon the examiners' review of the Paid and Denied Claim files, the majority of the files were not adequately documented. Many of the Denied Claim files were missing the notice of the claim, claim form(s), copies of the Explanation of Benefits (EOB's), correspondence relating to the release of claim payments or denials, and other documentation (paper or electronic) to support the claim handling activities. The Paid Claim Files were missing the notice of the claim, claim form(s), bills, copies of the EOB's, copies of claim checks/drafts, correspondence relating to the release of claim payments or denials, and other documentation (paper or electronic) to support the claim handling activities.

The examiners found that the Company did not retain adequate claim handling documentation in the claim files reviewed.

Standard: Claim files are handled in accordance with policy provisions and state law.

The Denied Claims review consisted of a review of Company reports and denied claim files. Due to multiple claim system constraints and the assignment of multiple claim numbers for the same service or event, the predominant finding was that claims were often initially denied for various reasons such as lack of information or documentation, but ultimately paid. Claim issues related to the denial of claims, indicates a need for further Company analysis of such claim denials and potential remediation for any identified errors related to: activities of daily living; covered persons, covered conditions, covered services timely submission of proofs of loss; waiver of premium, covered facilities, pre-existing conditions, advanced billings, and complete proofs of loss.

The Company offers several Long Term Care and Home Health Care policy forms that feature a Restoration of Benefits provision. This provision restores a claimant's maximum benefit under his/her policy when the claimant no longer requires qualified Long Term Care services for 180 consecutive days for the same cause or causes for which a previous Period of Expense began.

During the review of Denied Claims the examiners found that when the maximum benefit was paid under a contract containing this provision, the Company's letter accompanying the final payment inadequately advised claimants of the Restoration of Benefits feature when available to the policyholder. In the denial letters sent by the Company to the insured when a maximum benefit had been paid under a contract, it instructs the insured to, "Please refer to your policy schedule page. If you feel there are other facts that we should consider, please write: Conseco Senior Health Insurance Company, Claim Review Department, at the above address." The letter should also advise the policyholder that he or she could be entitled to future benefits under a restoration of benefits provision in their contract.

CONCLUSION

The examination was conducted by H. Brian Maynard, Craig Jackson, Susanna Stevens, Sean Connelly, Brian Dunn and Debra Boothby, and is respectfully submitted.

H. Brian Maynard

H. Brian Maynard
Market Conduct Examiner-in-Charge

Cynthia M Amann

Cynthia M Amann
Market Conduct Supervising Examiner

RECOMMENDATIONS

The recommendations made below identify and summarize the corrective measures the lead states find necessary to address the issues and concerns found and detailed in the Report. These recommendations are general in nature. For a more detailed corrective action plan, refer to the settlement agreement document. The listing of these recommendations does not take into consideration any actions that the Company has initiated subsequent to the examination period.

1. The Company must review and revise current complaint handling policies and procedures to collect, maintain and retain appropriate documentation. The Company's policies and procedures should ensure compliance with record retention statutes, rules and regulations of each specific state.

2. The Company must maintain a formal complaint register. The register must contain sufficient data to ensure compliance with complaint retention statutes, rules and regulations of each specific state.

3. The Company must review and revise complaint handling policies and procedures to communicate complaint procedures to the policyholders, to address all issues of a complaint and to address these issues in a timely and proper manner. The Company's policies and procedures should ensure compliance with complaint handling statutes, rules and regulations of each specific state.

4. The Company must review and revise claim processing procedures to ensure that claims files are properly and accurately documented and maintained in their entirety, including any adjuster comments made throughout the adjudication process. The Company's policies and procedures should ensure compliance with claim documentation and maintenance statutes, rules and regulations of each specific state.

5. The Company should develop and implement procedures to ensure compliance with the time requirements for acknowledgment of claims and claims correspondence. The Company's policies and procedures should ensure compliance with claim handling statutes, rules and regulations of each specific state.

6. The Company must develop and implement procedures to ensure that claim investigations are completed timely and if additional investigation is required, to provide the claimant appropriate status letters to explain the reason for the delay.

7. The Company must review and revise procedures to ensure that claims are settled and paid timely. The Company's policies and procedures should ensure compliance with claim handling statutes, rules and regulations of each specific state.

8. The Company must review and revise procedures to ensure all claims are adjudicated properly. If the claim is denied, the claimant is provided a proper explanation and denial reason according to contract provisions and claim handling statutes, rules and regulations of each specific state.

