

**REPORT OF  
EXAMINATION**

**OF**

**WASHINGTON NATIONAL INSURANCE COMPANY  
CARMEL, INDIANA**

**AS OF**

**DECEMBER 31, 2019**

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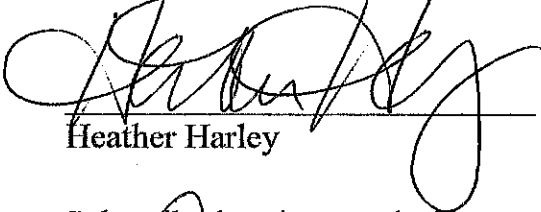
**EXAMINER'S AFFIDAVIT**

**STATE OF INDIANA  
COUNTY OF HAMILTON**

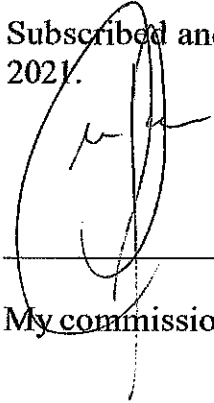
Heather Harley being duly sworn, states as follows:

1. I have the authority to represent Alabama in the examination of Washington National Insurance Company.
2. I have reviewed the examination workpapers and examination report, and the examination of Washington National Insurance Company was performed in a manner consistent with the standards and procedures required by the State of Alabama.

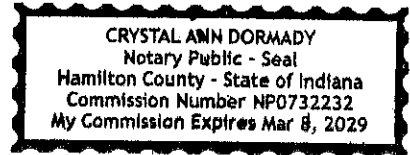
The affiant says nothing further

  
Heather Harley

Subscribed and sworn before me by Heather Harley on the 31st day of March, 2021.

  
\_\_\_\_\_

My commission expires March 8<sup>th</sup>, 2029





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GOVERNOR

JIM L.  
RIDLING  
COMMISSIONER

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March 31, 2021

Honorable Jim L. Ridling  
Commissioner of Insurance  
Alabama Department of Insurance  
201 Monroe Street, Suite 502  
Montgomery, AL 36104

Dear Commissioner Ridling:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners, a targeted scope market conduct examination as of December 31, 2019, has been made of

**Washington National Insurance Company  
Carmel, IN**

The examination was conducted remotely with help from Company management located at its home office at 11825 North Pennsylvania, Carmel, IN 46032. The report of examination is submitted herewith. Where the description "The Company" or "WNIC" appears herein, without qualification, it will be understood to indicate Washington National Insurance Company.

## SCOPE OF EXAMINATION

We have performed a targeted market conduct examination of Washington National Insurance Company a multi-state insurance company. The current examination covers the period of January 1, 2017 through December 31, 2019.

The examination was conducted in accordance with the NAIC *Market Regulation Handbook*. The purpose of this targeted market conduct examination was to review the marketing, advertising and claims practices of the Company related to the Company's Accidental Death and Dismemberment Policy that provide benefits for emergency room (ER) services, or any other accidental death and dismemberment policy, that pays claims for emergency room services. The examination also included payment to any service provider for emergency room services under this benefit such as urgent care centers and includes payment under any rider or amendment such as for illness.

This examination report includes significant findings of fact, as mentioned in the *Code of Alabama, 1975*, as amended and general information about the insurer and its financial condition. There may be other items identified during the examination that, due to their nature, are not included within the examination report but separately communicated to other regulators and/or the Company.

## **ORGANIZATION AND HISTORY**

Washington National Insurance Company is an Indiana company that is an indirect wholly owned subsidiary of CNO Financial Group, Inc., a Delaware publicly owned company. The business of Washington National Insurance Company is described as supplemental health (including specified disease, accident, and hospital indemnity insurance products) and life insurance products focused on middle income clients. There are also closed blocks of run-off business including annuities, Medicare Supplement and long-term care products. The Company is licensed throughout the United States. The primary business is found in Iowa, Illinois, Texas, Florida, South Dakota, and Ohio.

