MARKET CONDUCT EXAMINATION REPORT

ABILITY INSURANCE COMPANY
NAIC # 71471
222 South 15th Street, Suite 1202S
Omaha, NE 68102

ETS # KS057-M13

As of

December 31, 2011

KANSAS INSURANCE DEPARTMENT

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The Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

Ability Insurance Company
NAIC # 71471
222 South 15th Street, Suite 1202S
Omaha, NE 68102

hereafter referred to as "Ability" or the "Company", the following report of such examination is respectfully submitted,

Stacy Rinehart, FLMI, MCM, CIE, AIRC, AIC
Market Conduct Manager
Examiner-in-Charge

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of Ability Insurance Company, also referred to as the "Company", was conducted pursuant to, but not limited to K.S.A. 40-222.

There were concerns regarding the application of the waiver of premium benefits on long-term care policies, thus the Kansas Insurance Department (KID) examiners reviewed the Company's claim handling, general management and organization, and policyholder service issues. The review was performed at KID on electronic files provided by the Company and was conducted according to the guidelines and procedures recommended in the 2012 NAIC Market Regulation Handbook (MRH). The exam team utilized the standards and tests recommended in the Handbook which allows for an error tolerance of 7%. Silence on any NAIC standard or Company practice does not imply KID acceptance or endorsement of such practices. Applicable statutes and regulations cited throughout the report may be found in the Appendix.

The examination included a review of the claim files the company processed during the exam period of January 1, 2009 through December 31, 2011. Interrogatories were submitted to the Company prior to the file review segment of the examination, and written responses were provided. The examination included, but was not limited to, company operations and management, history and profile, prior market conduct examination reports, fines and penalties, Certificate of Authority, internal audit procedures, claim processing, and policyholder service.

EXECUTIVE SUMMARY

A targeted market conduct examination of Ability Insurance Company, also referred to as the "Company", was conducted pursuant to, but not limited to K.S.A. 40-222. The examination period was from January 1, 2009 through December 31, 2011. The exam focused on long-term care business, with a review of claims handling, operations and management, and policyholder service to be the main areas of focus.

While some violations were found, the Company did not fail any of the Standards tested. There were several delays in conducting the examination due to all of the Company responses going through outside legal counsel prior to being sent to the examiners. Regardless of the error ratios, the exam team has made several recommendations based on the issues revealed during the examination.

Recommendations

OPERATIONS AND MANAGEMENT

1. When receiving communications from the Kansas Insurance Department (KID), timely responses from the Company are expected. If additional time is needed, the Company shall contact KID (prior to the deadline) to request an extension.

POLICYHOLDER SERVICE

1. The Company shall ensure Waiver of Premium benefits are administered properly.

2. The Company shall ensure unearned premiums are refunded promptly upon cancellation of policies.

CLAIM HANDLING

1. The Company shall ensure interest is paid on claims when required.

2. The Company shall ensure all relevant communications from a claimant requesting a response are addressed promptly.

3. The Company shall ensure all claim documents are date-stamped upon arrival at the company (unless otherwise indicated by fax date/time stamp).

4. The Company shall investigate each claim that is submitted and either pay or deny clean claims in writing within 30 days.

[Note: The Company has indicated they will begin date-stamping communications in addition to electronically imaging them. Also, at the request of the Company's state of domicile, the Company had changed their procedures in how they are administering the Waiver of Premium benefits in the middle of the exam period (to the insured's benefit). The Company has also

indicated they have discontinued their practice of encouraging claimants to withdraw claims, as was noted in a previous market conduct examination. In addition, the Company does not allow claims to be withdrawn for any reason.]

DESK EXAMINATION

OPERATIONS AND MANAGEMENT

I. History and Profile

[Based on Company response to interrogatories:]
Ability Insurance Co. (formerly known as Medico Life Insurance Company (MLIC) until March 2009) and Ability Resources, Inc. (Ability Re) are wholly-owned subsidiaries of Ability Resources Holdings, Inc. (effective January 1, 2011). The ultimate parent is Ability Reinsurance Holdings Ltd (Ability Re Holdco). Ability Reinsurance (Bermuda) Ltd is a Bermuda registered company that reinsures a portion of Medico's risk. Ability Re is a Delaware company acting as a TPA.