APPENDIX A

The following is a list of states and the state's applicable statutory authority for conducting an examination.

PARTICIPATING STATE	EXAMINATION AUTHORITY CITE
ALABAMA	ALA. CODE §§27-2-20 through 27-2-27
ALASKA	ALASKA STAT. §§21.06.120 through 21.06.170
ARIZONA	ARIZ. ADMIN. COMP. R20-6-1701 through R20-6-1704; ARIZ. REV. STAT. ANN. §§20-142, 20-156 through 20-160.
ARKANSAS	ARK. CODE ANN. §§23-61-201 through 23-61-302
CALIFORNIA	CAL. INS. CODE §§730 through 738
COLORADO	COLO. REV. STAT. §§10-1-201 through 10-1-207
CONNECTICUT	CONN. GEN. STAT. §38a-14; CONN. GEN. STAT. §38a-8
DELAWARE	DEL. CODE ANN. tit. 18 §318 through 330
DISTRICT OF COLUMBIA	D.C. CODE §§31-1401 through 31-1407
FLORIDA	FLA. STAT §§624.316 through 624.322
GEORGIA	GA. CODE ANN. §§33-2-11 through 33-2-16
HAWAII	HAWAII REV. STAT. §§431:2-301 through 431:2-308
IDAHO	IDAHO CODE §§41-219 through 41-230
ILLINOIS	215 ILL. COMP. STATS. 5/132.1 through 5/132.7
INDIANA	IND. CODE §§27-1-3.1-1 through 27-1-3.1-18
IOWA	IOWA CODE §§507.1 through 507.17
KANSAS	KAN. STAT. ANN. §§40-222
KENTUCKY	806 KY. ADMIN. REGS. §2:110; KY REV. STAT §§304-2.210 through 304.2-300
LOUISIANA	LA. REV. STAT. ANN. §§22:1301 through 22:1302
MAINE	ME. REV. STAT. ANN. tit. 24-A §§221 through 228
MARYLAND	MD. ANN. CODE Ins. §§2-205 through 2-215
MASSACHUSETTS	MASS. GEN. LAWS ch. 175 §4
MICHIGAN	MICH. COMP. LAWS §500.222
MINNESOTA	MINN. STAT §60A.031
MISSISSIPPI	MISS. CODE ANN. §§83-5-201 through 83-5-207
MISSOURI	MO. REV. STAT. §§374.202 through 374.207
MONTANA	MONT. CODE ANN. §§33-1-401 through 33-1-413
NEBRASKA	NEB. REV. STAT. §§44-5901 through 44-5910
NEVADA	NEV. REV. STAT. §§679B.230 through 679B.300
NEW HAMPSHIRE	N.H. REV. STAT. ANN. §400-A:37
NEW JERSEY	N.J. REV. STAT. §§17:23-20 through 17:23-26
NEW MEXICO	N.M. STAT. ANN. §§59A-4-4 through 59a-4-21
NEW YORK	N.Y. INS. LAW §§309 through 313
NORTH CAROLINA	N.C. GEN. STAT. §§58-2-131 through 58-2-136
NORTH DAKOTA	N.D. CENT. CODE §§26.1-03-19.1 through 26.1-03-19.7
OHIO	OHIO REV. CODE ANN. §§3901.07 through 3901.071; §3901.045; §3901.36

OKLAHOMA	OKLA. STAT. tit. 36 §§309.1 through 309.7
OREGON	OR. REV. STAT. §§731.300 through 731.316
PENNSYLVANIA	PURDON STATUTES: 40 P.S. §§323.1 through 323.8
RHODE ISLAND	R.I. GEN. LAWS §§27-13.1-1 through 27-13.1-7
SOUTH CAROLINA	S.C. CODE ANN. §§38-13-10 to 38-13-60
SOUTH DAKOTA	S.D. CODIFED LAWS ANN. §§58-3-1 through 58-3-27
TENNESSEE	TENN. CODE ANN. §§56-1-408 through 56-1-413; TENN. CODE ANN. §56-1-401
TEXAS	CHAPTER 751 OF THE TEXAS INSURANCE CODE
UTAH	UTAH CODE ANN. §§31A-2-203 through 31A-2-205; UTAH INS. REG. R 590-150-1 through 590-150-4
VERMONT	VT. STAT. ANN. tit. 8 §§3563 through 3576
VIRGINIA	VA. CODE §§38.2-1317 through 38.2-1321.1
WASHINGTON	WASH. REV. CODE ANN. §§48.03.010 through 48.03.075; §48.02.065
WEST VIRGINIA	W.VA. CODE §33-20-12; W.VA. REGS. §§114-15-1 through 114-15-8
WISCONSIN	WIS. ADMIN. CODE §INS.50.50; WIS. STAT. §§601.43 through 601.45
WYOMING	WYO. STAT. §§26-2-116 through 26-2-131