The group is a successor to the bankruptcy reorganization of Conseco, Inc. in 2003. Some of the other subsidiaries of the group include both Bankers Life and Casualty Company and Colonial Penn Life Insurance Company that are described as the other two entities in addition to Washington National Life Insurance Company used by the group to manage its insurance business. Washington National Independent Producers (WNIP) and Performance Matters Associates (PMA) have been listed as the agencies handling the ADD policy. Performance Matters Associates, Inc. (PMA) is also shown as an indirect subsidiary of CNO Financial Group, Inc. The group emphasized organization on a group level rather than an individual company level. In January 2020, the group began to focus its business within two divisions being a consumer division and a worksite division with four lines of insurance products being annuity, health, life, and long-term care.

## **MANAGEMENT AND CONTROL**

Documents requested dealt with marketing, advertising and claims management. Unless noted, all documents identified in each universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Examiners requested a written overview of the Company's operations including management structure, type of carrier, states where the Company is licensed, and the major lines of business the Company had written for the experience period, including information if a regional office handled any portion of the Alabama business. The request included current organizational charts outlining the structure of Alabama operations with respect to management, marketing, and claims. The request also included any specialty operations conducted separately. The Company identified a universe of 20 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and

regulations, including Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12, using the guidelines set forth in Chapter 16, Section A, Standard 8 of the NAIC Market Regulation Handbook. No violations were noted; however, the following concern was noted:

**Concern 1:** The Company initially failed to provide a denied/rejected claim universe to the examiners stating that no such universe existed. The Department requests that the Company establish a reasonable process of both automated and manual audit of claim data for accuracy prior to responding to examiners in the future. The Company has stated that they had previously improved their claims data quality control processes, however, they failed to deliver the requested data and the examiners discovered the existence of a denied/rejected claims universe via the market conduct examination process. The examiners also noted that the Company was not confident in the final denied/rejected claim universe provided to the examiners and explained that a manual audit would be required to ensure data accuracy.

## **MARKET CONDUCT ACTIVITIES**

### **Advertising and Marketing**

Washington National Insurance Company offered general corporate advertising with very little specific advertisement of its products. The Company's website referred consumers to connect with a Performance Matters Associates (PMA) producers and Washington National Independent Producers (WNIP). The solicitation practices also included verbal phone calls to advertise the individual brochures and advertising materials were distributed to potential customers through the Company's agents.

The Company's website ([www.washingtonnational.com](http://www.washingtonnational.com)) provided information about its products, access to claim forms that can be submitted over the website, and an electronic form to be connected to a PMA agent.

The Company provided a summary to the examiners where it states that product information can be found on website <https://washingtonnational.com/families-individuals/health-insurance/accident/>. In addition, the Company website was reviewed and a general internet search was conducted with terms such as the Company name with "accident," "emergency" and "products." As noted below regarding the internet result, the emergency services provision is a highlight of the Company sales efforts in product information to producers as well as a general theme that the Company pays unrestricted cash. In one presentation, the utilization of the emergency room provision by the son of an executive of the Company was highlighted with six emergency room

visits. An online search revealed general social media posts about insurance, illness, accidents and other related items similar to the video streaming website search. The Company website was also searched that revealed emergency services listed as a coverage. All consumer sales and marketing materials are approved by the Company's Product Approval and Compliance (PAC) team before utilization. No violations were noted.

### **Producer Training**

The examiners reviewed the Company's producer training policies and procedures in accordance with NAIC market regulation standards. Once a producer becomes contracted with WNIC, a member of the Company's Sales Development team reaches out to producer in order to offer trainings on WNIC's products, processes and technology. These trainings are conducted via telephone and/or virtual training sessions. Producers are also provided with direct access to their sales development representative for future assistance or trainings. Producers can also utilize training on products via the Company's product specific agent guides and recorded "EZLearning" videos. As the examiners noted in the Organization and History section above, PMA is an owned subsidiary of Washington National Insurance Company's parent, CNO Financial Inc. Once the producer enters the certification process, the national training manager assigns the virtual training modules for the products the producer will sell. The producer is equipped with product brochures, agent guides and other available resources and given access to practice presentation kits and learning videos. No violations were noted.

### **Claims Payment Practices**

Examiners requested a brief description of how claims were handled during the experience period, from the date received through closure, including timeliness requirements. The Company identified a universe of 15 documents and provided seven additional documents in response to an examiner-issued information request. Further, examiners requested documentation demonstrating that claims were handled in accordance with policy provisions, as well as state and federal laws and regulations applicable during the experience period. The Company identified a universe of three documents. The Company also identified a universe of 4 documents in response to requests for annual claim audits for the State of Alabama. In accordance with the requirements of the examination, all 22 documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 6, and Chapter 20, Section G, Standard 1 of the NAIC Market Regulation Handbook. No violations were noted.

The Company provided the total number and dollar amount paid for claims in each year in the experience period for all benefits of the product and provide in



comparison the total number of claims and dollar amount paid under benefits for emergency room services (ERS) for Alabama policies.

Experience Period	Total # of Claims	# of ERS Claims	Total Paid Claims	Total ERS Paid Claims
1/1/2017-12/31/2017	1,2017	852	\$521,850	\$387,350
1/1/2018-12/31/2018	2,733	2,179	\$1,336,842	\$1,020,075
1/1/2019-12/31/2019	7,003	5,791	\$3,263,259	\$2,783,000

*Paid Claims*

The examiner selected a sample of 109 Alabama paid claims from the population of 8,821 transactions for the examination period (2017-2019). The sample was reviewed for compliance with the Company's policy provisions, timeliness of payments, and adequacy of documentation. There were two types of violations noted as a result of the sample review noted in the tables below. The remaining 109 claims in the sample were paid in compliance with ALA. ADMIN. CODE 482-1-124-.04(1)(2003).

**1 Violation ALA. ADMIN. CODE 482-1-124-.04(1)(2003).**(1) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days of the notification, mail or otherwise provide necessary claim forms, instructions or reasonable assistance so the claimant can properly comply with the insurer's reasonable requirements for filing a claim. (2) Upon receipt of proof of loss from a claimant, the insurer shall begin processing the claim within fifteen (15) days.

The Company failed to begin the processing for the following claim within 15 days after the receipt of proof of loss:

Sample #	Claim #	# of Days
22	180000000295	56

**4 Violations ALA. ADMIN. CODE 482-1-124-.05** (a) The insurer shall maintain claim files that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss, date and amount of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the five (5) preceding years in order to permit reconstruction of the insurer's activities relative to each claim.(b) Each relevant document within the claim file shall reflect as to date received, date processed or date mailed.

1) The Company failed to provide claim administration records for the following 4 claims within an electronic computer-based format and 2) The Company failed to adhere to record retention requirements for the following 4 claims.

Sample #	Claim #	Reason
58	190000015448	No claim record, this claim shows in claims administration system with an error. Company failed to provide claim record.
65	180000021626	No claim record, this claim shows in claims administration system with an error. Company failed to provide claim record.
90	190000028025	No claim record, this claim shows in claims administration system with an error. Company failed to provide claim record.
92	170000013073	No claim record, this claim shows in claims administration system with an error. Company failed to provide claim record.

### Rejected/Denied Claims

The examiners requested the Company to provide a denied claims universe in the examination handbook and data call. The company provided the following reply on July 30, 2020 in response to the denied claims section, *"This is not applicable. For the scope of this exam's state of authority, experience period, product type, and ER Service benefit code, there were no denied claims."* The examiners discussed the company's zero denied claim volume with the Company on August 6, 2020. The Company repeated their previous response that there were no denied claims. The examiners reviewed the responsive paid claim files that included information regarding the possible fraudulent activity investigated by the Special Investigation Unit ("SIU"). The discovery of a denied claim file was discovered within the SIU case notes. The examiners notified the Company regarding the existence of a denied claim within the state authority, experience period, product type, and ER service benefit code on September 23, 2020 within Information Request 006 requesting additional information regarding the denied claim notes within the SIU file. On September 28, 2020 the Company provided a response that the claim was rejected due to the admission to the ER was not within 72 hours of the accident. The examiners requested a telephone conference with the Company on September 29<sup>th</sup> to discuss the confirmation and acknowledgement of a denied claim. On September 30<sup>th</sup>, 2020 the company and examiners discussed the findings and to determine if there were more denied claims. The Company agreed to complete an audit of their previous claims administration and information systems to determine the reason for the conflicting data results of zero denied claims compared to the examiner's discovery of a denied claim in the SIU case notes. The Company explained that an "ad-hoc" data request was being prioritized within their protocols to determine the actual universe of denied

claims. The company's interim response on October 7, 2020 included language that the ad-hoc data request was validated to ensure accuracy. After a two-week time period, the Company provided a universe of 231 denied and/or rejected claims to the examiners on October 14, 2020. The examiners received approval to complete a small sample of denied/rejected claims from the Alabama Department of Insurance to provide a speedy review of the claims. The examiners received the denied/rejected claim files and requested documentation on October 29, 2020. On November 13, 2020 the company provided requested detailed information regarding the denied/rejected claim definition and an explanation of the error of denied/reject claims universe. The company provided the following definition of a denied claim: "*A claim is denied when based on the information submitted or gathered does not meet the policy benefit eligibility provisions. There is no distinction between the terms denial and rejected.*" The company provided the following confirmation of the volume of the denied/reject universe: "*We can confirm that the universe of 231 denied/rejected claims is complete using the ERS benefit services code for the scope of the exam and as reflected in the claims processing system. There could be opportunities for denied/rejected claims to be found under the Miscellaneous or Non-Covered Expense benefit codes but are not readily identifiable as an ERS benefit. The categories of Miscellaneous and Non-Covered Expense benefit codes could encompass any benefit provided under the policy. The only way to determine if it is ERS benefit services would require a manual review.*" The examiners have concerns regarding the Company's statement that there could be opportunities for more denied/rejected claims. The reason for the concern is that the company previously advised the examiners that the universe of 231 was audited and validated on October 7, 2020. The examiners are also concerned that the Company has a data integrity issues within their claims administration system, ad-hoc data reporting system, and data validating processes and procedures.

A sample of 25 Alabama denied and rejected claims was selected from a population of 231 denied and rejected claims for the examination period (2017-2019). The sample was reviewed for compliance with the Company's policy provisions and adequacy of documentation and in accordance with NAIC Market Regulation procedures. There were two areas of claim handling practices involving violations as noted below.

**2 Violations ALA. ADMIN. CODE 482-1-124-.04(1)(2003).** (1) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days of the notification, mail or otherwise provide necessary claim forms, instructions or reasonable assistance so the claimant can properly comply with the insurer's reasonable requirements for filing a claim. (2) Upon receipt of proof of loss from a claimant, the insurer shall begin processing the claim within fifteen (15) days.

The Company failed to begin the processing of the denial/rejection the following 2 claims within 15 days after the proper receipt of proof of loss:

Sample #	Claim #	# of Days
12	180000024252	86
18	190000015604	41

**1 Violations ALA. ADMIN. CODE 482-1-124-.04(9)(2003).** (9) When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination that the claim should be denied. The insurer shall state the reasons why the claim has been denied.

The Company failed to provide denied claim correspondence for the following 1 claim:

Sample #	Claim #	Reason
17	190000036217	Final letter of request for requirements and claim closure not located.

## RECOMMENDATIONS

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

1. **It is recommended** that the Company must ensure that all clean claims are paid within 15 days of receipt as per ALA. ADMIN. CODE 482-1-124-.04(1)(2003).
2. **It is recommended** that the Company must ensure that all clean claims are denied within 15 days of receipt as per ALA. ADMIN. CODE 482-1-124-.04(1)(2003).
3. **It is recommended** that the Company maintain all claims files that are accessible and retrievable and all claims files for five years in accordance with ALA. ADMIN. CODE 482-1-124-.05(2003), which states: (a) The insurer shall maintain claim files that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss, date and amount of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the five (5) preceding years in order to permit reconstruction of the insurer's activities relative to each claim.(b) Each relevant document within the claim file shall reflect as to date received, date processed or date mailed.
4. **It is recommended** that the Company must establish a reasonable process of both automated and manual audit of claim data for accuracy prior to responding to examiners.

## CONCLUSION

Acknowledgement is hereby made of the courtesy and cooperation extended by all persons representing Washington National Insurance Company during the examination.

The customary insurance examination procedures, as recommended by the National Association of Insurance Commissioners, have been followed and set forth in this report.

In addition to the undersigned, Joseph Cohen; all representing the Alabama Department of Insurance, participated in the examination of Washington National Insurance Company.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Heather Harley".

Heather Harley  
Examiner-in-charge