The former MLIC was the first operating company acquired by Ability Re. MLIC had previously written accident and health coverage in 43 states and the District of Columbia. For many years, the company's core product line was individual senior life insurance, with emphasis on the sale of final expense policies sold in conjunction with the organization's long-term care and Medicare supplement business. In addition to its core products, the company also issued modest numbers of cancer, hospital indemnity, disability income, and accidental death and dismemberment policies. MLIC stopped writing new business in September 2007. Prior to the purchase of the former MLIC by Ability Re, Medico and MLIC recaptured the majority of their Long Term Care policies from various Reinsurers. After the recapture, Medico ceded its block of Long Term Care insurance to the MLIC, and MLIC ceded all of its non Long-Term Care insurance to Medico. As a result, MLIC retained only Long Term Care risk, while Medico retains no Long Term Care risk. Following the transactions described above, Ability Re US purchased the stock of MLIC. Ability Re intends to initially focus on buying closed blocks of long-term care policies.

II. Prior Market Conduct Examination Reports

The KID examination team requested all market conduct exams completed within the last three years. There was a market conduct examination by Nebraska still pending when requested, and no other exams were finalized during the period.

III. Fines and/or Penalties

The KID examination team reviewed the actions from other states regarding fines and penalties for the last five years and found nothing that warranted additional inspection beyond the scope of this targeted examination.

Tests for Company Operations and Management

Standard 1
The regulated entity has an up-to-date, valid internal or external audit program.

The Company provided a document outlining their Internal Audit process related to claims as well as reports created during the exam period. There are no items of concern.

Recommendation: None

Standard 7
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

The Company maintained adequate records as required and provided items to the exam team as requested with a few exceptions.

Recommendation: None

Standard 8
The regulated entity is licensed for the lines of business that are being written.

The Kansas Certificate of Authority was reviewed and was found to be in compliance with Kansas law.

Recommendation: None

Standard 9
The regulated entity cooperates on a timely basis with examiners performing the examinations.

There were delays by the Company in responding to our office regarding inquiries, violations, and other communications.

Recommendation: When receiving communications from the Kansas Insurance Department (KID), timely responses from the Company are expected. If additional time is needed, the Company shall contact KID (prior to the deadline) to request an extension.

POLICYHOLDER SERVICE

Standard 5
Policy transactions are processed accurately and completely.

During the review of the claim files, it was noted that there were four policies in which the claim benefits had been paid that would have made the policy eligible for future Waiver of Premium (WOP) benefits, but the Company did not inform the policyholder that this benefit was taking effect. This is a violation of K.A.R. 40-1-34, Section 5(a). Two files contained policies in which the claims payments made the policies eligible for WOP, but the company did not implement the waiver, charging premiums unfairly, which is a violation of K.S.A. 40-2404(7)(b).

Recommendation: The Company shall ensure Waiver of Premium benefits are administered properly.

Standard 7
Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

One file was found when reviewing our claim sample in which the policy was terminated due to the insured being deceased, but the company had failed to refund unearned premium until the issue was brought to the Company's attention during this examination. The exam team had the Company provide a listing of all policies cancelled during the exam period, and one additional policy was identified that the Company had failed to provide premium refund upon cancellation. Per K.S.A. 40-2203(A)(13), the insurer should promptly return unearned premium upon cancellation, which the Company failed to do.

Recommendation: The Company shall ensure unearned premiums are refunded promptly upon cancellation of policies.

CLAIM HANDLING

The examiners reviewed the Company's claims procedures in addition to a review of actual claim files. The file review consisted of 76 claims processed during the exam period. The "Number of Errors" included in the samples below are defined as the total number of claims in the sample which contained errors.

General Claim Standards

Standard 1
The initial contact by the regulated entity with the claimant is within the required time frame.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	0	100%

Result: Pass

Recommendation: None

Standard 2
Timely investigations are conducted.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	0	100%

Result: Pass

Recommendation: None

Standard 3
Claims are resolved in a timely manner.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	1	99%

There was one claim reviewed in which the claim was paid beyond thirty days after receiving all pertinent information required to pay the claim, and applicable interest was not paid. This is a violation of K.S.A. 40-2228h(a) and K.S.A. 40-2228h(b).

Result: Pass

Recommendation: The Company shall ensure interest is paid on claims when required.

Standard 4
The regulated entity responds to claim correspondence in a timely manner.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	1	99%

On one claim file, the company received a survey response from a claimant that had concerns over her policy coverage, and had indicated "please respond quickly." The company failed to provide a response, which is a violation of K.S.A. 40-1-34, Section 6(c).

Result: Pass

Recommendation: The Company shall ensure all relevant communications from a claimant requesting a response are addressed promptly.

Standard 5
Claim files are adequately documented.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	3	96%

Three claim files could not be adequately be reconstructed as they contained documents that were not date-stamped and did not indicate otherwise when the company actually received them. This is a violation of K.A.R. 40-1-34, Section 4.

Result: Pass

Recommendation: The Company shall ensure all claim documents are date-stamped upon arrival at the company (unless otherwise indicated by fax date/time stamp).

Standard 6
Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	0	100%

Result: Pass

Recommendation: None

Standard 9
Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Claims	76	3	96%

There were two claim files in which the Company suggested to the insured or their representative upon the filing of a claim that the claim may not qualify and suggested they withdraw the claim. The Company failed to fully investigate eligibility and did not deny the claims in writing. This is a violation of K.S.A. 40-2404(9)(a) and K.S.A. 40-2404(9)(d) for misrepresenting policy provisions related to coverages as well as refusing to pay claims without conducting a reasonable investigation. In addition, these are in violation of K.S.A. 40-2228h(a) for neither paying, denying, or otherwise indicating what additional information was needed within 30 days of receiving the claims.

One claim file reviewed the Company indicated on the intake call that the insured did not meet benefit qualifiers, but later agreed to keep the file open for further documentation. The claim acknowledgement letter indicated that the Company would be obtaining some medical information, but failed to do so, and is in violation of K.A.R. 40-1-34, Section 7 for not conducting an investigation. Information was received by the insured's daughter, but the

Company failed to send written denial notice within 30 days of receiving the additional information, which is a violation of K.S.A. 40-2228h(d).

Result: Pass

Recommendation: The Company shall investigate each claim that is submitted and either pay or deny clean claims in writing within 30 days.

CONCLUSION

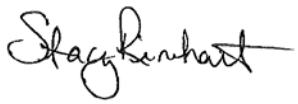
The following examiners from the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Stacy Rinehart Market Conduct Manager	LeAnn Crow Market Conduct Examiner	Tate Flott Market Conduct Examiner

Claudia Perney
Market Conduct Examiner

Respectfully submitted,



Stacy Rinehart, FLMI, MCM, CIE, AIRC, ACS
Market Conduct Manager
Examiner-In-Charge

APPENDIX

Related Kansas Insurance Statutes and Administrative Regulations

K.S.A. 40-222. Examinations

(a) Whenever the commissioner of insurance deems it necessary but at least once every five years, the commissioner may make, or direct to be made, a financial examination of any insurance company in the process of organization, or applying for admission or doing business in this state. In addition, at the commissioner's discretion the commissioner may make, or direct to be made, a market regulation examination of any insurance company doing business in this state.

…

(c) For the purpose of such examination, the commissioner of insurance or the persons appointed by the commissioner, for the purpose of making such examination shall have free access to the books and papers of any such company that relate to its business and to the books and papers kept by any of its agents and may examine under oath, which the commissioner or the persons appointed by the commissioner are empowered to administer, the directors, officers, agents or employees of any such company in relation to its affairs, transactions and condition.

…

(g) The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with the provisions of the Kansas administrative procedures act.

…

40-2203. Uniform policy provisions; rules and regulations for filing or submission of policies. (A) *Required provisions.* Except as provided in paragraph (C) of this section every such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section, but the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner of insurance which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner of insurance may approve.

…

(13) A provision as follows: *"Cancellation by insured:* The insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or death of the insured, the insurer will promptly return the unearned portion of any premium paid. The earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation." When approved by the commissioner, the "cancellation" provision appearing in subsection (B)(8) may be substituted for the above.

…

K.S.A. 40-2228h

Same; claims; procedures; rules and regulations

(a) Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of long-term care insurance shall pay a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that:

(1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or

(2) additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary.

(b) If any insurer issuing a policy of long-term care insurance fails to comply with subsection (a), such insurer shall pay interest at the rate of 1% per month on the amount of the claim that remains unpaid 30 days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

…

(d) Within 30 days after receipt of all the requested additional information, an insurer issuing a policy of long-term care insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states:

K.S.A. 40-2404. Unfair methods of competition and unfair or deceptive acts or practices

…

(7) Unfair discrimination.

…

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

…

(9) Unfair claim settlement practices. It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

…

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

K.A.R. 40-1-34. Unfair Claims Practices Act

Section 4. File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 5. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
…

Section 6. Failure to Acknowledge Pertinent Communications

…

(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

…

Section 7. Standards for Prompt Investigation of Claims

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.