COMPANY RESPONSE

Conseco Senior Health Insurance Company
11825 N. Pennsylvania Street
Carmel, IN 46082-1911

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March 20, 2008

Mr. Daniel A. Stemcosky
Market Conduct Division Chief
Commonwealth of Pennsylvania
Insurance Department
Bureau of Enforcement
1326 Strawberry Square
Harrisburg, PA 17120

Re: Pennsylvania Examination Warrant Number: 07-M12-032
Report of the Market Conduct Examination of
Conseco Senior Health Insurance Company

Dear Mr. Stemcosky:

Please accept this letter as the response of Conseco Senior Health Insurance Company ("Conseco Senior" or the "Company") to the Examination Report dated February 22, 2008. We request that this letter be included in any public dissemination of the Examination Report to allow readers of the report to have an understanding of our response to the findings contained therein.

As discussed in this letter and in the attachment hereto, we are confident we have effectively addressed or are addressing the findings identified in the Examination Report. As we have discussed previously with you and other representatives of the Pennsylvania Insurance Department, we plan to resolve all remaining issues through the implementation of a national multilevel improvement plan. Many aspects of this plan have been implemented and other portions of the plan will be implemented as agreed in the Regulatory Settlement Agreement executed by Conseco Senior, Conseco Senior's affiliate Bankers Life & Casualty Insurance Company, the Commissioner of the Florida Office of Insurance Regulation, the Director of the Illinois Division of Insurance, the Commissioner of the Indiana Department of Insurance, the Commissioner of the Pennsylvania Insurance Department, and the Commissioner of the Texas Department of Insurance (collectively "Lead Regulators").

Specifically, we remain committed to improving our claim adjudication process, including the quality of our claims review, the speed with which the review is conducted, and the manner in which we keep claimants informed of the status of their claim throughout the process. We are also committed to improving our complaint handling processes. To this end, we have made changes in our management team, reorganized our claims and complaint handling staff and reporting structures, invested in new systems, undertaken audits, increased our training, retained new consultants, and demonstrated to staff the Company's firm commitment to compliance and best practices. Many of these enhancements have been in place for some time or are under way. These enhancements are discussed more fully in Exhibit A to this letter.

Because you and the other Lead Regulators have agreed to work with us to develop and implement plans to address the issues identified during the examination, we have chosen not to exercise our right under 40 P.S. § 323.5 to submit detailed rebuttals and objections to any of the findings set forth in the Examination Report. However, the Company has identified concern in some instances regarding the applicability of certain Pennsylvania insurance laws to some of the alleged violations noted in the Exam Report. Although our decision not to submit such objections should not, and we understand will not, be construed as an admission of any of the findings set forth in the examination report, we acknowledge that certain aspects of the Company's complaint handling and claims handling processes can be improved.

Despite our concerns with certain provisions of the Examination Report, like you and your colleagues, we believe market conduct examinations serve a useful purpose by identifying areas in which business processes can be improved. In this instance, we believe that the examiners have identified certain areas where we can improve upon our service to our policyholders. We are committed to investing the necessary resources to bring about that improvement and look forward to working with you in developing and implementing an improvement plan for all jurisdictions that choose to participate in this process.

Thank you for your attention to this matter.

Sincerely,

W. Mark Johnson
SVP, Chief Compliance Officer
Conseco Senior Health Insurance Company

Enclosure

cc: Mr. Dennis Shoop (w/enclosures)
Mr. Terrance Keating (w/enclosures)

EXHIBIT A

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Conseco Senior Health Insurance Company
Summary of Improvement Plan

OBJECTIVES AND RESULTS TO DATE

One of the objectives for this National Improvement Plan is to strengthen compliance in all areas connected to long term care claims, and, in particular to improve claims handling, complaint handling, and customer satisfaction.

In 2006, the Company developed a LTC Vision Strategy that focused on:

- Improved accuracy of initial claim decisions and recertification of active claims
- Clear, timely telephonic and written communication with customers
- Simplified customer processes
- Significant reduction in claim turnaround times and inventory levels
- Significant improvement in call center service
- Consistent compliance with claim handling and complaint handling regulations
- Improved technology platform
- Improved training, root cause analysis of errors, and focused development of skills throughout Operations
- Improved management reporting to better enable management of the business

Since then, and as discussed below, the Company has implemented, or developed plans to implement, numerous process and control improvements relating to the administration of its Long Term Care policies. To accomplish these objectives, the Company has invested over $10 million and 40,000 hours of its resources' time. A chart showing the detail on the amounts spent and the amounts slated for future expenditure is attached herewith as Appendix A.

SUMMARY OF IMPROVEMENT PLAN ACTIVITIES

Although the specific changes to standards, processes, and procedures are too complex to be stated in this document, generally, we have made changes in our management team, re-organized our claims and complaint handling staff and reporting structures, invested in new systems, undertaken audits, increased our training, retained new consultants, and demonstrated to staff the company's commitment to compliance and best practices.

The following is a list of the major changes to be implemented by the Company, including information regarding the current estimate of implementation date. These actions are grouped by major subject area, allowing the items to be reviewed in relation to the specific Company process under review. However, several subject areas may apply to a single, complex company process.

I. Claims Adjudication

A. Reorganization

(1) As the result of a national search, hired senior management from outside the Company with significant Long Term Care (LTC) experience (Fall 2006)

(2) Partnering with LTC Group (LTCG), a proven and experienced LTC administrator for administration and system platforms. System and sourcing contract signed Fall 2007

(3) Claims team reorganized into specialized functions so that resources focused on particular parts of the process, enabling faster training, improved accuracy and streamlined approach (Spring 2007)

(a) Claims Support – gather requirements needed for making a decision, send verbal and written notice and follow-ups to providers and policyholders, send claim forms

(b) Claims Adjusters – analyze proof of loss documents gathered by Claims Support, review against policy language, recommend claims decisions, present potential denials to claim review committee

(c) Claims Examiners – review recommended claims decisions and pay claims

(4) Developed Claim Review and Support Team

(a) Claim Review Team – Manages escalated issues; researches problems with benefits; facilitates the formal appeals process; responds to policyholder complaints (Spring 2007)

(b) Claim Review Committee – consists of cross-functional representatives of company; reviews all recommended denials decisions; reviews complex cases and reviews recommended recertification closures (Summer 2007)

(c) Audit –experienced adjusters currently review: all denied claims; all claims over $10,000; all claims adjudicated by newly- hired adjusters; and a random selection of 3% of all claims released the previous day. Audit- the- auditor process implemented (Fall 2006)

B. Adjudication Best Practices

(1) Engaged consultants, including LTC Group (LTCG) and LifePlans, to review then current adjudication procedures and recommend best-in- practice procedures (Fall 2006)

(2) Claims divided into two categories: Initial vs. Continuation (Spring 2006). Focus on setting up Initial Claim correctly so that Continuation claim adjudication (80% of claims processed) is easier and less time consuming

(3) Began implementation (Spring 2007) - Initiated proactive approach to claimant service – emphasis on clear, timely telephonic and written communication with claimants to expedite the collection of necessary documents and to more clearly explain reasons for denial

(4) Implemented new, more accurate cognitive questionnaire, information referral services (offers solutions to individuals not qualifying for policy benefits), and non-interruption of services process (if certification of care expires, benefits continued while company re-evaluating eligibility) (Summer 2007)

(5) Outsourced managed care to LTC Group (Spring 2007)

(6) HHC initial claims processed by LTC Group using their system, LTCAS – allows for claim set up and processing on a superior claims system (Fall 2007)

(7) Other Best Practices - the elimination of prior claim payment review for each adjudication; improved accuracy, consistency and timeliness of claim decisions in accordance with policy contract language; changed Mail to Claim process, stopped rejecting advance bills and began pending claims while awaiting needed proofs of loss; potential Waiver of Premium benefit eligibility documented in Company's claim system (BICPS) at initial claim (Spring 2007)

(8) LTC Group Claims Migration Effort – initiative to migrate all claims to the LTCG system with a 1Q09 target date. Will establish sustainable, consistent platform to enhance Conseco's ability to process claims accurately and in compliance with state requirements

(9) Correspondence Codes (T-Codes) reviewed and narrowed to allow for adjuster use of only the most accurate Codes, resulting in more accurate and appropriate claims (paid and denied) communications to claimants. Daily management reports (planned 1Q08[1]) will disclose use of unapproved Codes

(10) Adjuster training, increased experience, and narrowed use of Correspondence Codes will enhance and result in more accurate explanation of benefits (Summer, Fall 2007, Winter 2008)

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[1] All future dates are targets that reflect the Company's current implementation plans. The target dates are subject to modification due to the happening of external events that could cause a delay. If it becomes evident to the Company that a target date must be extended, the Company will advise the Lead Regulators of the need for such an extension.

(11) Migration of claims to LTC Group system will result in claims generating LTC Group explanations of benefits forms (planned completion 1Q09)

(12) Claims documents generated from claims systems (BICPs) to be automatically retained in Company's policyholder file (Filenet) resulting in the enhanced retention and easier access of all pertinent claims documents (planned 1Q08)

(13) Interest Calculator (planned 1Q08) – will ensure accurate calculation and application of interest on pended claims

(14) Plan Code Repository (planned 1Q08) – will provide adjusters with a single source of information to identify all policy benefits and state mandates

(15) Accumulator – (planned 1Q08) – will, among other things, provide a semi-automated tool to determine the accumulated benefits paid on policies

C. Monitoring

(1) New Management Reports (Winter 2007) – tracks timeliness of claim processing by state and by process. Enables management to track work and ensure that adjusters are completing work according to each state's specific timeliness requirements

(2) New Monthly Core Metric Reports (Spring 2007) – tracks service levels with historical trends. Enables management to monitor the key metrics and ensure continual improved progress on service levels. Includes measures audit performance by payment and procedural accuracy

(3) Automated Workflow Development (AWD) follow- up tracking (planned 1Q08) – will allow for the tracking of claims follow-up requests for additional information on pended claims in accordance with state requirements. AWD is a workflow distribution system

(4) Standardized Managements Reports (planned 1Q08) – 3 tiers of claims data geared specifically to senior management, operations management specific to their areas of responsibility, and supervisors specific to their teams

D. Adjuster Training

(1) New hire personnel receive comprehensive training (Summer 2007)

(2) Training is specialized by technical complexity

1st tier – class room instruction
2nd tier – model production environment
3rd tier – live production environment

(3) New hire trainee work product is audited 100%

(4) Training is conducted by claims experienced adjusters, adult education and training and development professionals

II. Call Center

(1) New class of representatives trained and on floor with specialized responsibilities (Summer 2007)

(2) As the number of claims in inventory has dropped, the Average Speed to Answer (ASA) has improved

(3) When a call is made to the Call Center, callers now have the option at the outset to identify their call as being "claims related" or "other". Implementation of this "Call Split" allows for improved quality and time of service (Summer 2007)

III. Complaint Handling

(1) DOI and attorney complaints handled by specialized staff including several former adjusters reporting to an attorney

(2) Increased policyholder complaint handling staff from 3 up to 8 (Summer 2007)

(3) Adoption of standard definition of "complaint" across the enterprise to ensure complaints are captured consistently (Summer 2007)

(4) Enhanced Complaint Handling Processes

- All LTC Complaints/Inquiries entered into complaint register (IDB) upon receipt
- Items researched thoroughly by specialized complaint handling team to address all issues raised
- Complete response prepared and sent to audit
- IDB documented throughout process
- All responses go through audit process to ensure completeness and accuracy
- Finalized response sent to complainant within Company standard response times (based on state regulatory requirements)

(5) Complaint Register ("Inquiry Database" or "IDB") enhanced to allow for better root cause analysis, monitoring and trending and training (Fall 2007)

- Complaints vs. Inquiries identifiable
- Source of complaints readily available
- Limited and standardized root cause definitions to ensure consistent records (based upon NAIC model and state regulatory requirements)
- Identification of complaints as justified/unjustified (based on state regulatory requirements)

- Reporting/querying capabilities on all data elements captured in database allows for in depth trending analysis

(6) Improved Documentation of Complaint files through use of ISRA system

(7) The Company is currently developing and implementing a standard audit criterion on all responses including auditing for complaint record accuracy for all records

(8) The Company is currently developing and implementing standard trending metrics to monitor complaint turn around times, volumes and root causes

IV. Systems Migration to LTCG

(1) Claims Conversion planned for 1Q09

(2) First Policy Administration Conversion planned for 4Q09

(3) Second Policy Administration Conversion planned for 2Q10

Appendix to Exhibit A: