# THE COMMONWEALTH OF MASSACHUSETTS

## OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

## DIVISION OF INSURANCE

*Report on the Comprehensive Market Conduct Examination of*

# *Centre Life Insurance Company*

*Springfield, Massachusetts*

*For the Period January 1, 2020 through December 31, 2020*

**NAIC GROUP CODE: 0212**

**NAIC COMPANY CODE: 80896**

**EMPLOYER ID NUMBER: 04-1589940**

# TABLE OF CONTENTS


| | PAGE |
|---|---|
| SALUTATION | 3 |
| SCOPE OF EXAMINATION | 4 |
| EXAMINATION APPROACH | 4 |
| EXECUTIVE SUMMARY | 5 |
| COMPANY BACKGROUND | 6 |
| COMPANY OPERATIONS/MANAGEMENT | 7 |
| COMPLAINT HANDLING | 10 |
| POLICYHOLDER SERVICE | 10 |
| CLAIMS | 12 |
| SUMMARY | 13 |
| ACKNOWLEDGMENT | 13 |
| APPENDIX A – LIFE, ANNUITY, DISABILITY INCOME, AND LONG-TERM CARE EXAMINATION STANDARDS AND MASSACHUSETTS AUTHORITIES | |

# COMMONWEALTH OF MASSACHUSETTS
## Office of Consumer Affairs and Business Regulation
## DIVISION OF INSURANCE

1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 • Toll-free (877) 563-4467
http://www.mass.gov/doi

**CHARLES D. BAKER**
GOVERNOR

**KARYN E. POLITO**
LIEUTENANT GOVERNOR

**MIKE KENNEALY**
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

**EDWARD A. PALLESCHI**
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

**GARY D. ANDERSON**
COMMISSIONER OF INSURANCE


April 13, 2022

The Honorable Gary D. Anderson
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Anderson:

Pursuant to your instructions and in accordance with Massachusetts General Laws Chapter 175, § 4, a comprehensive examination has been made of the market conduct affairs of

**CENTRE LIFE INSURANCE COMPANY**

which is based at their home offices located at:

1350 Main Street
Springfield, Massachusetts 01103

The following report thereon is respectfully submitted.

## SCOPE OF EXAMINATION

The Massachusetts Division of Insurance (the "Division") conducted a comprehensive market conduct examination ("examination") of Centre Life Insurance Company (the "Company") for the period January 1, 2020 to December 31, 2020, with a focus on Massachusetts individual disability income ("IDI") business. The examination was called pursuant to authority in Massachusetts General Laws Chapter ("M.G.L. c.") 175, § 4. The examination was conducted under the direction, management, and control of the market conduct examination staff of the Division. Representatives from the firm of Rudmose & Noller Advisors, LLC ("RNA") were engaged to complete the examination.

## EXAMINATION APPROACH

The examination follows a tailored approach using the guidance and standards of the *2020 NAIC Market Regulation Handbook* ("the Handbook"), the examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations, and bulletins, and applicable Federal laws and regulations. The Division's market conduct staff supervised all procedures conducted by the examiners. Other procedures were more efficiently addressed in the Division's financial examination of the Company. For those objectives, RNA and the market conduct examination staff relied on procedures performed by the Division's financial examination team, to ensure that the market conduct objective was adequately addressed.

The Company did not issue any new policies or replacements during the examination period and has not issued new major medical policies since 1980 or IDI policies since 1998. In addition, the Company never issued life or annuity products during, or prior to, the examination. Accordingly, the examiners reviewed operational areas during this examination, including Company Operations and Management, Complaint Handling, Policyholder Service, and Claims. This examination report describes the procedures performed in these operational areas and the results of those procedures.

In addition to the procedural guidance in the Handbook, the examination included an assessment of the Company's policies and procedures. While the Handbook approach is designed to detect deficiencies through transaction testing, this assessment provides an understanding of the key controls that the Company's management uses to operate their business and meet key business objectives, including complying with applicable laws and regulations related market conduct activities.

The form of this examination report is "Report by Test", as described in Chapter 15, Section A of the Handbook. The Division considers a "finding" to be a violation of Massachusetts insurance laws, regulations, or bulletins. An "observation" and a “recommendation” are considered a departure from an industry best practice. The Division recommends that Company management evaluate any "finding" or "observation" for applicability to other jurisdictions. When applicable, the Company should take corrective actions in all jurisdictions. All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify unacceptable or non-compliant business practices does not constitute acceptance of such practices. The Company shall report to the Division any such corrective actions taken.

## EXECUTIVE SUMMARY

This summary of the examination of the Company is intended to provide a high-level overview of the examination results highlighting where recommendations were made or required actions were noted. The body of the report provides additional details. Company managerial and supervisory personnel from each operational area should review the examination report for results relating to their specific area.

The following is a summary of all observations and conclusions noted in this examination report. All Massachusetts laws, regulations and bulletins cited in this report may be viewed on the Division's website at www.mass.gov/doi.

The examination resulted in no recommendations or required actions with regard to Company Operations and Management, Complaint Handling, Policyholder Service, and Claims. The examination indicated that the Company is in compliance with all tested Company policies, procedures and statutory requirements addressed in these areas. Further, the tested Company practices appear to meet industry best practices in these areas.

## COMPANY BACKGROUND

The Company, formerly known as Massachusetts Casualty Insurance Company, was incorporated on October 6, 1926, and commenced business on October 1, 1927. On December 29, 1980, the Company's capital stock was purchased by Equitable Massachusetts, Inc., a subsidiary in the Equitable of Iowa Companies Group. On January 30, 1987, the Company's capital stock was acquired by Sun Life Assurance Company of Canada (U.S.), a Sun Life of Canada Group subsidiary. On February 5, 1999, the Company was acquired by Centre Reinsurance Holdings Limited, which contributed the Company's stock to Centre Solutions (U.S.) Limited ("CSUS"). CSUS is a Bermuda-domiciled insurance company, and a subsidiary of Centre Group Holdings (U.S.) Limited ("CGHUS"), whose ultimate parent of the Zurich Group of companies (the "Zurich Group") is Zurich Insurance Group Ltd ("ZIG") f/k/a Zurich Financial Services Ltd.

In May 2016, Centre Group Holdings Limited was merged with and into CMSH Limited. On May 30, 2016, Centre Solutions Bermuda Limited made a return of capital of its ownership in CGHUS to its direct parent, CMSH Limited. On May 31, 2016 CMSH Limited was merged with and into Zurich Finance Company AG, resulting in CGHUS becoming a subsidiary of Zurich Finance Company AG, a holding company domiciled in Switzerland. On June 28, 2019 CGHUS was contributed to Zurich Structured Finance, Inc., a holding company domiciled in Delaware, which is owned by Zurich Finance Company AG, which is ultimately owned and controlled by ZIG.

The Company is licensed as an individual accident and health insurer and has been in voluntary run-off since 2003. Accordingly, its IDI and medical policies are ceded to affiliates and non-affiliates. The Company remains authorized in all 50 states and the District of Columbia.

The Company does not have a financial strength rating, but ZIG's rated U.S. insurer affiliates have an A+ (Excellent) financial strength rating with a stable outlook from A.M. Best. The following financial information is as of, or for the year ended December 31, 2020:

| | |
|---|---|
| Admitted assets | $1,521.6 million |
| Statutory surplus | $84.9 million |
| Massachusetts business - direct written premium | $507,063 |

The key objectives of this examination were determined by the Division with emphasis on the following areas.

## I. COMPANY OPERATIONS/MANAGEMENT

### Corporate Governance:

*Summary of Company Policies and Procedures:*

- The six-member Company Board of Directors ("Board") is required to meet at least twice a year and includes the President and Chief Executive Officer and five Company or Zurich Group directors. The Board approves dividends to its shareholders, reviews audit plans, reviews financial information and plans, and receives regular reports from the Audit Investment Committee. In addition, the Board reviews internal controls, ratifies investment activity, elects Company officers, and reviews legal and reputational matters. The Board designated the Board of CGHUS to act as the Company's Audit Committee to meet regulatory requirements.
- Zurich Legacy Solutions ("ZLS") is a financial and management division of the Zurich Group and provides corporate services to and oversight of businesses in run-off, including the Company. ZLS also addresses enterprise risk management, compliance, legal, internal audit, and financial controls.

*Examination Procedures Performed*: RNA interviewed Company personnel responsible for corporate governance, internal and external audit, compliance risk assessment, and quality assurance processes. RNA also reviewed the minutes of Board meetings.

*Examination Conclusions*: The Company has documented its corporate decisions in its Board minutes. Also, the Company has adopted policies and procedures to ensure that appropriate audits or reviews are generally conducted timely with documented results.

### Third-Party Outsourcing:

*Summary of Company Policies and Procedures:*

- The Company's primary direct in-force business is IDI coverage. Disability Management Services, Inc. ("DMS" and the "administrator") a third-party administrator processes all policyholder services and claim transactions for the Company's IDI business. DMS was an affiliate until December 30, 2020, when ZIG sold its portion of DMS to Davies U.S., Incorporated.
- The DMS compliance function reports to the DMS General Counsel. The General Counsel reports to the DMS CEO and is also a member of the DMS Board. The DMS compliance department serves in an advisory and training role for the business units, which are responsible for implementing compliance requirements within business processes.
- DMS has an internal audit function, which performs claims processing, policyholder service, compliance, and quality assurance ("QA") reviews. The DMS internal audit function reports to a DMS in-house attorney. The DMS internal audit function is also responsible for annual reporting on contractual Service Level Agreement ("SLA") objectives covering the Company's IDI business. The Company also conducts independent audits of DMS claims and policy administration procedures using a third-party contactor.
- DMS has a Code of Business Conduct that is provided to all employees. DMS new hires, and all employees annually, sign an acknowledgement that they have followed the Code of Conduct, unless otherwise disclosed to management.

*Examination Procedures Performed:* RNA interviewed management about its use of third parties to perform Company functions and the monitoring procedures conducted over these third parties. Further,

RNA interviewed the administrator's management about its business processes and reviewed such documentation, as applicable, in connection with compliance, policyholder service, and claims testing.

*Examination Conclusions*: Based upon review and testing, it appears that the Company's contracts with entities assuming a business function on its behalf comply with statutory and regulatory requirements.

**Anti-fraud Efforts:**

*Summary of Company Policies and Procedures:*

- The Company has a written Anti-Fraud Plan that summarizes all related anti-fraud efforts and requires that management and employees take reasonable precautions to prevent and detect potential insurance fraud.
- The Special Investigative Unit ("SIU") includes members of the legal department. All suspected fraud cases are referred for SIU handling through the Vice President of Claims in conjunction with in-house counsel. The SIU is responsible for investigating, tracking, and reporting fraudulent activity.
- The Company conducts criminal and education background checks on all employment applicants. The Company generally does not hire anyone convicted of a Federal felony involving dishonesty or breach of trust. If the Company elected to hire such a person, the Company would seek approval from the Division before hiring.
- The Company has implemented Office of Foreign Asset Control compliance initiatives, including searches of the Specially Designated Nationals ("SDN") database for any policyholders, claimants, or vendors included in the SDN database.
- On an annual basis, each employee must certify compliance with the Company's Code of Ethics policy.

*Examination Procedures Performed*: RNA interviewed Company personnel responsible for anti-fraud initiatives, compliance procedures, and code of ethical conduct policies. In addition, RNA reviewed Company policies and procedures to address anti-fraud initiatives as part of claims and policyholder service testing.

*Examination Conclusions:* The Company has adopted reasonable procedures related to anti-fraud initiatives, compliance procedures, and code of ethical conduct policies. Based upon policyholder service and claims testing, it appears that the Company has reasonably implemented anti-fraud initiatives to detect, prevent, and investigate fraudulent insurance acts.

**Record Retention:**

*Summary of Company Policies and Procedures:*

- The Company has adopted record retention requirements for various documents and records.
- The requirements include record management maintenance and disposal guidelines, including document-specific retention timelines.

*Examination Procedures Performed*: RNA obtained a summary of the Company's record retention policies and procedures and evaluated them for reasonableness.

*Examination Conclusions:* The Company has record retention policies that appear reasonable.

**Privacy Compliance:**

*Summary of Company Policies and Procedures*:

- The Company provides required privacy disclosure notices annually to all policyholders.
- The Company does not share information with other companies for marketing purposes, and thus, no opt-out notice is required. Company policy is to disclose information as required or permitted by law to regulators, law enforcement agencies, anti-fraud organizations, and third parties who assist the Company in processing business transactions for its customers.
- The Company has developed and implemented information technology security policies and practices to safeguard non-public personal and health information.
- The Company restricts access to electronic and operational areas containing non-public personal financial and health information to authorized individuals and strictly monitors access procedures.

*Examination Procedures Performed*: RNA interviewed Company personnel responsible for privacy compliance and reviewed supporting documentation. Further, RNA

a) reviewed policyholder service and claims documentation for any evidence that the Company improperly collected, used, or disclosed non-public personal financial information, and
b) sought evidence that the Company improperly disclosed non-public personal health information in conjunction with testing policyholder services and claims.

*Examination Conclusions*: Based on RNA's review and testing, the Company's privacy practices appear to meet Massachusetts and Federal statutory and regulatory requirements.

**Annual Market Conduct Reporting:**

*Summary of Company Policies and Procedures:*

- The Company's policy administration and claims systems compile and retain IDI policyholder service and claim data for inclusion in the annual financial reporting to the Division and for inclusion in the NAIC's Market Conduct Annual Statement.

*Examination Procedures Performed*: RNA interviewed personnel responsible for policyholder service and claims processing. In addition, RNA reviewed the statutorily required 2020 annual financial reporting submitted to the Division, the examination data, and the Company's 2020 Massachusetts IDI policyholder and claims data for inclusion in MCAS. Upon request, the Division waived the Company's 2020 MCAS filing due to the low volume of activity. The waiver is limited to the 2020 MCAS.

*Examination Conclusions*: Based upon RNA's review and testing, the 2020 Massachusetts IDI policyholder service and claims data appear to be complete and accurate.

## II. COMPLAINT HANDLING

*Summary of Company Policies and Procedures:*

- Any written complaint or grievance received by the Company is considered a complaint and handled according to written procedures. The Company classifies complaints as either insurance regulatory (received from the Division), executive (received directly from a consumer, addressed to an officer of the Company), or internal (received by claims or policyholder service staff when assisting the consumer).
- All complaints received, from any medium or location are referred to the legal department which assigns the complaints to the appropriate business unit supervisor or manager to draft a response. The legal department reviews all complaint responses in accordance with the Division's timeliness requirement.
- Through its audit function, the Company reviews all complaint activity to identify any recurring, systemic, or potential problems. Management reporting of complaint activity is included in quarterly litigation reports provided by the legal department.
- Neither the Company nor its administrator uses social media platforms. However, the Zurich Group uses social media at the enterprise level, and handles any negative comments according to the Zurich Group's policies and procedures.

*Examination Procedures Performed*: RNA interviewed Company staff, including management personnel responsible for complaint handling. In addition, the examiners included a review of evidence of related processes and controls. The examination further determined the Company's complaint register did not contain any Massachusetts complaints.

*Examination Conclusions*: Based on the review, the Company's complaint register and the complaint procedures meet Massachusetts statutory and regulatory requirements.

## III. POLICYHOLDER SERVICE

**Insured-Requested Cancellation and Contract Change Requests:**

*Summary of Company Policies and Procedures*:

- The Company call center is available to answer policyholder questions about their policies or to process address and billing changes. All calls are documented in a workflow system, and staff sends a confirmation letter to the policyholder after the call confirming any actions taken.
- All contract changes require completing a form and the insured's signature. All forms and correspondence are scanned, imaged and processed in the workflow system.
- Insured-requested cancellations are processed when the signed form is received. Any unearned premium is returned to the insured and calculated from the date of the request.
- Benefit or elimination period changes are processed when a signed form is received. Reductions in benefit payments, or increases in the contractual elimination period, are processed effective with the date of request. Any unearned premium is returned to the insured and calculated from the date of the request. An underwriter reviews changes requesting an increase in benefits payments to determine whether the requested increase is in accordance with underwriting guidelines.

*Examination Procedures Performed:* RNA interviewed individuals responsible for policyholder service transaction processing. Further, RNA tested two IDI insured-requested cancellations and five IDI contract changes from the examination period to determine whether the cancellations and contract changes were processed accurately and timely.

*Examination Conclusions*: Based on testing, the Company's handling of insured-requested cancellations and contract changes meets contractual and Massachusetts statutory and regulatory requirements.

**Premium Billing, Lapse, Reinstatement, and Expiration Transactions:**

*Summary of Company Policies and Procedures*:

- IDI premium billings are automatically generated through a policy administration system approximately 30 days before the due date. Insureds may select from quarterly, semi-annual or annual billing or elect monthly electronic funds transfer. If payment is not received by the due date, a reminder notice is sent approximately 15 days in advance of the lapse date. A lapse notice is sent once the policy has lapsed for non-payment. The Company allows an additional 31-day grace period to make the payment to continue the coverage. If the insured wishes to reinstate the policy after the grace period expires, the insured must submit a reinstatement application, which must be reviewed and approved by an underwriter.
- Prior to the expiration of coverage, which is typically at age 65, an expiry notice is sent 90 days prior to expiration with a conditional renewal offer if contractually permitted. If there is no response, another letter is sent 45 days later. Once the coverage has expired, a notice of expiry is sent to the policyholder.

*Examination Procedures Performed:* RNA interviewed individuals responsible for premium billing, lapses, reinstatements, and expirations and examined evidence of related processes and controls. Further, RNA tested eight lapses, five reinstatements, and ten expirations to determine whether the transactions were processed accurately and timely.

*Examination Conclusions*: Based on testing, the Company's handling of lapses, reinstatements, and expirations meet contractual and Massachusetts statutory and regulatory requirements.

**Returned Mail, Unclaimed Checks, and Escheatment Practices:**

*Summary of Company Policies and Procedures*:

- All returned mail is scanned, imaged, and processed in a workflow system and staff try to identify the reason for the returned mail and if applicable, research a better address for the policyholder. Then, the Company sends the mail to the insured for a second time, either using the newly identified address or the previously used address. Although uncommon, where no better address for the insured is available, and the mail service returns the mail after a second mailing, the Company documents the insured as a lost policyholder.
- The administrator's accounting department tracks premium refund and claim checks not cashed for potential escheatment after three years. Three years after all efforts to reach the payee are exhausted, the funds are deemed abandoned property.
- The Company annually reports escheatable funds to the Massachusetts State Treasurer by November 1 as required by statute.

*Examination Procedures Performed:* RNA interviewed individuals responsible for returned mail, unclaimed checks, and escheatment and reviewed supporting information, including the 2020 escheatment filing with the Massachusetts State Treasurer.

*Examination Conclusions*: Based on review, the Company's handling of returned mail, unclaimed checks, and escheatment meets Massachusetts statutory and regulatory requirements.

## IV. CLAIMS

### Claims Handling Practices:

*Summary of Company Policies and Procedures*:

- The Company's IDI claims are processed through its administrator. Claims are organized in two areas, new or actively-managed claims and established claims. The established claims have total and permanent disabilities that require less on-going review or follow-up. A supervisory structure is in place to ensure staff follows proper claims handling, approval authorities and Company procedures.
- An internally-developed electronic claim handling and workflow system is used for history notes, diary reminders, and document management. When an insured submits a claim, it is assigned to a claim consultant considering caseload, diagnosis, and claim complexity. Generally, within a few days after receiving an assignment, staff call the claimant to gather basic information about the claim circumstances, and to discuss the claims process and policy coverage. In addition to gathering basic information, following the call, staff will send a written letter to the claimant confirming the call and outlining additional information, if needed, to process the claim. The claim documents include a HIPAA authorization form, allowing communication with the claimant's attending physician, for example.
- As claim information is received, the claim is evaluated based on the individual facts of the claim and policy coverage. Financial, medical, and occupational resources are available to consult on claim evaluations. In addition, if deemed necessary, outside consulting vendors are used. Attending physician statements and medical records are requested, and the claim investigation is tailored to obtain outstanding requirements. On-site investigations or independent medical examinations are performed as necessary, and follow-up letters are sent to the claimant at least every 30 days, if required, while the claim is pending a benefit eligibility decision.
- Claims are typically evaluated based on “Total Disability” using that definition in the policy, which can vary based upon the policy series and coverages selected. Those coverages often consider the insureds' inability to perform work duties in their "own occupation". An example of an optional rider is “Residual Disability” which pays a proportionate, or residual, benefit based, in part, on prior and post disability earned income.
- Claims consultants have authority limits, and a supervisor reviews any claim exceeding those limits. If a waiver of premium benefit is determined to be due on the policy, the claims consultant processes the waiver of premium benefit claim, which typically involves premium refunds due to the insured.
- The policies typically require periodic proof of loss documentation about the claimant's continued disability and ongoing benefit eligibility. The frequency of reporting may be tailored based on the facts of the claim.
- Time and service standards are used to monitor compliance with Company contractual goals, including the time to make initial claims decisions, make calls to claimants, periodic written communication, and other key metrics as documented in the SLA objectives.

*Examination Procedures Performed:* RNA interviewed Company personnel responsible for the claims handling. RNA selected IDI claims, including nine-newly reported or paid claims, one denied claim, three closed claims, two claims pending a benefit determination, and 17 claims either in active payment status, or where the waiver of premium benefit has been approved. In addition, RNA verified that claims were properly investigated, adjudicated, and paid, or denied following contract provisions and statutory requirements.

*Examination Conclusions*: Based upon review and testing, the Company's claims handling practices appear to meet contractual and Massachusetts statutory and regulatory requirements.

## SUMMARY

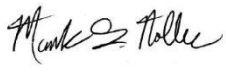
Based upon the procedures performed in this examination, RNA has reviewed and tested Company Operations/Management, Complaint Handling, Policyholder Service, and Claims as set forth in the *2020 NAIC Market Regulation Handbook,* the examination standards of the Division, and the Commonwealth of Massachusetts' insurance laws, regulations, and bulletins.

## ACKNOWLEDGEMENT

This acknowledgment is to certify that the undersigned is duly qualified and, in conjunction with RNA, applied certain agreed-upon procedures to the Company's corporate records for the Division to perform a comprehensive market conduct examination of the Company.

The undersigned's participation in this comprehensive market conduct examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC and the Handbook. In addition, this participation consisted of involvement in the planning (development, supervision, and review of agreed-upon procedures), communication, and status reporting throughout the examination, administration, and preparation of the examination report.

The Division acknowledges the cooperation and assistance extended to all examiners by the officers and employees of the Company during the comprehensive market conduct examination.



Mark G. Noller, CIE
Rudmose & Noller Advisors, LLC
Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts